TOC required

124.240 Arkansas Health and Opportunity for Me Program (ARHOME) 1-1-22

The ARHOME aid category covers individuals ages 19-64 who earn up to 138% of the federal poverty level.

Clients with household income above 20% of the federal poverty level shall pay the following cost sharing amounts for each service in calendar year 2022.

	Unit of Service	Copays
All Inpatient Hospital Services (inc MH/SUD)	Day	$ -
Mental/Behavioral Health and SUD Outpatient Services	Visit	$4.70
Behavioral Health Professional	Visit	$4.70
Durable Medical Equipment	Service	$4.70
Non-Emergency Use of the Emergency Department	Visit	$9.40
X-rays and Diagnostic Imaging	Visit	$4.70
Skilled Nursing Facility	Day	$20.00
Outpatient Facility Fee (e.g., Ambulatory Surgery Center	Visit	$4.70
Primary Care Visit to Treat and Injury or Illness (exc. Preventive, X-rays)	Visit	$4.70
Specialist Visit	Visit	$4.70
Generics	Prescription	$4.70
Preferred Brand Drugs	Prescription	$4.70
Non-Preferred Brand Drugs	Prescription	$9.40
Specialty Drugs (i.e. High-Cost	Prescription	$9.40
Imaging (CT/Pet Scans, MRIs	Visit	$4.70
Speech Therapy	Visit	$4.70
Occupational and Physical Therapy	Visit	$4.70
Preventative Care/Screening/Immunizations	Visit	$ -
Laboratory Outpatient and Professional Services	Visit	$4.70
Outpatient Surgery Physician/Surgical Services	Visit	$4.70
Pregnancy-Related Services	Visit	$ -
EPSDT	Visit	$ -
Other Outpatient Services	Visit	$4.70

Thereafter, any copayments may not exceed these amounts as updated each January 1 by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding calendar year and then rounded to the next higher 5-cent increment.

There are six levels of cost sharing in this aid category, depending on the individual's federal poverty level. Clients' total copayment obligations are capped each quarter for each level 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

Clients at or below 20% FPL are not subject to copayments. ARHOME clients who are deemed medically frail or identified as American Indian or Alaska Native are not subject to copayments. EPSDT services, for clients up to 21 years of age, are not subject to copayments. Pregnancy-related services are not subject to copayments.

Clients with household incomes above 100% of the federal poverty level who are enrolled in a qualified health plan will be subject to a monthly premium. Clients in the following income bands are obligated to pay the following premiums:

101%-120% FPL: $22.44/month

121%-138% FPL: $26.88/month

ARHOME clients at or below 100% FPL and those who are not enrolled in a qualified health plan are not subject to monthly premiums. ARHOME clients who are deemed medically frail or identify as American Indian or Alaska Native are not subject to a monthly premium.

133.100 Inpatient Hospital Coinsurance Charge for Medicaid ~~Beneficiaries~~ Clients Without Medicare

~~6-1-08~~1-1-22

For inpatient admissions, the Medicaid coinsurance charge per admission for non-exempt Medicaid ~~beneficiaries~~ clients aged 18 and older is 10% of the hospital's interim Medicaid per diem, applied on the first Medicaid covered day. (See Section 124.230 for Working Disabled cost-sharing requirements and Section 124.240 for ARHOME clients.)

Example:

A Medicaid ~~beneficiary~~ client is an inpatient for 4 days in a hospital whose Arkansas Medicaid interim per diem is $500.00. When the hospital files a claim for 4 days, Medicaid will pay $1950.00; the ~~beneficiary~~ client will pay $50.00 (10% Medicaid coinsurance rate).

1. Four (4 days) times $500.00 (the hospital per diem) = $2000.00 (hospital allowed amount).
2. Ten percent (10% Medicaid coinsurance rate) of $500.00 = $50.00 coinsurance.
3. Two thousand dollars ($2000.00 hospital allowed amount) minus $50.00 (coinsurance) = $1950.00 (Medicaid payment).

133.400 Co-payment on Prescription Drugs

~~6-1-08~~1-1-22

Arkansas Medicaid has a ~~beneficiary~~client co-payment requirement in the Pharmacy Program. The payment is applied per prescription. Non-exempt ~~beneficiaries~~client aged 18 and older are responsible for paying the provider a co-payment amount based on the following table: (See Section 124.230 for Working Disabled cost-sharing requirements and Section 124.240 for ARHOME clients. See the ARKids First-B provider manual for ARKids-First B cost-sharing requirements.)

Medicaid Maximum Amount	~~Beneficiary~~Client Co-pay
$10.00 or less	$0.50
$10.01 to $25.00	$1.00
$25.01 to $50.00	$2.00
$50.01 or more	$3.00

Alternative Benefit Plan

State Name: Arkansas | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: AR - 21 - 0010

Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act — **ABP2a**

The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan. — No

These assurances must be made by the state/territory if the Adult eligibility group is included in the ABP Population.

☑ The state/territory shall enroll all participants in the "Individuals at or below 133% FPL Age 19 through 64" (section 1902(a)(10)(A)(i)(VIII)) eligibility group in the Alternative Benefit Plan specified in this state plan amendment, except as follows: A beneficiary in the eligibility group at section 1902(a)(10)(A)(i)(VIII) who is determined to meet one of the exemption criteria at 45 CFR 440.315 will receive a choice of a benefit package that is either an Alternative Benefit Plan that includes Essential Health Benefits and is subject to all 1937 requirements or an Alternative Benefit Plan that is the state/territory's approved Medicaid state plan not subject to 1937 requirements. The state/territory's approved Medicaid state plan includes all approved state plan programs based on any state plan authority, and approved 1915(c) waivers, if the state has amended them to include the eligibility group at section 1902(a)(10)(A)(i)(VIII).

☑ The state/territory must have a process in place to identify individuals that meet the exemption criteria and the state/territory must comply with requirements related to providing the option of enrollment in an Alternative Benefit Plan defined using section 1937 requirements, or an Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan that is not subject to section 1937 requirements.

☑ Once an individual is identified, the state/territory assures it will effectively inform the individual of the following:

a) Enrollment in the specified Alternative Benefit Plan is voluntary;

b) The individual may disenroll from the Alternative Benefit Plan defined subject to section 1937 requirements at any time and instead receive an Alternative Benefit Plan defined as the approved state/territory Medicaid state plan that is not subject to section 1937 requirements; and

c) What the process is for transferring to the state plan-based Alternative Benefit Plan.

