EXHIBIT E

DEPARTMENT OF HUMAN SERVICES, DIVISION OF COUNTY OPERATIONS

SUBJECT: Continuity of Coverage (20 CAR pts. 500, 571)

DESCRIPTION:

Statement of Necessity
This rule addresses continuity of coverage in two situations. Each update requires revision of the Division of County Operations (DCO) Medical Services Policy (MSP) rule.

First, the Center for Medicaid and Children's Health Insurance Program (CHIP) Services issued an informational bulletin regarding federal eligibility requirements and available flexibilities to promote continuity of coverage of children and youth enrolled in Medicaid and CHIP. To comply with the requirements, DCO removes from the MSP the 90-day waiting period for children receiving ARKids B who have been disenrolled from group health plan coverage. The new requirement also necessitates an amendment to the Arkansas CHIP State Plan.

Second, clarification is needed regarding Child Support Enforcement Services and continuity of coverage of a child's healthcare benefits. DCO revises the MSP to clarify that benefits cannot be denied or terminated due to a refusal of a caretaker to cooperate with OCSE such that sanction will not occur or be enforced until after the 60-day postpartum period ends. Also, DCO clarifies good cause for refusal to cooperate in cases of rape or incest.

Summary of Changes

- Medical Services Policy:
  Section F-130: Added a Note to the Child Support Enforcement Services section that if the parent, guardian, or caretaker relative is currently pregnant, they may still be referred to OCSE but will not be sanctioned if they refuse or fail to comply. Sanction will not be applied until the month after the end of their 60-day postpartum period, or, if already sanctioned, it will be lifted until the month after the 60-day postpartum period ends. No sanction will be applied if cooperation occurs. Removed the descriptor "forcible" from cases of rape or incest.

  Section F-180: Removed ninety (90) day waiting period for ARKIDS B eligibility, including deletion or updating prior exceptions as needed for consistency, and added a note clarifying the federal definition of a group health plan.

- Arkansas Children's Health Insurance Program (CHIP) Eligibility State Plan: Amendment removing the 90-day waiting period.

PUBLIC COMMENT: No public hearing was held on this rule. The public comment period expired on February 9, 2026. The agency indicated that it received no public comments.

The proposed effective date is April 1, 2026.

FINANCIAL IMPACT: The agency indicated that this rule has a financial impact.

Per the agency, the total cost to implement this rule is $73,127 for the current fiscal year ($22,501 in general revenue and $50,626 in federal funds) and $12,507 for the next fiscal year ($3,848 in general revenue and $8,659 in federal funds). The total estimated cost by fiscal year to a state, county, or municipal government to implement this rule is $22,501 for the current fiscal year and $3,848 for the next fiscal year.

LEGAL AUTHORIZATION: The Department of Human Services has the responsibility to administer assigned forms of public assistance and is specifically authorized to maintain an indigent medical care program (Arkansas Medicaid). *See* Ark. Code Ann. §§ 20-76-201(1), 20-77-107(a)(1). The Department has the authority to make rules that are necessary or desirable to carry out its public assistance duties. Ark. Code Ann. § 20-76-201(12). The Department and its divisions also have the authority to promulgate rules as necessary to conform their programs to federal law and receive federal funding. Ark. Code Ann. § 25-10-129(b).

Office of Policy and Rules
P.O. Box 1437, Slot S295, Little Rock, AR 72203-1437
P: 501.320.6383 F: 501.404.4619

January 8, 2026

Mrs. Rebecca Miller-Rice
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
#1 Capitol, 5th Floor
Little Rock, AR 72201

Dear Mrs. Rebecca Miller-Rice:

Re: Continuity of Coverage

Please arrange for this rule to be reviewed by the ALC-Administrative Rules Subcommittee. If you have any questions or need additional information, please contact me at 501-320-6383 or by emailing Mac.E.Golden@dhs.arkansas.gov.

Sincerely,

Mac Golden

Mac Golden
Attorney III
Office of Policy and Rules

Attachments

QUESTIONNAIRE FOR FILING PROPOSED RULES WITH THE ARKANSAS LEGISLATIVE COUNCIL

DEPARTMENT Department of Human Services
BOARD/COMMISSION Division of County Operations
BOARD/COMMISSION DIRECTOR Mary Franklin
CONTACT PERSON Mac Golden
ADDRESS P. O. Box 1437, Slot S295 Little Rock, AR 72203-1437
PHONE NO. (501) 320-6383 **EMAIL** Mac.E.Golden@dhs.arkansas.gov
NAME OF PRESENTER(S) AT SUBCOMMITTEE MEETING
Mary Franlin
PRESENTER EMAIL(S) Mary.Franklin@dhs.arkansas.gov

INSTRUCTIONS

In order to file a proposed rule for legislative review and approval, please submit this Legislative Questionnaire and Financial Impact Statement, and attach (1) a summary of the rule, describing what the rule does, the rule changes being proposed, and the reason for those changes; (2) both a markup and clean copy of the rule; and (3) all documents required by the Questionnaire.

If the rule is being filed for permanent promulgation, please email these items to the attention of Rebecca Miller-Rice, miller-ricer@blr.arkansas.gov, for submission to the Administrative Rules Subcommittee.

If the rule is being filed for emergency promulgation, please email these items to the attention of Director Marty Garrity, garritym@blr.arkansas.gov, for submission to the Executive Subcommittee.

Please answer each question completely using layman terms.

****

1. What is the official title of this rule?
Continuity of Coverage

2. What is the subject of the proposed rule? 20 CAR Part 500, 571.

3. Is this rule being filed under the emergency provisions of the Arkansas Administrative Procedure Act? Yes ☐ No ☑

If yes, please attach the statement required by Ark. Code Ann. § 25-15-204(c)(1).

If yes, will this emergency rule be promulgated under the permanent provisions of the Arkansas Administrative Procedure Act? Yes ☐ No ☐

4. Is this rule being filed for permanent promulgation? Yes ☑ No ☐

If yes, was this rule previously reviewed and approved under the emergency provisions of the Arkansas Administrative Procedure Act? Yes ☐ No ☑

If yes, what was the effective date of the emergency rule? _____

On what date does the emergency rule expire?_____

5. Is this rule required to comply with a *federal* statute, rule, or regulation? Yes ☑ No ☐

If yes, please provide the federal statute, rule, and/or regulation citation.

42 CFR § 435.608; and Consolidated Appropriations Act, 2023 (CAA, 2023)

6. Is this rule required to comply with a *state* statute or rule? Yes ☐ No ☑

If yes, please provide the state statute and/or rule citation.

7. Are two (2) rules being repealed in accord with Executive Order 23-02? Yes ☐ No ☑

If yes, please list the rules being repealed.
If no, please explain.

Exception from the Governor

8. Is this a new rule? Yes ☐ No ☑

Does this repeal an existing rule? Yes ☐ No ☑
If yes, the proposed repeal should be designated by strikethrough. If it is being replaced with a new rule, please attach both the proposed rule to be repealed and the replacement rule.

Is this an amendment to an existing rule? Yes ☑ No ☐
If yes, all changes should be indicated by strikethrough and underline. In addition, please be sure to label the markup copy clearly as the markup.

9. What is the state law that grants the agency its rulemaking authority for the proposed rule, outside of the Arkansas Administrative Procedure Act? Please provide the specific Arkansas Code citation(s), including subsection(s).

