

## Plan Management Frequently Asked Questions-Calendar Year 2026

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

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

For the 2026 coverage year, DHS intends to implement the following purchasing requirements for the Section 1115 Demonstration Project, ARHOME.

A. For calendar year 2026, DHS intends to purchase within a service area:

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

DHS intends to purchase plans that meet the criteria in 1, 2, or 3 above and for which a Memorandum of Understanding (MOU) between DHS and the issuer for calendar year 2026 has been signed by both parties and AID. For a plan to be purchased by DHS for beneficiary coverage beginning January 1, 2026, the CY 2026 MOU must be signed by the parties. If the CY2026 MOU with a health issuer is not signed by the carrier by January 1, 2026, DHS will:

- a. Extend the CY 2025 MOU in one month increments with a budget neutrality limit of \$836.63; and
- b. Suspend auto-assignment of new members to that issuer until the first day of the next month after the new MOU is signed.

The budget neutrality cap for calendar year 2026 is \$878.46 per member per month averaged across each plan's member months.

An Issuer pursuing the addition of a new QHP to the ARHOME program for 2026 must receive approval from DHS for the potential addition (subject to AID certification) before contacting any of DHS's contractors related to the contractor's responsibilities in supporting the ARHOME waiver. Failure to do so may disqualify the QHP from participating in the ARHOME program in

2026. Prior to disqualification or other action to penalize the Issuer, DHS agrees to contact the Issuer to provide the Issuer with an opportunity to respond to any such allegation or incident and to understand the extent of any contact and its relationship to the current ARHOME waiver.

DHS will not enroll a new QHP in the ARHOME program after open enrollment begins for the 2026 plan year.

DHS shall pay the lesser of the actual total per member per month cost or the per member per month budget neutrality cap limit amount for calendar year 2026.

The total per member per month cost shall be determined using the following formula:

$$(\text{Net Premium} + \text{Net ACSR} + \text{CSR Reconciliation} + \text{Wrap Cost}) / \text{Member Months}$$

The CSR reconciliation will be determined by comparing the advanced cost share reduction (ACSR) to the actual CSR documented in the MIDAS file provided by the carrier.

By January 1, 2026, issuers shall provide to DHS the percent of each of their QHPs' 2026 premiums built in as CSR load. This amount of premium attributed to CSR load will be counted as ACSR in the CSR reconciliation calculation.

Beneficiaries will be responsible for copays as specified by Appendix C, the carrier will pay in-network and out-of-network charges according to its Marketplace plan design. DHS will pay the carrier the difference between the beneficiary's copay obligation under Appendix C and the member obligation under the Marketplace plan design. DHS will make these cost sharing reduction payments through ACSR payments and the final CSR reconciliation. Carriers will provide data to DHS on the amount of out-of-network charges ARHOME beneficiaries were obligated to pay, including any balance billed amounts. The data must be provided in a format and a timeframe established by DHS.

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

Wrap costs consist of dental and vision benefits for beneficiaries under 21, non-emergency transportation, out of network family planning services and success coaching services.

The plans shall report on the CSR incurred during Plan Year 2026 and paid for through the run out period by July 31, 2026. The CSR payments the Issuer made for out-of-network providers will be distinguishable from CSR payments the Issuer made for in-network providers. If advanced cost sharing reductions exceed the actual cost sharing reductions, the issuers will be liable to DHS for repayment of excessive advanced cost sharing reductions. If the actual cost sharing reductions exceed the advanced cost sharing reductions, DHS will compensate the issuer the difference in the amounts, subject to the

applicable budget neutrality cap limit. The Issuer may submit revised CSR data and claim additional CSR payments owed by DHS only until December 31, 2026.