☑ The state/territory assures it will inform the individual of:

a) The benefits available as Alternative Benefit Plan coverage defined using section 1937 requirements as compared to Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan and not subject to section 1937 requirements; and

b) The costs of the different benefit packages and a comparison of how the Alternative Benefit Plan subject to 1937 requirements differs from the Alternative Benefit Plan defined as the approved Medicaid state/territory plan benefits.

How will the state/territory inform individuals about their options for enrollment? (Check all that apply)

☒ Letter

☐ Email

☐ Other

Alternative Benefit Plan

Provide a copy of the letter, email text or other communication text that will be used to inform individuals about their options for enrollment.

An attachment is submitted.

When did/will the state/territory inform the individuals?

The State will provide a notice informing individuals of their eligibility under the Section 1902(a)(10)(A)(i)(VIII) eligibility group once they have been determined eligible through the Federally Facilitated Marketplace (FFM) or via the State's Eligibility and Enrollment Framework (EEF). Additional notices will provide greater detail explaining the process for selecting a Qualified Health Plan (QHP), the process for accessing services until the QHP or ESI enrollment is effective, ESI enrollment, the process for accessing supplemental services, the grievance and appeals process, and outlining the exemption process from the Arkansas Works Alternative Benefit Plan.

Please describe the state/territory's process for allowing individuals in the Section 1902(a)(10)(A)(i)(VIII) eligibility group who meet exemption criteria to disenroll from the Alternative Benefit Plan defined using section 1937 requirements and enroll in the Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan.

During the application process, if a member answers "yes" to the following question: "Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home?", the individual will be enrolled in the ABP that is the state plan and will be provided with a Choice Counseling notice. The Choice Counseling notice will outline the differences between traditional fee-for-service state plan (the ABP that is the state plan) or the fee-for-service ABP (the ABP that is aligned with the EHB benchmark plan) and informing them of their right to choose between the two. The notice will also include a toll-free-number that individuals will call to finalize their selection. If an affirmative selection is not made, the individual will remain in the traditional fee-for-service state plan (the ABP that is the state plan). Arkansas Medicaid will provide individuals who are exempt from the ABP with a Choice Counseling notice that informs them that they may choose between the ABP that is the Arkansas state plan or the ABP that is the FFS equivalent of the QHP offering. The notice will also inform them that they will be enrolled in the ABP that is the Arkansas state plan, unless they inform Arkansas Medicaid that they would like to be enrolled in the ABP that is the FFS equivalent of the QHP offering.

All individuals not identified as medically frail based on their responses on the single streamlined application will receive a general Medicaid eligibility notice. That eligibility notice will include, among other things, information about an individual's ability to identify as medically frail at a later time. The notice will define a medically frail individual as a person who has a physical or behavioral health condition that limits what he or she is able to do (like bathing, dressing, daily chores, etc.), a person who lives in a medical facility or nursing home, a person who has a serious mental illness, a person who has a long-term problem with drugs or alcohol, a person with intellectual or developmental disabilities, or a person with some other serious health condition. The document will inform all enrollees that they may identify as medically frail at any time and can discuss coverage options with their doctor, contact Member Services or visit the Medicaid website for additional information. Once an individual identifies as medically frail, they will receive a Choice Counseling notice and proceed through the steps identified above.

Individuals identified as American Indian or Alaskan Native (AI/AN) will not be required to enroll in QHP's, but can choose to opt into a QHP. New AI/AN applicants will be subject to FPL eligibility determinations and coverage will begin 30 days prior to the date an application is submitted for coverage. Adults who are AI/AN and who have not opted into a QHP will receive the ABP that is the state plan.

☑ The state/territory assures it will document in the exempt individual's eligibility file that the individual:

a) Was informed in accordance with this section prior to enrollment;

b) Was given ample time to arrive at an informed choice; and

c) Chose to enroll in Alternative Benefit Plan coverage subject to section 1937 requirements or defined as the state/territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

Where will the information be documented? (Check all that apply)

☒ In the eligibility system.

☐ In the hard copy of the case record.

☐ Other

What documentation will be maintained in the eligibility file? (Check all that apply)

☒ Copy of correspondence sent to the individual.

☐ Signed documentation from the individual consenting to enrollment in the Alternative Benefit Plan.

☐ Other

☑ The state/territory assures that it will maintain data that tracks the total number of individuals who have voluntarily enrolled in either Alternative Benefit Plan coverage subject to section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

Other information related to benefit package selection assurances for exempt participants (optional):

PRA Disclosure Statement

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C- ☐

Alternative Benefit Plan Cost-Sharing — ABP4

☐ Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A. Yes

☐ The state/territory has completed and attached to this submission Attachment 4.18-F to indicate the Alternative Benefit Plan's cost-sharing provisions that are different from those otherwise approved in the state plan.

An attachment is submitted.

Other Information Related to Cost Sharing Requirements (optional):

Only individuals with household income above 20% of the federal poverty level (FPL) and who are awaiting assignment to a qualified health plan shall pay cost-sharing, subject to the limitations below and in compliance with CFR 42 §§ 447.50 - 447.57.

There are six (6) levels of cost-sharing depending on the individual's federal poverty level (FPL). Total cost-sharing obligations are capped each quarter for each level as follows: 21%-40% FPL; 41%-60% FPL; 61%-80% FPL; 81%-100% FPL; 101%-120% FPL; and 121%-138% FPL. Cost-sharing may not exceed 5% of the lowest level of income within each FPL band, as updated each January 1.

Individuals at or below 20% FPL, those who are deemed medically frail, those identified as American Indian or Alaska Native, individuals aged 19-20 years who receive EPSDT services, and pregnancy-related services are not subject to cost-sharing. The State will use cost sharing as described in the cost sharing section of the State Plan.

