FEDERAL FINANCIAL REPORT

(Follow form instructions)

1. Federal Agency and Organizational Element to Which Report is Submitted	2. Federal Grant or Other Identifying Number Assigned by Federal Agency (To report multiple grants, use FFR Attachment)	Page 1 of 1 pages
DHHS-CCIIO	HBEIE-10000-01-03	

3. Recipient Organization (Name and complete address including Zip code)				
Arkansas Insurance Department 1200 West 3rd Street, Little Rock, AR 72201-1904				
4a. DUNS Number	4b. EIN	5. Recipient Account Number or Identifying Number (To report multiple grants, use FFR Attachment)	6. Report Type	7. Basis of Accounting
81501558	71-0847443		☐ Quarterly ☐ Semi-Annual ☐ Annual ☑ Final	☑ Cash ☐ Accrual

8. Project/Grant Period (Month, Day, Year)		9. Reporting Period End Date (Month, Day, Year)
From: 9/30/2010	To: 9/29/2012	09/29/2012

10. **Transactions**	Cumulative
(Use lines a-c for single or combined multiple grant reporting)	
Federal Cash (To report multiple grants separately, also use FFR Attachment):	
a. Cash Receipts	1,155,999.83
b. Cash Disbursements	1,155,999.83
c. Cash on Hand (line a minus b)	0
(Use lines d-o for single grant reporting)	
Federal Expenditures and Unobligated Balance:	
d. Total Federal funds authorized	1,200,928.00
e. Federal share of expenditures	1,155,999.83
f. Federal share of unliquidated obligations	0
g. Total Federal share (sum of lines e and f)	1,155,999.83
h. Unobligated balance of Federal funds (line d minus g)	44,928.20
Recipient Share:	
i. Total recipient share required	0
j. Recipient share of expenditures	0
k. Remaining recipient share to be provided (line i minus j)	0
Program Income:	
l. Total Federal share of program income earned	0
m. Program income expended in accordance with the deduction alternative	0
n. Program income expended in accordance with the addition alternative	0
o. Unexpended program income (line l minus line m or line n)	0

11. Indirect Expense	a. Type	b. Rate	c. Period From	Period To	d. Base	e. Amount Charged	f. Federal Share
				g. Totals:	0	0	0

12. Remarks: Attach any explanations deemed necessary or information required by Federal sponsoring agency in compliance with governing legislation:

13. Certification: By signing this report, I certify to the best of my knowledge and belief that the report is true, complete, and accurate, and the expenditures, disbursements and cash receipts are for the purposes and intent set forth in the award documents. I am aware that any false, fictitious, or fraudulent information may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 18, Section 1001)

a. Typed or Printed Name and Title of Authorized Certifying Official	c. Telephone (Area code, number, and extension)
Jay Bradford Commissioner	501-371-2621 d. Email Address jay.bradford@arkansas.gov
b. Signature of Authorized Certifying Official	e. Date Report Submitted (Month, Day, Year) 12/21/2012
	14. Agency use only:

Standard Form 425 - Revised 10/11/2011
OMB Approval Number: 0348-0061
Expiration Date: 2/28/2015

Center for Consumer Information and Insurance Oversight
State Planning and Establishment Grants for the
Affordable Care Act's (ACA) Exchanges
HBEIE100001-01-03
Final Project Report

Date: December 21, 2012

State: Arkansas

Project Title: Arkansas Health Insurance Exchange Planning

Project Reporting Period: - Final (9/30/10 – 9/29/2012)

Grant Contact Information

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Award number: HBEIE100001-01-03

Date submitted: 12/21/2012

The Arkansas Insurance Department (AID) applied for and was awarded the Planning Grant cited above for the period of September 30, 2010 through September 29, 2011. At AID's request, a no-cost extension (NCE) was granted which expanded the applicable period for one year. AID also applied for and was awarded an Administrative Supplement for planning purposes with an applicable period concurrent with the NCE. This document comprises the Final Report for both the original Planning Grant and the Administrative Supplement (known collectively as the Grant).

AID has submitted to HHS seven quarterly reports that document in detail the progress of tasks and activities funded by the Grant. In addition to accomplishments by quarter, these reports specified any changes in the use of the funds from the original Grant based on research findings, additional guidance from HHS and/or the political climate in Arkansas.

This Final Report is organized to summarize the Grant accomplishments, document how these activities impact the creation of Arkansas's Federally-facilitated Exchange Partnership and identify Lessons Learned as Arkansas moves forward with implementation of the Affordable Care Act (ACA).

The Planning Grant's primary focus was in three areas –

1. Employment of key staff to lead the planning effort,
2. Extensive, wide-ranging research to gather Arkansas-specific information for use in developing the state's Exchange, and
3. Initiation of structured opportunities for broad stakeholder participation in the development process.

The Administrative Supplement supported these three focus areas in that it requested additional support with staff salaries and funding for additional research that would impact policy recommendations.

As delineated on the Final Financial Status Report and discussed in this report, funds received from the grant were used by AID exclusively for the activities specified.

1. Key Staff

Governor Mike Beebe delegated responsibility for the planning and development of Arkansas's Health Insurance Exchange to the Arkansas Insurance Department (AID) led by Commissioner Jay Bradford. Before becoming Insurance Commissioner in 2009, Mr. Bradford served in the Arkansas Legislature for twenty-four years and held administrative positions in the Department of Human Services. He has more four decades of experience in the insurance industry and is a dedicated supporter of the Exchange. His political acumen and industry knowledge made him the ideal leader of this project.

With the award of the Planning Grant, AID established two staff positions, the Health Insurance Exchange Planning Director and the Project Planning Specialist.

On December 10, 2010, Commissioner Bradford announced the hiring Cynthia C. Crone as the Planning Director to assist in planning for the development of a Health Insurance Exchange for Arkansas. A licensed and certified nurse practitioner, Ms. Crone is an experienced program director with more than thirty years experience advocating collaborative, effective solutions to public health issues affecting vulnerable populations. She has served as clinician, consultant, teacher and administrator and has been recognized locally and nationally for leadership in innovative, effective program development and sustainability. In 2001 she was selected by the Robert Wood Johnson Foundation as one of 20 nurses from across the nation to participate in their three-year Executive Nurse Fellowship program designed to help prepare leaders to change the future health care system. She came to AID in December 2010 from the University of Arkansas for Medical Sciences' (UAMS) Partners for Inclusive Communities. Before that she was founding executive director of UAMS Arkansas CARES, an integrated treatment program for pregnant and parenting addicted women and their children and families (1992-2006), perinatal outreach nurse with Arkansas High Risk Pregnancy Program (1987-1991), and pediatric nurse practitioner and consultant with Arkansas Department of Health (ADH) (1978-1986).

The AID Health Insurance Exchange Planning Director is responsible for direction and oversight of the full range of project activities including program and financial management and reporting. Duties

include: Identifying and managing project goals, objectives, and dependencies; planning, scheduling, monitoring and revising project timelines and milestones; collaboration with senior management and staff, various state and federal government entities, consultants and other public and private stakeholders to gather, analyze and interpret data; development of full-scale project plans and associated communication/ integration documents; conducting meetings, program evaluation and project staff evaluations; conforming to shifting priorities, demands and timelines through analytical and problem-solving skills; and determining and assessing need for additional staff and/or consultants, and making the appropriate recruitments if necessary. The position reports directly to the Arkansas Insurance Commissioner.

In early 2011, Ms. Crone hired Bruce Donaldson for the position of Project Planning Specialist. Mr. Donaldson was a successful Employee Benefits Insurance Consultant with over 15 years solid experience in the small and large group insurance market. His background includes carrier and agency experience, knowledge of all premium financing arrangements, and attainment of the Certified Health Consultant designation.

The Specialist position provides overall project planning support with duties including coordinating daily activities/schedules and targeted research/problem-solving in response to planning team needs. He reports to and works closely with the Project Planning Director. He also coordinates stakeholder workgroup activities.

These two positions, augmented by temporary clerical support, formed a cohesive nucleus for AID's Health Insurance Exchange Planning efforts. They were required to wear many hats, often simultaneously –

- Coordinate activities with other departments/agencies within AID and the State;
- Respond to stakeholder concerns (phone and email);
- Speak to community groups (including the insurance industry) about ACA and Exchange planning;
- Help educate Arkansas lawmakers about ACA;
- Prepare Interagency Agreements/Memoranda of Understanding (MOUs) for services needed in the areas of research and stakeholder involvement;
- Prepare Requests for Proposal (RFPs), evaluate responses and choose contractor(s) to accomplish research and stakeholder involvement objectives;
- Oversee MOUs and contracts to assure expected results; and
- Prepare applications for additional Exchange development funding.

Committed to transparency and inclusiveness, Ms. Crone and Mr. Donaldson successfully "got the ball rolling" during the first year of Health Insurance Exchange Planning, overseeing establishment of the foundation for what will become the Arkansas FFE Partnership. They continue to be the linchpins of AID's Health Benefits Exchange Planning (now Partnership) Division (HBEPD) although through thoughtful planning and execution, they have now added additional funding (Level One Cooperative

Agreements) to secure staff and trusted contractors to share the work as development of the FFE Partnership accelerates.

2. Research

In order to effectively plan for a Health Insurance Exchange, AID used Grant funds to accomplish needed research in multiple areas; research specific to the State of Arkansas. AID looked to contractors to provide this service. After carefully identifying the research needs, AID sought to obtain background research through an RFP competitive bid process and through MOUs with other state agencies/educational institutions.

After evaluating nine RFP responses, AID contracted with First Data Government Solutions, LP (First Data) to accomplish a number of research projects and create specific deliverables as a result of their research. First Data included on their team three subcontractors, the Arkansas Foundation for Medical Care (AFMC), Powell and Associates, and Solucia Consulting (later known as SCIOinspire). The first two subcontractors were local Arkansas firms that brought state-specific knowledge and experience to the project. The third was a nationally recognized actuarial firm engaged with a number of other states in their Exchange planning.

AID also entered into MOUs with the Arkansas Center for Health Improvement (ACHI), UAMS and the University of Central Arkansas (UCA) to assist in the research efforts.

The research tasks to be accomplished included:

- Evaluate and recommend a Governance Model
- Conduct Marketplace Analysis
- Create a Financial Model
- Develop a Program Integration Plan
- Evaluate the State's existing technology and recommend an IT Integration Plan
- Develop a Business Operations Plan
- Assess needs and develop a plan for Communication, Education and Outreach
- Recommend an Evaluation Plan.

