ARKANSAS STATE PARTNERSHIP

HEALTH INSURANCE MARKETPLACE

YEAR ONE EVALUATION

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EXECUTIVE SUMMARY

The goal of this evaluation of the first year of Arkansas' State Partnership Health Insurance Marketplace (SPM) was to examine the effectiveness of processes and procedures used in implementing the SPM in Arkansas and the outcomes achieved with early implementation of the SPM. Arkansas Insurance Commissioner Jay Bradford, with governing authority delegated by Governor Mike Beebe, was responsible for implementing the SPM in Arkansas under a state/federal partnership. The Arkansas Health Connector Division (AHCD) within the Arkansas Insurance Department (AID) led the implementation of the SPM under the guidance of Deputy Commissioner Cindy Crone, APN, MNSc. The AHCD responsibilities included: 1) developing policies and procedures to support Qualified Health Plan (QHP) certification, re-certification, and plan monitoring; 2) advancing quality and payment transformation initiatives through the Marketplace; 3) supporting education and re-licensure of Marketplace assisters including licensed producers; 4) implementing Marketplace outreach and education activities; and 5) ensuring adequate staffing of the Arkansas Health Connector Resource Center(AHCRC) to provide timely response to consumer inquiries or complaints.

The evaluation plan for this report was developed in collaboration with the AID. The federally funded evaluation was supported through a contract between the Arkansas Insurance Department and the University of Arkansas for Medical Sciences Fay W. Boozman College of Public Health (COPH) under the direction of J. Mick Tilford, PhD. The COPH subcontracted with the Arkansas Foundation for Medical Care (AFMC) to assist with the evaluation.

OBJECTIVES AND DATA SOURCES

The evaluation plan focused on nine objectives that were to be completed in the first year following implementation of the SPM. The evaluation objectives included: evaluating the effectiveness of the governance process, evaluating the effectiveness of outreach and education efforts, developing a profile of qualified health plans enrolled and seeking to enroll in the SPM, evaluating the effectiveness of in-person assister (IPA) guide training, evaluating the effectiveness of IPAs and federal navigators, assessing the outcomes of open enrollment, evaluating consumer perceptions of health plans and services, evaluating provider perceptions of the implementation of the SPM and its impact on their operations, and finally, developing a plan for continued evaluation of the SPM based on lessons learned.

Data for the evaluation came from a number of sources including both qualitative and quantitative survey methods. Qualitative data were obtained from semi-structured interviews with key informants. These data were recorded and transcribed for analysis with all respondents remaining anonymous. A consumer survey was fielded that obtained responses from over 1,000 Arkansans participating in the SPM with approximately half of the respondents

having obtained insurance through Arkansas's expanded Medicaid program and the other half through direct purchase in the SPM. A provider survey was fielded with three groups of providers: hospitals, physician practices, and behavioral health providers. Finally, the evaluation relied on various data sources within the AID and other public sources to accomplish some of the objectives. The evaluation team thanks the consumers, providers, stakeholders, and carriers that gave their time and resources to help us accomplish our objectives.

KEY OUTCOMES

In 2014, Arkansas had three state insurers and one multi-state carrier participating in the SPM. Plans were offered in all seven regions of the state with the southeast and southwest having only two participating insurers. A total of 13,341 QHP items were reviewed by AID with all 71 plans (23 Gold, 16 Silver, 24 Bronze, and 8 Catastrophic) that were submitted by the four participating carriers certified for plan year 2014.

As of April 19, 2014, 43,446 (19.1%) of the 227,000 Arkansans who were eligible for Marketplace insurance enrolled through the SPM. Program enrollment grew to 68,131 Arkansans as of April 1, 2015. An analysis of active QHP status revealed that 82% of SPM enrollees were either current on payment, had first payment pending, or were still within the grace period.

In addition to subsidized purchases of health insurance through the SPM, the Arkansas Medicaid program also purchased high-level silver QHPs for approximately 213,000 enrollees. The Medicaid beneficiaries in the SPM (Health Care Independence Program (HCIP) enrollees) are thought to have improved the SPM by increasing the pool with low risk, healthy people, thus lowering the cost of subsidized insurance for all enrollees.

Through the combined enrollment of the Marketplace and the HCIP enrollees, the percentage of adults in Arkansas without health insurance fell from 22.5% in 2013 to 11.4% in 2014. The reduction in the percentage of uninsured was the largest decrease in the country and celebrated by many of the stakeholders who were involved in the implementation of the SPM.

The survey results from 1,212 consumers in the SPM provided important information about the characteristics of enrollees, including those enrolled through HCIP. A larger percentage of enrollees were female (approximately 60%), with an average age of 41 years. Approximately 19% of enrollees reported as being African American or black and approximately 4% listed themselves as Hispanic. Most of these characteristics were significantly different than national surveys of enrollees in state Medicaid programs.

The consumer survey included both Marketplace and HCIP enrollees, and as a result we were able to identify key findings with respect to prior insurance coverage for both groups. For

enrollees in the Marketplace, approximately 53% had insurance in the six months prior to obtaining health insurance coverage in the SPM compared to 27% in the HCIP. Enrollees in the HCIP were much less likely to have had any health insurance coverage since becoming an adult with 45.1% reporting receiving health insurance coverage for the first time since turning 18 years of age. In contrast, 20.1% of enrollees in the Marketplace reported receiving insurance for the first time as an adult.

The characteristics of enrollees receiving health insurance for the first time as an adult differed considerably between HCIP enrollees and Marketplace enrollees. The average age of respondents in the HCIP who reported having insurance for the first time as an adult was 36 years while Marketplace enrollees averaged 42 years. There also were large differences in health status between enrollees in the Marketplace and HCIP. Of enrollees who were getting insurance for the first time, 34.6% of enrollees reported excellent health status – a rate three times the sample average. However, only 7% of HCIP enrollees reported being in excellent health, a rate that is close to, but below the sample average. The large percentage of newly insured enrollees in the Marketplace who reported excellent health status points to the potential for cost advantages from including HCIP enrollees in the Marketplace to lower costs sufficiently to attract healthy enrollees.

Enrollees were compared on their ability to access health services using data from the National CAHPS® Benchmarking Database (NCBD). Overall, findings within the state of Arkansas were mostly consistent with national data with some exceptions. Approximately 82% of enrollees in the SPM reported getting needed care compared to 81% in the NCBD. Enrollee ratings associated with getting care quickly were lower in the SPM compared to the NCBD while ratings of customer service were higher in the SPM. Enrollees in Arkansas were less satisfied overall with their health plan compared to respondents in the NCBD with 62% of SPM enrollees rating their health plan favorably compared to 75% nationally. This difference may be due to the cost sharing features of plans purchased through the SPM that were not required of respondents in the NCBD.

The consumer survey provided data on health services utilization by enrollees. There was considerable variation in doctor visits across the seven regions. Enrollees in the southeast and south central regions had lower doctor utilization (54-60%) compared to the state average of 73.3% having at least one visit in the last six months. Enrollees were asked whether they had an urgent medical care condition that required care, and if so, whether they visited an emergency department. Overall, 18% of SPM enrollees indicated having at least one emergency department visit. Enrollees in southeast Arkansas had the highest emergency department utilization rate at 27.5%, which is consistent with the historically low access to health care services in that region. In contrast, enrollees in the northeast region had higher than average

rates of doctor utilization and lower than average rates of emergency department utilization. There was some concern raised over the high rate of utilization of doctors by SPM enrollees. Over 40% of respondents reported having three or more visits to the doctor in the past six months. Comparative data from alternative sources and longitudinal studies are needed to assess whether a pent-up demand for care exists among a large percentage of enrollees and how utilization patterns will change over time.

IMPACT ON HEALTH CARE PROVIDERS

Surveys were conducted with hospitals, clinics, and behavioral health providers to identify changes in patient volume, uncompensated care costs, and patient mix resulting from implementation of the SPM. Findings from the surveys suggested hospitals benefited the most from decreased uncompensated care costs with 77.8% of responding hospitals reporting a decrease following implementation. In contrast, approximately 22-27% of clinics and behavioral health providers reported a decrease in uncompensated care costs. Most hospitals reported no change in patient volume following implementation of the SPM and more hospitals reported a decrease in volume compared to an increase in volume. Twenty-five percent of clinics reported increases in patient volume, while 11% of behavioral providers reported an increase compared to 6% that reported a decrease in volume. All types of providers reported changes in patient mix following implementation of the SPM with increased volume in Medicaid and privately insured patients and decreased volume in uninsured patients.

The survey also included questions about education of patients and a large percentage of providers noted that education of patients was insufficient and that more work was warranted. In addition, providers reported difficulty in identifying patients by insurance type in the SPM. The inability to identify a patient’s insurance status (Marketplace or HCIP) creates billing problems as some patients have cost sharing provisions while others do not.

EVALUATION OF IMPLEMENTATION ACTIVITIES

The AHCD within AID faced many challenges in implementing the SPM that led to the key outcomes described above. A major focus of the implementation plan was the use of IPAs and navigators as well as community events and paid media advertising to provide consumers with the necessary information to enroll. The AHCD conducted a needs assessment to determine the number of IPAs to employ using federal grant funding. The AHCD eventually contracted for the employment, training, and management of over 500 IPAs to assist consumers to enroll in the SPM. The organizations with whom AHCD contracted invested substantially in community events by providing over 43,000 outreach and education events across the entire state. Successful implementation of this approach required the development and delivery of a training curriculum, execution of contracts with agencies to hire and provide services, and the

development of a system to monitor the process. All of the IPA and navigator activities, in addition to other activities associated with the development of the SPM, occurred in an uncertain environment with difficult state political issues and federal coordination problems, many of which are described in the evaluation report.

As a result of the emphasis on the use of IPAs and navigators to provide consumer assistance with the SPM, this evaluation assessed several key questions including the effectiveness of IPA training, the effectiveness of outreach and education activities, and the effectiveness of using IPAs and navigators as a system to provide information to consumers for enrollment into the SPM.

GOVERNANCE

The evaluation team used qualitative assessments to evaluate the governance structure and stakeholder engagement process that was established up by the AHCD under the direction of AID Deputy Commissioner Cynthia Crone, to implement the SPM. The governance structure for the AHCD included a steering committee, a plan management advisory committee, and a consumer assistance advisory committee. The AHCD also included a vendor for project management and planning in addition to staff and vendors for in-house operations, technology, legal, plan management, and consumer support. The qualitative interviews covered all aspects of the AHCD governance structure and were completed using semi-structured interviews.

In general, the results point to the successful implementation of all key activities despite time pressures and other political issues. The primary challenges in implementing the SPM identified by the evaluation team were: 1) delays and constant changes that came down from the federal and state levels, and 2) the state legislature's decision to shut down all consumer outreach and education efforts. Given the decision to shut down outreach and education efforts, there is considerable room for debate over whether the findings on the effectiveness of this approach to enroll and educate consumers would have been different without midcourse changes in policy. However, the evaluation team identified several issues that warrant further consideration.

IN-PERSON ASSISTER GUIDE EDUCATION AND EFFECTIVENESS

The process of training and licensing in-person assister guides (IPA) was complicated by the need to develop a suitable curriculum, to identify methods for delivering the curriculum (online or in-person), and the lack of tools for actually navigating the Marketplace given that a demonstration website from the federal government was not available. Despite the complicated issues surrounding education and licensure, the evaluation findings suggest that the curriculum and educational activities were successful.

The evaluation team found support for the premise that IPAs and navigators can facilitate consumer education and increase the ease of enrolling in the Marketplace. The findings indicate a positive relationship between IPA activities and enrollment based on data from the Guide Management System that was used to track and manage processes related to the IPAs. The evaluation did not address the cost-effectiveness of using IPAs or whether other approaches such as targeting low literacy areas would be a better option compared to the approach taken. The consumer survey found that only 28% of enrollees used a person to assist with enrollment into the SPM. Of the consumers who used assistance, approximately 40% used an insurance agent. The findings also indicated that enrollees who used in-person assistance to enroll were approximately 10 percentage points more likely to say that the enrollment process was definitely easy.

It is unknown to what extent the enrollment numbers and other outcomes of enrollment would have changed had outreach and education activities not been terminated. It is worth noting that enrollment in the Marketplace grew from approximately 43,000 enrollees in the first year to approximately 68,000 enrollees in the following year in the absence of any media or outreach and education activities. Still, a large number of Arkansans remain eligible for federally subsidized health insurance and face penalties for not obtaining insurance. Enrolling more Arkansans in the SPM is likely to further increase the volume of visits to primary care clinics and continue the decline in uncompensated care costs to the state that began with implementation of the SPM.

FUTURE EVALUATION ACTIVITIES

The evaluation team considered future evaluation activities based on lessons learned from the first year evaluation that could be useful as the SPM transitions from a federal/state partnership model to a state-based insurance marketplace. Several themes were identified that should be considered in this context. As a state-based health insurance marketplace, it is critical to consider the cost-effectiveness of different activities and to focus survey and data collection efforts toward this criteria. For example, the consumer survey fielded as part of this evaluation, contained numerous questions on the use of in-person assistance given the focus of the implementation approach. These types of questions are of much less importance and should be replaced by other domains not covered in the prior evaluation. In particular, it is important to study the effectiveness of branding. New questions could be added about why consumers obtain health insurance, whether consumers are aware of SPM branding and other messages, and whether consumers need other services currently not provided through the SPM.

While the consumer survey asked questions about general physical and mental health, more specific instrument for measuring health and productivity are available and should be considered. The historic decrease in the uninsured and the consequent increase in access to

health services by low income populations in Arkansas should have important health effects for SPM enrollees. Sensitive continued measures to understand the extent of this improvement is warranted.

The recent passage of Arkansas Act 1233 to create the Arkansas Healthcare Transparency Initiative of 2015 could lead to establishing significant data infrastructure for SPM evaluation aimed at cost-effectiveness. In particular, the creation of an all payer claims database could be used to construct a number of metrics including:

- Trends in per capita emergency department use
- Trends in per capita hospitalization use
- Overall expenditures by public and private payers
- Prices for bundles of services provided by public and private payers
- Risk adjusted per member per month expenditures by public and private payers
- Relationships between geographic access to health services and utilization of emergency departments

With simple identifiers included in the database, it would be possible to assess whether consumers are making rational decisions with respect to insurance purchases leading to new educational efforts to improve choices.

SUMMARY

Despite difficult timelines and other political and logistical challenges, the AHCD implemented the SPM and facilitated health insurance enrollment for a large percentage of people who otherwise would have remained uninsured. This historic achievement appears to have increased the use of primary care services and decreased uncompensated care costs in the state. A large number of Arkansans remain eligible for federally subsidized health insurance and efforts to increase their enrollment in the SPM should be a priority going forward. Future evaluations will be needed to establish whether the health and productivity of Arkansans who enrolled under the SPM improved and whether this grand experiment provided benefits in excess of costs.

INTRODUCTION

The development of the evaluation plan for the Arkansas State Partnership Health Insurance Marketplace (SPM) was based on a prior report to the Arkansas Insurance Department (AID) titled *Arkansas Health Benefits Exchange planning project: Evaluation Plan*. That evaluation plan was developed under contract by First Data and dated August 19, 2011 (Version 2.0). The prior evaluation plan provided guidance for four years beginning with implementation of the insurance exchange in Arkansas by the Arkansas Health Connector Division within AID. This report describes the first year evaluation based on the proposed methods and measures contained in that report.