V.20130807

State of Arkansas *As Engrossed: S3/8/21*
93rd General Assembly **A Bill**
Regular Session, 2021 SENATE BILL 410

By: Senator Irvin
By: Representative M. Gray

For An Act To Be Entitled

AN ACT TO AMEND TITLE 23 OF THE ARKANSAS CODE TO ENSURE THE STABILITY OF THE INSURANCE MARKET IN ARKANSAS; TO PROMOTE ECONOMIC AND PERSONAL HEALTH, PERSONAL INDEPENDENCE, AND OPPORTUNITY FOR ARKANSANS THROUGH PROGRAM PLANNING AND INITIATIVES; TO CREATE THE ARKANSAS HEALTH AND OPPORTUNITY FOR ME ACT OF 2021 AND THE ARKANSAS HEALTH AND OPPORTUNITY FOR ME PROGRAM; AND FOR OTHER PURPOSES.

Subtitle

TO AMEND TITLE 23 OF THE ARKANSAS CODE TO ENSURE THE STABILITY OF THE INSURANCE MARKET IN ARKANSAS; AND TO CREATE THE ARKANSAS HEALTH AND OPPORTUNITY FOR ME ACT OF 2021 AND THE ARKANSAS HEALTH AND OPPORTUNITY FOR ME PROGRAM.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code Title 23, Chapter 61, Subchapter 10 is amended to read as follows:

Subchapter 10 — ~~Arkansas Works Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021

23-61-1001. Title.

This subchapter shall be known and may be cited as the "~~Arkansas Works~~

~~Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021".

23-61-1002. Legislative intent.

Notwithstanding any general or specific laws to the contrary, it is the intent of the General Assembly for the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program to be a fiscally sustainable, cost-effective, and opportunity-driven program that:

~~(1) Empowers individuals to improve their economic security and achieve self-reliance;~~

~~(2) Builds on private insurance market competition and value-based insurance purchasing models;~~

~~(3) Strengthens the ability of employers to recruit and retain productive employees; and~~

~~(4)~~(1) Achieves comprehensive and innovative healthcare reform that reduces the rate of growth in state and federal obligations for ~~entitlement spending~~ providing healthcare coverage to low-income adults in Arkansas;

(2) Reduces the maternal and infant mortality rates in the state through initiatives that promote healthy outcomes for eligible women with high-risk pregnancies;

(3) Promotes the health, welfare, and stability of mothers and their infants after birth through hospital-based community bridge organizations;

(4) Encourages personal responsibility for individuals to demonstrate that they value healthcare coverage and understand their roles and obligations in maintaining private insurance coverage;

(5) Increases opportunities for full-time work and attainment of economic independence, especially for certain young adults, to reduce long-term poverty that is associated with additional risk for disease and premature death;

(6) Addresses health-related social needs of Arkansans in rural counties through hospital-based community bridge organizations and reduces the additional risk for disease and premature death associated with living in a rural county;

(7) Strengthens the financial stability of the critical access hospitals and other small, rural hospitals; and

(8) Fills gaps in the continuum of care for individuals in need of services for serious mental illness and substance use disorders.

23-61-1003. Definitions.

As used in this subchapter:

~~(1) "Cost-effective" means that the cost of covering employees who are:~~

~~(A) Program participants, either individually or together within an employer health insurance coverage, is the same or less than the cost of providing comparable coverage through individual qualified health insurance plans; or~~

~~(B) Eligible individuals who are not program participants, either individually or together within an employer health insurance coverage, is the same or less than the cost of providing comparable coverage through a program authorized under Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., as it existed on January 1, 2016;~~

(1) "Acute care hospital" means a hospital that:

(A) Is licensed by the Department of Health under § 20-9-201 et seq., as a general hospital or a surgery and general medical care hospital; and

(B) Is enrolled as a provider with the Arkansas Medicaid Program;

(2) "Birthing hospital" means a hospital in this state or in a border state that:

(A) Is licensed as a general hospital;

(B) Provides obstetrics services; and

(C) Is enrolled as a provider with the Arkansas Medicaid Program;

(3) "Community bridge organization" means an organization that is authorized by the Department of Human Services to participate in the economic independence initiative or the health improvement initiative to:

(A) Screen and refer Arkansans to resources available in their communities to address health-related social needs; and

(B) Assist eligible individuals identified as target populations most at risk of disease and premature death and who need a higher level of intervention to improve their health outcomes and succeed in meeting

their long-term goals to achieve independence, including economic independence;

~~(2)~~(4) "Cost sharing" means the portion of the cost of a covered medical service that is required to be paid by or on behalf of an eligible individual;

(5) "Critical access hospital" means an acute care hospital that is:

(A) Designated by the Centers for Medicare and Medicaid Services as a critical access hospital; and

(B) Is enrolled as a provider in the Arkansas Medicaid Program;

(6) "Economic independence initiative" means an initiative developed by the Department of Human Services that is designed to promote economic stability by encouraging participation of program participants to engage in full-time, full-year work, and to demonstrate the value of enrollment in an individual qualified health insurance plan through incentives and disincentives;

~~(3)~~(7) "Eligible individual" means an individual who is in the eligibility category created by section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, 42 U.S.C. § 1396a;

~~(4)~~(8) "Employer health insurance coverage" means a health insurance benefit plan offered by an employer or, as authorized by this subchapter, an employer self-funded insurance plan governed by the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, as amended;

(9) "Health improvement initiative" means an initiative developed by an individual qualified health insurance plan or the Department of Human Services that is designed to encourage the participation of eligible individuals in health assessments and wellness programs, including fitness programs and smoking or tobacco cessation programs;

~~(5)~~(10) "Health insurance benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services, but not including excepted benefits as defined under 42 U.S.C. § 300gg-91(c), as it existed on ~~January 1, 2016~~ January 1, 2021;

~~(6)~~(11) "Health insurance marketplace" means the applicable entities that were designed to help individuals, families, and businesses in

Arkansas shop for and select health insurance benefit plans in a way that permits comparison of available plans based upon price, benefits, services, and quality, and refers to either:

(A) The Arkansas Health Insurance Marketplace created under the Arkansas Health Insurance Marketplace Act, § 23-61-801 et seq., or a successor entity; or

(B) The federal health insurance marketplace or federal health benefit exchange created under the Patient Protection and Affordable Care Act, Pub. L. No. 111-148;

~~(7)~~(12) "Health insurer" means an insurer authorized by the State Insurance Department to provide health insurance or a health insurance benefit plan in the State of Arkansas, including without limitation:

(A) An insurance company;

