ARHOME
health & opportunity for me

IMPROVING YOUR HEALTH AND
EXPANDING YOUR OPPORTUNITIES

ARHOME Health and Economic Outcomes Accountability Oversight Advisory Panel

Quarterly Report

June 2022

ARKANSAS DEPARTMENT OF HUMAN SERVICES

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; and
- Any sanctions or penalties assessed on participating individual qualified health insurance plans;
- Community bridge organization outcomes;

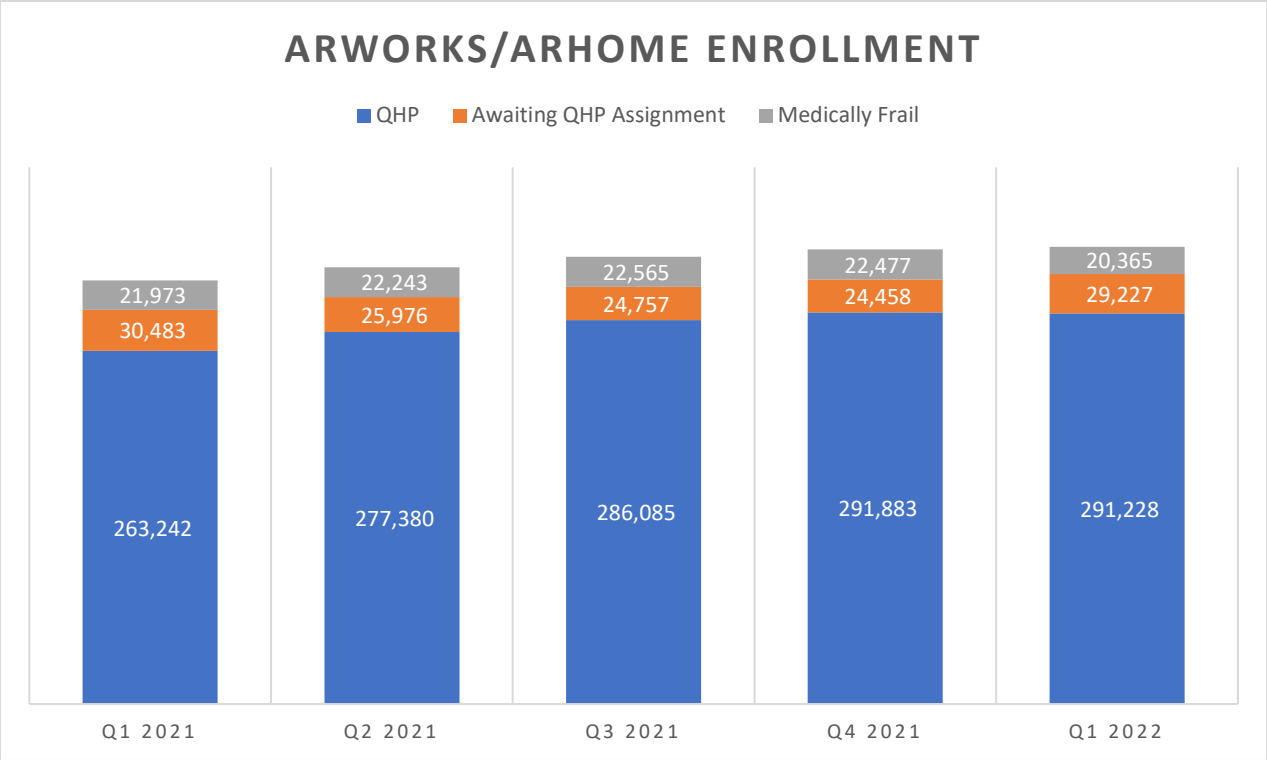
ARHOME Overview

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.

Eligibility and enrollment

Most ARHOME clients (about 85% at the start of 2022) enroll in a QHP offered on the state's health insurance Marketplace. Another 9% of ARHOME clients are awaiting enrollment in a QHP. After individuals are determined eligible for ARHOME, they have 42 days to select a QHP. Those who do not select a plan are auto-enrolled in a QHP. Those that are auto-enrolled have 30 days to change their plan before their QHP coverage begins. While individuals wait for QHP enrollment, they receive coverage through traditional fee for service Medicaid.

Another 6% of ARHOME clients are considered medically frail, meaning they have health care needs that are better served by the traditional Medicaid program. Medically frail clients do not enroll in a QHP, instead they receive health care services through traditional fee for service Medicaid.