The initial evaluation plan described the Arkansas Exchange as the Health Benefits Exchange consistent with naming the original division within AID the Health Benefits Exchange Partnership Division. The division subsequently changed to the Arkansas Health Connector Division (AHCD) following a market study and branding of the Arkansas Health Connector as the state's "Guide to Health Insurance." With this change, the Arkansas Exchange became formally known as the Arkansas State Partnership Health Insurance Marketplace.

The focus of the initial evaluation plan was on implementation of the SPM in Arkansas, the outcomes associated with implementation of the SPM, and whether the process was cost-effective. Implementation activities under the guidance of the AHCD included 1) developing policies and procedures to support Qualified Health Plan (QHP) certification, re-certification, and plan monitoring; 2) advancing quality and payment transformation initiatives through the Marketplace; 3) supporting continuing education and re-licensure of Marketplace assisters including licensed producers; 4) implementing Marketplace outreach and education activities, and 5) ensuring adequate staffing of the Arkansas Health Connector Resource Center to provide timely response to consumer inquiries or complaints. The successful completion of the implementation plans were expected to lead to increased enrollment in the SPM and decreased rates of uninsured individuals in Arkansas as well as improved quality of healthcare delivery and improved health outcomes for the population.

Results of the evaluation indicate that by April 19, 2014, 43,446 (19.1%) of the 227,000 Arkansans eligible for Marketplace insurance enrolled through the SPM. Program enrollment grew to 68,131 Arkansans as of April 1, 2015. An analysis of active status revealed that 82% of SPM enrollees were either current on payment, first payment was pending, or the enrollee remained within the grace period.

A full evaluation of the implementation, outcomes, and cost-effectiveness of the SPM as described in the initial planning proposal could not be accomplished in a first-year evaluation. For example, the original evaluation plan proposed getting information on use of the

emergency department to assess whether there was inappropriate utilization. Similarly, the original plans sought information on clinical outcomes related to cardiovascular and diabetes care, as well as Health Effectiveness Data Information Set (HEDIS) indicators. To calculate these measures would require electronic claims or medical record data as specified in the planning document. It was not possible to obtain claims data (and other proposed data sets) to calculate these measures for the first-year evaluation. Thus, the evaluation is limited in scope to activities that could be accomplished within the first year focusing on implementation and outcomes of open enrollment. We did not assess the cost-effectiveness of specific implementation activities, as evidence of effectiveness would be needed before assessing outcomes in relation to cost.

The evaluation was completed through a cooperative agreement between the University of Arkansas for Medical Sciences Fay W. Boozman College of Public Health (COPH) and the Arkansas Foundation for Medical Care (AFMC). We gratefully acknowledge the cooperation of the carriers, consumers, and other stakeholders in securing the necessary data for this report.

EVALUATION DATA AND ACTIVITIES

The initial evaluation plan called for several sources of data that could be used to evaluate how well the AHCD implemented the SPM and the outcomes of open enrollment. The major data source called for within the initial evaluation plan was a population-based consumer survey of enrollees. The evaluation team for this report responded to this call by developing a 102 question survey that asked consumers for information related to their health and recent use of health care services, their health care provider(s), how they enrolled and any assistance they received doing so, how satisfied they were with the assistance they received, how they chose a health plan and their experience using the health plan, and how satisfied they were with their experience with the enrollment process and health plan. The survey was mailed to enrollees in the state using addresses provided to AID by the carriers. Details of the methods and sampling procedures are described in the body of the report and summarized below.

The Arkansas Foundation for Medical Care (AFMC), a National Committee for Quality Assurance (NCQA) Certified Health Plan Employer Data and Information Set (HEDIS®) Survey Vendor and, as part of the evaluation, conducted the 2014 Consumer Health Care Survey with enrollees in the SPM health insurance plans. The survey instrument included questions from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0H Adult Commercial Survey, Centers for Medicare and Medicaid Services (CMS) Health Insurance Marketplace Survey and CMS Adult Qualified Health Plan Enrollee Experience Survey and additional questions designed to address specific evaluation needs. The survey was administered by mail and through SurveyMonkey® from November 2014 through February 2014 with a 27.6% response rate. The survey data was used to assess enrollee satisfaction in both the SPM and HCIP groups.

The initial evaluation plan also called for a number of data sources to evaluate the use of in-person assister guides (IPA) and navigators given the central role they would play in implementation of the SPM. We used qualitative techniques to gather data on the effectiveness of the IPAs and navigators as well as to study the governance process, outreach and education efforts, and other objectives. The qualitative data was obtained using semi-structured interviews as it was believed this method would produce better information on sensitive issues compared to focus groups. All of the qualitative information was collected in a manner to ensure anonymity. We also relied on existing data sources from AID and other organizations to characterize the outcomes of open enrollment and issues related to the training and effectiveness of IPAs and navigators. Greater description on the data sources as well as details on the qualitative methods can be found in the body of the report.

Finally, team members from AFMC developed and fielded a survey of providers to gauge their experience with the SPM. This survey was conducted with hospitals, physicians, and behavioral health care providers. The survey focused on the impact of the SPM on key metrics such as impact on uncompensated care costs, patient access, and reimbursement. The survey was fielded early in the implementation of the SPM and may not capture the full effects of the SPM as it grew substantially over time. An important recommendation for further evaluation is continued monitoring of providers with respect to these key metrics.

EVALUATION GOALS AND OBJECTIVES

Based on the prior evaluation plan and the feasibility of accomplishing goals within the first year, nine goals and an accompanying set of objectives were planned. The goals were developed in collaboration with the AHCD and formalized through a contract with the COPH. The COPH subcontracted with AFMC to complete four of the nine project goals (Profile Qualified Health Plans Enrolled and Seeking to Enroll in the SPM, Assess Outcome of Open Enrollment, Evaluate Impact on Consumer Health Care, and Evaluate Impact on Health Care Providers). This section summarizes each of the nine evaluation goals.

EVALUATE EFFECTIVENESS OF GOVERNANCE PROCESS

The effectiveness of the governance process was assessed through key informant interviews with members of the Steering Committee, Plan Management Committee, Consumer Assistance Advisory Committee, AID staff, and contractors working directly with the AHCD. The interviews focused on the individual’s perceptions of the stakeholder engagement process, remaining challenges for optimal program implementation, and future opportunities for program improvement. Individuals were asked to examine their understanding and value of the stakeholder engagement process, barriers and obstacles to an optimal system, and immediate priorities for operations/program changes. Lastly, we conducted key informant interviews with

select policy makers to assess current perceptions of program implementation, their role in planning and development, and their perceptions of remaining challenges to be addressed for optimal program performance.

EVALUATE EFFECTIVENESS OF THE OUTREACH AND EDUCATION EFFORTS

This objective sought to detail the outreach and education efforts through key information interviews with vendors contracted by AID to perform such activities. The interviews focused on each vendor's outreach and education efforts to measure the impact and change in consumer and other constituents' awareness of the SPM. Key constituents were also interviewed to assess the outreach and education efforts in which they participated with the vendors. The purpose of all of the interviews and subsequent analysis was to determine which efforts were most effective, and the effect of these efforts on enrollment.

PROFILE QUALIFIED HEALTH PLANS ENROLLED AND SEEKING TO ENROLL IN THE HEALTH INSURANCE MARKETPLACE FOR ARKANSAS

Profiles of the QHPs that enrolled in the SPM were completed to examine the effectiveness of the enrollment process. The data collected included the number of insurers involved, number of plans involved, number of plans certified, variety of metal levels (i.e. Platinum, Gold, Silver and Bronze), and the costs of various plans. Barriers to and promoters of the certification process, the ease of the certification process, and plan monitoring were assessed through a survey of carriers.

EVALUATE EFFECTIVENESS OF THE IN-PERSON ASSISTER GUIDE TRAINING

The effectiveness of the IPA guide training was assessed through examination of the training curriculum and process, interviews with organizations contracted to provide IPA services, and examination of the Guide Management System (GMS). The training curriculum was reviewed with the previous evaluation conducted by Boyette Strategic Advisors to provide baseline information for the assessment. The IPA service organizations contracted with AID were interviewed to determine the applicability of the material covered in the training curriculum and ease of access to the training. The GMS functioned as a reporting tool for AID to use in monitoring the IPA organizations and was examined in detail to assess the utility and effectiveness of the tool.

EVALUATE EFFECTIVENESS OF IN-PERSON ASSISTER GUIDES AND FEDERAL NAVIGATORS

Evaluating the effectiveness of the IPAs and Navigators included identifying the percentage of enrollees who used an IPA or Navigator while attempting to enroll or enrolling in the SPM and the overall contribution of the IPAs and Navigators to open enrollment. Enrollment data for the SPM, information from the Arkansas Health Connector Resource Center, and consumer survey data were used to assess use of IPA's and Navigators as well as satisfaction with their services.

ASSESS OUTCOME OF OPEN ENROLLMENT

The evaluation team assessed the outcome of open enrollment by tracking and trending the number of Arkansans eligible, the number of Arkansans actually obtaining insurance, and enrollee satisfaction with the enrollment process. Data was obtained from the Kaiser Family Foundation to determine potentially eligible enrollees and from AID to assess the actual number of enrollees and cancellations (those who initially purchased insurance, but terminated after a few months).

EVALUATE IMPACT ON CONSUMER HEALTH CARE

The evaluation team fielded a large survey of consumers in the Marketplace. The consumer survey data was used to assess access to care, ability to make timely appointments, and the ability of enrollees to find providers who are willing to accept new patients. The survey also asked questions about the affordability of the insurance plans, the use of preventive services, and satisfaction with care. Estimates of the overall quality of care were assessed with items from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey instruments and compared with national Medicaid data.

EVALUATE IMPACT ON HEALTHCARE PROVIDERS

The SPM was expected to impact health care providers by reducing uncompensated care costs. We fielded a survey of hospitals, physician practices, and behavioral health care providers to gain insight on uncompensated care costs and other aspects of the SPM as it effects healthcare providers. The survey was fielded within the first year of the SPM when a number of issues involving implementation were being reconciled. The evaluation includes both uncompensated care costs and other issues involved in implementation of the SPM from the provider perspective.

DEVELOP A YEAR TWO PLAN FOR ONGOING EVALUATION

Based on the information gaps identified in the first year evaluation, a number of metrics and strategies for evaluation that could improve the functioning of the new state marketplace are proposed. The plan was developed by considering the evaluation goals for the first year and the objectives laid out in guidance from the Centers for Medicare and Medicaid Services.

All of these efforts led to a comprehensive first year evaluation of the SPM and plans for future work. The following sections provide a detailed description and analysis of each of the nine project goals.

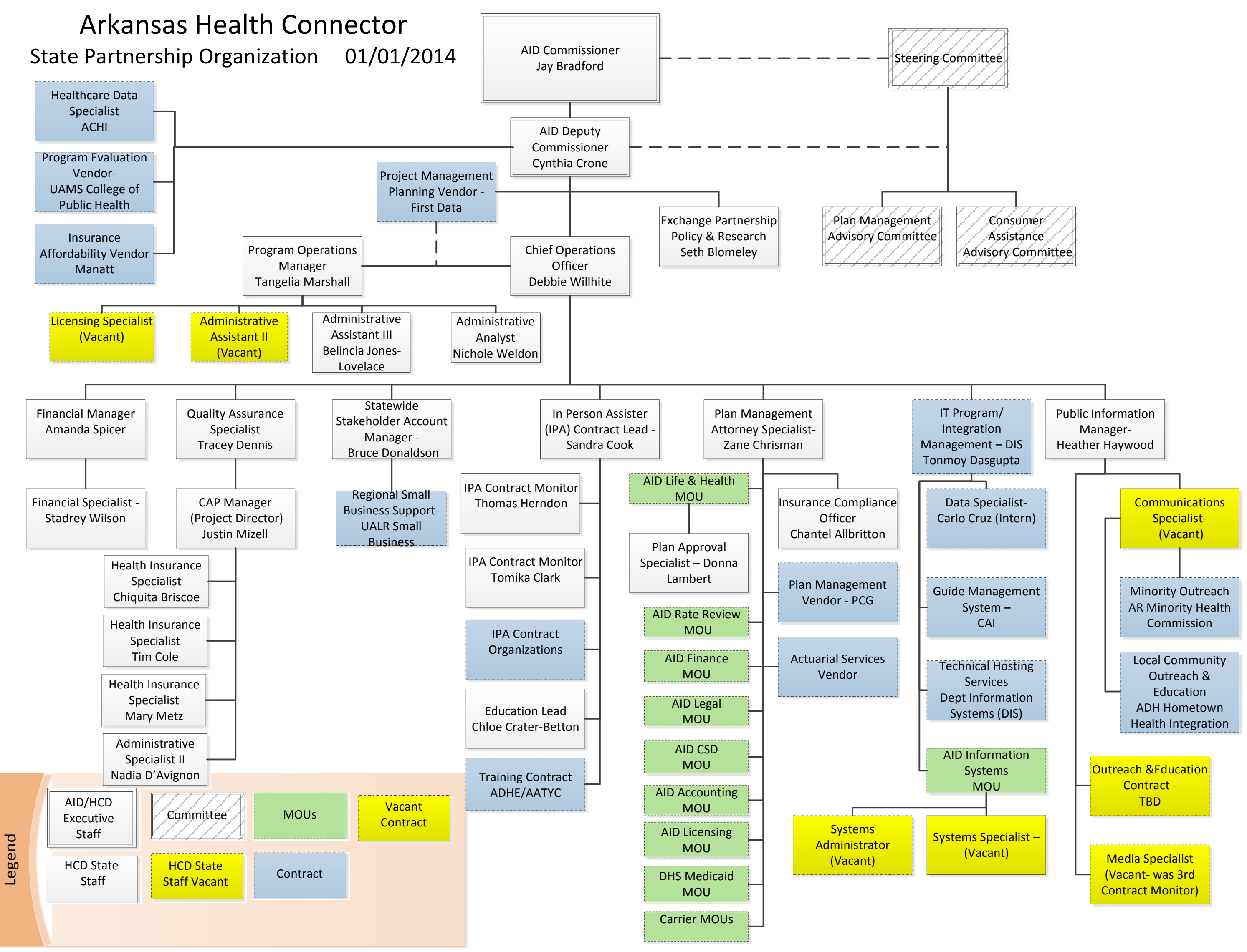
I. EVALUATE EFFECTIVENESS OF GOVERNANCE PROCESS

OVERVIEW

Governance processes and leadership for the Arkansas State Partnership Health Insurance Marketplace (SPM) included Arkansas Insurance Commissioner, Jay Bradford, as governing authority, Arkansas Insurance Department (AID) Arkansas Health Connector Division (AHCD) leadership and oversight director Cynthia Crone, later appointed to serve as AID Deputy Commissioner, chief operating officer (COO) Deborah Willhite, project management provided by contractor First Data, a fully staffed AHCD office handling various aspects of project implementation, collaboration with other divisions in the Insurance Department, and a detailed and evolving stakeholder engagement process that involved diverse stakeholders in considering various issues and making recommendations to the Insurance Commissioner regarding Marketplace planning, development, and implementation. The latter drew together diverse stakeholders to serve on one or more of three stakeholder committees: the Consumer Assistance Advisory Committee (CAAC), the Plan Management Advisory Committee (PMAC), and the Steering Committee (SC). The two advisory committees considered issues relevant to consumer assistance or plan management and made recommendations to the SC, which then made final recommendations to the Commissioner.

AID requested an evaluation of the governance process of the Arkansas Insurance Exchange Project led by the AHCD. We utilized qualitative methods in our evaluation to obtain feedback from members of the project's three stakeholder committees (the CAAC, the PMAC, and the SC), representatives from the other AID divisions that collaborated with the AHCD, policy makers who participated in planning and development, AHCD staff, contractors and consultants, and AHCD and AID leadership. The relationships between the different contractors, stakeholders and Division are shown in the organization chart below.

