



IMPROVING YOUR HEALTH AND
EXPANDING YOUR OPPORTUNITIES

ARHOME Health and Economic Outcomes Accountability Oversight Advisory Panel

Quarterly Report

April 14, 2023



Report Requirements

In approving Act 530 of 2021, the Arkansas General Assembly created the Arkansas Health and Opportunity For Me program (ARHOME) and the Health and Economic Outcomes Accountability Oversight Advisory Panel. The Act requires quarterly reporting to the Advisory Panel on the program's progress toward meeting economic independence outcomes and health improvement outcomes. A.C.A. § 23-61-1011 (see Appendix) requires the reports to include information on the following:

- Eligibility and enrollment;
- Health insurer participation and competition;
- Premium and cost-sharing reduction costs;
- Utilization;
- Individual qualified health insurance plan health improvement outcomes;
- Economic independence initiative outcomes;
- Any sanctions or penalties assessed on participating individual qualified health insurance plans; and
- Community bridge organization (i.e., Life360 HOME) program outcomes.

ARHOME Overview

ARHOME is Arkansas's Medicaid expansion program created by the federal Affordable Care Act (ACA). It serves adults between the ages of 19 and 64 with income below 138% of the federal poverty level. The program operates as a demonstration project (waiver) approved under the authority of Section 1115 of the Social Security Act, which allows the state to use Medicaid funding to purchase coverage through private Qualified Health Plans (QHPs) for eligible individuals. The federal government pays 90% of the cost of the program, and the state pays the remaining 10%. The ARHOME program was previously known as Arkansas Works, but Act 530 of 2021 changed the program to ARHOME, effective January 1, 2022. The federal Centers for Medicaid and Medicaid Services (CMS) approved the new five-year waiver (January 1, 2022, through December 31, 2026) on December 21, 2021.

CMS approved an amendment to the ARHOME Waiver on November 1, 2022. The amendment allows the state to implement the Life360 HOME program in which DHS will contract with hospitals to provide additional support and intensive care coordination for ARHOME's most at-risk beneficiaries.

Eligibility and enrollment

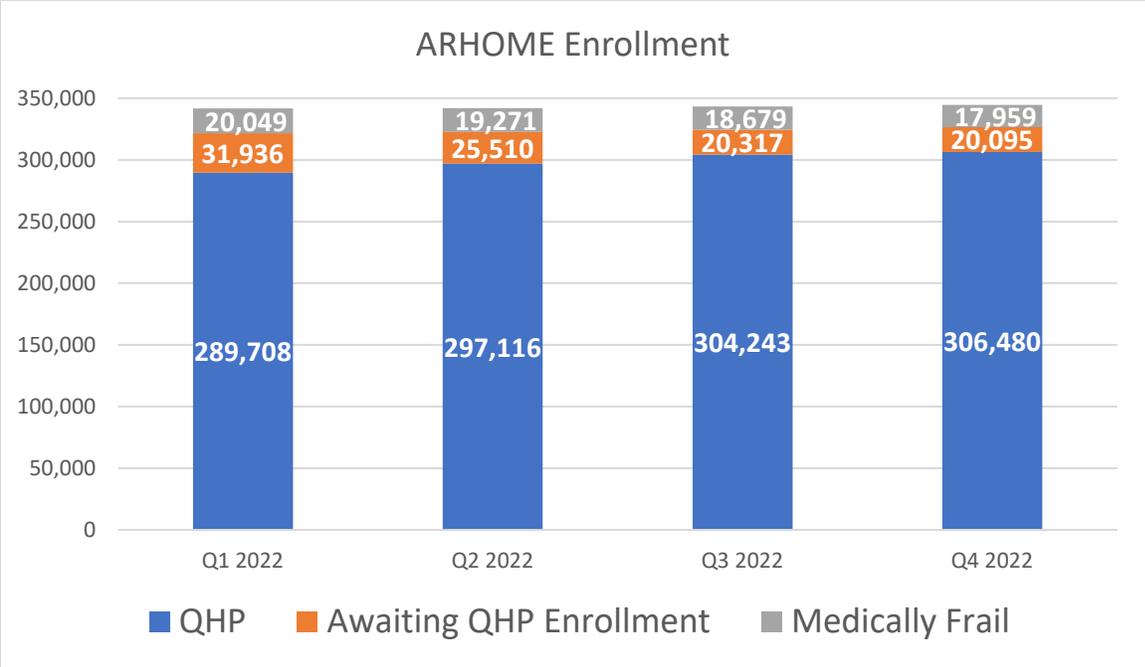
ARHOME enrollment has increased steadily since 2020 primarily due to the public health emergency (PHE) caused by the COVID-19 pandemic. Under the maintenance of effort (MOE)

requirements of the Families First Coronavirus Response Act (FFCRA) CMS prohibits states from disenrolling beneficiaries from Medicaid programs, except when the beneficiary passes away, becomes incarcerated, moves out of state, requests to be disenrolled, or shifts to a different Medicaid program. That means beneficiaries who otherwise might have been disenrolled because their income increased beyond the program limits have remained enrolled during the PHE.

Over the last four quarters, ARHOME enrollment growth has slowed to less than a half of a percent each quarter.

After individuals are determined eligible for ARHOME, they have 42 days to select a QHP offered on the state's health insurance Marketplace. Those who do not select a plan are normally auto-enrolled in a QHP. Those who are auto-enrolled have another 30 days to change their plan before their QHP coverage begins. Most ARHOME beneficiaries (about 89% at the start of Q4 2022) are enrolled in a QHP. Traditionally, only about 80% of beneficiaries are enrolled in a QHP at any point in time.

Due to the high percentage of QHP enrollees in the program, beginning September 1, DHS opted to suspend enrollee auto-assignment into QHPs to help with budgetary constraints. State law (A.C.A. § 23-61-1004(c)(2)(ii)), the DHS purchasing guidelines and the memorandum of understanding (MOU) with the carriers allow DHS to suspend auto-assignment if the total ARHOME enrollment exceeds 320,000 and the percentage of ARHOME beneficiaries enrolled in a QHP exceeds 80%. During the suspension, beneficiaries receive medical coverage through traditional Medicaid fee for service, meaning DHS is not paying a premium for those beneficiaries regardless of their use of medical services. Instead DHS is paying the Medicaid provider reimbursement rate for medical claims beneficiaries actually use. During the auto-assignment suspension, beneficiaries remain free to select a QHP if they choose. Typically, about 25% of new ARHOME enrollees select their plan. The agreement with the ARHOME carriers calls for the resumption of auto assignment when the percentage of ARHOME beneficiaries enrolled in a QHP dips below 80%. As of March 24, the percentage of ARHOME beneficiaries enrolled in a QHP is 85.4%.



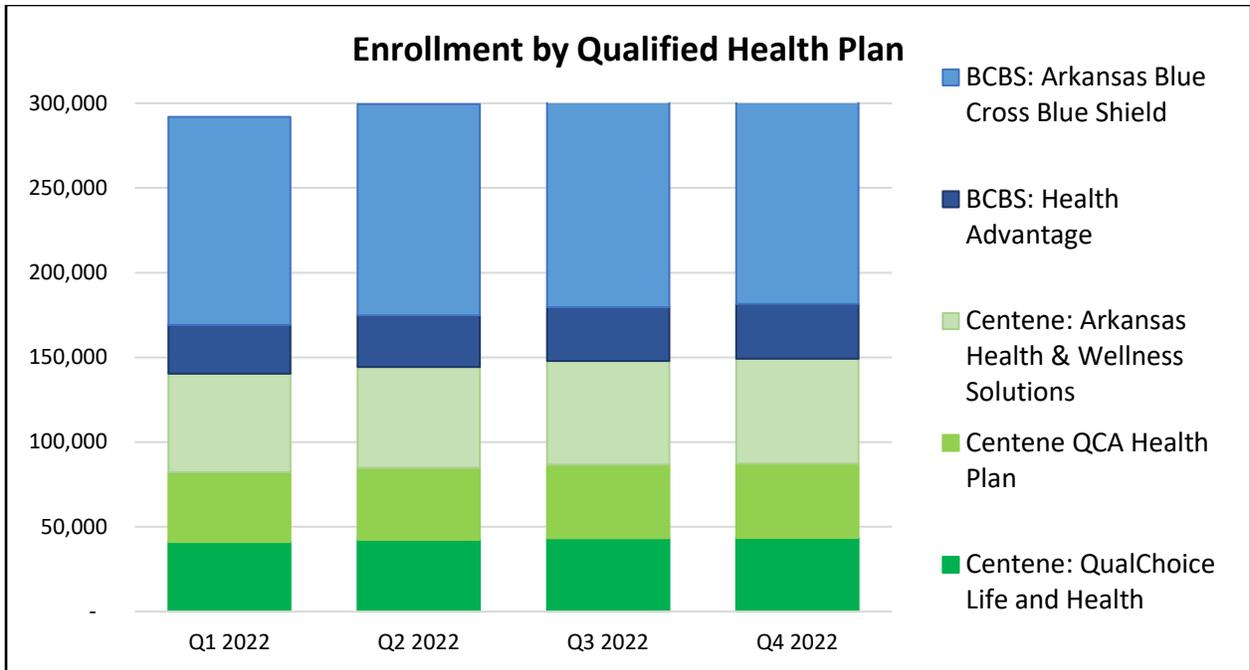
Enrollment as of the first day of each quarter (data pulled on February 6, 2023)

Another 5% of ARHOME beneficiaries are considered medically frail, meaning they have health care needs that are better served by the traditional Medicaid program. Medically frail beneficiaries do not enroll in a QHP, instead they receive health care services through traditional fee for service Medicaid.