Ark. Code §§ 20-76-201, 20-77-107, and 25-10-12

10. Is the proposed rule the result of any recent legislation by the Arkansas General Assembly?
Yes ☐ No ☑

If yes, please provide the year of the act(s) and act number(s).

11. What is the reason for this proposed rule? Why is it necessary?

The Center for Medicaid and Children's Health Insurance Program (CHIP) Services issued an informational bulletin regarding federal eligibility requirements and available flexibilities to promote continuity of coverage of children and youth enrolled in Medicaid and CHIP. To comply with the requirements, the Division of County Operations (DCO) removes from the Medical Services Policy the 90-day waiting period for children receiving ARKids B who have been disenrolled from group health plan coverage. The new requirement also necessitates an amendment to the Arkansas CHIP State Plan.

Also, clarification is needed regarding Child Support Enforcement Services and continuity of coverage of a child's healthcare benefits. DCO revises the MSP to clarify that benefits cannot be denied or terminated due to a refusal of a caretaker to cooperate with OCSE such that sanction will not occur or be enforced until after the 60-day postpartum period ends. Also, DCO clarifies good cause for refusal to cooperate in cases of rape or incest.

12. Please provide the web address by which the proposed rule can be accessed by the public as provided in Ark. Code Ann. § 25-19-108(b)(1).

ar.gov/dhs-proposed-rules

13. Will a public hearing be held on this proposed rule? Yes ☐ No ☑

If yes, please complete the following:

Date: _____

Time: _____

Place: _____

Please be sure to advise Bureau Staff if this information changes for any reason.

14. On what date does the public comment period expire for the permanent promulgation of the rule? Please provide the specific date. 02/09/2026

15. What is the proposed effective date for this rule? April 1, 2026

16. Please attach (1) a copy of the notice required under Ark. Code Ann. § 25-15-204(a)(1) and (2) proof of the publication of that notice.

17. Please attach proof of filing the rule with the Secretary of State, as required by Ark. Code Ann. § 25-15-204(e)(1)(A).

18. Please give the names of persons, groups, or organizations that you anticipate will comment on these rules. Please also provide their position (for or against), if known.

19. Is the rule expected to be controversial? Yes ☐ No ☑

If yes, please explain.

NOTICE OF RULE MAKING

The Department of Human Services (DHS) announces for a public comment period of thirty (30) calendar days a notice of rulemaking for the following proposed rule under one or more of the following chapters, subchapters, or sections of the Arkansas Code: §§20-76-201, 20-77-107, and 25-10-129. The proposed effective date of the rule is April 1, 2026.

The Director of the Division of County Operations (DCO) revises the Medical Services Policy Manual sections F-130, and F-180, and amends the Arkansas Children's Health Insurance Program (CHIP) State Plan to comply with federal requirements and to clarify Child Enforcement Services cooperation situations. DCO removes the 90-day waiting period for children receiving ARKids B who have been disenrolled from group health plan coverage and DCO clarifies that healthcare benefits cannot be denied or terminated due to a refusal of a caretaker to cooperate with the Office of Child Support Enforcement such that sanction will not occur or be enforced until after the 60-day postpartum period ends. The good cause for refusal to cooperate provisions was updated for cases of rape or incest. The proposed rule estimates a financial impact of $ 73,127.00 for State Fiscal Year (SFY) 2026 and $ 12,507.00 for SFY 2027.

The proposed rule is available for review at the Department of Human Services (DHS) Office of Policy and Rules, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download the proposed rule at ar.gov/dhs-proposed-rules.

Public comments can be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than February 9, 2026. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

If you need this material in a different format, such as large print, contact the Office of Policy and Rules at 501-320-6428.

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin. **4502292178**

Mary Franklin, Director
Division of County Operations

From: Legal Ads
To: Lisa Teague
Subject: Re: Full Run Ad (r.299)
Date: Thursday, January 8, 2026 10:26:15 AM
Attachments: image001.png

[EXTERNAL SENDER]

Scheduled for Sun 1/11, Mon 1/12, and Tues 1/13. Thanks.

Gregg Sterne, Legal Advertising
Arkansas Democrat-Gazette
legalads@arkansasonline.com

From: "Lisa Teague" <Lisa.Teague@dhs.arkansas.gov>
To: "legalads" <legalads@arkansasonline.com>
Cc: "Jack Tiner" <jack.tiner@dhs.arkansas.gov>, "Mac Golden" <Mac.E.Golden@dhs.arkansas.gov>, "Lakeya Gipson" <Lakeya.Gipson@dhs.arkansas.gov>, "Elaine Stafford" <elaine.stafford@dhs.arkansas.gov>
Sent: Wednesday, January 7, 2026 1:20:03 PM
Subject: Full Run Ad (r.299)

Good afternoon,

Please run the attached Notice of Public Hearing in the *Arkansas Democrat-Gazette* on the following days:

- Sunday, January 11, 2026
- Monday, January 12, 2026
- Tuesday, January 13, 2026

I am aware that the print version will only be provided to all counties on Sundays.

Invoice to: **AR Dept of Human Services**
P.O. Box 1437
Slot S535
Little Rock, AR 72203
ATTN: Lakeya Gipson
(Lakeya.Gipson@dhs.arkansas.gov)

Or email invoices to: dms.invoices@arkansas.gov

NOTE: Please reply to this email using “REPLY ALL”

Lisa Teague
Rules & Regulations Coordinator
Arkansas Department of Human Services
Office of Policy and Rules

P: 501.396.6428
lisa.teague@dhs.arkansas.gov

humanservices.arkansas.gov

From:	Lisa Teague
To:	Arkansas Register
Cc:	Mac Golden; Jack Tiner; Lakeya Gipson; Dara Hall
Subject:	DHS/DCO-Proposed Filing-Continuity of Coverage (r.299)
Date:	Thursday, January 8, 2026 11:19:00 AM
Attachments:	SOS Initial_Continuity of Coverage r. 299.pdf

Good morning,

Attached is the proposed filing for Continuity of Coverage. The public notice will run in the Arkansas Democrat-Gazette January 11,12, and 13, 2026. The public comment period ends February 9, 2026. Please post.

Thank you,

Lisa Teague
Rules & Regulations Coordinator
Arkansas Department of Human Services
Office of Policy and Rules

P: 501.396.6428
lisa.teague@dhs.arkansas.gov

humanservices.arkansas.gov

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY.

DEPARTMENT Department of Human Services
BOARD/COMMISSION Division of County Operations
PERSON COMPLETING THIS STATEMENT Jason Callan
TELEPHONE NO. (501) 320-6540 **EMAIL** Jason.Callan@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the Financial Impact Statement and email it with the questionnaire, summary, markup and clean copy of the rule, and other documents. Please attach additional pages, if necessary.

TITLE OF THIS RULE Continuity of Coverage

1. Does this proposed, amended, or repealed rule have a financial impact?
   Yes ☑ No ☐

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule?
   Yes ☑ No ☐

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☑ No ☐

   If no, please explain:

   (a) how the additional benefits of the more costly rule justify its additional cost;

   (b) the reason for adoption of the more costly rule;

   (c) whether the reason for adoption of the more costly rule is based on the interests of public health, safety, or welfare, and if so, how; and

   (d) whether the reason for adoption of the more costly rule is within the scope of the agency's statutory authority, and if so, how.