(B) A medical services plan;

(C) A hospital plan;

(D) A hospital medical service corporation;

(E) A health maintenance organization;

(F) A fraternal benefits society; ~~or~~

(G) Any other entity providing health insurance or a health insurance benefit plan subject to state insurance regulation; or

(H) A risk-based provider organization licensed by the Insurance Commissioner under § 20-77-2704;

(13) "Healthcare coverage" means coverage provided under this subchapter through either an individual qualified health insurance plan, a risk-based provider organization, employer health insurance coverage, or the fee-for-service Arkansas Medicaid Program;

~~(8)~~(14) "Individual qualified health insurance plan" means an individual health insurance benefit plan offered by a health insurer ~~through~~ that participates in the health insurance marketplace to provide coverage in Arkansas that covers only essential health benefits as defined by Arkansas rule and 45 C.F.R. § 156.110 and any federal insurance regulations, as they existed on ~~January 1, 2016~~ January 1, 2021;

(15) "Member" means a program participant who is enrolled in an individual qualified health insurance plan;

~~(9)~~(16) "Premium" means a monthly fee that is required to be paid by or on behalf of an eligible individual to maintain some or all health

insurance benefits;

~~(10)~~(17) "Program participant" means an eligible individual who:

(A) Is at least nineteen (19) years of age and no more than sixty-four (64) years of age with an income that meets the income eligibility standards established by rule of the Department of Human Services;

(B) Is authenticated to be a United States citizen or documented qualified alien according to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193;

(C) Is not eligible for Medicare or advanced premium tax credits through the health insurance marketplace; and

(D) Is not determined ~~to be more effectively covered through the traditional Arkansas Medicaid Program, including without limitation:~~ by the Department of Human Services to be medically frail or eligible for services through a risk-based provider organization;

~~(i) An individual who is medically frail; or~~

~~(ii) An individual who has exceptional medical needs for whom coverage offered through the health insurance marketplace is determined to be impractical, overly complex, or would undermine continuity or effectiveness of care; and~~

~~(11)(A) "Small group plan" means a health insurance benefit plan for a small employer that employed an average of at least two (2) but no more than fifty (50) employees during the preceding calendar year.~~

~~(B) "Small group plan" does not include a grandfathered health insurance plan as defined in 45 C.F.R. § 147.140(a)(1)(i), as it existed on January 1, 2016~~

(18) "Risk-based provider organization" means the same as defined in § 20-77-2703; and

(19) "Small rural hospital" means a critical access hospital or a general hospital that:

(A) Is located in a rural area;

(B) Has fifty (50) or fewer staffed beds; and

(C) Is enrolled as a provider in the Arkansas Medicaid Program.

23-61-1004. Administration ~~of Arkansas Works Program~~.

(a)(1) The Department of Human Services, in coordination with the State Insurance Department and other ~~necessary~~ state agencies, as necessary, shall:

(A) Provide ~~health insurance or medical assistance~~ healthcare coverage under this subchapter to eligible individuals;

(B) Create and administer the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program by:~~;~~

~~(C)~~(i) ~~Submit and apply~~ Applying for any federal waivers, Medicaid state plan amendments, or other authority necessary to implement the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program in a manner consistent with this subchapter; and

(ii) Administering the Arkansas Health and Opportunity for Me Program as approved by the Centers for Medicare and Medicaid Services;

(C)(i) Administer the economic independence initiative designed to reduce the short-term effects of the work penalty and the long-term effects of poverty on health outcomes among program participants through incentives and disincentives.

(ii) The Department of Human Services shall align the economic independence initiative with other state-administered work-related programs to the extent practicable;

(D) Screen, refer, and assist eligible individuals through community bridge organizations under agreements with the Department of Human Services;

~~(D)~~(E) Offer ~~incentive benefits~~ incentives to promote personal responsibility, individual health, and economic independence through individual qualified health insurance plans and community bridge organizations; and

~~(E)~~(F) Seek a waiver to ~~eliminate~~ reduce the period of retroactive eligibility for an eligible individual under this subchapter to thirty (30) days before the date of the application.

(2) The Governor shall request the assistance and involvement of other state agencies that he or she deems necessary for the implementation of the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program.

(b) ~~Health insurance benefits~~ Healthcare coverage under this subchapter shall be provided through enrollment in:

(1) ~~Individual premium assistance for enrollment of Arkansas Works Program participants in~~ An individual qualified health insurance ~~plans~~ plan through a health insurer; ~~and~~

(2) ~~Supplemental benefits to incentivize personal responsibility~~ A risk-based provider organization;

(3) An employer-sponsored health insurance coverage; or

(4) Fee-for-service Medicaid program.

(c) ~~The~~ Annually, the Department of Human Services~~, the State Insurance Department, the Division of Workforce Services, and other necessary state agencies shall promulgate and administer rules to implement the Arkansas Works Program.~~ shall develop purchasing guidelines that:

(1) Describe which individual qualified health insurance plans are suitable for purchase in the next demonstration year, including without limitation:

(A) The level of the plan;

(B) The amounts of allowable premiums;

(C) Cost sharing;

(D) Auto-assignment methodology; and

(E) The total per-member-per-month enrollment range; and

(2) Ensure that:

(A) Payments to an individual qualified health insurance plan do not exceed budget neutrality limitations in each demonstration year;

(B) The total payments to all of the individual qualified health insurance plans offered by the health insurers for eligible individuals combined do not exceed budget targets for the Arkansas Health and Opportunity for Me Program in each demonstration year that the Department of Human Services may achieve by:

(i) Setting in advance an enrollment range to represent the minimum and a maximum total monthly number of enrollees into all individual qualified health insurance plans no later than April 30 of each demonstration year in order for the individual qualified health insurance plans to file rates for the following demonstration year;

(ii) Temporarily suspending auto-assignment into the individual qualified health insurance plans at any time in a demonstration year if necessary, to remain within the enrollment range and budget targets for the demonstration year; and

(iii) Developing a methodology for random auto-assignment of program participants into the individual qualified health insurance plans after a suspension period has ended;

(C) Individual qualified health insurance plans meet and report quality and performance measurement targets set by the Department of Human Services; and

(D) At least two (2) health insurers offer individual qualified health insurance plans in each county in the state.