Valuable information was also gathered through the six stakeholder workgroups that met monthly, May through November 2011. Refer to Section 3 "Stakeholder Participation" of this report for additional information.

The research and assessments were accomplished and the recommendations/plans completed. As completed, each was approved by the HBEPD Director and disseminated via meetings of the Exchange Planning Workgroups/Steering Committee (later the Stakeholder Model) and the HBEPD website.

Governance Model

First Data conducted an email survey of the Exchange Planning Workgroups/Steering Committee and 35 members completed the survey. The results presented to AID in early July 2011 reflected the preference

for a public trust (quasi-governmental) model with AID as the state oversight agency (78.8%) (See http://hbe.arkansas.gov/GovernanceSurvey.pdf). This finding was affirmed by the Steering Committee and the six Exchange Planning workgroups in follow-up meetings.

UAMS posted a governance 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 prefer a connection with an "existing state agency," 69.4% preferred AID.

Political opposition to the Affordable Care Act (ACA) led to Arkansas legislators' opposition to the establishment of a State-based health insurance exchange. Exchange enabling legislation was not passed during the Arkansas General Assembly in early 2011.

The Exchange Planning Workgroups continued to address specific governance issues, including statewide versus regional structure for several months. In late 2011, HHS announced another option for Exchange Governance, a State-Federal Partnership. In December 2011 Arkansas's Governor Mike Beebe directed AID to proceed with plans for a Federally-Facilitated Exchange (FFE) Partnership Governance Model.

Marketplace Analysis

First Data's subcontractors Powell and Associates and SCIOinspire initially took the lead in this area of research in the summer of 2011. Their findings were later supplemented by the work of the University of Central Arkansas (UCA) and the Arkansas Center for Health Improvement (ACHI).

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. 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 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) covered 624 enrollees as of May, 2012.

Medicaid and ARKids First, the state's Child Health Insurance Program (CHIP), cover close to one quarter of the State's population, or 675,000 people (Arkansas DHS, 2012). Approximately 60% of Medicaid enrollees are low income children (100% to 140% of federal poverty level (FPL) depending on age, or up to 200% FPL through CHIP), while the other 40% consist of low-income parents (up to only 17% FPL),

pregnant women (up to 200% through Medicaid and CHIP), and people who are aged, blind, and disabled (up to 75% of FPL).

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 predicted 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
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
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

Year	2013		2014	
	Insured	Uninsured	Insured	Uninsured
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

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) dominates the business with 75% market share; all others are in single digits. The total number of covered lives (including dependents) by all carriers is about 119,566 Arkansans. Arkansas Blue Cross Blue Shield covers 91,499 lives and all others cover the balance, or approximately 28,067.

Group market: For the Group Health Insurance marketplace, there are 24 health insurance carriers with $443,087,573 of yearly earned premium. That covers about 130,194 Arkansans including dependents: There are three carriers that dominate 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, the Health Benefits Exchange Partnership Division (HBEPD) entered into an MOU 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 FFE Partnership.

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 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 FFE Partnership,
- Barriers to participation in the Arkansas FFE Partnership,
- Considerations that would positively influence participation in the Arkansas FFE Partnership,
- Plans likely to be offered on the Arkansas FFE Partnership,
- 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 FFE Partnership 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 MOU with the Arkansas Center for Health Improvement (ACHI) to conduct 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 has reviewed published literature and state-based studies to estimate the extent of churning and the points at which individuals are expected to churn. ACHI also studied the ARHealthNetworks population (a waiver program targeted at businesses who employ low-income individuals and self-employed individuals) as a proxy for expansion populations both in Medicaid and the Exchange. For the Exchange, ACHI is looking at 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 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. ACHI worked with HBEPD leadership and others to reach a consensus on what 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)

Financial Model

Cognizant of the requirement that Exchanges must be self-sufficient after 2014, Arkansas's Exchange Planning research provided a high level estimate of Exchange operational costs and revenues. 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 is estimated that premium fees will ensure financial sustainability of the Exchange.

Minimal work has been done to establish the financial management infrastructure for the Exchange in Arkansas (included in the Business Operations Plan, see http://hbe.arkansas.gov/BOPlan.pdf). Developing the infrastructure was deemed premature without final determination of the governance model.

Program Integration

A significant portion of the HBE planning effort was devoted to identifying opportunities to leverage existing functionality/processes for use in the Exchange. First Data 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 were 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 the same entities were also working together on other statewide initiatives such as the Health Information Exchange so were already thinking of opportunities to collaborate and leverage their resources.

Toward development of Arkansas's Program Integration Plan (See http://hbe.arkansas.gov/PIPlan_20110817cc.pdf), First Data consultants reviewed numerous documents and websites regarding state agencies/organizations' programs and regulations:

Agency	Document/Website
Arkansas Insurance Department (AID)	• http://www.insurance.arkansas.gov • http://hbe.arkansas.gov • One Year Later: The Benefits of the Affordable Care Act for Arkansas • Health Benefits Exchange Survey • Planning for the Arkansas Health Benefits Exchange • Arkansas Insurance Department 2009 Annual Report • Arkansas Insurance Department Organizational Chart (rev. 3/11)
Arkansas Department of Human Services (ADHS)	• http://humanservices.arkansas.gov/ • Access Arkansas Website https://access.arkansas.gov/Welcome.aspx • Medicaid Eligibility Quick Reference Guide • Medicaid Application Form • SNAP Eligibility and Benefit Information • SNAP Quick Reference Guide • Arkansas Medicaid Program Overview SFY 2010 • Governor Beebe's Proposal on Transforming Arkansas Medicaid • Transforming Arkansas Medicaid • Arkansas Health System Reform & Medicaid Transformation • "Transforming Arkansas Health Care" Draft Work plan—May 2011 • How to use Direct Data Entry to Verifying Eligibility – PPT Presentation HP • Arkansas Medicaid • Arkansas Department of Human Services Organizational Chart, January • 2011 • State Medicaid Health Information Technology Plan (SMHP) • Arkansas Medicaid Enterprise (rev. March 4, 2011)
Arkansas Office of Health Information Technology (OHIT)	• http://ohit.arkansas.gov/Pages/default.aspx • Health Information Exchange Council (HIE) • HIT Task Force • HIE Summary of Strategic and Operational Plans, February 18, 2011 • HIE Maps: Broadband and Wireline Access by Arkansas Counties
Arkansas Department of Health (ADH)	• www.healthy.arkansas.gov • Guide to Program and Services, Fiscal Year 2010 • Arkansas Department of Health Annual Report 2008 • Arkansas Department of Health Brochure – Working hard every day to make your life better

Agency	Document/Website
	• Statewide Pocket Guide and Fast Facts Brochure • Top 10 Health Achievements in the Decade of the 21st Century • Arkansas Department of Health Organizational Chart (rev. March 2011)
Arkansas Department of Information Services (DIS)	• http://www.dis.arkansas.gov/ • Enabling Legislation • Preparing to Implement HITECH – A State Guide for Electronic Health • Information Exchange • Arkansas Department of Information Services 2010 Annual Report

The results identified that the Exchange would work closely with AID and other state agencies in several key areas. First of these is working with AID in health plan management. Initial planning determined that AID would be responsible for establishing the regulatory standards, including solvency standards, for a qualified health plan (QHP) within the state and the Exchange would define, implement and monitor the processes and procedures for QHP certification and rating. AID's Rate Review Division staff would play a key role in the evaluation of the premium pricing structures of the QHPs. Stakeholder recommendations were that AID would certify and monitor Exchange Navigators using processes similar to those for licensed insurance producers. Additionally, it was anticipated that AID's Consumer Services Division will manage complaints and appeals for the Exchange regarding health plans, Navigators, and producers.

The Department of Human Services (DHS) (which includes the state's Medicaid agency) was identified as a key partner in the enrollment and eligibility functions of the Exchange. Their expertise and experience are critical components to the effective, efficient implementation of the Exchange eligibility and enrollment portal. Early interagency planning by DHS Policy, County Operations (the Division that performs Medicaid enrollment functions) and Medicaid leadership; the AID Commissioner and Exchange Planning Director; Office of Health Information Technology (OHIT) Director 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."

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

The DHS County Operations Division would also play an ongoing role in community outreach efforts as well as managing appeals to Medicaid eligibility determinations and redeterminations. An interest in integrating additional program eligibility determinations such as for SNAP and childcare assistance exists. This would be done only if it did not interfere with required timelines for Arkansas's functional Exchange/Medicaid eligibility/enrollment system. AID continues to walk step-by-step with DHS to assure that the Exchange development is consistent with the changes DHS must make because of ACA requirements and in compliance with required 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 and Shared Health and Records Exchange (SHARE) that may be an important asset for the Exchange. Additionally, their experience in IT procurement will be beneficial.

The Arkansas Center for Health Improvement (ACHI) has policy expertise to offer the Exchange and has legislative authority over developing the All Payer Claims Database for Arkansas which could potentially serve as an asset in the quality plan rating components of the Exchange.

One other state department identified as instrumental in the development of the Exchange 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).

With the recent decision to explore the FFE Partnership Model, Arkansas is actively exploring how state-facilitated operations for plan management and consumer assistance will align with FFE requirements and federal eligibility and enrollment functions.

IT Systems Integration

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. First Data's analysis included:

- Structured interviews with key state agencies and other partner organizations;
- Review of detailed information of current and future systems;
- Review of other states' (early adopters) research and initiatives;
- Knowledge of the health care industry;
- An inventory of current and future systems related to the HBE;
- Evaluation of system hardware and software solutions and resources; and
- Creation of alternative technology models.

Arkansas completed its Gap Assessment of the state's current IT infrastructure. As part of this 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 stakeholders external to state government. The meetings were designed to provide detailed insight regarding the capabilities and functions of current systems. The First Data team carefully evaluated the information from the formal interviews, subsequent discussions with various stakeholders 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. The HBE Planning Staff worked with the Information Technology Workgroup, the State Health Information Technology (HIT) Advisory Council and other stakeholders to collect this information.

The inventory effort focused on identifying common system components required for the HBE and the agencies which currently have these components or are planning to acquire these components. This will allow for reuse and maximization of funding sources as we implement the FFE Partnership Model in 2014 and assess needs for transitioning to a State-based Exchange in future years as needed.

During the discussions, attention was given to the following potential system components:

- Portal
- Data Exchange
- Security
- Document Management
- Customer Relationship Management (CRM)
- Reporting
- Financial (premium collection and payment)
- Health plan management
- System Information.

