

## Plan Management Frequently Asked Questions-Calendar Year 2023

Q1. Will individuals eligible for the Arkansas Health and Opportunity For Me (ARHOME) Program be able to enroll in any silver level Qualified Health Plan (QHP)?

A1. Per requirements specified in Arkansas Insurance Department (AID) guidance, all issuers must offer an Essential Health Benefits (EHB)-only silver plan in order to offer QHPs in the Marketplace. Issuers will then utilize this plan to operationalize specific cost-sharing bands meeting the guidelines published in Appendix C. The Statement of Benefits must be filed with AID meeting these guidelines, but will not be offered through the Exchange. The Arkansas Department of Human Services (DHS) does not plan to accept QHP-initiated enrollment limitations on ARHOME participation in a QHP unless enrollment is similarly limited for non-ARHOME purchasers of Marketplace plans.

For the 2023 coverage year, DHS intends to implement the following purchasing requirements for the Section 1115 Demonstration Project, ARHOME.

A. For calendar year 2023, DHS intends to purchase within a service area:

- (1) The lowest cost qualifying EHB-only silver-level plan offered in the service area;
- (2) The next lowest cost qualifying EHB-only silver-level plan offered in the service area that is offered by a different carrier than the lowest cost EHB-only silver-level plan (referenced in item #1 above); and
- (3) Any other carrier's lowest cost qualifying EHB-only silver-level plan, so long as such plan's cost falls within 10% of the lowest cost qualifying EHB-only silver-level plan available to ARHOME Program eligibles in the service area.

DHS intends to purchase plans that meet the criteria in 1, 2, or 3, above and for which a Memorandum of Understanding (MOU) between DHS and the issuer for calendar year 2023 has been signed by both parties and AID. For a plan to be purchased by DHS for beneficiary coverage beginning January 1, 2023, the CY 2023 MOU must be signed by the parties. If the CY2023 MOU with a health issuer is not signed by January 1, 2023, DHS will:

- a. Extend the CY 2022 MOU in one month increments with the budget neutrality limit of \$716.41; and
- b. Suspend auto-assignment of new members to that issuer until the first day of the second month after the new MOU is signed.

Plans that enter the market during calendar year 2023 and meet the criteria in 1, 2, or 3 above will be purchased to cover beneficiaries beginning on the first of the month that begins a minimum of thirty days (30) after the MOU has been completed.

The budget neutrality cap estimate for calendar year 2023 is \$758.85 per member per month averaged across each plan's member months.

DHS shall pay the lesser of the actual total per member per month cost or the final per member per month budget neutrality cap limit amount approved by the Centers for Medicare and Medicaid Services (CMS) for calendar year 2023. The total per member per month cost shall be determined using the following formula:

$$\text{(Gross Premium + ACSR + CSR Reconciliation + wrap cost) / member months}$$

The CSR reconciliation will be determined by comparing the advanced cost share reduction (ACSR) to the actual CSR shown in the MIDAS file provided by the carrier. DHS will not pay the QHP for any cost sharing incurred by enrollees for out of network providers, except in cases of needed emergency services. Emergency services means inpatient and outpatient services that are

- furnished by a provider qualified to furnish the services and
- are needed to evaluate or stabilize an emergency medical condition.

The plans must have the ability to track and apply the cost sharing maximum allowable amount that is the individual's obligation to pay in accordance with Appendix C and submit that information to DHS on a daily basis. The plans must have the ability to accept and apply information from DHS on the cost sharing amounts incurred by the individual or his or her household members while in fee for service Medicaid or enrolled in another QHP.

The plans shall report all necessary data to DHS to effectuate this section. If advanced cost sharing reductions exceed the actual cost sharing reductions, the issuers will be liable to DHS for repayment of excessive advanced cost sharing reductions. If the actual cost sharing reductions exceed the advanced cost sharing reductions, DHS will compensate the issuer the difference in the amounts, subject to the applicable budget neutrality cap limit.

B. For plans meeting all of the requirements above that DHS purchases, DHS will require the following:

- (1) The issuer must submit quarterly reports in the format required by DHS to enable DHS to meet its obligations to the Health and Economic Outcomes Accountability Oversight Advisory Panel and to the Centers for Medicare and Medicaid Services (CMS).
- (2) The issuer must submit an annual quality assessment and performance improvement strategic plan that includes all of the following:
  - a) Activities, including the use of incentives to the QHP's members or providers to support the DHS Health Improvement Initiative;
  - b) Activities, including the use of incentives to the QHP's members to support the DHS Economic Independence Initiative;

- c) Activities to meet quality and performance metrics;
- d) Activities to improve the health outcomes of individuals in each of the following groups:
  - i. Who are pregnant, with a particular focus on women with high-risk pregnancies
  - ii. With mental illness
  - iii. With substance use disorders
  - iv. With two or more chronic diseases
  - v. Living in rural areas of the state
- e) Activities to encourage the use of preventive care.

Q2. What additional coverage and network requirements are QHPs required to follow?

