Project Narrative
Arkansas Level One Establishment Cooperative Agreement

The State of Arkansas was the first state to indicate an interest in pursuing the State Partnership Exchange Model and maximizing the local flexibility allowed under this Exchange Model. The Governor delegated responsibility for planning and implementing the State Partnership Exchange model to the Commissioner of the Arkansas Insurance Department (AID) and its new division, the Health Benefits Exchange Partnership Division (HBEPD). AID was the grantee for a Planning Grant in the fall of 2010, a Level One Establishment Grant in February 2012 (known as the Level One A), and a second Level One Establishment Grant in September 2012 (known as the Level One B), each outlining steps toward the goal of having a fully functional Exchange for Arkansas residents by January 2014. HBEPD has been successful in meeting grant requirements and engaging numerous and diverse stakeholders. Stakeholder inclusion and a solid consumer focus are strengths of Arkansas's planning process. This Level One Establishment Grant application (known as the Level One C) reports the many successes of Arkansas's Exchange Planning efforts to date and requests funding for continued planning and implementation of Arkansas's State Partnership Exchange.

Arkansas's efforts are focused on partnering with the U.S. Department of Health and Human Services (DHHS) and Arkansas government and private partners to efficiently connect Arkansas Medicaid and private qualified health plans (QHPs) with the Federally-facilitated Health Insurance Marketplace and to locally operate, evaluate and continuously improve the Consumer & Stakeholder Engagement & Support and Plan Management Functions of the State Partnership Exchange in Arkansas. With Governor Beebe's endorsement and strong leadership by Insurance Commissioner Jay Bradford and AID's Exchange Partnership Planning Team, AID is actively working to implement an effective State Partnership Exchange Model in Arkansas so that quality, affordable and understandable health coverage is available to our residents.

EXISTING EXCHANGE PLANNING AND EXCHANGE ESTABLISHMENT PROGRESS

Beginning in December 2010 with the appointment of Cynthia Crone as Director of AID's Health Benefits Exchange Planning effort, organized, steady progress has been made toward assuring that Arkansas and its residents are prepared to benefit from implementation of the ACA and most specifically the opportunities for expanded insurance coverage offered by the Exchange. AID's first step, using funds from the Planning Grant, was to direct research aimed at gathering information about the insurance status of the state's citizens, insurance carriers doing business in the state, processes and technology systems in place within State government that might be leveraged for Exchange operation, and the wishes of stakeholders regarding the best way to operate an Exchange for Arkansas. A review of this initial research and particularly the wishes of key stakeholders contributed to the Governor's directive to AID to pursue the State Partnership Exchange Model for Arkansas. This direction led to the need for additional, targeted research, the establishment of processes to make policy decisions and additional qualified staff to create the structure necessary to support the state's ability to fully participate in and benefit from the State Partnership Exchange.

Key Findings of Background Research

Over the last two years, AID has overseen research covering a broad range of topics conducted by several different groups and individuals. In 2011, AID selected First Data Government Solutions, LP (First Data) and the University of Arkansas for Medical Sciences (UAMS) as primary contractors for Arkansas's exchange planning activities. First Data had three subcontractors, SCIOInspire (formerly Solutia), Powell and Associates, and Arkansas Foundation for Medical Care (AFMC). The latter two are Arkansas-based companies. The UAMS work was performed by Partners for Inclusive Communities, the College of Public Health, and Arkansas Center for Health Improvement (ACHI), home

to Arkansas's Surgeon General. In 2012, AID contracted with the University of Central Arkansas (UCA) to conduct a survey and gather additional information about the Arkansas insurance marketplace and likely promoters or barriers to issuer participation in the federal Health Insurance Marketplace in Arkansas. We also consulted with actuaries to assess the financial implications of state insurance mandates on eligible essential health benefit (EHB) benchmark plans. Following our initial planning review and discussions of potential strategies to mitigate the impact of expected consumer "churning" among Insurance Affordability Programs in Arkansas, and at CCIIO's recommendation, AID entered into a small professional services contract with Manatt Health Solutions to look at continuity of care/coverage issues and assist in identifying potential strategies to minimize the impact of churning. Manatt provided HBEPD with three potential options to discuss with the Insurance Commissioner, Medicaid Director and Surgeon General that led to a more expansive contract with Manatt and their subcontractor, Optumas, to do more in-depth research in an expedited manner with a goal of selecting a viable solution option and implementing it in advance of FFE Open Enrollment. Manatt and Optumas subject matter experts were in Little Rock for an initial site visit February 6-8, 2013. They met with Medicaid and HBEPD staff to gather information about the alignment of Medicaid standard benefits and the Arkansas EHB. They also met with key stakeholders individually and in two group settings as well as with the Governor and his key staff.

In late 2012 through our policy consultation contract with ACHI, HBEPD joined with Arkansas Medicaid to fund a study by RAND Health to estimate the economic impact of exchange establishment and Medicaid expansion in Arkansas as allowed under ACA. This study also provided updated estimates of the numbers expected to enroll in the Exchange.

Key findings to date follow.

Health Status: On many health indicators, Arkansans' health status is below the national average. Life expectancy at birth is 76 years, two years less than the national average. Nearly 38% of Arkansas children are overweight or obese, and this percentage increases to 67% for adults. According to Kaiser Family Health's *Health Status* report, nearly 10% of the population had been diagnosed with diabetes and in 2008 there were 226 deaths per 100,000 of the population due to heart disease where nationally there were 187. Many Arkansans suffer from poor health and are in need of coordinated care and disease management, often for chronic, complex and co-morbid diseases.

Health Care Delivery System: Currently, 19% of Arkansas's population lives in a primary care health professional shortage area (Kaiser Family Health [KFH] State Health Facts [SHF] *Primary Care HCSAs,* 2012), and in 2008 Arkansas ranked in the bottom ten states for having only 19 physicians per 10,000 of the population while the national average was 26 (KFF SHF, *Physicians per 10,000 Civilian Population,* 2008*).* Arkansas Medicaid is a fee-for-service program with reimbursement rates that are generally well below commercial and, until recently, well below Medicare reimbursement rates. This low reimbursement coupled with Arkansas's rural geography has historically impeded provider access in the Medicaid program and generally. Arkansas is working today to develop innovative ways to improve services currently offered to its Medicaid enrollees to ensure better health outcomes. The Arkansas Department of Human Services (DHS), Arkansas Medicaid, Arkansas Blue Cross and Blue Shield, and QualChoice of Arkansas developed the Arkansas Health Care Payment Improvement Initiative to align incentives across payers, thereby reducing variation in quality and increasing cost efficient practices. Further, with CMS Innovations Center funding, 75 primary care practices in Arkansas are being transformed into patient-centered medical homes, targeting individuals with complex medical needs or chronic conditions and offering more intensive care coordination and support.

Numbers of Insured/Uninsured: Arkansas has a large and growing number of uninsured individuals and ranks among the top ten states in terms of uninsured residents (Kaiser Family Foundation (KFF) *State Health Facts (SHF)* for 2009-2010). ACHI estimates that about 17% of Arkansans, or approximately one half million of our State's residents, are currently uninsured. This includes 25% of 18 – 64 year olds. First Data contractors SCIOInspire and

Powell and Associates estimate that 587,000 Arkansans, or 20% of our population, will be uninsured in 2013, the year before Exchanges become operational. Of that number 80,000 will be small group eligible and 507,000 will be uninsured individuals.

According to the National Association of Insurance Commissioners (NAIC) (2011), Arkansas's employer sponsored insurance market covered 1.2 million Arkansans in 2010 through self-insured employers (884,000), large group employers (211,000), and small group employers (105,000). The individual market covered 115,000 Arkansans. Arkansas's ACA Pre-existing Condition Insurance Plan (PCIP) covers 886 enrollees.

Medicaid and ARKids First cover close to one quarter of the State's population, or 795,889 people (Arkansas DHS, December 2012).

Expected Enrollment 2014: Based on actuarial projections informed by micro-simulation modeling (See Marketplace Report at http://hbe.arkansas.gov/MP.pdf), it is expected that 211,000 Arkansas residents will enroll in private insurance plans and 175,000 will enroll in Medicaid in 2014, assuming that Arkansas will expand Medicaid income limits as allowed under ACA. This will half Arkansas's uninsured rate from approximately 20% in 2013 to just over 10% in 2014. This will include 120,209 previously uninsured Arkansans and ~71% of those Arkansans eligible to enroll in Medicaid in 2014. By 2019, the uninsured population is estimated to decrease to ~9% of the population.

Arkansas trends in insurance membership and costs as predicted by SCIOInspire are depicted in the following tables.

Membership Trend	2014	2015	2016	2017	2018	2019
Medicare	2.9%	2.9%	2.8%	3.1%	3.0%	2.9%
Medicaid/CHIP	1.0%	1.5%	5.0%	-2.3%	0.4%	0.5%
Employer-sponsored Private Health Insurance	-0.4%	0.6%	-1.4%	-1.1%	-0.6%	0.5%
Individual (Exchange)	0.0%	14.4%	18.2%	21.3%	7.0%	0.8%
Individual (Grandfathered)	-8.0%	-8.9%	-10.0%	-11.3%	-13.0%	-15.2%
Uninsured	0.0%	-6.0%	-3.4%	3.1%	0.8%	-1.5%

Cost Trend	2014	2015	2016	2017	2018	2019
Medicare	3.1%	1.9%	2.9%	3.2%	3.6%	3.9%
Medicaid/CHIP	6.0%	6.0%	2.9%	8.2%	6.4%	6.7%
Employer-sponsored Private Health Insurance	4.9%	5.5%	6.1%	3.5%	3.9%	5.3%
Individual	4.9%	5.5%	6.1%	3.5%	3.9%	5.3%
Uninsured	4.9%	5.5%	6.1%	3.5%	3.9%	5.3%

Powell and Associates predict selected coverage variables in 2013, 2014, and 2019 as noted below.

Variable	2013	2014	2019
Number of individuals covered by employer plan	1,103,499	1,018,552	1,006,987
Number of individuals eligible for employer coverage but not enrolled (insured vs. self-insured)	80,000		
Number of small employers not offering health coverage (less than 50 employees)	28,765		
Number of individuals covered by full-coverage and individual major medical plans	544,295	499,264	438,314

Variable	2013	2014	2019
Number of individuals in self-insured plans	695,204	641,688	634,402
Number of individuals in mini-med or limited benefit plans	N/A	N/A	N/A
Number of individuals enrolled in Medicaid	682,000	856,641	899,207
Number of individuals enrolled in another public plan including dual eligibles	136,400	171,328	179,841
Number of individuals eligible for Medicaid but not enrolled		70,000	
Number of individuals not insured	587,000	301,106	279,901

Demographics of the Arkansas population relative to insured/uninsured status in 2013 and 2014, as predicted by Powell and Associates, are presented in the following tables.

Year	2013	2014
Population	2,930,594	2,949,350
Population <65	2,508,499	2,524,553

Year	2013		2014	
	Insured	Uninsured	Insured	Uninsured
Population <65	1,921,499	587,000	2,251,263	273,290
Income				
<138% FPL	393,402	284,819	534,623	147,939
139% - 400% FPL	840,721	230,170	987,016	90,729
>400% FPL	687,376	72,011	729,624	34,623
Age				
0-4	157,181	33,038	177,268	14,169
5-18	443,607	134,351	521,133	60,524
19-25	126,972	91,643	175,374	44,641
26-35	265,641	102,632	323,056	47,573
36-45	356,741	99,555	413,395	45,821
46-55	339,796	76,113	382,310	36,261
55-64	231,560	49,668	258,727	24,301
Work status				
Employed	1,838,432	557,185	2,152,780	258,169
Unemployed	83,067	29,815	98,483	15,121

Year	2013		2014	
	Insured	Uninsured	Insured	Uninsured
Health status (1)				
Excellent	708,567	167,903	809,100	72,979
Very good	638,817	180,283	742,908	81,435
Good	404,448	168,342	493,155	83,301
Fair	112,976	50,327	139,057	25,291
Poor	56,690	20,145	67,043	10,284
Household size				
1	853,637	377,122	1,060,378	178,258
2	852,659	163,141	949,550	72,750
3	167,006	34,797	186,868	16,226
4	44,200	9,450	49,232	4,761
5+	3,998	2,491	5,235	1,295
Education/literacy status				
Child N/A	476,145	127,099	550,923	56,182
Not finished High School	235,093	141,897	309,661	69,741
High School graduate	422,860	163,141	512,964	76,788
Some College	405,930	108,639	467,889	49,973
College graduate	258,387	36,115	280,352	16,036
Graduate degree	123,084	10,109	129,475	4,571
Internet access (2)	2013		2014	
Accesses Internet	1,652,104		1,662,677	
Does not access Internet	1,056,263		1,063,023	
Has access at home	1,706,271		1,717,191	
Has no access at home	1,002,096		1,008,509	

1) Health status is self reported by survey participants

2) Internet access statistics are only available for the entire population >3 years old. They do not match to health insurance data in the model

Expected Enrollment by 2016: RAND Health (Price and Saltzman, 2013) (See Appendix G) estimated that 400,000 Arkansas residents would become newly enrolled in insurance coverage by 2016 with Medicaid expansion to 138% of the Federal Poverty Level and assuming separate individual and small group markets within the subsidized private Exchange market in Arkansas. Using their COMPARE model, RAND researchers estimated that the number of nonelderly people with health insurance post-ACA implementation would be nearly 2.3 million by 2016 compared to

1.9 million without ACA changes. The model estimated an additional 190,000 of the additional 400,000 people with insurance will be enrolled in Medicaid and the remaining growth in coverage will be in the non-group market through the Exchange. RAND predicted very little net change in the coverage through employer-sponsored insurance. Important for Arkansas's outreach and education planning, RAND Health made predictions of enrollment and uninsured by County. The table below from the RAND report is a comparison of nonelderly enrollment projections without ACA (Baseline) and with ACA.

Measure	2016 Baseline	2016 ACA
Enrolled in Medicaid (<65)	675,000	865,000
Enrolled in Nongroup Exchange (<65)	NA	288,000
Total Enrollment (<65)	1,894,000	2,296,000
Uninsured (<65)	571,000	170,000

Current Marketplace

Individual Market: The research done in the summer of 2011 used 2010 reporting and reflected that there were 53 carriers issuing individual policies in the State of Arkansas. Total annual earned premium for that market was reported at approximately $244,076,578. One carrier (Arkansas Blue Cross Blue Shield) dominated the business with 75% market share; all others are in single digits. The total number of covered lives (including dependents) by all carriers was about 119,566 Arkansans. Arkansas Blue Cross Blue Shield covered 91,499 lives and all others cover the balance, or approximately 28,067.

Group market: For the Group Health Insurance marketplace, there were 24 health insurance carriers with $443,087,573 of yearly earned premium. That covered about 130,194 Arkansans including dependents: Three carriers dominated the small group market in Arkansas:

- Arkansas Blue Cross Blue Shield - 65,835 covered lives
- United Healthcare - 27,573 covered lives
- QualChoice Health Plan - 25,912 covered lives.

Using funds obtained through an Administrative Supplement to the Planning Grant, HBEPD entered into an interagency agreement in 2012 with the University of Central Arkansas (UCA) to examine the existing competition in the individual and small group (50 or fewer employees) health insurance markets among health insurers currently operating and potential new entrants for the State of Arkansas, and their willingness and interest in participating in Arkansas's State Partnership Exchange.

The first step in the process was to update the 2010 information reported earlier with 2011 data. There were 45 issuers on the AID 2011 list of Individual Comprehensive Health Coverage providers. The top ten issuers on that list accounted for 97.16% of the Arkansas market. There were 18 issuers on the 2011 list of Small Group Employer Comprehensive Health Coverage providers. The top ten issuers on that list accounted for 98.64% of the Arkansas market. The decision was made to survey the top ten issuers on each of these lists. Because several issuers were active in both the individual and small group markets, 17 issuers were selected for the study.

Market share information was also obtained from the insurance departments of the seven states adjacent to Arkansas (Kentucky, Louisiana, Mississippi, Missouri, Oklahoma, Tennessee, and Texas). Issuers with five percent or more market share in any of those states but not already included were added to the study. From these issuers, any whose service area did not include Arkansas, i.e., Blue Cross Blue Shield plans and Tennessee Farm Bureau were removed. This resulted in the addition of three insurers for a total of 20 issuers in the study.