FIGURE I-1. AHCD ORGANIZATIONAL CHART



We conducted a total of 43 key informant interviews with A) SC members (N=16); B) PMAC members (N=10); C) CAAC members (N=6); D) AID division representatives who collaborated with the AHCD (N=5); E) AHCD staff members (N=9) and F) AHCD and AID leadership, contractors responsible for project management, and consultants (N=10). In addition, 18 of these individuals were identified by AHCD as falling into their policy maker category. (Please note that many individuals fell into more than one category, e.g., one individual interviewed might have been a member of the PMAC and the SC.)

PARTICIPANT SELECTION & DATA COLLECTION METHODS

Potential interviewees were identified by AHCD. Individuals were contacted by the UAMS project manager and those who agreed to an interview were scheduled by the project manager in conjunction with AHCD staff. Interviews occurred during a two-month period from July 23rd through September 25th 2014. All interviews but two were conducted by qualitative methods expert Dr. Karen Drummond. (Two were conducted by Dr. Sharla Smith, who was interviewing those individuals for another aspect of the evaluation; for the convenience of our participants, Dr. Smith added our Governance evaluation questions to her interviews in those two cases.) Most interviews took place via phone (though a few were conducted at the AID offices).

Interviews ranged from 15 - 45 minutes, and covered topics from a semi-structured interview guide (see Appendix I-A) approved by AHCD. Questions were asked as appropriate for each individual's involvement in various aspects of project governance. In accordance with the nature of semi-structured interviews as well as the time constraints of some participants, not all questions were asked of every participant but an attempt was made to cover the most important topics of the relevant governance aspects. All interviews were digitally audio-recorded with the participant's permission. Recordings were uploaded to a secure project folder behind the UAMS firewall. Recordings were transcribed verbatim by contract arrangement with AFMC and returned to UAMS for analysis. Recordings and transcriptions remained confidential and were not shared with anyone outside of the evaluation team.

DATA ANALYSIS

Dr. Drummond initially performed a rapid analysis of notes taken during interviews to identify preliminary themes. Upon receipt of transcripts, Dr. Drummond reviewed each one for accuracy. A summary template was used to analyze transcripts, containing each of the five main areas of the Governance evaluation – steering committee feedback, advisory committee feedback, AID division feedback, policy maker feedback, and project management feedback. Dr. Drummond read through each transcript, line-by-line, adding feedback to the relevant topic within the analysis template, including verbatim quotes. After all transcripts were analyzed, Dr.

Drummond reviewed the completed analysis template to identify common themes/patterns for each of the governance areas. All quotes in this report remain anonymous, identifying participants only by their role.

RESULTS SUMMARY

Overall feedback on Governance processes was extremely positive. Most individuals felt that the Health Connector Division and First Data contractors have done a tremendous job of leading a very complex project under extreme pressures and numerous obstacles. Key overall successes identified were: strong stakeholder engagement processes through the committees; the ability to launch the marketplace under difficult conditions; a robust consumer outreach effort initially (before such efforts were blocked by the state legislature); the challenging but successful development of habilitation services (a new required insurance benefit); and high enrollment numbers, as highlighted nationally in the August 2014 Gallup poll results.

Advisory and Steering Committee members reported that the appropriate stakeholders were involved; discussions and decisions were balanced among stakeholder groups (with relevant stakeholders sometimes having a greater voice on certain issues, but always as appropriate and never to the exclusion of others); individuals (including guests who were not official members of the committees) were able to voice their concerns and questions; and committees were effective in conducting their mission.

Policy makers felt that the implementation of the Marketplace was successful and often credited Cindy Crone's strong leadership at AHCD for this success, as well as the work of the stakeholder committees. Several individuals voiced a strong hope that the stakeholder engagement foundation laid by the AHCD in this project will be harnessed by the new Arkansas Health Insurance Marketplace (AHIM), not necessarily involving the same stakeholders, but to work from the strong foundation laid by the current project and to carry the institutional knowledge forward.

The primary challenges identified appear to be mostly in two categories: 1) the delays and constant changes that came down from the Federal level, and 2) the State legislature's opposition and decision to shut down all consumer outreach and education efforts. Individuals working within the AHCD or in the AID Divisions were most affected by the first issue, while the Consumer Assistance Advisory Committee and the individuals within AHCD who worked directly on consumer assistance issues were the most affected by the second (though individuals outside of these categories also mentioned this as a major obstacle to the project).

Some committee members felt that the committees were less engaged over time (with dwindling attendance), and wondered if the frequency of meetings could have been reduced in response to the decrease in urgent decisions to be made at present.

AHCD staff were proud of the project's accomplishments, particularly given numerous challenges and pressures. Several individuals felt that it would have been very helpful for leadership to openly and more frequently acknowledge the climate of uncertainty regarding project funding and changes in individuals' duties. Though they realized that such issues were not entirely in leadership's control, they wanted more open communication to the entire team and noted that even to hear leadership acknowledge the uncertainty would have helped to ease employees' anxiety and quiet the office rumor mill.

STEERING COMMITTEE

Commissioner Bradford appointed the Steering Committee (SC) in March of 2012 to make recommendations relative to the development of the SPM. Appointees included representatives from government (executive agency leaders, Governor's office, state legislature), private industry (health insurance and health care), and consumer advocacy groups. The SC met monthly to discuss planning/implementation issues, provide active and visible leadership, consider and approve or disapprove recommendations from the two advisory committees to forward to the Commissioner, and garner support for Marketplace implementation and sustainability. First Data served a facilitation role. Meetings were open to the public and interactive video conferencing was used for distant participation. Monthly progress reports and meeting summaries were posted on the AHCD website.

We interviewed 16 members of the SC. Interviews covered the topics of stakeholder engagement in the committee, decision making processes, and committee operations.

STAKEHOLDER ENGAGEMENT IN STEERING COMMITTEE

- All SC members felt that relevant stakeholders were involved in the SC.
- Leadership continuously examined whether to include/invite new stakeholders.
- Leadership also reached out to additional stakeholders individually via email to provide updates and solicit feedback, and to invite participation.
- Attendance at committee meetings dropped over time.

"There was a broad spectrum of agencies, advocates, carriers, medical professionals, I mean, I was very impressed with the range of expertise and relevance of people and processes that were represented through the Steering Committee or through the two different advisory groups."

"I think so. It was pretty broad. There was not full participation at all times. I know some legislative members were members and were not there much of the time but they may have been hearing the information another way, through another venue. But I think overall it was a good sampling."

STEERING COMMITTEE DECISION MAKING

SC members reported that they were careful to take stakeholder feedback into account in making decisions, and felt that most SC recommendations forwarded to the Commissioner were consistent with advisory committee recommendations. Committee leadership was responsive in explaining why a particular decision might not be supported by the Commissioner (a rare event, according to our participants).

"We've had some pretty intense discussions in the Steering Committee before making recommendations to the commissioner. But you know, it was real interesting. Sometimes the Steering Committee would say, "No, we need to send it back to Plan Management. They need to look at this and look at that." And that was great, because something might come up in the interim that they didn't have access to. Whether it's something new that the feds have said or, you know, Private Option all of a sudden was in the mix. How does that affect all of this? So they'd send it back […] which I thought was good, as opposed to just plowing ahead without that input."

"But I think on the whole, it was a, to me it was a great way to bring, as you say, narrow that funnel and bring those recommendations, have another whole group look at them, and nine times out of ten we took the majority recommendation, but sometimes we didn't. And then we always knew though that the final decision was not ours, it was the Commissioner's. So it wasn't like we were, you know, feeling that kind of heat, but sometimes there was another voice that brought something that hadn't been brought to the table the first go-around."

“You know they’d say, ‘Did we all agree?’ and ‘These are the issues we will bring forward to the commissioner.’ And then they got rapid responses back through Cindy Crone from Jay Bradford about what he could support or couldn’t support. I can’t remember any specific examples [when he couldn’t support a recommendation], but it seems like mainly it was because they were awaiting more information. Like it’s not that it was a ‘no’ as much as it’s ‘I can’t make that decision at this time until we get additional information.’ So maybe it was more of, ‘This has to pend for now.’”

COMMITTEE OPERATIONS

SC members felt that the committee was effective and efficient, and that the consultants were key to the efficiency of the SC.

“They obviously relied upon each other’s recommendations and whether that was the committees, the individual Plan Management Committee, or Consumer Committee, or sub-committees of those groups. I think everybody respected that and they would have some questions, but I think it was a very efficient process.”

“I think the Steering Committee operated very efficiently and very professionally. And I think the way it was delegated out and I do believe the consultants that worked with the Steering Committee in particular helped drive some of that. They were great. You know a lot of white papers up front, so everybody was on the same page when they would show up to a meeting.”

“I really have to give a lot of credit to PCG. They did extraordinary briefing and leading the discussion in technical areas and moving us along, getting us to a place where we could make a recommendation. And then people, like the co-chairs, would kind of try to pull consensus to the extent you could and get to a motion and a vote. So once again I think the Steering Committee worked very well.”

CHALLENGES

The greatest challenge reported was the legislative blocking of the outreach and education efforts:

"Well I think the biggest challenge of the Steering Committee and the division has been the lack of legislative support for outreach and engagement. I think you end up seeing that in the proportion of the 250,000 folks that were eligible for a tax credit and roughly 40-45,000 of them availed themselves of that tax credit to purchase insurance."

"How do you try to educate Arkansans that have never had insurance before on actually having an insurance policy? You know, what does that mean and how do you arrange to go to doctors and what about preventive care and especially when the state was not able to do the education and outreach. We started strong, but of course because of some legislative restrictions and things like that we weren't really able to finish strong. But I think that the biggest challenge was given our environment and how it was evolving, how do you market this program and educate a state on both enrolling in health care and then what does it actually mean to be a card-carrying member, somebody that has health insurance? Not going to the emergency room every time you are sick, you know things like that. So I think that was certainly something that we had to try to deal with."

"The thing I think everybody on the Steering Committee would like to see happen is us to be able to once again do some outreach. That's not under our control at this point. So, I think that would be the biggest thing to be able to help the Steering Committee and the sub-committees make decisions. And, also, to make sure that the decisions and recommendations we were making were the best for the consumer that is out there."

ADVISORY COMMITTEES

Two advisory committees were created in May of 2012 to align with the state-operated functions of the Marketplace – the Consumer Assistance Advisory Committee (CAAC) and the Plan Management Advisory Committee (PMAC). The committees met once per month to consider scheduled policy issues and make recommendations relevant to Marketplace implementation. They reviewed issue briefs and alternative policy recommendations, discussed options, and made formal recommendations to the Steering Committee. Three non-government co-chairs led each committee, one each representing the insurance industry, healthcare providers, and consumer advocacy groups. Co-chairs were also members of the Steering Committee.

CONSUMER ASSISTANCE ADVISORY COMMITTEE (CAAC)

We interviewed 6 members of the CAAC. Interviews covered the topics of stakeholder engagement, committee discussion and decision making processes, perceived successes and challenges, and remaining challenges.

STAKEHOLDER ENGAGEMENT IN CAAC

- Most participants felt that the relevant stakeholders were invited. Two pointed out difficulties in engagement (actual consumers not at the table; more minority voices needed; younger people missing).
- Participants reported that some individuals in the CAAC meetings seemed to have a greater voice in discussions, but that this was often because of knowledge or passion about the particular issue being discussed.
- All participants reported that the committee co-chairs worked hard to ensure that all voices were heard in discussions.

"For the most part, we had a really broad range of stakeholders and really had a great meeting to try to attempt to reach out to a lot of different types of organizations and groups where we had invited 30 or 40 groups to the table and then they thought of who else we needed at the table and so anyway, I do feel like yes, it was a very inclusive group. Not everyone attended but yes, I do feel like all groups were represented or many groups were represented."

"We worked really hard at that. Yes and no, I guess is the answer. Yes and no. Yes, in that there were still some of the same usual players there, but they were really advocates and in touch with the people they served, the people most affected by the policy. But, they weren't those people. See what I'm saying? They weren't the people, those most impacted by the decisions and things that we were talking about doing, were not at the table. Better than before, better than some other efforts I've been in because we worked really hard at that. And we had an exclusive goal as a consumer advisory committee, we want to make sure that we reach as many constituencies around the state as we can, and those most in need. So, I think we did pretty good. But, the voices of the people, what I call the real people, were still missing."

"I definitely think it is a good representation. I just feel there should probably more, of course, Latino voices, more Marshall Island voices, more minority voices that represent those populations and their service interest, health interests. But, as far as the different types…it seems like there was a really, really good effort made to make it as broad as possible and I felt very good about the representation. As far as the different components, the different types of people that were at the table, notwithstanding what I stated earlier, the racial makeup of it. And I would also say the youthful voices. I didn't see a lot of young aged representation on the committee which could have really helped us relate to the college students, the young parents, the kind of the 18-30 age group. I didn't see a lot of representation there."

PRIMARY SUCCESSES

- Number of Arkansans enrolled
- Stakeholder discussions
- IPA program setup

"You know we have over 200,000 people insured now that weren't insured a year ago and that's just an amazing job. It's hard to pick at, to swat the gnats when you've enrolled over 200,000 people. It's quite an achievement."

"I think the bringing together the ideas and concerns and thoughts. And somehow being able to manage all that to the extent of meeting the needs that we could meet. Developing the process of the program, the outreach program, the way we did. That, in my opinion, was effective. I think that was one of the main successes was just bringing together so many various stakeholders with different backgrounds, yet everyone had a similar mission. That was to see that people, whoever your targeted audience were, that all of those people, all those audiences would be different. The stakeholders had different missions and visions within their own organizations. Being able to bring all those partners and voices together and actually be effective and accomplishing something we are actually number one. As far as what we were really trying to do and get more people insured. That, to me, was the greatest success."

"I would say assisting thousands of Arkansans in enrolling in health coverage. We, despite an occasionally, often tough political environment, with getting funding through the legislature, and despite the legislature completely stalling the outreach and education money that would have provided for a public information campaign, I feel like the Consumer Assistance Program, particularly the In-Person-Assister Program, had an amazing impact."

PRIMARY CHALLENGES

- External forces (federal government delays, federal data hub, Arkansas state politics)
- Legislative block on outreach
- Internal issues (committee attendance, collaboration across diverse interests, loss of consultant support)

PLAN MANAGEMENT ADVISORY COMMITTEE

We interviewed 10 members of the PMAC. Interviews covered the topics of stakeholder engagement, committee discussion and decision making processes, perceived successes and challenges, and remaining challenges.

STAKEHOLDER ENGAGEMENT IN PMAC

- Most members felt that there was a good mix of stakeholders on the committee. Three members reported that consumer representation was insufficient, particularly actual consumers. Two individuals said that the insurance industry was over-represented on the committee.
- Stakeholders were very engaged initially, and less so as federal requirements began to guide decisions.
- Healthcare providers were invited but less involved.
- Most felt that discussions and decisions were balanced, and when some individuals had a greater voice it was because of more knowledge or a greater stake in the subject. Co-chairs ensured that all voices could be heard. Only one member felt that decisions were led by the Department and the consultants.

"I would say generally speaking I think that they've gone kind of to extraordinary efforts to try to get representatives from all of the different stakeholders involved in some form or fashion. Now you know there might be a particular interest group or whatever who feels like they might wanted to be involved that haven't been, for example, pharmacy. I don't really remember anyone representing the pharmaceutical industry or pharmacists, but for example we have nurses represented on the committee, physicians represented on the committee, insurance industry, agent brokers, a variety of different folks are there so and consumer advocates as well."