4. If the purpose of this rule is to implement a *federal* rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue		General Revenue	
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total		Total	

(b) What is the additional cost of the state rule?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	$22,501	General Revenue	$3,848
Federal Funds	$50,626	Federal Funds	$8,658
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	$ 73,127.00	Total	$ 12,507.00

5. What is the total estimated cost by fiscal year to any private individual, private entity, or private business subject to the proposed, amended, or repealed rule? Please identify those subject to the rule, and explain how they are affected.

Current Fiscal Year	**Next Fiscal Year**
$	$

6. What is the total estimated cost by fiscal year to a state, county, or municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year	**Next Fiscal Year**
$ 22,501.00	$ 3,848.00

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☐ No ☑

If yes, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

(3) a description of the factual evidence that:
(a) justifies the agency's need for the proposed rule; and
(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

Statement of Necessity and Rule Summary
Continuity of Coverage

Statement of Necessity

This rule addresses continuity of coverage in two situations. Each update requires revision of the Division of County Operations (DCO) Medical Services Policy (MSP) rule.

First, the Center for Medicaid and Children's Health Insurance Program (CHIP) Services issued an informational bulletin regarding federal eligibility requirements and available flexibilities to promote continuity of coverage of children and youth enrolled in Medicaid and CHIP. To comply with the requirements, DCO removes from the MSP the 90-day waiting period for children receiving ARKids B who have been disenrolled from group health plan coverage. The new requirement also necessitates an amendment to the Arkansas CHIP State Plan.

Second, clarification is needed regarding Child Support Enforcement Services and continuity of coverage of a child's healthcare benefits. DCO revises the MSP to clarify that benefits cannot be denied or terminated due to a refusal of a caretaker to cooperate with OCSE such that sanction will not occur or be enforced until after the 60-day postpartum period ends. Also, DCO clarifies good cause for refusal to cooperate in cases of rape or incest.

Summary of Changes

- Medical Services Policy

  Section F-130: Added a Note to the Child Support Enforcement Services section that if the parent, guardian, or caretaker relative is currently pregnant, they may still be referred to OCSE but will not be sanctioned if they refuse or fail to comply. Sanction will not be applied until the month after the end of their 60-day postpartum period, or, if already sanctioned, it will be lifted until the month after the 60-day postpartum period ends. No sanction will be applied if cooperation occurs. Removed the descriptor "forcible" from cases of rape or incest.

  Section F-180: Removed ninety (90) day waiting period for ARKIDS B eligibility, including deletion or updating prior exceptions as needed for consistency, and added a note clarifying the federal definition of a group health plan.

- Arkansas Children's Health Insurance Program (CHIP) Eligibility State Plan: Amendment removing the 90-day waiting period.

F-130 Child Support Enforcement Services

MS Manual April 1, 2026~~03/27/2023~~

The Office of Child Support Enforcement (OCSE) is mandated to provide services to all Health Care recipients who have assigned their rights to medical support to the State. Each applicant or recipient who is responsible for the care of a dependent child must cooperate with OCSE in establishing legal paternity and obtaining medical support for each child who has a parent absent from the home. (See exception below.)

OCSE must provide all appropriate services to Health Care applicants and recipients without the OCSE application or fee. The OCSE agency is required to petition for medical support when health insurance is available to the absent parent at a reasonable cost. OCSE will also collect child support payments from the absent parent unless OCSE is notified by the recipient in writing that this service is not needed. Child support payments collected on behalf of Health Care recipients are received and distributed to the custodial parent through the OCSE Clearinghouse. However, no recovery cost will be collected.

1. Referrals

   When a child's parent, guardian, or caretaker relative voluntarily requests a referral to be made, or is receiving Health Care, an OCSE referral will be made at initial approval. Refer to Exception and Note below.

   Act 1091 of 1995, amended by Act 1296 of 1997, requires that both parents sign an affidavit acknowledging paternity, or obtain a court order, before the father's name will be added to the birth certificate.

   NOTE: If the father's name is included on the birth certificate of a child born April 10, 1995, or later, paternity has already been established. As paternity establishment is the only service the Office of Child Support Enforcement can offer to a family when both parents are in the home, there is no need to make a referral in these instances.

   NOTE: For child-only cases, cooperation with OCSE is voluntary. The only time that a referral to OCSE is necessary is when a parent, guardian, or caretaker relative is eligible in another Health Care eligibility group in which cooperation with OCSE is mandatory. Cooperation with OCSE will be strictly voluntary when a:

   - Parent, guardian, or caretaker relative is not receiving Health Care, but the children are receiving Health Care;
   - Parent, guardian, or caretaker relative is the only one receiving Health Care and the children are not receiving Health Care; or
   - Parent, guardian, or caretaker relative is receiving Health Care in an exempt category.

   A parent is considered to be absent for Health Care purposes when the absence is due to

divorce, separation, incarceration, institutionalization, participation in a Rehabilitation Service Program away from home, or military service. These considerations are regardless of support, maintenance, physical care, guidance, or frequency of contact.

2. Good Cause

An applicant or recipient may have good cause not to cooperate in the state's efforts to collect child or Medical support. The applicant or recipient may be excused from cooperating if they believe that cooperation would not be in the best interest of the child, and if the applicant or recipient can provide evidence to support this claim.

The following are circumstances under which DCO may determine that the applicant or recipient has good cause for refusing to cooperate:

- Cooperation is anticipated to result in serious physical or emotional harm to the child.
- Cooperation is anticipated to result in physical or emotional harm to the individual that is so serious it reduces the ability to care for the child adequately.
- The child was born as a result of ~~forcible~~ rape or incest.
- Court proceedings are in progress for the adoption of the child.
- The individual is working with an agency helping to decide whether or not to place the child for adoption.

3. Refusal to Cooperate-Sanction

A child's Health Care benefits cannot be denied or terminated due to the refusal of a parent or another legally responsible person to assign rights or cooperate with OCSE in establishing paternity or obtaining medical support. Health Care for the parent or caretaker relative will end after the appropriate notice has expired.

If a parent or another legally responsible person states that they refuse to cooperate with the OCSE referral process during any case action (such as during the initial application or case change), the sanction can be applied by the DHS Eligibility Worker.

Note: If the parent, guardian, or caretaker relative is currently pregnant, they may still be referred to OCSE but will not be sanctioned if they refuse or fail to comply. Sanction will not be applied to the pregnant member's coverage until the month after the end of their 60-day post-partum period. If the parent, guardian, or caretaker relative has already been sanctioned then reports a pregnancy, sanction will be lifted until the month after the 60-day post-partum period ~~–~~ends. . If cooperation occurs, no sanction will be applied.

F-130 Child Support Enforcement Services

MS Manual 04/01/26

The Office of Child Support Enforcement (OCSE) is mandated to provide services to all Health Care recipients who have assigned their rights to medical support to the State. Each applicant or recipient who is responsible for the care of a dependent child must cooperate with OCSE in establishing legal paternity and obtaining medical support for each child who has a parent absent from the home. (See exception below.)

OCSE must provide all appropriate services to Health Care applicants and recipients without the OCSE application or fee. The OCSE agency is required to petition for medical support when health insurance is available to the absent parent at a reasonable cost. OCSE will also collect child support payments from the absent parent unless OCSE is notified by the recipient in writing that this service is not needed. Child support payments collected on behalf of Health Care recipients are received and distributed to the custodial parent through the OCSE Clearinghouse. However, no recovery cost will be collected.