Two survey instruments were designed to gather information about each issuer's participation in the individual and small group health insurance markets – one for issuers operating in Arkansas and one for issuers operating in adjacent states but not in Arkansas. The surveys included questions about:

- Geographic distribution of individual and small group products,
- Likelihood of participation in the Arkansas State Partnership Exchange,
- Barriers to participation in the Arkansas State Partnership Exchange,
- Considerations that would positively influence participation in the Arkansas State Partnership Exchange,
- Plans likely to be offered on the Arkansas State Partnership Exchange,
- Factors that might influence the issuer's decision to participate, including:
  - Expected number of participants on the Exchange,
  - Impact of newly eligible Medicaid recipients under managed care contracts (Arkansas currently has no Medicaid managed care contracts),
  - DHHS required accreditation,
  - Possibility of a state-wide coverage requirement,
  - Possibility of requiring participants to offer all metallic level plans,
  - Possible limitation on the number of plans within each metallic level by issuer,
  - Inclusion of a Medicaid-like Basic Health Plan (BHP) option,
  - Quality improvement reimbursements/incentives designed to improve quality of patient outcomes,
  - Qualified health plan cost-sharing standards,
  - A competitive bidding process for participating issuers,
  - Possibility of mandatory participation in the SHOP Exchange,
  - Allowing employers with more than 50 employees to participate in the SHOP Exchange in 2014, and
  - A combined risk pool for the Arkansas State Partnership Exchange Individual and SHOP Exchanges.
- Space was also provided for additional feedback.

The survey was distributed on June 25, 2012 and by mid July, 17 issuers had responded. UCA determined that two of the companies that did not respond provide only supplemental health plans and they were removed from the study. Of the 17 issuers that responded, two companies provide supplemental plans only, two issuers withdrew from the comprehensive health coverage market nationwide and one issuer no longer writes individual or small group comprehensive health coverage in Arkansas, leaving twelve (12) potential Exchange issuers providing answers to the survey questions. Ten of the respondents issue health insurance coverage in Arkansas and two respondents issue health insurance coverage in one or more of the seven adjacent states, but not in Arkansas.

After discussing their preliminary findings with the HBEPD director, the HBEPD staff, members of the Plan Management Advisory Committee and others in mid July, UCA agreed to expand the scope of their survey to include additional companies. Their final report is available at http://hbe.arkansas.gov/MarketplaceResearch.pdf.

Using funds from the Administrative Supplement, HBEPD also entered an interagency agreement with the Arkansas Center for Health Improvement (ACHI) to do some preliminary research on the "churning" issue predicted to disrupt continuity of coverage and providers when consumers move between Medicaid coverage and Qualified Health Plan (QHP) coverage with subsidies offered through the Exchange. ACHI reviewed published literature, state-based studies and the AR Health Networks population to estimate the extent of churning and the points at which individuals are expected to churn. The ARHealthNetworks population (a waiver program targeted at businesses who employ low-income individuals and self-employed individuals) was used as a proxy for expansion populations both in Medicaid and the Exchange. For the Exchange, ACHI examined the duration of coverage to serve as an estimate of expected churn. Additionally, ACHI has written a policy brief (See Appendix A) examining Arkansas-specific churn

issues and possible options for addressing churn, including pros and cons for each option. The brief also discusses split family coverage issues, including options to address those situations.

Also using Planning Grant Administrative Supplement funds, ACHI researched quality metrics used by accreditation and other agencies for health plans and combined those metrics into a format for comparison. ACHI also reviewed delivery model quality initiatives (patient-centered medical homes, for instance) at the state level for inclusion in comparisons. Ultimately, ACHI worked with HBEPD leadership and others to create a list of quality metrics to propose for judging health plan quality for plans offered in the FFE in Arkansas (See Appendix B).

One final study completed by ACHI using Administrative Supplement Funds looked at the coverage cost per Medicaid aid category including projections based on historical data. (See Appendix C)

Economic Impact of ACA in Arkansas: The previously referenced RAND study (See Appendix G)) estimated the economic impact of the Exchange and Medicaid Expansion for Arkansas. While federal funds would be used to cover most of the 400,000 additional people covered for insurance post ACA, the state would lose some federal money through cuts in Medicare reimbursement, a reduction in Medicaid Disproportionate Share Hospital (DSH) payments, and additional taxes on insurance plans. The net effect of these changes is an estimated increase of roughly $430 million. This total comes from $750 million from federal Medicaid spending plus $850 million in federal subsidies for the Exchange, minus approximately $1,180 million due to the various cuts. Because of the community multiplier effect of this net increase in federal spending, the total impact on the state's gross domestic product (GDP) will be a gain of around $550 million. Additionally, employment would rise by about 6,200 and mortality is estimated to decrease by 1200 lives annually. In the county-level analysis, total state and local tax revenue would increase by about $19 million. Based on the increased enrollment and spending distributions for Arkansas, the state could see a decrease of about $67 million dollars in uncompensated spending costs in 2016.

Legal Authority and Governance

Arkansas's 2011 legislative session convened in January, shortly after the Exchange Planning Grant was awarded and prior to implementation of the various stakeholder inclusion activities described below. AID supported passage of HB 2138 to establish an Arkansas Health Benefits Exchange. Insurance carriers, producers, consumer advocacy organizations including Arkansas Advocates for Children and Families and AARP-Arkansas, ACHI, Arkansas Hospital Association, and Arkansas Foundation for Medical Care supported the bill. However, the opposition to ACA by a vocal minority of Republican legislators, and partisan politics of the 2011 session, prevented the bill's passage. It was assigned to the House Committee on Insurance and Commerce for interim study.

Following the legislative session, planning activities to garner support for an Arkansas Exchange continued. Legislators were appointed to the Steering Committee. Others attended Workgroup Sessions and Community meetings. Timing for State Exchange Authority was complicated by the fact that the General Assembly did not meet again in regular session until 2013. Non-budget items are rarely heard during a fiscal session of the legislature and require a supermajority vote for inclusion. Governor Beebe stated he would not call a special legislative session to seek Exchange authority nor establish Exchange authority through an Executive Order. He has consistently stated that he would not "go against the wishes" of the Legislature which failed to pass the Exchange enabling legislation in 2011.

Without enabling legislation, an official governance structure had not been designated for Exchange planning. Stakeholder feedback regarding possible governance options was obtained through various methods with findings consistent with HB 2138 that recommended a quasi-governmental model connecting a non-profit board with the AID. As part of our planning process, we gathered the following information regarding the best governance structure:

- Targeted Survey - Our contractor, First Data, conducted an email survey of the Exchange Planning Workgroups/Steering Committee and 35 members completed the survey. The results reflected the

preference for a public trust (quasi-governmental) model with AID as the State oversight agency (78.8%). This finding was affirmed by the Steering Committee and the six Exchange Planning workgroups in follow-up meetings.

- Survey of the general public – Our contractor, UAMS, posted a survey on the Exchange Planning website and had 432 valid responses. Forty-six percent (46%) of those favoring exchange planning recommended "A public organization overseen by a separate non-profit commission/board", 36.5% recommended a "State Agency," and 17.8% recommended a "not-for-profit organization." Of those who preferred a connection with an "existing state agency," 69.4% preferred AID.

- Community Meetings - With a few exceptions, most participants wanted to see AID regulate insurance plans and companies. On the issue of operational control, there was less agreement. Three models of governance were identified: (1) placement within a state agency, (2) awarding governance of the Exchange to a not-for-profit through a bidding process, and (3) governance by a board or commission. Of the three models, each had supporters and detractors. Participants noted concern that the Exchange needs to be free from excessive regulations, while maintaining strong accountability. Several persons stated that in order to meet tight deadlines, the Exchange will need to be nimble with regard to purchasing and hiring. That will also be important for making changes in response to continuous improvement activities. There were advocates for various combinations of the three models. Regardless of the governance model, the participants felt that there should be public accountability. In addition, the group charged with oversight should be representative of the geographic, professional, and cultural diversity of those impacted by the Exchange and should operate under strong conflict of interest policies.

- *Survey by Self-Chartered Health Care Reform Workgroup:* Although the Arkansas Exchange Planning Grant did not pay for nor direct this survey, a statewide survey of 501 registered Arkansas voters (margin of error +/-4.5%, confidence level 95%) was conducted by Opinion Research Associates for a Self-Chartered Health Care Reform (Industry) Workgroup. The telephone survey was conducted August 20-28, 2011 and findings were reported to the Exchange Planning Steering Committee. Key findings included:
  - 74% prefer a State- run Exchange, 10% prefer a Federal Exchange, 16% don't know/don't care;
  - 66% support legislators giving Arkansas authority to develop a State Exchange (34% strong; 32% somewhat);
  - 60% support Governor Beebe issuing an Executive Order for Exchange development (37% strong; 23% somewhat);
  - 67% reported they would trust a State Exchange more than a Federal Exchange;
  - 56% supported Arkansas moving forward on planning and developing a HBE prior to a Supreme Court decision on the Affordable Care Act provisions;
  - 51% supported the idea of HBE; 31% opposed; 19% "doesn't know/no response"
  - Self-identified Tea Party members were the strongest supporters of a State-run Exchange, followed by those identifying themselves as Republicans.

The Exchange Planning Workgroups continued to address specific governance issues, including a statewide versus regional structure throughout 2011.

When CMS identified the option for a State Partnership Exchange Model, the Governor in December 2011 directed AID to begin planning for a State Partnership Exchange Model. AID formally established the Health Benefits Exchange Partnership Division under the administrative direction of Cynthia Crone and the Division began to establish the infrastructure needed for Arkansas to partner with DHHS in the development of a state partnership exchange. HBEPD advised DHHS that Arkansas will be responsible for both the Plan Management and Consumer Assistance functions of the State Partnership Exchange as allowed by federal and state statutes and published

guidance. Arkansas's plans were confirmed in Governor Beebe's Declaration letter to DHHS Secretary Sebelius on December 12, 2012. (See http://hbe.arkansas.gov/FFE/GovBeebePartnershipLetter.pdf.) As stated in the letter, this puts Arkansas in a good position to transition to a State-Based Exchange in the future should legislative or other action so direct. Subsequent to the Governor's letter, on December 17, 2012, HBEPD submitted Arkansas's completed Blueprint Application to DHHS for a State Partnership Exchange in 2014. On December 31, 2012, Arkansas received conditional approval from CMS to operate as a State Partnership Exchange (See Appendix F). A letter from Secretary Sebelius to the Governor on January 3, 2013 confirmed that HHS was granting Arkansas conditional approval to establish a State Partnership Exchange in 2014. (See http://hbe.arkansas.gov/AR_Partnership_Release.pdf)

AID/HBEPD has been actively negotiating two MOUs with DHHS/CMS/CCIIO officials; one for Plan Management and one for Consumer Assistance. When finalized, these will document each Partner's responsibilities under the State Partnership Exchange model. At CCIIO's request these negotiations were put on hold early in February 2013.

Stakeholder Consultation

Stakeholder involvement is valued and a strength of the Arkansas planning effort. Public and private stakeholders are participating through various activities facilitated by HBEPD staff and contractors. Key activities/stakeholder involvement strategies are listed below:

Stakeholder Group	Consultation Strategy
Steering Committee - 2011	Begun in May 2011, a 21-member Steering Committee appointed by the Insurance Commissioner met for two hours bi-weekly to coordinate planning efforts and make recommendations to the Commissioner, legislators and Governor about development of a State-run Exchange. Local and First Data Consultants assumed facilitation duties for the Steering Committee. Meeting summaries can be found on the Exchange Planning website at http://hbe.arkansas.gov/Steering.html. Comprised of two liaisons to each of six workgroups, two representatives of the major contractors (University of Arkansas for Medical Sciences [UAMS] and First Data), Governor's Office, Arkansas Center for Health Improvement (home of AR Surgeon General), AR Department of Human Services (DHS) Director, and two legislators (one Democrat; one Republican), the Steering Committee met until November 15, 2011 when it recommended that efforts to plan a State-run Exchange cease due to political opposition.
Steering Committee 2012 – 2013	Commissioner Bradford appointed a new Steering Committee in March 2012 to make recommendations relative to State Partnership Exchange development in Arkansas. Diverse committee members include representatives from government (Executive agency leaders, Governor's office, Legislature), private industry (health insurance and health care), and consumer advocacy groups (individual and small business). An orientation was held in April and the Steering Committee meets monthly to discuss planning/implementation issues, manage collaboration among the FFE planning efforts, provide active and visible leadership, approve or disapprove recommendations from the Plan Management or Consumer Assistance Advisory Committees to forward to the Commissioner, and garner support for FFE implementation and sustainability. First Data serves a facilitation role. Meetings are open and interactive video conferencing is used for distant participation. Monthly progress reports and meeting summaries can be found at http://hbe.arkansas.gov/.

Stakeholder Group	Consultation Strategy
Six Workgroups 2011	Six workgroups each met monthly in 2011: Community Leaders, Consumers, Information Technology, Outreach/ Education/ Enrollment, Providers, and State Agencies. These groups chartered in April, 2011 to discuss issues, strategies, and solutions, made recommendations to the Steering Committee. Average attendance ranged from 10 to 15 and guests were welcome. SKYPE attendance was used by some at distant locations. Meeting summaries can be found on the Exchange Planning website at http://hbe.arkansas.gov/StateRun.html.
Advisory Committees 2012 - 2013	Under a new Stakeholder Engagement Process, two Advisory Committees were created to align with the state operated functions of the State Partnership Exchange—Plan Management and Consumer Assistance. These active and diverse Committees meet for a minimum of three hours each month (the Plan Management Committee consistently meets six hours per month) to consider scheduled policy issues and make recommendations related to State Partnership Exchange implementation. They review issue briefs and alternative policy recommendations, seek additional information, and make formal recommendations to the Steering Committee that makes recommendations to the Insurance Commissioner. Following an April, 2012 orientation, the Committees began meeting in May, 2012. Each has formed subcommittees. Three (non-government) co-chairs from each Committee sit on the Steering Committee. Committee products can be viewed at http://hbe.arkansas.gov/FFE/Consumer.html and http://hbe.arkansas.gov/FFE/Plan.html.
Community Meetings 2011	During the summer of 2011, UAMS led 66 "information and listening" sessions in 17 towns/cities across Arkansas targeting four stakeholder groups: Community Leaders, Providers, Consumers, and All Citizens. Three special population sessions were held targeting Spanish-speaking and Marshallese residents. More than 500 Arkansans attended. Specific outreach was made to minority groups and those with special health care needs. Interpreters were available. A report of this effort was presented at the Stakeholder Summit in October 2011.
Community Meetings 2012	On July 18, 2012 approximately 200 stakeholders participated in community meetings held in seven locations across the state using interactive video technology to connect stakeholders with the AID Commissioner and HBEPD Director for a State Partnership Exchange Update and live Q & A session. Live web stream was also available. The morning and afternoon meetings were held in Little Rock and via interactive technology to sites in each of Arkansas's four congressional districts. HBEPD staff was available at each site to interact with attendees before and after the meetings. Both the morning and afternoon sessions were recorded and are available on the HBEPD website at http://hbe.arkansas.gov/. Sessions were transcribed and translated into Spanish for distribution as needed. Plans are to hold these type town meetings at least quarterly in 2013.
Web-Based Survey 2011	UAMS conducted research and created a web-based survey to solicit residents' input into planning. The survey was "live" July 12 – August 25, 2011. There were 432 valid responses to the survey. (See http://hbe.arkansas.gov/StakeholderInput.pdf).

Stakeholder Group	Consultation Strategy
State Agency Health Improvement Leaders 2011 - 2013	Arkansas Center for Health Improvement (ACHI), home of Arkansas's Surgeon General, convenes a monthly leadership meeting where Arkansas's four major health improvement activities are addressed: Health Benefit Exchange (HBE), Health Information Technology (HIT), Workforce, and Payment Transformation. The Governor's Policy Office, State Agency directors and chief of staff from the Departments of Insurance, Human Services, Health, Office of HIT, and the UAMS meet for updates and strategic discussions.
HBE Stakeholder Summit 2011	A one-day statewide stakeholder summit was held October 11, 2011. Past Director of The Federal Health Benefits Exchanges, Joel Ario, and Arkansas Surgeon General Joe Thompson, MD, MPH, served as keynoters, addressing HBE development, issues, and progress to date, with time provided for questions and feedback from participants.
Legislative Reports 2011 - 2013	Insurance Commissioner and HBEPD Staff have formally presented at 13 legislative committee meetings. One-on-one or small group discussions are held as needed to update legislators or answer specific questions. The Project funded one legislator's attendance at the Utah Invitational Exchange Meeting in 2011. Several Legislators attended the August, 2011 NPRM meeting in Denver as DHHS guests. On December 4, 2012, the Commissioner and the HBEPD Director spoke at the New Arkansas Senator Orientation to educate incoming legislators about the State Partnership Exchange and the information was well received. Staff has also participated with legislators through meetings of the Public Health Committee on Medicaid Expansion, Rules Committee on Arkansas EHB Rules and the Insurance and Commerce Committee Meeting regarding the State Partnership Exchange.
One-to-One or Group Stakeholder Meetings 2011 - 2013	Meetings with industry, government, and civic leaders are held at the request of planning staff or the stakeholder(s) to update/dialogue on HBEs in general and Arkansas-specific planning activities. These include key informant interviews as part of the background research effort, and presentations to industry, civic or employer groups. HBEPD staff continues to be frequent presenters at conferences and events throughout the state. A plan to implement a statewide speaker's bureau is underway for 2013. UAMS, University of Arkansas (UofA) and Arkansas Department of Health (ADH) are key partners for this outreach effort.
HBE Website at www.hbe.arkansas.gov 2011 - 2013	HBE information and planning efforts are posted on the HBE Website, including meeting notices, summaries, Q & A, and issue briefs. Readers are directed to staff for questions/comments.