Enrollment as of the first day of each quarter as of April 4, 2022

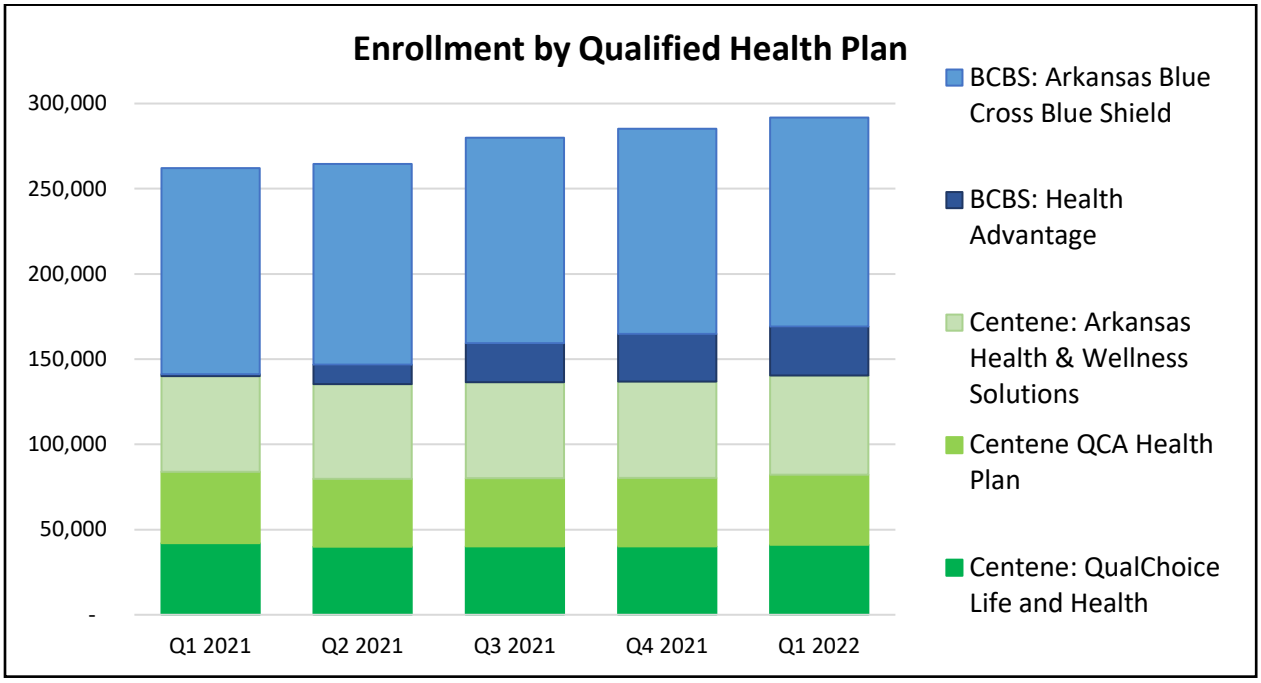
Enrollment increased during 2020 and 2021 primarily due to the public health emergency caused by the COVID 19 pandemic. CMS prohibited states from disenrolling clients from Medicaid programs for any reason, except when the client passes away, becomes incarcerated, moves out of state, requests to be disenrolled, or shifts to a different Medicaid program. That means clients who might have been disenrolled due to aging out of the program or because their income increased beyond the program limits have remained enrolled.

Health insurer participation and competition

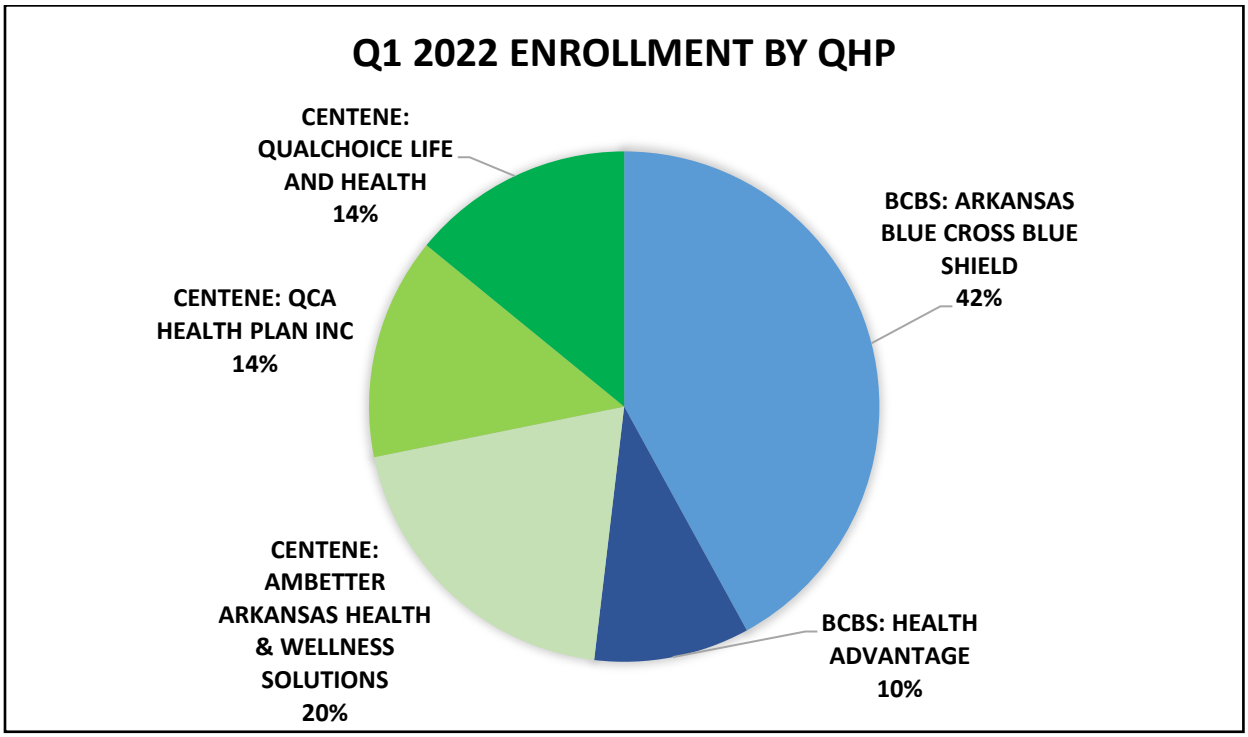
The ARHOME program currently purchases QHP coverage from two insurance carriers, Centene and Arkansas Blue Cross and Blue Shield (BCBS). Centene offers three QHPs for ARHOME clients, and BCBS offers two.