A2. QHPs must cover services provided by acute crisis units (ACUs), including ACUs based in Outpatient Behavioral Health Agencies (OBHAs) and those based in hospitals. QHPs must cover mobile crisis intervention services as defined in the Medicaid State Plan for its Medicaid enrollees. QHPs must accept any willing provider of these services in their provider networks during CY2023.

QHPs must accept any willing provider in their provider networks during CY 2023 for all Rural and Maternal Life 360 HOMEs approved by DHS. QHPs will be given three (3) months to negotiate with and add any providers identified by DHS on the Rural and Maternal Life 360 HOMEs list beginning with the date that the list is provided to the issuers.

An Issuer’s provider network must include at least one Federally Qualified Health Center or Rural Health Clinic for each rating area in which it offers an ARHOME plan.

Q3. What is the auto-assignment methodology for ARHOME eligibles who do not select a plan?

A3. ARHOME eligibles have at least 42 days to select a plan. For those individuals who do not select a plan, DHS will auto-assign them only to those plans that meet the purchasing guidelines described above. If the total enrollment in ARHOME enrollment exceeds 320,000 and the percentage of enrollees in the QHPs exceeds 80% of total program enrollment, 2023 DHS will suspend auto-assignment of newly determined eligible individuals if DHS determines it is necessary to meet budgetary targets or avoid exceeding the budget neutrality cap. If DHS takes this action, auto-assignment will remain suspended until the percentage of enrollees in the QHPs no longer exceeds 80% of total enrollment.

Auto-assignments will be distributed among qualifying plans with the aim of achieving a target minimum market share of ARHOME QHP enrollees for each plan in a service area. The target minimum market share in a service area will vary based on the number of competing plans in that service area as follows:

Two plans: 33% of ARHOME QHP enrollees in that service area;

Three plans: 25% of ARHOME QHP enrollees in that service area;  
Four plans: 20% of ARHOME QHP enrollees in that service area;  
More than four plans: 10% of ARHOME QHP enrollees in that service area.

Plans will be auto-assigned individuals until they enroll the lesser of the number of individuals needed to hit the target minimum market share or the maximum number of enrollees permitted by the Insurance Department. If a plan is no longer permitted to enroll additional individuals, the plan will not count as an ARHOME plan for the purposes of establishing the target minimum market share in the service area.

Q4. Do QHPs have to be statewide to serve the ARHOME Program?

A3. As noted in the Issuer Bulletin, Arkansas's policy goal is for issuers to compete on a statewide basis. For the 2023 calendar year, the State will allow QHP issuers to choose their service areas, based on the rating regions established in the Issuer Bulletin and Insurance Commissioner approval.

Q5. Which plans may utilize cost sharing and premiums?

A5. DHS will purchase plans as described in Question 1 and make payments to the QHPs on behalf of Medicaid enrollees for the cost of their coverage. Individuals will be responsible for the required cost sharing (copayments) as specified in Appendix C and subject to a household quarterly cap of 5% of their household income. To ensure individuals do not exceed 5% of their household income, plans will limit individuals' cost sharing each quarter based on their federal poverty level (FPL). The limits will serve as both the individual limit and the household limit, meaning both the individual or the individual's household members on Medicaid (those in an ARHOME QHP or fee for service Medicaid) will contribute to meeting the cost sharing limit. The quarterly cost sharing limit is as follows for each income band.

0-20% FPL: \$0  
>20%-40% FPL: \$27  
>40%-60% FPL: \$54  
>60%-80% FPL: \$81  
>80%-100% FPL: \$108  
>100%-120% FPL: \$135  
>120%-138% FPL: \$163

Q6. Are any enrollees or services exempt from copays?

A6. The High Value Silver Plan 0%-20% FPL may not charge the enrollee cost sharing. Other enrollees who are exempt from paying copays for any service are:

- American Indians or Native Alaskans
- Enrollees receiving hospice care
- Pregnant women
- Enrollees who are 19 or 20

Services that are exempt from enrollee-incurred copays are:

- Pregnancy-related services, including prenatal care, delivery, and postpartum care
- Preventive services
- Emergency services, including emergency transportation
- Family planning services and supplies
- Provider-preventable conditions
- Any other service designated as requiring \$0 copay in Appendix C

Q7. What incentives are QHPs required to provide to beneficiaries?

A7. To improve health and economic outcomes, QHPs are required to provide at least two health improvement incentives to encourage the use of preventive care and two health improvement incentives for each of the following populations:

- Pregnant women, particularly those with high-risk pregnancies
- Individuals with mental illness
- Individuals with substance use disorder
- Individuals with two or more chronic conditions
- Individuals living in rural areas of the state

QHPs also are required to provide two economic independence incentives to encourage advances in beneficiaries' economic status or employment prospects.

QHPs are required to submit to DHS by December 1, 2022, a description of each incentive, including the amount of any financial reward; the goal of the incentive; the target audience; and the plan for communicating the incentive to individuals or providers.

Q8. Will any future state or federal legislative or regulatory action impact these purchasing guidelines?

A8. Yes, these purchasing guidelines are subject to change by any state or federal legislative or regulatory action.