As appropriate systems were identified, additional information was gathered about these systems. Examples of critical information include the following:

- System volume (users, transactions, etc.)
- Hardware and software characteristics
- Interfaces
- Documentation
- Consistency with state standards
- Scalability
- Implementation costs
- Support needs (cost and staffing).

State IT policies and standards, developed and published by the Arkansas DIS, provide guidance on a wide variety of technical subjects including security and encryption, virus and spyware protection, network requirements, project management, etc. They also provide a variety of common products and services available to all agencies. The DIS also provides the capability to support these products and services should the agency request it. In terms of IT architecture, the State of Arkansas has deployed systems utilizing numerous operating systems, hardware platforms, software frameworks, and databases.

The overall sentiment provided through IT system planning interviews was a low expectation of current assets in "live" use that should be utilized by the HBE. The Exchange IT Gap Analysis identified each system that was reviewed and the results of the analysis. In recent months, IT Workgroup sessions and many additional discussions between agencies have occurred. Requests for Proposals (RFPs) for the Medicaid Management Information System and Access Arkansas Rules Engine were posted and then pulled when the Medicaid Director left the agency and a new one was employed. Also, Arkansas has moved from planning a state-run exchange to consideration of the FFE Partnership Model. Under the FFE Partnership, Arkansas will be responsible for Plan Management and use SERFF as the IT system. DHS

issued a revised RFP and released an Intent to Award in October 2012. The proposed system is an enterprise-scale commercial of the shelf (COTS) framework that will enable DHS to modernize software infrastructure and satisfy the provisions of the ACA. Currently, contract negotiations are underway between DHS and the chosen vendor.

Business Operations

First Data's background research contract included the requirement to recommend 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 in the final planning report were based on an Arkansas-operated Exchange. They were submitted to the Planning Team and Steering Committee for review. They were considered to be organic because as more information is known both from the state and federal level, the recommendations will be adjusted to maximize the success of the Exchange in Arkansas. The recommendations included a suggested planning/implementation timeline and a budget for start-up and annual operations that would need to be adjusted based on which Exchange components are eventually state or federally operated. As noted above, once operational, the state based Exchange would be self-supporting through the existing fee on health insurance carriers.

After the Governor instructed that AID plan for an FFE Partnership, First Data worked with HBEPD to modify the table below from the original Business Operations Plan to reflect adjustments (see italics) for an FFE Partnership.

Function	Status of Planning
Exchange website	*This is a federal function under the Partnership Model.* Arkansas participated in UX2014 design activities and worked with DHHS, Arkansas DHS (Medicaid and County Operations), AID and Department of Information Systems (DIS) to determine how best to implement a seamless user experience for Arkansas consumers. HBEPD also worked with DIS to explore a single-sign on Eligibility/Enrollment solution for the Arkansas website which will be archived for possible use at a later time.
Premium tax credit and cost-sharing reduction calculator	*This is a federal function under the Partnership Model.*
Quality rating system	Preliminary discussions with the AID Rate Review, Life and Health and Consumer Services Division and the Arkansas Center for Health Improvement have begun in an effort to identify areas of collaboration in determining quality criteria and data sources including a developing All Payer Claims Database (APCD), and needed alignment of administrative functionalities. A need for more study was identified and will be undertaken using Level One Establishment grant funds.
Navigator program	Extensive discussions among members of the Steering Committee, the

Function	Status of Planning
	Workgroups and at the Community Meetings led to consensus that Navigators must be certified and monitored, may be organizations or individuals and will be funded by a traditional grant program. The Navigator will serve as a guide and educator to highlight the benefits and penalties associated with the Exchange for those citizens who otherwise lack the educational, financial and/or technological resources to understand or access the system. Navigators will also refer for complaint or grievance resolution. *Under the Partnership Model, the Navigator Program will be administered by DHHS and managed by HBEPD. A new In Person Assister (IPA) Program will be developed by HBEPD to compliment the Navigator Program.*
Eligibility determinations for Exchange participation, advance payment of premium tax credits, cost-sharing reductions and Medicaid	*This is a federal function under the Partnership Model. The Exchange Planning team will work closely with DHHS and Arkansas DHS staff on many levels including extensive planning about rules engine functions for eligibility determinations and appropriate cost sharing.*
Seamless eligibility and enrollment process with Medicaid and other state health subsidy programs	Discussions to date have concentrated on seamless eligibility and enrollment through the Exchange for Medicaid/CHIP and private insurance. *There is interest in incorporating other state health subsidy programs and the feasibility of that will be explored further as planning continues with state and federal partners.*
Enrollment process	Preliminary discussions of the enrollment process have occurred as part of the overall IT system discussions. *Under the Partnership Model, enrollment is a federal function. During the next planning phase, requirements definitions will assist in designing a seamless Exchange-Medicaid enrollment process.*
Certification, recertification and decertification of qualified health plans	Determined that this function will be assumed by AID using criteria developed collaboratively by the Federal-State Exchange Partnership. Level One Establishment Grant funds will be used to develop certification criteria.
Call center	*This is a federal function under the Partnership Model.* A call center will be part of the Exchange operation serving to assist individuals with enrollment, refer individuals to a Navigator or other in person assister and serve as a linkage to other functions such as complaints and appeals that will be handled primarily by the AID Consumer Services Division.

Communication, Education and Outreach

First Data subcontractor, Arkansas Foundation for Medical Care (AFMC), developed a proposal for the Arkansas Communication/Education/Outreach Plan. AFMC is experienced in outreach and education to low income and culturally diverse groups in Arkansas including families eligible for or receiving Medicaid services.

Recognizing that the Exchange communications, outreach and education audience will include not only consumers of diverse backgrounds, educational levels, and cultures, but also small business owners, health care providers, and other stakeholders, the plan that is implemented must carefully target Exchange messages and their delivery to match the priorities and communication styles of the intended audience, without alienating other groups.

Reaching such a complex group requires a wide range of messages, delivery systems and approaches—and these needs along with cost and feasibility were considered in the development of a Communications plan. Recommendations are for a three-phased approach designed to move the Exchange step by step toward the overall goal of increasing the number of Arkansans with health insurance. The Communications plan also made recommendations for the Navigator Program.

Communications/Education/Outreach Plan: This plan outlines a tactical work plan with a timetable for implementation (See http://hbe.arkansas.gov/CEOPlan.pdf). It has two overall goals:

- Increase the number of Arkansans with health insurance; and
- Gain public support of the HBE.

Objectives are to:

- Achieve high levels of public support for the HBE through legislative, coalition, health care providers and partner collaboration;
- Within year one, reach 75% of the consumer and small business populations who are eligible to purchase insurance through the HBE with awareness of the HBE and overarching messaging;
- Within year two, reach 90% of the consumer and small business populations who are eligible to purchase insurance through the HBE with awareness of the HBE and overarching messaging; and
- Drive 90% of the 587,000 eligible Arkansans to contact the HBE to enroll in health insurance.

Plan for the Navigator Program: AFMC recommendations for Arkansas's Navigator Program were based on research using the Arkansas SHIIP volunteer model, the NAIC Whitepaper on the Roles of Navigators and Producers, the UAMS Health Benefits Exchange Survey and community meeting data, studies funded by the RWJF, the Northwest Arkansas Agents for a Better Arkansas Health Benefits Exchange recommendations, the National Association of Health Underwriters report on the Role of Navigators and the Navigator efforts of other states pursuing an HBE, as well as sustainability considerations and federal funding restrictions.

Recommendations are that the role of a Navigator be to raise awareness of the availability of qualified health plans through the HBE and to assist those wishing to enroll in the Exchange. General assistance can be provided in an individual or group setting, but care must be taken to protect personal health information (PHI). Navigators should be responsible for distributing accurate, fair and impartial information concerning enrollment in QHPs and should serve an educational role with regard to informing individuals and businesses of the availability of premium tax credits and cost-sharing reductions in accordance with federal tax laws. Individuals may complete enrollment through the Exchange portal, phone, mail or in person or by a broker/producer, depending on the preference of the individual customer. The Navigator's role should be one of advocate, educator and guide, particularly for those who may not be computer-literate or well-versed in insurance terminology.

Further recommendations include:

- Actively recruiting suitable individuals or entities to serve specific populations that have historically been difficult to reach or underserved, such as the Hispanic communities or the Marshallese population in Washington County, and those in rural or underserved geographic areas. Such Navigators should ideally be a community member who is perceived as a peer. All

information should be culturally and linguistically appropriate to the needs of the population being served by the Exchange.

- Utilize AID resources and procedures already established for handling complaints and concerns regarding the Exchange, a Navigator, producer or participating health plans.
- Create a training/certification structure for both Navigators and producers assisting customers with enrollment through the Exchange, and that the current AID licensing structure is considered. This certification structure would include:
    - Definition of the actions and responsibilities requiring certification;
    - Services that can be provided under certification;
    - A criminal background check and review of the state and federal "excluded provider" lists:
    - Rules regarding full disclosure of potential conflicts of interest;
    - Training in providing full disclosure to clients;
    - Accountability and consumer protection standards, including any requirements for individual or agency/organization Navigator liability coverage;
    - HIPAA law and protection of personal health information (PHI) training;
    - Any forms clients will be required to sign before disclosing PHI to a Navigator; and
    - Requirement that producer/Navigator maintain means of electronic communication.
- Provide training, certification, and recertification through an online training course. If the Exchange has adequate resources, the online training would be strengthened by an observational "in-person" training component. A modest training fee ($25 recommended) will help cover the cost of training without being a financial burden on potential Navigators. A certification/recertification fee ($25/$15) is also proposed to cover administrative costs. Options for credit card, bank draft, and payment by check are recommended.
- Operate the Navigator Program as a traditional, competitive grant program with a predetermined funding amount available by a geographic area or method of distribution determined by the Exchange. A flat fee vs. fee per enrollee payment is recommended.
- Compensation amounts and mechanism should be transparent to consumers and presented in writing to potential enrollees working with a Navigator;
- Identify an alternative revenue source for the first six months of the program to ensure prompt and adequate payment for Navigators; and
- Hire a consultant to help design, develop, and implement the Navigator program structure as a traditional grant program.

Outreach, education and Navigator recommendations were presented to the Steering Committee and later endorsed by the Planning Team, Steering Committee, and Workgroups. Funds for a contractor to develop Arkansas's Navigator Program were requested and received in Arkansas's Level One Establishment funding. DHHS subsequently determined that the award of Navigator grants is a federal function. Arkansas is planning to implement a companion In Person Assister (IPA) contract program to be coordinated with the federal Navigator Program.