The following chart shows ARWorks/ARHOME enrollment in each QHP on the first day of each quarter of 2021. BCBS began offering one of its plans, Health Advantage, in January 2021, so its

enrollment, shown in navy blue in the following chart, was still developing during the first half of 2021.



Premium payments, less recouped premium payments for the first month of each quarter as of April 28, 2022



Premium payments, less recouped premium payments for the first month of each quarter as of April 28, 2022

Premium and cost-sharing reduction costs

For ARHOME clients, 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, 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

Currently individuals at or below 100% of the federal poverty level ($27,750 for a family of four) do not pay a premium or any copays for the care they receive. Individuals above 100% pay a $13 premium each month for their coverage. They also pay a $4 or $8 copay when they access medical services, up to a maximum of $60 per quarter.

The silver-level plans sold on the Marketplace charge higher copays than the $4 or $8 ARHOME clients pay. For example, a plan might normally have a $50 copay for a doctor's visit. ARHOME clients pay just $4 of that $50 copay, and DHS pays 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 clients. This is an estimated up-front payment to cover client 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.

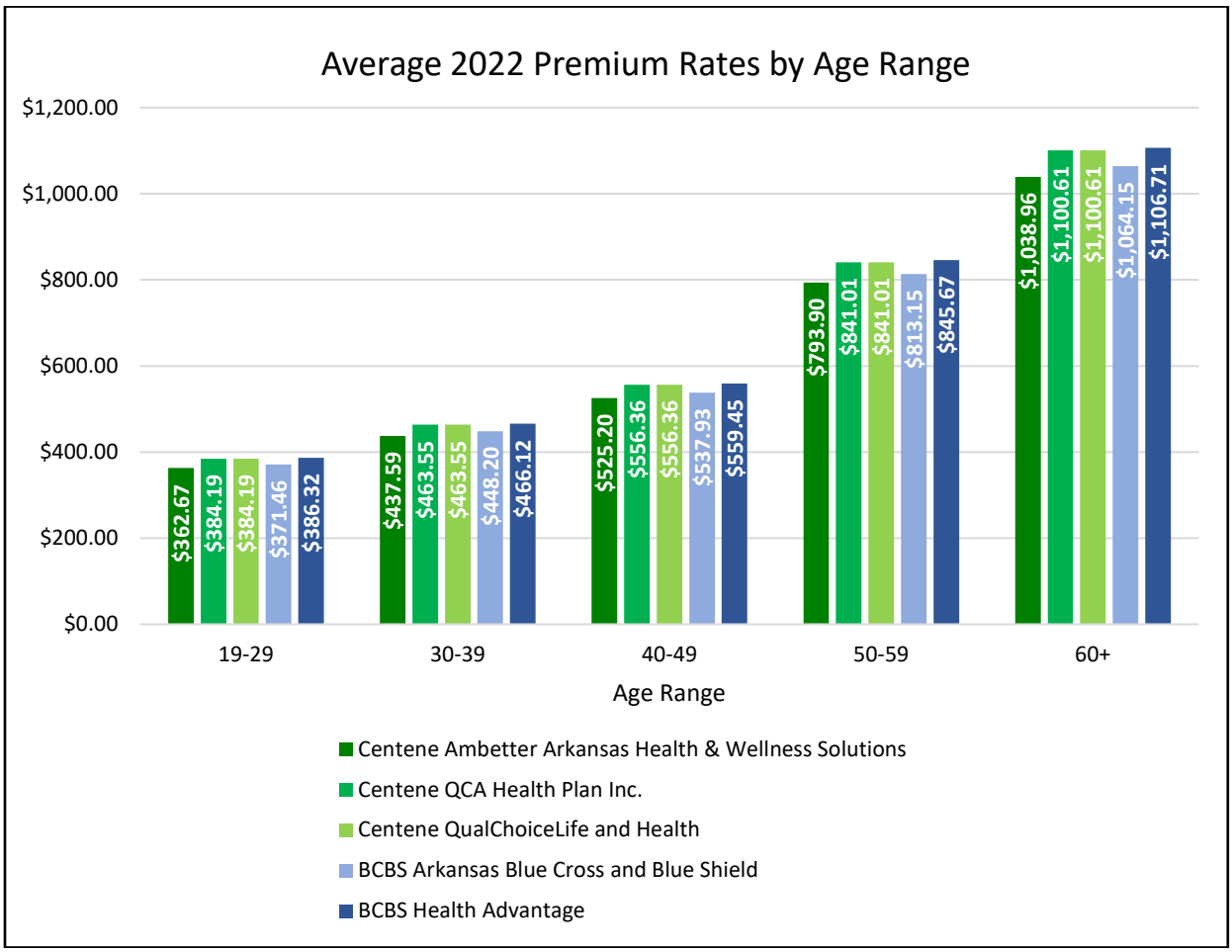
For each client, DHS pays the plan's monthly premium (less $13 per month the plans charge to clients above 100% of FPL) and an ACSR payment. For 2021, the ACSR averaged about 40% of the premium and in 2022, the ACSR averages about 43% of the premium amount. The table below provides the total premium and ACSR payments made to the QHPs for 2021 and the first quarter of 2022.