1. Referrals

   When a child's parent, guardian, or caretaker relative voluntarily requests a referral to be made, or is receiving Health Care, an OCSE referral will be made at initial approval. Refer to Exception and Note below.

   Act 1091 of 1995, amended by Act 1296 of 1997, requires that both parents sign an affidavit acknowledging paternity, or obtain a court order, before the father's name will be added to the birth certificate.

   NOTE: If the father's name is included on the birth certificate of a child born April 10, 1995, or later, paternity has already been established. As paternity establishment is the only service the Office of Child Support Enforcement can offer to a family when both parents are in the home, there is no need to make a referral in these instances.

   NOTE: For child-only cases, cooperation with OCSE is voluntary. The only time that a referral to OCSE is necessary is when a parent, guardian, or caretaker relative is eligible in another Health Care eligibility group in which cooperation with OCSE is mandatory. Cooperation with OCSE will be strictly voluntary when a:

   - Parent, guardian, or caretaker relative is not receiving Health Care, but the children are receiving Health Care;
   - Parent, guardian, or caretaker relative is the only one receiving Health Care and the children are not receiving Health Care; or
   - Parent, guardian, or caretaker relative is receiving Health Care in an exempt category.

   A parent is considered to be absent for Health Care purposes when the absence is due to

divorce, separation, incarceration, institutionalization, participation in a Rehabilitation Service Program away from home, or military service. These considerations are regardless of support, maintenance, physical care, guidance, or frequency of contact.

2. Good Cause

An applicant or recipient may have good cause not to cooperate in the state's efforts to collect child or Medical support. The applicant or recipient may be excused from cooperating if they believe that cooperation would not be in the best interest of the child, and if the applicant or recipient can provide evidence to support this claim.

The following are circumstances under which DCO may determine that the applicant or recipient has good cause for refusing to cooperate:

- Cooperation is anticipated to result in serious physical or emotional harm to the child.
- Cooperation is anticipated to result in physical or emotional harm to the individual that is so serious it reduces the ability to care for the child adequately.
- The child was born as a result of rape or incest.
- Court proceedings are in progress for the adoption of the child.
- The individual is working with an agency helping to decide whether or not to place the child for adoption.

3. Refusal to Cooperate-Sanction

A child's Health Care benefits cannot be denied or terminated due to the refusal of a parent or another legally responsible person to assign rights or cooperate with OCSE in establishing paternity or obtaining medical support. Health Care for the parent or caretaker relative will end after the appropriate notice has expired.

If a parent or another legally responsible person states that they refuse to cooperate with the OCSE referral process during any case action (such as during the initial application or case change), the sanction can be applied by the DHS Eligibility Worker.

Note: If the parent, guardian, or caretaker relative is currently pregnant, they may still be referred to OCSE but will not be sanctioned if they refuse or fail to comply. Sanction will not be applied to the pregnant member's coverage until the month after the end of their 60-day post-partum period. If the parent, guardian, or caretaker relative has already been sanctioned then reports a pregnancy, sanction will be lifted until the month after the 60-day post-partum period ends. If cooperation occurs, no sanction will be applied.

F-180 Other Health Insurance Coverage

MS Manual 04/01/26~~01/01/22~~

For most eligibility groups, an individual may be covered by other health insurance without affecting their eligibility for Health Care. There are two (2) exceptions to this which are described below.

Adult Expansion Group

An individual who is eligible for or enrolled in Medicare is not eligible for the Adult Expansion Group.

ARKids B

Children who are enrolled in ~~have~~ a group health plan ~~insurance or who have been covered by health insurance other than Health Care in the ninety (90) days preceding the date of application~~ will not be eligible for ARKids B unless one (1) of the following conditions ~~are~~is is met:

NOTE: 45 CFR 146.145 defines a group health plan to be an employee welfare benefit plan to the extent that the plan provides medical care to employees (current and former) or their dependents directly through insurance, reimbursement, or otherwise. These plans are considered comprehensive health plans compliant with the Affordable Care Act (ACA)- and would not include supplemental health policies.

~~a. The premium paid by the family for coverage of the child under the group health plan exceeded five percent (5%) of household income.~~

~~**NOTE:** A group health plan means an employee welfare benefit plan that provides medical care to employees or their dependents directly or through insurance, reimbursement, or otherwise.~~

~~The child's parent is determined eligible for advance payment of the premium tax credit for enrollment in a QHP through the Exchange because the Employer Sponsored Insurance in which the family was enrolled is determined unaffordable in accordance with 26 CFR 1.36B-2(c)(3)(v).~~

~~b. The cost of family coverage that includes the child exceeds nine and five tenths percent (9.5%) of the household income.~~

~~c. The employer stopped offering coverage of dependents (or any coverage) under an employer-sponsored health insurance plan.~~

~~d. A change in employment, including involuntary separation, resulted in the child's loss of employer-sponsored insurance (other than through full payment of the premium by the parent under COBRA).~~

~~e.~~a. The child has special health care needs. Special health care needs are defined as the health care and related needs of children who have chronic physical, developmental, behavioral, or emotional conditions. Such needs are of a type or amount beyond that required by children generally.

~~f.~~b. ~~The child lost coverage due to the death or divorce of a parent.~~ Health insurance coverage is available to a child through a person other than the child's custodial adult and is determined to be inaccessible (for example, the absent parent lives ~~out~~ out-~~of~~ of-state and covers the child on their HMO, which the child cannot access due to distance). This determination will be made on a case-by-case basis by the eligibility worker based on information provided by the applicant.

~~If a parent or guardian voluntarily terminates insurance within the ninety (90) days preceding application for a reason other than those listed above, the children will **not** be eligible for ARKids B.~~

The applicant's declaration regarding the child's health insurance coverage will be accepted.

This is a special requirement for ARKids B only and does not apply to ARKids A or other Health Care categories.

F-180 Other Health Insurance Coverage

MS Manual 04/01/26

For most eligibility groups, an individual may be covered by other health insurance without affecting their eligibility for Health Care. There are two (2) exceptions to this which are described below.

Adult Expansion Group

An individual who is eligible for or enrolled in Medicare is not eligible for the Adult Expansion Group.

ARKids B

Children who are enrolled in a group health plan will not be eligible for ARKids B unless one (1) of the following conditions is met:

NOTE: 45 CFR 146.145 defines a group health plan to be an employee welfare benefit plan to the extent that the plan provides medical care to employees (current and former) or their dependents directly through insurance, reimbursement, or otherwise. These plans are considered comprehensive health plans compliant with the Affordable Care Act (ACA) and would not include supplemental health policies.

a. The child has special health care needs. Special health care needs are defined as the health care and related needs of children who have chronic physical, developmental, behavioral, or emotional conditions. Such needs are of a type or amount beyond that required by children generally.
b. Health insurance coverage is available to a child through a person other than the child's custodial adult and is determined to be inaccessible (for example, the absent parent lives out- of-state and covers the child on their HMO, which the child cannot access due to distance). This determination will be made on a case-by-case basis by the eligibility worker based on information provided by the applicant.

The applicant's declaration regarding the child's health insurance coverage will be accepted.