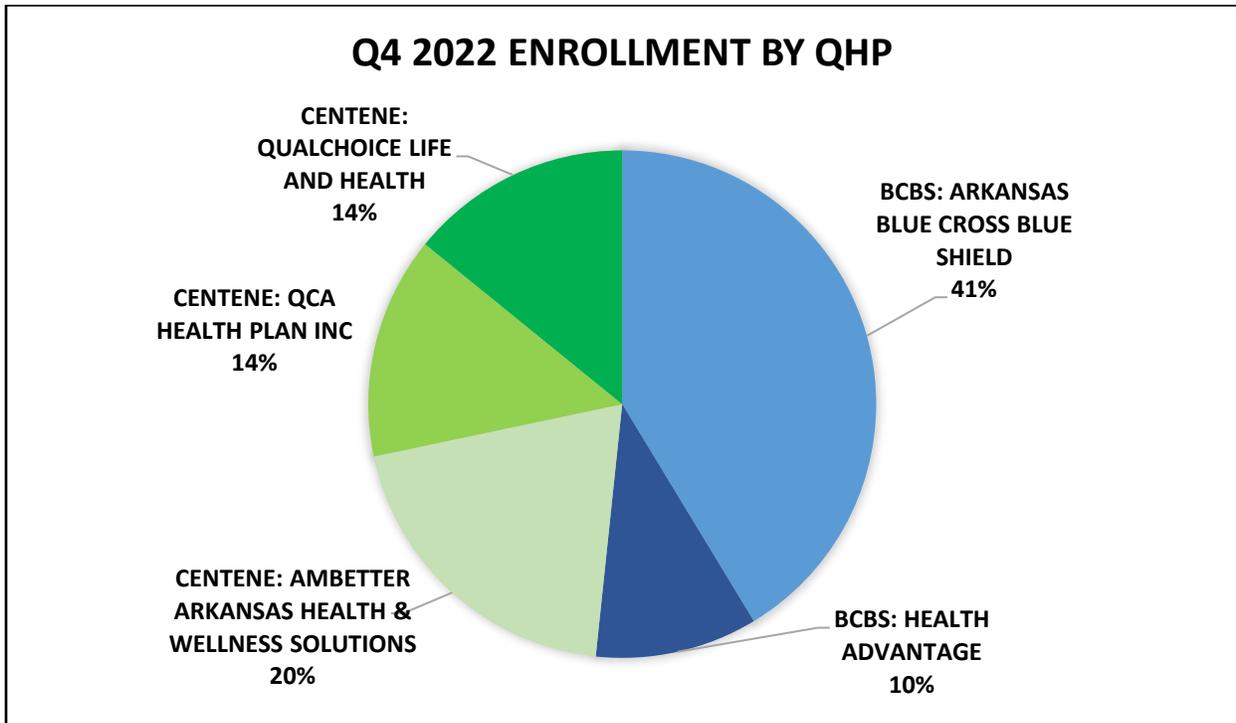
Health insurer participation and competition

The ARHOME program currently purchases QHP coverage from two insurance carriers, Centene and Arkansas Blue Cross and Blue Shield (BCBS). Centene offers three QHPs for ARHOME beneficiaries, and BCBS offers two.

The following charts show ARHOME enrollment in each QHP on the first day of each quarter of 2022 and the percentage of ARHOME enrollees enrolled in each QHP in the fourth quarter of 2022.



QHP enrollment on the first day of each quarter as of 1/27/23.



QHP enrollment on the first day of the second quarter of 2022 as of 1/27/23.

Premium and cost-sharing reduction costs

For ARHOME beneficiaries, DHS purchases the lowest cost qualifying silver-level plan offered in a service area and those within 10% of the lowest cost plan. The plans DHS purchases are available to the public on the Arkansas Health Insurance Marketplace and cover the 10 essential health benefits all Marketplace plans are required to cover under the Affordable Care Act, which include:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Pregnancy, maternity and newborn care
- Mental health & substance use disorder services
- Prescription drugs
- Rehabilitative and habilitative services & devices
- Laboratory services
- Preventive & wellness services and chronic disease management
- Pediatric services

Individuals in fee for service awaiting enrollment in a QHP receive the same benefits as those offered by the QHPs.

Cost Sharing

Prior to 2023 individuals at or below 100% of the federal poverty level (\$14,580 for a single person) did not pay a premium or any copays for the care they receive. Individuals above 100% FPL paid a \$13 premium each month for their coverage. They also paid a \$4 or \$8 copay when they accessed medical services, up to a maximum of \$60 per quarter.

DHS changed the cost sharing structure of the ARHOME program, beginning January 1, 2023. The changes are outlined in the following table:

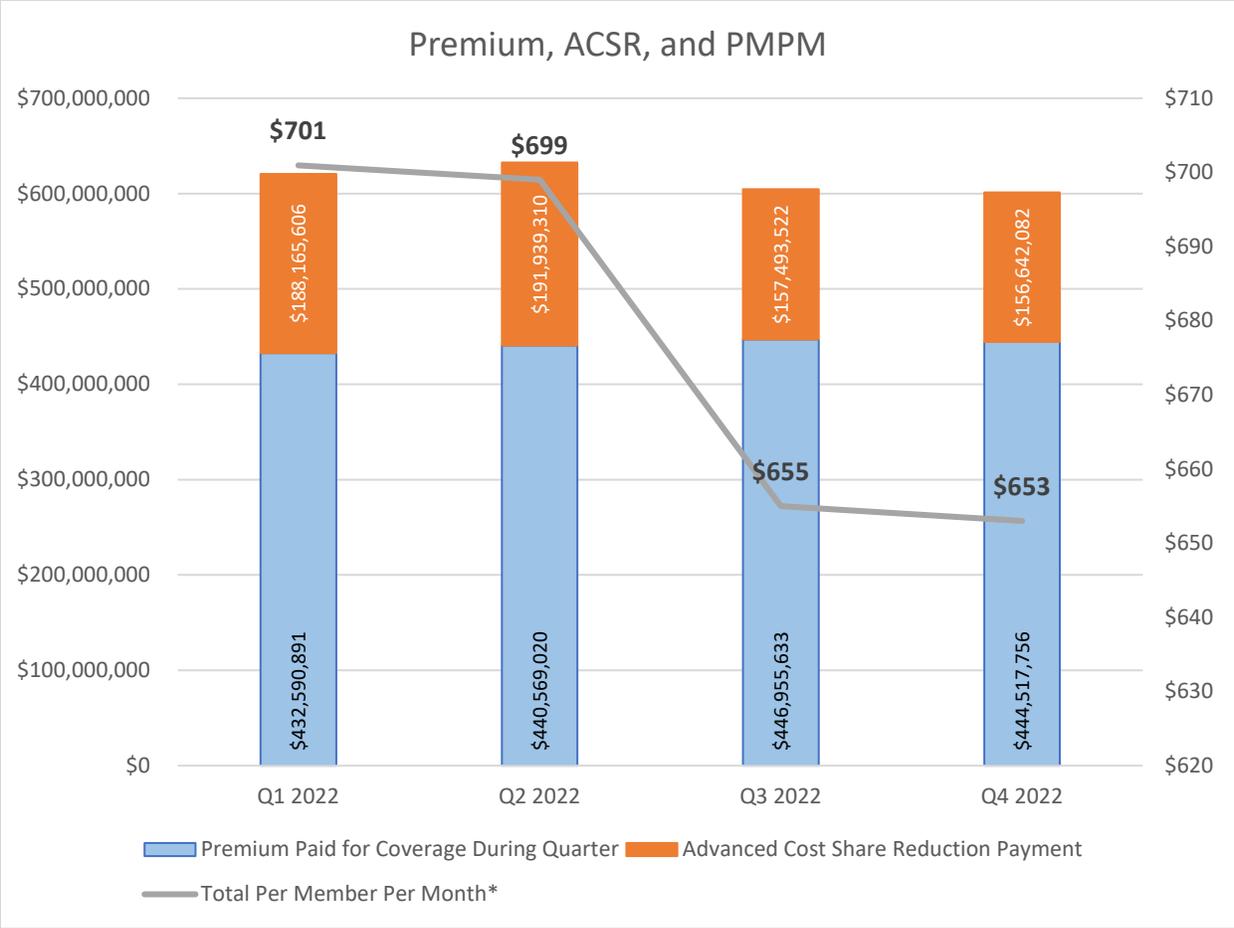
	Prior to 2023	Beginning 2023
Beneficiaries who are subject to cost sharing	Only ARHOME beneficiaries above 100% FPL who are enrolled in a QHP	Beneficiaries above 20% FPL enrolled in a QHP and those awaiting enrollment in a QHP. Some individuals are exempt (e.g., 19- and 20-year-olds)
Premiums	\$13 per month	No premiums, per CMS
Service-specific copay amounts	\$4/\$8, depending on the service	\$4.70/\$9.40, depending on the service. Some services are exempt (e.g., emergency services)