Contractor UAMS Partners for Inclusive Communities (Partners) moved their administrative home to the University of Arkansas at Fayetteville. A contract with Partners through UofA to continue statewide stakeholder engagement is in process. Partners will work closely with the State Exchange Partnership Outreach and Education campaign efforts. This collaborative work will build on common federal and state level messaging for a State Partnership Exchange model.

Funding under the Level One A grant allowed the expansion of stakeholder involvement. On May 29, 2012, the HBEPD staff added an experienced Consumer Assistance Specialist to ensure a positive consumer experience, critical to the success of Arkansas's State Partnership Exchange. Sandra Cook's primary focus is on the coordination and development of the various consumer assistance programs, functions and requirements including developmental activities associated with the Arkansas In-Person Assister Program. She began immediately to expand consumer participation among underserved/hard-to-reach populations, including Hispanics, African Americans, individuals with disabilities, Marshallese, Asians, and expanding representation from various geographic locations (Delta area), etc. Ms. Cook developed relationships with UAMS Center for Rural Health's Health Literacy program in order to ensure that training and outreach materials are understandable to populations with low literacy rates. Additionally, she developed relationships with the Arkansas Minority Health Commission to participate in a series of quarterly health forums designed to educate communities regarding health disparities. Our Level One A funding also provided for a contractor to develop the Arkansas Navigator Program. Public Consulting Group (PCG) was chosen through a competitive bidding process. Consultants from PCG have helped staff the Consumer Assistance Advisory Committee, provided policy briefs and alternative options for development of the Arkansas IPA Program. Using funds from the Level One B grant, PCG's consulting contract was extended through September 30, 2013 to allow them to continue working with the CAAC and their participation in the recruitment and training of IPAs.

Ms Cook oversees the work of PCG whose scope of work originally specified the Navigator program but was modified after CCIIO clarified that in a State Partnership Exchange, the Navigator program was CMS' responsibility while the state is responsible for the IPA Program. The scope of work is to design, develop and implement the Arkansas IPA Program according to the FFE and Arkansas guidelines and requirements. PCG developed a project work plan that details approach, staffing, project tasks, quality management plan, communications plan, issues, risks and change control. The three (3) primary areas of responsibility for PCG are: IPA eligibility, certification and training; IPA Entity application; and IPA operations (including policies and procedures).

Our Level One B grant proposal outlined the development and implementation of the In Person Assister (IPA) program under the Consumer Assistance Specialist. After the grant funds were awarded in September 2012, we began to operationalize the IPA program and prepared to fill the newly funded positions for both the IPA program and our Communications area (responsible for outreach and education). As these plans took shape, we did further analysis of the projected workload and determined that it would be more efficient to reallocate positions between these two areas and closely align their responsibilities. As the first step, Ms. Cook was reallocated to the IPA Contract Lead position with responsibility for all aspects of the IPA Program and continued oversight of the Consumer Assistance Consultant (PCG). Her former position was repurposed to be that of a Communications Specialist to assist the newly hired Public Information Manager. The IPA Program and the Communications area will work in tandem to continue community outreach while overseeing implementation of the IPA Program and HBEPD extensive Outreach and Education efforts. The IPA Program and Outreach and Education effort will also work hand-in-hand with the Arkansas Health Connector Resource Center discussed later in this document.

The Consumer Assistance Advisory Committee (CAAC) is responsible for developing recommendations regarding Communication/Outreach and Consumer Services surrounding the State Partnership Exchange and the Arkansas IPA Program. In addition to various State agencies (Health, Information Services, Human Services, etc.), the committee membership includes representatives from consumer advocacy groups, small business owners, insurance producers, dental associations, religious community, disability community, UAMS College of Public Health, legal community, unions, and more.

The CAAC has also developed a sub-committee dedicated specifically to IPA Entity recruitment. The sub-committee held a half-day "brainstorming session" to provide input on a state operated IPA Program designed to maximize enrollment in the FFE, generate interest in becoming IPAs, provide feedback to HBEPD regarding training for IPAs, and identify the potential barriers the state may encounter to enrolling consumers in the Exchange. During the "brainstorming session," participants addressed issues of outreach and recruitment; barriers to enrollment; IPA identification; and IPA training requirements. A number of populations that will need to be targeted for outreach were identified including: Hispanics; African Americans; unemployed persons; individuals with various disabilities (hearing impaired, mental illness, developmentally disabled, etc.); homeless individuals; and more. In order to reach the identified populations, several strategies were suggested including in person contact; community meetings; radio; and print publications. Locations for outreach were also identified such as grocery stores; flyers placed in children's backpacks; barber/beauty shops; tobacco shops; Salvation Army; domestic violence shelters, etc. Barriers to enrolling consumers included issues of trust; cultural differences; health literacy; attitude toward ACA, etc. Several organizations were identified as potential IPA entities or organizations familiar with underserved/hard-to-reach populations, including Mid-Delta Community Consortium; Potlatch; Hispanic Women of Arkansas (HWOA); Mexican Consulate; churches; Chambers of Commerce; Arkansas Nurses Association; Independent Contractors, Inc.; fishing/hunting licensing offices; Walmart; sororities and fraternities. Requirements for IPA training included: cultural competency; customer service skills; HIPAA; ethics; QHPs and their ratings; provider networks, and more.

CAAC has made the following recommendations regarding the IPA Program to the Steering Committee:

- IPA Eligibility Requirement
  - The goals and duties of the program, beyond those required under federal regulation were defined.
  - Brokers and producers were identified as eligible to become IPAs.
- IPA Certification Requirements
  - Standards for certification, re-certification and de-certification were defined.
  - Frequency of certification was outlined.
  - Definitions for conflict of interest and professionally accepted ethical standards were agreed upon.
- IPA Training Requirements
  - Determined training competencies for individual IPAs.
  - Delivery method of initial training, on-going and refresher training defined.
- IPA Entity application process – initial, renewal, denial, termination
- IPA monitoring methods, monitoring requirements and performance metrics (centered on the job responsibilities of the IPA Contract Monitors)
- Payment and evaluation of IPA entities
- Performance metrics and payment

CAAC's recommendations to the Steering Committee were approved, some with modification, and forwarded to the Commissioner who also approved them for adoption. Based on recent HHS guidance, the area of performance metrics is still open to discussion with no firm recommendations having been made other than that the IPA Entity evaluation metrics will be based on all core functions (e.g. enrollment, outreach and education, referral to complaint resolution, etc.). Information regarding CAAC activities is available on our website at http://hbe.arkansas.gov/FFE/Consumer.html.

HBEPD and our Consumer Assistance vendor, PCG have been working steadily to develop the RFP for IPA Entities as specified in our Level One B grant. The RFP is on schedule to be posted in mid-February. Responses from eligible organizations around the state will result in multiple contracts with IPA entities that will provide individuals to

be trained and serve as IPA Guides throughout each of Arkansas's 75 counties. These IPA Guides will be integral to our Outreach and Education efforts as well as to preparing individual Arkansans for Open Enrollment and will begin work in early June. Funding for the IPA program through September 30, 2013 was included in our Level One B grant. In this grant application, we are asking to extend that funding through March 31, 2014.

HBEPD is also working steadily to develop the RFP for the development and delivery of IPA Guide training. As specified in our Level One B grant, we plan to hire a vendor to develop and execute the training plan based on the curriculum recommended by the CAAC and using the expertise of HBEPD staff and the materials being developed as part of our Outreach and Education efforts and the federal Health Insurance Marketplace outreach and education campaign. Each IPA Guide must successfully complete the training with at least an 80% score on applicable testing to be certified to function in this role in Arkansas. The goal is for training to begin in early June 2013 and HBEPD envisions it occurring in three sequential segments – first an Outreach and Education segment that prepares the IPA Guide for these type activities; second completion of the federal Navigator training and last completion of Arkansas-specific Partnership Exchange training. This RFP is on track to be posted in late February 2013.

Ms. Cook is also working with our Consumer Assistance consultant, PCG, on the development of the policies, processes and procedures needed for operation of the IPA Program once all the staff and IPA entity contractors are in place.

An inter-agency agreement was signed in September 2012 for State Partnership Exchange outreach and education branding work by Arkansas Center for Health Improvement (ACHI)/University of Arkansas Medical Sciences (UAMS) Creative Services to implement Phase 1 of our Outreach and Education campaign. Services provided thus far include scientific survey to measure opinions among an estimated 500 effected Arkansans and five (5) focus group sessions at various locations around the state. The survey results were used as a tool in development of the outreach and education branding approach and will also be used to develop messages to inform Arkansas consumers about the State Partnership Exchange in a way that can be easily understood. Presentations by ACHI/UAMS included creative concepts for commercials and print. A key result of work thus far is the selection of the name and tagline for the Outreach and Education work to be provided by Arkansas; "Arkansas Health Connector: Your Guide to Health Insurance".

In January HBEPD finalized the selection of the graphic for the branding of the Arkansas Health Connector program. This creative work was performed by Information Network of Arkansas (INA), the contractor that is also updating the HBEPD website.

Arkansas
HEALTH
CONNECTOR
Your Guide to Health Insurance

Next steps include the development of content for the website and the creation and distribution of educational materials throughout the state.

Arkansas is implementing a comprehensive three phased Outreach and Education campaign to begin in the Spring of 2013 and sustained through March 2014. The campaign is being led by HBEPD's new Public Information Manager, Heather Haywood who brings to the position more than 20 years with marketing and public relations campaigns throughout the State of Arkansas. She has a wealth of lessons learned and media contacts ready to enrich and expand our Outreach and Education efforts. Working closely with her in the role of Communications Specialist is Terri Clark who brings to HBEPD over 16 years experience developing and executing public outreach campaigns. They will work closely with contractors, the IPA Guides, Arkansas Department of Health's Home Town Health infrastructure and the Arkansas Health Connector Resource Center to operationalize this comprehensive, multi-phase outreach and education campaign.

The interagency agreement with ACHI/UAMS Creative services is taking the lead on Phase I which is an education campaign focused on ACA and what it means in Arkansas for individuals and employers. Phase 1 is part of the Level One A grant and is planned to roll out in the Spring of 2013 sustained 4-6 months. Plans for this phase include development of materials for a Speaker's Bureau including PowerPoint presentations, supporting collateral materials and a direct mail campaign to solicit speaking engagements; media and direct mail campaign to recruit organizations to become IPA/Guides; and a public information campaign to address misinformation about the ACA. The beginning of Arkansas's Phase I Outreach and Education Campaign will coincide with the launch of a new Arkansas Health Connector website that will provide online education, information links and answer FAQs in collaboration with CCIIO. The beginning of Phase 1 will introduce an additional facet of the Outreach and Education Campaign with the announcement of the Arkansas Health Connector Resource Center through which consumers or others can access Exchange Partnership information provided by trained human resources who will be available to answer and log questions, thereby helping to continuously improve our outreach and education campaign. We believe that an excellent "first consumer experience" is critical for long-term Exchange success. The Arkansas Health Connector Resource Center is discussed in more detail in the "Proposal to Meet Program Requirements" section of this application.

Once on staff, Ms. Haywood's first tasks were to finalize the RFP for Phase 2 of the Outreach and Education campaign and begin planning for Phase 3. As described in our Level One B grant application, Phase 2 is the part of the campaign that targets Arkansas's uninsured and underinsured citizens including those who work in small businesses to provide them with information in preparation for Open Enrollment. This is the "get ready--open enrollment is coming" phase of the campaign. We are on track for the RFP to be posted in late February and for the campaign to run June 1 through September 30.

Phase 3 of the Outreach and Education campaign is slated to intensify our efforts during Open Enrollment to make sure every effected Arkansan is aware that "the time is now" to enroll in a health plan and how to get assistance to do so if needed. It is designed to maximize enrollment in eligible health plans. Funds for this Phase 3 effort are being requested in this Level One C grant request and are discussed more fully in the "Proposal to Meet Program Requirements" section of this application.

Concurrent with the CAAC, a very active stakeholder involvement effort is occurring with the Plan Management Advisory Committee (PMAC) and is discussed in detail in the Business Operations section below. The diverse PMAC often meets as much as six hours per month to consider policy and implementation issues of the State Partnership Exchange. Information regarding PMAC activities is available on our website at http://hbe.arkansas.gov/FFE/Plan.html.

In August 2012, CAAC decided to establish a Medicaid Integration Subcommittee comparable to the one established by the PMAC to discuss "churning" and other issues related to the interaction between Medicaid and the QHPs on the Exchange. At their first meeting on August 30, it was joined by members of the PMAC Subcommittee and thereafter met as one group. The Subcommittee continued to meet at least monthly through December discussing issues related to consumers moving from Exchange QHP to Medicaid and from Medicaid to QHP because of changes in life circumstances, attempting to identify and mitigate disruptions in coverage. In December they voted to temporarily suspend their meetings pending the results of the work being undertaken by Manatt Health Solutions and their subcontractor Optumas regarding continuity of coverage options for Arkansas.

An area of expressed concern raised by both the CAAC and PMAC is the potential worsening of already existing health care provider shortages, especially in the rural areas of Arkansas. As noted above, our policy consultant, ACHI, studied this issue and recently released their report (See Appendix B) based on a review of the literature. The report identified specific provider specialties expected to be in greater demand with the expansion of insurance coverage as a result of the Exchange, i.e., primary care, substance use disorder, mental health, chronic disease, and emergency room medicine, and how certain non-physician clinicians—physician assistants and nurse practitioners—might help fill the primary care gap. A recently reported market place study by CCIIO contractor Econometrics suggested only a 5% to 6% use adjusted decrease in Arkansas primary care and specialty physicians and short term, long term, and specialty hospital providers per 1,000 population between 2014 and 2016. Even though these data suggest the provider supply changes will not be as great as some have feared, stakeholders report it is often difficult for consumers with Medicaid coverage to access care in some areas of the state now. These stakeholders express concern that this Medicaid provider shortage may be exacerbated when more Arkansans have private plan coverage. Discussions of these provider issues have been part of the deliberations of the Medicaid Integration Subcommittee and will be addressed in the Manatt/Optumas study.

Long-term Operational Costs

As documented in the Arkansas Planning Review Report letter from our project officer dated July 10, 2012 (see Appendix D), "a key risk identified by the Arkansas team was difficulty in maintaining State support of the Partnership Model without clear information on the following topics: long-term operating costs and funding of Partnership functions, use of fees on the FFE…"

Cognizant of the requirement that Exchanges must be self-sufficient after 2014, Arkansas's Exchange Planning background research provided a high level estimate of Exchange operational costs and revenues when Arkansas was still exploring a State-based Exchange. Using background research actuarial projections of average premium costs per month in 2014, and applying Arkansas's current 2.5% premium fee to the estimated number of private plan enrollees in 2014, it was estimated that premium fees could be a source of financial sustainability of the Arkansas operated Exchange. In November 2012, CMS/DHHS/CCIIO provided guidance estimating that a 3.5% carrier fee will be imposed by the Federally-facilitated Exchange for FFE and State Partnership Exchange States. We expect further discussion/clarification on this in the months to come. We also expect continued funding through federal grants to support Arkansas Plan Management and Consumer Assistance functions provided for the FFE following 2014.

Program Integration

A significant portion of the HBE planning effort in 2011 was devoted to identifying opportunities to leverage existing functionality/processes for use in a state-based Exchange. The initial effort cast a broad net to contact state agencies as well as other stakeholder organizations to learn what might be applicable or replicable for the Exchange. The agencies and organizations studied have been involved in Exchange planning activities from the beginning as participants in the HBE Steering Committee and/or the various HBE Workgroups, most notably the State Agency and

IT Workgroups. Many of these same entities are also working together on other statewide initiatives such as the Health Information Exchange so were already thinking of opportunities to work together to leverage their resources. The Arkansas's Program Integration Plan created as the result of these efforts is posted on the HBEPD website at http://hbe.arkansas.gov/PIPlan_20110817cc.pdf.

In December 2011 when the Governor directed AID to pursue the State Partnership Exchange model, HBEPD began sifting through the research done to determine what opportunities for collaboration and program integration existed in the model where the state would have responsibilities in two areas: Plan Management and Consumer & Stakeholder Engagement & Support.