This is a special requirement for ARKids B only and does not apply to ARKids A or other Health Care categories.

CHIP Eligibility

State Name: Arkansas

OMB Control Number: 0938-1148

Transmittal Number: AR - 14 - 0016

Expiration date: 10/31/2014

Separate Child Health Insurance Program
Non-Financial Eligibility - Substitution of Coverage **CS20**

Section 2102(b)(3)(C) of the SSA and 42 CFR 457.340(d)(3), 457.350(i), and 457.805

Substitution of Coverage

☑ The CHIP Agency provides assurance that it has methods and policies in place to prevent the substitution of group health coverage or other commercial health insurance with public funded coverage. These policies include:

■ Substitution of coverage prevention strategy:

	Name of policy	Description	
+	~~ARKids-B Eligibility Criteria~~ Monitoring Health Insurance Status & Maximum Threshold	~~If a parent or guardian voluntarily terminates within 90 days preceding application for a reason other than those allowed conditions or exemptions specifically stated in eligibility criteria policy, the child will be ineligible.~~ See new language on last page	X

~~A waiting period duri which a indiv dual is eligible du to ha ing dropp d grou he erage.~~ ~~Yes NO~~

~~How long is the wait ng per od?~~

- ○ ~~One month~~
- ○ ~~Two months~~
- ◉ ~~90 days~~
- ○ ~~Other~~

■ ~~The state allows exemptions from the waiting period for the following reasons:~~

- ■ ~~The premium paid by the family for coverage of the child under the group health plan exceeded 5 percent of household income.~~
- ■ ~~The child's parent is determined eligible for advance payment of the premium tax credit for enrollment in a QHP through the Marketplace because the ESI in which the family was enrolled is determined unaffordable in accordance with 26 CFR 1.36B-2(c)(3)(v).~~
- ■ ~~The cost of family coverage that includes the child exceeded 9.5 percent of the household income.~~
- ■ ~~The employer stopped offering coverage of dependents (or any coverage) under an employer-sponsored health insurance plan.~~
- ■ ~~A change in employment, including involuntary separation, resulted in the child's loss of employer-sponsored insurance (other than through full payment of the premium by the parent under COBRA).~~
- ■ ~~The child has special health care needs.~~
- ■ ~~The child lost coverage due to the death or divorce of a parent.~~

~~Does the state allow other exemptions in addition to those listed above?~~ ~~Yes~~

CHIP Eligibility

	Describe	
+	Health insurance coverage is available to a child through a person other than the child's custodial adult and is determined to be inaccessible (e.g., the absent parent lives out-of-state and covers the child on his or her HMO which the child cannot access due to distance.	X

☐ Describe the processes the state employs to facilitate enrollment of CHIP-eligible children who have satisfied the waiting period.

CHIP-eligible children who have satisfied the 90-day waiting period are enrolled using the application and the submission of information already provided by the family immediately preceding the waiting period

☐ Describe the processes the state employs to coordinate coverage of children subject to a waiting period with other insurance affordability programs, including safeguards to prevent gaps in coverage for children transitioning from another insurance affordability program to CHIP after satisfying the waiting period.

CHIP-eligible children who have satisfied the 90-day waiting period are enrolled using the application and the submission of information already provided by the family immediately preceding the waiting period, and State coordinates with the insurance program the child is transitioning from to ensure there are no gaps in coverage.

The state provide[s] assuran[ces] that:

☑ It does n[ot] requi[re] new app[lic]atio[n] or th[e] sub[mi]ssion of inform[a]tion al[rea]dy provi[de]d by the family immediately preceding th[e] w[ai]ti[ng] p[e]riod f[o]r th[e] purpo[se] of enro[lli]ng CHIP-eligible child[re]n who have satisfied a waiting period.

☑ For children subject to the waiting period, it will promptly transfer each individual's electronic account to the applicable insurance affordability program and notify such program of the date on which the waiting period ends for each individual.

☑ If the state covers pregnant women, the waiting period does not apply to pregnant women.

If the state elects to offer dental only supplemental coverage, the following assurances apply:

☑ The other coverage exclusion does not apply to children who are otherwise eligible for dental only supplemental coverage as provided in section 2110(b)(5) of the SSA.

☑ The waiting period does not apply to children eligible for dental only supplemental coverage.

PRA Disclosure Statement

NEW LANGUAGE:

To prevent crowd out of private insurance, third party liability questions are on the Assistance Application, Renewal form, as well as the Verification of Earnings completed by the employer. The Third Party Liability (TPL) Unit conducts a cross match with group health insurance providers to determine current and recent health insurance status. This match will take place any time a new group health insurance plan is registered for an individual or changes are made to an existing group health insurance plan. The Department will compile a quarterly Substitution of Coverage report showing CHIP applications which were denied due to having other health insurance. If substitution exceeds twenty (20) percent, the department will collaborate with CMS to identify a strategy to reduce substitution.I nformation about changes in health insurance status is used to determine whether children remain eligible for CHIP at renewal and is measured against the 20% substitution threshold. Children are not disenrolled during the continuous eligibility period regardless of insurance status.

CHIP Eligibility

State Name: Arkansas

OMB Control Number: 0938-1148

Transmittal Number: AR - 25 - 0005

Separate Child Health Insurance Program
Non-Financial Eligibility - Substitution of Coverage **CS20**

Section 2102(b)(3)(C) of the SSA and 42 CFR 457.340(d)(3), 457.350(i), and 457.805

Substitution of Coverage

☑ The CHIP Agency provides assurance that it has methods and policies in place to prevent the substitution of group health coverage or other commercial health insurance with public funded coverage. These policies include:

■ Substitution of coverage prevention strategy:

Add	Name of policy	Description	Remove
Add	Monitoring Health Insurance Status & Maximum Threshold	To prevent crowd out of private insurance,third party liability questions are on the Assistance Application, Renewal form, as well as the Verification of Earnings completed by the employer. The Third Party Liability (TPL) Unit conducts a cross match with group health insurance providers to determine current and recent health insurance status. This match will take place any time a new group health insurance plan is registered for an individual or changes are made to an existing group health insurance plan. The Department will compile a quarterly Substitution of Coverage report showing CHIP applications which were denied due to having other health insurance. If substitution exceeds twenty (20) percent, the department will collaborate with CMS to identify a strategy to reduce substitution. Information about changes in health insurance status is used to determine whether children remain eligible for CHIP at renewal and is measured against the 20% substitution threshold. Children are not disenrolled during the continuous eligibility period regardless of insurance status.	Remove

A waiting period during which an individual is ineligible due to having dropped group health coverage. No

If the state elects to offer dental only supplemental coverage, the following assurances apply:

☑ The other coverage exclusion does not apply to children who are otherwise eligible for dental only supplemental coverage as provided in section 2110(b)(5) of the SSA.

☐ The waiting period does not apply to children eligible for dental only supplemental coverage.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20181119

The application form and the promotional materials for ARKids-A and ARKids-B identify the two programs as ARKids First. Applications may be made at the local DHS County Office, by mail, or through the internet, and a toll free number is available to clients. Applications in English or Spanish may be printed from the ARKids First website at www.arkidsfirst.com. Applications in other languages are available upon request.

