Project Narrative
Arkansas Level One Establishment Cooperative Agreement

The State of Arkansas was the first state to declare that it will pursue the Federally-facilitated Exchange Partnership (FFE Partnership) Model and maximize the local flexibility allowed under this Exchange Model. The Governor delegated responsibility for planning and implementing the FFE Partnership model to the Commissioner of the Arkansas Insurance Department (AID) and its new division, the Health Benefits Exchange Partnership Division (HBEPD). AID was the grantee for a Planning Grant in the fall of 2010 and a Level One Establishment Grant in February 2012, both outlining steps toward the goal of having a fully functional Exchange for Arkansas residents by January 2014. HBEPD has been successful in meeting grant requirements and engaging numerous and diverse stakeholders. Stakeholder inclusion and a solid consumer focus are strengths of Arkansas's planning process. This Level One Establishment Grant application reports the many successes of Arkansas's Exchange Planning efforts to date and requests funding for continued planning and implementation of Arkansas's FFE Partnership.

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

Existing Exchange Planning and Exchange Establishment Progress

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

Key Findings of Background Research

Over the last eighteen months, AID has overseen research covering a broad range of topics conducted by several different groups and individuals. In 2011, AID contracted with First Data Government Solutions, LP (First Data) and the University of Arkansas for Medical Sciences (UAMS) as primary contractors for Arkansas's exchange planning activities. First Data had three subcontractors, SCIOInspire (formerly Solutia), Powell and Associates, and Arkansas Foundation for Medical Care (AFMC). The latter two are Arkansas-based companies. The UAMS work was performed by Partners for Inclusive Communities, the College of Public Health, and Arkansas Center for Health Improvement (ACHI), home to Arkansas's Surgeon General. In 2012, AID contracted with the University of Central Arkansas (UCA) to conduct a survey and gather additional information about the Arkansas insurance marketplace and coverage needs. We also consulted with actuaries to assess the financial implications of state insurance mandates on alternative essential health benefit (EHB) benchmark plans. Following our initial planning review and

discussions of potential strategies to mitigate the impact of expected consumer "churning" among Insurance Affordability Programs in Arkansas, and at CCIIO's recommendation, AID entered into a small professional services contract with Manatt Health Solutions to look at continuity of care/coverage issues and assist in identifying potential strategies to minimize the impact of churning. Manatt provided HBEPD with three potential options to discuss with the Insurance Commissioner, Medicaid Director and Surgeon General that led to a consensus decision to request funds through this Level One Grant application for Manatt and their subcontractor, Optumas, to do more in-depth research in an expedited manner with a goal of selecting a viable solution option and implementing it in advance of FFE Open Enrollment. Key findings to date follow.

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

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

Numbers of Insured/Uninsured: Arkansas has a large and growing number of uninsured individuals and ranks among the top ten states in terms of uninsured residents (Kaiser Family Foundation (KFF) *State Health Facts (SHF)* for 2009-2010). ACHI estimates that about 17% of Arkansans, or approximately one half million of our State's residents, are currently uninsured. This includes 25% of 18 – 64 year olds. First Data contractors SCIOInspire and Powell and Associates estimate that 587,000 Arkansans, or 20% of our population, will be uninsured in 2013, the year before Exchanges become operational. Of that number 80,000 will be small group eligible and 507,000 will be uninsured individuals.

According to 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 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 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 predict selected coverage variables in 2013, 2014, and 2019 as noted below.

Variable	2013	2014	2019
Number of individuals covered by employer plan	1,103,499	1,018,552	1,006,987
Number of individuals eligible for employer coverage but not enrolled (insured vs. self-insured)	80,000		
Number of small employers not offering health coverage (less than 50 employees)	28,765		
Number of individuals covered by full-coverage and individual major medical plans	544,295	499,264	438,314
Number of individuals in self-insured plans	695,204	641,688	634,402
Number of individuals in mini-med or limited benefit plans	N/A	N/A	N/A
Number of individuals enrolled in Medicaid	682,000	856,641	899,207
Number of individuals enrolled in another public plan including dual eligibles	136,400	171,328	179,841
Number of individuals eligible for Medicaid but not enrolled		70,000	
Number of individuals not insured	587,000	301,106	279,901

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

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

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

Year	2013		2014	
	Insured	**Uninsured**	**Insured**	**Uninsured**
Health status (1)				
Excellent	708,567	167,903	809,100	72,979
Very good	638,817	180,283	742,908	81,435
Good	404,448	168,342	493,155	83,301
Fair	112,976	50,327	139,057	25,291
Poor	56,690	20,145	67,043	10,284

Year	2013		2014	
	Insured	Uninsured	Insured	Uninsured
Household size				
1	853,637	377,122	1,060,378	178,258
2	852,659	163,141	949,550	72,750
3	167,006	34,797	186,868	16,226
4	44,200	9,450	49,232	4,761
5+	3,998	2,491	5,235	1,295
Education/literacy status				
Child N/A	476,145	127,099	550,923	56,182
Not finished High School	235,093	141,897	309,661	69,741
High School graduate	422,860	163,141	512,964	76,788
Some College	405,930	108,639	467,889	49,973
College graduate	258,387	36,115	280,352	16,036
Graduate degree	123,084	10,109	129,475	4,571
Internet access (2)	**2013**		**2014**	
Accesses Internet	1,652,104		1,662,677	
Does not access Internet	1,056,263		1,063,023	
Has access at home	1,706,271		1,717,191	
Has no access at home	1,002,096		1,008,509	

1) Health status is self reported by survey participants

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

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 is 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, HBEPD implemented an MOA 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 are 45 issuers on the AID 2011 list of Individual Comprehensive Health Coverage providers. The top ten issuers on that list account for 97.16% of the Arkansas market. There are 18 issuers on the 2011 list of Small Group Employer Comprehensive Health Coverage providers. The top ten issuers on that list account 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 are active in both the individual and small group markets, 17 issuers were selected for the study.

Market share information was also obtained from the insurance departments of the seven states adjacent to Arkansas (Kentucky, Louisiana, Mississippi, Missouri, Oklahoma, Tennessee, and Texas). Issuers with five percent or more market share in any of those states but not already included were added to the study. From these issuers, any whose service area does 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,
  - 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 Plan Management Specialist and members of the Plan Management Advisory Committee in mid July, UCA agreed to expand the scope of their survey to include additional companies. Their final report is due to HBEPD by September 15, 2012.

Using funds from the Administrative Supplement, HBEPD also entered an MOU with the Arkansas Center for Health Improvement (ACHI) to do some preliminary research on the "churning" issue predicted to disrupt continuity of coverage and providers. 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 is currently studying 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 drafted a brief (See Appendix A) examining Arkansas-specific churn issues and possible options for addressing churn, including pros and cons for each option. The brief also discusses split family coverage issues, including options to address those situations.

Also using Planning Grant Administrative Supplement funds, ACHI is researching quality metrics used by accreditation and other agencies for health plans and will be combining those metrics into a format for comparison. ACHI has also begun reviewing delivery model quality initiatives (patient-centered medical homes, for instance) at the state level for inclusion in comparisons. Ultimately, ACHI will work with HBEPD leadership and others to come to a consensus on what quality metrics to propose for judging health plan quality for plans offered in the FFE in Arkansas (due September 29, 2012). We understand that plan quality will be assessed using national accreditation standards during transition years.

Legal Authority and Governance

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

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

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

- Targeted Survey - Our contractor, First Data, conducted an email survey of the Exchange Planning Workgroups/Steering Committee and 35 members completed the survey. The results reflected the preference for a public trust (quasi-governmental) model with AID as the State oversight agency (78.8%). This finding was affirmed by the Steering Committee and the six Exchange Planning workgroups in follow-up meetings.

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

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

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

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

When CMS identified the option for an FFE Partnership Model, the Governor in December 2011 directed AID to begin planning for an FFE Partnership Model. Arkansas has no current plans to transition to a State Exchange.

Stakeholder Consultation

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

Stakeholder Group	Consultation Strategy
Steering Committee - 2011	Begun in May 2011, a 21-member Steering Committee appointed by the Insurance Commissioner met for two hours bi-weekly to coordinate planning efforts and make recommendations to the Commissioner, legislators and Governor about development of a State-run Exchange. Local and First Data Consultants assumed facilitation duties for the Steering Committee. Meeting summaries can be found on the Exchange Planning website at http://hbe.arkansas.gov/Steering.html. Comprised of two liaisons to each of six workgroups, two representatives of the major contractors (University of Arkansas for Medical Sciences [UAMS] and First Data), Governor's Office, Arkansas Center for Health Improvement (home of AR Surgeon General), AR Department of Human Services (DHS) Director, and two legislators (one Democrat; one Republican), the Steering Committee met until November 15, 2011 when it recommended that efforts to plan a State-run Exchange cease.
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 Interactive Video 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 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

Stakeholder Group	Consultation Strategy
	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 to sites in each of Arkansas's four congressional districts. HBEPD staff was available at each site to interact with attendees before and after the meetings. Both the morning and afternoon sessions were recorded and are available on the HBEPD website at http://hbe.arkansas.gov/. Sessions are being transcribed and translated into Spanish for distribution as needed. Plans are to hold these type town meetings at least quarterly.
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 Agency Health Improvement Leaders	Arkansas Center for Health Improvement (ACHI), home of Arkansas's Surgeon General, convenes a monthly leadership meeting where Arkansas's four major health improvement activities are addressed: Health Benefit Exchange (HBE), Health Information Technology (HIT), Workforce, and Payment Transformation. The Governor's Policy Office, State Agency directors and chief 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 Health Benefits Exchanges, Joel Ario, and Arkansas Surgeon General Joe Thompson, MD, MPH, served as keynoters, addressing HBE development, issues, and progress to date, with time provided for questions and feedback from participants.

Stakeholder Group	Consultation Strategy
Legislative Reports	Insurance Commissioner and HBEPD Staff have formally presented at 13 legislative committee meetings. One-on-one or small group discussions are held as needed to update legislators or answer specific questions. The Project funded one legislator's attendance at the Utah Invitational Exchange Meeting in 2011. Several Legislators attended the August, 2011 NPRM meeting in Denver as DHHS guests.
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. More than 50 presentations have been made to date.
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.

Funding under the Level One Establishment Grant allowed the expansion of stakeholder involvement. On May 29, 2012, the HBEPD staff added an experienced **Consumer Assistance Specialist** to ensure a positive consumer experience, critical to the success of Arkansas' Federally-facilitated Exchange. Sandra Cook's primary focus is on the coordination and development of the various consumer assistance programs, functions and requirements including developmental activities associated with the Arkansas In-Person Assister Program. She began immediately to expand consumer participation among underserved/hard-to-reach populations, including Hispanics, African Americans, individuals with disabilities, Marshallese, Asians, and representation from various geographic locations (Delta area), etc. Ms. Cook developed relationships with UAMS Center for Rural Health's Health Literacy program in order to ensure that training and outreach materials are understandable to populations with low literacy rates. Additionally, she developed relationships with the Arkansas Minority Health Commission to participate in a quarterly health forum designed to educate communities regarding health disparities. The Consumer Assistance Specialist oversees the work of the **Navigator/Consumer Assistance Consultant**, Public Consulting Group (PCG).