	Premium Paid for Coverage During Quarter	Advanced Cost Share Reduction Payment
Q1 2021	$371,090,318.40	$149,169,560.85
Q2 2021	$373,424,820.18	$150,023,211.99
Q3 2021	$387,983,666.67	$155,529,462.41
Q4 2021	$393,203,000.34	$157,599,207.00
Q1 2022	$433,193,475.59	$188,051,710.46

Source: 10591 Arkansas Works Premium and CSR Payments and Adjustments by Month and Carrier 04282022

Premium expenditures increased about 17% between Q1 2021 and Q1 2022, mostly due to an 11% increase in the number of enrollees (member months). Also contributing to the expenditure increase is an increase in the premium rates charged by the QHPs. On average, the ARHOME program is spending about 5% more in premiums per member per month.

The carriers set the premiums they charge for each plan they sell on the Marketplace, and DHS purchases the lowest cost plan and those within 10% of the lowest cost plans. The 2022 premiums DHS pays 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. Currently the premiums differ only by QHP, age and tobacco use. For all QHPs, there is no difference between the premiums charged for tobacco users compared with non-tobacco users in the 19- to 20-year-old age range. For all other ages, the rate for tobacco users is 20% higher than the rate for non-tobacco users.

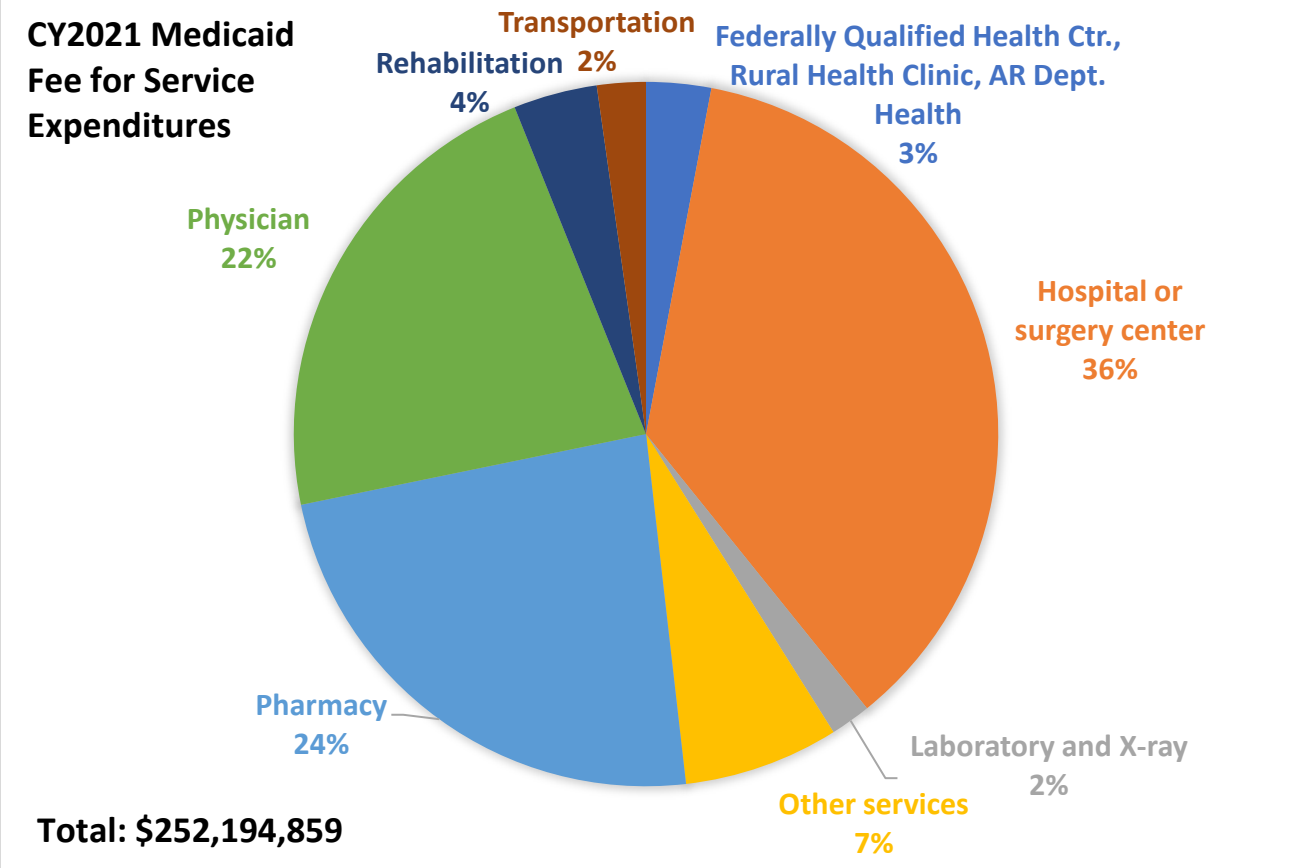


On average, the ARHOME program paid about $489 per member per month (PMPM) in premiums in the first quarter of 2022 and another $212 in ACSR payments.

Quarter	Average (PMPM) Premium Paid	Average (PMPM) ACSR Paid
Q1 2021	$465.23	$187.01
Q2 2021	$461.47	$185.40
Q3 2021	$458.48	$183.79
Q4 2021	$456.30	$182.89
Q1 2022	$488.88	$212.23