	Prior to 2023	Beginning 2023																
Copay limits	\$60 per quarter	Quarterly copay limit is based on household federal poverty level <table border="1" data-bbox="899 373 1414 716"> <thead> <tr> <th>FPL</th> <th>Copay Limit</th> </tr> </thead> <tbody> <tr> <td>0%-20%</td> <td>\$0</td> </tr> <tr> <td>21%-40%</td> <td>\$27</td> </tr> <tr> <td>41%-60%</td> <td>\$54</td> </tr> <tr> <td>61%-80%</td> <td>\$81</td> </tr> <tr> <td>81%-100%</td> <td>\$108</td> </tr> <tr> <td>101%-120%</td> <td>\$135</td> </tr> <tr> <td>121%-138%</td> <td>\$163</td> </tr> </tbody> </table>	FPL	Copay Limit	0%-20%	\$0	21%-40%	\$27	41%-60%	\$54	61%-80%	\$81	81%-100%	\$108	101%-120%	\$135	121%-138%	\$163
FPL	Copay Limit																	
0%-20%	\$0																	
21%-40%	\$27																	
41%-60%	\$54																	
61%-80%	\$81																	
81%-100%	\$108																	
101%-120%	\$135																	
121%-138%	\$163																	
Beneficiaries whose copays contribute to meeting the copay limit	Individual only	The ARHOME beneficiary and all Medicaid beneficiaries who pay copays in the individual's family (not including ARKids B beneficiaries), per CMS requirements																

Advanced Cost Sharing Reduction Payment

The silver-level plans sold on the Marketplace charge higher copays than the \$4.70 or \$9.40 ARHOME beneficiaries pay. For example, a plan might normally have a \$50 copay for a doctor's visit. ARHOME beneficiaries pay just \$4.70 of that \$50 copay, and DHS is responsible for the rest. DHS makes a monthly payment, known as an Advanced Cost Share Reduction (ACSR) payment, to the QHPs to cover the amount of the copay not paid by ARHOME beneficiaries. This is an estimated up-front payment to cover beneficiary copays. At the end of the year, the estimated amounts are compared against actual copays incurred, and reconciliation payments are made to settle any uncovered costs or overpayments.

For each beneficiary, DHS pays the plan's monthly premium and an ACSR payment. For the first two quarters of 2022, the ACSR averaged about 43% of the premium amount. DHS lowered the ACSR percentage paid to the carriers to 35% of the premium beginning July 1 to avoid exceeding the budget neutrality cap set in the waiver agreement with CMS (\$717.25 per member per month for 2022). This change resulted in an 18% decrease in ACSR payments made between Q2 and Q3 of 2022 and a 6% decrease in the per member per month cost of the program. The 2022 cost share reduction reconciliation process has not been completed, so final expenditures are not yet available.

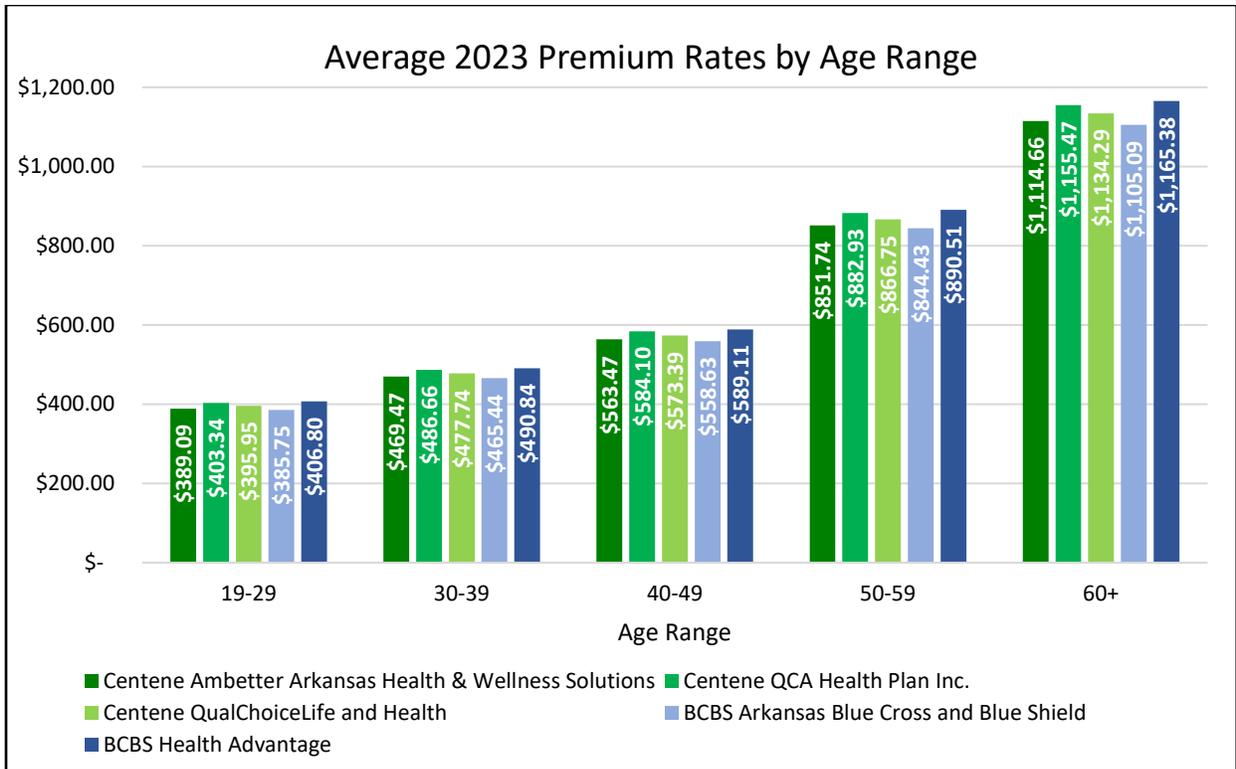


Source: 11832 10591 Arkansas Works Premium and CSR Payments and Adjustments by Month and Carrier 101022
 *Does not include wrap costs for non-emergency transportation or EPSDT services for 19- and 20-year-olds

Qualified Health Plan Rates

The carriers set the premiums they charge for each plan they sell on the Marketplace. The 2022 premiums DHS paid for each plan range from just under \$310 per month for a 19-year-old non-smoker in one plan to more than \$1,260 per month for 64-year-old tobacco user in another plan. The average premium paid in 2022 was \$485.50 per member per month.

The carriers' 2023 premium rates are shown in the following chart.