(d)(1) The Department of Human Services, the State Insurance Department, and each of the individual qualified health insurance plans shall enter into a memorandum of understanding that shall specify the duties and obligations of each party in the operation of the Arkansas Health and Opportunity for Me Program, including provisions necessary to effectuate the purchasing guidelines and reporting requirements, at least thirty (30) calendar days before the annual open enrollment period.

(2) If a memorandum of understanding is not fully executed with a health insurer by January 1 of each new demonstration year, the Department of Human Services shall suspend auto-assignment of new members to the health insurers until the first day of the month after the new memorandum of understanding is fully executed.

(3) The memorandum of understanding shall include financial sanctions determined appropriate by the Department of Human Services that may be applied if the Department of Human Services determines that an individual qualified health insurance plan has not met the quality and performance measurement targets or any other condition of the memorandum of *understanding.*

(4)(A) If the Department of Human Services determines that the individual qualified health insurance plans have not met the quality and health performance targets for two (2) years, the Department of Human Services shall develop additional reforms to achieve the quality and health performance targets.

(B) If legislative action is required to implement the additional reforms described in subdivision (d)(4)(A) of this section, the Department of Human Services may take the action to the Legislative Council or the Executive Subcommittee of the Legislative Council for immediate action.

(e) The Department of Human Services shall:

(1) Adopt premiums and cost sharing levels for individuals enrolled in the Arkansas Health and Opportunity for Me Program, not to exceed aggregate limits under 42 C.F.R. § 447.56;

(2)(A) Establish and maintain a process for premium payments, advanced cost-sharing reduction payments, and reconciliation payments to health insurers.

(B) The process described in subdivision (e)(2)(A) of this section shall attribute any unpaid member liabilities as solely the financial obligation of the individual member.

(C) The Department of Human Services shall not include any unpaid individual member obligation in any payment or financial reconciliation with health insurers or in a future premium rate; and

(3)(A) Calculate a total per-member-per-month amount for each individual qualified health insurance plan based on all payments made by the Department of Human Services on behalf of an individual enrolled in the individual qualified health insurance plan.

(B)(i) The amount described in subdivision (e)(3)(A) of this section shall include premium payments, advanced cost-sharing reduction payments for services provided to covered individuals during the demonstration year, and any other payments accruing to the budget neutrality target for plan-enrolled individuals made during the demonstration year and the member months for each demonstration year.

(ii) The total per-member-per-month upper limit is the budget neutrality per-member-per-month limit established in the approved demonstration for each demonstration year.

(C) If the Department of Human Services calculates that the total per-member-per-month for an individual qualified health insurance plan for that demonstration year exceeds the budget neutrality per-member-per-month limit for that demonstration year, the Department of Human Services shall not make any additional reconciliation payments to the health insurer for that individual qualified health insurance plan.

(D) If the Department of Human Services determines that the budget neutrality limit has been exceeded, the Department of Human Services shall recover the excess funds from the health insurer for that individual qualified health insurance plan.

~~(d)(1)~~(f)(1) ~~If the~~ ~~Within thirty (30) days of a reduction in~~ federal medical assistance percentages ~~as described in this section~~ for the Arkansas Health and Opportunity for Me Program are reduced to below ninety percent (90%), the Department of Human Services shall present to the Centers for Medicare and Medicaid Services a plan within thirty (30) days of the reduction to terminate the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program and transition eligible individuals out of the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program within one hundred twenty (120) days of ~~a~~ the reduction ~~in any of the following federal medical assistance percentages:~~

~~(A) Ninety-five percent (95%) in the year 2017;~~

~~(B) Ninety-four percent (94%) in the year 2018;~~

~~(C) Ninety-three percent (93%) in the year 2019; and~~

~~(D) Ninety percent (90%) in the year 2020 or any year after the year 2020~~.

(2) An eligible individual shall maintain coverage during the process to implement the plan to terminate the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program and the transition of eligible individuals out of the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program.

~~(e) State obligations for uncompensated care shall be tracked and reported to identify potential incremental future decreases.~~

~~(f) The Department of Human Services shall track the hospital assessment fee imposed by § 20-77-1902 and report to the General Assembly subsequent decreases based upon reduced uncompensated care.~~

~~(g)(1) On a quarterly basis, the Department of Human Services, the State Insurance Department, the Division of Workforce Services, and other necessary state agencies shall report to the Legislative Council, or to the Joint Budget Committee if the General Assembly is in session, available information regarding the overall Arkansas Works Program, including without limitation:~~

~~(A) Eligibility and enrollment;~~

~~(B) Utilization;~~

~~(C) Premium and cost-sharing reduction costs;~~

~~(D) Health insurer participation and competition;~~

~~(E) Avoided uncompensated care; and~~

~~(F) Participation in job training and job search programs.~~

~~(2)(A)~~(g)(1) A health insurer ~~who~~ that is providing an individual qualified health insurance plan or employer health insurance coverage for an eligible individual shall submit claims and enrollment data to the ~~State Insurance Department~~ Department of Human Services to facilitate reporting required under this subchapter or other state or federally required reporting or evaluation activities.

~~(B)~~(2) A health insurer may utilize existing mechanisms with supplemental enrollment information to fulfill requirements under this subchapter, including without limitation the state's all-payer claims database established under the Arkansas Healthcare Transparency Initiative Act of 2015, § 23-61-901 et seq., for claims and enrollment data submission.

(h)(1) The Governor shall request a block grant under relevant federal law and regulations for the funding of the Arkansas Medicaid Program as soon as practical if the federal law or regulations change to allow the approval of a block grant for this purpose.

(2) The Governor shall request a waiver under relevant federal law and regulations for a work requirement as a condition of maintaining coverage in the Arkansas Medicaid Program as soon as practical if the federal law or regulations change to allow the approval of a waiver for this purpose.

23-61-1005. Requirements for eligible individuals.