Intra-agency integration: We identified that HBEPD will work closely with other divisions of AID in several key areas. First of these is health plan management. Initial planning determined that AID would be responsible for establishing the regulatory and certification standards including solvency standards for QHPs within the state. This would require intra-agency cooperation among the HBEPD, Life and Health, Rate Review, Finance, Liquidation, Legal, Consumer Services, License and Information Services Divisions. AID plans to use SERFF and the federal Health Insurance Oversight System (HIOS) in its Plan Management implementation. AID's Rate Review Division staff will play a key role in the evaluation of the premium pricing structures of the QHPs. Additionally, it is anticipated that AID's Consumer Services Division's (CSD) Consumer Assistance Program (CAP) will manage complaints regarding health plans, Navigators, In Person Assisters (IPAs) and licensed producers. The AID License Division will certify and monitor licensed producers for competency to sell health insurance through the Health Insurance Marketplace.

HBEPD has developed solid day-to-day working relationships with the Rate Review Division as it has finalized plans to use SERFF and HIOS to communicate QHP status to the FFE. Collaboratively we have developed procedures to assure efficient review and approval of QHPs information and rates submitted for possible inclusion on the Exchange. HBEPD's new Finance Manager, Amanda Spicer, is working closely with the AID Accounting Division to assure that policies and procedures internal to HBEPD are in concert with AID's financial processes. HBEPD has developed a close working relationship with the Life and Health Division and through this Level One C grant is requesting funds to support a staff position to accommodate the additional work of that Division as the result of the State Partnership Exchange Plan Management functions. Through this grant we are also requesting funds to support a staff position in the Information Services Division to assure that Exchange related systems are in sync with and supported by AID and other state systems. In concert with the Consumer Services Division we are developing the Arkansas Health Connector Resource Center discussed in more detail later in this grant application. With funds from this Level One C grant, we will support a staff position as well as assume some of the costs of the Center's daily operations.

Inter-agency integration: AID works with multiple state agencies in planning for FFE implementation in Arkansas. Key to this collaborative effort is the Arkansas Department of Human Services (DHS) which houses the state's Medicaid agency and is expected to be a critical partner in flow of information about FFE-Medicaid eligibility and enrollment. Their eligibility and enrollment expertise and experience will be invaluable to Arkansas's developing State Partnership Exchange. DHS county offices will also play an ongoing role in managing appeals to Medicaid eligibility determinations and redeterminations.

Early interagency planning involving leadership of DHS' Research and Policy, County Operations (the Division that performs Medicaid enrollment functions), Information Systems and Medicaid Divisions; the AID Commissioner and HBEPD Director; the Office of Health Information Technology (OHIT); and the State's Department of Information Services (DIS) resulted in a shared Exchange Eligibility/Enrollment strategy using the Access Arkansas portal as the "Exchange Face". DHS issued RFPs for a new MMIS system and rules engine in 2011. Both were "pulled" in November 2011 when the State Medicaid Director resigned. A new Medicaid Director, Andy Allison, began work in

Arkansas on December 5, 2011. DHS has since issued a revised RFP and is in negotiations with the chosen contractor. HBEPD is actively monitoring these activities.

Even with our change from planning a state-based Exchange to the State Partnership Exchange Model, Arkansas remains committed to a "no wrong door" consumer experience and is planning for a seamless user experience where consumers can enter through Access Arkansas or the FFE portal and have their Insurance Affordability Program (Medicaid, CHIP, QHP with premium tax credits or other cost reductions) eligibility/enrollment achieved in "real time". DHS is taking the lead in FFE Eligibility and Enrollment integration with our State Medicaid program. AID is taking the lead in loading QHPs to the FFE portal through SERFF and in collaborative planning efforts to minimize negative effects of expected consumer movement between Insurance Affordability Programs available for our residents.

A continuing interest in integrating additional program eligibility determinations such as for SNAP and child care assistance remains strong in Arkansas. Information technology implementation "sprints" are planned by DHS (under the to-be-awarded MMIS and Rules Engine contract) and FFE-Medicaid Eligibility/Enrollment design constitutes the first sprint. Therefore, planning for broader than Exchange eligibility/enrollment integration will not interfere with required timelines for Arkansas's functional FFE/Medicaid eligibility/enrollment system. AID is walking step-by-step with DHS and DHHS to assure that State Partnership Exchange eligibility and enrollment development is consistent with ACA requirements, provides a first class user experience, and is in compliance with cost allocation requirements.

The Exchange will also tap into the expertise of the Office of Health Information Technology (OHIT) as they are developing Arkansas's Health Information Exchange. OHIT is developing the Master Person Index that may be an important asset for the State Partnership Exchange.

With resources afforded by the Exchange Planning Grant, staff from DHS, AID, Arkansas Foundation for Medical Care (outreach and education subcontractor for Arkansas's HBE background research), and the Governor's office attended three User Experience 2014 (UX 2014) planning sessions where broad stakeholder participation helped to design the prototype for first class Exchange user experience.

The Arkansas Center for Health Improvement (ACHI) has provided HBEPD with policy expertise and has legislative authority over Arkansas's developing All Payer Claims Database Plus (APCD+) which could potentially serve as an asset in the quality plan rating components of the Arkansas State Partnership Exchange. Using Level One A grant funds appropriated in late April 2012, HBEPD entered into an interagency agreement with ACHI to study the utility of Arkansas's developing APCD+ for State Partnership Exchange quality improvement efforts. After careful study and discussion with other states, ACHI determined that a database such as APCD is not the best option for measuring quality information for the Exchange. Consequently, ACHI's scope of work going forward has been modified to one where they develop several options for measuring health plan quality and present them to HBEPD with risks and benefits and a full analysis of each.

Another State department identified as instrumental in the development of the Exchange Partnership is the Department of Information Services (DIS) which has strategic and operational expertise on single point of entry sign-on authentication, customer call centers, state IT architecture, and maximizing mobile functionality (social media). Using Level One grant funds, HBEPD entered into an interagency agreement with DIS for the services of a full time program manager to assist with intra- and interagency and state-federal IT-Program Integration. Carder Hawkins, CPM, skillfully filled that role until he accepted the position as AID Deputy Commissioner for Information Technology in November 2012. We see Mr. Hawkins' appointment to this role as a "value add" for the AID-FFE work as well as interstate collaborative effort for implementation of the State Partnership Exchange. In December DIS assigned another very capable employee, Tonmoy Dasgupta, to fill this role going forward. Mr. Dasgupta is an experienced systems analyst and project manager who has immediately immersed himself into HBEPD's work.

Research done in 2011 did not recognize any significant opportunities to work with the Arkansas Department of Health (ADH). However, as HBEPD has begun to operationalize the State Partnership Exchange Consumer Assistance functions, a couple of the consumer support networks already in place at ADH appear to mesh well with both our IPA Program and our plans for Outreach and Education (O&E).

HBEPD is finalizing an interagency agreement with ADH to provide staff support and expertise to our IPA Program through the ADH Home Town Health program. In our Level One B grant we requested and were awarded funds for regional IPA Specialists to be employed by ADH. In our continuing discussion with ADH, it became apparent that five or six regional staff would not be as effective as incorporating these responsibilities into the Home Town Health programs that are already in place in each of Arkansas's 75 counties. In these programs local business and professional residents team with local consumers to identify local health needs and work toward collaborative solutions. Under our agreement with ADH, outreach and education of community leaders and consumers about the Exchange as well as support for local IPAs will become a priority for these Home Town Health programs. HBEPD will make Outreach and Education materials available to ADH for use throughout the state and will foster routine communication between ADH and the contracted IPA entities.

As previously reported, one particular concern related to a first class user experience and IAP design and costs—both ultimately affecting consumer outcomes-- is consumer "churning" between Medicaid and private QHP coverage through the Exchange. There are no Medicaid managed care plans in Arkansas. Current income eligibility for Arkansas Medicaid is among the lowest in the nation (~17% FPL). Based on research by others and State experience, we expect a significant amount of consumer movement between Medicaid and private plans. It is important that strategies are planned and implemented to prevent disruption of coverage or provider networks with consumer eligibility changes. Background research findings to date have not determined Medicaid costs per various eligibility categories so that cost projections for the expanded MAGI population can be evaluated as a function of projected churning. More data and analyses are needed so we can address policy alternatives in an expedited manner.

Using funds awarded under the Level One B, we have contracted with Manatt Health Solutions and their subcontractor, Optumas, a nationally recognized actuarial firm, to study continuity of coverage options in Arkansas. Because of a delay in approval from the Arkansas Legislature to spend the Level One B grant funds, the contract was not finalized until late December 2012. This vendor immediately began research and data gathering and made their first onsite visit to Arkansas February 6-8 to meet with our interagency leadership team, the Governor and his key staff, and stakeholder groups comprised of consumers, health care industry leaders and policy makers. The Manatt team's onsite time also included a presentation to the Plan Management Advisory Committee's regular monthly meeting. One innovative and supported option for study is "Medicaid buying into private QHPs." This option will be studied along with Arkansas's innovative claims-based payment system that pays for evidence-based episodes of care using a medical home model and comparing these models with Arkansas's traditional fee-for-service program and a (new for Arkansas) Medicaid managed care model. Consumer demand, provider capacity, costs and continuity of coverage will all be evaluated to assist with policy development aimed at curbing costs and improving outcomes and the consumer experience.

Having identified and followed through on these opportunities to leverage processes and expertise, the Exchange Partnership staff is continuously looking for other opportunities to create additional interagency agreements designed to enhance the overall operation of the State Partnership Exchange in Arkansas.

Business Operations of the Partnership Model Exchange

Arkansas's Initial Planning Review took place in Bethesda, MD on May 17 and 18, 2012. The Arkansas team led by Insurance Commissioner Jay Bradford and HBEPD Director Cindy Crone represented all the State agencies who are

working collaboratively to establish the State Partnership Exchange. Participants included the Arkansas Surgeon General, Joe Thompson, MD, the DHS Director of County Operations, Joni Jones, and assistant director, Linda Greer, the Medicaid Director, Andy Allison, PhD, the DHS IT Director, Dick Wyatt, and representatives from the Medicaid Policy Office (Sheena Olson), the Governor's office (Jennifer Flinn), the AR Department of Information Services (Carder Hawkins) and additional HBEPD support and contractor staff. Prior to the meetings HBEPD submitted the Concept of Operations document and Project Management Plan to CCIIO for review and discussion while on site. Dick Wyatt shared during the meeting DHS' plan for using agile methodology for development of Medicaid's interface with the FFE. The discussions were open and productive. We feel that CCIIO/CMS gained a better understanding of how Arkansas plans to create our portion of the State Partnership Exchange and the Arkansas team took away from the meeting clearer guidance in some areas (such as Navigators and In Person Assisters) but a growing list of issues still needing CMS guidance such as the state's long-term financial responsibilities. (See Appendix D, letter from State Officer with Arkansas's Planning Review Report.) Subsequent to the Planning Review, HBEPD staff meets regularly by phone with our CCIIO project officer and other CCIIO/CMS staff to work through outstanding action items. Planning in 2013 will estimate the cost of Arkansas's IPA and Plan Management programs.

HBEPD submitted our updated CCIIO Design Review documentation on Monday September 17, 2012 and attended our second Planning Review in Bethesda, MD October 1-2, 2012. Many of the same people participated either onsite in Maryland or by interactive video from Little Rock. In the Exchange Progress letter from our CCIIO project officer, Emily Pedneau, Arkansas was commended for our progress and for our continued efforts to help CCIIO work through many of the complex issues of the Partnership Model. (See Appendix E) HBEPD continues to meet regularly by phone with our CCIIO project officer and other CCIIO/CMS staff as we work through outstanding action items and outstanding questions. We are maintaining and reporting to our approved Work Plan.

HBEPD completed the Blueprint Application and submitted it on December 17, 2014. We received notice of conditional approval from CMS dated December 31, 2012.

Using Level One A funds, HBEPD hired a Grants/Contracts Specialist to oversee grants accounting, reporting and the multitude of contracts and interagency agreements needed for establishing the State Partnership Exchange in Arkansas. Will Roark was hired in May to manage grant accounting and reporting and develop financial operations policies and procedures. Mr. Roark resigned HBEPD effective September 7 and was replaced on December 17 by Amanda Spicer. Ms. Spicer brings to the position extensive experience managing grants, contracts and program budgets. In recognition of the position's primary responsibilities, the working title of her position has been changed to Financial Manager.

A Plan Management Specialist, Zane Chrisman, was hired on May 7, 2012, to serve as a liaison between members of the PMAC, the HBEPD, insurance companies, consumers, advocates, state agency employees and the Federal Exchange counterparts on any issue or question arising as to plan management, essential health benefits, or qualified health plans. She meets regularly with the co-chairs of the PMAC and other interested stakeholders and continuously researches questions related to plan management functions. Ms. Chrisman researches any legal questions related to the Exchange, as well as reviewing and drafting legal documents and memoranda. She has six years of prior insurance regulatory experience working both for the Arkansas Insurance Department and as in-house counsel with a private life and health insurance company. Ms. Chrisman has been reviewing pertinent federal laws and regulations related to ACA, the current Level One grant requirements, state health benefit laws and regulations, and all documentation provided by PCG describing its understanding of those same regulations. She outlined similarities and differences between the potential EHB benchmark plans as Arkansas stakeholders studied various plans in order to recommend the best EHB Benchmark Plan for the state.

AID entered into a professional services contract with Public Consulting Group, Inc. (PCG) on April 20, 2012 for Plan Management consultation to assist with development of QHP certification criteria and processes. PCG is responsible for assisting HBEDP and the PMAC in analyzing and reaching consensus on the appropriate mechanisms for QHP certification, monitoring and oversight. The work to be accomplished includes development of position briefs, facilitation of PMAC meetings, discussions with the staff of other AID divisions and interaction with CCIIO/CMA representatives to assure full understanding of the requirements. This work results in recommendations to HBEPD and the AID Commissioner as well as written processes.

Using funds from the Level One B grant, PCG's contract for Plan Management consultation was extended through September 30, 2013. While PCG continued their interaction with the PMAC, additional tasks to be completed under that contract include assisting in AID in development of policies, processes and procedures for QHP review and certification; preparing a tool for reviewing the short and long term success of the QHP launch; and assisting with design and development of QHP account management functions. As reflected in the "Proposal to Meet Program Requirements" section of this application, we are seeking funds to extend this consulting contract beyond the September 30th date to cover the initial open enrollment and second plan certification period.

The Plan Management Advisory Committee (PMAC) met for the first time in May. During that meeting, the committee reviewed the statutory requirements for selecting the EHB, the state mandated benefits, and the benefits offered by the seven Arkansas eligible benchmark plans. Following much discussion during several subsequent meetings in which costs vs. benefit was weighed, the PMAC recommended to the Steering Committee that the Blue Cross Blue Shield PPO plan be selected as the benchmark for the state of Arkansas by a final vote of 16-11. Many of those voting against the recommendation were concerned that preventive benefits were not adequately covered and/or that this recommendation would raise a state separation of powers issue as one of the state mandated benefits applied to the PPO product but did not apply to the HMO products in the state. The Steering Committee did not accept the recommendation, but rather recommended that the Commissioner choose any of the State's three small group plans.

In June and July, the PMAC began discussing Active Purchaser vs. Open Marketplace strategies for Exchange Partnership plan selection. Two extended 4 hour meetings were held in June to discuss options available to become an Active Purchaser and the range of choices within those potential options. Some of these areas included additional quality assessments, network adequacy requirements, Medicaid integration, and encouraging broad participation in the Exchange. Additional information was also presented on the pediatric dental and vision benefits that needed to be supplemented. By the end of June, the group determined to focus on three areas: Medicaid Integration, statewide offerings, and recruitment of new issuer entrants. There were questions related to what must be included in pediatric dental, and the decision on the EHB Supplement was held until July.

A week prior to the July meeting, the United States Supreme Court released its decision that would allow states to determine whether they would expand Medicaid without the penalty of losing all existing Medicaid funds. This decision disrupted the original plans of the PMAC, causing the discussion surrounding Active Purchaser questions to be more informative in nature given the recent ruling. The PMAC was able to address the pediatric dental supplement as answers had been received from CCIIO. The Committee voted unanimously to supplement the benchmark plan chosen with the ARKids B (CHIP) pediatric dental benefit that did not include orthodontia. The Committee also voted to approve a recommendation to require QHPs to structure plans to remove the pediatric dental benefit from imbedded plans if the consumer so chose.