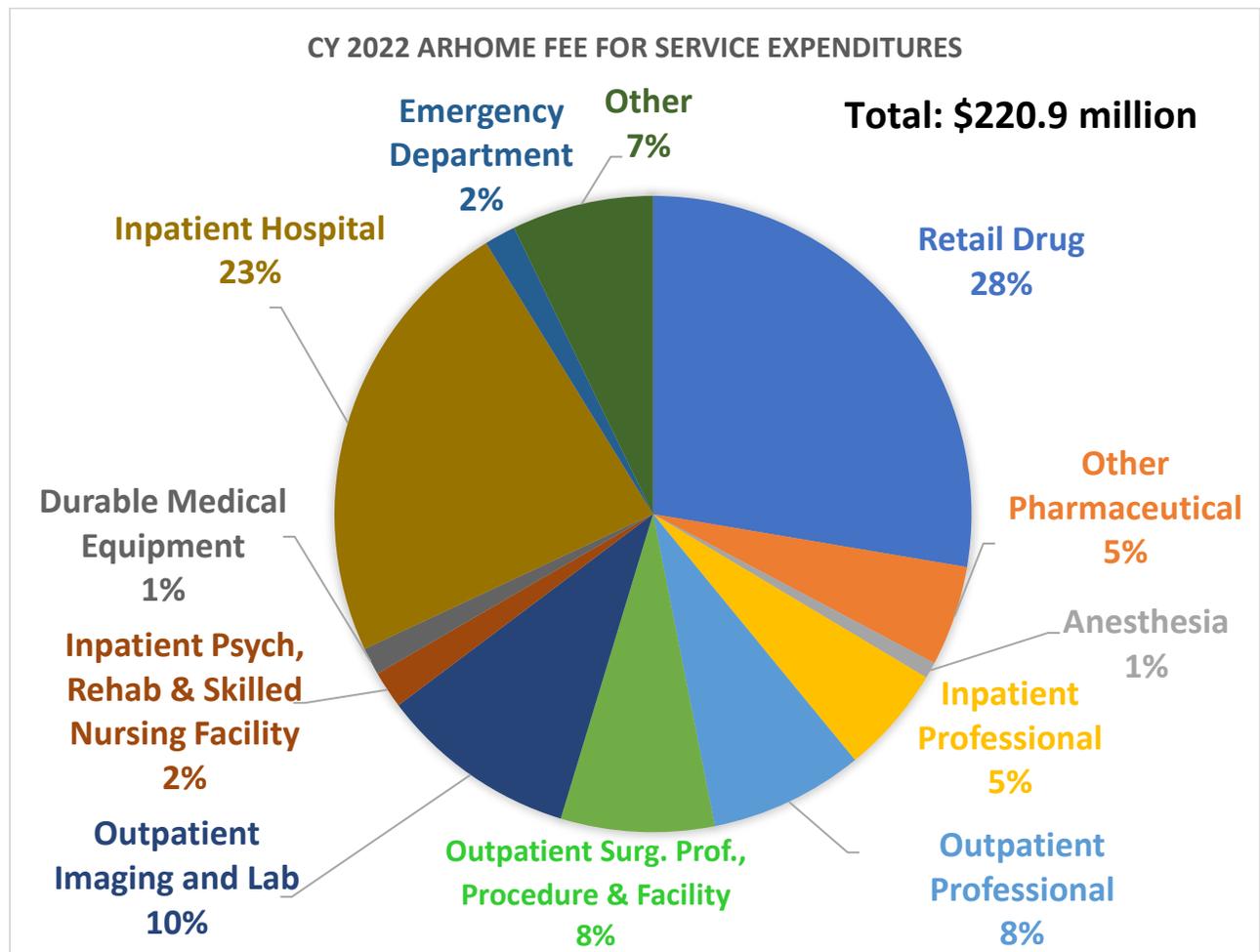
The rates increased between 3% and 7%, depending on the carrier and the plan, compared with the 2022 premium rates.

	Average % Increase in Rates Between 2022 and 2023
Centene Ambetter Arkansas Health & Wellness Solutions	7%
Centene QCA Health Plan Inc.	5%
Centene QualChoiceLife and Health	3%
BCBS Arkansas Blue Cross and Blue Shield	4%
BCBS Health Advantage	5%

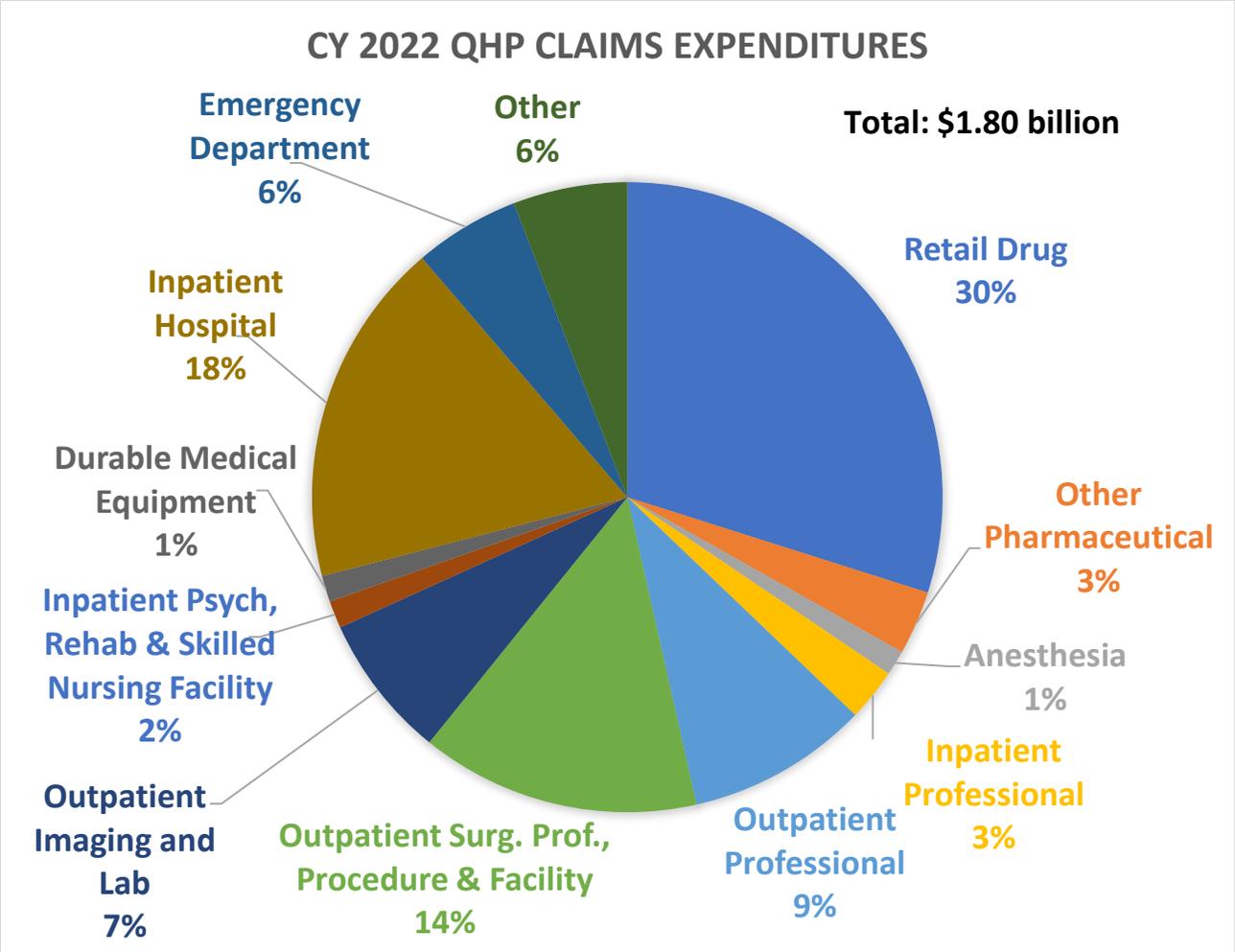
The ACSR rates for 2023 were set at 40% of the premium rate.

Utilization

Medical claims for ARHOME beneficiaries are processed in different systems, depending on whether the beneficiary is in a QHP or in traditional fee for service Medicaid. FFS Medicaid claims are paid from the Medicaid MMIS billing system, while the individual QHPs process medical claims through their own systems for ARHOME beneficiaries. The chart below shows expenditures for ARHOME beneficiaries enrolled in traditional fee for service Medicaid (medically frail and individuals awaiting QHP enrollment) for CY 2022.



The QHPs are required to provide to DHS quarterly data on the claims they pay on behalf of ARHOME beneficiaries. The following chart shows the claims that QHPs reported paying during CY 2022 for ARHOME beneficiaries.