PCG contracted with AID to assist in the development of the Arkansas In-Person Assister (IPA) Program. (The scope of work originally specified the Navigator program but was modified after CCIIO clarified that in an FFE Partnership, the Navigator program was CMS' responsibility while the state is responsible for the IPA Program.) The scope of work is to design, develop and implement the Arkansas IPA Program according to the FFE and Arkansas guidelines and requirements. PCG is responsible for developing a project work plan that details approach, staffing, project tasks, quality management plan, communications plan, issues, risks and change control. The three (3) primary areas of responsibility for PCG are: IPA eligibility, certification and training; IPA Entity application; and IPA operations.

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

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

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

- IPA Eligibility Requirement
  - The goals and duties of the program, beyond those required under federal regulation were defined.
  - Brokers and producers were identified as eligible to become IPAs.
- IPA Certification Requirements
  - Standards for certification, re-certification and de-certification were defined.
  - Frequency of certification was outlined.
  - Definitions for conflict of interest and professionally accepted ethical standards were agreed upon.
- IPA Training Requirements
  - Determined training competencies for individual IPAs.
  - Delivery method of initial training, on-going and refresher training defined.

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

An area of expressed concern raised by both the CAAC and PMAC is the potential worsening of already existing **health care provider shortages**, especially in the rural areas of Arkansas. Our policy consultant, ACHI, is studying this issue and recently released a preliminary report (See Appendix B) based on a review of the literature. This report identified specific provider specialties expected to be in greater demand with the expansion of insurance coverage as a result of the Exchange, i.e., primary care, substance use disorder, mental health, chronic disease, and emergency room medicine, and how certain non-physician clinicians—physician assistants and nurse practitioners—might help fill the primary care gap. A recently reported market place study by CCIIO contractor Econometrics suggested only a 5% to 6% use adjusted decrease in Arkansas primary care and specialty physicians and short term, long term, and specialty hospital providers per 1,000 population between 2014 and 2016. Even though these data suggest the provider supply changes will not be as great as some have feared, stakeholders report it is often difficult

for consumers with Medicaid coverage to access care in some areas of the state now. These stakeholders express concern that this Medicaid provider shortage may be exacerbated when more Arkansans have private plan coverage. Discussions of these provider issues have resulted in requests for more study of Medicaid-Private Plan integration issues including an exploration of innovative strategies to assure continuity of coverage and a better alignment of reimbursement rates across Medicaid and QHPs. Based on these type discussions, Medicaid-Exchange Integration Subcommittees have been established from both the PMAC and CAAC. Concurrently, dialogue about potential Medicaid-Exchange integration solutions has escalated among health agency leaders resulting in a collaborative resolve to study these integration issues in the immediate future.

Long-term Operational Costs

As documented in the Arkansas Planning Review Report letter from our project officer dated July 10, 2012 (see Appendix C), "a key risk identified by the Arkansas team was difficulty in maintaining State support of the Partnership Model without clear information on the following topics: long-term operating costs and funding of Partnership functions, use of fees on the FFE…" With the continuing absence of any guidance on these issues, HBEPD has done minimal work to establish the financial management infrastructure for the Exchange in Arkansas.

Cognizant of the requirement that Exchanges must be self-sufficient after 2014, Arkansas's Exchange Planning background research provided a high level estimate of Exchange operational costs and revenues when Arkansas was still exploring a State-based Exchange. Using background research actuarial projections of average premium costs per month in 2014, and applying Arkansas's current 2.5% premium fee to the estimated number of private plan enrollees in 2014, it was estimated that premium fees could be a source of financial sustainability of the Arkansas operated Exchange. The potential for using these fees to sustain Arkansas-operated components of the FFE Partnership has not been addressed. Arkansas awaits federal guidance in determining long-term operations costs and financing options for state-operated functions under the FFE Partnership Model.

Program Integration

A significant portion of the HBE planning effort in 2011 was devoted to identifying opportunities to leverage existing functionality/processes for use in a state-based Exchange. The initial effort cast a broad net to contact state agencies as well as other stakeholder organizations to learn what might be applicable or replicable for the Exchange. The agencies and organizations studied have been involved in Exchange planning activities from the beginning as participants in the HBE Steering Committee and/or the various HBE Workgroups, most notably the State Agency and IT Workgroups. Many of these same entities are also working together on other statewide initiatives such as the Health Information Exchange so were already thinking of opportunities to work together to leverage their resources. The Arkansas's Program Integration Plan created as the result of these efforts is posted on the HBEPD website at http://hbe.arkansas.gov/PIPlan_20110817cc.pdf.

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

Intra-agency integration: We identified that HBEPD will work closely with other divisions of AID in several key areas. First of these is health plan management. Initial planning determined that AID would be responsible for establishing the regulatory and certification standards including solvency standards for QHPs within the state. This will require intra-agency cooperation among the HBEPD, Life and Health, Rate Review and Financial Divisions. AID plans to use SERFF and the federal Health Insurance Oversight System (HIOS) in its Plan Management implementation. AID's Rate Review Division staff will play a key role in the evaluation of the premium pricing structures of the QHPs.

Additionally, it is anticipated that AID's Consumer Services Division's (CSD) Consumer Assistance Program (CAP) will manage complaints regarding health plans, Navigators, In Person Assisters (IPAs) and licensed producers. We are working to develop the Exchange procedures required to assure a smooth, efficient collaboration within AID.

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

Early interagency planning involving leadership of DHS' Research and Policy, County Operations (the Division that performs Medicaid enrollment functions), Information Systems and Medicaid Divisions; the AID Commissioner and HBEPD Director; the Office of Health Information Technology (OHIT); and the State's Department of Information Services (DIS) resulted in a shared Exchange Eligibility/Enrollment strategy using the Access Arkansas portal as the "Exchange Face". DHS issued RFPs for a new MMIS system and rules engine in 2011. Both were "pulled" in November 2011 when the State Medicaid Director resigned. A new Medicaid Director, Andy Allison, began work in Arkansas on December 5, 2011.

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

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

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

With resources afforded by the Exchange Planning Grant, staff from DHS, AID, Arkansas Foundation for Medical Care (outreach and education subcontractor for Arkansas's HBE background research), and the Governor's office attended three User Experience 2014 (UX 2014) planning sessions where broad stakeholder participation helped to design the prototype for first class Exchange user experience. We expect some UX2014 design features will be used for the FFE user experience.

The Arkansas Center for Health Improvement (ACHI) has policy expertise to offer the Exchange and has legislative authority over Arkansas's developing All Payer Claims Database Plus (APCD+) which could potentially serve as an asset in the quality plan rating components of the Exchange. Using Level One Grant funds obtained in February 2012, HBEPD entered into an MOA with ACHI to study the utility of Arkansas's developing APCD+ for FFE

Partnership quality improvement efforts. This work is just now getting underway. Craig Wilson remains the HBEPD/ACHI liaison for this effort and broader policy issues.

One other State department identified as instrumental in the development of the Exchange Partnership is the Department of Information Services (DIS) which has strategic and operational expertise on single point of entry sign-on authentication, customer call centers, state IT architecture, and maximizing mobile functionality (social media). Using Level One grant funds, HBEPD entered into a MOA with DIS for the services of a full time program manager to assist with intra- and interagency and state-federal IT-Program Integration. Carder Hawkins, CPM, is skillfully filling this role and is a tremendous asset.

As previously reported, one particular concern related to a first class user experience and IAP design and costs—both ultimately affecting consumer outcomes-- is consumer "churning" between Medicaid and private QHP coverage through the Exchange. There are no Medicaid managed care plans in Arkansas. Current income eligibility for Arkansas Medicaid is among the lowest in the nation (~17% FPL). Based on research by others and State experience, we expect a significant amount of consumer movement between Medicaid and private plans. It is important that strategies are planned and implemented to prevent disruption of coverage or provider networks with consumer eligibility changes. Background research findings to date have not determined Medicaid costs per various eligibility categories so that cost projections for the expanded MAGI population can be evaluated as a function of projected churning. Claims data from Medicaid and some private insurers have been collected and analyses are expected by ACHI under our consultation agreement by September 2012. More data and analyses are needed so we can address policy alternatives in an expedited manner. We are requesting funds under this Level One Funding Opportunity for further study, strategies development, and aggressive implementation of the selected strategy in time for Open Enrollment, October 1, 2013.

Having identified these opportunities to leverage processes and expertise, the Exchange Partnership staff is methodically detailing each working relationship and creating further interagency agreements designed to enhance the overall operation of the FFE in Arkansas.

Business Operations of the Partnership Model Exchange

Arkansas's Initial Planning Review took place in Bethesda, MD on May 17 and 18, 2012. The Arkansas team led by Insurance Commissioner Jay Bradford and HBEPD Director Cindy Crone was representative of all the State agencies who are working collaboratively to establish the FFE Partnership. Participants included the Arkansas Surgeon General, Joe Thompson, MD, the DHS Director of County Operations, Joni Jones, and assistant director, Linda Greer, the Medicaid Director, Andy Allison, PhD, the DHS IT Director, Dick Wyatt, and representatives from the Medicaid Policy Office (Sheena Olson), the Governor's office (Jennifer Flinn), the AR Department of Information Services (Carder Hawkins) and additional HBEPD support and contractor staff. Prior to the meetings HBEPD submitted the Concept of Operations document and Project Management Plan to CCIIO for review and discussion while on site. Dick Wyatt shared during the meeting DHS' plan for using agile methodology for development of Medicaid's interface with the FFE. The discussions were open and productive. We feel that CCIIO/CMS gained a better understanding of how Arkansas plans to create our portion of the FFE Partnership and the Arkansas team took away from the meeting clearer guidance in some areas (such as Navigators and In Person Assisters) but a growing list of issues still needing CMS guidance such as the state's long-term financial responsibilities. (See Appendix C, letter from State Officer with Arkansas's Planning Review Report.) Subsequent to the Planning Review, HBEPD staff meets regularly by phone with our CCIIO project director and other CCIIO/CMS staff to work through outstanding action items. Planning in 2012 will estimate the cost of Arkansas's IPA and Plan Management programs as we await federal guidance regarding ongoing financial options for the Arkansas-operated functions of the FFE Partnership Model.

Using Level One funds, the HBEPD hired a **Grants/Contracts Specialist** to oversee grants accounting, reporting and the multitude of contracts and MOUs needed for establishing the FFE Partnership in Arkansas. Will Roark was hired in May and is developing financial operations policies and procedures.

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

The Arkansas Insurance Department (AID) entered into a professional services contract with Public Consulting Group, Inc. (PCG) on April 20, 2012. PCG is responsible for assisting AID and the PMAC in developing a project work plan that details the approach, staffing, project tasks, quality management plan, and communication plan, and details any issues or risks with QHP certification, monitoring and oversight. PCG is expected to deliver the following components by February 2013:

- Development of an approach and plan for solicitation of health plan submissions;
- Recommendations on strategies for health plan submissions;
- Recommendations for EHB benchmark plan selection;
- Development of QHP evaluation methodology to include enrollee satisfaction and monitoring of complaints and appeals;
- Development of timelines and criteria development of QHP certification/recertification;
- Development of materials to instruct issuers regarding the processes employed by the Department for health plan certification and QHP monitoring;
- Development of processes and the underlying requirements necessary to evaluate QHPs' ability to support delivery of quality healthcare;
- Development of processes and requirements necessary for QHPs to report on their efforts to ensure quality healthcare is being delivered, and their on-going improvement processes;
- Development of QHP rating system for individual and SHOP plans;
- Development of processes and materials necessary for the education of individual consumers including small businesses about QHPs and quality ratings;
- Establishment of dialog between Arkansas and the NAIC related to QHP certification process;
- Assist AID in securing a list of data requirements that issuers will be required to submit in the certification process;
- Ensure necessary modifications are made to the current software used by AID for plan certification and data submission requirements;
- Development of processes and a strategy for securing the necessary technology to accept additional plan data independent of SERFF; and
- Development of processes for AID to access additional SERFF stored data.