"I think that from the onset that - and this is the group that is the hardest to represent - I think from the onset of this planning process that the consumer was not represented there. And I thought there was actually an over-representation of the insurance market in the process. That's a really hard thing to…it's kind of like embracing smoke. It's a hard thing to say who is the consumer and how are they fairly represented. And then representing the insurance companies, the insurance industry, the hospitals, physicians, providers, I mean that's a lot of, that's a much easier population to define. To define the consumer is very difficult. And so how to do that is hard. But yeah there was certainly an effort. It was not an overt effort to exclude anybody, but I just think they were underrepresented in the process. Please understand I don't mean that in a real negative way. And I think just about everybody on there, matter of fact everybody on there, felt, if you asked them, they felt that they represented what's best for Arkansas and not what's best for their industry. But usually you view the world from the world in which you came, and so there's an inherent bias just by where your frame of knowledge emanated from."

"I think that what my perspective is is that several years ago when there was very, very little guidance from the federal government, Cindy and her folks, they were not going to let that hold them back to accomplish the goals that they had set and the expectations that were there for them despite the fact that they didn't have hardly any guidance from the federal government about what they could or couldn't do. So, I found in meetings and discussions early on to be particularly helpful. But, again, part of it was there wasn't a whole lot that anybody could look to from the federal government. As the federal government has kind of gotten their act together with respect to requirements and expectations and those kind of things, my perspective is the roles in both the Plan Management and the Steering Committee have diminished some because there have been fewer and fewer real decisions to be made because it was being dictated from the top down and they would just say, "Well, this is what CMS is requiring of us now." So, I would say, just kind of to summarize, early on there seemed to be a lot more interaction and a lot more true input into the process then I have found to be the case in the last nine months, maybe to a year."

"I have to say I think it was fairly balanced. I really do, and I think a great deal of credit goes to [name redacted], who took great care I think to make sure that it was. I was really, just in all honesty, when I first came in I thought, "Oh the insurers are driving this bus and its going and there's not going to be any way to bring another voice into that." My first impression was incorrect, it really was. I found that as I became more involved in the process I felt like everyone was really going to great pains to be very balanced in the approach. I think, I don't know who chose the committee members originally, but whoever did it did a very good job of bringing people into the room who were able to be balanced in their viewpoint."

PRIMARY SUCCESSES

- Stakeholder collaboration, educating each other
- Selecting and tailoring plans - habilitation benefit development in particular
- Developing recommendations for the Commissioner

"I think that the committee, which pulled together an attractive, you know, a diverse group of stakeholders, has been real successful at building a little culture of openness and common interest and I think that's enormously valuable and I hope that we'll find a way to keep that going because we've got three competitive insurance companies, and we've got advocates and providers in the room, and you've got maybe twenty members and fifty people attend the meeting and I think what could be quarrelsome turns out to be a very helpful constructive dialogue and I think we are all comfortable with each other and many things include humor as well as discussion. And the Department of Insurance provides a good atmosphere for that and their staff is real attentive to us, so it's conducive."

"One thing that I felt was really well handled – and it was not easy but it was very well handled – was coming up with a definition for habilitative services during that process, and it involved numerous meetings, lots of people in the room, lots of different perspectives. Habilitative services is not something that has ever been covered by insurance companies before, so the insurance companies had no idea how to deal with it and were resistant to the idea of covering something they didn't understand. The providers were trying to communicate to the insurance companies exactly what that is, you know, and I mean it was it was very well handled. And after, gosh, must have been five or six somewhat heated meetings we ended up coming up with a definition that I think it works for Arkansas and that in my mind is a key success."

"I think that for all intents and purposes, the Plan Management Committee was able to deliver some pretty solid recommendations to the Steering Committee and to the Commissioner about issues that need to be addressed and how to structure the Marketplace so that you encouraged insurers to participate in it, encouraged individuals to participate in the Marketplace."

PRIMARY CHALLENGES:

- Time constraints / pressure to make quick recommendations
- Uncertainty linked to external forces (federal government, state legislature)
- Non-industry stakeholders' lack of understanding of insurance industry

"The main challenge is, it's kind of been with everything that the time pressure, and just to be able to adequately sit down and go through the education process and understand what's real and what's imagined and those sorts of things. And getting to really good policy decisions that take in the perspective of everyone. I think that's just the time challenge, because for example, even more routine decisions related to the 2015 plan year, you know we were having to start trying to make those when we only had a month or two left. And part of it was because of the uncertainty with the federal government and how they might be changing the rules and regulations that operate them. So I think that's the biggest frustration."

"I think the uncertainty. The uncertainty at a federal level and also the uncertainty at our legislative level. And the fact that our legislature, at least a significant portion of it, was resistant to the whole idea and kept the whole process underfunded and sort of in limbo the entire time, whether or not it would be…you can come up with these proposals, but it may never see the light of day because there's no funding for it. So I think that the biggest hurdle has been…and if the…if just to get the thing accomplished in the first place wasn't big enough but the hurdle was just this terrible uncertainty, both at the federal level what the Supreme Court was going to do, and ultimately what the legislature was going to fund made it pretty difficult."

"Well, I think that the, you know probably what I would call the advocates, or the individuals in the respective groups, would want every single thing accommodated the way it is today when we are moving into a new market environment. You can't be all things to all people and some tough decisions have to be made and it's going to irritate some folks. I think that was a big challenge. You've got a diverse set of interests in the room and trying to navigate those interests, pick the right way versus picking the way that accommodates everybody's interests was a challenge. I mean, you know, you can't…if you have a decision to be made about network adequacy, you can't take everybody in the room's definition of network adequacy and approve it and say, "We are going with everybody's definition." There's going to be some times where you just irritate some people and their wishes are not going to be met. So, I think the diversity in the group coupled with you know, their own interests, coupled with a lot of lack of [knowledge about] how, you know, a marketplace health insurance program works was the biggest challenge."

INTRA-AGENCY DIVISIONS

The AHCD collaborated with other divisions of AID throughout the project. AHCD worked with Compliance, Rate Review, Finance, Liquidation, Legal, Consumer Services, License & Information Systems, Accounting, and Information Services. To establish regulatory and certification standards including solvency standards for Qualified Health Plans (QHPs) in Arkansas, AHCD worked with the Compliance, Rate Review, Finance, Liquidation, Legal, Consumer Services, License, and Information Systems divisions of AID. For example, the Rate Review division played a key role in evaluating the premium pricing structures of the QHPs. The Consumer Services division provided consumer support regarding questions and complaints. The License division helped with licensing and monitoring the thousands of navigator and non-navigator Marketplace assisters (including licensed producers), ensuring competency to assist with enrollment or to sell insurance plans through the Marketplace. The Accounting division ensured that AHCD policies and procedures were in compliance with state and AID financial processes. And the Compliance division collaborated on preparations for the QHP certification review.

We interviewed five individuals representing five of the divisions within AID that collaborated with the AHCD. (To protect interviewee anonymity, we do not reveal the divisions each one represented in this report.) Overall, these individuals felt that the collaboration between their division and AHCD worked very well.

STRENGTHS HIGHLIGHTED IN WORKING WITH AHCD

- Strong leadership & project management (AHCD leadership & contractors)
- AHCD staff
- Good communication between divisions

"I think Cindy is one of the most energetic administrators that I've worked with here at the department and I've been here for twenty years. She has her fingers in, eyeballs in on every single email, proposed draft, MOU etc. It's unbelievable how she's a hands-on manager. She does not typically delegate everything out. She watches what her staff is doing. I have no suggestions and no suggestions of improvement. She's much more energetic than me I think in reviewing things."

"I think we've had a pretty good working relationship, because of the Director that's down there and her personnel. We work as a team, so to speak. They just became an extra part of us, an extra section. They notify us about what they need. And we proceed to do what we are supposed to do inside our division. You know, and we do most of that by email, or meeting, or telephone call, whatever, but we do have a lot of communication. So it's quite a bit."

"It's always been excellent. Oh sure it's been excellent, you know Cindy's great to work with. She's just a workaholic. She has been just really been good to work with and her staff and especially, from my standpoint, the plan management piece, [name redacted] and [name redacted], we work most closely with them, and I certainly I've, I don't know what we would have done without them."

"I think communication has worked well. We've been open to them if they have questions or have problems. We have a lot of open communications between the divisions. We tend to have meetings. I think we're doing quite well as far as communicating back and forth. It's been a good relationship I think."

"As far as coordinating things - we call them Suite 201, because they could never figure out what their name was, so we referred to them as Suite 201 - working with them was not a challenge. Once they got the right people, in the right places, with the job function that would suit the individuals, communication was wonderful. So I can't say that we need to have more inter-communication because that's going well. […] [Regarding] communication, they have the right people in place to where it's easy to talk to them. […] The communication could have been worked on and has been. So, you know, we're doing real well with that. You should have called me several months back. It would have been different. […] [But now] they do their job, I do my job, then you know we talk about it."

CHALLENGES FACED IN WORKING ON THE PROJECT

- Tight deadlines, high volume of work
- Legislative approvals required for each piece
- Delays in information from federal government

"There have been bumps in the road. It's been difficult, and especially it was difficult last year because we had a very tight time frame and we had, we were doing something we had never done before and so it was tough, and a lot of people worked a lot of long hours. My staff was working on weekends and getting all the stuff done. And this year has been much more…it's going to go on much more smoothly because just because we've done it before."

"It's gone as well as you can expect given the biggest obstacles probably you know, is having to deal with all the legislative piece. And keeping the funding and just going over there and you have to keep the money rolling. You've got, you know, to go over there and justify every little thing."

"Well it's not been the division so much as there have been dependent on information coming down from the federal government and sometimes that's not as quick as it could be to help us get the job done."

POLICY MAKERS

Eighteen of 43 individuals we interviewed were identified by AHCD as policy makers. Feedback from these individuals regarding the overall implementation of the Marketplace was overwhelmingly positive. Some of the things that policy makers highlighted regarding implementation were:

- Stakeholder engagement process
- Transparency of the process
- Outreach campaign
- Integration of HCIP (Private Option)
- Marketplace was implemented despite numerous challenges
- Enrollment numbers / decrease in number of uninsured
- Arkansas becoming a leader in the nation

"I think the process has been great. I think the structure that they set up first of all, to get stakeholder input has been essential to the process and the respect that's given to the viewpoint of the stakeholders by the staff in the Department I think has been critical for generating frankly a lot of goodwill and a lot of support within the key stakeholder communities for the Marketplace. I hope that when or if we transition to a state marketplace run by the other board that's been appointed, I hope that they will look at the process that was established by the Department and try to mirror that as much as possible just because it has been so good to eliminate fights with that would inevitably, I mean you just try to eliminate as many bombs that can be thrown at you as possible. And I think the Department has done a really good job of that."

"I think that the press has been in the room and it's been very transparent which is something I didn't bring up but I think is important. It has been very transparent, the press has always been welcome and I even see the main reporters who have covered it, and they have changed. I guess I've gone to the meetings long enough that the reporters have changed. I don't know what that says but I see them following up after the meetings and very open, very engaged, and so I feel like the transparency has been nice and of course I think that's very important."

"I think it's been very successful and I certainly think it's because of the commitment of the Insurance Department, who headed up everything that happened with the Arkansas Connector. I was so pleased with the actual ads that have been done, the Get In campaign. We put all the Get In logos and things like that on our notices that came from our agency early on so that people could connect up and connect our messages to the early ads. Again, those were stopped. We were told that we had to stop. But I mean that process at the beginning, it was really, really good and I think we probably would have had even more success had we been able to continue that. So the call center support has been very strong. All of my call center staff know the ones over with the AID that were created specifically to support the Arkansas Connector process, [name redacted] and his team. So I think they've done a very, very good job in doing the implementation and coordinating this project for the state. I mean it's just hard to argue with being number one, so we must have done some things right with an assignment that was phenomenally complex. By the time we really got going with building some of these systems, we had about five months to get that doorway up and running, and get people trained and get brokers and agents licensed and all of that, so it was really a Herculean effort and with tremendous success. So I think you can see I'm a fan."

"You know it took all of us working together to go through this first year. So I think Arkansas had a tremendous opening day for opening enrollment on October 1st of 2013 from every level. From eligibility, when we were able to do the outreach and let people know about the Get In campaign, then we had our mobile enrollment units out at the Clinton Center and all of our county offices had been briefed. We knew what we could or couldn't say about actual insurance coverage because we had been trained on we can't talk about actual insurance policies but we can at least tell clients that you might want to consider where you receive your services or what your own personal medical conditions are that may help you make your choices. Like I said, I felt like from a client perspective, a provider perspective, a carrier perspective, an eligibility and enrollment perspective, our greatest success was the opening day for enrollment. And of course now we've got over 200,000 of the low-income people, which is obviously our focus, the ones below 138, over 200,000 people that have been enrolled. So I saw where we were ranked by the Gallup poll as the number one state in the nation for the percentage of our low-income uninsured that have now gotten insured. So I feel like all of that was because of the preparation that we did through the work that was guided by the Steering Committees and the Advisory groups."

"I can only comment about Cindy and her group and they were terrific. Jay Bradford gave them enough rope to hang themselves and they didn't. They were diligent and thoughtful and listened. They became, and I think Cindy would agree with this, at the onset she was - and there was nobody in the country who was really knowledgeable in how these things should work - and Cindy took it upon herself to – not only she, but the whole group that worked with her – to become very knowledgeable in the nuances of an exchange. And to their credit, they side-stepped a lot of potholes, and also to their credit there's going to be a lot of states out there that will use the Arkansas model and the Arkansas discussions that Cindy and her colleagues put together and they're going to avoid a lot of mistakes that they would have made otherwise had not Cindy and her group and her task force thought through these problems and come up with solutions and at least discussed the options with it, so I mean I think she did a great job."

CHALLENGES TO IMPLEMENTATION

- Outreach stopped
- Federal government delays
- Public perceptions
- Time constraints, pressures
- Federal enrollment system

"Well I think we would have done a whole lot better if our money hadn't been cut off for education. That really hurt and to this day I don't understand, but I'm not gonna start getting into that."

"The main challenges is overcoming the public's perception that Obamacare is a bad thing instead of Obamacare is something that's there to help consumers. That's been the biggest challenge."

"When they did the first certifications of the plans, in other words, that first summer, it was awfully hard on the (AHCD) staff. Awfully hard, because they were working under terrible deadlines, and there were glitches that were happening with not just the computers on the federal level but how to manage with the carriers and work through a centralized system for certification through the feds. But they stepped up to the plate. And I know they worked long, long hours during that certification period. I think we've got it a little more streamlined this time, so it's being fine-tuned, and [looking at] what else is new. And that's what you do when you start a new system. So I think they're way ahead of where they last year at this time in getting plans certified."

"Obviously, the big snafu with the rollout was the computer. You know, it was just a worst case scenario. Not necessarily anything we had any control over, but I think we did a decent job of damage control, trying to explain to people "Please don't give up," you know. "Tomorrow is a new day, we will worry about tomorrow's snafu tomorrow." So, I think managing, mitigating, I guess, is a better word, that disastrous kind of rollout has been a real issue. […] Had the rollout been smoother, we might have had a lot more people who. Somebody who was on the edge. "Do I want to, do I not?" when they tried a couple of times, we probably lost a few people who just said, "Forget it." We would have loved to have seen higher numbers but I think that we are overall pleased with what we ended up with."