Evaluation Plan

First Data subcontractor, Arkansas Foundation for Medical Care (AFMC), developed the Evaluation Plan (See http://hbe.arkansas.gov/EPlan.pdf). AFMC is a nonprofit educational organization dedicated to the clinical evaluation and improvement of health care in Arkansas and throughout the country.

In developing this evaluation plan, AFMC tried to simultaneously take two perspectives. The first perspective was that of the policy maker who wants to know whether the Exchange, as established in Arkansas, satisfactorily performs what lawmakers have termed "essential functions." The second perspective is broader - to develop an evaluation plan that would address whether the Exchange was able to meet its public policy goals and whether any publicly anticipated or feared consequences were observed.

This proposed evaluation plan was designed to be a comprehensive assessment of Arkansas's new health insurance exchange. Evaluation is focused on three primary components: implementation, outcomes, and efficiency.

- Implementation evaluation focuses on the process of Exchange introduction to the public. A solid implementation evaluation serves as the foundation for outcomes and efficiency evaluations since the latter depend on successful implementation.
- Outcomes evaluation centers on the policy objectives of the Exchange. Thus, this evaluation plan also aims to address various policy-relevant potential effects of the new Exchange.
- Efficiency evaluations identify whether the Exchange was implemented with minimal waste and whether the health outcomes were achieved in the most cost-effective manner.

It is essential that cooperative partnerships with other evaluation efforts occur in the measurement of the implementation, outcomes and efficiency of the Exchange in order for the impact to be successful and for the Exchange to experience the most in cost-effectiveness. The measures presented in the evaluation plan are designed to track many aspects of health care, including satisfaction with care, quality of care, access to care, utilization of care, and cost of care. Although funding for an evaluation requires a financial commitment upfront, the benefits result in health improvement for Arkansans and a cost-effective and efficient health system which lead to potentially greater cost savings long-term.

The Evaluation Plan recommended the following:

- To measure the HBE implementation effectiveness, conduct a population-wide survey to capture awareness and use of the HBE as well as calculating enrollment and re-enrollment, tracking disenrollment and gaps in coverage.
- To ensure that enrollees are satisfied with their healthcare coverage purchased through the HBE, conduct the CAHPS Health Plan survey to measure enrollee satisfaction.
- Since Navigators are predicted to play an instrumental role in consumers accessing the HBE, survey consumers at the time of enrollment to capture whether they used a Navigator and how satisfied they were with their Navigator.
- With a predicted increase in consumers accessing care, survey providers to see if they feel they can adequately meet the needs of their existing patients and deliver care to new patients.
- One way to measure the success of the HBE is to track the number of uninsured Arkansans as well as crowd-out.
- The calculation of quality measures will measure whether enrollees' are receiving quality and timely care.

- Measuring access to care to determine if problems arise after more people access healthcare services as well as measuring utilization of care to determine if enrollees are accessing preventive services, not accessing the emergency department for non-urgent care and are not being readmitted to the hospital.
- Track the costs of care by plan and issuer to help identify any outlier expenditures.

Arkansas requested and received funding through their Level One Establishment grant to further plan and develop a method of evaluation consistent with implementation of the FFE Partnership Model.

3. Stakeholder Participation

Stakeholder involvement is an obvious and recognized 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 supported fully or in part by Planning Grant funds 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	Commissioner Bradford appointed a new Steering Committee in March to make recommendations relative to FFE Partnership 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 teleconferencing is used for distant participation. Monthly progress reports and meeting summaries can be found at http://hbe.arkansas.gov/.
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

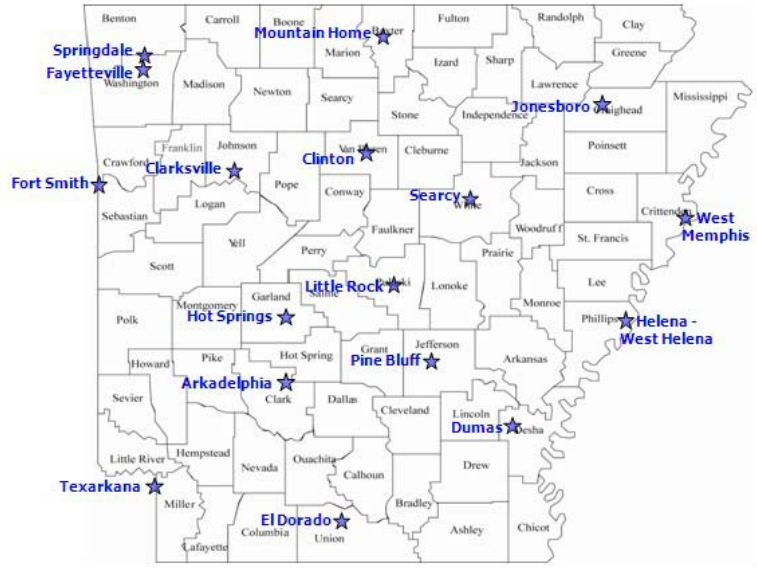
Stakeholder Group	Consultation Strategy
	ranged from 10 to 15 and guests were welcome. SKYPE attendance was used by some at distant locations. Meeting summaries can be found on the Exchange Planning website at http://hbe.arkansas.gov/StateRun.html.
Advisory Committees 2012	Under a new Stakeholder Engagement Process, two Advisory Committees were created to align with the state operated functions of the FFE Partnership—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 FFE Partnership 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 an FFE Partnership 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 at 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.
Web-Based Survey	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).
State Health Agency Leaders Meeting	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 and Quality Transformation. The Governor's Policy Office, State Agency directors and chief staff from the Departments of Insurance, Human Services, Health, Office of HIT, and the UAMS meet for updates and strategy sessions.
HBE Stakeholder Summit	A one-day statewide stakeholder summit was held October 11, 2011. Past Director of The Federal Office of Health Benefits Exchanges, Joel Ario, and Arkansas Surgeon General Joe Thompson, MD, MPH, served as keynoters, addressing HBE

Stakeholder Group	Consultation Strategy
	development, issues, and progress to date, with time provided for questions and feedback from participants.
Legislative Reports	Insurance Commissioner and HBEPD Staff have formally presented at 15 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.
One-to-One or Group Stakeholder Meetings	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.
HBE Website at www.hbe.arkansas.gov	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.

Under an MOU with AID, UAMS Partners for Inclusive Communities worked with the UAMS College of Public Health to facilitate stakeholder involvement in four planned ways: Community Listening Sessions across the state, a Web-Based Survey, the Statewide Stakeholder Summit, and public hearings across the state in each of four congressional districts. Key informant interviews were conducted to help with design for each of the four primary strategies. The first two strategies were implemented over the summer of 2011; the Stakeholder Summit was held October 11, 2011, and the public hearings were held in for 2012 through a No Cost Extension of the Arkansas HBE Planning Grant.

Community Meetings: More than 500 persons attended 66 community information dissemination and listening sessions in 17 cities/towns across the state.

Health Benefits Exchange Community Meeting Locations



Following a brief presentation on ACA and Exchanges, participants were encouraged to ask questions and provide their views/comments related to core Exchange areas. A summary report was prepared and presented to the Steering Committee. Findings were also reported at the October 2011 Stakeholder Summit and posted on the HBE Planning website. (See http://hbe.arkansas.gov/StakeholderInput.pdf)

Participants shared spontaneous ideas about issues ranging from cost containment to avoiding adverse selection and were given the opportunity to present other items that Arkansas should consider in Exchange development. Participants were given the link to the Health Benefits Exchange Planning Website and shown how to use it. They were invited to attend open planning group meetings and encouraged to submit additional comments or questions via email or phone once they had time to reflect on the information presented. Several did begin attending workgroup meetings, either in person or via SKYPE.

Areas of general stakeholder agreement were:

- Majority are for an Arkansas-operated Exchange, designed by and for Arkansans;
- Most are for Arkansas Insurance Department regulation of plans and companies;
- Most want Exchange to be as inclusive as possible, yet start small and grow larger to ensure early success (e.g. define small business as 50 in the beginning);
- No support for new taxes; most preferred a premium fee for Exchange sustainability;
- Support for tracking quality indicators to include customer satisfaction.

Areas with less consensus were:

- A strong and vocal minority of participants were opposed to planning an Exchange at all.
- Governance control - State Agency, Non-Profit, or Hybrid?
- Will there be enough health care providers?
- Any willing QHP, active purchaser, or hybrid model for purchasing?
- Role of Navigators vs. Licensed Producers?

Web-Based Survey: A survey was developed following review of the literature and other state Exchange surveys and key informant interviews. It was "live" on the AID Health Benefits Exchange website from July 12 – August 25, 2011. Forced field and open "narrative" comments from 432 valid survey responses were analyzed from this convenience sample. A report was presented to the Steering Committee and posted on the Health Benefits Exchange Planning website. (See http://hbe.arkansas.gov/StakeholderInput.pdf). Among findings were the following:

- 68% are for an Arkansas Exchange;
- 70% want Arkansas Insurance Department regulation of plans;
- 32% believe Exchange Planning should stop;
- 52% believe Arkansas should have an Active or Hybrid purchasing model;
- 74% believe persons with incomes >400% FPL should be allowed to shop on the Exchange;
- 49% believe "small group" should be defined as < 50 employees until 2016;
- 75% believe Navigators should be certified or licensed; and
- Most believe Exchange Sustainability should be through Insurer Fees.

Stakeholder Summit: The Exchange Stakeholder Summit was held October 11, 2011, in Little Rock. Around 150 persons attended, including approximately ten state legislators. A summary of participant evaluations was posted on the HBE Website at http://hbe.arkansas.gov/SummitSummaries.pdf.

In addition to the activities of UAMS Partners for Inclusive Communities, the Exchange Planning staff has continuous interaction with various stakeholders throughout the state as specified in previous Quarterly Reports.

4. Lessons Learned

The information accumulated from the various research efforts and input from expert consultants and diverse stakeholders is being and will be used by AID and the FFE Partnership to guide development of the best program for Arkansas. However, there were other "lessons learned" from the many activities funded by the Planning Grant that are worth noting (not listed by priority).

Staffing –

- Strong and active support by the Arkansas Insurance Commissioner, an experienced, effective policy-maker, was critical to the planning effort.
- Initial leadership of the newly created Planning Division by a director who is a strong administrator with state government and health care experience and a Specialist with substantial insurance experience created a good balance from which to plan and begin implementation of the ACA Exchange effort.
- Gathering information, learning about the organization and staffing within AID and in other state agencies and working with professional consultants gave AID an opportunity to systematically identify the skill sets needed as it made plans to add staff to the Health Benefits Exchange Partnership Division.