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

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

A week prior to the July meeting, the United States Supreme Court released its decision that would allow states to determine whether they would expand Medicaid without the penalty of losing all existing Medicaid funds. This decision disrupted the original plans of the PMAC, causing the discussion surrounding Active Purchaser questions to be more informative in nature given the recent ruling. The PMAC was able to address the pediatric dental supplement as answers had been received from CCIIO. The Committee voted unanimously to supplement the benchmark plan chosen with the ARKids B (CHIP) pediatric dental benefit that did not include orthodontia. The Committee also voted to approve a recommendation to require QHPs to structure plans to remove the pediatric dental benefit from imbedded plans if the consumer so chose. The second vote was passed with 11 in favor, 6 opposed and 1 abstention.

PMAC meets twice monthly and has made the following recommendations to the Steering Committee:

- EHB Benchmark Plan Selection – The Committee recommended that the largest small group plan in Arkansas be chosen as the benchmark plan.
- Dental plan Substitution – The Committee recommended that pediatric dental benefits be supplemented by using the Arkansas CHIP plan.
- Structure of QHP Plans – The Committee recommended that if a medical plan offered an imbedded plan containing pediatric dental, that it be structured such that the pediatric dental portion could be removed to allow for additional competition within the Exchange.

The Plan Management Specialist assisted in researching what other states have done in order to implement EHB. Arkansas statute allows the state to pass rules to implement federal requirements. Based upon current statutes and our research, the Legal Division and HBEPD crafted an EHB determination rule that would develop a process to support the requirements of the ACA and would take into consideration the process that HBEPD has undertaken to receive community feedback. This (EHB) Rule 103 was published on June 28, 2012. A public hearing was held on July 31, where two individuals presented comments. One of the comments addressed technical corrections and requested limiting the rule to the 2012 EHB determination. Another commenter requested language to address grandfathered plans. The additional language was denied as the state is working to implement an NAIC model rule to address the particular issue that was raised. Another comment requested language to restrict the Commissioner's choice of plans to what was allowed solely under Arkansas law. This was denied because of potential conflicts with federal law. The proposed rule is now slated for legislative review on August 21, 2012.

The ACA has defined certain requirements for network adequacy. The State of Arkansas does not have network adequacy requirements in place, except for HMOs that have this function regulated by the Department of Health. The network adequacy rule is still in the draft phases but is intended at this point to implement eventual requirements both inside and outside of the Exchange.

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

IT Gap Analysis and Exchange IT Systems

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

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

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

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

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

The RFI was posted on June 1, 2012 for information regarding a solution for an integrated grant management and learning management solution for use in the support of an Arkansas Navigator program. Five responses were received by the June 22, 2012 deadline. Further review and action on the RFI responses has been postponed based on additional guidance received from CCIIO following the issuance of the RFI that resulted in a change from an Arkansas Navigator Program to an Arkansas In Person Assister (IPA) program that would include contracting for IPA services to meet the needs of Arkansas consumers. It is expected that the IT solution need as described in the RFI will remain essentially the same other than replacing "grants management" with "contract management". We are currently awaiting additional guidance from CCIIO on the IPA program before procuring IT services in this area. Funds are available from the first Level One Grant award for this effort.

Arkansas is planning to utilize **SERFF** to provide a single point of interaction for Arkansas issuers to submit plans for certification and renewal and for Arkansas state regulators to certify, renew and manage QHPs participating in the FFE partnership. The SERFF role and approach leverages existing systems, assists states in certifying QHPs and facilitates integration. Using existing information technology investment vs. building new technology will mitigate costs and lessen the burden to issuers adapting to a new system. NAIC will increase SERFF functionality that will allow for improved data collection and reporting. Per an Addendum received in June, AID will pay a one-time fee of $84,451 which will cover all costs associated with delivering SERFF functionality to support Plan Management functions for QHPs for the Arkansas FFE Partnership. Funds are available from the first Level One Grant award for this effort.

Organizational Structure

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

With the shift in focus to creating an Arkansas FFE Partnership, HBEPD was repurposed as the division of AID responsible for the planning and implementation of the Arkansas operated services and support associated with a FFE Partnership. The Division is led by a director that reports to the AID Commissioner and is responsible for both state and vendor staff currently engaged for services needed by the Division (See SF-424 Attachment for the Division Organizational Chart). Operational procedures for the division include weekly HBEPD staff meetings to review the schedule of the week ahead as well as completed and pending activities from the previous week. There is also a recurring bi-weekly status report that is completed by all Exchange state and vendor staff and which is further utilized on a bi-weekly status conference call that allows vendors to report on the status of their assigned tasks and provides the entire team with an update of the status across all areas of the HBEPD. The Division's work is additionally monitored through tracking of Action Items, Issues and Risks associated with the aggressive timeline and work plan required for the deadlines associated with implementation.

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

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

The Stakeholder Engagement Model was formally presented on April 4, 2012 when HBEPD sponsored an FFE Partnership orientation to restart the planning process toward the FFE Partnership instead of toward the originally planned state-based Exchange. Representatives from CCIIO (Teresa Miller, Amanda Cowley and Emily Pedneau)

and the Director of DHHS Region VI (Marjorie Petty) participated in the meeting. Key state leaders participating included the Insurance Commissioner, the Surgeon General and the Medicaid Director. Members of the re-constituted Steering Committee and Advisory Committees attended and had an opportunity to review and discuss the new Stakeholder Engagement Model. The model has been in use since that meeting with some revisions to structure the documentation process as members gained experience using it.

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

The **Steering Committee** includes Senior Management representation of the following:

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

Each Steering Committee meeting may include additional invitees, including but not limited to – project team members (includes vendor support staff), subject matter experts/content providers and Advisory Committee members.

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

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

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

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

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

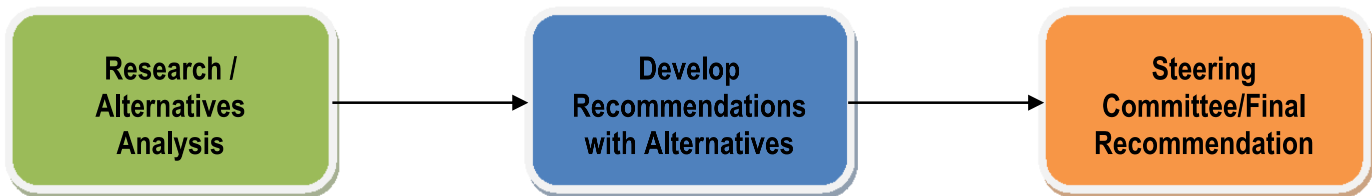
- One co-chair represents Consumer Advocacy (Individuals and/or Small Business);
- One co-chair represents the Health Insurance Industry (Issuer/Producer/Broker); and

- One co-chair represents the Healthcare Community (Provider and/or Quality).

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

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

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



Reuse, Sharing and Collaboration

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

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

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

- Forum #1 brought together more than 30 states and CCIIO/CMS to discuss the development of Health Insurance Exchanges and potential use of SERFF in Plan Management. NAIC provided a demonstration of

SERFF functionality as it worked currently and preliminary mock-ups showing how SERFF might be modified to support Plan Management.

- Forum #2 was to continue and expand on the discussion on Health Insurance Exchanges and the role of SERFF in Plan Management.
- Forum #3 involved the SERFF Plan Management project team and provided updates on project timelines, progress on analysis and design, and plans for implementation and training. NAIC staff provided an overview of key areas of Plan Management: 1) QHP Certification; 2) Issuer Account Management; 3) QHP Oversight; and 4) QHP Renewal/Certification/Decertification.
- Forum #4 was where NAIC staff provided updates toward leveraging SERFF for Plan Management functions related to the health insurance exchanges. Presentations were: 1) Updates to the project timeline and scope; 2) Enhancements planned for a summer 2012 release; 3) An update on efforts to achieve uniform data sets for Plan Management; 4) The critical path for SERFF in Phase 1, and information related to Phase 2 functionality; and 5) A panel discussion with CCIIO, the states and issuers.

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

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

HBEPD has had an opportunity to study the business model flowchart of the certification process in a FFE model. It presents a high level overview of the process flows of a QHP as it initiates from Insurer into SERFF to HIOS and finally up on the federal exchange portal. NAIC is working closely with CCIIO to define special needs and requirements for FFE and Partnership Exchanges using SERFF for QHP Certification. SERFF will allow states to individualize data collection and processes.

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

The HBEPD and CSD-CAP staff are committed to working collaboratively to expand CAP efforts in preparation for 2014 Health Benefits Exchange implementation. Coordinated efforts will focus on outreach education, complaints

resolution, and data collection/analysis to inform Exchange planning/implementation and health insurance system improvements at all levels—consumers, carriers, producers, and providers.

Program Integrity

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

AID has in place an accounting and financial department that is strictly governed by existing state policy. Arkansas audit procedures are performed yearly and are implemented to insure that no one person or position has sole authority to receive, process, and make payments. These policies are in force to provide an effective and efficient system of checks and balances. Additionally, Level One Grant funding has allowed us to hire a Grants/Contracts Specialist dedicated to the financial management of the federal grants accorded under ACA. Will Roark was hired to fill this position in May, 2012. He is currently leading the effort to develop HBEPD specific policies and procedures to supplement and provide adequate checks and balances to our existing AID accounting office. The Grants/Contracts Specialist is tracking and reporting all expenses, receivables, and expenditures in collaboration with the AID accounting office. Individual DHHS grants are tracked by specific grant identification and account numbers so that expenses, payments and draw-downs are separately and appropriately accounted for and reported.

Affordable Care Act Requirements

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

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

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

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

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

Minimum Loss Ratio (MLR) - As MLR filings are made with AID, the RRD will process all MLR filings utilizing its recently developed MLR tracking program to effectively monitor these filings. RRD will verify the issuers' calculations

of rebates, or lack thereof, and ensure that all rebates are made in the required time frame and in the proper amount. MLR tracking is essential for accurate review of all rate filings. In August 2012 Arkansas consumers were awarded $7.8 million in rebates. No further action is required.

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

Other ACA requirements:

- AID issued Rule 102 which required all carriers in the individual market to offer a child only policy. AID also began review of all policies to insure that any pre-existing condition provisions do not apply to anyone under age 19.
- AID will not approve any policy that does not comply with the ACA requirement that coverage be extended to children to age 26 on their parents' policy.
- AID adopted Rule 76 entitled "Arkansas External Review Regulation" which puts in place the NAIC model rule, thereby complying with the federal regulation regarding external review.