AHCD STAFF FEEDBACK ON PROJECT MANAGEMENT

We interviewed nine members of the AHCD staff regarding their work on the project and their perceptions of project management (leadership and contractor First Data). Interviews covered the topics of project successes, challenges, and management.

PROJECT SUCCESSES

- Meeting project goals despite multiple challenges
- Getting Arkansans covered / improving access to care
- Paving the way nationally / becoming national leaders

"Pretty much we've had something the entire time we've been going through this project, there has been somebody there that has been saying, and "You have to wait. We can't give you this information now." "We don't want to give you the leeway you to need in order to carry on with your particular goal or process because we are getting ready to have a new election, there is getting ready to have court case, there is getting ready to be something and because this might happen, we don't want to do anything to really assist you." So, a lot of our job has pretty much been an uphill battle most of the time. So, when you kind of look at it that way, just the fact we are still here is [a success]. That right there is a success. And being able to come into work on a daily basis. That is a success. You… I think you kind of…working in the environment that we work in, you take the little successes and those are almost big successes. And I think trying to explain that to somebody who is not here might be, is kind of difficult."

"I think the main successes have been that we were able to launch or implement the Marketplace in Arkansas and to see an increase in the amount of coverage that has gone to those individuals who had not previously had coverage."

“I guess the giant successes would be October 2012, whenever we went and had our partnership review with the federal government, we sat down and we said ‘Okay, here is our blueprint that we filled out and this all the work that we have done toward it.’ Not only did they accept three-fourths of it immediately so that we didn’t have to do anything more going forward, it’s actually something that is going to be helpful for the AHIM board now that they are filling out their blueprint because it’s not work that they will have to go back and redo and have to get reapproved. Not only do we have those pieces, but a large part of the things that we were doing and the questions that we were asking both in that meeting and before that meeting and after that meeting. We would say, ‘Have you considered this?’ ‘Are you doing this?’ and ‘This is what we would like to do.’ And the federal government and the people at CCIIO would sit there and look at it and say ‘Oh, well these are your plans!’ and then they would end up adopting them sometimes almost verbatim. And then you would see that turn into kind of a national law. So it wasn’t…they didn’t...occasionally, they would say, ‘This is what Arkansas is doing.’ But quite often you would just see something and say, ‘Oh, well you know, we’ve seen that before!’ So I think that has been a great success for us as a state just the fact we were able to, we were the first state to apply for partnership. We were the second state approved as a partnership. And then in this whole changing realm in order to be this small state, to be one of the ones that has come out as a national leader and to have a lot of our ideas related to healthcare be able to become effectuated on a national scale, I think has been great and especially when you look at in terms of that fact that you know we haven’t had a lot of ‘Go ACA!’ going on at home. So I think that in and of itself is really great.”

PROJECT CHALLENGES

- State politics (especially limits on consumer outreach)
- Federal delays
- Federal enrollment website
- HCIP (Private Option) enrollment

"Well…a lot of the challenges we've had have been political. I mean I think basically, if you just say that I mean you can look at the newspaper and see that's what it was. When you get your grant money from the federal government saying, 'Okay, go and build this exchange. You are required to have it by the federal government, so here is your money.' But then you still have to go get that money appropriated by the state. And then the state is like, 'Well, but we don't know that we want this exchange. And we think we might have a new legislature next year and so we are just going to get rid of it.' Or 'We know there is court case that's coming up and so we don't think that there is a reason to do anything until after the court case gets heard.' And so there is a lot of 'Okay, let's kind of stop and push that back and not do anything.'"

"For the division as a whole…just the legislative process. The project being affiliated with a state agency probably hurt it. I don't know that it could have went with any other agency because I think [they] only were awarded to state government. But yeah just the legislative part of it became so challenging. You had special language put on the bill that didn't allow us to conduct outreach and education during the open enrollment period, not renewing contracts. It was tough. I am very proud of what we achieved in light of the legislative and political struggles we had."

"I would choose the greatest challenge is trying to negotiate the land mine of all the politics. Without a doubt. Trying to move forward to provide information with our hands tied behind our back without the ability to have needed advertising."

"I think that the challenges for the overall group was certainly the language in the appropriations bill that we had last spring barring any kind of Outreach and also eliminating our in-person assister program. It was a very very significant challenge and it did make things much more difficult. We were already a bit hamstrung because we had previously not been appropriating money for outreach that we had in our grant and so at that point everything was at the grassroots [level]. Reaching out to outside organizations, working through them to do as much outreach as possible but of course after July 1st we were unable to do that and I think that that's been a very very big challenge for us."

*"We are constantly having to wait for federal law to come out. So if ever you are around anybody who is implementing ACA, then quite often you will hear the joke about 'soon,' there is this constant joke about 'soon.' And we've gotten to the point where we try not to ever use the word 'soon' ourselves, because of this. But basically, as we are trying to do all of this, **we have basically been trying to build a jet while in the process of flying it**. And quite often, we are waiting for laws and regulations to come down from the federal government and we are trying to comment on those and we are trying to build what we need related to the plan without having those regulations already in place. So, we are contacting to the federal government, we're trying to influence them about what we think needs to happen. Then, they will have a proposal come out and we will say, 'Okay, that's a great rule, but, you might have forgotten this.' Or 'Have you have considered this particular piece?' Or 'How do you think that this is going to interact with this over here?' And so you've had issues related to that and quite often the federal government will always say, 'Well that rule is coming soon. We can't tell you, but it's coming soon.' And then, we will get to the point of and say, 'Well, you told us it is coming soon for the last three months, so how soon is soon?' So, they say, 'It's going to be very soon. It's going to be imminent…imminently soon.' So there has been a lot of frustration in my position in terms of trying to build policy and plans when you don't have all of the pieces that you need in front of you. It's almost like you are trying to build a structure but you are also trying to build the pieces that you need to build the structure. It's kind of a simultaneous development."*

FEEDBACK REGARDING PROJECT MANAGEMENT

Comments overall regarding project management, for both AHCD leadership and contractor First Data, were positive.

- Strengths highlighted:
- Strong leadership from Director (Cindy Crone)
- Excellent management contractor (First Data)
- Addition of Debbie Willhite in COO position
- Culture of teamwork

"Of course, this all would not have happened if it wasn't for Cindy. You have to have somebody there that is truly a unique person and she is an amazing woman. What she is capable of doing, but she works long hours, but she is amazing. You know, having a strong director, I think is crucial."

“Cindy is a great leader. I mean she’s one of those you know, when they talk about people who walk the walk and talk the talk, that’s Cindy. You know, you have to have respect for her for that. I mean she just she really is. She also gives clear direction, she listens, when you have a difference of opinion about something, she’ll listen to what you have to say. And if you convinced her, then she changes it. If you haven’t then it goes the other way! Which is really good. So overall I would say in terms of the way the whole project, the whole scheme of things have been managed, it’s, it’s been really good.”

“Okay, well for me Cindy, she’s not a manager. She’s beyond that. She is clearly a leader. You know, when I’m saying, like a, when I’m saying she is not a manager she is like a super manager. She did some things very well. She is data-driven, she wanted information to make decisions. She would be involved in almost every activity, she knew where the priorities lay and she was able to address accordingly. One of the soft areas that Cindy excels in, you know, which is lost to project managers, is inspiring the team. You know the thing is that she herself, in her personal life, she takes time to help the poor and needy, despite her hectic days, you know in the evenings. But what happened is, she would let anybody volunteer to help during the open enrollment because you know we were, it was all so new and we were more knowledgeable than most other people. So we would go the state fair, we would go to the TV stations to answer questions, and we were being there in the front lines seeing the pain of the people and how they really needed it and that I think that was a little inspiring. There was so many people, like my personal experience was a woman breaking down, you know needing the help they needed this way and hearing their stories it helps to inspire the people, who went beyond their regular 8-5 kind of mentality, it was not like government operations at all. Everybody was committed. I think that aspect, she needs to get credit for that.”

“First Data, I mean if…if it wasn’t for them, you know…they just did a really great job of keeping all of us on target, you know, running in the same direction towards the end goal. Without them, I don’t think this would work. Everybody would be scattered and doing their own thing in their own little silos. You know, you end up with that. So, very important to have a good project manager. And First Data has been for us right from the get-go. It was really incredible! Of course being new to all this, you know, I was going, “Why do you need all this?” Then, I, finally after a few months, saw how this was working. I was really impressed. Keeping everybody moving and tight and accountable for what we need to do and get everything done. So, it’s been a learning experience for me but I really appreciate it. I don’t think it could be done without a good, quality project manager like First Data.”

“When [name redacted] came in, I think [name redacted] added an organization – she became in my mind an organized refreshed mediator, she was the person that you could go to if you needed someone to intercede, or if you had a concern, or if you had a question, or a complaint, and she took the weight certainly off Cindy and she was accessible in ways that perhaps Cindy would not have been simply because of her travel schedule, meeting schedule, and the role that she played.”

“I think the saving grace for us has been the fact that through potlucks and flexibility in terms of this culture, flexibility in terms of picking up dry cleaning or picking up my child, or I’ve got to get an allergy shot can y’all postpone until I’m back? If there were not that core sense of teamwork I think we all could have become very compartmentalized whereas you would have had apathy because people are thinking, ‘Shoot, I don’t know, that’s your problem. I have my own crap going on.’ But that has never really been the case and to their credit that’s why when people have had issues that have required more manpower you have never ever heard someone say, ‘That ain’t my problem.’ Everybody is there to staple. Everybody’s there to look at licensing. Everyone’s there to pull their shifts at State Fair. I mean, God love them I don’t know how they did it, but they have created a core sense of family and team which I think has been I think the saving grace. Had there not been that culture in place when I came aboard either intentionally done or just by choosing the same people that have the same mindset and the same sense of camaraderie and loyalty I think the lack of communication and the frustration could have led to people being very closed off, boxed-up, in their office, in their cubbies, saying, ‘I don’t know what the hell’s going on. I don’t give a shit. I’m just going to do my own work.’”

CHALLENGES HIGHLIGHTED:

- Not enough transparency, especially in times of uncertainty – created anxiety
- Some perceived that the Director sometimes was too hands-on, involved in every detail
- Transition from initial First Data project manager to successor
- Two individuals reported that not all staff were treated equitably in terms of overtime expectations and approval to use vacation time

"You know if I had any complaint whatsoever it would be that…it would be that in our times of transition I wish that there had been a little more transparency. I understand when we've made major decisions either in terms of staffing, job description, who would leave, who would stay, changes based on needing to restructure once roles diminished, or evaporated, because of the funding with the advertising and outreach, it perhaps would have been nicer if there had been a coming to Jesus meeting. First saying 'We all aware of this, we are aware that people are anxious, wondering what will happen, have seen a lot of meetings behind closed doors, we recognize it; however we are not in a position to address questions yet, decisions have still not been made, issues are still up in the air. But know that we are working on it.' I think if that had been done directly immediately at the onset a lot of what I have felt was the tension, the anxiety that existed here in January, February, and March could have been alleviated."

"On the leadership staff as far as like the director, there was a lot of times that they were MIA other than big discussions or big happenings and we may have heard about it from other ways, other conditions that we might have heard something that's going to affect our division they heard it from some other part of the insurance department. So it caused some mistrust, because the employees with every Health Connector Division felt that other people outside the Health Connector Division knew more than what they knew about their own division. But there wasn't much other leadership. And I don't know if that was the struggle between the director and the Chief Operating Officer. I'm not sure. But there did seem to be a blurriness of whose responsibility was what."

"I think the division director is very hands-on, she hired people to do the work, but kind of micromanages it. It's a big, it's a big very state-wide project so I understand that, but would even micromanage areas that she didn't have expertise in."

"That's, that's a difficult one, cause we've had you know, we had [name redacted] first from First Data, now [name redacted]. And they're completely different styles. Okay and [name redacted] was more of here's what you said you would do, what are you doing? You know, where's it at? [Name redacted] is more, um, hate to use this word, but dictatorial. Like do this, do this, do this kind of thing. Which causes some angst in some people."

PROJECT LEADERSHIP / MANAGEMENT

We interviewed eight individuals to obtain project leadership / management perspectives, including AID leadership, AHCD leadership, and management contractors/consultants. Because much of this data was identifiable, we have included only those quotes that do not identify individual participants.

PROJECT SUCCESSES/STRENGTHS

- Implementing the partnership exchange
- Stakeholder engagement
- Enrollment/Decrease in uninsured
- Project staff
- Outreach & Education
- HCIP (Private Option)

"Implementing a partnership, getting a partnership implemented was a significant success in of itself. Much of that though, in my opinion, occurred because of that underlying, I don't want to say grassroots support, but we created a process that has enabled that to occur."

"I think the process that we had with respect to the Steering Committee and the Advisory Committees, and the inclusion of all the different communities within the state of Arkansas has to me been one of the most significant successes within the context of certainly governance, but also in general."

"I actually had my doubts in the rather formal process that was suggested by the consulting groups at the beginning because I thought it would be fairly cumbersome and would make the department less nimble. And as it turns out while there were some issues with that it didn't play out as much as suspected, and actually proved to be a beneficial process definitely and one in which I think most if not all the stakeholders were involved. I think the timing and structure of the process worked, particularly the idea that there were two working committees and then you know the steering committee that really served as the policy umbrella and I think could ferret out the, kind of some of the some of the issues that would come to them that were clearly one-sided, you know that the carriers has dominated on the issues and it clearly wasn't in the interest of the state to do something that would benefit them so greatly. So I think that proved to be a good process and you know to be honest I think it exposed a little bit and forced Blue Cross Blue Shield in particular, which has dominated the market, to the table and almost required them to relay what they were thinking, you know, whereas before they have kind of worked outside the purview of really of the people who they have served and this is really a truly different atmosphere. That forced them to do that, which was beneficial."

"I think the ultimate goal and intent of the whole program is to enroll people who are uninsured and Arkansas has had one of the highest rates of enrollment for the total uninsured population in the country so I think that's a huge success, and recognized by everyone involved."

"A great staff that was dedicated to making it work. All of them have put in many, many, many hours above what they were contracted or hired to do. Their dedication has been outstanding."

"And then we have the guide organizations which I would say, back to our successes, I think our outreach and education campaign and our guides were tremendous successes. Both of them were shut down politically but the outreach education campaign I think ended because it was so good. I don't know if you were around and saw any of the Get In campaign but it really moved the needle like 30 points in three months, which was incredible public awareness."

PROJECT CHALLENGES

- Political challenges
- Constant delays & changes
- Outreach program shut down by legislature
- Hiring delays

"Really the political volatility because what we had was not just policy to work through but real timelines, and hurry up and wait. It was like we started and it was, 'Well wait, because we're not going to have state-based exchanges.' And then it was, 'Wait for the Supreme Court decision, this will all go away.' 'Wait for the election, because this is going to go away.' And it didn't. And there was always something, 'Wait!' And as you can see, I mean the opponents are still doing everything they can to stop it. So that political challenge."

"The opposition from various legislators to the process. I mean, we've had to go back to some committees multiple times because of either a failure to render a decision or because they disapproved something and then we had to come back and try again."

"Terrific political challenges from the very conservative members of our legislature. By virtue of the Arkansas Constitution we cannot spend any grant money and all [project] efforts are federal funded without an appropriation from the legislature and by virtue of our constitution we have to have 75% of the members to get an appropriation and so we've been through some really really tough battles where we were able to get most of our appropriations. But it's been very, you know it's a hard project. We are way out in front of a lot of other states, not really volunteered for that it just happen by elimination. And we had a terrific burden having to deal with people who are really trying to scuttle the whole effort. And so that has made our job very difficult."