Planning for a Governance Model - This effort to identify the best Governance Model for Arkansas sparked spirited debate among a wide variety of stakeholders which is healthy for a new undertaking such as this. It also served as an early form of outreach and education as information about ACA and Exchange development was widely disseminated.

IT Integration - Understanding the existing IT assets in the State of Arkansas is a critical step in planning the FFE Partnership HBE roadmap. The Arkansas planning initiative laid the foundation for developing alternative approaches and the level of effort which will be required, as well as some of the demands which will be placed on the agencies. Ultimately, strategic decisions will be required which will shape the outcome of the FFE Partnership architecture in Arkansas. A strong commitment to state agency and federal collaboration will be critical to the successful FFE Partnership.

Stakeholder Integration –

- The general public is subject to a myriad of misinformation about ACA and the Health Insurance Exchange. Even as we shared correct information through various communication channels, others were continuing to spread misinformation and foster scare tactics.

- We cannot over-state the value of diverse stakeholders sitting around the table and sharing their positions, ideas and listening to each other.
- To get the full value of stakeholder participation, there needs to be a structure where they can discuss issues, reach a consensus and make recommendations to the Arkansas Insurance Commissioner for consideration and/or action. (Note: After our experience in 2011, we revamped the Stakeholder Engagement Model to provide such an avenue.)

Federal Assistance and Support – One of the unexpected bonuses of the Planning Grant experience was the consistent support provided by our HHS Project Officers. A collaborative relationship existed from the beginning and remains consistent even following changes in Project Officers. We have easy access to and routine communication with federal staff, assuring that we can take advantage of available federal resources.

5. Conclusion

The work accomplished using the Planning Grant funds provided critical building blocks that enabled HBEPD to gather valuable information and create the foundation for implementation of a workable Exchange for Arkansans. This foundation included the creation of a diverse Stakeholder Engagement Model to ensure broad participation in this effort. We will build on this foundation to develop the Arkansas FFE Partnership Model using funds received through Level One Establishment Grants.

Appendix A

ARKANSAS CENTER FOR HEALTH IMPROVEMENT

Arkansas Options to Address "Churning" and Split Coverage within Families

Introduction

Under provisions in the Patient Protection and Affordable Care Act (PPACA)—which will significantly expand the availability of insurance coverage nationwide—over 500,000 Arkansans will become newly eligible either for Medicaid or subsidies to purchase insurance in the Federally-Facilitated Exchange Partnership (the "Exchange").

This newly eligible population will include a significant number of low-income adults with complex health care needs and pent-up demand for health care services who will often shift between subsidy programs or between subsidy programs and the private insurance market over time (commonly known as "churning"). That shifting may be caused by changes in income and access to employer-sponsored insurance. Churning may also be a result of paperwork and administrative requirements of the public program, for example, the need to complete paperwork for a regular redetermination of eligibility may result in shifting in and out of the public program. States must explore ways to ensure continuity of coverage when these shifts occur and choose policies that promote seamless transitions across coverage options.

This brief will examine some of the transition points at which Arkansans may encounter gaps in coverage, and it will examine policies to promote continuous coverage across transition points. It will also explore lessons learned from other states with Exchange implementation and will provide Arkansas-specific recommendations for providing continuous coverage.

Churning and Its Effects

While churning is not new for state Medicaid programs—with 43 percent of adult enrollees nationwide experiencing a disruption in coverage within 12 months of their initial enrollment—research shows that churning will be widespread when Medicaid is expanded and the Exchanges are established. For example, a *Health Affairs* study[i] estimated that within six months, more than 35 percent of all adults with family incomes below 200 percent of the federal poverty level will experience a shift in eligibility from Medicaid to an insurance exchange, or the reverse; within a year, 50 percent will. A state-specific analysis of the potential for churn in the Arkansas Exchange population—using the ARHealthNetworks population as a proxy—is currently underway.

Churning is not only a concern for consumers because of gaps in accessing services—especially for those with chronic illnesses, who would potentially see reduced effectiveness of disease

management programs—but also a concern for insurers, health care providers and state governments. Other consequences of churning include:

- Administrative costs for payers from enrolling, dis-enrolling and re-enrolling;
- Administrative costs for providers from verifying eligibility, resolving billing issues and reconciling claims; and
- Inconsistencies in measuring quality of care.

Disruptions in coverage can result in significant delays in seeking care, which can place individuals at risk for preventable hospitalizations and missed diagnoses, as well as financial ruin.

A 2011 study by *The Commonwealth Fund*[ii] showed that about one-half of surveyed adults who became uninsured after losing a job with benefits skipped a recommended medical treatment (52 percent), did not get specialist or other physician care when needed (47 percent), or did not fill a prescription because of cost (47 percent). Nearly three-quarters of workers who became uninsured after losing a job reported at least one problem with medical bills or accrued medical debt in the past year, while 40 percent were forced into difficult decisions or trade-offs in the past year, such as declaring bankruptcy, taking out a mortgage or loan, or not paying for food, heat, or rent.

Exchange policy and operational decisions in Arkansas will have a direct effect on the level of churning in and out of coverage or between coverage types. Drawing upon the experiences of other states, it will be important for Arkansas policymakers to consider the costs and benefits of these decisions. Decision points that will have a significant effect on churning include:

- Conditions of participation both for exchange qualified health plans and Medicaid managed care organizations should Medicaid opt for managed care;
- Alignment of benefit packages and provider networks between public programs and exchange plans;
- Alignment of eligibility rules including timing of determinations and income verification for exchange based subsidies and public programs;
- Alignment of open enrollment periods within the exchange and recertification periods for public insurance programs; and
- Decisions surrounding lockout policies for failure to pay premiums.

The differentiation in Medicaid programs and insurance marketplaces from state to state will result in varied approaches to these decisions. Thus far, Massachusetts is the only state that currently has Exchange to managed care organization (MCO) transition of care requirements in place. Other states have been managing transitions of care between MCOs and other programs for years.

Massachusetts—MCOs administer the Massachusetts Medicaid program. The state has extensive contract language with the MCOs to guide coverage transitions between Medicaid and the Health Connector, the state's Exchange. For example, contract provisions require MCOs to perform readiness reviews prior to beneficiary enrollment, minimize disruptions in care, and ensure uninterrupted access to medically necessary services. Contracts also require MCOs to provide transition plans to certain enrollee subsets. While gaps in coverage remain, Massachusetts boasts the highest continuity of coverage ratio in the nation.

New Mexico—The State Coverage Insurance (SCI) program is an existing program that facilitates smooth coverage transitions between Medicaid MCOs; it is expected to be utilized for transitions between Medicaid and expansion populations. When women covered by the SCI become pregnant, for instance, they are allowed to stay on SCI but have access to the MCO and providers. When the child is born, they are screened and enrolled in Medicaid or SCHIP and assigned to the mother's MCO so that the mother and child have the same MCO and provider throughout the process.

Arkansas ***shares some of the transition of care issues*** with these states. For instance, beneficiaries who have an ongoing treatment cycle with a particular chemotherapy drug for cancer may have problems with transitions if that particular drug is not a part of the receiving plan's formulary. Coverage transitions during postpartum periods can be particularly tenuous for new mothers. Arkansas Medicaid now covers all pregnancy-related medical costs for women below 200 percent of federal poverty level. Although the child remains covered by Medicaid following birth, the mother is no longer covered by Medicaid after delivery. Importantly, there will also be a transition to Medicaid coverage once a pregnancy determination has been made and eligibility for Medicaid is verified.

According to Medicaid officials, some inpatient stays by jailed individuals—primarily those related to pregnancy—are covered by Medicaid. At release or upon parole in 2014, however, nearly all inmates will qualify for Medicaid. Consequently, inmates with serious illnesses will have an immediate source of health care coverage, assuring access to prescription drugs and ongoing treatment of serious mental illness, HIV/ AIDS, hepatitis, cancer, and other conditions. Outreach targeted at recently released individuals will be important for continuity of any care received while incarcerated.

Beyond these shared transition issues, however, **Arkansas may experience some state-specific churning issues**. Churn can be expected among the ARKids B population, also known as the state's Children's Health Insurance Program. ARKids B covers children whose parents earn up to 200 percent of federal poverty level. Until 2015 when the federal government will fund this program at 100 percent, an 80/20 match rate—the state covering the smaller portion—will apply. Churning may occur between ARKids A and B and between ARKids B and the Exchange at the 200 percent poverty level mark. As discussed below, this scenario also creates split plans within families.

Certain waiver programs that would otherwise have potential for churn—such as the Arkansas Breastcare program (which provides Medicaid coverage for women diagnosed with breast cancer via a no-pay screening program administered by the Arkansas Department of Health), the ARHealthNetworks program (a limited benefit safety net insurance program primarily targeted at small businesses and sole proprietors), and Family Planning program (which provides family planning services for those under 200 percent of poverty level)—may cease and be subsumed into the newly eligible population.

One population in which Arkansas could experience some significant churn is among those with behavioral health disorders. Experience from Massachusetts—a state that expanded health insurance coverage significantly in 2006—indicates that those presenting for behavioral health services had a disproportionately lower rate of insurance coverage. This was true despite expanded eligibility and a series of concerted outreach and enrollment efforts.

According to the Substance Abuse and Mental Health Services Administration,[iii] Arkansas has a higher prevalence of serious mental illness and psychological distress among those who will be eligible for Medicaid and the Exchange under the PPACA. Among the Medicaid expansion population, for example, the prevalence of serious mental illness for Arkansans ages 18-64 is 11 percent, while the national average is seven percent. Among the Exchange-eligible population, the prevalence of serious mental illness for Arkansans ages 18-64 is ten percent, while the national average is six percent. The prevalence of serious psychological distress among Arkansans who will be newly eligible for Medicaid and the Exchange is more than 50 percent higher than the national average.

Needless to say, targeted outreach and enrollment efforts for these individuals will be greatly needed. Behavioral health-oriented In-Person Assistance support could be developed, including access to the Exchange at key locations such as community mental health and addiction treatment centers. Also, more flexible renewal processes could be extended to those receiving care for chronic behavioral health conditions. Importantly, given that rates of smoking are two to four times higher among people with psychiatric and substance abuse disorders,[iv] premium rating based on tobacco use will need to be analyzed closely, as it could have an unintended, deleterious effect on this population.

Below are some broad options for Arkansas policymakers that seek to mitigate coverage gaps and smooth coverage transitions.