SHOP

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

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

Our Exchange Planning Steering Committee recommended a targeted outreach education effort in the fall of 2011 to small businesses. This was needed to counteract negative messages aimed at business owners. The HBEPD entered into a contract with ACHI/UAMS to design an education program targeting small business owners. The design work is complete and catchy, positive radio and print media ads were to be launched in October 2011 using Exchange Planning funds. However, the ads were delayed due to Legislative objection. We are now planning to run the ads in the fall of 2012 using already awarded Level One funds.

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

PROPOSAL TO MEET PROGRAM REQUIREMENTS

Building on the work of the last almost two years and using funds provided by our Planning Grant (awarded 9/30/10 with Administrative Supplement awarded 3/8/12) and Level One Grant (awarded 2/22/12), the HBEPD is making steady progress toward implementing the FFE-Partnership model for Arkansas. Some activities (primarily early research) have been completed and are providing state-specific information. These activities are discussed in detail in the previous section of this document. Other activities such as re-working of our web page and many

outreach and awareness activities are just getting underway. Delay is related primarily to delayed State Legislative approval for spending the Level One Grant funds.

Arkansas chose to explore implementation of the FFE-Partnership model because it allows local development and oversight of the Exchange activities that most directly interact with Arkansans and the insurance carriers who do business in our state. From the onset of our planning efforts, we devoted much of our energy and resources to interaction with a wide range of stakeholders and consumer groups. As we continue to nurture and grow those relationships, HBEPD feels that we are well positioned to represent and assist Arkansans as they negotiate the new Health Insurance Exchange landscape.

Arkansas Insurance Department (AID) has a long, successful history of working with and regulating our insurance issuers. We are building on these relationships and regulatory structure as we define our EHB benchmark and the criteria for QHP certification that are compliant with state and federal regulations and in the best interest of our consumers. Throughout all our efforts we are working closely with our sister state agencies, our CCIIO project officer and others at CCIIO, CMS and DHHS to assure adequate, timely collaboration with our Federal partners.

As we have learned more about the challenges Arkansas faces and the requirements of the FFE Partnership, we have identified the need for additional resources to increase the HBEPD staff, continue utilizing valued consultants, engage new consultants as needed for specialized research, expand targeted outreach activities and develop the infrastructure needed to create, operate, monitor, and improve a statewide In Person Assister (IPA) program and Arkansas QHP certification and monitoring program. Through this Level One Grant application, Arkansas is seeking funds for identified needs to continue implementation activities in two specific areas of the FFE Partnership: 1) Consumer and Stakeholder Engagement and Support, and 2) Plan Management.

Working together to develop the FFE Partnership Model for Arkansans, we are confident that DHHS and Arkansas can and will develop an efficient, user-friendly health benefits exchange partnership that meets our mutual goal of increasing health insurance coverage of low and moderate income Arkansans by making quality, affordable plans easily accessible.

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

Current Exchange Pathway

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

Partnership Activities

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

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

Plan Management Activities – The shared business functions of certifying, renewing and managing the QHPs available through the FFE in Arkansas are elements of Plan Management and will be the responsibility of the state in the FFE Partnership. State regulators and insurers need an efficient, effective and compliant means to submit and review health plans for certification and inclusion in the FFE. Currently, AID uses the National Association of Insurance Commissioners (NAIC) System for Electronic Rate and Form Filling (SERFF) to support handling of insurance policy rate and form filings from Arkansas' issuers.

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

HBEPD staff is in continuous communication with NAIC, monitoring the progress of their SERFF modifications, participating in their user forums and making plans to test the changes at the appropriate time. Funds to support the use of SERFF were included in the Level One grant awarded February 2012 and appear sufficient to meet Arkansas's needs.

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

- The addition of a full time staff position in the role of **Insurance Compliance Officer**. Using the certification criteria established for QHPs and the rules promulgated by AID and CCIIO, this person will review each plan applying to be a QHP and offer products on the FFE. S/He will be the lead user of SERFF within the Division and the one with primary responsibility for uploading an approved, certified plan to the FFE. S/He will also monitor plan performance, participate in recertification activities and, as needed, decertification activities for all plans available to Arkansans via the FFE. This position will work under the direction and supervision of the Plan Management Specialist.
- The continuation of **Plan Management consultation** services being provided by Public Consulting Group (PCG) – As discussed earlier in this document, PCG has provided extensive consultation to HBEPD and in particular the PMAC in the form of issue briefs, facilitated sessions in person, conference calls and meetings with CCIIO/CMS. Their current contract under the previous Level One Grant was for planning how Arkansas could best implement the Plan Management activities of an FFE Partnership. AID would like to continue PCG's contract to maintain continuity and their expertise as we now implement the plans that have been made. Under this new contract PCG will:
    - *Facilitate Qualified Health Plan Technical Assistance Workgroup* to be formed in March 2013 for the purpose of serving as an interface between issuer administrators who are representing QHPs and AID staff. Scope of the workgroup will include responding to questions about the QHP application process and rules governing the QHP process, facilitating meetings bringing together

AID and QHP staff, troubleshooting issues as the Arkansas FFE Partnership approaches launch date, and assisting AID with ongoing QHP launch planning and readiness assessment;

- *Assist AID in Development of Operational QHP Policy and Procedures* to updating AID publications and bulletins as necessary. PCG will assist AID staff by identifying QHP requirements that need to be reflected in agency publications. PCG will then assist with the drafting and review of the materials to assure compliance with federal rules and Arkansas Partnership policy.
- *Prepare a QHP Implementation Review tool* for reviewing the short and longer term success of the QHP launch. This will involve review of the stages of design and development to assure goals and objectives of these phases were met. Further, PCG will prepare tools to measure consumer satisfaction with the QHP process, both in terms of clarity of information provided about the QHPs and the ease of identifying and selecting optimal plans. The purpose of designing these tools before launch will be to have them ready for immediate assessment of the QHP process from Day 1 launch forward in order to gather feedback in time-sensitive ways.
- *Assist with Design and Development of QHP Account Management Functions***.** CMS has indicated that each QHP issuer that participates in an FFE will be assigned an account manager responsible for day-to-day support, technical assistance, and communication. Account managers will work with State departments of insurance as needed to address issuer questions and problems. PCG will work with AID to help establish the right account management functions for the Arkansas FFE Partnership. PCG will further assist in identifying ongoing account management functions, including documentation and approval requirements for plan updates and response chains for categories of QHP inquiries. PCG will assist in developing resource strategies to fulfill account management functions.

Navigator Program – Preliminary direction from CMS is that the state will have a role in supporting, administering and overseeing (as applicable) aspects of the FFE Navigator program. Pending more definitive guidance, HBEPD has chosen to focus resources in other areas. We are committed to coordinate Navigator program functions with those of the state's IPA program (see below) in our efforts to have a seamless service for consumers, avoid costly duplication and enroll as many Arkansas residents as possible.

In Person Assister (IPA) Program – HBEPD is working closely with CCIIO to fully understand the role of the State IPA and to develop the IPA program for Arkansas that will complement the FFE Navigator program. While awaiting the final guidance from CMS, we have gleaned enough from conversations with CCIIO staff to guide our CAAC in the planning for Arkansas's IPA program. As discussed previously in this document, under the leadership of the CAAC, the Consumer Assistance Specialist and PCG consulting staff, HBEPD has carefully deliberated the many facets that will make up Arkansas's IPA program, including the strengths we have from past experience (particularly outreach and enrollment efforts for our successful ARKids First program, which has resulted in 90% of Arkansas's children being covered) and challenges we face. Using previous research, we know where the uninsured live in the state and have taken that into consideration when designing our program. After much debate and discussion, we have arrived at a defined set of qualifications for both those entities that AID will contract with to provide the IAP service as well as the qualifications for the individual IPAs who will be working for the IPA entities and interacting with the consumers. We have determined the certification requirements and training competencies required of each IPA.

Given the magnitude of this state-wide undertaking and the short window of time to get the program totally operational, HBEPD must increase its in-house staff and consultant contracts to administer, direct and monitor the program.

AID is requesting **five new full time positions** to be created within the HBEPD to work under the direction of the Consumer Assistance Specialist and be fully allocated to the IPA program:

- **IIPA Contract Lead** whose time will be totally focused on the program, its design, implementation, recruitment of contractors (IPA entities) and continuous monitoring. This individual will establish and maintain lines of communication with the AID Consumer Assistance Program (CAP) and the FFE Call Center to assure "warm hand-offs" as appropriate and that any reports regarding IPA performance are investigated to resolution.
- **IPA Education Lead** to assure the development and deployment of the prescribed IPA education to each IPA entity and individual, and oversight of the certification process. S/He will also be responsible for development and deployment of any required continuing education throughout the life of the IPA program. Monitoring IPA recertification will also be part of this person's responsibility.
- **IPA Contract Monitors (2)** will oversee the contracts between AID and each of the IPA entities (see below). This role includes training new contracting entities on program matters, including the proper way to invoice for services, the submission of required reporting, and opportunities for amending contracts if needed. They will work for the IPA Contract Lead but also closely with the HBEPD Grants/Contracts Specialist.
- **Administrative Assistant** to assure the IPA unit runs smoothly by facilitating the flow of information and paper.

The additional staff noted above will focus on the mechanics of the implementation – obtaining adequate numbers of IPAs in the correct areas of the state, assuring training and certification, paying invoices for services rendered, required reporting and complaint investigation.

In addition to the new staff positions dedicated to the developing IPA Program, Arkansas proposes to accomplish a significant portion of IPA start-up teaching, support, supervision, and direct IPA service implementation through **professional services contracts** listed below. These contracts will be awarded according to state procurement rules via RFP or MOUs.

- *IPA Specialists:* To promote community education/facilitation and to function as an additional AID-local community liaison resource for local IPA entities serving difficult cases, AID is requesting funds to enter into an MOU with the Arkansas Health Department (ADH) for the creation of IPA Specialists. Arkansas's 75 counties are divided into five (5) health regions by the Department of Health (ADH). Each county has a "Home Town Health" Program where local business and professional residents team with local consumers to identify local health needs and work toward collaborative solutions. The Home Town Health programs are supported by ADH. AID will contract with ADH for IPA Specialists who will live in the region served and, primarily through the local Home Town Health infrastructure, seek to "personalize" Exchange education to the 75 counties. Using materials developed by the Outreach/Education contract, and personalizing to local communities as needed, the IPA Specialists would seek speaking engagements within local civic and church entities to educate communities and targeted consumers about the Exchange and connect consumers with certified IPAs. The IPA Specialists would begin work six months ahead of IPA entity contracting and would, in the early days, also assist with recruiting and/or meeting potential IPA entities to be funded through State contracts. Contracting with the Arkansas Department of Health would allow this work to begin much more quickly than if we use the state's (4 month minimum) Request for Proposal procurement process, as an interagency agreement allows immediate contracting upon agreement between the two State agencies. Each Health Region would have a full-time IPA Specialist. Two regions (Central and Northwest) have a greater population; therefore we are asking that each of those regions employ 1.5 FTE IPA Specialists for a total of 6 FTE IPA Specialists statewide. The IPA Specialists would receive direction from AID's Consumer Assistance Specialist and IPA Training Lead.

This approach would allow us the ability to have more state administered support for all of the IPA entities but to not have these positions added as permanent staff positions. Current consensus is that the need for IPAs will reduce after year one and that there may not be a need for the Regional IPA Specialists on an ongoing basis. This need will be monitored, however, for possible contract extensions of the positions or the adding of positions as permanent staff in future grant requests as appropriate.