~~(a)(1) To promote health, wellness, and healthcare education about appropriate healthcare-seeking behaviors, an eligible individual shall receive a wellness visit from a primary care provider within:~~

~~(A) The first year of enrollment in health insurance coverage for an eligible individual who is not a program participant and is enrolled in employer health insurance coverage; and~~

~~(B) The first year of, and thereafter annually:~~

~~(i) Enrollment in an individual qualified health insurance plan or employer health insurance coverage for a program participant; or~~

~~(ii) Notice of eligibility determination for an eligible individual who is not a program participant and is not enrolled in employer health insurance coverage.~~

~~(2) Failure to meet the requirement in subdivision (a)(1) of~~

~~this section shall result in the loss of incentive benefits for a period of up to one (1) year, as incentive benefits are defined by the Department of Human Services in consultation with the State Insurance Department.~~

~~(b)(1) An eligible individual who has up to fifty percent (50%) of the federal poverty level at the time of an eligibility determination shall be referred to the Division of Workforce Services to:~~

~~(A) Incentivize and increase work and work training opportunities; and~~

~~(B) Participate in job training and job search programs.~~

~~(2) The Department of Human Services or its designee shall provide work training opportunities, outreach, and education about work and work training opportunities through the Division of Workforce Services to all eligible individuals regardless of income at the time of an eligibility determination.~~

(a) An eligible individual is responsible for all applicable cost-sharing and premium payment requirements as determined by the Department of Human Services.

(b) An eligible individual may participate in a health improvement initiative, as developed and implemented by either the eligible individual's individual qualified health insurance plan or the department.

(c)(1)(A) An eligible individual who is determined by the department to meet the eligibility criteria for a risk-based provider organization due to serious mental illness or substance use disorder shall be enrolled in a risk-based provider organization under criteria established by the department.

(B) An eligible individual who is enrolled in a risk-based provider organization is exempt from the requirements of subsections (a) and (b) of this section.

(2)(A) An eligible individual who is determined by the department to be medically frail shall receive healthcare coverage through fee-for-service Medicaid.

(B) An eligible individual who is enrolled in the fee-for-service Medicaid program is exempt from the requirements of subsection (a) of this section.

~~(c)~~(d) An eligible individual shall receive notice that:

(1) The ~~Arkansas Works Program~~ Arkansas Health and Opportunity

for Me Program is not a perpetual federal or state right or a guaranteed entitlement;

(2) The ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program is subject to cancellation upon appropriate notice; ~~and~~

(3) ~~The Arkansas Works Program is not an entitlement program~~ Enrollment in an individual qualified health insurance plan is not a right; and

(4) If the individual chooses not to participate or fails to meet participation goals in the economic independence initiative, the individual may lose incentives provided through enrollment in an individual qualified health insurance plan or be unenrolled from the individual qualified health insurance plan after notification by the department.

23-61-1006. Requirements for program participants.

~~(a) A program participant who is twenty-one (21) years of age or older shall enroll in employer health insurance coverage if the employer health insurance coverage meets the standards in § 23-61-1008(a).~~

~~(b)(1) A program participant who has income of at least one hundred percent (100%) of the federal poverty level shall pay a premium of no more than two percent (2%) of the income to a health insurer.~~

~~(2) Failure by the program participant to meet the requirement in subdivision (b)(1) of this section may result in:~~

~~(A) The accrual of a debt to the State of Arkansas; and~~

~~(B)(i) The loss of incentive benefits in the event of failure to pay premiums for three (3) consecutive months, as incentive benefits are defined by the Department of Human Services in consultation with the State Insurance Department.~~

~~(ii) However, incentive benefits shall be restored if a program participant pays all premiums owed.~~

(a) The economic independence initiative applies to all program participants in accordance with the implementation schedule of the Department of Human Services.

(b) Incentives established by the department for participation in the economic independence initiative and the health improvement initiative may include, without limitation, the waiver of premium payments and cost-sharing requirements as determined by the department for participation in one (1) or

more initiatives.

(c) Failure by a program participant to meet the cost-sharing and premium payment requirement under § 23-61-1005(a) may result in the accrual of a personal debt to the health insurer or provider.

(d)(1)(A) Failure by the program participant to meet the initiative participation requirements of subsection (b) of this section may result in:

(i) Being unenrolled from the individual qualified health insurance plan; or

(ii) The loss of incentives, as defined by the department.

(B) However, an individual who is unenrolled shall not lose Medicaid healthcare coverage based solely on disenrollment from the individual qualified health insurance plan.

(2) The department shall develop and notify program participants of the criteria for restoring eligibility for incentive benefits that were removed as a result of the program participants' failure to meet the initiative participation requirements of subsection (b) of this section.

(3)(A) A program participant who also meets the criteria of a community bridge organization target population may qualify for additional incentives by successfully completing the economic independence initiative provided through a community bridge organization.

(B) If successfully completing the initiative results in an increase in the program participant's income that exceeds the program's financial eligibility limits, a program participant may receive, for a specified period of time, financial assistance to pay:

(i) The individual's share of employer-sponsored health insurance coverage not to exceed a limit determined by the department; or

(ii) A share of the individual's cost sharing obligation, as determined by the department, if the individual enrolls in a health insurance benefit plan offered through the Arkansas Health Insurance Marketplace.

23-61-1007. Insurance standards for individual qualified health insurance plans.

(a) Insurance coverage for a ~~program participant~~ member enrolled in an

individual qualified health insurance plan shall be obtained, at a minimum, through silver-level metallic plans as provided in 42 U.S.C. § 18022(d) and § 18071, as they existed on ~~January 1, 2016~~ January 1, 2021, that restrict out-of-pocket costs to amounts that do not exceed applicable out-of-pocket cost limitations.

(b) ~~The Department of Human Services shall pay premiums and supplemental cost sharing reductions directly to a health insurer for a program participant enrolled in an individual qualified health insurance plan~~ As provided under § 23-61-1004(e)(2), health insurers shall track the applicable premium payments and cost sharing collected from members to ensure that the total amount of an individual's payments for premiums and cost sharing does not exceed the aggregate cap imposed by 42 C.F.R. § 447.56.

(c) ~~All participating health insurers offering individual qualified health insurance plans in the health insurance marketplace~~ All health benefit plans purchased by the Department of Human Services shall:

(1)~~(A) Offer individual qualified health insurance plans conforming~~ Conform to the requirements of this section and applicable insurance rules~~.~~;

~~(B)~~(2) Be certified by the State Insurance Department; ~~The individual qualified health insurance plans shall be approved by the State Insurance Department; and~~

~~(2)~~(3)(A) Maintain a medical-loss ratio of at least eighty percent (80%) for an individual qualified health insurance plan as required under 45 C.F.R. § 158.210(c), as it existed on ~~January 1, 2016~~ January 1, 2021, or rebate the difference to the Department of Human Services for ~~program participants~~ members.