A **ARKids-B Title XXI CHIP Separate Child Health Program**

In November 2013, CMS recommended the State transition the ARKids-B 1115(a) demonstration waiver Title XXI CHIP Medicaid expansion program to a Title XXI CHIP separate child health program through the CHIP state plan and advised that if this was done, orthodontia services would have to be added to the ARKids-B program's benefit package of services. As the current ARKids-B 1115(a) demonstration waiver's renewal was due to end December 31, 2013, the State requested and CMS approved an extension of the ARKids-B demonstration waiver to allow the State time to prepare, submit, and have approved an amendment to the CHIP state plan.

Effective 1/1/14 ARKids-B beneficiaries ages 6 through 18 in families with incomes from 100% FPL up to 142% FPL were moved to Title XIX Medicaid ARKids-A (MAGI CHIP SPA Group 2/CS2 PDF page) but continue to be funded through title XXI CHIP.

Children ages 0 through age 18 in families with a household income above 142% FPL up to and including 211% FPL are eligible for ARKids-B. There is no asset test. The State maintains qualifying criteria for ARKids-B that includes income criteria based on modified adjusted gross income methodologies as defined at 42 CFR §435.603. ~~As allowed under 42 CFR §457.805, all ARKids-B enrollees must not have had employer-sponsored or group health insurance within 90 days prior to program enrollment. The State maintains, at minimum, the required exemptions to the period of uninsurance as specified at 42 CFR §457.805~~. There is no presumptive eligibility. Retroactive eligibility may be determined up to three months prior to the date of application. ARKids-B offers a less comprehensive benefit package than the State's traditional Title XIX Medicaid program (ARKids-A) and requires co-payments.

The State elected a copayment as the only cost sharing requirement, because it is the most equitable form of cost sharing. The State did not want to assess an enrollment fee nor monthly premiums because it wanted the family's cost sharing responsibility to be related solely to usage. Cost sharing is required for services that are not categorized as well-health. The State will keep the current copayment structure in place for ARKids-B enrollees.

		CS19 CS20 CS27	Social security number Substitution of coverage Continuous eligibility	Section 4.1.9.1 Section 4.4.4 Sections 4.1.8 & 4.1.9.2
AR-13-0022 Effective/Implementation Date: 1/1/14	MAGI Eligibility & Methods	CS9 CS15	Conception to Birth MAGI-based income methodology	Sections 4.1.1; 4.1.2 & 4.1.3 Incorporated within a separate subsection under Section 4.3
AR-17-0006 Effective/Implementation Date: 1/1/18	Non-Financial Eligibility	CS18	Citizenship	Supersedes previously approved CS18
AR-18-0003 Effective/Implementation Date: 1/1/18	Eligibility Processing	CS24	Change Arkansas to an Assessment State	Supersedes previously approved CS24
AR 25-0005 **Effective/Implementation Date: June 3, 2025**	Eligibility Processing	CS20	Removal of the 90-day waiting period for children receiving ARKids B who have been disenrolled from group health plan coverage	Supersedes previously approved CS20

SPA # 6, Purpose of SPA: Separate State CHIP (ARKids-B Program)

Effective Date: 8-1-15

Implementation Date: 8-1-15

SPA # 7. Purpose of SPA: Add Intensive Home & Community-Based Family & Child/Youth Support Health Services Initiative

SPA # 13, Purpose of SPA:
The state is assuring that it covers age-appropriate vaccines and their administration, without cost sharing.

Proposed effective date: October 1, 2023

Proposed implementation date: October 1, 2023

SPA # 14, Purpose of SPA:

The purpose of this SPA is to improve access to continuous glucose monitors (CGMs) through pharmacy claim submission processing for reimbursement to pharmacies and DME providers. Beneficiaries eligible for CGMs include those with Type 1 diabetes or any other type of diabetes with either insulin use or evidence of level 2 or level 3 hypoglycemia, or beneficiaries diagnosed with glycogen storage disease type 1a. Patch type insulin pumps, blood glucose monitors (BGMs) and testing supplies will be covered in the same manner. Coverage is being extended to comply with Arkansas Act 393 of 2023.

Proposed effective date: April 1, 2024

Proposed implementation date: April 1, 2024

SPA # 15 , Purpose of SPA:

The purpose of this SPA is to end the Healthy Smiles Managed Care waiver for dental services and transition the dental program to fee-for-services (FFS).

Proposed effective date: November 1, 2024

Proposed implementation date: November 1, 2024

SPA#16 (AR 25-0007), Purpose of SPA: *pending*

The purpose of this SPA is to add Targeted Case Management Services for Incarcerated Juveniles to the ARKids-B and Unborn Child Sections of the CHIP state plan and to attest to the state's compliance with sections 2102(d) and 2110(b)(7) of the Consolidated Appropriations Act.

Proposed effective date: January 1, 2025

Proposed implementation date: September 1, 2025

SPA#17 (AR 25-0006), Purpose of SPA:

The purpose of this SPA is to remove the 90-day waiting period for children receiving ARKids B who have been disenrolled from group health plan coverage.

Proposed effective date: June 3, 2025

Proposed implementation date: June 3, 2025

SPA#18 (AR 25-0005), Purpose of SPA:

The purpose of this SPA is to remove the 90-day waiting period for children receiving ARKids B who have been disenrolled from group health plan coverage.

Proposed effective date: June 3, 2025
Proposed implementation date: June 3, 2025

pregnant women (if applicable) and the income standard for that group:

4.1.2.1-PC ☐ Age:_____through birth (SHO #02-004, issued November 12, 2002)

See page CS9.

4.1. ☐ Income of each separate eligibility group (if applicable):

4.1.3.1-PC ☐ 0% of the FPL (and not eligible for Medicaid) through _____% of the FPL (SHO #02-004, issued November 12, 2002)

See page CS9.

4.1. ☐ Resources of each separate eligibility group (including any standards relating to spend downs and disposition of resources):

4.1. ☐ Residency (so long as residency requirement is not based on length of time in state):

4.1. ☐ Disability Status (so long as any standard relating to disability status does not restrict eligibility):

Not applicable.

4.1. ☒ Access to or coverage under other health coverage:

~~CHIP enrollees cannot be eligible for Title XIX Medicaid. CHIP enrollees cannot have access to a state health benefits program. Enrollees in the Title XXI CHIP Unborn Child separate child health program may not have health insurance that covers pregnancy related services.If a parent or guardian voluntarily terminates within 90 days preceding application for a child for the Title XXI CHIP ARKids B separate child program an insurance in which the child is covered for a reason other than those allowed conditions or exemptions specifically stated in eligibility criteria, the child will be ineligible for the ARKids B separate child health program.~~ See ~~also~~ page CS20 – Substitution of Coverage.

4.1. ☒ Duration of eligibility, not to exceed 12 months:

Continuous eligibility does not apply to the Unborn Child CHIP separate child program.

4.4. Eligibility screening and coordination with other health coverage programs

See page CS24 for eligibility processing.