- *IPA Training:* Arkansas believes that **training for both IPAs and for agents and brokers** will directly impact the effectiveness of the IPA program. The Arkansas CAAC recently recommended a training curriculum that identified specific areas of training needs, organized into seven major categories:
  - Understanding the FFE Partnership and what it means for Arkansans
  - Consumer Privacy and Confidentiality
  - Qualified Health Insurance Plans – for both the individual market and for SHOP –in the FFE Partnership
  - Tax Credits and other Cost Reductions available to consumers
  - Medicaid and ARKids First
  - Understanding Your Audience
  - Post Enrollment Support

  This extensive library of knowledge will need to be organized and delivered in a manner that will effectively communicate key information to IPAs, brokers, and agents. Different types of IPAs may need different modules. The information will need to be delivered via a combination of in-person, online, and video conference training and prepare IPAs to pass competency requirements for IPA certification.

  The successful development and delivery of this comprehensive training curriculum will be critical to the ultimate success of FFE enrollment. We estimate a large portion of training costs will be for development of on-line training programs. Arkansas estimates $2,500,000 will be needed for **IPA Training** of the more than 600 initial IPAs, supervisors and other staff in Arkansas. Since much of the developed IPA content can also be utilized to train agents and brokers on the FFE, Arkansas requests only $500,000 for training producers and agents licensed to write health insurance policies in Arkansas and desiring to sell insurance products in the FFE. Therefore, the total training estimate is $3,000,000. Both contractors will need to coordinate training content and certification requirements with AID and the FFE Navigator and SHOP Programs. See budget detail.

- *IPA Entities:* Based on Arkansas's IPA program design and recruitment planning by the CAAC and its subcommittees, Arkansas is poised to recruit, train, support, and monitor a diverse workforce of IPAs to facilitate enrollment into the FFE. We envision that the number of IPAs will increase or decrease according to Open Enrollment Periods. For example, we estimate 535 IPAs will be needed statewide for the first Open Enrollment Period and 134 IPAs will be needed statewide beginning April, 2014 and until the next Open Enrollment Period when more IPAs will be needed. We anticipate that each Open Enrollment period will require fewer and fewer IPAs as consumers become more confident and experienced with enrollment. While approximately 25% of IPAs will be full time, year-round workers, we estimate that a large group of IPAs will be temporary or part-time workers, something like "well-trained census workers".

  Under our model, certified IPAs will be affiliated with an IPA entity that will contract with AID for IPA funding. The IPA contract entities will be accountable for IPA contract deliverables, including engaging IPAs, ensuring training/certification, and supervision and support of individual IPAs. IPA Entities will apply for IPA funding specific to the population (number and demographics) they plan to serve. IPA Entity cost projections are based on hourly IPA pay of $12 per hour and IPA Supervisor pay of $16.50 per hour. IPA entities will also be paid for fringe benefits, organization overhead (including wireless fees and equipment costs for

laptop computer and smart phone), and travel costs for IPAs and Supervisors. See budget narrative for detail including Arkansas's request for IPA funds for the June through September 2013 time period. We expect to request IPA funding for the initial Open Enrollment period and remainder of first year IPA contract costs in subsequent funding requests.

HBEPD requests funding to **contract with IPA entities** throughout the state to provide IPA services through the time period of this Level One Grant application. Our timeline calls for contracting with the IPA entities by May to insure that individual IPAs are in place and ready to participate in training by July, 2013. We expect to have IPAs "on the ground" performing targeted work in communities across Arkansas between July and October, 2013 to educate Arkansans about the FFE and the upcoming Open Enrollment period. These workers will then have initial relationships and experience to facilitate actual enrollment during the initial Open Enrollment period October 2013 – March 2014.

HBEPD projects IPA costs for the initial Open Enrollment period based on estimates that 210,000 (60%) of the 350,000 non-Medicaid eligible uninsured individuals in Arkansas will seek or receive IPA assistance to enroll through the FFE. We estimate that, on average, each enrollment will take 2.25 hours to complete (including travel time). This creates a need for 472,500 hours of IPA assistance during the six month initial Open Enrollment period (210,000 X 2.5 = 472,500). Assuming that IPAs will be "productive" 85% of the time (34 hours per week), this equates to the need for 535 full time equivalent IPAs for Open Enrollment (472,500 hours needed/34 hours per week IPA productivity/26 weeks = 535). It is further estimated that each IPA will require 1.5 hours of supervision per week, resulting in the need for 24 IPA Supervisors during Open Enrollment (26 weeks X 1.5 hours/week X 535 IPAs X 1.15 [.85 productivity] = 24). Following March, we estimate the number of IPAs and IPA supervisors will decrease by 75% to 134 IPAs and 6 supervisors.

IPA contract entities will be expected to provide multiple methods for enrollee participation and these methods are expected to include a variety of group sessions and individual sessions, in both public and private venues, tailored to the geographic, cultural, physical and mental health needs of the consumer audience they are responsible for serving. Inherent within these expectations is the need for efficient scheduling to ensure IPAs are able to meet the volume expectations for their defined population. We will work with IPA entities to efficiently schedule appointments and travel to minimize both mileage and travel time.

One last needed component of the IPA program is **continued consultation by Public Consulting Group**. Their knowledge has been invaluable to the CAAC and HBEPD needs them to continue working with that advisory committee with particular emphasis on recruiting IPAs and IPA entities to participate in the program. PCG is also committed to working with HBEPD and CCIIO on the integration of the state IPA and the FFE Navigator programs. This could include at least the development of state protocols and the validation of communication channels. Further, we plan to monitor others' IPA development activities and gain additional insight from local advocates and national ones, such as *Enroll America*.

Eligibility and Enrollment Interface with the FFE – HBEPD staff is monitoring the work of the State DHS and the Medicaid agency as they have taken the lead on this FFE Partnership activity. The state is committed to a "no wrong door" approach. If/When HBEPD needs to take a more active role to assure that consumers have a seamless experience, we are prepared to do so.

Research and Implementation of Solutions Designed to Support Continuity of Coverage/Care. The implementation of the ACA in Arkansas is expected to trigger an unprecedented expansion of health insurance coverage for adults in the State through expanded Medicaid and new premium tax credits to subsidize coverage purchased in the Federally Facilitated Exchange (FFE). Assuming the state goes forward with the Medicaid

expansion allowed under ACA, as many as 250,000 Arkansas residents will be eligible to enroll in the expanded Medicaid program in 2014 and thereafter – a 40% growth in enrollment--and an additional 211,000 people are expected to access private QHP coverage through the FFE, most with federal PTC subsidies. Many of these Arkansans will have gained health insurance coverage for the first time in their lives.

As has been earlier reported in this document, Arkansas Medicaid today is primarily a fee-for-service program. The State has begun to initiate reimbursement and delivery reforms across the Medicaid, Medicare and private sector markets, including payment for bundled episodes of evidenced based care delivered through Primary Care Medical Homes. However, the current fee-for-service reimbursement model creates little incentive among providers to manage care or costs, and maintains a volume driven financial incentive typical of fee-for-service reimbursement models. Further, provider reimbursement rates in Arkansas Medicaid overall remain low, resulting in poor provider participation and, therefore, limited access to some specialties. Provider access problems are particularly acute in rural areas of the State.

The anticipated increase in the number of residents with access to health insurance coverage presents Arkansas with both a challenge and an opportunity. The State seeks to meet the challenge and exploit the opportunity by aligning its purchasing strategies across Medicaid, ARKids First and QHPs, so that individuals and families have continuous access to the same plans, products and providers that meet consistent standards of quality and efficiency. The State intends to evaluate the possibility of achieving this goal by certifying a core set of health plans to serve the non-elderly, non-disabled Medicaid and ARKids First beneficiaries as well as consumers purchasing coverage in the Exchange.

We are requesting funds through this Level One Grant Application to obtain additional research and to implement strategies to mitigate negative impacts of consumer "churning"—the expected movement by a large percentage of low income Arkansans among the various Insurance Affordability Programs (IAPs)—in time for Open Enrollment, October 1, 2013. If we were to do so, the State could achieve key policy and reform goals including:

- Leveraging our purchasing power to drive cost-effective premiums for Medicaid and individual market products;
- Aligning quality improvement and measurement initiatives across the government and a large portion of the private insurance market;
- Implementing innovative payment and delivery system reforms;
- Minimizing churning and maximizing continuity of coverage and care by permitting families with both public and private coverage and individuals whose income shifts to stay in the same plans, accessing the same providers.

We have spent the past several months working to define the scope of this work and agreeing to the aggressive timelines necessary to achieve the needed results in time for FFE Open Enrollment in October 2013. We have identified a contractor team singularly qualified and experienced to assist in this critical work *in the timeframe needed.* Further, the identified team led by Deborah Bacharach of Manatt Health Solutions and Manatt subcontractor Steve Schramm of Optumas has the trust of federal and state officials key to approval of resulting innovative designs.

The contractors will assist Arkansas with development and implementation of an integrated continuum of health insurance coverage for Arkansans who are eligible for Arkansas IAPs: Medicaid, ARKids First (Arkansas' Child Health Insurance Program), and premium tax credits (PTCs) or other cost sharing reductions available through Qualified Health Plans (QHPs) in the FFE. Through this 12-month project, beginning in October 2012, the State will: (a) conduct a rigorous policy, legal, actuarial, fiscal and operational evaluation of three coverage integration options; and, (b) select and implement a model for integrating Arkansas's IAP coverage continuum. These options are:

- QHP Model (Arkansas Medicaid Agency contracts with select QHP issuers to enroll Medicaid/CHIP eligible consumers in QHP products. Under this model, consumers eligible for Medicaid/CHIP will be able to enroll in the same QHP products as do consumers eligible for PTCs to purchase coverage in the Exchange—most likely the lowest cost and second lowest cost silver plans offered. They would receive the EHB package, supplemented by rider coverage purchased on their behalf by Arkansas Medicaid from the QHP issuer for Medicaid services required over and above the EHB (e.g. non-emergency transportation, EPSDT services). Alternatively, some or all of the additional coverage could be provided on a fee-for-service basis outside the QHP. The Medicaid program would pay QHP and any rider premiums directly to the QHP issuer to cover the cost of benefits and supplemented to pay the cost of consumer cost sharing, consistent with the actuarial value for the State's Medicaid project (i.e. to ensure co-premium and consumer cost sharing consistent with Arkansas Medicaid program requirements).

- Medicaid Product Model (Arkansas Medicaid Agency contracts with select QHP issuers for a Medicaid product to be offered to Medicaid/CHIP consumers.) As an alternative, the State will evaluate a model through which Arkansas Medicaid will contract with some or all QHP issuers to provide Medicaid products in which non–elderly, non-disabled Medicaid eligible consumers will be able to enroll. Consumers determined Medicaid eligible would be able to shop and enroll in a Medicaid product in the Exchange. The products would reflect Medicaid benefits and consumer cost sharing requirements established by Arkansas Medicaid and meeting Medicaid's requirement for benchmark benefits for the new adults group. In implementing this option, the State would seek to align and standardize, to the greatest extent possible, Medicaid and QHP product requirements including provider networks, benefits, and quality and reporting obligations. One issue we would need to consider is whether plans will pay lower rates to providers in their Medicaid network and the implications of lower rates for continuous access to care for enrollees whose incomes fluctuate above and below 138% of the FPL and for families with a mixture of public and private coverage.