Option #1: Require the same policies to be offered both to Medicaid and Exchange-subsidized individuals.

A state could operationalize this option by contracting with a MCO(s) to provide Medicaid to newly eligibles. Because Arkansas is not currently restricted by a MCO contract to administer its Medicaid program, the state has a number of options available to influence continuity of care should it decide to engage a MCO for newly eligibles. For example, the state could require all

MCO entities applying to administer Medicaid to offer the same coverage option in the Exchange so that churning individuals do not switch benefit coverage or providers in a given enrollment period; the only evident change to the consumer would be cost-sharing on premiums, co-pays, etc.

Pros:

- Continuity of coverage and care
- Change in coverage is behind-the-scenes
- Could result in cost savings to Medicaid
- Could allow for increases in provider reimbursement
- Puts a new face on Medicaid for newly eligibles

Cons:

- Could reduce competition in Exchange
- Limits choice for consumers because they are locked in
- Run the risk of providers restricting care

Option #2: Offer a Basic Health Program (BHP) as allowed by PPACA.

A BHP would provide insurance to those with incomes between 133 to 200 percent federal poverty level (FPL). Individuals would receive their coverage through this program rather than through the Exchange and would receive, at a minimum, the same essential health benefits. States would receive 95 percent of the federal subsidies that would have been provided in the exchange to eligible individuals in the form of tax credits and cost sharing reductions. States have the potential to provide stronger and more affordable benefit packages under a BHP than what would be available through the Exchange.

In Arkansas it is likely that a large number of those eligible for premium subsidies through the Exchange will fall into the income group between 133 to 200 percent of FPL. Importantly, a BHP would separate these individuals from the rest of the risk pool, making them ineligible for premium subsidies and cost sharing through the Exchange. This could have a negative effect on premiums in the individual market by separating a large group that otherwise would have participated in the Exchange.

Pros:

- Affordability
- Could simplify coverage for families by keeping parents and children on similar, coordinated programs
- Continuity of coverage and care at 133% FPL
- Protects vulnerable, low-income Arkansans from subsidy clawbacks

Cons:

- State financial risk (Health status of BHP population is uncertain which makes financial viability of BHP uncertain)
- Impact on Exchange (Potential for drawing individuals from the Exchange which could change remaining risk pool in Exchange and modify Exchange costs and revenues)
- Impact on access (Provider networks and provider rates may not be sufficient to ensure adequate access)
- State capacity and infrastructure needed to administer a BHP may be constrained
- Movement in and out of Medicaid/BHP would still occur at 200% FPL

Option #3: Require continuous eligibility for 12-month period or limit enrollment/eligibility changes to once or twice per year.

Under the proposed rules for Exchanges, there will be three types of enrollment periods: an initial open enrollment period, annual open enrollment periods, and enrollment periods based on qualifying events, such as loss of minimum essential coverage, the birth or adoption of a child, etc. Open enrollment periods such as those proposed under the exchange rules are a relied-upon avenue to mitigate adverse selection today and are used by large employers, self-insured plans, and public employee health plans.

Under PPACA, Medicaid eligibility remains based on monthly income at the time of application. New Medicaid eligibility rules under PPACA provide states new options to assess continuing Medicaid eligibility based on projected annual income or by taking into account anticipated changes in income, which would minimize coverage gaps and transitions between Medicaid and Exchange coverage due to small income fluctuations. For example, the final Medicaid eligibility rule signals new opportunities for states to seek waivers under Section 1115 of the Social Security Act. These waivers will support states seeking 12-month continuous eligibility, Express Lane Eligibility for adults, or other policy goals that CMS does not have explicit PPACA statutory authority to include within the final rule.

Pros:

- Continuity of coverage and care
- Less administrative burden on payers and providers

Cons:

- Could induce gaming of the system
- From a cost perspective, it could keep some enrolled when otherwise not eligible for long periods of time
- Could pose some design/management issues on the funding side

Option #4: Ensure that care coordination continues even if gaps in insurance coverage occur.

Understandably, there may be gaps in insurance coverage that remain irrespective of policies implemented to reduce coverage gaps. That does not necessitate, however, that care coordination cease in the interim. Care coordination models could be developed that follow the patient, as opposed to following the coverage. In other words, a care coordinator facilitating appointments, tests, referrals, etc., should continue with those tasks regardless of coverage, such that a patient receives timely care. As soon as the patient obtains new coverage, the care coordinator should facilitate the transition to a new care coordinator or primary care provider, as needed.

Pros:

- Continuity of coordination of care, despite a lack of coverage in the short-term
- Patient satisfaction during what could be a turbulent time
- Facilitates smoother transition between coverage periods
- Could help to prevent avoidable hospital admissions, especially for those with chronic conditions
- Assists patient in locating reduced cost services while they lack formal insurance coverage

Cons:

- No available source of payment for care during coverage gaps
- Payers have little incentive to pay for care coordination if patient is not enrolled

Option #5: (Specific to Employer-based coverage) Allow those who opt for COBRA coverage to use subsidies for which they would otherwise qualify to purchase an individual plan toward the COBRA plan.

PPACA did not eliminate the availability of a former employee's opting for COBRA coverage following employment termination, but the cost of continuing coverage under COBRA is absorbed in whole by the former employee. The cost—and the realization that subsidized coverage through the Exchange may be forthcoming—may cause many to forego COBRA coverage even for short periods of time. To incentivize choice of COBRA coverage with the purpose of filling the gap after employment termination (whether voluntary or not), those eligible for subsidies through the Exchange should be allowed to apply the subsidies to COBRA coverage, at least until the next open enrollment period or until the individual obtains new employer-based coverage, whichever occurs first.

Pros:

- Continuity of coverage and care
- Saves on administrative costs generated from moving among health plans

- Enables individual to avoid penalties associated with waiting periods for new employer-based coverage
- Could reduce adverse selection in Exchange (those with low risk are more likely to wait until they get employer-based coverage again)

Cons:

- May require a waiver from the federal government
- Additional subsidy comes at a cost for federal government
- Employer will continue to retain former employee's risk in pool

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Split Coverage among Families

Although it is the most widely publicized issue, churning is not the only coverage issue that must be addressed by states. Expanded options for insurance coverage—whether subsidized through the Exchange or by Medicaid—are sound policy advances, but expanded options will result in increasingly complex coverage situations within families. It is important to cover families in one plan for several reasons:

- Parents have to learn only one health plan's policies and procedures.
- In some MCOs and with family practitioners, parents and kids can be seen together if enrolled in a common plan.
- For long-term viability, a reformed system needs to be consumer-friendly—does not make sense to split families into separate programs and plans.

Much like churning, the existence of varying insurance coverage within families is not a new issue; expanded options for coverage, however, exacerbate the issue. Over 16 million Medicaid or CHIP-eligible children have parents with income within the Exchange-eligibility range.[v] Seventy-five percent of Exchange-eligible parents will have one or more children who are eligible for CHIP or Medicaid and must enroll them in these programs.[v]

With expanded coverage under PPACA, two of the most evident situations in which varied coverage within a family can occur are: (a) when one parent is employed and the other is not and (b) when children are covered by Medicaid and parents are not. The coverage differentiation for these situations is demonstrated by the charts below.

For a family of four in which one parent is employed and family income is 300% of federal poverty level (Note: the employer coverage for the parent is not extended to adult dependents, *e.g.*, spouse or those over age 26).

Family Member	Eligibility Status	Insurer
Father (unemployed)	Subsidies to purchase in Exchange	Individual Qualified Health Plan
Mother (employed)	Employer Coverage	SHOP Qualified Health Plan
Child 1, age 12	Employer Coverage (Mother's policy)	SHOP Qualified Health Plan
Child 2, age 5 (developmentally disabled)	DDS Waiver	Medicaid

For a family of four in which one parent is employed and family income is 190% of federal poverty level. (Note: the employer coverage for the parent is not extended to adult dependents, *e.g*., spouse or those over age 26.)

Family Member	Eligibility Status	Insurer
Father (employed)	Employer Coverage	SHOP Qualified Health Plan
Mother (unemployed, pregnant)	SOBRA, then Subsidies to purchase in Exchange	Medicaid, then Individual Qualified Health Plan
Child 1, age 14	ArKids B	Medicaid/SCHIP
Child 2, age 12	ArKids B	Medicaid/SCHIP

To address "split" coverage within families—*i.e*., different family members being covered by different insurers because of eligibility status—**Tennessee** has proposed a bridge coverage option. The option seeks to enable members of a nuclear family to have coverage through a common insurer/provider network, regardless of eligibility status, and to facilitate continuity by allowing individuals to retain coverage if eligibility status changes. Under the plan, Tennessee's Medicaid MCOs will provide a single card for use by an entire family while a dependent was enrolled in Medicaid/SCHIP and for a defined period thereafter.

There is little information from other states on how, if at all, they will directly address this issue. In addition to the BHP described above (which would potentially address both churning and split coverage,) here are a couple of options for Arkansas.

Option #1: Adopt a similar plan as Tennessee's "bridge" option.

Tennessee is in a much different position than Arkansas: its Medicaid/SCHIP enrollees are already in MCOs. To the extent that Arkansas adopts a Medicaid MCO strategy for the current and/or expansion population, it could require the MCO to offer the same coverage and networks for dependents/parents.

Option #2: Allow "renting" of an out-of-network provider at an in-network fee schedule if provider is the PCP of children.

If a consumer wishes to purchase coverage for which the network does not include the PCP of children or other dependents, the plan could "rent" the services of the provider at an in-network fee schedule only for the beneficiary. While this "rental" mechanism would mitigate split networks within families, it would not address different coverage policies and procedures. An additional drawback is that "rental" providers may not agree to other contractual provisions required of in-network providers, such as quality measures, prior-authorization requirements, etc.

Conclusion

For families who have little experience with insurance coverage and low health literacy, it will be important for policymakers to address churning and split coverage. In a period in which coverage will be expanded dramatically, the state has the opportunity to streamline existing infrastructure and leverage Exchange opportunities to ensure that coverage is more accessible and less complicated for consumers. The state should carefully consider options in this brief, as well as any other available options, to ensure that design aspects promote coordination—and to the greatest extent possible, commonality—across insurance programs.

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[i] Sommers, BD and Rosenbaum, S. *Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges,* Health Affairs (February 2011). http://content.healthaffairs.org/content/30/2/228.full (Accessed July 24, 2012).