States must describe how they will assure that:

4.4.1. ☒ only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance (including access to a State health benefits plan) are furnished child health assistance under the plan. (Sections 2102(b)(3)(A), 2110(b)(2)(B)) (42 CFR 457.310(b), 42 CFR 457.350(a)(1) and 42 CFR 457.80(c)(3))

Confirm that the State does not apply a waiting period for pregnant women applicants

See page CS20

~~At eligibility determination and redetermination, an applicant for/beneficiary of the Title XXI CHIP ARKids B separate child health program is reviewed to determine that the applicant/beneficiary is not Title XIX Medicaid eligibility and that the parent or guardian did not voluntarily terminate an insurance policy in which the child was covered within 90-days preceding application for the child for ARKids-B, for a reason other than those allowed conditions or exemptions specifically stated in eligibility criteria,. At eligibility determination and redetermination, an applicant for/beneficiary of the Title XXI CHIP Unborn Child separate child health program is reviewed to determine that the applicant/beneficiary is not Title XIX Medicaid eligible and is not under an insurance policy that covers pregnancy related services prior to enrollment in the State's Unborn Child program. The Unborn Child separate child health program does not assess a waiting period for applicants. See also page CS10 – Children Who Have Access to Public Employee Coverage.~~

The application form and the promotional materials for ARKids-A and ARKids-B identify the two programs as ARKids First. Applications may be made at the local DHS County Office, by mail, or through the internet, and a toll free number is available to clients. Applications in English or Spanish may be printed from the ARKids First website at www.arkidsfirst.com. Applications in other languages are available upon request.

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		CS19 CS20 CS27	Social security number Substitution of coverage Continuous eligibility	Section 4.1.9.1 Section 4.4.4 Sections 4.1.8 & 4.1.9.2
AR-13-0022 Effective/Implementation Date: 1/1/14	MAGI Eligibility & Methods	CS9 CS15	Conception to Birth MAGI-based income methodology	Sections 4.1.1; 4.1.2 & 4.1.3 Incorporated within a separate subsection under Section 4.3
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AR 25-0005 **Effective/Implementation Date: June 3, 2025**	Eligibility Processing	CS20	Removal of the 90-day waiting period for children receiving ARKids B who have been disenrolled from group health plan coverage	Supersedes previously approved CS20

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Effective Date: 8-1-15

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The state is assuring that it covers age-appropriate vaccines and their administration, without cost sharing.

Proposed effective date: October 1, 2023

Proposed implementation date: October 1, 2023

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The purpose of this SPA is to improve access to continuous glucose monitors (CGMs) through pharmacy claim submission processing for reimbursement to pharmacies and DME providers. Beneficiaries eligible for CGMs include those with Type 1 diabetes or any other type of diabetes with either insulin use or evidence of level 2 or level 3 hypoglycemia, or beneficiaries diagnosed with glycogen storage disease type 1a. Patch type insulin pumps, blood glucose monitors (BGMs) and testing supplies will be covered in the same manner. Coverage is being extended to comply with Arkansas Act 393 of 2023.

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The purpose of this SPA is to end the Healthy Smiles Managed Care waiver for dental services and transition the dental program to fee-for-services (FFS).

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Proposed implementation date: November 1, 2024

SPA#16 (AR 25-0007), Purpose of SPA: *pending*

The purpose of this SPA is to add Targeted Case Management Services for Incarcerated Juveniles to the ARKids-B and Unborn Child Sections of the CHIP state plan and to attest to the state's compliance with sections 2102(d) and 2110(b)(7) of the Consolidated Appropriations Act.

Proposed effective date: January 1, 2025

Proposed implementation date: September 1, 2025

SPA#17 (AR 25-0006), Purpose of SPA:

The purpose of this SPA is to remove the 90-day waiting period for children receiving ARKids B who have been disenrolled from group health plan coverage.

Proposed effective date: June 3, 2025

Proposed implementation date: June 3, 2025

SPA#18 (AR 25-0005), Purpose of SPA:

The purpose of this SPA is to remove the 90-day waiting period for children receiving ARKids B who have been disenrolled from group health plan coverage.

Proposed effective date: June 3, 2025
Proposed implementation date: June 3, 2025

pregnant women (if applicable) and the income standard for that group:

4.1.2.1-PC ☐ Age:_____through birth (SHO #02-004, issued November 12, 2002)

See page CS9.

4.1. ☐ Income of each separate eligibility group (if applicable):

4.1.3.1-PC ☐ 0% of the FPL (and not eligible for Medicaid) through _____% of the FPL (SHO #02-004, issued November 12, 2002)

See page CS9.

4.1. ☐ Resources of each separate eligibility group (including any standards relating to spend downs and disposition of resources):

4.1. ☐ Residency (so long as residency requirement is not based on length of time in state):

4.1. ☐ Disability Status (so long as any standard relating to disability status does not restrict eligibility):

Not applicable.

4.1. ☒ Access to or coverage under other health coverage:

See page CS20 – Substitution of Coverage.

4.1. ☒ Duration of eligibility, not to exceed 12 months:

Continuous eligibility does not apply to the Unborn Child CHIP separate child program.

4.4. Eligibility screening and coordination with other health coverage programs

See page CS24 for eligibility processing.

States must describe how they will assure that:

4.4.1. ☒ only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance (including access to a State health benefits plan) are furnished child health assistance under the plan. (Sections 2102(b)(3)(A), 2110(b)(2)(B)) (42 CFR 457.310(b), 42 CFR 457.350(a)(1) and 42 CFR 457.80(c)(3))

Confirm that the State does not apply a waiting period for pregnant women applicants

See page CS20

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMCS Informational Bulletin

DATE: December 18, 2023

FROM: Daniel Tsai, Deputy Administrator and Director, Center for Medicaid & CHIP Services

SUBJECT: Ensuring Eligible Children Maintain Medicaid and Children's Health Insurance Program Coverage

The purpose of this CMCS Informational Bulletin (CIB) is to remind states about federal eligibility requirements and available flexibilities to promote continuity of coverage of children and youth enrolled in Medicaid and the Children's Health Insurance Program (CHIP). As of March 2023, at the end of the Medicaid continuous enrollment condition, nearly 42 million children were enrolled in Medicaid and CHIP.[1] Together, the programs provide health coverage to over half of all children in the United States (U.S.), including millions of children and youth with special health care needs. Medicaid and CHIP cover essential services and supports for children, including visits to the pediatrician, regular screenings, mental health care, childhood immunizations, and emergency care. In addition to better short-term health and well-being, Medicaid and CHIP coverage has also been shown to provide long-term health, educational, and economic gains for children. For example, in a recent analysis, the Congressional Budget Office (CBO) found that an additional year of Medicaid coverage in childhood would lead to improved labor outcomes in adulthood, including higher earnings.[2]

It is crucial that states do all they can to protect children's health coverage. The Consolidated Appropriations Act, 2023 (CAA, 2023) ended the Medicaid continuous enrollment condition on March 31, 2023, requiring states to, over time, complete full Medicaid renewals and disenroll and refer individuals to other sources of coverage if they are determined to no longer be eligible. This process is often referred to as "unwinding." CMS is particularly concerned about children that are disenrolled for procedural or administrative reasons (e.g., missing renewal form information). Many of these children are likely still eligible for coverage otherwise.

Since the beginning of the unwinding period, enrollment in Medicaid and CHIP among children has declined by 2.2 million. While some children may have transitioned to other forms of health coverage, children have higher eligibility levels than adults, and it is likely that many children that have been disenrolled for procedural reasons or other administrative barriers are still income eligible for Medicaid and CHIP coverage. This may have devastating effects on children's health and well-being.