- Bridge Plan. A potential "add-on" to the Medicaid Product Model above would be for QHP issuers offering Medicaid products to also offer a "Bridge Plan" for families with members in both public and private coverage and individuals who move between public and private coverage. This Bridge Plan would enable these consumers to stay in the QHP, thus avoiding potential changes in provider networks, benefits and cost sharing. We would examine the Tennessee Bridge Plan (for which CCIIO approval is expected shortly) and variations being explored by other states (e.g., Washington).

The identified scope of work includes:

- Convening internal and external stakeholders;
- Conducting legal, policy and operational analyses;
- Completing a comprehensive actuarial analysis including fiscal implications for State Medicaid and consumers;
- Engaging CCIIO and CMCS;
- Selecting a model for integration; and,
- Planning for implementation.

Important to Arkansas's needs, this scope of work includes actuarial analyses to be conducted from both a demand perspective and a provider capacity perspective. The analysis from the demand perspective will address estimated participation in the FFE in Arkansas and evaluate the unique risks that subsets of this expanded population may have. The analysis from a provider capacity perspective will address the issue of provider access, given the consumer population expansion under HBE, for various provider types throughout the differing regions of the State.

Following evaluation and selection of its coverage integration model, the State and its contractors will commence an aggressive 8-month implementation period to operationalize the State's integration approach in tandem with Exchange Open Enrollment in October 2013. To implement the IAP integration plan, the State will, depending on which integration option it selects:

- Develop an integrated plan for contracting and oversight operations by Arkansas Medicaid and the Arkansas Insurance Department (AID);
- Ensure operational integration with State Medicaid, AID and the FFE;
- Develop memoranda of understanding between and among State Medicaid, AID and the FFE;
- Develop the Medicaid benchmark benefit and obtain Secretary approval;
- Determine a mechanism for delivering required benchmark benefits (beyond those otherwise included in the QHP benefit) in an integrated coverage model (i.e. rider versus fee-for-service mechanism);
- Create Medicaid plan standards and requirements;
- Draft a Medicaid plan model contract; and,
- Effectuate integrated plan solicitation and contracting.

Consumer Outreach and Education – This is an area where we have not made as much progress as we had hoped. Early efforts at general outreach activities (radio ads, print media) in the fall of 2011 were stopped following opposition by state legislators, and essentially put on hold until after the Supreme Court's ruling in late June. We are now moving ahead quickly to establish branding for the Arkansas FFE Partnership (to be available by September 30, 2012) and to revitalize and expand a media campaign aimed as general awareness and combating misconceptions and fears that have been voiced by many consumers. Branding activities are supported by the remaining funds in our Planning Grant. The extensive statewide media campaign being planned will be supported by funds in the Level One Grant we received in February 2012. These activities are being accomplished through MOUs with other state agencies with the proven resources and networks to do the job.

We have also identified the need for **video conferencing and live streaming capability** for our Town Meetings. We used this technology compliments of the University of Arkansas for our July 18, 2012 Town Meetings. However, going forward we will need to manage this within HBEPD. We are planning one Town Meeting per quarter and have included $25,000 to support video conferencing at seven sites and live streaming of morning and afternoon sessions each quarter. This technology also allows recording of the sessions to post on our website for any stakeholders who wish to view at their leisure.

As we ramp up our outreach activities, we have identified the need for a full time **Communications Specialist** for HBEPD and are requesting funds for that position in this Level One Grant application. The individual selected will have dual roles within the Division. First s/he will work closely with local, regional and national media outlets to provide timely responses to media requests as well as perform writing and editing duties relative to major communication projects in the Exchange. In the second role, this person will oversee the outreach activities related to the FFE Partnership with particular emphasis on development of social media strategies and the campaign described below that is being designed to support Open Enrollment. The Communications Specialist will report directly to the HBEPD Director and assume a senior leadership position in the Division.

In preparation for Open Enrollment October 1, 2013, we are requesting funds via this Level One Grant for an **outreach campaign targeted at uninsured Arkansans**. We plan to approach the state's uninsured in two ways – media saturation and direct mailing to those identified as uninsured. Given the population we are targeting and the rural nature of our state, we will allocate a substantial amount to do advertising in small local weekly newspapers and via local radio and television. We have learned that our statewide newspaper is not readily available in outlying areas of the state but local weekly newspapers are plentiful and present a better advertising venue. We will also use billboards, radio, television and all available forms of electronic media to get the word out. We plan to improve our

social media skills and presence. Additionally, we plan to do at least three direct mailings to more than 200,000 non-Medicaid eligible households regarding their opportunity to enroll for health insurance through the FFE. We will contract with an expert communications agency to create materials for these mailings as well as for the IPAs to distribute as they make their way around the state. Efforts will be focused on getting the uninsured or underinsured to enroll.

Strategy to Address Early Benchmarks

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

As discussed earlier in this document, HBEPD conducted an extensive operational gap analysis or the "as-is" services and capacity of existing State activities compared to the activities required for Exchanges. We also conducted an IT gap analysis of the "as-is" systems. Subsequent to these activities the decision was made to pursue the FFE Partnership model rather than a state-based exchange.

Likewise, in 2011, HBEPD conducted an actuarial and market analysis. As noted earlier, we continue to do market research through an MOU with the University of Central Arkansas (UCA) and through our Plan Management and ACHI consultants. We plan to expand our market analysis through this requested funding by studying provider capacity and expected costs of the newly insured populations based on health status (Optumas via Manatt).

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

The one benchmark where there has been little activity is long-term operational cost analysis and the development of a sustainability plan. We await guidance from CCIIO/CMS needed to identify what the state's long-term operational cost responsibilities will be.

Organizational Structure

The HBEPD is a division of the Arkansas Insurance Department (AID) and is responsible for the planning and implementation of the Exchange operated services and supports associated with a FFE Partnership. The Division consists of a director that reports to the AID Commissioner and is responsible for both state and vendor staff currently engaged for services needed by the Division. Operational procedures for the division include weekly Exchange staff meetings to review the schedule of the week ahead as well as completed and pending activities from the previous week. There is also a recurring bi-weekly status report that is completed by all Exchange state and vendor staff and which is further utilized on a bi-weekly status conference call that allows vendors to report on the status of their assigned tasks and provides the entire team with an update of the status across all areas and interdependencies of the HBEPD and contractors. The Division's work is additionally monitored through Action Items, Issues and Risks associated with the aggressive timeline and work plan required for the deadlines associated with implementation.

HBEPD utilizes a network of MOUs with other state entities to access information, supplement Division staff and enhance opportunities to communicate Exchange information to the broadest possible audience. These include the Arkansas Center for Health Improvement (ACHI), the Arkansas Department of Human Services which encompasses Medicaid and County Operations, the Department of Information Services which provides an IT project manager and several of the state's universities. HBEPD also has agreements with other AID divisions to provide assistance including Rate Review, Life and Health and Consumer Services.

Using funding from this Level One Grant, HPEBD will increase staff from seven FTEs to fifteen FTEs over the next few months. This will change the focus of the Division from a planning mode to one of implementing the plans that have been made. As discussed above, one new FTE is in the Plan Management area, five FTEs are in the Consumer Assistance area to implement the IPA program and one new FTE is a Communications Specialist.

HBEPD has identified the need to add a **Division Operations Manager** to be responsible for planning, directing and coordinating operations by formulating policies, managing daily operations, and planning the use of materials and human resources. HBEPD is a new division with new staff created within AID specifically to implement the FFE Partnership. This position will be the focal point for establishing standard operating procedures for the Division while coordinating staff resources to assure collaboration and minimize duplication of effort. This person will report to the Division Director and must be knowledgeable of all aspects of the Division's activities.

Another strong component of our organization structure is **the consultation provided by our project management vendor, First Data.** In this Level One Grant we are requesting funds to continue their contract as well as to expand their role in the area of quality assurance (QA). First Data is responsible for procurement planning for program and IT solutions, ongoing preparation of resource needs (job descriptions, cost projections, etc.) and assisting with the coordination, evaluation and management of the various planning and implementation activities across the state staff and all vendors. First Data's ongoing integration efforts include facilitating the Steering Committee meetings and other Executive level meetings as needed as well as managing the Action Item, Risk and Issues lists. First Data also works with CCIIO/CMS staff as needed to help maintain productive communication and knowledge transfer. By stepping up their role in QA, First Data will assure consistency between our various implementation efforts, thoroughly documented processes and confirmation of deliverables from other vendors. The continuation of their contract is essential to maintaining Arkansas's steady progress toward an FFE Partnership.

Coordination between State Entities and Federal Government

HBEPD is part of an interagency leadership group that is working with CCIIO and CMS to develop the FFE Partnership for Arkansas. In addition to AID, the group includes the Surgeon General and his staff from ACHI; a representative from the Governor's office; a representative from DIS and DHS leadership representing Medicaid, County Operations, Research and Policy and IT. This group participated in the Initial Planning Review Meeting in Bethesda, MD in May and continues their collaboration with CCIIO/CMS by having regular conference calls with Arkansas's CCIIO project officer.

Arkansas's CCIIO project officer will participate in Design and Implementation Reviews and meet with others at CMS as needed to share information, concerns and work through solutions aimed at a successful FFE Partnership. Medicaid IT representatives also meet as needed with CMS representatives as they work their way through systems changes to support the successful FFE in Arkansas.

Reuse, Sharing and Collaboration

HBEPD is planning to utilize SERFF to provide a single point of interaction for Arkansas issuers to submit plans for certification and renewal and for Arkansas state regulators to certify, renew and manage QHPs participating in the FFE. SERFF's role and approach leverages existing systems, assists states in certifying QHPs and facilitates integration. Using existing information technology investment vs. building new systems will mitigate costs and lessen the burden to issuers adapting to a new system. The HBEPD staff has attended all NAIC/SERFF forums and any SERFF related forums at State Grantee Meetings. They are preparing to participate in testing the system when appropriate and to work with issuers to assure proper use of the modified system. Funds for these activities were included in HPEBD's first Level One Grant.

The HBEPD and CSD-CAP staff are committed to working collaboratively to expand CAP efforts in preparation for 2014 Health Benefits Exchange implementation. Coordinated efforts will focus on outreach education, complaints resolution, and data collection/analysis to inform Exchange planning/implementation and health insurance system improvements at all levels—consumers, issuers, producers, and providers. Funds to support this collaboration were included in HBEPD's first Level One Establishment Grant.

HBEPD is working collaboratively with the AID Rate Review Division to maximize use of their state-of-the-art video and teleconferencing technology to make it easier for more stakeholders to participate in Town Meetings, committee meetings and working sessions on critical topics. Funds to expand video conferencing and web live streaming capabilities are included in this grant request.

Financial Integrity Mechanisms

The Grants/Contract (G/C) Specialist manages and oversees all planning related grants, contracts and financial monitoring/reporting, including procurement. In addition we are currently developing policies and procedures to ensure internal policies to control and detect fraud, waste and abuse are developed and followed, and financial information is available to the public. Systems are in place to assure separate accounting and bookkeeping for different grants. When a federal grant is awarded, it is assigned a separate state WBS element number, separate cost center, separate fund code and separate fund center for tracking purposes.

All contracts requiring competitive bids are procured according to state and federal policy. The AID financial office records electronically all contracts awarded with grant funds. To pay on a contract, a vendor must submit an invoice specific to the deliverable that is required for payment.