“It was more work than anyone could possibly imagine in all the details. And the federal issues, the delays, and the constant stuff, for a lot of adjustments that needed to be made on the fly because products were not ready when they were supposed to, it was just a lot of, it was a constant change environment. And while we were also still trying to ramp up staff, get them trained, we were never really sure whether we were going to get all of the people through the training, you know, were the IPAs going to actually sign up and be available the way that we wanted, a lot of that stuff. Every single thing we did was brand new, never done before. So, you know that, in and of itself, just created this uncertain level of work that needed to occur already there at the point of that early enrollment timeframe.”

“Yeah and I mean and I used to joke, back in 2011, 2012, the feds, whether it was the IRS, HHS or all, they were publishing seventy and eighty page documents once a week. And the expectation was that people were out there reading these things. You would have a full day job and you would spend all evening trying to catch up on the legalese jargon that was being pushed out. It was brutal.”

LIMITATIONS

Limitations of our Governance evaluation included that prospective participants were identified by AHCD and thus some perspectives may not have been captured in our evaluation. We were unable to recruit many members of the CAAC. Overall, we were unable to speak to many consumer advocate members of the committees, so the consumer perspective is less directly represented in our evaluation. Moreover, ACHD staff participants may have felt some coercion to participate, particularly given that an ACHD staff member was involved in helping to schedule these interviews and that some took place in AHCD offices. Another limitation was that we conducted an entirely qualitative evaluation. Some individuals may have felt more comfortable sharing negative feedback in a fully anonymous survey. However, AHCD preferred that we pursue the qualitative evaluation utilizing interviews to obtain feedback. Given that respondents to surveys often choose not to fill in open-ended questions, our qualitative evaluation likely elicited more detailed comments from participants.

II. EVALUATE EFFECTIVENESS OF OUTREACH AND EDUCATION EFFORTS

OVERVIEW

AID oversaw the development and execution of a range of activities to promote the SPM, including branding and promoting the In-Person Assistance (IPA) Guide Program, developing a state branded website, earned and paid media, and outreach to consumers. Additionally, AID oversaw branding and message testing among various demographic groups across the state.

AID launched a robust marketing and consumer outreach and education strategy to inform consumers of the new coverage options available under the ACA. AID's consumer outreach and education began in the summer of 2013 to give consumers and small businesses a basic understanding of health insurance and a basic understanding of Exchanges, QHPs, and the ACA affordability provisions before open enrollment began in October of that year. While a "special language amendment" to the State Fiscal Year 2015 Appropriation Acts for the Arkansas Insurance Department and Arkansas Department of Human Services limited outreach activities after July 1, 2014, the main findings related to AID's consumer outreach and education efforts—based on interviews with outreach and education vendors—strongly support the need for continued consumer outreach and education related to the ACA and SPM.

Outreach and education efforts were tied together through the Arkansas Health Connector Resource Center (AHCRC), a collaborative effort within AID between the AHCD and the Consumer Services Division (CSD). The AHCRC was created to assist consumers, brokers, health providers, issuers or employers by answering question they had about how the ACA impacts them. The center facilitated access to IPAs to discuss enrollment options, access to licensed insurance producers, and also allowed groups to schedule speaking engagements. Additionally, the AHCRC provided consumers a place to lodge complaints, grievances or appeals related to QHPs by phone, email, or in-person. All consumer communications with the AHCRC were logged and used for reporting. The CSD provided monthly, quarterly and annual reports to the AHCD for use in quality improvement, call tracking and management, as well as to help identify emerging complaint and call trends so that they could be addressed and monitored in a timely and ongoing manner.

Arkansas planned a three-phased Outreach and Education campaign to run from the spring of 2013 through March 2014. An inter-agency agreement signed September 2012 for branding work by Arkansas Center for Health Improvement (ACHI)/University of Arkansas for Medical Sciences (UAMS) Creative Services facilitated the implementation of Phase 1 of the Outreach and Education campaign. This phase included development of PowerPoint presentations and supporting materials for a Speakers Bureau and a direct mail campaign to solicit speaking engagements; media and direct mail campaign to recruit organizations to become IPAs; and a

public information campaign to address misinformation about the ACA. A survey to measure Marketplace opinions among an estimated 500 affected Arkansans and five focus group sessions at various locations around the state were used in development of the branding approach and later to develop messages to inform Arkansas consumers about the SPM in a way that could be easily understood. Presentations by ACHI/UAMS included creative concepts for commercials and print. A key result of this work was the selection of the name and tagline for the Arkansas Outreach and Education campaign; "Arkansas Health Connector: Your Guide to Health Insurance."

Phase 2 was the part of the campaign that targeted Arkansas's uninsured and underinsured residents including those who work in small businesses to provide them with information in preparation for Open Enrollment. This was the "get ready--open enrollment is coming" phase of the campaign. The contract for Phase 2 was awarded to Mangan Holcomb Partners (MHP) following a state competitive bidding process. MHP subcontracted with Lattimer Communications, which specializes in minority outreach, specifically to African-American and Latino populations. The vendors targeted community influencers, small businesses, hospitals, dentists, and other health care providers as groups that will help spread the message about the Marketplace.

The Outreach and Education campaign formally kicked off July 1, 2013, with the launching of the ARHealthConnector.org website, managed by MHP, and multiple other promotions. The campaign ran advertising in each county in Arkansas and included specific campaign messaging for multiple audiences. The 13-week campaign included ads on 28 television stations, 24 regional radio stations and 118 community radio stations, in 120 community newspapers, on 227 billboards, 100 gas pumps, and two Central Arkansas Transit Authority buses. It included direct mail to 254,000 households and 172,000 small businesses. The campaign was extensive and involved many partners. Call-in informational programs, which featured Governor Beebe and Commissioner Bradford among others, were aired on the Arkansas Educational Telecommunications Network (AETN, the Arkansas public broadcasting channel), KTHV-Channel 11 in Little Rock, and KARK-Channel 4 in Little Rock. AHCD and MHP also coordinated the publication of educational inserts in *Arkansas Business*, *Talk Business*, and *Arkansas Times*.

Phase 3 of the Outreach and Education campaign was developed to intensify the outreach and education efforts during Open Enrollment to make sure every affected Arkansan was aware that "the time is now" to enroll in a health plan and how to get assistance to do so if needed. It was designed to maximize enrollment in QHPs with updated advertisements that would have stressed enrollment deadlines and options. Unfortunately, the Phase 3 campaign was not approved by the Legislature. The Arkansas Legislative Council reviews contracts executed by state agencies. The contract amendment which would have authorized the spending of federal

1311 funding for the MHP contract, which would have funded the campaign starting October 1, 2013, was not approved. This legislative action occurred September 30, 2013, the day before open enrollment began. In an attempt to close the gaps in outreach and education left by the loss of the MHP campaign, the AHCD collaborated with contract workers to organize enrollment events throughout the state and worked to ensure that IPA Guides were available at these events to help Arkansans sign up for plans.

OUTREACH AND EDUCATION VENDOR & CONSTITUENT INTERVIEWS

Using qualitative methods, we assessed the effectiveness of AID's outreach and education efforts and the support vendors and constituents received from the AHCD from the launch of the campaign through the end of open enrollment.

The evaluation team developed semi-structured interview guides (see Appendix II-A) approved by AHCD. The open-ended questions that focused on the vendor or constituent organization's experiences and activities and their perceived effectiveness.

Evaluation staff with formal interview training conducted telephone interviews with representatives from eight outreach and education vendors and five constituent organizations from August to October 2014. All interviews were audio recorded with the participant's permission and lasted between 30 to 45 minutes. Interviews were digitally audio-recorded and the recordings were uploaded to a secure project folder behind the UAMS firewall. The recordings were transcribed verbatim through contract arrangement with AFMC and returned to UAMS for analysis. A summary template based upon the interview guide was used to analyze transcripts. Each transcript was reviewed line-by-line to identify common themes within each interview guide topic. Recordings and transcriptions remained confidential and were not shared with anyone outside of the evaluation team.

WHAT WORKED: SUCCESSFUL STRATEGIES AND BEST PRACTICES

LEVERAGING THE SUPPORT OF EXISTING PARTNERSHIPS

There was considerable consensus among the respondents about the most effective outreach and education activities. All of the respondents described the importance of partnering with community-based organizations and agencies already serving large numbers of individuals eligible for the Marketplace and HCIP. For example, one vendor described its partnership with the Head Start Association in coordinating outreach activities across the state. Partnerships like this allowed the outreach and education vendors to use existing frameworks of community organizations to educate and provide enrollment assistance to the populations served by these groups.

"The activities that were coordinated at the community level so that you had a community coalition as the center of the outreach and enrollment and they could pull resources from the insurance department for that whether it was boots on the ground assistance, whether it was materials. Having that backup from the insurance department and the ability of the insurance department to connect that community coalition that was pushing out, you know, pushing for the event or pushing out enrollment information. To connect that coalition with the necessary resources and provide those necessary resources. Those turned out to be the most effective mechanisms for getting people the help they needed for enrollment. And I think the main reason is you have that trust factor with the community coalition. You know? You're going to be more likely in your home town to trust the people that you know, the organizations that you know. So, I'm going to feel much more comfortable say getting information from somebody I go to church with or somebody who I work with or somebody I know through other things that I do in the community. I just think that that trust factor is there for the community but an essential component of that was the backup from the insurance department, having the materials, having the ability to get resources that were needed."

USING LOCAL VENUES AND EVENTS TO CONDUCT OUTREACH AND EDUCATION

All of the organizations identified the importance of coordinating outreach and education activities alongside established local events. They identified a variety of venues where they successfully reached consumers including regional and state fairs, libraries, community college campuses, small businesses and churches. Respondents described how stand-alone enrollment events were often less successful than piggy-backing ACA outreach, education, and enrollment events onto IPA Guide organization activities and other community events.

"In addition to partnering with certain organizations, the events that seemed to have the biggest impact were the ones where they were not just a stand-alone outreach or education activity but they were part of some activity in the community where people were already gathered together."

RELATIONSHIP WITH AID

The outreach and education vendors and constituents reported that they had a great working relationship with AID. They credited AID staff for very good communication, prompt responses to questions, and continuous engagement.

"We moved heaven and earth to mount a campaign, a statewide campaign that was significant in its scope and there's no way we could have done that without a productive relationship with that staff."

"I do want to say though, that I really have been impressed through this whole process with the staff at the insurance department and how accessible they've been to hospitals, to individuals in the community, to people who are trying to get help and assistance, they've been very respectful of their instructions from the legislature whether those were implied instructions or whether they were explicit. They have also been so great at being very consumer focused and helping hospitals in particular get out there and help their patients get enrolled and it would be, I would be remiss if I didn't mention how impressive all of the staff was in that whole process and has continued to be focusing on enrollment and outreach. To the extent that they are able to do that now and helping us with the resources that we need in order to take on that job".

REACHING LARGE NUMBERS OF PEOPLE THROUGH EVENTS AND LOCAL MEDIA

Enrollment events served as important opportunities for vendors to reach large numbers of people. To increase participation in outreach and education activities, participants developed and established relationships with community advocates, produced and aired informational commercials, and provided meals that were funded by outside groups. While paid media was very helpful, low-cost marketing options such as unpaid media and brochures and other informational materials were equally successful. The most effective activities listed by respondents included:

- The call-in shows with AETN
- Community meetings where organizations had a captive audience;
- Church jurisdictional annual meetings;
- Individual brochures; and
- Television commercials

"I think the call-in shows with AETN were very effective…And the reason that I thought with respect to the call-in show for effectiveness, I think it provided an opportunity from an anonymous standpoint for individuals to get their questions answered from experts".

"I think they were all interconnected. It was a very tightly integrated communications program probably the most tightly integrated campaign from messaging through execution that our agency has ever done. I don't think that you could extract any part of it and have it be as effective as it was."

CHALLENGES AND BARRIERS

Vendors identified several challenges in conducting outreach and education activities.

LIMITED EFFECTIVENESS OF COMMUNITY FORUMS

Respondents raised concerns about the effectiveness of the community forums originally planned to be held in every county. Most respondents felt that they were not coordinated well and were often poorly attended. Many vendors and the constituents described that in terms of having contact with large numbers of people state fairs and health fairs were effective, but felt that the actual impact on each individual was minimal.

"I think that some of the forums around the state were not as effective, primarily because of the…I think it was just generally the lack of participation. But, I am not sure those could, that there could have been any improvement in the participation in those that would have made them beneficial. Like I am saying, I don't think they could have timed them any better. I don't think they could have provided any more effective communication about the dates and the times of those and the content of those that would have improved them. I just think that those generally don't work and it's more of a one-on-one approach that works better. (okay) Also, I think it provided an opportunity for opponents of the law, generally, to voice their issues rather than talk about the practicalities of enrollment, eligibility and enrollment."

- Other activities that were deemed less effective included:
- Door-to-door activities;
- One-on-one activities;
- Community based meetings with broad based education;
- Premium items pens and pencil distributed during state fairs and other health events; and
- Posters placed in clinics.

MISCONCEPTIONS AND POLITICAL OPPOSITION TO THE AFFORDABLE CARE ACT

Respondents reported that confusion and political hostility to the ACA created significant barriers to outreach and enrollment. In addition, the passage of a “special language amendment” to the State Fiscal Year 2015 Appropriation Acts for the Arkansas Insurance Department that severely limited outreach activities after July 1, 2014, led to a much smaller outreach and education “footprint” and to confusion among governmental entities and other outreach and education stakeholders.

> *“The main challenge was the fact that the legislature held up funding for the outreach and education public relations I guess sort of piece of that the public information campaign after October 1 of 2013 and then completely eliminated the ability for the state to utilize money for either staff salaries or subcontracts or other things related to outreach and education after the legislative session in 2014.”*

> *“A big challenge was people who really were not open to learning about the marketplace. There were a lot of people who had their mind made up this is not a good thing and didn’t want to be confused with any of the facts. Back to what I said about resources, I would also say that we really wanted to be and needed to be everywhere at the same time and just couldn’t.”*

TIME CONSTRAINTS

There were significant time constraints in providing activities, developing advertisements, and distributing resources. Many respondents indicated challenges they faced in implementing outreach and education activities within the short timeline available between the beginning of their contract and the initiation of open enrollment.

> *“Our challenges were the amount of time that we had to mount the campaign. We were able, we went from concept to focus group to production and in the market in about a 5 week period which was for a campaign of this scale unheard of but we were able to do that.”*

> *"Every time we were trying to do our job there was some political entity trying to undo it that would keep us from being able to fully execute the job that we had been hired to do. I think we were unable to complete the task because our contract was not extended beyond end of September that created some challenges and hardships on us towards the end of the campaign because we had made commitments not legally binding commitments but we had we had made you know strategic commitments on what was going to happen next there was a good deal of that work that had to be abandoned you know you know and all."*

> *"I think an earlier decision on the use of brokers and agents would have been helpful (okay) and getting them involved in the outreach and education activities. I think providing more and more timely information about website challenges would have been helpful."*

> *"We were using the federal infrastructure but we had some state requirements and sometimes the feds timeline did not, well it just didn't work for us at the state level, because sometimes our timeline at the state level was we were trying to move a little more quickly than the feds were and so the feds delayed getting some education resources out for example out and we were wanting to get people licensed at the state level and federal education wasn't ready, the federal infrastructure for certifying that the education was done wasn't ready. So just the timeline between the feds, the necessary things from the federal government and then trying to get things done at the state level, those just didn't jive."*

MANY CONSUMERS HAD LIMITED HEALTH INSURANCE LITERACY

Several of the vendors identified low health insurance literacy as a major barrier to education and outreach activities. Many of the consumers that participated in the outreach and education activities—especially among the Hispanic and Marshallese communities—had never been insured before and had a limited understanding of insurance in general. Vendors reported that when consumers did not speak English and they did not speak the consumer's native language, using interpreter services was difficult and often ineffective. Language barriers also created difficulty because key terms and concepts associated with health insurance do not translate well.