The Plan Management Specialist assisted in researching what other states have done in order to implement EHBs. Arkansas statute allows the state to pass rules to implement federal requirements. Based upon current statutes and our research, the Legal Division and HBEPD crafted an EHB determination rule that would develop a process to support the requirements of the ACA and would take into consideration the process that HBEPD has undertaken to

receive community feedback. This (EHB) Rule 103 was published on June 28, 2012. A public hearing was held on July 31, where two individuals presented comments. One of the comments addressed technical corrections and requested limiting the rule to the 2012 EHB determination. Another commenter requested language to address grandfathered plans. The additional language was denied as the state is working to implement an NAIC model rule to address the particular issue that was raised. Another comment requested language to restrict the Commissioner's choice of plans to what was allowed solely under Arkansas law. This was denied because of potential conflicts with federal law. The proposed rule was presented to the Arkansas Joint Subcommittee on Administrative Rules and Regulations on August 21, 2012 where it was passed. (See Rule 103 at http://www.insurance.arkansas.gov/Legal%20Dataservices/rulesandregs/Rule103.pdf)

In August, the PMAC completed recommendations for the Active Purchaser vs. Open Marketplace topic area for all but one topic (Medicaid-Exchange Integration) pending additional recommendations from the Medicaid Integration Subcommittee.

- PMAC recommended that the Arkansas Partnership Exchange not require network adequacy standards that exceed federal ACA requirements in the first year. The Steering Committee and Commissioner accepted this recommendation.
- PMAC acknowledged the emerging importance of Arkansas's Payment Improvement Initiative in advancing quality and affordability and recommended that the Arkansas Partnership Exchange may engage or require carriers to adopt specific quality improvement strategies as a condition of having their QHPs certified to be marketed and sold on the Exchange. The Commissioner accepted the recommendation.
- PMAC recommended that the Arkansas Partnership Exchange should not require carriers to offer their QHPs statewide as a condition of Exchange certification. The Steering Committee recommended adding consideration of a regional approach with the goal of statewide coverage. The Commissioner accepted the revised recommendation.
- PMAC recommended that the Arkansas Partnership Exchange would not limit the number of plans or benefit designs that may be offered by carriers in the Exchange. In a departure from the PMAC recommendation, the Steering Committee recommended that the Arkansas Partnership Exchange may limit the number of plans or benefit designs that may be offered by carrier on the exchange. The Commissioner accepted the revised recommendation
- PMAC recommended passing on the options related to incentivizing carriers. The Commissioner accepted the recommendation.
- PMAC recommended that accreditation standards not be required outside of the Exchange. The Steering Committee and Commissioner accepted the recommendation. (See Bulletin 1-2013 http://www.insurance.arkansas.gov/Legal%20Dataservices/Bulletins/1-2013.pdf)
- PMAC recommended that the Arkansas Partnership Exchange utilize ACA quality standards on day 1 of the Exchange. The Steering Committee and Commissioner accepted the recommendation.
- PMAC recommended that the Arkansas Partnership Exchange utilize a certification approach to selective contracting. The Steering Committee discussed and recommended that the Arkansas Partnership Exchange utilize a certification approach for plan selection, which was accepted by the Commissioner.
- PMAC recommended that the Arkansas Partnership Exchange not require participation by carriers in payment reform initiatives but the Steering Committee recommended deleting this PMAC recommendation as not necessary.

In September, the Arkansas Essential Health Benefit Benchmark Plan Selection was completed by the AID Commissioner and the EHB was submitted to CCIIO on September 24, 2012. (See Directive 2-2012 at

http://www.insurance.arkansas.gov/Legal%20Dataservices/Directives/2-2012.pdf) CCIIO's Proposed Rules and Notices of Proposed Rulemaking in November resulted in modifications to the EHB being submitted in late December. These modifications included a proposed definition of habilitative services, establishing the maximum age limit for pediatric dental and vision as "to age 19" and changing the benchmark pediatric vision plan from the federal employee benefit plan to the Arkansas CHIP vision plan as was allowed in revised CCIO guidance. Discussion of habilitative services continued through multiple meetings in January with an additional EHB change defining habilitative services being submitted at the end of the month. (See Directive 1-2013 at http://www.insurance.arkansas.gov/Legal%20Dataservices/Directives/1-2013.pdf)

HBEPD staff participated in FFE Eligibility and Enrollment Learning Collaborative project meetings beginning in August 2012. Arkansas is one of eight (8) states invited to participate in the FFE Eligibility and Enrollment Learning Collaborative that is part of an initiative to bring together state and federal partners to address common challenges, pursue innovations in Medicaid program design and operation, and enable timely and effective ACA implementation. Initial focus is on eligibility and enrollment systems, identifying critical coordination and integration points between Medicaid/CHIP and the FFE and strategies to harmonize policies, operations, and systems to ensure a seamless eligibility pathway for consumers. This project is being led by Manatt Health Solutions who is contracted by CCIIO to manage this effort.

The ACA has defined certain requirements for network adequacy. The State of Arkansas does not have network adequacy requirements in place, except for HMOs that have this function regulated by the Department of Health. The network adequacy rule is still in the draft phases but is intended at this point to implement eventual requirements both inside and outside of the Exchange. All network adequacy regulations will likely transfer to AID. Assessment of network adequacy will be tied to carrier direct determination or through proof of accreditation as required by CCIIO.

Discussions of the three adverse selection risk mitigation strategies ("3 Rs") indicate that Arkansas prefers the federal government to manage all three strategies: risk adjustment, reinsurance and risk corridor.

During the fall of 2012, HBEPD facilitated a series of "Health Coverage Discussions" among representatives of health care providers, policy and insurer groups. Through our meetings with these groups individually we learned that each had misconceptions about the other's recommendation in defining health care services such as preventive services A and B as defined by the U.S. Preventative Services Task Force (USPSTF) and required to be covered under a state's selected EHB benchmark plan. By bringing them together, we hope to dispel these misconceptions and foster more productive working relationships between them as key stakeholders in Arkansas's State Partnership Exchange. This work is ongoing and positive to date.

Using funds from our Level One A grant, we have taken advantage of an AID contract for actuary consulting firm, Lewis and Ellis, Inc. David Dillon of this firm has also been conducting a study to determine the effect of premium increases on the uninsured population who uses tobacco. This report was issued on February 4, 2013 (See Appendix H) for discussion at the February PMAC meeting. He is also working on a study to review the rating areas currently utilized in Arkansas and evaluate the effect of limiting those rating areas to increase competition and decrease premium prices within the state. As a part of that study, he is also evaluating service areas to see if it would make sense to tie together service and rating areas within the state of Arkansas. A draft of Mr. Dillon's report was provided to HBEPD for initial review on February 7, 2013. Mr. Dillon also attended the Deloitte Exchange Simulation modeling workshop in Boston with the AID HBEPD, Life and Health and Finance Division directors; actuaries from two Arkansas issuers; and a representative of the Governor's office. As discussed in the "Proposal to Meet Requirements" section of this grant request, we are requesting funds for additional actuarial services to be provided by one of the firms under contract with AID.

IT Gap Analysis and Exchange IT Systems

First Data developed an IT Integration Plan (See http://hbe.arkansas.gov/ITIntegrationPlan.pdf) after reviewing applicable state documents and websites and interviewing relevant staff. This work was completed when the state was still considering a state-based Exchange.

As part of this Gap Assessment effort, meetings were held with key State stakeholders, including those that supervise the functions of DHS, OHIT, DIS, EBD (Employee Benefits Division that manages State and Public School employees and retirees), and AID, as well as, external state stakeholders. The meetings were intended to provide detailed insight regarding the capabilities and functions of the current systems. The First Data team carefully evaluated the information in the documentation along with the findings of the formal agency interviews, subsequent discussions with various stakeholders including those with the August 2011 IT Workgroup meeting, and other states' research.

One of the primary objectives of the interviews was to develop a comprehensive list of current systems and applications that could be used or reused to fulfill certain functional needs and integrate with the Health Benefits Exchange, maximizing funding sources. The HBEPD staff worked with the Information Technology Workgroup, the State Health Information Technology (HIT) Advisory Council and other stakeholders to collect this information.

When planning for a state-based Exchange ended, HBEPD set about identifying the IT support needed for the State Partnership Exchange model. A current Arkansas IT inventory was submitted to DHHS/CMS/CCIIO on July 23, 2012. DHS Office of Information Systems' Director, Dick Wyatt, was lead for this effort. Ultimately, strategic decisions will be required which will shape the outcome of the State Partnership Exchange architecture in Arkansas. Our continued and strong commitment to state agency and federal collaboration will be critical to the successful State Partnership Exchange. HBEPD staff has listened to SOTA teleconferences led by CCIIO and attended by Arkansas DHS IT staff and we plan to become routinely involved in these teleconferences.

The Arkansas Navigator IT RFP (Level One A grant funds) was posted on March 8, 2012 with a submission due date of April 20th. There were no responses to the RFP. The Exchange Planning team's follow up with the vendor community and assessment by the Office of State Procurement (OSP) resulted in OSP issuing an Unsuccessful Bid Letter to AID. The Unsuccessful Bid Letter advised AID to issue a Request for Information (RFI) seeking recommended solutions within the realm of the defined requirements to determine a best fit through the RFI responses and possible subsequent demonstrations by vendors. Per OSP, AID could then negotiate a "reasonable pricing structure" with the vendor determined to have the best fit and, subject to approval of the negotiations, a contract can be issued.

The RFI was posted on June 1, 2012 for information regarding a solution for an integrated grant management and learning management solution for use in the support of an Arkansas Navigator program. Five responses were received by the June 22, 2012 deadline. Further review and action on the RFI responses was postponed based on additional guidance received from CCIIO following the issuance of the RFI that resulted in a change from an Arkansas Navigator Program to an Arkansas In Person Assister (IPA) program that would include contracting for IPA services to meet the needs of Arkansas consumers. After further guidance from CCIIO, it was determined that the IT solution need as described in the RFI will remain essentially the same other than replacing "grants management" with "contract management". Two of the five responses were found to not meet the minimum expectations for services or experience. The remaining three vendors were invited for onsite presentations and Q&A sessions with an evaluation team. These sessions were followed by the solicitation of additional clarifications and completion of a "solution fit" matrix by each of the three vendors. Evaluation of all follow up responses resulted in further narrowing to two of the three remaining vendors who were then asked for best and final pricing information. HBEPD selected Computer Aid, Inc. (CAI) as the vendor for the IPA IT solution. Notifications were sent to all vendors that responded to the

opportunity in the second week of January. An initial meeting was held with CAI on January 15, 2013 and initial data gathering has begun as contract negotiations are being finalized. The solution as identified will provide HBEPD with application functionality for the management of the IPA Entity contracts as well learning management system functionality for the maintenance and tracking of training and certifications. Funds are available from the Level One A grant for this effort.

Arkansas will use the System for Electronic Rate and Form Filing (SERFF) to provide a single point of interaction for Arkansas issuers to submit plans for certification and renewal and for Arkansas state regulators to certify, renew and manage QHPs participating in the State Partnership Exchange. The SERFF role and approach leverages existing systems, assists states in certifying QHPs and facilitates integration. Using existing information technology investment vs. building new technology will mitigate costs and lessen the burden to issuers adapting to a new system. NAIC will increase SERFF functionality that will allow for improved data collection and reporting. Using Level One A funds, AID paid a one-time fee of $84,451 to cover all costs associated with delivering SERFF functionality to support Plan Management functions for QHPs for the Arkansas State Partnership Exchange. The originally projected date of enhanced SERFF implementation was January 1, 2013. It has now been postponed to March 29, 2013. HBEPD is concerned that this delay gives issuers little time to get plans published and certified.

A Memorandum of Understanding was executed between AID HBEPD and Information Network of Arkansas (INA) for services to revise the HBEPD website pages within the AID's website and to develop an additional section for the Arkansas Health Connector program. Work to be completed by this vendor includes:

- Website design to comply with the State's Common Look and Feel Initiative
- Website development utilizing CMS materials
- Migrate existing and add new content
- Upload documents for use on the website
- Compliant with federal and state accessibility law
- Compliant with state human readable and machine readable privacy law
- Special website features will include:
    - Calendar
    - Contact Us form/s
    - Integrating Google Translator
    - Responsive website design for mobile devices
- Increased security through regular security audits.

When the work is completed, HBEPD staff will be able to maintain the website without dedicated IT resources. Deployment of the new website is estimated for March 2013. Funds are available from the Level One A grant for this effort.

Organizational Structure

First Data's background research work in 2011 included recommending an operational structure within which the Exchange could do its business. The First Data Team conducted interviews with representatives of state agencies (program and IT staff); consulted other stakeholder groups; attended work groups and Steering Committee meetings; researched the best communication, outreach, education and evaluation strategies; investigated the Arkansas insurance market and gathered information about uninsured Arkansans--all in an effort to gather the broadest picture of how Arkansas can best establish a successful Exchange. The recommendations presented at that time were based on an Arkansas-operated Exchange and are available for review on the HBEPD website at http://hbe.arkansas.gov/BOPlan.pdf.

With the shift in focus to creating an Arkansas State Partnership Exchange, HBEPD was repurposed as the division of AID responsible for the planning and implementation of the Arkansas operated services and support associated

with a State Partnership Exchange. The Division is led by a director that reports to the AID Commissioner and is responsible for both state and vendor staff currently engaged for services needed by the Division (See SF-424 Attachment for the HBEPD Organizational Chart).

During development of the Level One B grant application in August, 2012, AID leadership proposed a staff expansion to encompass the tasks known to them at the time. That expansion included the addition of eight positions with most tied to the development of the IPA program. While we received the Notice of Award for the Level One B grant on September 27, 2012, spending appropriation was significantly delayed. We were not able to meet with Arkansas Legislative Council (ALC) Joint Budget Personnel Committee until December 13, 2012, ALC-PEER for review of our Miscellaneous Federal Grant appropriation request until December 14, 2012 and full ALC for review of our full appropriation request until December 21, 2012. The Arkansas Insurance Department finally secured appropriation approval to spend the grant funds on December 21st. During this delay we laid the ground work for hiring by advertising, reviewing applications and interviewing the most qualified applicants.

During the delay and after the November Presidential election, HBEPD also received much additional guidance from CCIIO/CMS on the expectations of a state that chose the State Partnership Exchange model. Some of this guidance impacted our planned IPA Program as well as our Outreach and Education plans. As a result, we decided to restructure the staff of these two HBEPD areas. The Consumer Assistance Specialist was hired as the IPA Contract Lead and her position was repurposed into a Communication Specialist to assist with the ever expanding Outreach and Education effort. During this delay, we also gave serious thought to the impact of Arkansas's November Legislative elections which resulted in a majority shift in the Arkansas House and Senate, with control of both chambers now belonging to the Republican Party for the first time since Reconstruction. Members of the Republican Party indicated the 2013 General Assembly would address whether or not the state would continued Partnership Exchange planning. This and an increasing number of inquiries from diverse stakeholders plus a rapidly changing Exchange establishment environment signaled to AID and HBEPD the need for a position devoted to research and policy analysis related to the State Partnership Exchange development. To that end, HBEPD repurposed an unfilled Administrative Analyst position (with increased funding) to a Policy and Research Specialist to report directly to the HBEPD Director and focus on timely data gathering, analysis and reporting.

As reflected on the attached HBEPD Organization Chart, Sandra Cook in her new role as the IPA Contract Lead has responsibility for the IPA Program. To lead communications as well as the Outreach and Education effort in collaboration with Ms. Cook, HBEPD hired Heather Haywood as Public Information Manager and Terri Clark as Communications Specialist. Both come to HBEPD with extensive state-wide public relations experience. For the position of Policy and Research Specialist, HBEPD employed Seth Blomeley who has experience working as a Capitol reporter and as a state agency public information officer. One additional staff change was the promotion of Tangelia Clary–Marshall to the position of Program Operations Manager where she has assumed additional responsibilities for overall day to day operation of the Division. Additional positions funded by the Level One B grant are in the process of being filled.

With the significant expansion of HBEPD staffing, HBEPD's contractor First Data spearheaded the effort to put in writing internal procedures and processes as well as a comprehensive New Employee Orientation program. This work was completed and ready for use when Nichole Weldon joined the staff in October as the Administrative Assistant III.

Operational procedures for the division include weekly HBEPD staff meetings to review the schedule of the week ahead as well as completed and pending activities from the previous week. There is also a recurring bi-weekly status report that is completed by all Exchange state and vendor staff and which is further utilized on a bi-weekly status conference call that allows vendors to report on the status of their assigned tasks and provides the entire team with an update of the status across all areas of the HBEPD. The Division's work is additionally monitored through tracking

of Action Items, Issues and Risks associated with the aggressive timeline and work plan required for the deadlines associated with implementation.

The HBEPD staff and their management contractor, First Data, took time in early 2012 to redesign the approach to stakeholder involvement in a way that would lead to decisions that must be made to implement the State Partnership Exchange for Arkansas. Concurrently, HBEPD was meeting with the Legislature to obtain approval to spend the Level One grant funds, posting/interviewing/hiring additional staff and posting RFPs for subject matter expert consultants in plan management and Navigators/consumer assistance.