The G/C Specialist verifies the deliverable was received and provides a signatory on the invoice submitted for payment. The G/C Specialist notes which cost center or grant the invoice is to be paid from and which line item the invoice is to be paid from. The G/C Specialist then submits the invoice to the AID accounting office whose staff deducts the appropriate amount from the assigned GL number, and remits payment to the vendor.

The AID Accounting Division records amounts electronically and gives a copy of the record to the G/C Specialist at the end of the month. The G/C Specialist keeps a separate accounting ledger in Excel format to ensure proper checks and balances with the internal AID accounting office, and compares the submitted monthly reconciliation report with the internal grant budget to ensure the expenditures were deducted from the correct accounts according to federal and state policy.

In addition, the G/C Specialist, under supervision of the HBEPD director, must authorize expenditures internally for items such as purchasing, and externally such as submitting payment on a contract, before it is submitted to the AID business office for payment.

The G/C Specialist is also establishing additional policies and procedures to monitor the expenditure of travel funds. Procedures are being implemented to insure that before any travel arrangements are made using grant funds, the travel is both necessary and essential to the development of grant activities.

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

Challenges

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

- Arkansas's Legislative process for obtaining approval to spend grant funds once awarded, create and fill staff positions, and secure consulting contracts is part tedious attention to detail and part political. With our recent experience, HBEPD is better prepared to meet the detailed, time-sensitive requirements. We are hopeful that the continuous openness we've shown to our legislators throughout our planning process coupled with the able support of the AID Commissioner and the Governor's office will lead to approval of our requests the first time they are presented to Legislative committees. Although we have had a vocal minority of opponents since creation of the ACA, we have not lost a key vote.

- Misinformation is being perpetuated by those opposed to ACA throughout Arkansas. Beginning with our recent Town Meetings and continuing with our soon to be implemented outreach and awareness efforts, HBEPD is making a concerted, organized effort to provide concise, accurate information to all Arkansans.

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

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

There are a couple of challenges we have identified that are beyond our control to influence at this point:

- There remain many unanswered questions and unissued guidelines from CCIIO/CMS regarding the implementation of the FFE Partnership Model. We will continue to ask for guidance and, when appropriate, suggest solutions for CCIIO/CMS to consider. Of particular concern the lack of information about long-term FFE Partnership fees and financing, the expectations for the federally managed Navigator Program as related to the state-managed IPA Program, and specific points of plan management such as processes and requirements for FFE approval of any state requested QHP criteria beyond federal minimum requirements.

- In light of the recent Supreme Court decision, Arkansas has not decided what it plans to do about Medicaid expansion. This raises many questions about what will be available for this at-risk population between 17% and 100% of FPL if Arkansas does not expand its program. There are also questions about churning between the IAP programs and we plan to address churning and related issues through this Level One Funding.

Arkansas is eager to continue planning and implementation activities toward successful open enrollment and ongoing improvements and enhancements of the FFE Partnership in Arkansas. We respectfully request approval of the funding requests outlined in this application, and look forward to our Plan Management and Consumer Assistance Design Reviews this fall.

Department of Health and Human Services
Centers for Medicare & Medicaid Services
Office of Acquisitions and Grants Management

7500 Security Boulevard
Baltimore, MD 21244-1850

NOTICE OF AWARD

AUTHORIZATION (Legislation/Regulations)
Section 1311 of the Affordable Care Act, Health Insurance Exchange

1. DATE ISSUED *MM/DD/YYYY*: 09/27/2012
2. CFDA NO.: 93.525
3. ASSISTANCE TYPE: Cooperative Agreement

1a. SUPERSEDES AWARD NOTICE dated
except that any additions or restrictions previously imposed remain in effect unless specifically rescinded

4. GRANT NO.: 1 HBEIE120136-01-00
Formerly
5. ACTION TYPE: New

6. PROJECT PERIOD *MM/DD/YYYY* From 09/27/2012 Through 09/26/2013

7. BUDGET PERIOD *MM/DD/YYYY* From 09/27/2012 Through 09/26/2013

8. TITLE OF PROJECT (OR PROGRAM)
Cooperative Agreement to Support Establishment of the Affordable Care Act's Health Insurance Exchar

9a. GRANTEE NAME AND ADDRESS
Arkansas Insurance Department
1200 W 3rd St
Little Rock, AR 72201-1904

9b. GRANTEE PROJECT DIRECTOR
Ms. Cynthia Crone
1200 WEST THIRD ST
LITTLE ROCK, AR 72201-1904
Phone: 501-683-3634

10a. GRANTEE AUTHORIZING OFFICIAL
Mr. Jay Bradford
1200 WEST THIRD ST
LITTLE ROCK, AR 72201-1904
Phone: 501-371-2623

10b. FEDERAL PROJECT OFFICER
Ms. Susan Lumsden
200 Independence Ave Sw Rm 738-G
Washington, DC 20201-0004
Phone: 301-492-0000

ALL AMOUNTS ARE SHOWN IN USD

11. APPROVED BUDGET (Excludes HHS Direct Assistance)
I HHS Grant Funds Only
II Total project costs including grant funds and all other financial participation [II]

a.	Salaries and Wages	550,580.00
b.	Fringe Benefits	174,647.00
c.	Total Personnel Costs	725,227.00
d.	Equipment	47,900.00
e.	Supplies	46,107.00
f.	Travel	121,186.00
g.	Construction	0.00
h.	Other	202,461.00
i.	Contractual	17,452,191.00
j.	TOTAL DIRECT COSTS	18,595,072.00
k.	INDIRECT COSTS	0.00
l.	TOTAL APPROVED BUDGET	18,595,072.00
m.	Federal Share	18,595,072.00
n.	Non-Federal Share	0.00

12. AWARD COMPUTATION FOR GRANT

a. Amount of HHS Financial Assistance (from item 11 m)	18,595,072.00
b. Less Unobligated Balance From Prior Budget Periods	0.00
c. Less Cumulative Prior Award(s) This Budget Period	0.00
d. AMOUNT OF FINANCIAL ASSISTANCE THIS ACTION	18,595,072.00
13. Total Federal Funds Awarded to Date for Project Period	18,595,072.00

14. RECOMMENDED FUTURE SUPPORT
(Subject to the availability of funds and satisfactory progress of the project):

YEAR	TOTAL DIRECT COSTS	YEAR	TOTAL DIRECT COSTS
a. 2		d. 5	
b. 3		e. 6	
c. 4		f. 7	

15. PROGRAM INCOME SUBJECT TO 45 CFR PART 74, SUBPART F, OR 45 CFR 92.25, SHALL BE USED IN ACCORD WITH ONE OF THE FOLLOWING ALTERNATIVES: [b]
- a. DEDUCTION
- b. ADDITIONAL COSTS
- c. MATCHING
- d. OTHER RESEARCH (Add / Deduct Option)
- e. OTHER (See REMARKS)

16. THIS AWARD IS BASED ON AN APPLICATION SUBMITTED TO, AND AS APPROVED BY, HHS ON THE ABOVE TITLED PROJECT AND IS SUBJECT TO THE TERMS AND CONDITIONS INCORPORATED EITHER DIRECTLY OR BY REFERENCE IN THE FOLLOWING:
- a. The grant program legislation cited above.
- b. The grant program regulations cited above.
- c. This award notice including terms and conditions, if any, noted below under REMARKS.
- d. HHS Grants Policy Statement including addenda in effect as of the beginning date of the budget period.
- e. 45 CFR Part 74 or 45 CFR Part 92 as applicable.

In the event there are conflicting or otherwise inconsistent policies applicable to the grant, the above order of precedence shall prevail. Acceptance of the grant terms and conditions is acknowledged by the grantee when funds are drawn or otherwise obtained from the grant payment system.

REMARKS (Other Terms and Conditions Attached - [x] Yes [ ] No)
Please Refer to the Standard and Special Terms and Conditions.

GRANTS MANAGEMENT OFFICER: Michelle Feagins, Grants Management Officer

17. OBJ CLASS 4115	18a. VENDOR CODE 1710847443A9	18b. EIN 710847443	19. DUNS 081501558	20. CONG. DIST. 02
FY-ACCOUNT NO.	DOCUMENT NO.	ADMINISTRATIVE CODE	AMT ACTION FIN ASST	APPROPRIATION
21. a. 2-5992638	b. HBEIE0136A	c. SEPI	d. $18,595,072.00	e. 7520115
22. a.	b.	c.	d.	e.
23. a.	b.	c.	d.	e.

AWARD ATTACHMENTS

Arkansas Insurance Department 1 HBEIE120136-01-00

1. Terms & Conditions

Cooperative Agreement for the State of Arkansas to Support Establishment of the Affordable Care Act's Health Insurance Exchanges
Level One Establishment

Standard Terms & Conditions
Attachment A

1. **The HHS/CMS Center for Consumer Information and Insurance Oversight (CCIIO) Program Official.** The Program Official assigned with responsibility for technical and programmatic questions from the Grantee is Susan Lumsden (Susan.Lumsden@cms.hhs.gov).

2. **The HHS/Center for Medicaid, CHIP and Survey & Certification (CMCS) Contact Official.** The Center within CMS responsible for reviewing and approving funding documents referred to as Advance Planning Documents (APDs) that are submitted by the State to receive federal matching funds for goods and services that benefit the Medicaid program. The CMCS Contact Official is Charles Lehman (Charles.Lehman@cms.hhs.gov).

3. **The HHS/Centers for Medicare and Medicaid Services (CMS) Grants Management Specialist.** The Grants Management Specialist assigned with the responsibility for the financial and administrative aspects (non-programmatic areas) of grants administration questions from the Grantee is Vivian Smith in the Division of Grants Management (Vivian.Smith@cms.hhs.gov).

4. **The HHS Grants Policy Statement (HHS GPS).** This Cooperative Agreement is subject to the requirements of the HHS GPS that are applicable to the Grantee based on your recipient type and the purpose of this award. This includes any requirements in Part I and II (available at http://www.hhs.gov/grantsnet/adminis/gpd/index.htm) of the HHS GPS that apply to an award.

   Consistent with the HHS GPS, any applicable statutory or regulatory requirements, including 45 CFR Part 92, directly applies to this award in addition to any coverage in the HHS GPS.

5. **Cost Principles for State, Local, and Indian Tribal Governments.** This cooperative agreement is subject to the requirements as set forth in 2 CFR Part 225, Cost Principles for State, Local, and Indian Tribal Governments (previously OMB Circular A-87). Program may require grantees to continue to provide estimates for cost allocation during periodic phases involving associated funds of the cooperative agreement.

6. **Subaward Reporting and Executive Compensation.** This cooperative agreement is subject to the reporting requirements of the Federal Funding Accountability and Transparency Act of 2006 (Pub. L. 109-282), as amended by section 6202 of Public Law 110-252 and implemented by 2 CFR Part 170. Grant and cooperative agreement recipients must report information for each first-tier subaward of $25,000 or more in Federal funds and executive total compensation for the recipient's and subrecipient's five most highly compensated

executives as outlined in Appendix A to 2 CFR Part 170. For the full text of the award term, go to http://cciio.cms.gov/resources/fundingopportunities/ffata.html. For further assistance, please contact Iris Grady, the Grants Management Specialist assigned to monitor the subaward and executive compensation reporting requirements at divisionofgrantsmanagement@cms.hhs.gov.