"The two main challenges would be the health insurance illiteracy and the attitudes about the Affordable Care Act in general- the people that were opposed to the Affordable Care Act and wanted nothing to do with learning about the marketplace."

OVERALL EXPERIENCE

All of the vendors and the constituents perceived that Arkansas's sharp reduction in its uninsured rate reflected, at least in part, the effectiveness of the outreach and education campaign. Unfortunately, only one organization measured pre-post outreach and education efforts to increase awareness. Despite the inability to measure pre-post outreach efforts, all outreach and education vendors were confident that the efforts increased awareness of the ACA and SPM among Arkansans.

At the same time, outreach and education vendors felt the termination of the outreach and education activities would reduce the enrollment for the next plan year. They felt Arkansans might need additional education because the concepts may not be well known, the law may change, and additional assistance may be required in renewing their plans. Outreach and education vendors and constituents made many recommendations to improve outreach and education moving forwarding, including:

- Local coalitions help with enrollment for the next plan year;
- Radio and television commercials aired during the next enrollment term;
- Information mailed concerning the changes in the laws; and
- Constituents receive instructions for the renewal process.

RECOMMENDATIONS

The vendors interviewed cited low levels of health insurance literacy among vulnerable populations and the limited effectiveness of the community forum model as major challenges to outreach and education efforts. Both constituents and vendors noted the limited timeframe in which to complete activities and lack of resources available as additional barriers. When Phase 3 of the Outreach and Education campaign was not approved by the Legislature, outreach and education efforts were severely limited. The AID had some capacity to take on consumer complaints and follow up through the AHCRC. To reach more consumers, Arkansas should consider developing a more robust outreach and education field campaign.

It was estimated that the outreach and education efforts would generate a call volume of about 50 calls per week to the AHCRC during the peak of Phase II of the exchange implementation, with anticipated open enrollment call volume in excess of 969 calls per day

generated by the Phase II and III Outreach and Education campaigns. However, the actual number of calls that were received fell far below the expected volume. We attribute this deficit in expected call volume to the fact that Phase III of the outreach and education campaign, the phase that was developed to intensify the outreach and education effort during open enrollment, was not approved by the legislature. As a result, as many Arkansans were not reached as were expected. The number of calls ranged from a low of approximately 600 in July, 2013 to a high of approximately 3750 in October, 2013. The call volume handled by the AHCRC is shown in Figures II-1 and II-2 below.

FIGURE II-1. NUMBER OF CALLS HANDLED AHCRC JULY 2013-AUGUST 2014

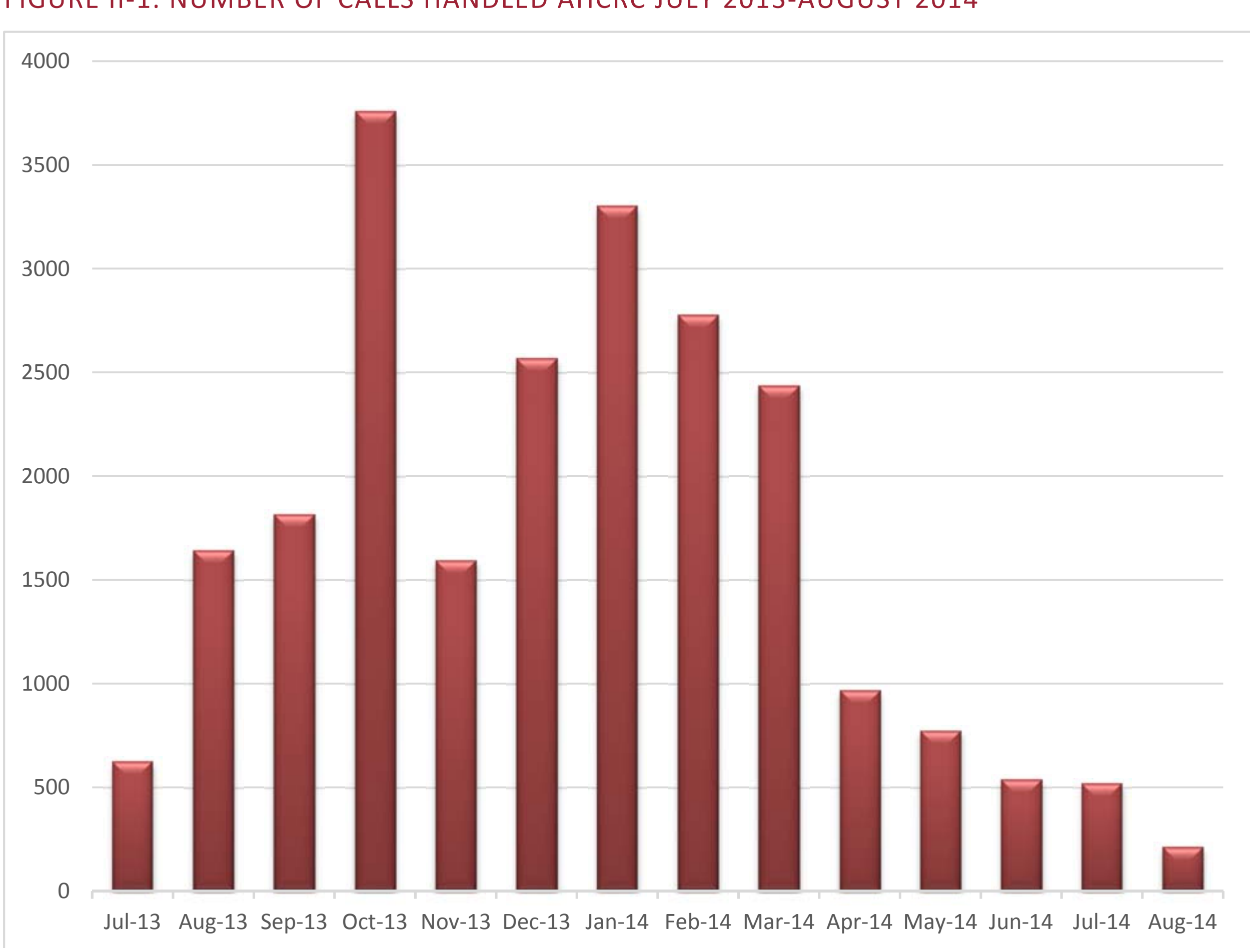
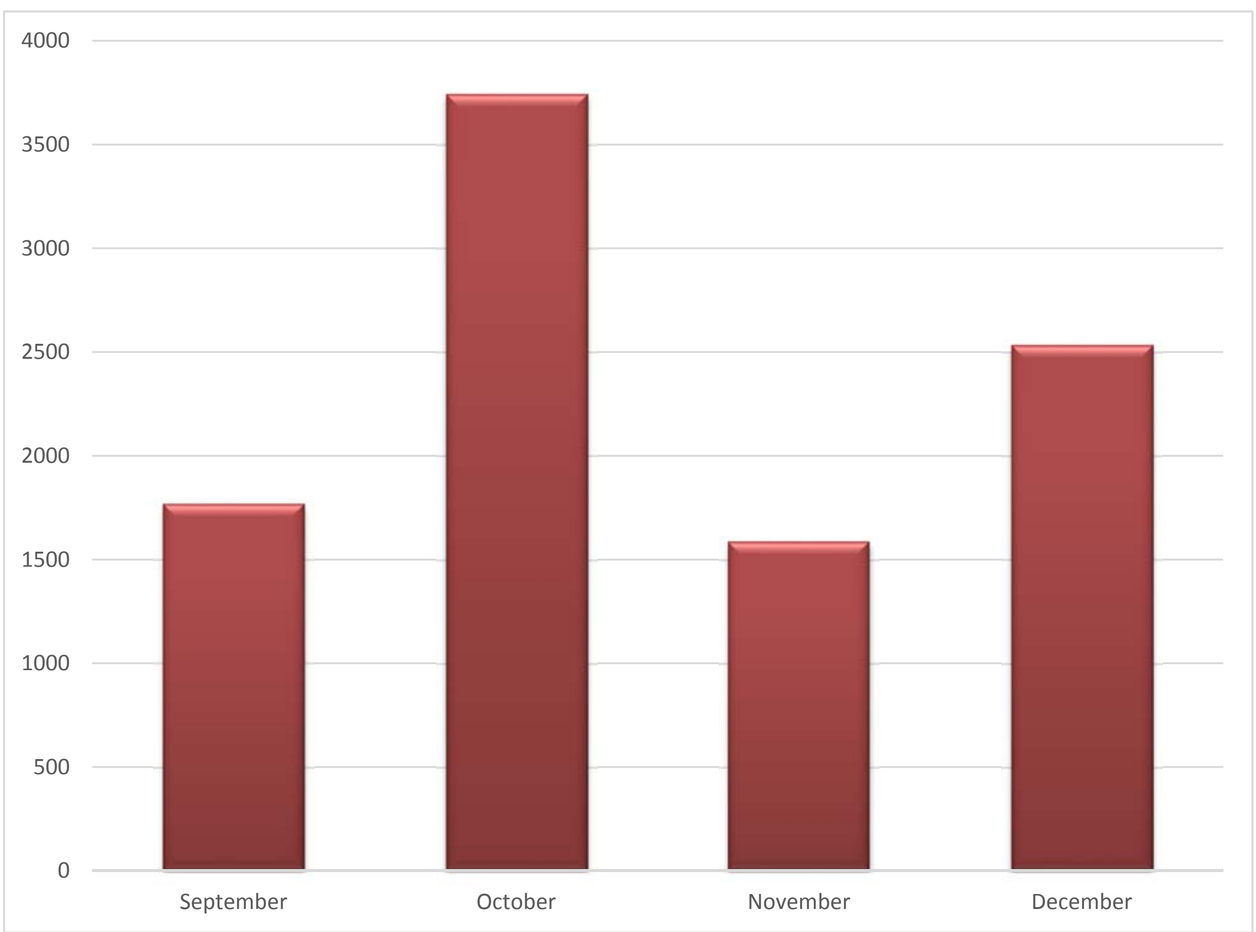
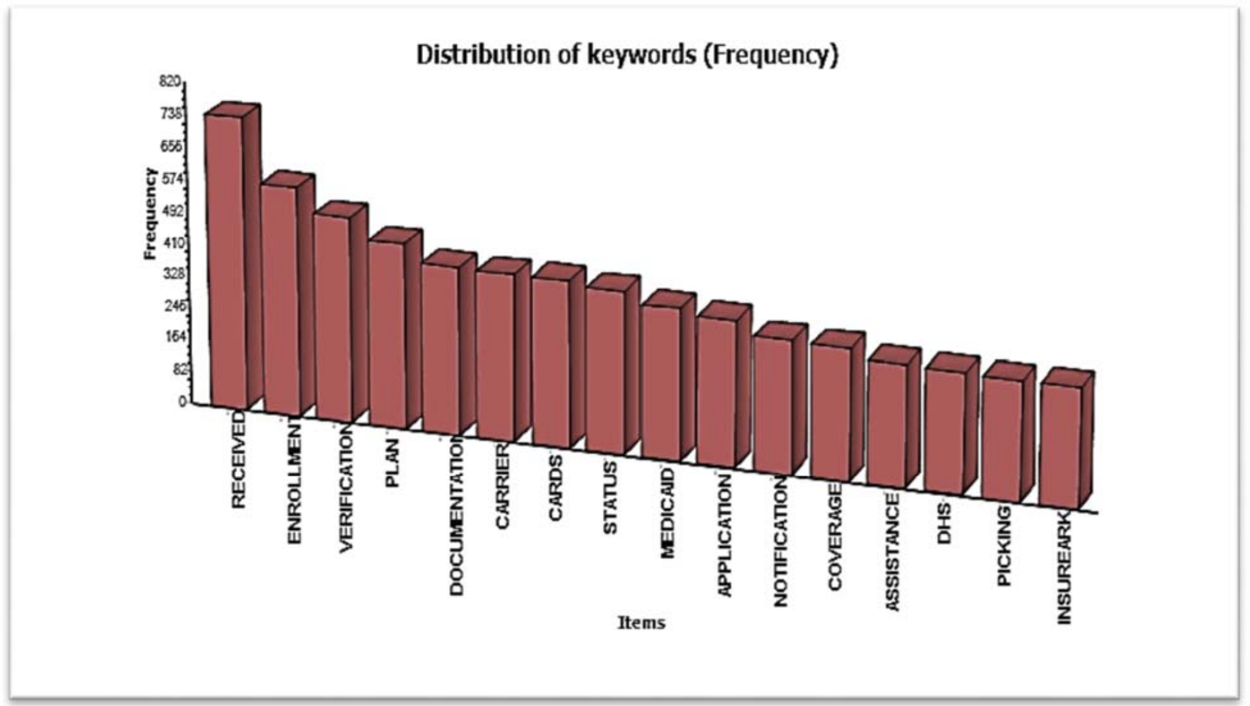


FIGURE II-2. TOTAL NUMBER OF CALLS HANDLED BY AHCRC SEPTEMBER 2013-DECEMBER 2013



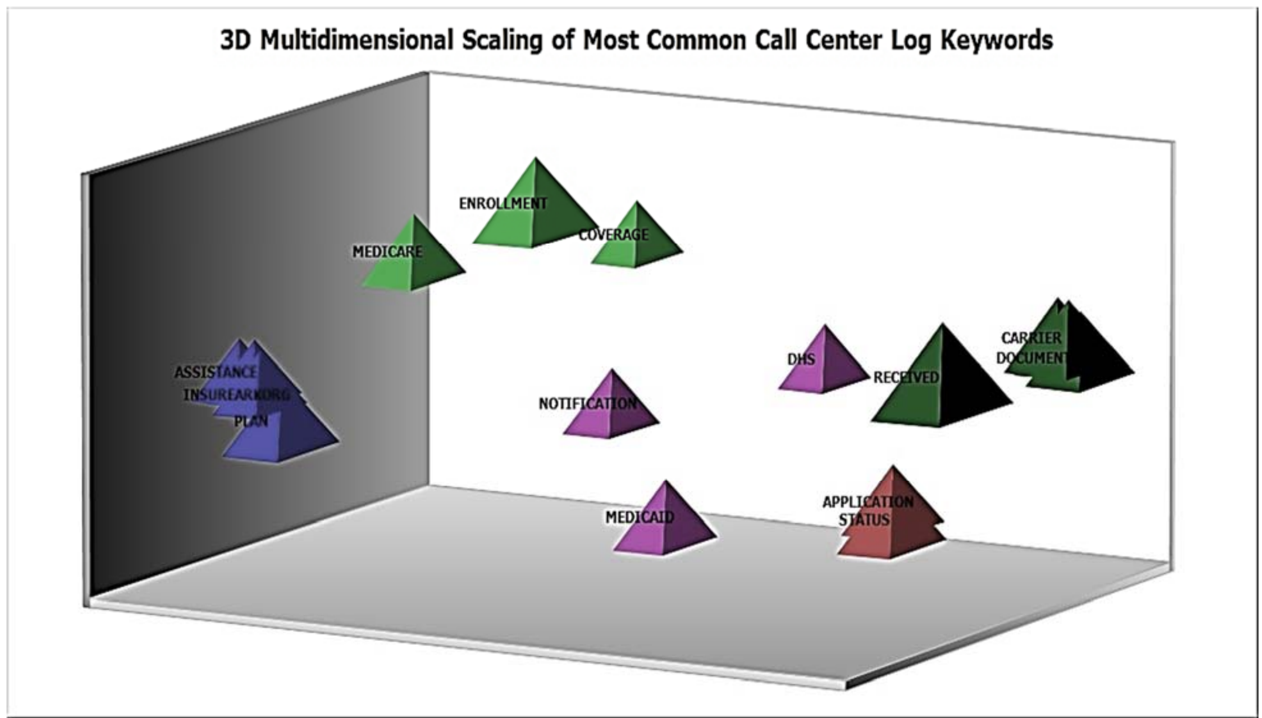
Text mining techniques were used to analyze summary notes from assistance calls received by the AHCRC. Both the frequency of keyword terms and the associations between these terms were analyzed. A frequency chart and a slightly more complex infographic were developed from the analysis. The frequency chart is depicted in Figure II-3 below. Keywords that were used more frequently were more often a topic of an assistance call, some of the words most frequently used included enrollment, verification, plan and documentation.

