# ARKANSAS REGISTER

## Proposed Rule Cover Sheet

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Name of Department Department of Human Services

Agency or Division Name Division of County Operations

Other Subdivision or Department, If Applicable N/A

Previous Agency Name, If Applicable N/A

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Name of Rule Continuity of Coverage

Newspaper Name Arkansas Democrat Gazette

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Location and Time of Public Meeting N/A

## 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

## 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.

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 members 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.

# 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.

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<br><br>CS20<br><br>CS27 | Social security number<br><br>Substitution of coverage<br><br>Continuous eligibility | Section 4.1.9.1<br><br>Section 4.4.4<br><br>Sections 4.1.8 & 4.1.9.2 |
| **AR-13-0022**<br>Effective/Implementation Date: 1/1/14 | MAGI Eligibility & Methods | CS9<br><br>CS15 | Conception to Birth<br><br>MAGI-based income methodology | Sections 4.1.1; 4.1.2 & 4.1.3<br><br>Incorporated within a separate subsection under Section 4.3 |
| **AR-17-0006**<br>Effective/Implementation Date: 1/1/18 | Non-Financial Eligibility | CS18 | Citizenship | Supersedes previously approved CS18 |
| **AR-18-0003**<br>Effective/Implementation Date: 1/1/18 | Eligibility Processing | CS24 | Change Arkansas to an Assessment State | Supersedes previously approved CS24 |
| **AR 25-0005**<br>**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.

**4.1.7** ☒ 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.

**4.1.8** ☒ 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.~~

# 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.

# 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