7. **Trafficking in Persons.** This award is subject to the requirements of Section 106 (g) of the Trafficking Victims Protection Act of 2000, as amended (22 U.S.C. 7104). For the full text of the award term, go to http://cciio.cms.gov/resources/fundingopportunities/trafficking-term.html.

8. **Fraud, Waste, and Abuse.** The HHS Office of the Inspector General (OIG) maintains a toll-free number (1-800-HHS-TIPS [1-800-447-8477]) for receiving information concerning fraud, waste, or abuse under grants and cooperative agreements. Information also may be submitted by email to hhstips@oig.hhs.gov or by mail to Office of the Inspector General, Department of Health and Human Services, Attn: HOTLINE, 330 Independence Ave., SW, Washington DC 20201. Such reports are treated as sensitive material and submitters may decline to give their names if they choose to remain anonymous.

9. **Central Contractor Registration and Universal Identifier Requirements.** This award is subject to the requirements of 2 CFR part 25, Appendix A. For the full text of the award term, go to http://www.cciio.cms.gov/resources/fundingopportunities/award-term-for-central-contractor-registration.html.

10. **FY 2012 Appropriations Provision.** HHS recipients must comply with all terms and conditions outlined in their grant award, including grant policy terms and conditions contained in applicable Department of Health and Human Services (HHS) Grant Policy Statements, and requirements imposed by program statutes and regulations and HHS grant administration regulations, as applicable; as well as any requirements or limitations in any applicable appropriations acts.

Special Terms & Conditions
Attachment B

1. **Budget and Project Period.** The budget and project period for the Cooperative Agreement to Support Establishment of the Affordable Care Act's Health Insurance Exchanges (Level One Application due date August 15, 2012) is from September 27, 2012 through September 26, 2013.

2. **Personnel Changes.** The Grantee is required to notify the CCIIO Project Officer and the HHS Grants Management Specialist within thirty (30) days of any personnel changes affecting the grant's Authorized Organizational Representative, Project Director, Assistant Project Director, and/or the Financial Officer as well as any named Key Contractor staff.

3. **Contractual Personnel Changes.** Because the bandwidth of expertise is tight in the Exchange arena, Grantees must inform the Project Officer as to Contractual resources and key personnel changes.

4. **Required Grant/Cooperative Agreement Reporting.** The templates for the Required Cooperative Agreement Reporting will be forthcoming.

   a. **Project Report.** The Grantee is required to submit Progress Reports to the HHS Grants Management Specialist and to the CCIIO Project Officer. Progress Reports are due as follows:

      Period of Performance: September 27, 2012 through December 31, 2012
      Due: January 30, 2013

      Period of Performance: January 1, 2013 through June 30, 2013
      Due: July 30, 2013

      Period of Performance: July 1, 2013 through September 26, 2013. The final Progress Report will serve as the Final Project Report and should report not only on activities that occurred during the period of performance, but should be cumulative and report on work performed throughout the project period. This report is due no later than 90 days after the end of the project period.
      Due: December 26, 2013

   b. **Periodic Deliverables.** See Program Requirements per the Funding Opportunity Announcement.

   c. **Public Report.** The Grantee is required to prominently post specific information about the Exchange grants/cooperative agreements on its Internet websites to ensure that the public has information on the use of funds.

5. **Required Financial Reports.** The Federal Financial Report (FFR or Standard Form 425) has replaced the SF-269, SF-269A, SF-272, and SF-272A financial reporting forms. All grantees must utilize the FFR to report cash transaction data, expenditures, and any program income generated.

   Grantees must report on a quarterly basis cash transaction data via the Payment Management System (PMS) using the FFR in lieu of completing a SF-272/SF272A. The FFR, containing cash transaction data, is due within 30 days after the end of each quarter. The quarterly reporting due dates are as follows: 1/30, 4/30, 7/30, 10/30. A Quick Reference Guide for completing the FFR in PMS is at:
   www.dpm.psc.gov/grant_recipient/guides_forms/ffr_quick_reference.aspx.

   Within 90 calendar days of the budget/project period end date, Grantees must also report on the FFR their expenditures and any program income generated in lieu of completing a Financial Status Report (FSR) (SF269/269A). Expenditures and any program income generated should only be included on the final, hard-copy FFR.

See below for the due date for the final, hard-copy FFR:

Budget/Project period	***Reporting Period and Due Date***
September 27, 2012 through September 26, 2013	*Final report -* 12-month reporting period— September 27, 2012 through September 26, 2013 DUE: December 26, 2013

A hard copy of the final FFR, containing cash transaction data, expenditures, and any program income generated, should be mailed and received by our office within 90 calendar days of the budget/project period end date. Grantees should access the following link in order to electronically complete and print the final FFR: http://www.whitehouse.gov/omb/grants_forms/.

The final FFR should be mailed to the attention of Grants Management Specialist, Vivian Smith, at the following address:

Centers for Medicare and Medicaid Services
Office of Acquisition and Grants Management
200 Independence Ave., SW
Room 739H
Washington, D.C. 20201

Award recipients shall liquidate all obligations incurred under the award not later than 90 days after the end of the project period and before the final FFR submission. It is the award recipient's responsibility to reconcile reports submitted to PMS and to CMS. Failure to reconcile final reports in a timely manner may result in canceled funds.

For additional guidance, please contact your Grants Management Specialist, Vivian Smith.

Payment under this award will be made by the Department of Health and Human Services, Payment Management System administered by the Division of Payment Management (DPM), Program Support Center. Draw these funds against your account that has been established for this purpose. Inquiries regarding payment should be directed to:

Director, Division of Payment Management
Telephone Number 1-877-614-5533
P. O. Box 6021
Rockville, Maryland 20852

6. **Attendance at Meetings and Sharing.** It is extremely important for States to share with one another lessons learned and best practices; as such it is expected that grantees attend CMS (CCIIO and/or CMCS) grantee meetings or workshops; it is also highly encouraged for grantees to attend regional or other types of meetings/workshops that would further their work to establish their Exchanges.

7. **Collaborative Responsibilities.** Close coordination between the Department of Insurance and the Medicaid Director is required. Grantees will be expected to show evidence, including but not limited to, regular communication and meetings, and Memoranda of Agreement based on business owners of processes, and inclusion in critical milestones.

8. **Consumer Assistance Program (Section 1002).** As Exchange grantees engage in planning and implementation activities around the Core Area of Providing Assistance to Individuals and Small Businesses, Coverage Appeals, and Complaints, they must keep in mind that it is not possible to replace CAP grant funding with 1311 funding. The activities must be integral to the Exchange and are subject to the minimum requirements of Section 1311, not those in Section 1002. Funds applied for must not supplant other grant funds, or otherwise misuse or misappropriate grant funds.

9. **Basic Health Program.** Exchange Establishment Cooperative Agreement funds cannot be used by the state for the purpose of applying for a waiver of the Exchange requirements. To the extent that there are Exchange establishment activities that would need to be coordinated with or overlap with activities undertaken pursuant to sections 1331 and 1332, Establishment Cooperative Agreement funding could be available for those activities. However, funding under the Establishment Cooperative Agreements may not be used solely for waiver activities, the Basic Health Program or investigation of the feasibility of those options.

10. **Risk Adjustment.** States must seek approval to commence specific tasks associated with risk adjustment. Please submit plans to carry out tasks related to risk adjustment to your Project Officer for review and approval prior to commencing activities.

11. **Quality Rating System.** Prior to carrying out activities related to Quality, please consult with your Project Officer for technical assistance.

12. **Funding the Navigator Program.** State Exchange Establishment funds may be used for functions and/or activities that pertain to the development of a Navigator program. Funds to support the Navigator program's operations must come from the operational funds of the State Exchange, not from Section 1311 funds awarded under this cooperative agreement.

13. **Exchange Procurements.** Per 45 CFR Part 92.36, States are required to follow their "own procurement procedures which reflect applicable State and local laws and regulations, provided that the procurements conform to applicable Federal law and the standards identified in this section [45 CFR Part 92.36]." As part of this cooperative agreement, substantial Federal involvement with the recipient is anticipated during performance. As such, CMS' purpose is to support the recipient's activities and work jointly with the award recipient in a partnership role. As part of this collaborative process, CMS will want to review vendor proposals to provide feedback and engage in discussions with cooperative agreement awardees. CMS is committed to providing expert technical assistance to States as they work to design and deploy their Exchanges, as required under the Affordable Care Act (ACA). This high-quality technical assistance increases the opportunities for reuse, sharing, and collaboration, and reduces implementation cost. CMS has identified three key steps States are

strongly recommended to take in procurement of Exchange IT contracts to assure procurements meet re-use and transparency expectations:

1. Prepare an Independent Government Cost Estimate (IGCE) prior to release of Request for Proposals (RFPs) and share the results of that study with CCIIO.
2. Use a vendor screening process before entering into contract negotiations with any vendors.
3. Include contract clauses that promote reuse.

More detail around these best practices may be found in "Best Practices and Requirements in Contracting and Procurement for Exchange Information Technology Systems" which is available at: https://servis.cms.gov/resources/document_detail?doc_detail_id=d882c8c3-274d-69f0-ede9-501a9ac78e52.

14. **Cost Allocation.** States are required to allocate costs among Medicaid, CHIP, and the Exchange for shared services by benefitting program, consistent with 2 CFR Part 225 (previously OMB Circular A-87) cost allocation principles and related HHS guidance, including but not limited to Guidance for Exchange and Medicaid Information Technology (IT) Systems 2.0.

15. **Reuse of Exchange IT Systems Artifacts.** Grantees will be required to use the following language in any contracts issued. This language is intended to give clear direction to States on their responsibility to ensure maximum opportunity for reuse of Exchange IT systems artifacts, models, materials and/or processes.

Intangible property

This contract is in support of <State>'s implementation of the Patient Protection and Affordable Care Act of 2010, and is subject to the certain property rights provisions of the Code of Federal Regulations and a Grant from the Department of Health and Human Services, Centers for Medicare & Medicaid Services. This Contract is subject to, and incorporates by reference, 45 CFR 74.36 and 45 CFR 92.34 governing rights to intangible property. Intangible property includes but is not limited to: computer software; patents, inventions, formulae, processes, designs, patterns, trade secrets, or know-how; copyrights and literary, musical, or artistic compositions; trademarks, trade names, or brand names; franchises, licenses, or contracts; methods, programs, systems, procedures, campaigns, surveys, studies, forecasts, estimates, customer lists, or technical data; and other similar items. The Contractor may copyright any work that is subject to copyright and was developed, or for which ownership was purchased, under this Contract. The Contractor must deliver all intangible property, including but not limited to, intellectual property, to <State> in a manner that ensures the Centers for Medicare & Medicaid Services, an agency of the Department of Health and Human Services, obtains a royalty-free, nonexclusive and irrevocable right to reproduce, publish, or otherwise use the work for Federal purposes, and to authorize others to do so. Federal purposes include the purpose of administering <State> exchanges under the Affordable Care Act of 2010. The Contractor is further subject to applicable regulations governing patents and inventions, including those issued by the Department of Commerce at 37 CFR Part 401.

16. **Acceptance of Application and Terms of Agreement.** Initial expenditure of funds by the Grantee constitutes acceptance of this award.