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

- (1) The issuer must submit quarterly reports in the format required by DHS to enable DHS to meet its obligations to the Health and Economic Outcomes Accountability Oversight Advisory Panel and to the Centers for Medicare and Medicaid Services (CMS).
- (2) The issuer must submit an annual quality assessment and performance improvement strategic plan that includes all of the following:
  - a) Activities, including the use of incentives to the QHP's members or providers to support the DHS Health Improvement Initiative;
  - b) Activities, including the use of incentives to the QHP's members to support the DHS Economic Independence Initiative;
  - c) Activities to improve the health outcomes of individuals in each of the following groups:
    - i. Those who are pregnant, with a particular focus on women with high-risk pregnancies
    - ii. Those with mental illness
    - iii. Those with substance use disorders
    - iv. Those with two or more chronic diseases
    - v. Those living in rural areas of the state
  - d) Activities to encourage the use of preventive care.

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

A2. QHPs must cover services provided by acute crisis units (ACUs), including ACUs based in Outpatient Behavioral Health Agencies (OBHAs) and those based in hospitals. QHPs must cover mobile crisis intervention services as defined in the Medicaid State Plan for the QHP's ARHOME enrollees. QHPs must accept any willing provider of these services in their provider networks during CY2026.

QHPs must accept any willing provider in their provider networks during CY 2026 for all Maternal Life 360 HOMEs approved by DHS. QHPs will be given three (3) months to negotiate with and add any providers identified by DHS on the Maternal Life 360 HOMEs list beginning with the date that the list is provided to the issuers.

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

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

A3. ARHOME enrollees have at least 42 days to select a plan. For those individuals who do not select a plan, DHS will auto-assign them only to those plans that meet the purchasing guidelines described above. If the total number of ARHOME beneficiaries enrolled in QHPs exceeds 210,000 or the percentage of enrollees in the QHPs exceeds 80% of total program enrollment, DHS may suspend auto-assignment of newly determined eligible individuals if DHS determines it is necessary to meet budgetary targets. If DHS takes this action, auto-assignment will remain suspended until the number of ARHOME beneficiaries enrolled in a QHP drops below 180,000 or the percentage of enrollees in the QHPs no longer exceeds 80% of total enrollment.

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

Two plans: 33% of ARHOME QHP enrollees in that service area;  
Three plans: 25% of ARHOME QHP enrollees in that service area;  
Four plans: 20% of ARHOME QHP enrollees in that service area;  
More than four plans: 10% of ARHOME QHP enrollees in that service area.

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

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

A4. Yes.

Q5. Which plans may utilize copays?

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

0-20% FPL: \$0  
>20%-40% FPL: \$27  
>40%-60% FPL: \$54

>60%-80% FPL: \$81  
>80%-100% FPL: \$108  
>100%-120% FPL: \$135  
>120%-138% FPL: \$163

Q6. Are any enrollees or services exempt from copays?

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

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

Services that are exempt from enrollee-incurred copays are:

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

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

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

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

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

QHPs that intend to participate in ARHOME in CY 2026 are required to submit to DHS by November 1, 2025, a description of each incentive, including the amount of any financial reward; the goal of the incentive; the target audience; and the plan for communicating the incentive to individuals or providers.

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

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

Q9. What notice requirements are QHPs required to follow?

A9. Carriers will provide to DHS templates for open enrollment notices, new Enrollee packets, renewing Enrollee packets, invoices, explanation of benefits (or other notice informing Enrollees they have met their copay limit or their copay limit/status has changed) and copies of plan ID cards for the 2026 plan year. The documents shall be provided to DHS by July 15, 2025, and are subject to revisions as allowed by law and requested by DHS when information does not align with program policies. The Issuer must also provide to DHS member communications of incentives the Issuer is using to comply the incentives described in A7 within 10 days of its distribution.

Issuers must provide Enrollees with the following information in new and renewing Enrollee Packets developed for plan year 2026:

- The availability of non-emergency transportation through Medicaid fee for service and instructions for accessing it
- For 19- and 20-year-olds, the availability of vision and dental benefits through Medicaid fee for service and instructions for accessing them
- The populations and services that are exempt from copays

Q10. Are QHPs responsible for the quality of care their enrollees receive?

A10. Yes. DHS will measure the QHP's performance on specified health care quality metrics that DHS has selected for Plan Year 2026. DHS will establish performance targets on the selected metrics the QHP must meet during Plan Year 2026.