ARHOME WAIVER

EXHIBIT C

DHS

The Centers for Medicare and Medicaid Services (CMS) has determined that Arkansas' ARHOME waiver will not comply with the new budget neutrality rules taking effect next year because of the 2025 federal budget law.

The ARHOME waiver will not be renewed in its current form, but **this does not mean that Medicaid expansion is ending or that we will lose enhanced funding**. Coverage will continue for eligible ARHOME enrollees beyond Jan. 1.

KEY INFORMATION:

- We know that changes to the program are in store. These changes will not be immediate, and DHS has submitted a formal request to CMS for an extension to provide sufficient time for a transition.

- The changes will center on service delivery, not on eligibility. No action is needed by beneficiaries currently served by ARHOME, which as of July 1 numbered approximately 202,000 individuals.

- We look forward to robust discussions with a wide range of partners as we design and implement a new Medicaid delivery system for beneficiaries. While it's too early to know specifics of how this new approach will look, our commitment to connecting eligible Arkansans to effective health care will remain our guiding principle at the core of this work.

- We will continue with our existing implementation plan for the community engagement and work requirements, which included a soft launch on July 1 and will transition to a full launch with penalties in place for non-compliance starting Jan. 1, 2027. The requirement will apply to Arkansans aged 19 to 64 enrolled in ARHOME unless they are in an exempt category like pregnant and postpartum women, disabled veterans, caregivers, and those with special medical needs. Full details on the program are posted at ar.gov/engage.

- Separate from the changes to the waiver, Centene announced last month that it has decided to end its participation in ARHOME starting in 2027. DHS will work to transition individuals served by Centene plans to a different plan. DHS will provide additional information on next steps, including open enrollment instructions, in the near future.

- We will provide frequent updates about the future of our program as our efforts progress.

BUDGET NEUTRALITY

- The driver of this change is a shift in how CMS determines a waiver to be budget neutral, which means not expected to increase federal Medicaid expenditures compared to what would have been spent without the demonstration. This change to a more rigorous approach to budget neutrality was included in last year's federal budget bill.

- Previously, waivers were approved for budget neutrality based on anticipated costs with the waiver compared to a weighted calculation of baseline expenditures if the waiver were not in place. That baseline expenditure figure used historic trends rather than actual expected costs, and this provided more flexibility.

- Under the new budget neutrality approach, the Chief Actuary of CMS must certify that the cost of coverage under the waiver is less than or equal to the cost if the waiver were not in place. This is a more rigid standard, and the determination must be made before the waiver is approved or renewed.

- Additional details on budget neutrality changes are available on the CMS website.