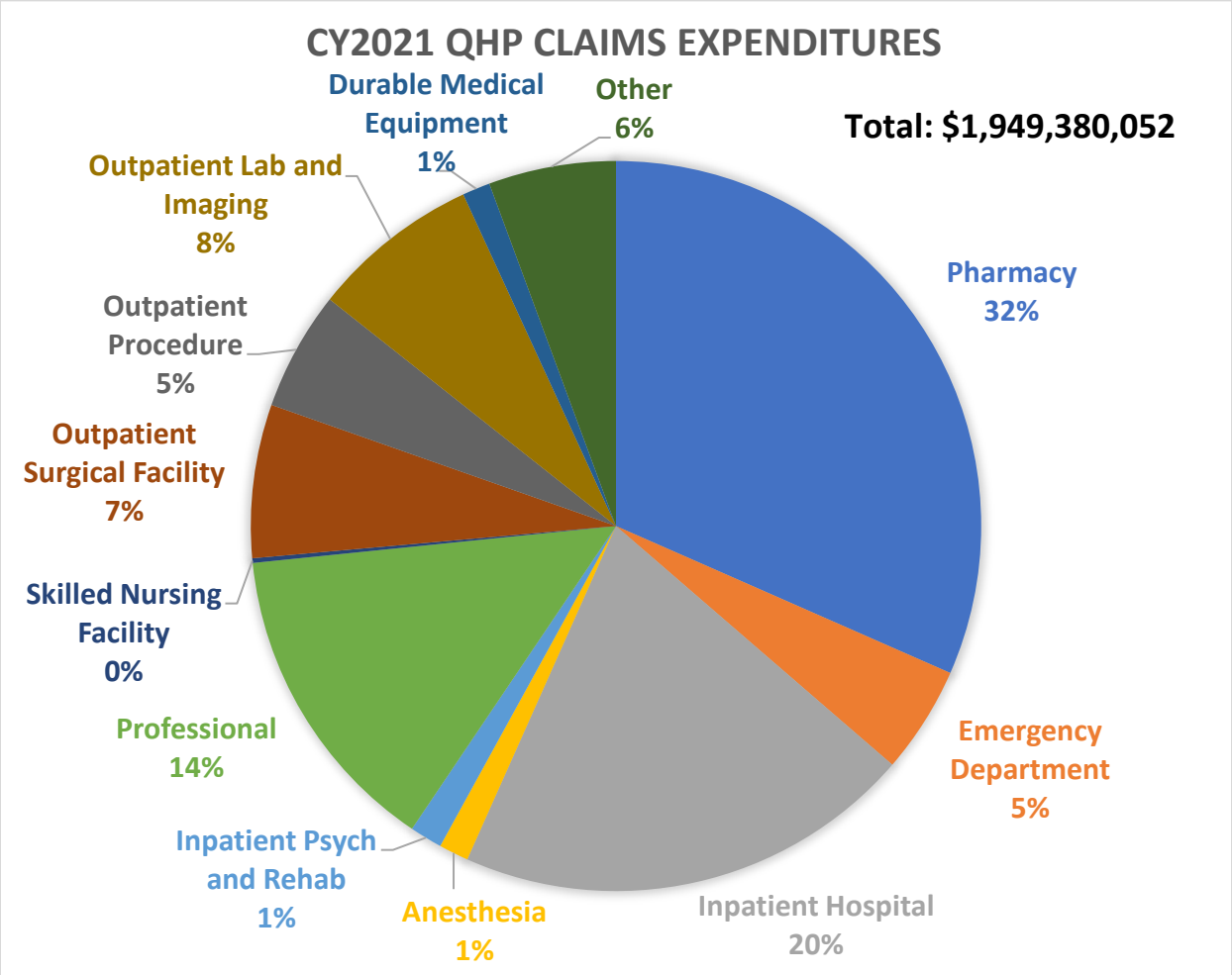
Utilization

Medical claims for ARHOME clients are processed in different systems, depending on whether the client 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 clients. The chart below shows expenditures for ARHOME clients enrolled in traditional fee for service Medicaid (medically frail and individuals awaiting QHP enrollment) for the first quarter of 2022.



Expenditures are those paid during Q1 2022 as of 4/4/22

The QHPs are required to provide to DHS quarterly data on the claims they pay on behalf of ARHOME clients. The QHP claims data are organized differently from the claims in Medicaid's fee for service system. As a result, the claim types are not perfectly comparable. The following chart shows the claims that QHPs reported paying during the first quarter of 2022 for ARHOME clients.



Individual qualified health insurance plan health improvement outcomes

One of the main goals of the ARHOME program is to improve clients' health. New program provisions require QHPs to take responsibility for generating that improvement. 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

QHPs are also required to submit an annual strategic plan that includes activities 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 results of these initiatives won't be available until 2023, historical performance on health quality measures has been assessed, and performance targets for 2022 have been set. The following table provides the program and QHP performance on selected health quality metrics for 2019 and 2020. Program breakouts on the metrics are also available by race and by rural/urban areas of the state.

Measure	Reporting Category	CY	AR Works Overall¥	By Qualified Health Plan				Segments within ARHOME					
								By Urban/Rural		By Race/Ethnicity			
				Blue Cross Blue Shield	Ambetter	QCA	Qual Choice	Urban	Rural	White	Black	Other	Unknown
TOTAL ENROLLEES		2020	**282,096**	**122,741**	**53,378**	**41,790**	**39,587**	**158,640**	**121,874**	**153,926**	**51,093**	**20,926**	**56,151**
Primary Care Access and Preventive Care													
Cervical Cancer Screening (CCS-AD)	Ages 21-64	2019	**46.0%**	44.4%	42.1%	31.0%	30.2%	46.2%	45.9%	45.3%	50.4%	50.9%	41.0%
		2020	**43.5%**	41.3%	38.4%	29.3%	29.6%	43.8%	43.2%	43.0%	48.6%	46.4%	38.0%
Chlamydia Screening (CHL-AD)	Ages 21-24	2019	**53.9%**	53.6%	53.6%	**55.5%**	55.2%	52.7%	55.5%	49.5%	65.6%	57.0%	50.9%
		2020	**52.5%**	49.7%	54.7%	52.3%	55.4%	52.4%	52.6%	46.8%	65.0%	50.3%	53.7%
Breast Cancer Screening	Ages 50-64	2019	**50.8%**	**54.0%**	49.1%	38.7%	42.2%	50.5%	51.0%	49.0%	55.4%	57.9%	50.7%
		2020	**47.7%**	50.9%	47.1%	40.5%	41.0%	48.2%	47.2%	46.0%	52.8%	52.6%	47.5%

Values shown in green represent the established performance targets for 2022 or the best performance by a QHP in 2019 and 2020.