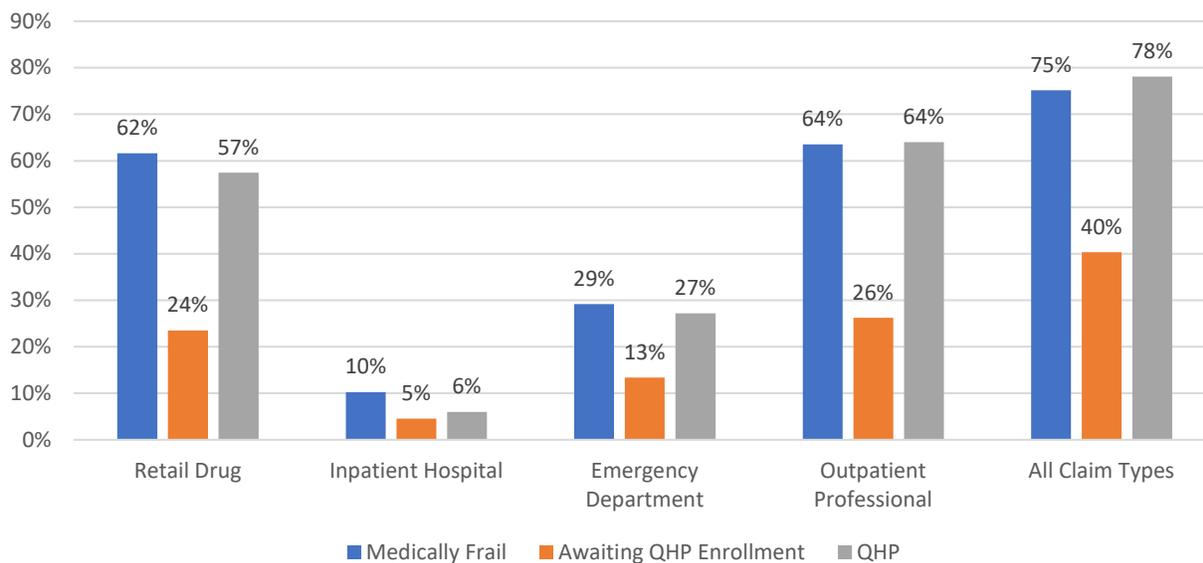


The following charts show the utilization of health services by

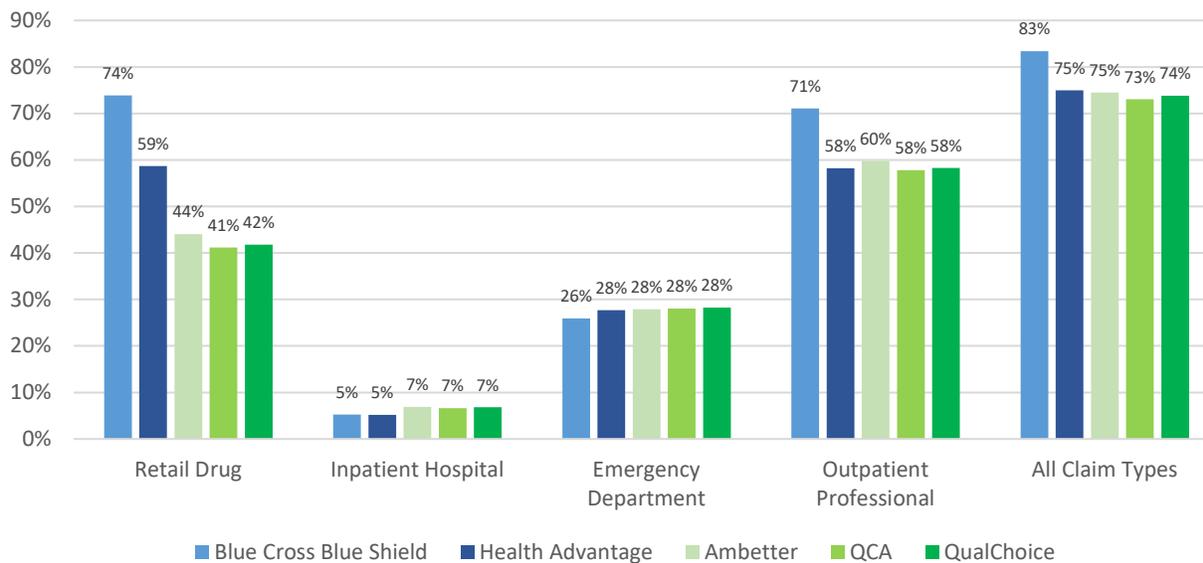
- Percent of beneficiaries with health claims
- Number of claims per beneficiary among beneficiaries with a claim in each service category (e.g., number of pharmacy claims per beneficiary among all beneficiaries with a pharmacy claim)
- Expenditures per beneficiary among beneficiaries with a claim in each service category (e.g., total pharmacy expenditures per beneficiary among all beneficiaries with pharmacy claims)

The data are provided for Q1-Q3 2022 for medically frail, beneficiaries awaiting enrollment in a QHP, all beneficiaries in a QHP, and by each individual QHP.

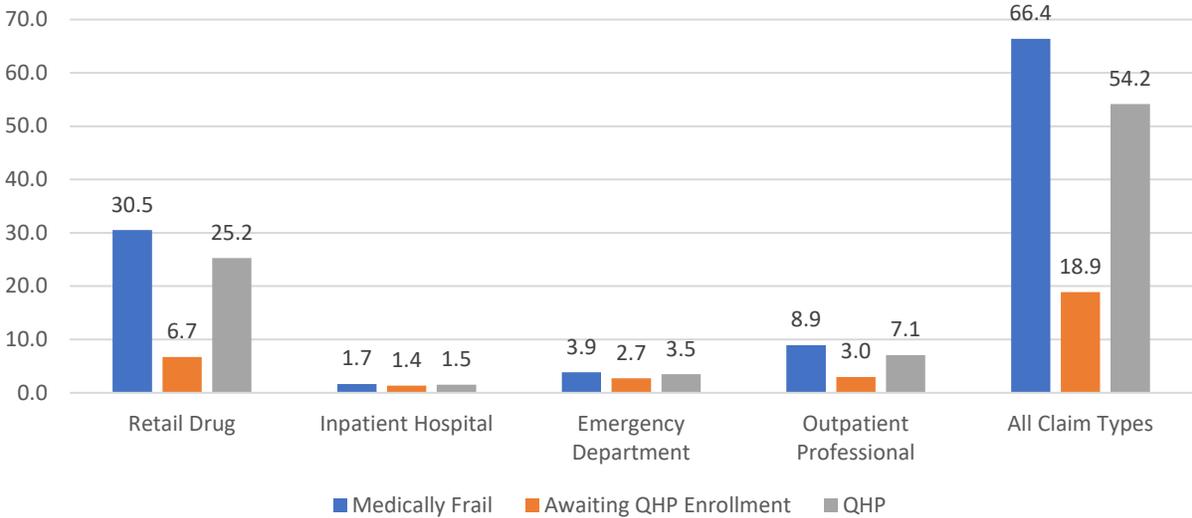
CY 2022 Percent of Enrollees with Claims



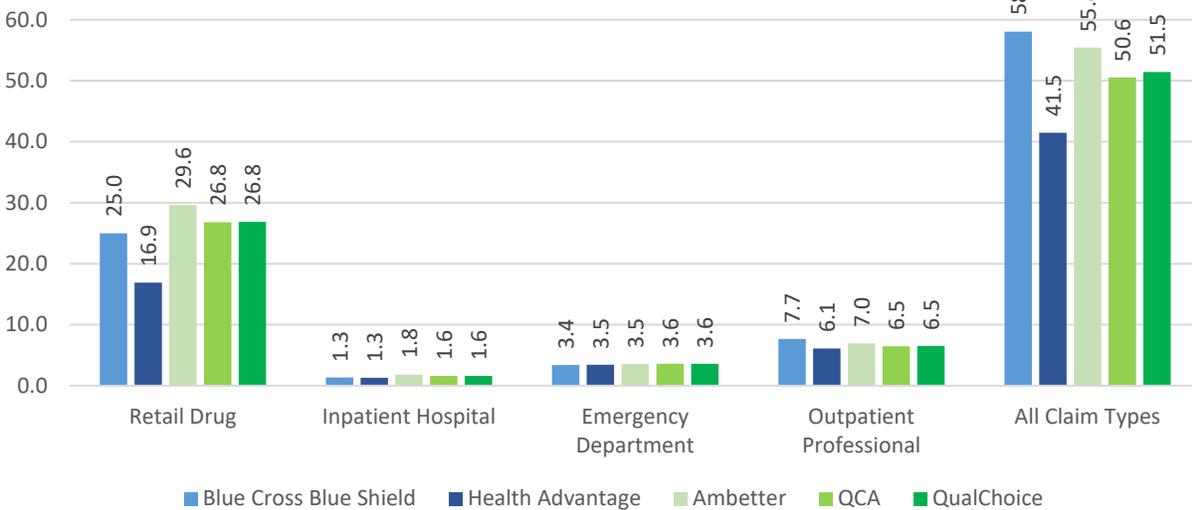
CY 2022 Percent of Enrollees with Claims