The Arkansas Insurance Commissioner accepted First Data's recommendation that the Exchange Planning effort establish a Stakeholder Engagement Model that enlists stakeholders at multiple levels, builds support for the initiative, improves communication and supports better resistance management. The engagement model facilitates formation of the sponsorship network and a structure with clearly defined leadership. This establishes the leadership bodies that will align roles and responsibilities, make decisions, allocate resources and provide ongoing support to sustain Arkansas's State Partnership Exchange.

The Stakeholder Engagement Model was formally presented on April 4, 2012 when HBEPD sponsored a State Partnership Exchange orientation to restart the planning process toward the State Partnership Exchange instead of toward the originally planned state-based Exchange. Representatives from CCIIO (Teresa Miller, Amanda Cowley and Emily Pedneau) and the Director of DHHS Region VI (Marjorie Petty) participated in the meeting. Key state leaders participating included the Insurance Commissioner, the Surgeon General and the Medicaid Director. Members of the re-constituted Steering Committee and Advisory Committees attended and had an opportunity to review and discuss the new Stakeholder Engagement Model. The model has been in use since that meeting with some revisions to structure the documentation process as members gained experience using it.

This model establishes a structure that is sustainable across political administrations and can assist in developing and managing key relationships at all levels. Primary sponsorship and decision-making will be the responsibility of the AID Commissioner, while stakeholders at all levels will help drive and support the State Partnership Exchange implementation in the State of Arkansas.

The Steering Committee includes Senior Management representation of the following:

- Insurance Department (AID) (2);
- Department of Human Services (DHS) (2);
- Arkansas Health Agency Leaders (1);
- Advisory Committee Co-Chairs (6);
- Department of Finance & Administration (DFA) (1);
- Legislature (2);
- Governor's Office (1); and
- At-Large Members (3).

Each Steering Committee meeting may include additional invitees, including but not limited to – project team members (includes vendor support staff), subject matter experts/content providers and Advisory Committee members. Minutes of meetings are available at http://hbe.arkansas.gov/FFE/Steering.html.

The HBEPD Director serves as the Chair of the Steering Committee. The Chair works with the Steering Committee and the Advisory Committees to establish and maintain a schedule of topics and discussions for the Steering Committee. The Steering Committee manages collaboration among the State in-flight projects, provides the transformation with active and visible leadership and will be able to secure and garner the necessary political and financial support for a long-term transformation.

Throughout the course of decision-making, it is important to keep Advisory Committee stakeholders engaged. Advisory Committee representation on the Steering Committee supports early and continued stakeholder involvement and directly addresses the Arkansas stakeholders' request to "have a seat at the decision-making table."

The Steering Committee meets monthly for no more than 2 hours to support regular decision-making regarding Advisory Committees' recommendations while protecting the time investment made by the Executive and Legislative leaders. The Steering Committee meeting is scheduled to complement the AID Commmissioner's monthly communications calendar ensuring that the decisions of the Steering Committee are available for the Commissioner to communicate to the Governor's Office (or other appropriate) calendar milestones.

Two standing Advisory Committees have been established to support the Stakeholder Engagement model –Plan Management and Consumer Assistance. The Plan Management Advisory Committee focuses on the definition and delivery of the Qualified Health Plan (QHP) guidelines and the Consumer Assistance Advisory Committee focuses on the In Person Assister guidelines, outreach efforts and consumer complaint resolution.

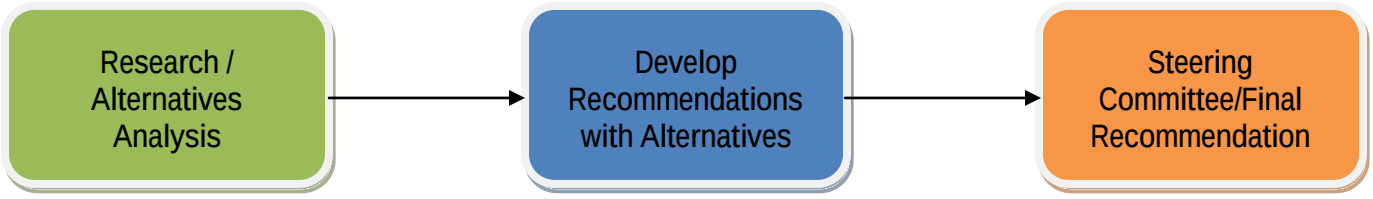
The AID Commissioner has designated three (3) co-chairs for each Advisory Committee that will represent the committee (along with the AID lead) at the Steering Committee -

- One co-chair represents Consumer Advocacy (Individuals and/or Small Business);
- One co-chair represents the Health Insurance Industry (Issuer/Producer/Broker); and
- One co-chair represents the Healthcare Community (Provider and/or Quality).

The role of the Advisory Committees is to evaluate and provide alternatives to the Steering Committee, as well as support communication and engagement across the stakeholder communities. The Advisory Committees will coordinate directly with the AID Exchange staff and contractors to discuss, evaluate and determine viable alternatives for consideration. The AID Lead will coordinate with the Advisory Committee to establish and maintain a schedule of topics for the Advisory Committee. The co-chairs will serve as day-to-day contacts if interim planning discussions or adjustments are necessary. Each Advisory Committee meets monthly for at least 3-4 hours in order to facilitate ongoing conversations and resolution of issues/concerns presented by the Federally-facilitated Exchange efforts.

Each Advisory Committee works closely with a consultant with expertise in their particular area. As previously noted, AID separately awarded Public Consulting Group (PCG) consulting contracts for Plan Management and for Navigator/Consumer Asistance. Both consultants began work with the advisory committees at their inception in April. Each Advisory Committee, in consultation with AID and the PCG consultant, developed a topic calendar for the year that outlines the key areas that must be addressed in planing for an State Partnership Exchange. This calendar is used to guide dicussions toward recommendations to the Steering Committee for the Comissioner's consideration.

The basis of the FFE Stakeholder Engagement Model is Advisory Committees providing recommended approaches to a single Steering Committee. The following graphic illustrates the general flow of effort and information within the expected Stakeholder Engagement model.



Reuse, Sharing and Collaboration

The business functions of certifying, renewing and managing the Qualified Health Plans (QHPs) available in the Exchange are elements of Plan Management and will be the state's responsibility in the State Partnership Exchange.

State regulators and insurers need an efficient, effective and compliant means to submit and review health plans for certification and inclusion in the Exchange. Currently, AID uses the National Association of Insurance Commissioners (NAIC) System for Electronic Rate and Form Filling (SERFF), developed in 1998, to support handling of insurance policy rate and form filings from Arkansas's issuers.

As previously noted HBEPD is planning to utilize SERFF to provide a single point of interaction for Arkansas issuers to submit plans for certification and renewal and for Arkansas state regulators to certify, renew and manage QHPs participating in the FFE. SERFF's role and approach leverages existing systems, assist states in certifying QHPs and facilitates integration. Using existing information technology will mitigate costs and lessen the burden to issuers of adapting to a new system. HBEPD staff member Bruce Donaldson has attended all NAIC/SERFF forums and any SERFF related forums at State Grantee Meetings. He reports progress in SERFF adjustments to meet plan management needs to HBEPD and other effected AID staff.

- Forum #1 brought together more than 30 states and CCIIO/CMS to discuss the development of Health Insurance Exchanges and potential use of SERFF in Plan Management. NAIC provided a demonstration of SERFF functionality as it worked currently and preliminary mock-ups showing how SERFF might be modified to support Plan Management.
- Forum #2 was to continue and expand on the discussion on Health Insurance Exchanges and the role of SERFF in Plan Management.
- Forum #3 involved the SERFF Plan Management project team and provided updates on project timelines, progress on analysis and design, and plans for implementation and training. NAIC staff provided an overview of key areas of Plan Management: 1) QHP Certification; 2) Issuer Account Management; 3) QHP Oversight; and 4) QHP Renewal/Certification/Decertification.
- Forum #4 was where NAIC staff provided updates toward leveraging SERFF for Plan Management functions related to the health insurance exchanges. Presentations were: 1) Updates to the project timeline and scope; 2) Enhancements planned for a summer 2012 release; 3) An update on efforts to achieve uniform data sets for Plan Management; 4) The critical path for SERFF in Phase 1, and information related to Phase 2 functionality; and 5) A panel discussion with CCIIO, the states and issuers.

NAIC/SERFF have identified 5 goals and objectives held by stakeholders in the SERFF Plan Management project:

- G01- Enhance SERFF so that state departments of insurance can use it to meet their plan management functions;
- G02- Streamline the process for insurers submitting plans for inclusion on the Exchange;
- G03- Support integration between applications involved in Exchange operations;
- G04- Provide flexibility to the states in how SERFF is used for Plan Management; and
- G05- Minimize duplicative entry.

HBEPD has had an opportunity to study the business model flowchart of the certification process in a FFE model. It presents a high level overview of the process flows of a QHP as it initiates from Insurer into SERFF to HIOS and finally up on the federal exchange portal. NAIC is working closely with CCIIO to define special needs and requirements for FFE and Partnership Exchanges using SERFF for QHP Certification. SERFF will allow states to individualize data collection and processes. Tonmoy Dasgupta has begun to coordinate state-NAIC requirements development and planning for the Arkansas-SERFF Plan Management Functions. This work includes close collaboration between the HBEPD Plan Management Specialist and the Life and Health Compliance Officer.

AID's Consumer Services Division (CSD) is designed to assist insurance consumers with complaints and inquiries regarding insurance companies, agents, and adjusters. CSD investigates all complaints, working with the insurance company and the consumer to determine the appropriate course of action. Prior to 2011, all CSD staff members were generalists, addressing all life, health, and property/casualty calls. In 2010, CSD was awarded a CCIIO Consumer Assistance Program (CAP) grant to help consumers with issues related to provisions of the Affordable Care Act. Services under this program include: assisting consumers with filing of complaints and any needed appeals processes; collecting, tracking, and assessing consumer problems and inquiries; educating consumers on their rights and responsibilities with respect to group health plans and health insurance coverage; and assisting consumers with enrollment in group health plans or health insurance coverage by providing information, referral, and assistance. The CSD added a CAP manager and new investigator to devote 100% effort to health issues. Another investigator was reassigned to this effort, transitioning from a generalist to a 100% health specialist. CSD has provided outreach and education, using staff and print and electronic media advertising. When Federal funds were exhausted in June 2012, AID CSD continued consumer assistance activities addressing health insurance concerns. CSD applied for another CCIIO Consumer Assistance Program grant in July 2012 to assist CSD in meeting anticipated service increases related to State Partnership Exchange implementation. CSD was notified in August that the grant was funded and received their legislative appropriation for these funds on December 21, 2012, the same day that HBEPD's Level One B funding was approved.

The HBEPD and CSD-CAP staffs are committed to working collaboratively to expand CAP efforts in preparation for 2014 State Partnership Exchange implementation. CSD-CAP and HBEPD are working to catalogue consumer inquiries and complaints in an effort to standardize responses, identify trends and work to continuously improve consumer services associated with the State Partnership Exchange.

Program Integrity

As part of our planning assessments we included review of existing monitoring tools for consideration when the Exchange system is designed. As the State Partnership Exchange Model is finalized and we begin to establish the Exchange organization, we are putting in place the oversight, auditing and fraud, waste, and abuse prevention tools needed to assure proper stewardship of public funds. We are constantly monitoring that resources are used efficiently and appropriately from the outset and ongoing.

AID has in place an accounting and financial department that is strictly governed by existing state policy. Arkansas audit procedures are performed yearly and are implemented to insure that no one person or position has sole authority to receive, process, and make payments. These policies are in force to provide an effective and efficient system of checks and balances. Additionally, Level One grant funding has allowed us to hire a Grants/Contracts Specialist dedicated to the financial management of the federal grants accorded under ACA. Will Roark was hired to fill this position in May, 2012. He resigned on September 7 and was replaced on December 17 by Amanda Spicer. Ms. Spicer brings to the position extensive experience managing grants, contracts and program budgets. In recognition of the position's primary responsibilities, the working title of her position has been changed to Financial Manager. She is working closely with the AID Accounting Division to assure that policies and procedures internal to HBEPD are in concert with AID's financial processes and she has implemented HBEPD specific policies and procedures to supplement and provide adequate checks and balances to our existing AID accounting office. The Financial Manager is tracking and reporting all expenses, receivables, contracts and expenditures in collaboration with the AID accounting office. Individual DHHS grants are tracked by specific grant identification and account numbers so that expenses, payments and draw-downs are separately and appropriately accounted for and reported.

Affordable Care Act Requirements

Rate Review - The AID currently has prior approval authority over individual health insurance rates for all issuers. In recent years the Commissioner has negotiated with issuers for all rate increases, and recently negotiated a lower rate affecting approximately 90,000 policyholders soon after being appointed Commissioner in 2009. He reduced the increase in rates by approximately 4% for the year 2010.

The AID was recipient of Initial Rate Review and Cycle II grant funding from CCIIO which helped Arkansas move toward an effective Rate Review program for all health insurance markets. Specifically, AID issued two bulletins (6-2011 and 7-2011) to increase requirements for individual rate filings and to obtain prior approval authority in the small group market. Effective September 1, 2011, all rate increases over the 10% threshold are subject to the new filing requirements in these Bulletins. Arkansas has been designated by CCIIO as having an "Effective Rate Review Program".

Rate review will help keep down the premium costs for Arkansas small businesses and families. The RRD will have an independent expert review proposed health plan rate increases submitted by insurance issuers. Arkansans will be able to access the issuer's justifications submitted as part of the rate review process online on the RRD's website. This site will also link to the Arkansas HBE website as well as the federal website (www. Healthcare.gov). Citizens will be able to provide public comment on all rate filings.

The AID Rate Review Division (RRD) will continue all current activities and tasks related to the Affordable Care Act (ACA), including but not limited to rate filings for major medical policies. The AID Life and Health Division will work closely with RRD and will utilize all programs, job aids and other rate review tools developed by RRD. The Life and Health Division will support RRD in all required HHS and Health Information Organizations (HIOS) filings and reporting requirements related to planning for Rate Review. Consumer and plan outreach and other similar activities related to Rate Review will remain within the RRD scope of services.

In June, 2012 the RRD hosted a National Rate Review conference in Little Rock where the HBEPD director presented a session on State Level Collaboration Between Rate Review and Exchange Implementation. Between twenty-five and thirty states and territories attended this conference in person and a number more attended by live, interactive video.

Minimum Loss Ratio (MLR) - As MLR filings are made with AID, the RRD will process all MLR filings utilizing its recently developed MLR tracking program to effectively monitor these filings. RRD will verify the issuers' calculations of rebates, or lack thereof, and ensure that all rebates are made in the required time frame and in the proper amount. MLR tracking is essential for accurate review of all rate filings. In August 2012 Arkansas consumers were awarded $7.8 million in rebates. No further action is required.

Reinsurance, Risk Corridor and Risk Adjustments - The RRD plans to be the AID liaison for planning and implementation of these adverse selection mitigation strategies. The Reinsurance program could be State or Federally operated under the Partnership option. Risk Adjustment and Risk Corridor Programs will be run by the Federal Government and Arkansas plans to defer operations of the Temporary Reinsurance program to the federal government.

Other ACA requirements:

- AID issued Rule 102 which required all carriers in the individual market to offer a child only policy. AID also began review of all policies to insure that any pre-existing condition provisions do not apply to anyone under age 19.
- AID will not approve any policy that does not comply with the ACA requirement that coverage be extended to children to age 26 on their parents' policy.

- AID adopted Rule 76 entitled "Arkansas External Review Regulation" which puts in place the NAIC model rule, thereby complying with the federal regulation regarding external review.

SHOP

HBEPD has facilitated numerous stakeholder forums and targeted workgroups aimed at fostering discussion and gathering information from the individuals and groups who will be most impacted by the development of the Exchange.

Based on expressed concern that employers would drop coverage after Exchanges are introduced, our Exchange Planning Policy Consultant from the Arkansas Center for Health Improvement (ACHI) prepared a policy brief in August, 2011, titled, "Will Employers Drop, Keep, or Add Health Insurance in 2014?" (Link to full article: http://www.achi.net/HCR%20Docs/110808%20ISSUE%20BRIEF%20EMPLOYER%20RESPONSE.pdf). It reviewed factors that suggest employers will drop, keep, or add coverage and reviewed five national studies (Mercer, McKinsey, Congressional Budget Office, RAND, and Urban Institute). The report concluded that the overall availability of employer-sponsored insurance is not likely to change much after 2014.