(B) However, the Department of Human Services may approve up to one percent (1%) of revenues as community investments and as benefit expenses in calculating the medical-loss ratio of a plan in accordance with 45 C.F.R. § 158.150;

(4) Develop:

(A) An annual quality assessment and performance improvement strategic plan to be approved by the Department of Human Services that aligns with federal quality improvement initiatives and quality and reporting requirements of the Department of Human Services; and

(B) Targeted initiatives based on requirements established

by the Department of Human Services in consultation with the Department of Health; and

(5) Make reports to the Department of Human Service and the Department of Health regarding quality and performance metrics in a manner and frequency established by a memorandum of understanding.

~~(d) The State of Arkansas shall assure that at least two (2) individual qualified health insurance plans are offered in each county in the state.~~

~~(e)~~(d) A health insurer offering individual qualified health insurance plans for ~~program participants~~ members shall participate in the Arkansas Patient-Centered Medical Home Program, including:

(1) Attributing enrollees in individual qualified health insurance plans, including ~~program participants~~ members, to a primary care physician;

(2) Providing financial support to patient-centered medical homes to meet practice transformation milestones; and

(3) Supplying clinical performance data to patient-centered medical homes, including data to enable patient-centered medical homes to assess the relative cost and quality of healthcare providers to whom patient-centered medical homes refer patients.

(e)(1) Each individual qualified health insurance plan shall provide for a health improvement initiative, subject to the review and approval of the Department of Human Services, to provide incentives to its enrolled members to participate in one (1) or more health improvement programs as defined in § 23-61-1003(9).

(2)(A) The Department of Human Services shall work with health insurers offering individual qualified health insurance plans to ensure the economic independence initiative offered by the health insurer includes a robust outreach and communications effort which targets specific health, education, training, employment, and other opportunities appropriate for its enrolled members.

(B) The outreach and communications effort shall recognize that enrolled members receive information from multiple channels, including without limitation:

(i) Community service organizations;

(ii) Local community outreach partners;

(iii) Email;

(iv) Radio;

(v) Religious organizations;

(vi) Social media;

(vii) Television;

(viii) Text message; and

(ix) Traditional methods such as newspaper or mail.

(f) On or before ~~January 1, 2017~~ January 1, 2022, the State Insurance Department and the Department of Human Services may implement through certification requirements or rule, or both, the applicable provisions of this section.

~~23-61-1008. [Expired.]~~

23-61-1009. Sunset.

This subchapter shall expire on ~~December 31, 2021~~ December 31, 2026.

23-61-1010. Community bridge organizations.

(a) The Department of Human Services shall develop requirements and qualifications for community bridge organizations to provide assistance to one (1) or more of the following target populations

(1) Individuals who become pregnant with a high-risk pregnancy and the child, throughout the pregnancy and up to twenty-four (24) months after birth;

(2) Individuals in rural areas of the state in need of treatment for serious mental illness or substance use disorder;

(3) Individuals who are young adults most at risk of poor health due to long-term poverty and who meet criteria established by the Department of Human Services, including without limitation the following:

(A) An individual between nineteen (19) and twenty-four (24) years of age who has been previously placed under the supervision of the:

(i) Division of Youth Services; or

(ii) Department of Corrections;

(B) An individual between nineteen (19) and twenty-seven (27) years of age who has been previously placed under the supervision of the

Division of Children and Family Services; or

(C) An individual between nineteen (19) and thirty (30) years of age who is a veteran; and

(4) Any other target populations identified by the Department of Human Services.

(b)(1) Each community bridge organization shall be administered by a hospital under conditions established by the Department of Human Services.

(2) A hospital is eligible to serve eligible individuals under subdivision (a)(1) of this section if the hospital:

(A) Is a birthing hospital;

(B) Provides or contracts with a qualified entity for the provision of a federally recognized evidence-based home visitation model to a woman during pregnancy and to the woman and child for a period of up to twenty-four (24) months after birth; and

(C) Meets any additional criteria established by the Department of Human Services.

(3)(A) A hospital is eligible to serve eligible individuals under subdivision (a)(2) of this section if the hospital:

(i) Is a small rural hospital;

(ii) Screens all Arkansans who seek services at the hospital for health-related social needs;

(iii) Refers Arkansans identified as having health-related social needs for social services available in the community;

(iv) Employs *local qualified staff* to assist eligible individuals in need of treatment for serious mental illness or substance use disorder in accessing medical treatment from healthcare professionals and supports to meet health-related social needs;

(v) Enrolls with Arkansas Medicaid Program as an acute crisis unit provider; and

(vi) Meets any additional criteria established by the Department of Human Services.

(B) The hospital may use funding available through the Department of Human Services to improve the hospital's ability to deliver care through coordination with other healthcare professionals and with the local emergency response system that may include training of personnel and improvements in equipment to support the delivery of medical services through

telemedicine.

(4) A hospital is eligible to serve eligible individuals under subdivision (a)(3) of this section if the hospital:

(A) Is an acute care hospital;

(B) Administers or contracts for the administration programs using proven models, as defined by the Department of Human Services, to provide employment, training, education, or other social supports; and

(C) Meets any additional criteria established by the Department of Human Services.

(c) An individual is not required or entitled to enroll in a community bridge organization as a condition of Medicaid eligibility.

(d) A hospital is not:

(1) Required to apply to become a community bridge organization; or

(2) Entitled to be selected as a community bridge organization.

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 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)(6)(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 co-chairs 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 co-chair shall be selected by majority vote of all legislative members serving on the advisory panel.

(d)(1) The advisory panel shall review, make nonbinding recommendations, and provide advice concerning the proposed quality

performance targets presented by the Department of Human Services for each participating individual qualified health insurance plan.

(2) The advisory panel shall deliver all nonbinding recommendations to the Secretary of the Department of Human Services.

(3)(A) The Secretary of the Department of Human Services, in consultation with the State Medicaid Director, shall determine all quality performance targets for each participating individual qualified health insurance plan.

(B) The Secretary may consider the nonbinding recommendations of the advisory panel when determining quality performance targets for each participating individual qualified health insurance plan.