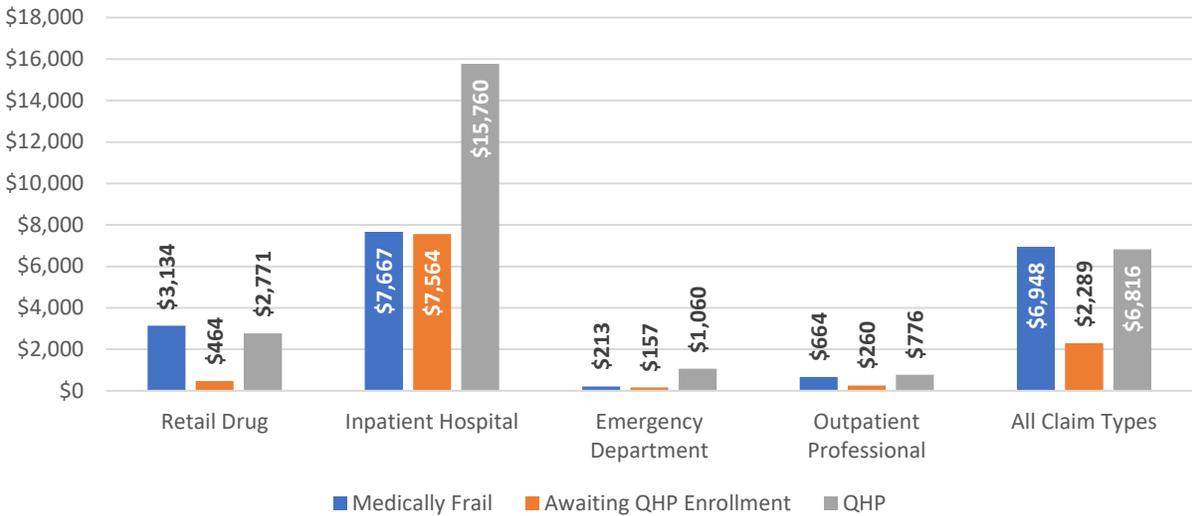
CY 2022 Claims Per Beneficiary With Claims in Each Care Category



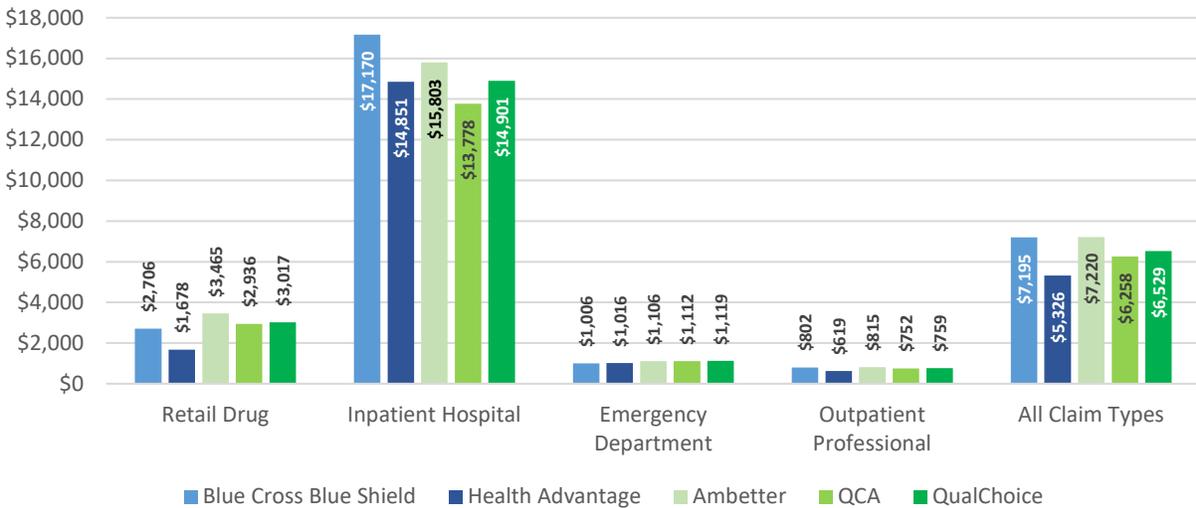
CY 2022 Claims Per Client With Claims in Each Care Category



CY 2022 Expenditures Per Client With Claims in Each Care Category



CY 2022 Expenditure Per Client With Claims in Each Care Category



Individual qualified health insurance plan health improvement outcomes

One of the main goals of the ARHOME program is to improve beneficiaries' health. New program provisions require QHPs to take responsibility for generating that improvement. In 2022, QHPs must 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

For 2023, DHS is requiring QHPs provide at least two health improvement incentives to encourage the use of preventive care and two incentives for the targeted populations. QHPs also submitted annual strategic plans that included activities they would take to meet quality and performance metrics and activities to improve the health outcomes of people living in rural areas and the populations listed above.

While it's too early to assess the results of these initiatives, the 2022 performance targets on the following metrics were set in December 2021 based on historical performance on health quality measures for 2019 and 2020. The 2023 performance targets were set in January 2023 based on performance in 2019, 2020 and 2021. The performance targets were based on the best performing QHP for each metric over the three years and are highlighted in orange in the table below. For 2023, an additional sets of targets were established based on the median performance of all five QHPs across the three years and based on individual QHP improvement targets. These additional targets allowed the QHPs to get credit for improvement, even if they don't match the performance of the best performing QHP.

Program breakouts on the metrics are also available by race and by rural/urban areas of the state.

Measure	CY	ARHOME Overall _y	By (QHP) _{yy}					Rural/Urban		By Race			
			BCBS: Blue Cross Blue Shield	BCBS: Health Advantage	Centene: Ambetter	Centene: QCA	Centene: Qual Choice	Urban	Rural	White	Black	Other	Unknown
Preventive Care													
Cervical Cancer Screening, 21-64 Years	2019	46.0%	44.4%	N/A	42.1%	31.0%	30.2%	46.2%	45.9%	45.3%	50.4%	50.9%	41.0%
	2020	43.5%	41.3%	N/A	38.4%	29.3%	29.6%	43.8%	43.2%	43.0%	48.6%	46.4%	38.0%
	2021	41.7%	42.3%	16.0%	40.0%	30.8%	31.1%	42.0%	41.3%	40.7%	45.9%	46.4%	36.2%
Chlamydia Screening in Women, 21-24 Years	2019	53.9%	53.6%	N/A	53.6%	55.5%	55.2%	52.7%	55.5%	49.5%	65.6%	57.0%	50.9%
	2020	52.5%	49.7%	N/A	54.7%	52.3%	55.4%	52.4%	52.6%	46.8%	65.0%	50.3%	53.7%
	2021	53.9%	51.3%	50.0%	53.1%	56.8%	57.3%	54.4%	53.1%	48.7%	66.3%	55.2%	51.3%
Breast Cancer Screening, 50-64 Years	2019	50.8%	54.0%	N/A	49.1%	38.7%	42.2%	50.5%	51.0%	49.0%	55.4%	57.9%	50.7%
	2020	47.7%	50.90%	N/A	47.1%	40.5%	41.0%	48.2%	47.2%	46.0%	52.8%	52.6%	47.5%
	2021	44.5%	47.6%	N/A	44.4%	39.3%	40.2%	44.7%	44.3%	42.4%	50.7%	47.6%	44.9%
Maternal and Perinatal Care													
Contraceptive Care – Postpartum Women, Most or Moderately Effective Contraception - 60 Day: 21-44 Years	2019	54.3%	54.7%	N/A	53.9%	50.4%	58.4%	52.7%	56.6%	55.3%	54.5%	49.4%	53.6%
	2020	48.9%	46.6%	N/A	50.0%	46.5%	49.8%	47.3%	51.3%	52.5%	48.1%	40.7%	43.9%
	2021	45.8%	46.4%	38.7%	44.6%	43.6%	49.8%	42.8%	50.0%	48.2%	44.7%	41.8%	39.6%
Contraceptive Care – All Women, Most or Moderately Effective Contraception: 21-44 Years	2019	25.5%	27.0%	N/A	24.0%	24.3%	24.3%	25.7%	25.3%	25.2%	26.0%	26.4%	25.6%
	2020	23.8%	25.2%	N/A	22.3%	22.4%	21.5%	24.1%	23.4%	23.5%	24.2%	23.9%	24.1%
	2021	22.9%	24.6%	19.0%	21.3%	22.4%	22.0%	23.0%	22.7%	22.4%	23.7%	23.3%	23.4%
Low Birth Weight, Percentage of live births weighing < 2,500 grams	2019	10.2%	10.2%	N/A	10.5%	9.8%	9.3%	10.3%	10.1%	8.7%	14.8%	8.6%	8.8%
	2020	10.8%	11.1%	N/A	10.8%	11.5%	9.6%	11.3%	10.0%	9.7%	15.9%	5.8%	9.7%
	2021	10.8%	9.8%	11.6%	12.1%	11.7%	9.6%	11.6%	9.9%	9.0%	17.1%	8.9%	7.4%
Very Low Birth Weight, Percentage of live births weighing < 1,500 grams	2019	1.4%	1.2%	N/A	1.7%	1.2%	1.2%	1.3%	1.4%	1.0%	2.4%	0.6%	1.5%
	2020	1.6%	1.6%	N/A	1.8%	1.7%	1.2%	1.8%	1.3%	1.3%	2.9%	1.0%	1.0%
	2021	1.6%	1.3%	2.5%	1.7%	1.5%	1.3%	1.9%	1.2%	1.2%	2.7%	1.4%	1.3%
Pre-Term Birth, Percentage of live births 17 - 36 weeks gestation	2019	13.5%	13.3%	N/A	14.0%	14.4%	12.2%	13.3%	13.7%	13.6%	16.1%	10.9%	10.3%
	2020	12.8%	13.6%	N/A	14.2%	11.8%	11.2%	13.2%	12.2%	12.8%	15.9%	9.1%	10.6%
	2021	13.0%	12.7%	13.2%	15.2%	13.1%	11.1%	12.9%	13.1%	12.4%	16.4%	10.0%	11.1%