Measure	Reporting Category	CY	AR Works Overall¥	By Qualified Health Plan				Segments within ARHOME					
								By Urban/Rural		By Race/Ethnicity			
				Blue Cross Blue Shield	Ambetter	QCA	Qual Choice	Urban	Rural	White	Black	Other	Unknown
Maternal and Perinatal Care													
Contraceptive Care – Postpartum Women (CCP-AD)	Most or Moderately Effective Contraception – 60 Day: Ages 21-44	2019	**54.3%**	54.7%	53.9%	50.4%	**58.4%**	52.7%	56.6%	55.3%	54.5%	49.4%	53.6%
		2020	**48.9%**	46.6%	50.0%	46.5%	49.8%	47.3%	51.3%	52.5%	48.1%	40.7%	43.9%
Contraceptive Care – All Women (CCW-AD)	Most or Moderately Effective Contraception: Ages 21-44	2019	**25.5%**	**27.0%**	24.0%	24.3%	24.3%	25.7%	25.3%	25.2%	26.0%	26.4%	25.6%
		2020	**23.8%**	25.2%	22.3%	22.4%	21.5%	24.1%	23.4%	23.5%	24.2%	23.9%	24.1%
Low Birth Weight†	Percentage of live births weighing < 2,500 grams	2019	**10.2%**	10.2%	10.5%	9.8%	9.3%	10.3%	10.1%	8.7%	14.8%	8.6%	8.8%
		2020	**10.8%**	11.3%	10.8%	11.9%	**8.6%**	11.3%	10.0%	9.7%	15.9%	5.8%	9.7%
Very Low Birth Weight†	Percentage of live births weighing < 1,500 grams	2019	**1.4%**	**1.2%**	1.7%	**1.2%**	**1.2%**	1.3%	1.4%	1.0%	2.4%	0.6%	1.5%
		2020	**1.6%**	1.6%	1.8%	1.5%	1.5%	1.8%	1.3%	1.3%	2.9%	1.0%	1.0%
Pre-Term Birth†	Percentage of live births 17 - 36 weeks gestation	2019	**13.5%**	13.1%	14.0%	14.4%	12.2%	13.3%	13.7%	13.6%	16.1%	10.9%	10.3%
		2020	**12.8%**	13.5%	14.2%	12.0%	**11.0%**	13.2%	12.2%	12.8%	15.9%	9.1%	10.6%
Care of Acute and Chronic Conditions													
Diabetes Short-Term Complications Admission Rate, per 100,000 Member Months (PQI01-AD)	Ages 19-64	2019	**26.2**	**14.2**	16.8	16.4	22.4	27.4	24.8	26.6	26.8	20.2	26.7
		2020	**21.4**	14.2	15.5	30.9	27.5	24	18.2	22.6	26.2	10.2	17.7
COPD or Asthma in Older Adults Admission Rate, per 100,000 Member Months (PQI05-AD)	Ages 40-64	2019	**40.9**	24.9	32.2	**18.3**	23.4	39.3	42.8	45.8	26.4	33	41.1
		2020	**23.2**	14.3	17.2	19.2	7.7	22.5	24.1	25.6	20.4	8.5	23.4

Measure	Reporting Category	CY	AR Works Overall¥	By Qualified Health Plan				Segments within ARHOME					
								By Urban/Rural		By Race/Ethnicity			
				Blue Cross Blue Shield	Ambetter	QCA	Qual Choice	Urban	Rural	White	Black	Other	Unknown