(e) The advisory panel shall review:

(1) The annual quality assessment and performance improvement strategic plan for each participating individual qualified health insurance plan;

(2) Financial performance of the Arkansas Health and Opportunity for Me Program against the budget neutrality targets in each demonstration year;

(3) Quarterly reports prepared by the Department of Human Services, in consultation with the Department of Commerce, on progress towards meeting economic independence outcomes and health improvement outcomes, including without limitation:

(A) Community bridge organization outcomes;

(B) Individual qualified health insurance plan health improvement outcomes;

(C) Economic independence initiative outcomes; and

(D) Any sanctions or penalties assessed on participating Individual qualified health insurance plans;

(4) Quarterly reports prepared by the Department of Human Services on the Arkansas Health and Opportunity for Me Program, including without limitation:

(A) Eligibility and enrollment;

(B) Utilization;

(C) Premium and cost-sharing reduction costs; and

(D) Health insurer participation and competition; and

(5) Any other topics as requested by the Secretary of the

Department of Human Services.

(f)(1) The advisory panel may furnish advice, gather information, make recommendations, and publish reports.

(2) However, the advisory panel shall not administer any portion of the Arkansas Health and Opportunity for Me Program or set policy.

(g) The Department of Human Services shall provide administrative support necessary for the advisory panel to perform its duties.

(h) The Department of Human Services shall produce and submit a quarterly report incorporating the advisory panel's findings to the President Pro Tempore of the Senate, the Speaker of the House of Representatives, and the public on the progress in health and economic improvement resulting from the Arkansas Health and Opportunity for Me Program, including without limitation:

(1) Eligibility and enrollment;

(2) Participation in and the impact of the economic independence initiative and the health improvement initiative of the eligible individuals, health insurers, and community bridge organizations;

(3) Utilization of medical services;

(4) Premium and cost-sharing reduction costs; and

(5) Health insurer participation and completion.

20-61-1012. Rules.

The Department of Human Services shall adopt rules necessary to implement this subchapter.

SECTION 2. Arkansas Code § 19-5-984(b)(2)(D), concerning the Division of Workforce Services Special Fund, is amended to read as follows:

(D) The ~~Arkansas Works Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq., or its successor; and

SECTION 3. Arkansas Code § 19-5-1146 is amended to read as follows:

19-5-1146. ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program Trust Fund.

(a) There is created on the books of the Treasurer of State, the Auditor of State, and the Chief Fiscal Officer of the State a trust fund to be known as the "~~Arkansas Works Program~~ Arkansas Health and Opportunity for

Me Program Trust Fund".

(b) The fund shall consist of:

(1) Moneys saved and accrued under the ~~Arkansas Works Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq., including without limitation:

(A) Increases in premium tax collections; and

(B) Other spending reductions resulting from the ~~Arkansas Works Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq.; and

(2) Other revenues and funds authorized by law.

(c) The Department of Human Services shall use the fund to pay for future obligations under the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program created by the ~~Arkansas Works Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq.

SECTION 4. Arkansas Code § 23-61-803(h), concerning the creation of the Arkansas Health Insurance Marketplace, is amended to read as follows:

(h) The State Insurance Department and any eligible entity under subdivision ~~(e)(1)~~ (e)(2) of this section shall provide claims and other plan and enrollment data to the Department of Human Services upon request to:

(1) Facilitate compliance with reporting requirements under state and federal law; and

(2) Assess the performance of the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program established by the ~~Arkansas Works Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq., including without limitation the program's quality, cost, and consumer access.

SECTION 5. Arkansas Code § 23-79-1601(2)(A), concerning the definition of "health benefit plan" regarding coverage provided through telemedicine, is amended to read as follows:

(2)(A) "Health benefit plan" means:

(i) An individual, blanket, or group plan, policy, or contract for healthcare services issued or delivered by an insurer, health maintenance organization, hospital medical service corporation, or self-insured governmental or church plan in this state; and

(ii) Any health benefit program receiving state or federal appropriations from the State of Arkansas, including the Arkansas Medicaid Program~~, the Health Care Independence Program [expired], commonly referred to as the "Private Option",~~ and the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program, or any successor program.

SECTION 6. Arkansas Code § 23-79-1801(1)(A), concerning the definition of "health benefit plan" regarding coverage for newborn screening for spinal muscular atrophy, is amended to read as follows:

(1)(A) "Health benefit plan" means:

(i) An individual, blanket, or group plan, policy, or contract for healthcare services issued or delivered by an insurer, health maintenance organization, hospital medical service corporation, or self-insured governmental or church plan in this state; and

(ii) Any health benefit program receiving state or federal appropriations from the State of Arkansas, including the Arkansas Medicaid Program~~, the Health Care Independence Program [expired], commonly referred to as the "Private Option",~~ and the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program, or any successor program.

SECTION 7. Arkansas Code § 26-57-604(a)(1)(B)(ii), concerning the remittance of the insurance premium tax, is amended to read as follows:

(ii) However, the credit shall not be applied as an offset against the premium tax on collections resulting from an eligible individual insured under the ~~Health Care Independence Act of 2013, § 20-77-2401 et seq. [repealed], the Arkansas Works Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq., the Arkansas Health Insurance Marketplace Act, § 23-61-801 et seq., or individual qualified health insurance plans, including without limitation stand-alone dental plans, issued through the health insurance marketplace as defined by § 23-61-1003.

SECTION 8. Arkansas Code § 26-57-610(b)(2), concerning the disposition of the insurance premium tax, is amended to read as follows:

(2) The taxes based on premiums collected under the ~~Health Care Independence Act of 2013, § 20-77-2401 et seq. [repealed], the Arkansas Works~~

~~Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq., the Arkansas Health Insurance Marketplace Act, § 23-61-801 et seq., or individual qualified health insurance plans, including without limitation stand-alone dental plans, issued through the health insurance marketplace as defined by § 23-61-1003 shall be:

(A) At the time of deposit, separately certified by the commissioner to the Treasurer of State for classification and distribution under this section; and

(B) Transferred to the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program Trust Fund and used as required by the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program Trust Fund;

SECTION 9. EFFECTIVE DATE.

This act is effective on and after January 1, 2022.

/s/Irvin

APPROVED: 4/1/21