Measure	CY	ARHOME Overall _{yr}	By (QHP) _{yr}					Rural/Urban		By Race			
			BCBS: Blue Cross Blue Shield	BCBS: Health Advantage	Centene: Ambetter	Centene: QCA	Centene: Qual Choice	Urban	Rural	White	Black	Other	Unknown
Care of Acute and Chronic Conditions													
Diabetes Short-Term Complications Admission Rate, 19-64 Years (Lower is Better)	2019	26.2	14.2	N/A	16.8	16.4	22.4	27.4	24.8	26.6	26.8	20.2	26.7
	2020	21.4	14.2	N/A	15.5	30.9	27.5	24.0	18.2	22.6	26.2	10.2	17.7
	2021	21.9	16.7	23.0	14.6	18.7	17.7	23.0	20.2	22.0	26.4	16.0	18.8
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate, 40-64 Years (Lower is Better)	2019	40.9	24.9	N/A	32.2	18.3	23.4	39.3	42.8	45.8	26.4	33.0	41.1
	2020	23.2	14.3	N/A	17.2	19.2	7.7	22.5	24.1	25.6	20.4	8.5	23.4
	2021	19.4	17.5	12.2	17.1	11.7	8.7	15.5	24.1	24.7	14.4	6.8	9.2
Heart Failure Admission Rate, 19-64 Years (Lower is Better)	2019	23.9	13.9	N/A	13.5	12.3	13.9	28.1	18.8	19.4	36.8	13.7	28.7
	2020	22.8	14.4	N/A	16.3	18.3	10.9	27.0	17.4	19.8	36.8	13.8	21.6
	2021	21.7	14.8	18.1	18.4	13.1	11.7	25.3	17.1	19.6	34.8	10.8	18.8
Asthma in Younger Adults Admission Rate, 19-39 Years (Lower is Better)	2019	4.8	3.1	N/A	3.3	2.1	2.1	5.1	4.5	4.1	9.6	2.4	2.9
	2020	2.1	1.6	N/A	2.0	1.7	2.8	2.0	2.2	1.9	4.5	1.4	0.6
	2021	1.7	1.8	0.0	1.0	1.2	1.8	1.5	2.0	1.6	3.0	1.1	0.9
Plan All-Cause Readmissions, Observed/Expected Ratio: 19-64 Years (Lower is Better)	2019	0.8506	0.8071	N/A	0.8003	0.7065	0.9174	0.8268	0.8801	0.8635	0.8239	0.7190	0.8502
	2020	0.7743	0.7072	N/A	0.7528	0.4663	0.3911	0.7834	0.7624	0.7967	0.8003	0.7193	0.6705
	2021	0.8457	0.7291	7.1528	0.8802	0.9275	0.8545	0.8301	0.8754	0.8318	0.8896	0.7701	0.8879
Asthma Medication Ratio, 19-64 Years	2019	46.9%	48.4%	N/A	45.3%	50.0%	54.5%	50.2%	43.3%	47.6%	47.4%	51.0%	42.9%
	2020	42.4%	43.6%	N/A	36.9%	43.0%	36.1%	45.6%	38.2%	43.3%	40.0%	41.9%	41.7%
	2021												
Behavioral Health Care													
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment, Initiation of AOD Treatment - Total AOD Abuse or Dependence: 19-64 Years	2019	37.9%	37.4%	N/A	38.5%	44.0%	41.5%	37.3%	38.8%	39.1%	31.8%	36.9%	39.5%
	2020	39.2%	39.8%	N/A	40.2%	37.4%	38.5%	39.3%	39.2%	40.5%	32.5%	37.7%	41.2%
	2021	40.1%	41.5%	42.5%	40.8%	38.8%	38.3%	40.4%	39.8%	41.5%	34.9%	39.4%	39.4%
Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment, Engagement of AOD Treatment - Total AOD Abuse or Dependence: 19-64 Years	2019	8.6%	9.6%	N/A	9.8%	10.3%	8.6%	8.3%	9.0%	9.5%	5.1%	8.6%	8.4%
	2020	9.7%	9.5%	N/A	12.0%	9.1%	10.1%	9.2%	10.4%	10.7%	4.6%	9.8%	10.6%
	2021	11.8%	12.1%	13.2%	13.5%	11.4%	9.8%	12.0%	11.3%	12.8%	7.6%	10.1%	11.8%
By (QHP)_{yr}													
Rural/Urban													
By Race													

Measure	CY	ARHOME Overall	BCBS: Blue Cross Blue Shield	BCBS: Health Advantage	Centene: Ambetter	Centene: QCA	Centene: Qual Choice	Urban	Rural	White	Black	Other	Unknown
Antidepressant Medication Management, Effective Acute Phase Treatment: 19-64 Years	2019	52.9%	55.5%	N/A	56.0%	48.7%	54.8%	52.6%	53.3%	55.0%	40.5%	48.2%	56.6%
	2020	54.0%	56.7%	N/A	55.1%	50.8%	52.2%	54.4%	53.4%	56.6%	39.4%	51.9%	56.6%
	2021	58.1%	59.2%	72.2%	60.7%	57.2%	58.1%	58.8%	57.1%	60.7%	45.4%	56.5%	60.3%
Antidepressant Medication Management, Effective Continuation Phase Treatment: 19-64 Years	2019	37.1%	39.6%	N/A	39.2%	35.6%	35.6%	38.0%	36.0%	39.3%	25.6%	32.0%	39.7%
	2020	38.1%	41.3%	N/A	38.3%	35.2%	35.0%	38.2%	38.0%	40.5%	24.6%	37.0%	40.7%
	2021	41.4%	43.1%	61.1%	42.2%	38.6%	41.9%	41.9%	40.6%	44.0%	27.5%	39.5%	44.6%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia, 19-64 Years	2019	44.1%	47.2%	N/A	34.8%	65.0%	38.5%	41.1%	47.3%	47.5%	36.6%	41.2%	42.1%
	2020	47.2%	44.2%	N/A	46.4%	52.1%	43.3%	45.7%	49.1%	50.8%	43.2%	48.5%	39.1%
	2021	41.2%	44.8%	40.0%	39.9%	40.6%	41.0%	38.4%	45.0%	44.8%	33.6%	41.9%	35.4%
Use of Pharmacotherapy for Opioid Use Disorder, Overall Total: 19-64 Years	2019	39.0%	47.1%	N/A	36.5%	40.2%	45.1%	35.0%	45.4%	42.3%	15.6%	28.6%	34.4%
	2020	51.3%	54.0%	N/A	54.1%	55.3%	51.6%	49.4%	54.1%	55.2%	19.9%	45.0%	49.6%
	2021	56.8%	60.7%	65.4%	57.8%	56.6%	56.1%	54.6%	60.9%	59.8%	28.1%	54.1%	53.9%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications, 19-64 Years	2019	79.2%	80.5%	N/A	80.6%	75.2%	81.1%	79.6%	78.8%	80.3%	75.2%	78.9%	78.3%
	2020	77.6%	78.3%	N/A	79.2%	76.0%	79.4%	77.3%	78.1%	78.1%	79.5%	73.2%	75.7%
	2021	79.7%	80.2%	78.1%	81.1%	80.5%	79.4%	79.5%	79.8%	80.5%	80.0%	79.9%	74.1%
Use of Opioids at High Dosage in Persons Without Cancer (<i>Lower is Better</i>), 19-64 Years	2019	1.1%	1.3%	N/A	1.1%	1.1%	0.7%	1.4%	0.7%	1.0%	0.8%	0.7%	1.5%
	2020	1.0%	1.4%	N/A	1.2%	0.3%	0.2%	1.5%	0.6%	1.0%	0.8%	1.5%	1.3%
	2021	0.8%	0.9%	1.8%	0.9%	0.6%	0.4%	1.1%	0.5%	1.0%	0.4%	0.7%	0.6%
Concurrent Use of Opioids and Benzodiazepines, 19-64 Years (<i>Lower is Better</i>)	2019	20.9%	21.5%	N/A	17.8%	16.0%	20.0%	21.6%	20.1%	23.7%	11.1%	17.7%	20.8%
	2020	18.9%	20.9%	N/A	16.3%	13.8%	15.0%	19.2%	18.5%	21.2%	11.0%	18.6%	18.3%
	2021	17.2%	20.1%	15.8%	14.0%	12.3%	11.7%	17.3%	17.0%	19.4%	10.5%	13.8%	16.2%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence, Received Follow-Up Within 30 Days of ED Visit: 19-64 Years	2019	8.7%	8.6%	N/A	11.8%	4.3%	2.9%	8.7%	8.7%	9.1%	7.2%	8.8%	8.7%
	2020	11.0%	8.5%	N/A	16.8%	10.3%	9.1%	10.7%	11.5%	12.5%	5.9%	9.0%	11.3%
	2021	11.7%	8.7%	9.6%	15.9%	12.5%	12.3%	11.5%	12.0%	12.9%	7.1%	13.1%	12.0%
Follow-Up After Emergency Department Visit for Mental Illness, Received Follow-Up Within 30 Days of ED Visit: 19-64 Years	2019	37.3%	41.7%	N/A	35.4%	30.1%	18.6%	33.9%	42.2%	40.3%	26.6%	33.3%	40.5%
	2020	33.0%	32.6%	N/A	27.7%	27.8%	33.3%	30.9%	35.9%	35.1%	28.2%	31.0%	31.2%
	2021	28.7%	26.9%	18.1%	27.7%	26.0%	32.6%	27.3%	30.3%	31.2%	17.3%	38.6%	30.3%