[1] CMS, "March 2023 Medicaid and CHIP Enrollment Data Highlights," July 2023, available at https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html.
[2] Congressional Budget Office, "Exploring the Effects of Medicaid During Childhood on the Economy and the Budget: Working Paper 2023-27," November 1, 2023, available at https://www.cbo.gov/publication/59231

States have the opportunity to adopt strategies that reduce red tape to help keep eligible children covered. The Centers for Medicare & Medicaid Services (CMS) is calling upon all states to redouble their efforts to implement policies and operational processes, conduct enhanced outreach, adopt all available waivers and flexibilities, and monitor data to ensure children who remain eligible for Medicaid and CHIP do not lose coverage.

monthly premiums, states may elect to permanently eliminate or temporarily suspend premiums during the unwinding period. In addition, CMS' proposed rule published in September 2022 proposed to eliminate premium lock-out periods.[45] Premium lock-out periods have permitted states to specify a period of time that an individual must wait after non-payment of premiums until being allowed to reenroll in CHIP. Applicable states are encouraged to either eliminate premium lock-out periods permanently or suspend this policy during the unwinding period. CMS encourages states that are constrained in their ability to eliminate such cost-sharing to instead establish affordable annual enrollment fees rather than collecting monthly premium payments. Affordable enrollment fees encourage continued enrollment throughout the year and eliminate the possibility of disenrollment for failure to pay monthly premiums. Where states maintain premiums, to help prevent missed or late premium payments, states could deploy targeted outreach and enhanced notice strategies.

Many states have a tiered premium structure based on a child's household income. Upon review of available data sources during an *ex parte* renewal, a state may find that a CHIP-enrolled child appears subject to either a higher or lower premium amount than their current premium band. Under these circumstances, states are strongly encouraged to adopt the following premium assignment principles:[46]

- *Lower Cost Premium Band*: If available data shows the child is eligible for a lower cost premium band, the state should move the child to the lower cost premium band and send a notice to the household informing them of the change and the basis for the determination. No additional action is needed by the beneficiary.
- *Higher Cost Premium Band*: If the available data shows the child may be subject to a higher cost premium band, the state should maintain the child in the same premium band and give the household an opportunity to refute the information that was obtained from data sources. If a beneficiary provides documentation/additional information in response to a request for information, the state should revise the premium band based on that documentation/information. If the beneficiary does not respond to the request for information, the state should not terminate coverage but rather assign the premium band based on the available data.

f. Modifying Policies for Substitution of Coverage in Separate CHIP

Unlike Medicaid, separate CHIP requires children to be uninsured to be eligible for coverage,[47] except if a state elects to provide premium assistance through its separate CHIP.[48] States with separate CHIPs are required to use reasonable methods to ensure that separate CHIP coverage is not substituting for group health plan coverage.[49] One method some states use to implement this requirement is applying a waiting period, which is a period of uninsurance (not to exceed 90

[45] CMS, "Proposed Rule: Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes, " September 7, 2022, available at: https://www.federalregister.gov/documents/2022/09/07/2022-18875/streamlining-the-medicaid-childrens-health-insurance-program-and-basic-health-program-application.

[46] CMS, "Supporting Seamless Coverage Transitions for Children Moving Between Medicaid and CHIP in Separate CHIP States," December 12, 2022, available at https://www.medicaid.gov/resources-for-states/downloads/supporting-medicaid-chip-transitions.pdf.

[47] Section 2101(a) of the Act and 42 C.F.R. §§ 457.1, 457.2 and 457.10.

[48] Section 2105(c)(10) of the Act.

[49] 42 C.F.R. § 457.805(a).

days) after an individual has disenrolled from group health plan coverage, Medicaid, or CHIP before they can enroll/re-enroll in CHIP.[50] CMS encourages states to eliminate such waiting periods to reduce potential barriers or delays for otherwise eligible children to enroll in CHIP. States may adopt alternative methods for addressing concerns about substitution of group health plan coverage, such as monitoring. Examples of common substitution monitoring strategies include adding questions to health coverage applications about enrollment in private coverage and conducting database checks to ensure CHIP beneficiaries do not have other coverage.

g. Delaying Procedural Disenrollments for Children to Enhance Outreach

One of the key strategies offered by CMS is the state option to delay procedural disenrollments for beneficiaries for one or more months while the state conducts targeted renewal outreach. This strategy allows beneficiaries who would otherwise lose coverage for procedural reasons, such as failure to return a renewal form, additional time to complete their renewal form or provide other necessary information and gives states additional time to conduct outreach. This strategy can be targeted to specific populations at risk of losing coverage, including children. This strategy is available for states to implement throughout the unwinding period, or on an ad hoc basis for cohorts of renewals based on certain defined criteria (e.g., if the percent of anticipated procedural disenrollments exceeds a specified threshold). States must use the additional time to conduct targeted outreach to encourage beneficiaries to return renewal forms.

States seeking to elect this strategy should request concurrence for an exception to timely determinations of eligibility per regulations at 42 C.F.R. § 435.912(e). States interested in implementing this strategy should send an email requesting concurrence to the CMS unwinding mailbox (CMSUnwindingSupport@cms.hhs.gov) and note the use of this strategy in their unwinding plans.

V. Outreach to Families and Strengthening Community Partnerships

Children may lose coverage if their parents or guardians believe they or their children no longer meet the eligibility requirements and do not respond to renewal forms and/or requests for information. Families may not realize their children may still be eligible for coverage through Medicaid or CHIP due to higher income thresholds for children. In addition, families with young children enrolled in Medicaid and CHIP may have never had to complete a renewal before (e.g., if their child was a "deemed newborn" and/or if their child was enrolled just before or while the continuous enrollment condition was in effect).

CMS encourages state Medicaid and CHIP agencies to collaborate with other state agencies and community partners to ensure families have up-to-date information about the redetermination process—including what is required to keep children in coverage.

State Medicaid and CHIP agencies can:

[50] 42 C.F.R. § 457.805(b)(2).

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Children and Adults Health Programs Group

December 16, 2025

Janet Mann
State Medicaid Director
Wisconsin Department of Health Services
State of Arkansas, Department of Human Services
112 West 8th Street, Slot S401
Little Rock, AR 72201

Dear Director Mann:

Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendments (SPAs), AR-25-0005 and AR-25-0006, submitted on June 30, 2025, with additional information submitted on December 16, 2025, have been approved. The effective date for these SPAs is June 3, 2025.

Section 2102(b)(3)(C) of the Social Security Act requires states to have a description in the state plan of procedures used to ensure that CHIP does not substitute for group health plan coverage. Through SPA AR-25-0005, Arkansas removes its waiting period policy, as required by CMS regulations at 42 CFR § 457.805(b), and updates its existing substitution monitoring strategies. Arkansas also adds a maximum percentage threshold to measure the level of substitution occurring in the state that, if exceeded, will prompt the state to work with CMS to identify additional strategies to prevent substitution. Through AR-25-0006, the state makes corresponding technical edits throughout the CHIP state plan to remove references to waiting periods.

Your Project Officer is Abbie Walsh. She is available to answer your questions concerning this amendment and other CHIP-related matters and can be reached at Abagail.Walsh@cms.hhs.gov.

If you have additional questions, please contact Mary Beth Hance, Acting Director, Division of State Coverage Programs, at (410) 786-1536. We look forward to continuing to work with you and your staff.

Sincerely,

Jessica Stephens
Acting Deputy Director