Heart Failure Admission Rate, per 100,000 Member Months (PQI08-AD)	Ages 19-64	2019	**23.9**	13.9	13.5	**12.3**	13.9	28.1	18.8	19.4	36.8	13.7	28.7
		2020	**22.8**	14.4	16.3	18.3	10.9	27	17.4	19.8	36.8	13.8	21.6
Asthma in Younger Adults Admission Rate, per 100,000 Member Months (PQI15-AD)	Ages 19-39	2019	**4.8**	3.1	3.3	**2.1**	**2.1**	5.1	4.5	4.1	9.6	2.4	2.9
		2020	**2.1**	1.6	2	1.7	2.8	2	2.2	1.9	4.5	1.4	0.6
Plan All-Cause Readmissions (PCR-AD)	Observed/ Expected Ratio: Ages 19-64	2019	**0.8506**	0.8071	0.8003	0.7065	0.9174	0.8268	0.8801	0.8635	0.8239	0.719	0.8502
		2020	**0.7743**	0.7072	0.7528	0.4663	0.3911	0.7834	0.7624	0.7967	0.8003	0.7193	0.6705
Asthma Medication Ratio (AMR-AD)	Ages 19-64	2019	**46.9%**	48.4%	45.3%	50.0%	**54.5%**	50.2%	43.3%	47.6%	47.4%	51.0%	42.9%
		2020	**42.4%**	43.6%	36.9%	43.0%	36.1%	45.6%	38.2%	43.3%	40.0%	41.9%	41.7%
Behavioral Health Care													
Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment (IET-AD)	Initiation – Total AOD Treatment: Ages 19-64	2019	**37.9%**	37.4%	38.5%	**44.0%**	41.5%	37.3%	38.8%	39.1%	31.8%	36.9%	39.5%
		2020	**39.2%**	39.8%	40.2%	37.4%	38.5%	39.3%	39.2%	40.5%	32.5%	37.7%	41.2%
	Engagement - Total AOD Treatment: Ages 19-64	2019	**8.6%**	9.6%	9.8%	10.3%	8.6%	8.3%	9.0%	9.5%	5.1%	8.6%	8.4%
		2020	**9.7%**	9.5%	**12.0%**	9.1%	10.1%	9.2%	10.4%	10.7%	4.6%	9.8%	10.6%
Antidepressant Medication Management (AMM-AD)	Effective Acute Trtmnt: Ages 19-64	2019	**52.9%**	55.5%	56.0%	48.7%	54.8%	52.6%	53.3%	55.0%	40.5%	48.2%	56.6%
		2020	**54.0%**	**56.7%**	55.1%	50.8%	52.2%	54.4%	53.4%	56.6%	39.4%	51.9%	56.6%
	Effective Contin Trtmnt:	2019	**37.1%**	39.6%	39.2%	35.6%	35.6%	38.0%	36.0%	39.3%	25.6%	32.0%	39.7%
		2020	**38.1%**	**41.3%**	38.3%	35.2%	35.0%	38.2%	38.0%	40.5%	24.6%	37.0%	40.7%
Adherence to Antipsychotics for Individuals With Schizophrenia (SAA-AD)	Ages 19-64	2019	**44.1%**	47.2%	34.8%	**65.0%**	38.5%	41.1%	47.3%	47.5%	36.6%	41.2%	42.1%
		2020	**47.2%**	44.2%	46.4%	52.1%	43.3%	45.7%	49.1%	50.8%	43.2%	48.5%	39.1%
Use of Pharmaco-therapy for Opioid Use Disorder (OUD-AD)	Overall Total: Ages 19-64	2019	**39.0%**	47.1%	36.5%	40.2%	45.1%	35.0%	45.4%	42.3%	15.6%	28.6%	34.4%
		2020	**51.3%**	54.0%	54.1%	**55.3%**	51.6%	49.4%	54.1%	55.2%	19.9%	45.0%	49.6%