[ii] Doty, MM, Collins, SR, Robertson, R, and Garber, T. *Realizing Health Reform's Potential*, The Commonwealth Fund (August 2011). http://www.commonwealthfund.org/Publications/Issue-Briefs/2010/Oct/Realizing-Health-Reforms-Potential-Young-Adults.aspx (Accessed July 24, 2012).

[iii] Substance Abuse and Mental Health Administration. *2008-2010 National Survey of Drug Use and Health*. https://info.samhsa.gov/views/kmxe-c85p/files/BUkd4PddjZug9izX9aiLn0DBPVmwtYPJdKD3ELEENlo?filename=NSDUH%20state%20profile_Arkansas.pdf&content_type=application/pdf%3B%20charset%3Dbinary (Accessed July 24, 2011).

[iv] Kalman D, Morissette SB, George TP. American Journal on Addictions. 2005;14,106-123.

[v] McMorrow, S, Kenney, GM, and Coyer, C. *Addressing Coverage Challenges for Children Under the Affordable Care Act,* Urban Institute (May 2011). http://www.urban.org/UploadedPDF/412341-Affordable-Care-Act.pdf (Accessed May 29, 2012).

Appendix B

ARKANSAS CENTER FOR HEALTH IMPROVEMENT

MEMORANDUM

To: Cindy Crone

From: Will Watson

Date: 9/27/2012

Re: Health Plan Quality Metrics

Summary

This memorandum and attached spreadsheets are intended to fulfill a contract deliverable to ascertain Arkansas-specific health plan quality metrics, if any, to advance ongoing quality improvement for the Federally-facilitated Exchange Partnership in Arkansas (Exchange) for planning purposes. It is also intended to inform further exploration of quality measures for potential future adoption in the Exchange.

Introduction

Health plans offered on the Exchange must be accredited.[1] The following two agencies have been deemed by the United States Department of Health and Human Services (DHHS) as the accrediting agencies for health benefits exchanges nationwide: 1) URAC, formerly known as the Utilization Review Accreditation Commission, and 2) the National Commission on Quality Assurance (NCQA).[2] The Exchange is scheduled to be operational on January 1, 2014, at which time qualified health plans must be accredited. Currently, Arkansas law does not require health plans to be accredited.

Discussion

NCQA accreditation measures were retrieved from the *2013 Standards and Guidelines for the Accreditation of Health Plans*, and *HEDIS® 2013: Technical Specifications for Health Plans*. URAC accreditation measures were obtained upon request from URAC. Measures from Medicare, Medicaid, , National Quality Forum

(NQF) Nursing Homes, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), the 2012 Physician Quality Reporting System Measures List (PQRS), the Agency for Healthcare Research and Quality (AHRQ), and AHRQ Composite Measures were all obtained either from searches of those organizations' websites or the Internet. NCQA Patient-Centered Medical-Homes (PCMH) quality measures and the general URAC quality measures were obtained upon request from their respective organizations.

The Patient Protection and Affordable Care Act (PPACA) requires health plans to meet quality measures in scope of accreditation, clinical quality measures, level of accreditation, and network adequacy.[3] Scope of accreditation measures deal with patient experience ratings, consumer access, utilization management, and quality assurance.[4] Clinical quality measures are those which encompass multiple conditions as well as those conditions relating to the domains of prevention, mental health and substance abuse disorders, chronic care, and acute care, measures applicable to both children and adults.[5] "Level of accreditation" involves a determination of whether plans must be accredited at the plan, carrier, or other product type level.[6] Network adequacy measures whether plans have sufficient numbers and types of providers, geographic distribution of providers, and access to a general provider directory.[7]

These two accrediting agencies require slightly different types of measures in order for quality health plans to be accredited. URAC requires health plans to meet measures relating to scope of services; network management, i.e., how an issuer deals, and interacts, with contracted providers; credentialing, i.e., ensuring the proper licenses to practice are acquired and/or maintained; utilization management, i.e., tracking usage of services, consumer protection, and quality management.[I] NCQA requires that plans meet measures in quality management and improvement, utilization management, credentialing and recredentialing, members' rights and responsibilities, and member connections.[II]

Both NCQA and URAC require quality metrics for health plans that are substantially different than those currently being collected in Arkansas. Currently, Medicaid and Medicare[III] gather quality information

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[I] A detailed catalog of the URAC quality health plan accreditation measures can be found inTab 1 of the attachment.. The catalog of the URAC clinical measures, which is a part of the URAC quality health plan accreditation measures, can be found in Tab 15.URAC Quality Measures of the attachment.

[II] A detailed catalog of the NCQA quality measures can be found in Tab 2 of the attachment. The catalog of the HEDIS® measures and CAHPS survey, which is a part of URAC quality health plan accreditation measures, can be found in Tab 16. HEDIS 2013: Effectiveness of Care and Tab 17. CAHPS 5.0 Health Plan, respectively.

[III] Tabs 3-6 in the attachment.

related almost exclusively to the quality of clinical care given/received. Medicare has measures dealing with general information—three measures that deal with the construction of databases relating to cardiovascular care, strokes, and nursing care; timely and effective care; readmissions, complications, and death; use of medical imaging; survey of patient's experiences; payment; volume; and voluntary measures relating to emergency department (ED) use. The data for those measures are collected through Medicare enrollment and claims data. However, data is also collected from the CMS certification and Survey Provider Enhanced Reporting (CASPER) system, the QIO Clinical Data Warehouse through the CMS Abstraction and Reporting Tool (CART) or vendors, the Joint Commission on the Accreditation of Healthcare Organizations, the Centers for Disease Control, and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS).[8]

Medicaid measures can be split into adult, pediatric, and inpatient measures. The categories of adult measures are prevention and health promotion, management of acute conditions, management of chronic conditions, family experiences of care, care coordination, and availability of care. The pediatric measures include access to care, prevention, effectiveness of care, behavioral, and chronic care. Data are collected primarily through Medicaid enrollment and claims data.

In August 2012 the Exchange Advisory and Steering committees opted to adopt no additional health plan quality metrics other than the minimum required by the PPACA. On September 17, 2012, the Insurance Commissioner Jay Bradford accepted that recommendation. In future years the Exchange—i.e., once a competitive environment is achieved—should consider adopting additional quality metrics that complement Arkansas's health system transformation efforts. More specifically, the Exchange should consider adopting measures relating to the Comprehensive Primary Care Initiative (CPCI), an initiative to build a foundation for patient-centered medical homes (PCMHs). If the Exchange chooses URAC as its accrediting agency, the Exchange should consider measuring at the health plan level the following additional measures that are associated with the CPCI:[IV]

1) Diabetes Composite (All or Nothing Scoring): Hemoglobin A1c Control (<8 percent), Low Density Lipoprotein (<100), Blood Pressure <140/90, Tobacco Non Use, Aspirin Use

2) Diabetes Mellitus: Hemoglobin A1c Poor Control (>9 percent);

3) Hypertension (HTN): Blood Pressure Control;

[IV] A detailed catalog of the CPCI PCMH quality measures can be found in Tab 7. CPCI PCMH of the attachment.

4) Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)

5) Coronary Artery Disease (CAD) Composite: All or Nothing Scoring - drug Therapy for Lowering LDL-Cholesterol

6) Coronary Artery Disease (CAD) Composite: All or Nothing Scoring - Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)

7) Risk-Standardized, All Condition Readmission

8) Ambulatory Sensitive Conditions Admissions: Chronic Obstructive Pulmonary Disease

9) Ischemic Vascular Disease (IVD): Complete Lipid Profile and LDL Control <100 mg/dL

10) Ambulatory Sensitive Conditions Admissions: Congestive Heart Failure

11) Notification of ED visits at local hospitals in timely fashion

12) Notification of admission and clinical information exchange at the time of admission

13) Notification of discharge, clinical information exchange, and care transition management at hospital discharge

14) Practice medication reconciliation process completed within 72 hours of hospital discharge

15) Information exchange related to referrals between primary care and at least two types or service lines that provide high-volume (defined by the practice) specialty care

16) CG-CAHPS: Getting Timely Care, Appointments, and Information, How Well Your Doctors Communicate, Patients' Rating of Doctor, Access to Specialists, Health Promotion and Education, Shared Decision Making

17) CAHPS: Health Status/Functional Status

18) Falls: Screening for Fall Risk

19) Influenza Immunization

20) Tobacco Use Assessment and Tobacco Cessation Intervention

20) Depression Screening; and,

21) Colorectal Cancer Screening.

If the accrediting agency chosen is the NCQA, we suggest the above measures listed for URAC absent measure 3–Hypertension (HTN): Blood Pressure Control—as this measure is already required by NCQA.

Endnotes

[1] CFR 45 § 156.275(a)(1)
[2] CFR 45 § 156.275(c)(1)
[3] CFR 45 § 156.275(c)(2)(ii-iv)
[4] CFR 45 § 156.275(c)(2)(i)
[5] CFR 45 § 156.275(c)(2)(ii)
[6] CFR 45 § 156.275(c)(2)(iii)
[7] CFR 45 § 156.230(a-b)
[8] U.S. Department of Health & Human Services. *What are the Data Sources?* Accessed at: http://www.hospitalcompare.hhs.gov/Data/AboutData/Data-Sources.aspx on September 28, 2012.

Appendix C

ACHI
Arkansas Center for Health Improvement

MEMORANDUM

To: Cindy Crone

From: Jennifer Holder

Date: 09/27/12

Re: Cost per Medicaid Beneficiary by Aid Category

Introduction

This memorandum is intended to fulfill a contract deliverable to supply information about cost per Medicaid beneficiary by aid category,[1] including projections based on historical cost.

Method

ACHI analyzed the medical and pharmaceutical costs for Medicaid adults (19+) in several aid categories. To analyze the cost per beneficiary, the total number of unique beneficiaries in each aid category were divided by the total cost of that category for 2008, 2009, and 2010. Next, average percent change was obtained using the midpoint formula, calculating the average percent of the initial and ending values from 2008 to 2010. Shown in Table 1, the 2012 two-year projection was calculated by multiplying the average percent change by the cost in year 2010. Also represented in Table 1 is the total medical and pharmaceutical cost for each year. These totals were calculated using unique and unduplicated adult beneficiaries overall as the denominator. Table 2 shows the trend over a three year period. The midpoint formula was used dividing two years instead of one as the denominator.

Summary Description of Aid Categories

Beneficiaries are assigned to an aid category based on eligibility. This analysis examines the cost associated with 51 aid categories. These categories were grouped and reported as a single line category. A detailed description of these categories is provided in Appendix 1. The groups are as follows:

[1] The data and analysis provided here may be used as a benchmark for guiding policy but should not be used for projecting costs of potential Exchange eligibles.