Our Exchange Planning Steering Committee recommended a targeted outreach education effort in the fall of 2011 to small businesses. This was needed to counteract negative messages aimed at business owners. The HBEPD entered into a contract with ACHI/UAMS to design an education program targeting small business owners. The design work is complete and catchy, positive radio and print media ads were to be launched in October 2011 using Exchange Planning funds. However, the ads were delayed due to legislative objection. We are now planning to run the ads as part of Phase 1 of our outreach and education campaign.

Since hiring the Plan Management Specialist, HBEPD has been actively engaged with CCIIO and CMS to ensure a successful implementation of the SHOP program with the federal government. Currently, Arkansas is waiting for additional regulations and answers to questions from CCIIO related to what roles and responsibilities Partnership states will assume within the SHOP program. It is our understanding that the individual and SHOP markets will be separate as part of the State Partnership Exchange Model. We await guidance on Agent/Broker training and FFE "certification" requirements for the SHOP.

PROPOSAL TO MEET PROGRAM REQUIREMENTS

Building on the work of the last two-plus years and using funds provided by our Planning Grant (awarded 9/30/10 with Administrative Supplement awarded 3/8/12), Level One A grant (awarded 2/22/12) and Level One B grant (awarded 9/27/12), HBEPD is making systematic, steady progress toward implementing the State Partnership Exchange model for Arkansas. Early and on-going research coupled with guidance from CMS and our CCIIO state officer has supported our efforts to date as well as planning for the future.

Arkansas chose the State Partnership Exchange model because it allows local development and oversight of the functions that most directly interact with Arkansans and the insurance issuers and producers who do business in our state. From the onset of our planning efforts, we devoted much of our energy and resources to interaction with a wide range of stakeholders and consumer groups. As we continue to grow and learn from those relationships, HBEPD has branded the Arkansas Health Connector as a vehicle to represent and assist Arkansans as they negotiate the new Health Insurance Marketplace.

As we continue to learn more about the challenges Arkansas faces and the requirements of the State Partnership Exchange, we have identified the need for additional HBEPD staffing resources, the continued utilization of valued

consultants, further expansion of our outreach activities, a collaborative endeavor with the State's Consumer Assistance Program (CAP) to assure consumer access to timely and accurate information, and the implementation of the In Person Assister (IPA) Guide and QHP certification and monitoring programs. Through this Level One C grant application, Arkansas is seeking funds to continue implementation activities in two specific areas of the State Partnership Exchange: 1) Consumer and Stakeholder Engagement and Support, and 2) Plan Management.

Working together, we are confident that DHHS and the Arkansas Insurance Department can and will implement an efficient, user-friendly State Partnership Exchange model that meets our mutual goal of increasing health insurance coverage of low and moderate income Arkansans by making quality, affordable plans easily accessible.

The specific activities we plan to undertake with the requested funding are described in the following sections.

Current Exchange Pathway

As indicated throughout this document, Arkansas is taking deliberate, planned steps to implement the State Partnership Exchange model by January 1, 2014 with Open Enrollment October 1, 2013. There are no current plans for a State-based Exchange. However, as more well defined regulations and requirements are provided from CCIIO, we will continuously evaluate this stance and assure that the State's leadership is apprised of any DHHS guidance that could trigger reconsideration of this position. We acknowledge that DHHS views the development of a State Partnership Exchange as a logical stepping stone to evolve into a State-based Exchange at some future date but await direction from our legislators on this issue.

Partnership Activities

Arkansas is approaching development of its State Partnership Exchange in the most collaborative manner possible with DHHS. Within the state we are including all interested stakeholders in the process and seeking to leverage existing resources whenever possible. Our in-state collaboration includes other divisions within AID as well as other State agencies/departments including Medicaid (within the Arkansas Department of Human Services [ADHS]), the State's Surgeon General and his staff at Arkansas Center for Health Improvement (ACHI), the Department of Information Services (DIS), the Arkansas Department of Health (ADH) and the Governor's office. Representatives of these agencies and others in a health leadership role in our state meet with our CCIIO project officer and other CMS or DHHS staff on a regular basis via teleconference or in person in an effort to foster full understanding and agreement on the manner in which AID is planning implementation of the State Partnership Exchange in Arkansas.

Our relationship with CCIIO has been a healthy "back and forth". Given that the State Partnership Exchange model was one of the later Exchange options identified, CMS is still working to finalize all the guidelines and regulations. And given that Arkansas was the first state to indicate a preference for the State Partnership Exchange, we have had the opportunity to ask specific questions prior to written direction and have had the opportunity on more than one occasion to voice our opinion on the preferred way to structure a particular operating procedure. The HBEPD team participates fully in conversations with CCIIO representatives on at least a weekly basis and more often by email. We also take full advantage of webinars and conference calls held by CCIIO staff to explain new requirements such as the Blueprint and this Level One funding opportunity. Building on our successful Design Review in October 2012 for both Plan Management and Consumer Assistance and the approval of our Blueprint Application in January, we anticipate another Design Review and an Implementation Review with CCIIO prior to the beginning of Open Enrollment in October 2013.

Plan Management Activities – The shared business functions of certifying, renewing and managing the QHPs available through the Health Insurance Marketplace in Arkansas are the responsibility of the state in the State Partnership Exchange operating Plan Management functions. As reported earlier in this document, HBEPD will use

SERFF to provide a single point of interaction for Arkansas issuers to submit plans for certification and renewal and for Arkansas state regulators to certify, renew and manage QHPs participating in the Exchange. Using existing information technology investments will mitigate costs and lessen the burden to issuers of adapting to a new system.

HBEPD staff and contractors are in continuous communication with NAIC, monitoring the progress of their SERFF modifications, participating in their user forums and making plans to test the changes at the appropriate time.

HBEPD has identified the need for additional funding under this Level One grant application in three Plan Management areas:

- The funding of a dedicated staff position in AID's Life and Health (L&H) Division in the role of Plan Approval Specialist. An experienced, qualified individual already on staff at AID (Donna Lambert) has been identified to assume this position full time. She will be responsible for reviewing health insurance contracts, endorsements, rates and rules for compliance with Arkansas Insurance Code and QHP requirements for inclusion in the Health Insurance Marketplace. This position will remain in the L&H Division of AID but she will work under the guidance of the HBEPD Plan Management Specialist in her full-time role addressing QHP certification, monitoring and ongoing improvements.
- The continuation of Plan Management consultation services being provided by Public Consulting Group (PCG) – As discussed earlier in this document, PCG has provided extensive consultation to HBEPD and in particular the PMAC in the form of issue briefs, facilitated sessions in person, conference calls and meetings with CCIIO/CMS. Their current contract under the previous Level One B grant ends September 30, 2013 and AID would like to continue PCG's contract to maintain continuity and their expertise as we now implement QHP certification processes, evaluate the success of the certification plans we have put in place and revised in preparation for Plan Year 2015 QHP certifications. Under this new contract PCG will:
    - *Assist HBEPD and The PMAC in establishing Year 2 QHP Certification Criteria* - In adopting "open marketplace versus active purchaser" policies for Year 1 QHP certification, AID authorized possible criteria for future years. These included flexibility to establish network adequacy standards exceeding the federal minimum standards, engaging or requiring carriers to adopt specific quality improvement strategies, which may include participation in the Arkansas Payment Improvement Initiative, requirements for carriers to offer plans on a regional or statewide basis, limiting the number of plans offered within metal levels and establishing QHP performance benchmarks and quality standards that exceed federal minimum standards. PCG will develop issue briefs to frame consideration of these issues, provide options and brief the PMAC and HBEPD staff to facilitate decision making.
    - *Facilitate Implementation of Year 2 QHP Certification Criteria* - Given the additional time to prepare for Year 2 certification criteria, Arkansas may choose to adopt options that were deferred in Year 1, such as QHP participation in the Arkansas Payment Improvement Initiative. PCG will provide technical assistance both to HBEPD and to health plans as required to support establishment and operation of new programs or efforts that emerge from certification criteria adopted for 2015.
    - *Complete Year 2 Revision to the Plan Management Procedures Manual* - PCG will continue the extensive Plan Management operational consulting it has provided to HBEPD. PCG will author an updated version of the Plan Management Policies and Procedures Manual to reflect program changes for 2015 and work with division staff to make any necessary adjustment to departmental work protocols related to plan management.
    - *Implement State-Specific QHP Performance Benchmarks based on Quality Data* - Provide analytic tools to establish state specific QHP performance benchmarks to be used to provide plan quality

information to consumers. Work with HBEPD and ACHI to establish data requirements necessary to collect and report benchmark information. Facilitate development of date-driven quality reports.

- *Support Medicaid-Exchange Continuity of Coverage* - Establish operational protocols necessary to promote continuity between Medicaid and Exchange coverage as consumers move back and forth. Issues may include assisting QHPs with technical requirements of Medicaid, including any separate network adequacy provisions and interfaces with the Medicaid eligibility and enrollment portal.

- The continuation of Actuarial Consultation services – Actuarial review and analysis of 2014 QHP applications as needed prior to AID approval for submission to CMS for federal approval and subsequent loading into the Health Insurance Marketplace. Specific analyses are needed in the areas of new QHP plan filings and rate review; catastrophic plans; and metal tier confirmation for a plan level.

Legal Services – Early in our planning and as part of our Level One A grant, we recognized that there would be an occasional need for legal services/consultation. To date, we have been able to use the services of attorneys on staff at AID to assist when time allowed. As we proceed with development of the State Partnership Exchange and prepare to certify QHPs and manage scores of contracts and related procurements, it is apparent that such an arrangement is no longer feasible. Therefore, as part of this Level One C grant we request funds to employ a full time attorney specialist to work with HBEPD and our partner agencies. This staff member will draft proposed legislation, amendments to current legislation, amendments to agency regulations, and represent the agency at legislative hearings. The individual will also review and analyze data and documentation related to division/agency's legal matters and work with AID Executive Management and Legal Division to determine the agency's position on emergent issues as well as represent the Division in proceedings which may occur in various settings and jurisdictions.

Navigator Program – Although specifics have not yet been provided, DHHS/CMS has stated that the state will have a role in monitoring and supporting the Navigators chosen by CMS to function in Arkansas. In preparation for this additional responsibility and in recognition of the need to assist in coordinating the Navigators and IPA Guides who will be assisting our citizens, HBEPD has chosen to expand the role of the IPA Contract Monitor and by this grant requests funding to establish a third IPA Contract Monitor position to meet this expanded need. We are committed to a close, collaborative working relationship between the Navigators and the IPA Guides in Arkansas. We believe this begins with assuring that their training experiences are comparable and continues with coordination of their activities. IPA Contract Monitors will be assigned to a specific group of contracted IPA Entities and, depending on Navigator assignments, will work with both the state contracted IPA entities and the appropriate federally funded Navigator(s) to maximize their ability to reach, educate and enroll Arkansans who are in need of health insurance.

In Person Assister (IPA) Program – HBEPD is working closely with CCIIO to fully develop the role of the State IPA Guide and to develop the IPA program for Arkansas that will complement the federal Navigator program. As discussed previously in this document, under the leadership of the CAAC, the Consumer Assistance Specialist (now the IPA Contract Lead) and PCG consulting staff, HBEPD has modified our organization to more closely align the IPA Program and the Outreach and Education efforts. Policies, procedures and processes that will govern the IPA Program have been drafted and are being reviewed prior to implementation. We have completed interviews for unfilled HBEPD positions in the IPA program and hope to have this new staff on board shortly.

The RFP to solicit the IPA Entities is in final review with plans to post it for responses later this month. We are also finalizing our response evaluation process so that we assure qualified entities are selected that represent all areas of our state as well as special populations that have been identified. As part of Phase 1 of our Outreach and Education campaign, we are taking deliberate steps to contact organizations that have been identified by our stakeholder

groups as being potential IPA Entities. We want to make sure they are aware of the RFP and the potential it has for the populations their organizations serve.

Our Level One B grant funding supports the first four months of these IPA Entity contracts (June – September 2013), providing for initial IPA Guide recruitment, training and start up. In this grant request, we are requesting funding for the next six months of these IPA Entity contracts (October 2013 – March 2014).

Our IPA program design remains the same as described in the Level One B grant. We envision that the number of IPAs will increase or decrease according to Open Enrollment Periods. For example, we estimate 535 IPAs will be needed statewide for the first Open Enrollment Period and 134 IPAs will be needed statewide beginning April, 2014 and until the next Open Enrollment Period when more IPAs will be needed. We anticipate that each Open Enrollment period will require fewer and fewer IPAs as consumers become more confident and experienced with enrollment. While approximately 25% of IPAs will be full time, year-round workers, we estimate that a large group of IPAs will be temporary or part-time workers, something like "well-trained census workers".

Under our model, certified IPAs will be affiliated with an IPA entity that will contract with AID for IPA funding. The IPA contract entities will be accountable for IPA contract deliverables, including engaging IPAs, ensuring training/certification, and supervision and support of individual IPAs. IPA Entities will apply for IPA funding specific to the population (number and demographics) they plan to serve. IPA Entity cost projections are based on hourly IPA pay of $12 per hour and IPA Supervisor pay of $16.50 per hour. IPA Entities will also be paid for fringe benefits, organization overhead (including wireless fees and equipment costs for laptop computer and smart phone), and travel costs for IPAs and Supervisors. See budget narrative for detail including Arkansas's request for IPA funds for the October 2013 through March 2014 time period. We expect to request IPA funding for additional months in subsequent funding requests.

In addition to the new IPA Contract Monitor staff position and the continuation of the IPA Entity contracts, Arkansas requests funds to continue the Arkansas Home Town Health Public Information (PI) Specialists services through our MOU with the Arkansas Department of Health (ADH). This is the service identified as Regional IPA Specialists when funded under our Level One B grant. Following award of that grant and after a series of meetings between HBEPD and ADH staff, we determined that asking ADH to employ IPA Regional Specialists was not the most efficient way to accomplish our goals. Rather, we designed the MOU as a collaborative effort for the broadest possible dissemination of State Partnership Exchange information by utilizing the existing, already successful Arkansas Home Town Health program. Arkansas's 75 counties are divided into five (5) health regions. Further, each county has a "Home Town Health" Program where local business and professional residents team with local consumers to identify local health needs and work toward collaborative solutions. The Home Town Health programs are supported by ADH and include the services of their Public Information (PI) Specialists. PI Specialists live in the region served and, through the local Home Town Health infrastructure within their region, will seek to "personalize" Exchange education within the 75 counties. The PI Specialists will distribute materials developed by the HBEPD Outreach and Education contract (personalized to local communities as needed) through their existing working relationships with civic and government groups, churches, clubs, schools, businesses, etc. We envision the PI Specialist role to be more of a community educator/facilitator than a direct consumer enrollment assistance role. The PI Specialists will also serve as conduits from consumers to the IPA Guides or licensed producers as needed and will establish working relationships with IPA Entities in their area of the state to foster appropriate and timely referrals to IPA Guides. The PI Specialists will receive direction from the Arkansas HBEPD Communications Specialist who is also responsible for our Arkansas Health Connector Speaker's Bureau. We expect the PI Specialists to be critical assets in meeting the anticipated requests for speakers as our initial Outreach and Education campaign becomes fully implemented. Funding through the interagency agreement will allow ADH to appropriately staff for the addition of this new public education role.

Phase 3 of the Outreach and Education Campaign - As described previously in the Progress section of this grant application, HBEPD's Outreach and Education campaign will be implemented in three phases. Funded by our Level One A grant, Phase 1 is underway with the assistance of the Arkansas Center for Health Improvement (ACHI)/University of Arkansas Medical Sciences (UAMS) Creative Services via an interagency agreement. In addition to branding the effort as the "Arkansas Health Connector", they are preparing a general information campaign to begin shortly and sustain 4 to 6 months. Heather Haywood joined HBEPD recently as Public Information Manager and is finalizing the RFP for Phase 2 to be funded by our Level One B grant. Ms. Haywood brings to the Division over 20 years of marketing and public relations campaign experience in the State of Arkansas and is eager to begin development of Phase 2 which is targeted to Arkansas's uninsured and underinsured, including those who work in small businesses. Our message will be specific information needed to prepare consumers for Open Enrollment and this campaign will run from June 1 to September 30, 2013. Ms. Haywood will assure that the best contractor is secured and performs as expected.

In this Level One C grant application we are requesting funds for Phase 3 (Call to action: Get Enrolled) of our Outreach and Education campaign to expand the aggressive campaign during Open Enrollment (October 1, 2013 – March 31, 2014). The undertaking of this campaign is immense as Arkansans do not understand ACA; Arkansans are unaccustomed to buying health insurance on their own and the concept of purchasing health insurance through the Health Insurance Marketplace is new nationwide.