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				Blue Cross Blue Shield	Ambetter	QCA	Qual Choice	Urban	Rural	White	Black	Other	Unknown
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)	Ages 19-64	2019	**79.2%**	80.5%	80.6%	75.2%	**81.1%**	79.6%	78.8%	80.3%	75.2%	78.9%	78.3%
		2020	**77.6%**	78.3%	79.2%	76.0%	79.4%	77.3%	78.1%	78.1%	79.5%	73.2%	75.7%
Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)	Ages 19-64	2019	**1.1%**	1.3%	1.1%	1.1%	0.7%	1.4%	0.7%	1.0%	0.8%	0.7%	1.5%
		2020	**1.0%**	1.4%	1.2%	0.3%	0.2%	1.5%	0.6%	1.0%	0.8%	1.5%	1.3%
Concurrent Use of Opioids and Benzo-diazepines (COB-AD)	Ages 19-64	2019	**20.9%**	21.5%	17.8%	**16.0%**	20.0%	21.6%	20.1%	23.7%	11.1%	17.7%	20.8%
		2020	**18.9%**	20.9%	16.3%	13.8%	15.0%	19.2%	18.5%	21.2%	11.0%	18.6%	18.3%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug (FUA-AD)	Follow-Up Within 30 Days: Ages 19-64	2019	**8.7%**	8.6%	11.8%	4.3%	2.9%	8.7%	8.7%	9.1%	7.2%	8.8%	8.7%
		2020	**11.0%**	8.5%	**16.8%**	10.3%	9.1%	10.7%	11.5%	12.5%	5.9%	9.0%	11.3%
Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)	Follow-Up Within 30 Days: Ages 19-64	2019	**37.3%**	**41.7%**	35.4%	30.1%	18.6%	33.9%	42.2%	40.3%	26.6%	33.3%	40.5%
		2020	**33.0%**	32.6%	27.7%	27.8%	33.3%	30.9%	35.9%	35.1%	28.2%	31.0%	31.2%
Follow-Up After Hospitalization for Mental Illness (FUH-AD)	Follow-Up Within 30 Days: Ages 19-64	2019	**37.0%**	**43.4%**	24.6%	37.2%	35.6%	37.8%	36.0%	36.6%	32.7%	37.4%	41.2%
		2020	**36.7%**	41.6%	39.0%	23.5%	29.7%	37.2%	36.1%	37.2%	33.1%	38.4%	37.2%

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 (submitted in August 2021) 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.

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 green on the table on pages 7-10. DHS may require a corrective action plan in 2023 from any QHP that fails to meet performance targets during Plan Year 2022

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 partner with hospitals to provide additional support for several ARHOME focus populations:

- Women with high-risk pregnancies
- Individuals in rural areas with behavioral health needs

- Young adults who are most at risk of long-term poverty, including those who were previously in foster care, incarcerated, or in the Division of Youth Services custody and those who are or 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. 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 will coordinate with the client's medical providers, but medical services will continue to be covered by the individual's QHP or fee-for-service Medicaid.

The Life360 HOME model remains under CMS review, and discussions regarding federal approval of this component of the program are ongoing.

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)

(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 of the Department of Human Services 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.