Plan Management Frequently Asked Questions-Plan Year 2022

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 2022 coverage year, DHS intends to implement the following purchasing requirements for the Section 1115 Demonstration Project, ARHOME.

A. For plan year 2022, 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);

(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; and

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 2022 has been signed by both parties and AID. For a plan to be purchased by DHS for beneficiary coverage beginning January 1, 2022, the CY 2022 MOU must be signed by the parties. If the CY2022 MOU with a health issuer is not signed by January 1, 2022, DHS will:

a. Extend the CY 2021 MOU in one month increments with the budget neutrality limit of $685.56; 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 2022 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 2022 is $716.41 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 2022. The total per member per month cost shall be determined using the following formula:

((Gross Premium-Premium paid by member) +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.

The plans must have the ability to track and apply the premium and cost sharing maximum allowable amounts that are the individual's obligation to pay in accordance with Appendix C and submit that information to DHS on a quarterly basis.

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.

(2) The issuer must submit an annual quality assessment and performance improvement strategic plan that includes:

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:

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 chronic diseases

e) The strategic plan must include initiatives for improving health outcomes in rural areas.

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 CY2022. QHPs must accept any willing provider in their provider networks during CY 2022 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.

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 on or after August 31, 2021, the total monthly enrollment in Arkansas Works or ARHOME enrollment exceeds 320,000 and the percentage of enrollees in the QHPs exceeds 80% of total program enrollment, beginning January 1, 2022, DHS will suspend auto-assignment of newly determined eligible individuals in each month until the percentage of enrollees in the QHPs no longer exceeds 80% of total enrollment.

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

Two issuers: 33% of ARHOME Program participants in that service area;
Three issuers: 25% of ARHOME Program participants in that service area;
Four issuers: 20% of ARHOME Program participants in that service area;
More than four issuers: 10% of ARHOME Program participants in that service area.

Issuers 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 carrier is no longer permitted to enroll additional individuals, the carrier will not count as an ARHOME participant for the purposes of establishing the target minimum market share in the region.

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 2022 plan 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 Section A 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 (premiums and copayments) as specified in Appendix C and subject to an overall quarterly cap of 5% of household income based on the following income bands:

0-20% FPL
21%-40% FPL,
41%-60% FPL,
61%-80% FPL,
81%-100% FPL,
101%-120% FPL, and
121%-138% FPL.

Individuals in the following income bands are obligated to pay premiums:

101%-120% FPL of $22.44/month
121%-138% FPL of $26.88/month

The amount of the copayment cap for each band is as follows:

21%-40% FPL is $20.96/quarter
41%-60% FPL is $40.92/quarter
61%-80% FPL is $60.89/quarter
81%-100% FPL is $80.85/quarter
101%-120% FPL is $95.29/quarter
121%-138% FPL is $114.15/quarter

Q6. Is cost sharing allowed to be charged to the consumer for the High Value Silver Plan 0%-20% FPL?

A6. The High Value Silver Plan 0%-20% FPLmay not charge the consumer cost sharing.
Q7. What incentives are QHPs required to provide to beneficiaries?

A7. To improve health and economic outcomes, QHPs are required to provide at least one health improvement incentive to encourage the use of preventive care and one health improvement incentive 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

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

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 legislative or regulatory action and are contingent on CMS's approval of Arkansas's 1115 demonstration waiver.