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Group 1 - Supplemental Security Income (SSI): monthly payments are made to individuals with low-income that are aged, blind, or disabled. Aged is consider 65 or over.

Group 2 - Aid to Aged, Blind, and Disabled (AABD): supplementary aid to the aged, blind or disabled.

Group 3 - Pregnant Women (PW): women included under the Sixth Omnibus Budget Reconciliation Act (SOBRA) and presumptive eligibility for women seeking prenatal care.

Group 4 - Under Age 18 (U-18): includes individuals under the age 18, newborns, and SOBRA newborn.

Group 5 - Medically Needy: These categories were grouped and reported as a single line category. A detailed description of these categories is provided in Appendix 1.

Group 6 - Foster Care: includes adoption assistants, foster care programs, spend-down eligible, and the medically needy.

Group 7 - Qualified Medicare Beneficiary (QMB): assists low-income Medicare beneficiaries.

Group 8 – Other: assists low-income individuals enrolled in ARKids First or using family planning services.

Analysis

Based on information from a key informant, Linda Greer at the Arkansas Department of Human Services, Division of County Operations (DCO), the analysis focused on the following three categories: Transitional Employment Assistance (TEA), Transitional Medicaid (TM), and Aid to Families with Dependent Children Medically Needy Exceptional Category (AFDC-EC) as being the closest proxies to potential Exchange eligibles. Some members in these categories gain Medicaid eligibility because they are parents or caretaker relatives of minor children. While they may or may not have a disability or other health issue, adult beneficiaries in other aid categories are likely to have some kind of disability or health issue. In order to establish a comparison, several other categories were analyzed.

Cost totals in 2009 were disproportionate to the 2008 and 2010. Due to the dip in 2009, removing this outlier resulted in a better analysis. This distinction may have been due to the large scale recession that altered health care spending and consumer behavior. A separate calculation was conducted on the pharmaceutical cost because the recession didn't seem to affect the total cost; however, other factors likely resulted in the decrease in cost for most categories. In 2004, the Evidence-based Prescription Drug Program was established. This program considers the most economical drug choices for effective treatment. Under the Medicare Prescription Drug Benefit (Part D), dual-eligible beneficiaries began receiving benefits through Medicare instead of Medicaid in 2006. As of January 2008, under the Federal Deficit Reduction Act of 2005, pharmaceutical manufacturers that entered into a rebate agreement with the Centers for Medicare and Medicaid Services (CMS) would be required to submit payment to the state for the eligible drugs that are invoiced by Arkansas Medicaid.

There was a significant increase in medical costs in the U-18 category. The few adults in this category are mothers who turned 19 while in the SOBRA program; therefore, the costs fluctuate wildly given the small population. After the analysis of the AFDC-EC group and speaking with DHS staff about the findings, the AFDC-EC group did not appear to be a close proxy because of the potential of medically-needy eligibles. Importantly, none of the categories that were pointed to as being close proxies have similar costs;

therefore, use of this information to estimate potential costs for newly eligibles is not advisable. Given the ages of the foster care group, the 2008 and 2009 cost for Foster Care may potentially be similar to the cost of young adult Exchange eligibles. That being said, the cost for this Foster Care group may be slightly inflated due to a high prevalence of mental health needs.

Table 1[2] below shows the three broad sets of cost analyzed: Medical, Pharmacy, and Total. The three pinpoint eligibility categories and groups are represented within each set.

[2] The 2012 projected amount for Group 6 was not included in the analysis due to an uncertainty with the variables pulled.

Table 1:

Medical

Eligibility Category	Description	2008	2009	2010	Projected 2012	Excluding 2009 % Change 2008 - 2010
20	TEA	$ 8,346.53	$ 7,400.52	$ 8,676.64	$ 9,013.16	3.88
25	TM	$ 2,735.84	$ 2,330.47	$ 3,159.48	$ 3,613.55	14.37
26	AFDC-EC	$16,924.57	$17,290.81	$15,780.16	$ 14,675.80	-7.00
Group 1	SSI	$20,071.21	$21,786.37	$22,340.46	$ 24,731.12	10.70
Group 2	AABD	$29,888.75	$34,792.33	$33,937.53	$ 38,243.15	12.69
Group 3	PW	$12,278.61	$11,791.70	$13,523.95	$ 14,829.38	9.65
Group 4	U-18	$ 1,341.28	$ 4,702.90	$ 4,089.95	$ 8,229.68	101.22
Group 5	Medically Needy	$39,753.59	$39,611.07	$47,641.56	$ 56,241.48	18.05
Group 6	Foster Care	$ 4,147.92	$ 4,526.59	$79,668.40	NA	NA
Group 7	QMB	$ 6,876.61	$ 8,110.60	$ 7,296.47	$ 7,728.78	5.92
Group 8	Other	$ 378.24	$ 373.47	$ 366.88	$ 355.70	-3.05

Pharmacy

Eligibility Category	Description	2008	2009	2010	Projected 2012	Excluding 2009 % Change 2008 - 2010
20	TEA	$ 731.26	$ 690.45	$ 586.85	$ 458.26	-21.91
25	TM	$ 338.68	$ 336.94	$ 263.65	$ 197.96	-24.92
26	AFDC-EC	$ 1,036.57	$ 893.92	$ 754.98	$ 517.65	-31.44
Group 1	SSI	$ 2,246.02	$ 2,104.41	$ 1,970.34	$ 1,712.68	-13.08
Group 2	AABD	$ 754.30	$ 575.15	$ 591.81	$ 448.94	-24.14
Group 3	PW	$ 157.16	$ 166.27	$ 149.07	$ 141.20	-5.28
Group 4	U-18	$ 21.44	$ 41.50	$ 83.02	$ 180.91	117.90
Group 5	Medically Needy	$ 835.67	$ 812.55	$ 624.45	$ 443.79	-28.93
Group 6	Foster Care	$ 939.95	$ 1,217.14	$ 879.91	$ 821.85	-6.60
Group 7	QMB	$ 198.79	$ 81.65	$ 80.56	$ 12.37	-84.65
Group 8	Other	$ 241.33	$ 257.11	$ 263.32	$ 286.27	8.72

Total

Eligibility Category	Description	2008	2009	2010	Projected 2012	Excluding 2009 % Change 2008 - 2010
20	TEA	$ 8,602.56	$ 7,674.44	$ 8,797.96	$ 8,995.55	2.25
25	TM	$ 2,768.81	$ 2,405.87	$ 3,099.69	$ 3,449.22	11.28
26	AFDC-EC	$17,177.57	$17,516.42	$15,857.76	$ 14,590.68	-7.99
Group 1	SSI	$21,198.39	$22,803.07	$23,272.22	$ 25,442.76	9.33
Group 2	AABD	$28,350.43	$34,821.08	$33,997.02	$ 40,155.01	18.11
Group 3	PW	$12,139.13	$11,652.11	$13,328.22	$ 14,572.84	9.34
Group 4	U-18	$ 1,346.64	$ 4,048.84	$ 4,112.59	$ 8,279.93	101.33
Group 5	Medically Needy	$39,451.46	$39,322.08	$47,127.07	$ 55,483.17	17.73
Group 6	Foster Care	$ 4,714.50	$ 5,274.37	$74,873.83	$206,880.56	176.31
Group 7	QMB	$ 6,874.62	$ 8,107.75	$ 7,292.00	$ 7,721.67	5.89
Group 8	Other	$ 411.56	$ 413.87	$ 405.76	$ 400.00	-1.42

Appendix 1:

GROUP	CATEGORY	DISCRIPTION
	20	Transitional Employment Assistance (TEA)
	25	Transitional Medicaid
	26	Aid to Families with Dependent Children Medically Needy Exceptional Category (AFDC-EC)
Group 1	**SSI**	Supplemental Security Income
	09	PACE with SSI
	13	Aged Individual
	14	Aged Spouse
	33	Blind Individuals
	35	Blind Child
	43	Disabled Individuals
	44	Disabled Spouse
	45	Disabled Child
Group 2	**AABD**	Aid to Aged, Blind, and Disabled
	07	Breast and Cervical Cancer Prevention and Treatment
	08	Tuberculosis – Limited Benefits
	10	Working Disabled
	11	AA Aged
	15	PACE regular
	31	Aid to the Blind
	41	Aid to the Disabled
	49	TEFRA Waiver for Disabled Child
Group 3	**PW**	Pregnant Women
	61	Women Health Waiver- Pregnant Women, Infants & Children Poverty Level (SOBRA).
	62	Pregnant Women Presumptive Eligibility
	65	Pregnant Women No Grant
Group 4	**U-18**	Under Age 18
	51	Under Age 18 No Grant
	52	Newborn
	63	SOBRA Newborn
Group 5	**Medically Needy**	Medically Needy Income Level (MNIL)
	16	AA categorically related with income not greater than the MNIL.
	17	AA categorically related with income greater than the MNIL
	26	AFDC categorically related with income not greater than the MNIL.
	27	AFDC categorically related with income greater than the MNIL.

GROUP	CATEGORY	DISCRIPTION
	36	AB categorically related with income not greater than the MNIL.
	37	AB categorically related with income greater than the MNIL
	46	AD categorically related with income not greater than the MNIL.
	47	AD categorically related with income greater than the MNIL.
	56	Under 18 categorically related with income not greater than the MNIL
	57	Under 18 categorically related with income greater than the MNIL
	66	Pregnant women with income not greater than the MNIL.
	67	Pregnant women with income greater than the MNIL.
	76	AFDC categorically related with income not greater than the MNIL
	77	AFDC categorically related with income greater than the MNIL.
Group 6	**Foster Care**	
	91	Foster Care
	92	IV-E Foster Care
	96	Foster Care Medically Needy Exceptional Category
	97	Foster Care Medically Needy Spend Down
Group 7	**QMB**	Qualified Medicare Beneficiary
	18	Aid to the Aged-Qualified Medicare Beneficiary (QMB)
	38	Aid to the Blind-Qualified Medicare Beneficiary (QMB)
	48	Aid to the Disabled-Qualified Medicare Beneficiary (QMB)
	58	Qualifying Individual-1 (Medicaid pays only the Medicare premium.)
	78	Qualifying Individual-2 (Medicaid pays only the Medicare premium.)
	88	Specified Low Income Qualified Medicare Beneficiary (SMB) (Medicaid pays only the Medicare premium.)
Group 8	**Other**	
	01	ARKids First Demonstration
	69	Family Planning