As the objective of this phase is to move consumers to purchase health insurance, we will evaluate the success of previous phases, as well as similar campaigns, as we craft and/or modify our advertising methods and materials. Because our Public Information Manager has extensive experience providing information to the citizens of our very rural state, she recognizes the challenges of communicating with the uninsured target audience and the amount of effort it will take to get them to enroll through the Health Insurance Marketplace. A sustained six month campaign will include state-wide outreach and advertising developed to reach English and Spanish speaking audiences including radio, TV, newspaper, magazines, web, and billboards. The campaign will emphasize collaboration, executing a grass roots campaign in all 75 Arkansas counties using collateral material distribution including brochures, information flyers, bulletins and newsletters along with the continuation of the Speaker's Bureau. Direct mail campaigns will again be targeted to uninsured Arkansans to make sure they have ample opportunity to enroll and get any assistance they need from the IPA Guides, Navigators and the Arkansas Health Connector Resource Center. Phase 3 will also be performed by a contractor who may or may not be the one who implements Phase 2. Extending that contract will be an option under our procurement laws should the Phase 2 contractor be willing to continue and should that contractor perform in a manner acceptable to HBEPD.

The Outreach and Education campaign will be informed by specific, current, and ongoing data and evaluation that monitors Health Insurance Marketplace enrollment across the state, enabling the contractor to adapt their strategic messaging, medium, or saturation in areas of greatest need (geographic or other target population). This contractor will also, through the HBEPD Public Information Officer, provide updated materials to be used by the HBEPD Communications Specialist, the ADH PI Specialists in their Home Town Health programs and IPA entities.

Arkansas Health Connector Resource Center – As we prepared to implement Phase 1 of the Outreach and Education campaign, we realized that when we begin to flood the state with information about ACA, the Health Insurance Marketplace and the Arkansas Health Connector, we must be prepared to respond to questions and requests for additional information. When consumers, brokers, health providers or issuers have a question about how all this impacts them, they need quick, quality answers to their questions. These questions and answers will further serve to guide ongoing improvements in our Outreach and Education and IPA programs.

Using funds from this Level One C grant, HBEPD will collaborate with the AID Consumer Services Division's Consumer Assistance Program (CSD-CAP) to establish the Arkansas Health Connector Resource Center to be

located in the Consumer Services Division (CSD). This Center will provide answers to questions, access to an IPA Guide or licensed insurance producer, accept requests for speakers from our Speaker's Bureau and later provide consumers a place to lodge complaints, grievances or appeals related to a QHP on the Exchange. Additionally, data will be collected and analyzed to determine trends and provide information for ongoing improvement of our programs and State Partnership Exchange.

Arkansans will be able to access the Resource Center via a toll-free phone number, email or in person to deliver a great customer experience for Arkansans. CSD's ASSCAP grant (awarded August 2012) funds five staff positions: a Manager, two Resource Center Specialists and two Administrative Specialists in addition to operating expenses, supplies, equipment, etc. that will make up the core of the Resource Center. As HBEPD is developing its extensive Outreach and Education campaign, materials and presentations will include the toll-free number and email address for the Resource Center. Given the number of Arkansans we expect this campaign to reach, HBEPD is concerned about Resource Center staffing and by this Level One C grant application is requesting to fund one new Resource Center Specialist to be located in CSD. This staff member will help meet the increased volume of calls and email we expect the Resource Center to experience. In this Level One C grant we are also requesting operational expenses to support this staff member as well as funds for the increased toll-free charges. The Manager will oversee the day to day operations of the staff, assuring that all contacts are handled expediently and professionally and that all requests are logged and closed. The expectation is that the Administrative Specialists will answer basic calls and forward more difficult calls to the Resource Center Specialists. To assure that these Specialists have the best, most current information, they will participate in IPA Guide training and routinely receive updated information from the IPA Program and the Public Information Manager.

To assure HBEPD's contributions to the Resource Center (in addition to the staff position and IPA Guide training noted above) are given adequate attention and resources, we plan to establish the Stakeholder Accountability section as a distinct section within HBEPD (similar to the IPA Program section) and add two staff positions with funding from this Level One C grant. It is imperative that we be accountable to our stakeholders as they approach and experience Open Enrollment. And we feel that this effort is of such importance that it must be distinct and well structured.

- Using funds from this grant we will employ a Stakeholder Accounts Manager to head up the Stakeholder Accountability section. This person will work closely with the CSD Director to assure that needed HBEPD resources/training/staff expertise are made available to the Resource Center in an organized, productive manner. This person will supervise the Stakeholder and Licensed Producer/Agent position, thus assuring a direct conduit between the insurance community and the Resource Center. This person will also supervise the Quality Assurance Specialist described below.
- Using funds from this grant we will employ a Quality Assurance Specialist to coordinate with the CSD/CAP manager on the day to day work of the Resource Center. This specialist will participate in IPA Guide training and be kept up to date on both the IPA Program and the Outreach and Education campaign in order to assure that appropriate information is made available to the staff of the Resource Center. This person will serve as the third level of escalation for calls that are beyond the knowledge of the Resource Center Specialists. This Specialist will review monthly reports to identify trends in calls and make corrections in training, IPA assignment or program operations as needed.

Careful organization and implementation of the Arkansas Health Connector Resource Center and consistent collaboration between HBEPD's Stakeholder Accountability section and CSD/CAP is a critical next step in Arkansas's development of the State Partnership Exchange. It will effectively leverage existing knowledge, expertise and infrastructure to achieve a first class consumer experience as Arkansans become insured – many for the first time ever.

State Entity Technology and System Functionality – HBEPD's contractor, Tonmoy Dasgupta is responsible for monitoring and assisting with a variety of information technology activities that are occurring at an accelerated pace as we move closer to Open Enrollment on October 1, 2013. He cannot physically be at more than one meeting or one design session at a time and because we are very aware of the need to take steps now to assure long term integration with existing AID/state operations, we are by this Level One grant requesting two additional IT systems resources, one to be a dedicated position in AID's Information Systems Division and the second to be an additional contractor from the Arkansas Department of Information Services (DIS). Mr. Dasgupta as the IT Oversight and Management Lead will oversee the work of these two new staff members. We have defined their primary areas of responsibility as follows:

- IT Systems Specialist from AID Information Systems to oversee delivery of IT solutions needed by HBEPD with particular emphasis on National Association of Insurance Commissioners (NAIC) systems used by AID including but not limited to the State Based Systems (SBS) for use with complaint tracking through the Arkansas Health Connector Resource Center and the relationship with AID's Consumer Services Division (CSD) and the System for Electronic Rate and Form Filing (SERFF) for use with plan management activities. This position will monitor target objectives, schedules and committed costs to ensure project compliance; monitor integration of new systems with existing AID systems to assure compatibility and prevent disruption and accept any other unforeseen IT related duties critical to the success of the ACA.
- Systems Integration Lead (contract with DIS) to ensure that IPA IT vendor, Computer Aid, Inc. (CAI) is complaint with the architectural and technical requirements of CMS. This position will research and ensure that applicable privacy and security standards (CMS and State of Arkansas) have been met for all new systems built for the ACA; attend requirement gathering, joint application design (JAD) and Sprint planning sessions; monitor project risks and develop contingency plans as required; review test plans and test results across sprints; contribute to and oversee quality of user acceptance testing plan, monitor results and follow-up; monitor target objectives, schedules and committed costs to ensure project compliance; monitor integration of new systems with existing AID systems to assure compatibility and prevent disruption; and accept any other unforeseen IT related duties critical to the success of the ACA.

Strategy to Address Early Benchmarks

Although many early benchmarks appear more relevant to the development of a State-based Exchange than to the development of a State Partnership Exchange, Arkansas did address these benchmarks during our early planning phase.

As discussed earlier in this document, HBEPD conducted an extensive operational gap analysis or the "as-is" services and capacity of existing State activities compared to the activities required for Exchanges. We also conducted an IT gap analysis of the "as-is" systems. Subsequent to these activities the decision was made to pursue the State Partnership Exchange model rather than a state-based exchange. As noted above, HBEPD is tracking the Eligibility and Enrollment Interface work being done by DHS and we are actively preparing to use SERFF for enrollment of certified QHPs. Having recently awarded a contract for development of the IPA IT system, we are also working closely with that vendor to assure it meets the contract management and e-Learning needs of our IPA program and integrates well with the state/agency technology. Lastly, we are nearing completing of a redesign of our website to make it more user-friendly as we embark on our Outreach and Education campaign.

Likewise, in 2011 and 2012, HBEPD conducted an actuarial and market analysis. As noted earlier, we continue to do market research through our Plan Management and ACHI consultants. We are now involved in an intense research effort being led by Manatt Health Solutions and their subcontractor Optumas to look at continuity of care/coverage issues and assist in identifying potential strategies to minimize the impact of churning.

Evidence of our early and continued engagement with a wide range of stakeholders is illustrated throughout this document. Our Stakeholder Engagement Model assures adequate representation from consumers, health providers and the insurance industry as we debate to consensus the preferred methods to implement Arkansas's Partnership role in Plan Management and Consumer & Stakeholder Engagement & Support.

In November 2012, CMS notified states that they would charge up to 3.5% in issuer fees to pay for Exchange operation, including the Plan Management and Consumer Assistance functions operated by the State Partnership Exchanges. We anticipate these fees will exceed costs of operation of State Partnership Exchange functions and will advocate continued state funding at levels that sustain quality operations.

Organizational Structure

As discussed previously in this grant application, HBEPD remains a division of the Arkansas Insurance Department (AID) and is responsible for the planning and implementation of the state operated services and supports associated with a State Partnership Exchange. The Division consists of a director that reports to the AID Commissioner and is responsible for both state and vendor staff currently engaged for services needed by the Division. HBEPD has written internal procedures and processes as well as a comprehensive New Employee Orientation program in addition to those of the Agency.

HBEPD utilizes a network of MOUs with other state entities to access information, supplement Division staff and enhance opportunities to communicate Exchange information to the broadest possible audience. These include the Arkansas Center for Health Improvement (ACHI), the Arkansas Department of Human Services (DHS) which encompasses Medicaid and County Operations, the Department of Information Services (DIS) which provides IT staff, the Arkansas Department of Health (ADH) whose Home Town Health program assists in community education about the Exchange and the state's largest university.

Using funding from this Level One grant, HPEBD will increase staff from fifteen FTEs to twenty-one FTEs over the next few months in addition to contract staff and professional consultants. Given HBEPD's increasing scope of responsibility and the immense importance to the State of Arkansas of the success of the State Partnership Exchange effort, we are requesting through this Level One C grant that appropriate funds be provided to support the director of this Division being elevated to a Deputy Commissioner position with appropriate salary adjustments.

In an organization the size and complexity of HBEPD, there are also general operating costs that we request be funded through this Level One C grant such as continued salaries for staff, supplies, rent, travel, etc. that are specified in detail in the Budget Narrative portion of this grant application.

Coordination between State Entities and Federal Government

As has been previously reported, HBEPD is part of an interagency leadership group that is working with CCIIO and CMS to develop the State Partnership Exchange for Arkansas. In addition to AID, the group includes the Surgeon General and his staff from ACHI; a representative from the Governor's office; a representative from the Office of Health Information Technology and DHS including leadership representing Medicaid, the Arkansas Department of Health and the University of Arkansas for Medical Sciences. Many from this group participated in the Initial Planning Review Meeting in Bethesda, MD in May and in the second Planning Review in October. They continue their collaboration with CCIIO/CMS by conference calls with Arkansas's CCIIO project officer as needed.

Arkansas's CCIIO state officer coordinates in Design and Implementation Reviews and meets with others at CMS as needed to share information, concerns and work through solutions aimed at a successful State Partnership Exchange. Medicaid IT representatives also meet as needed with CMS representatives as they work their way through systems changes to support the successful Health Insurance Marketplace in Arkansas.

Reuse, Sharing and Collaboration

As noted throughout this document, HBEPD will use SERFF to provide a single point of interaction for Arkansas issuers to submit plans for certification and renewal and for Arkansas state regulators to certify, renew and manage QHPs participating in the Health Insurance Marketplace. SERFF's role and approach leverages existing systems, assists states in certifying QHPs and facilitates integration. Using existing information technology investment vs. building new systems will mitigate costs and lessen the burden to issuers adapting to a new system. The HBEPD staff has attended all NAIC/SERFF forums and any SERFF related forums at State Grantee Meetings. We are preparing to participate in testing the system when appropriate and to work with issuers to assure proper use of the modified system. We also plan to use the NAIC's SBS system for complaint tracking through the Arkansas Health Connector Resource Center.

HBEPD is working collaboratively with the AID Rate Review Division to maximize use of their state-of-the-art video and teleconferencing technology to make it easier for more stakeholders to participate in Town Meetings, advisory committee meetings and working sessions on critical topics.

Our collaboration with Arkansas Department of Health's Home Town Health Program provides for information dissemination through existing and trusted local networks,

Financial Integrity Mechanisms

The Finance Manager is responsible for conducting the full range of technical and fiscal activities required to prepare, submit and manage grant proposals, contracts, procurement and grants accounting. HBEPD has been successful in receiving funding through several sequential federal grants. Systems are in place to assure separate accounting and bookkeeping for each grant. When a federal grant is awarded, it is assigned a separate state WBS element number, separate cost center, separate fund code and separate fund center for tracking purposes.

HBEPD operating expenses (salaries, supplies, etc.) and contracts are assigned to a cost center and a specific grant. The Finance Manager, under supervision of the HBEPD Director, must authorize expenditures internally for items such as purchasing, and externally such as for payment on a contract, before it is submitted to the AID Accounting Division for payment. She then verifies the deliverable was received and provides a signatory on the invoice submitted for payment, noting which cost center or grant the invoice is to be paid from and which line item the invoice is to be paid from. The invoice is forwarded to AID Accounting Division which pays the vendor.

The AID Accounting Division records amounts by grant electronically and gives a copy of the record to the Finance Manager at the end of the month. The Finance Manager keeps a separate accounting ledger in Excel format to ensure proper checks and balances with the internal AID Accounting Division, and compares the submitted monthly reconciliation report with the internal grant budget to ensure the expenditures were deducted from the correct accounts according to federal and state policy. Any discrepancies between AID Accounting and HBEPD are reconciled.

The Finance Manager has established additional policies and procedures to monitor the expenditure of travel funds; procedures that insure before any travel arrangements are made using grant funds, the travel is both necessary and essential to the development of grant activities.

A thorough, independent State Legislative Audit is conducted once per year to ensure financial integrity of the Department. These audits meet generally accepted government auditing standards, and reports are presented to a State Legislative Committee.

Challenges

The primary challenges HBEPD has identified in successful, timely implementation of the State Partnership Exchange are ongoing challenges:

- Arkansas's Legislative process for obtaining approval to spend grant funds once awarded, create and fill staff positions, and secure consulting contracts is part tedious attention to detail and part political. As noted earlier, we did not receive Legislative approval to spend the Level One B funds (awarded September 27, 2012) until December 21, 2012. We are hopeful that the continuous openness we've shown to our legislators throughout our planning process coupled with the able support of the AID Commissioner and the Governor's office will lead to approval of our requests in a more timely manner. However, the Arkansas General Assembly that just took office is controlled in both chambers by the Republican Party for the first time since Reconstruction which could actually increase this challenge going forward as many of those legislators are not supporters of ACA or the Health Insurance Marketplace.

- Misinformation is being perpetuated throughout Arkansas by those opposed to ACA. A major focus of Phase 1 of our Outreach and Education campaign is a concerted, organized effort to provide concise, accurate information to all Arkansans.

- It takes time and valuable resources to bring new staff and/or consultants on board. We have redesigned and expanded our new employee orientation to deploy when new staff is hired. To minimize the learning curve for consultants, we plan to keep many of the same ones in place to continue the valuable work they are doing.

- Arkansas is involved in multiple health system improvement efforts which all place demands on the same staff, agency, and other leaders at a time of limited resources. Interagency coordination and collaboration are intentional and funding through this cooperative agreement will assist in advancing the important work of Arkansas's State Partnership Exchange implementation.

- As a state with the third lowest per capita income, we expect a high percentage of churning between insurance affordability programs and have contracted with Manatt Health Solutions to help design and implement an effective state-specific strategy to decrease churning and promote continuity of care.

- There remain many unanswered questions and unissued guidelines from CCIIO/CMS necessary for effective coordination and monitoring between the federal Navigator and state IPA programs. We will continue to ask for guidance and, when appropriate, suggest solutions for CCIIO/CMS to consider.

- Arkansas still has not decided what it plans to do about Medicaid expansion. This raises many questions about what will be available for this at-risk population between 17% and 100% of FPL if Arkansas does not expand its program.

Arkansas is eager to continue implementation of the State Partnership Exchange in Arkansas. We feel we are on track with carefully designed activities underway to maximum enrollment of uninsured Arkansans in affordable health insurance programs. We respectfully request approval of the funding requests outlined in this application, and look forward to our Design and Implementation Reviews in the coming months.