Measure	CY	ARHOME Overall ₁	By (QHP) ₂					Rural/Urban		By Race			
			BCBS: Blue Cross Blue Shield	BCBS: Health Advantage	Centene: Ambetter	Centene: QCA	Centene: Qual Choice	Urban	Rural	White	Black	Other	Unknown
Follow-Up After Hospitalization for Mental Illness: Age 19 to 64, Received Follow-Up Within 30 Days of Discharge: 19-64 Years	2019	37.0%	43.4%	N/A	24.6%	37.2%	35.6%	37.8%	36.0%	36.6%	32.7%	37.4%	41.2%
	2020	36.7%	41.6%	N/A	39.0%	23.5%	29.7%	37.2%	36.1%	37.2%	33.1%	38.4%	37.2%
	2021	34.6%	39.1%	27.9%	31.9%	32.6%	32.5%	34.9%	34.4%	36.3%	30.0%	32.0%	32.2%

Other Reporting Requirements

For three of the ARHOME statutory reporting requirements, it's too early in the program to provide outcomes or data. This section of the report provides updates for these items, with more information to be provided as it becomes available.

Economic independence initiative outcomes

QHPs are required to offer one economic independence incentive to encourage advances in beneficiaries' economic status or employment prospects. Additionally, their annual strategic plans must include activities to support the DHS Economic Independence Initiative. The QHPs cited the following activities in their 2022 strategic plans as those they are implementing to promote economic independence in 2022.

- Promote member participation in employment, education, and training programs through website, member portal, and welcome centers.
- Train member-facing staff on the economic independence goals of ARHOME and incorporate messaging promoting participation in employment, education, and training activities in appropriate member interactions.
- Refer members to the Arkansas Division of Workforce Services' (ADWS) website and programming.
- Provide a financial incentive to members who provide proof of completion of ADWS's free Career Readiness Certificate (CRC) at the Platinum, Gold, Silver or Bronze level.
- Host a dedicated web page to address the DHS Economic Independence Initiative (EII).
- Partner with the Little Rock Workforce System and the Rural Life360 HOMEs (see Community Bridge Organizations below) to host career expos and job/health fairs. These fairs will feature community organizations and the use of incentives to encourage attendance.

Information about the specific efforts, beneficiary outreach and participation in the economic independence initiatives will be provided at the June 2023 ARHOME Advisory Panel meeting.

Sanctions or penalties assessed on participating individual qualified health insurance plans

DHS will measure the QHP's performance on the health care quality metrics that DHS has selected for Plan Year 2022. DHS has established performance targets on the selected metrics each QHP must meet during Plan Year 2022. The selected performance targets are highlighted in orange on the table on pages 15-18. DHS may require a corrective action plan in 2023 from any QHP that fails to meet performance targets during Plan Year 2022. Results for 2022 will be presented during the September 2023 ARHOME Advisory Panel meeting.

For 2023, DHS will measure the QHPs' performance on based on three performance targets

- One based on the best QHP performance for each health metric in 2019, 2020, and 2021

- One based on the median performance of all QHPs performance across 2019, 2020, and 2021.
- A QHP-specific improvement target, based on 4% improvement from the QHP's best performance from 2019, 2020 and 2021.

A QHP earns a number of points specified in 2023 the memorandum of understanding the QHPs have signed for each target it meets. The total number of points the QHP earns will determine the per-member month penalty assessed.

Community bridge organization outcomes

A significant new feature planned for ARHOME is the Life360 HOME, a program modeled after the federal community bridge organization concept. Under the Life360 HOME plan, DHS will contract with hospitals to become one of three different types of Life360 HOMEs to provide additional support for three ARHOME focus populations:

- **Maternal Life360 HOMEs:** Women with high-risk pregnancies
- **Rural Life360 HOMEs:** Individuals in rural areas with behavioral health needs
- **Success Life360 HOMEs:** Young adults who are most at risk of long-term poverty, including those who were previously in foster care, incarcerated, or in the juvenile justice system and those who are veterans.

DHS will contract with hospitals to provide a broad array of intensive care coordination services for these populations within the ARHOME program (and to beneficiaries in other Medicaid programs who are participating in the Maternal Life360 HOME program). The care coordination services include home visitation for women with high-risk pregnancies and assistance addressing social determinants of health needs and enhancing life skills. The Life360 HOME hospitals will coordinate with the beneficiaries' medical providers, but medical services will continue to be covered by the individual's QHP or fee-for-service Medicaid.

CMS approved the Life360 HOME program on November 1, 2022. DHS has begun talks with interested hospitals and has received letters of intent (the first step in the application process) from four hospitals that would like to enroll in the program. DHS is currently working with those hospitals to move toward enrollment and enrollment of beneficiaries. More information about the program can be found at www.ar.gov/life360.

Appendix

23-61-1011. Health and Economic Outcomes Accountability Oversight Advisory Panel.

- (a) There is created the Health and Economic Outcomes Accountability Oversight Advisory Panel.
- (b) The advisory panel shall be composed of the following members:
- (1) The following members of the General Assembly:
 - (A) The Chair of the Senate Committee on Public Health, Welfare, and Labor;
 - (B) The Chair of the House Committee on Public Health, Welfare, and Labor;
 - (C) The Chair of the Senate Committee on Education;
 - (D) The Chair of the House Committee on Education;
 - (E) The Chair of the Senate Committee on Insurance and Commerce;
 - (F) The Chair of the House Committee on Insurance and Commerce;
 - (G) An at-large member of the Senate appointed by the President Pro Tempore of the Senate;
 - (H) An at-large member of the House of Representatives appointed by the Speaker of the House of Representatives;
 - (I) An at-large member of the Senate appointed by the minority leader of the Senate; and
 - (J) An at-large member of the House of Representatives appointed by the minority leader of the House of Representatives;
 - (2) The Secretary of the Department of Human Services;
 - (3) The Arkansas Surgeon General;
 - (4) The Insurance Commissioner;
 - (5) The heads of the following executive branch agencies or their designees:
 - (A) Department of Health;
 - (B) Department of Education;
 - (C) Department of Corrections;
 - (D) Department of Commerce; and
 - (E) Department of Finance and Administration;
 - (6) The Executive Director of the Arkansas Minority Health Commission; and
 - (7)
 - (A) Three (3) community members who represent health, business, or education, who reflect the broad racial and geographic diversity in the state, and who have demonstrated a commitment to improving the health and welfare of Arkansans, appointed as follows:
 - (i) One (1) member shall be appointed by and serve at the will of the Governor;
 - (ii) One (1) member shall be appointed by and serve at the will of the President Pro Tempore of the Senate; and
 - (iii) One (1) member shall be appointed by and serve at the will of the Speaker of the House of Representatives.
 - (B) Members serving under subdivision (b)(7)(A) of this section may receive mileage reimbursement.
- (c)
- (1) The Secretary of the Department of Human Services and one (1) legislative member shall serve as the cochairs of the Health and Economic Outcomes Accountability Oversight Advisory Panel and shall convene meetings quarterly of the advisory panel.
 - (2) The legislative member who serves as the cochair shall be selected by majority vote of all legislative members serving on the advisory panel.
- (d)