FIGURE II-3. FREQUENCY OF KEYWORDS IN CALLS HANDLED BY AHCRC



The following infographic (Figure II-4) organizes terms by strength of association (how often they occurred during the same call). Color coding creates groups of terms with the strongest associations. Proximity in the graph indicates relative strength of an association between terms, especially terms in the same color coded group. Size of the pyramid shaped icons represents the relative frequency of occurrence. For example, Medicare, enrollment and coverage are a color coded grouping, indicating that these terms were often used in the same assistance calls. Within the grouping, enrollment is positioned between Medicare and coverage, indicating that enrollment has a stronger association with the two other terms than Medicare and coverage do with each other. The enrollment icon is larger than the Medicare icon, which is larger than the coverage icon, representing relative frequency of occurrence, and corresponds to position on the frequency chart above.

FIGURE II-4. STRENGTH OF ASSOCIATION OF TERMS IN CALLS HANDLED BY AHCRC



We recommend addressing the following issues with regard to outreach and education efforts moving forward:

- Continued funding to support public education and marketing campaign to inform Arkansans of health insurance options
- Prioritize target audiences to meet enrollment objectives.
    - Specifically target multi-cultural audiences. Pay specific attention to messages for families with mixed immigration status
- Develop marketing strategies for retention of new and current health insurance enrollees
- Develop a more comprehensive plan to address tracking of education and outreach efforts

III. PROFILE OF QUALIFIED HEALTH PLANS ENROLLED AND SEEKING TO ENROLL IN THE ARKANSAS STATE PARTNERSHIP HEALTH INSURANCE MARKETPLACE

NUMBER OF INSURANCE ISSUERS INVOLVED

For the inaugural plan year, 2014, the AHCD invited 23 insurance issuers to participate in the SPM. Four insurers chose to participate: Arkansas Blue Cross Blue Shield (AR BCBS), Blue Cross Blue Shield Association Multi-state plan (BCBS MSP), QualChoice (QCA), and Ambetter (Arkansas Health and Wellness Solutions, a company of Centene Corporation). Regional distribution varied among insurance issuers. Table III-A illustrates the number and location of carriers per service region. Both Blue Cross Blue Shield plans are available in all regions, QualChoice in five regions, and Ambetter in three regions. As noted in the table, the number of carriers is particularly low in both the Southeast and Southwest regions with only two of the four carriers available in each region for SPM enrollees.

TABLE III-A. 2014 NUMBER AND LOCATION OF CARRIERS BY REGION

Rating Area	Plans			
Central	BCBS MSP Individual Medical	AR BCBS Individual Medical	AR Ambetter Individual Medical	QCA Individual Medical
Northeast	BCBS MSP Individual Medical	AR BCBS Individual Medical	--	QCA Individual Medical
Northwest	BCBS MSP Individual Medical	AR BCBS Individual Medical	AR Ambetter Individual Medical	QCA Individual Medical
South Central	BCBS MSP Individual Medical	AR BCBS Individual Medical	--	QCA Individual Medical
Southeast	BCBS MSP Individual Medical	AR BCBS Individual Medical	--	--
Southwest	BCBS Individual MSP Medical	AR BCBS Individual Medical	--	--
West Central	BCBS Individual MSP Medical	AR BCBS Individual Medical	AR Ambetter Individual Medical	QCA Individual Medical

Arkansas had a total of three state insurers and one multi-state carrier participating in the SPM for plan year 2014. Within the US, the number of insurers per exchange varied by state.

New Hampshire and West Virginia each had one insurer participating in the individual health exchange marketplace and one multi-state carrier. New York had the most insurers, a total of 17 state-based and 1 multi-state carriers, participating in their state-based marketplace. The average number of state-based carriers per state was 5.5 with the most common number being 2 state-based issuers per state (19.6%, 10 out of 51 states and the District of Columbia).[1] However, the number of insurers may be further limited in certain areas of each state as all insurers within a state marketplace do not necessarily service every area or region.

NUMBER OF INSURANCE PLANS INVOLVED AND NUMBER CERTIFIED

The AHCD of AID worked closely with the Center for Consumer Information and Insurance Oversight (CCIIO), part of the Centers for Medicare & Medicaid Services (CMS), to implement federal requirements for plans offered through insurance exchanges. Federal requirements for each plan offered within the SPM included services for 10 benefit categories, or essential health benefits (EHB):

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

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[1] Kaiser Family Foundation. Number of issuers participating in the individual health insurance marketplace. Last accessed October 2014 at http://kff.org/other/state-indicator/number-of-issuers-participating-in-the-individual-health-insurance-marketplace/

Initially, five insurers provided letters of intent to undergo the plan certification process: AR BCBS, BCBS MSP, Ambetter, QCA, and United Security Life and Health Insurance. One insurer, United Security Life and Health Insurance, withdrew during the early phases of the plan review process. The insurance plan review for the remaining four carriers was a lengthy process involving continuous communication between each carrier and AID to meet all requirements of plan certification. Per an AID August monthly report to their Steering Committee, a total of 13,341 Qualified Health Plan (QHP) items were reviewed. Ultimately, AID certified all 71 plans that were submitted by the four participating carriers for plan year 2014. Table III-B presents the regional distribution of the plans, several of which are offered in multiple regions.

TABLE III-B. 2014 INDIVIDUAL MARKET PLANS BY REGION AND METAL LEVEL

Rating Area	Plans				Total
	BCBS Individual MSP Medical	AR BCBS Individual Medical	AR Ambetter Individual Medical	QCA Individual Medical	71 (23 Gold, 16 Silver, 24 Bronze, 8 Catastrophic)
Central	3; 1 in each level (Gold, Silver, Bronze)	8; 2 Gold, 2 Silver, 3 Bronze and 1 Catastrophic	18; 6 in each level of Gold, Silver and Bronze only	12; 4 Gold, 2 Silver, 4 Bronze and 2 Catastrophic	41 (13 Gold, 11 Silver, 14 Bronze, 3 Catastrophic)
Northeast	3; 1 in each level (Gold, Silver, Bronze)	8; 2 Gold, 2 Silver, 3 Bronze and 1 Catastrophic	--	6; 2 Gold,1 Silver, 2 Bronze and 1 Catastrophic	17 (5 Gold, 4 Silver, 6 Bronze and 2 Catastrophic)
Northwest	3; 1 in each level (Gold, Silver, Bronze)	8; 2 Gold, 2 Silver, 3 Bronze and 1 Catastrophic	18; 6 in each level of Gold, Silver and Bronze only	12; 4 Gold, 2 Silver, 4 Bronze and 2 Catastrophic	41 (13 Gold, 11 Silver, 14 Bronze, 3 Catastrophic)
South Central	3; 1 in each level (Gold, Silver, Bronze)	8; 2 Gold, 2 Silver, 3 Bronze and 1 Catastrophic	--	6; 2 Gold,1 Silver, 2 Bronze and 1 Catastrophic	17 (5 Gold, 4 Silver, 6 Bronze and 2 Catastrophic)
Southeast	3; 1 in each level (Gold, Silver, Bronze)	8; 2 Gold, 2 Silver, 3 Bronze and 1 Catastrophic	--	--	11 (3 Gold, 3 Silver, 4 Bronze and 1 Catastrophic)
Southwest	3; 1 in each level (Gold, Silver, Bronze)	8; 2 Gold, 2 Silver, 3 Bronze and 1 Catastrophic	--	--	11 (3 Gold, 3 Silver, 4 Bronze and 1 Catastrophic)

Rating Area	Plans				Total
West Central	3; 1 in each level (Gold, Silver, Bronze)	8; 2 Gold, 2 Silver, 3 Bronze and 1 Catastrophic	18; 6 in each level of Gold, Silver and Bronze only	6; 2 Gold,1 Silver, 2 Bronze and 1 Catastrophic	35 (11 Gold, 10 Silver, 12 Bronze, 2 Catastrophic)

* Catastrophic plans are only available to individuals up to age 30 or those with no other affordable options (including those that are eligible for hardship exemptions).

VARIETY OF METAL LEVELS (I.E. GOLD, SILVER, AND BRONZE)

MEDICAL PLANS

There are four specific levels of coverage defined under the ACA – Platinum, Gold, Silver, and Bronze. The levels differ in the actuarial value (AV), i.e. the percentage of total health care cost that the plan will pay. On average, the higher the AV, the lesser the cost sharing by the individual. However, the actual percentage of health care costs a plan will pay for any given enrollee will generally be different from the AV depending upon the health care services used and the total cost of those services.

There are also catastrophic plans available to individuals up to age 30 and to those with no other affordable options (including those that are eligible for hardship exemptions). An affordable option is defined as <8% of the consumer's household income. The SPM included a total of 71 various Gold, Silver, Bronze, and Catastrophic plans (Table III-C). No Platinum plans were offered.

TABLE III-C. TYPES OF PLANS BY METAL LEVELS

Level of Coverage	Number of Plans
Gold	23
Silver	16
Bronze	24
Catastrophic	8
Total	71

TABLE III-D. DISTRIBUTION OF INDIVIDUAL PLANS BY METAL LEVELS AND REGION

Rating Area	Gold	Silver	Bronze	Catastrophic
Central	13	11	14	3
Northeast	5	4	6	2
Northwest	13	11	14	3
South Central	5	4	6	2
Southeast	3	3	4	1
Southwest	3	3	4	1
West Central	11	10	12	2
Total	53	46	60	14

SMALL BUSINESS HEALTH OPTIONS PROGRAM

Arkansas Blue Cross and Blue Shield offered three Small Business Health Options Program (SHOP) medical plans in all seven service regions of the state, one each in Bronze, Silver and Gold metal level.

DENTAL

A total of four stand-alone dental (SAD) providers offered 20 individual coverage plans. The plans included various metal levels as well as individual, family, and pediatric dental plans. All are preferred provider organization (PPO) plans. SAD plans were required to offer either a 70% (low) or 85% (high) AV level. Details regarding the SAD carriers, levels, and numbers of plans offered are provided in Table III-E.

TABLE III-E. DENTAL PLANS BY LEVEL OF PLAN

Carrier	Level of Plan	Number of Plans
Arkansas BCBS Individual Dental	Pediatric-only High	1
	High	2
	Low	1
Arkansas Best Individual Dental	Pediatric-only High	1
	Pediatric-only Low	1
	High	2

Carrier	Level of Plan	Number of Plans
	Low	2
Arkansas Delta Dental Individual Dental	Pediatric-only High	1
	Pediatric-only Low	1
	High	1
	Low	1
Arkansas Dentegra Individual Dental	Pediatric-only High	1
	Pediatric-only Low	1
	High	2
	Low	2
Total by Level	Pediatric-only High	4
	Pediatric-only Low	3
	High	7
	Low	6
Total		20

COSTS

GEOGRAPHIC AREA

Ambetter, AR BCBS, and BCBS MSP plan premiums vary by region. Regional variation of premiums differs by issuers, e.g., the variation factor or ratio is different for Ambetter compared to AR BCBS. Tables III-F and III-G summarize the variation in premium observed by rating area. QualChoice, however, was not included in the regional variation analysis since none of the 42 plans distributed over five rating areas were available in more than one area. All rates reported are unadjusted rates.

TABLE III-F. AR BCBS AND BCBS MSP INDIVIDUAL MEDICAL PLAN PREMIUM VARIATION BY RATING AREA*

	Central	North East	North West	South Central	South East	South West	West Central
Adult (age 40)	$286	$265	$268	$264	$283	$286	$256
Child (age 0-20)	$142	$132	$133	$131	$141	$142	$127
Family (2 adults age 40 and 2 children <20 yrs.)	$856	$795	$804	$790	$847	$856	$766
Adult (age 64)	$671	$623	$630	$619	$664	$671	$600

* AR BCBS offered eight plans in all seven rating areas; BCBS MSP offered three plans in all seven rating areas

TABLE III-G. AMBETTER INDIVIDUAL PLAN PREMIUM VARIATION BY RATING AREA*

	Central	North East	North West	South Central	South East	South West	West Central
Adult (age 40)	$356	–	$414	–	–	–	$371
Child (age 0-20)	$177	–	$206	–	–	–	$184
Family (2 adults age 40 and 2 children <20 yrs.)	$1065	–	$1239	–	–	–	$1111
Adult (age 64)	$835	–	$972	–	–	–	$872

*Ambetter offered 18 plans in three rating areas – rating areas 1 (Central), 3 (Northwest) and 7 (West Central)

AGE

Premium costs vary by age within the SPM. Per CMS guidance, uniform age bands were used to establish premium variations for enrollees up to a ratio of 1:3. One-year age bands were established for individuals age 21-63. However, a single age band was used for children ages 0-20 and older adults 64 and older. Table III-H provides examples of monthly average premiums without tax credits for non-smokers based on the age bands for the Arkansas insurance exchange.

TABLE III-H. AVERAGE MONTHLY PREMIUM COST WITHOUT TAX CREDITS (NON-SMOKER)

Age	Monthly average premium *without tax credits*
0-20	$ 153.80
21	$ 242.20
30	$ 274.90
40	$ 309.50
50	$ 432.60

Age	Monthly average premium *without tax credits*
60	$ 657.40
64 and older	$ 726.50

SMOKING STATUS

Of the 71 plans available throughout the state, all Ambetter and QCA plans varied by a ratio of 1.2:1 (state allowed standard) for tobacco users, which is less than the federally allowed standard of 1.5:1. All AR BCBS and BCBS MSP medical plans (n=11), however charge the same premiums to tobacco users as they would to non-tobacco users. Ambetter plans charge a higher premium for tobacco users across all age groups including 0-20. QCA plans charge the same premium for tobacco users and non-users in age group 0-20 but charge a higher premium to smokers ages 21 and older, when compared to non-smokers. In other words a tobacco user would pay a 20% higher premium than a non-user for any QCA and most Ambetter plans but not for an AR BCBS or BCBS MSP medical plan. The additional rate is paid 100% by the consumer as tax credits are not allowed for tobacco use upcharges.

PREMIUM CAP

The premium limit or premium cap (%) is the maximum monthly premium an eligible individual or family is expected to pay as a healthcare premium. It is calculated as a total percent of annual income and increases as income increases. Table III-I summarizes the premium cap based on income level for the SPM.

TABLE III-I. PREMIUM CAP (AS % OF INCOME)

Income (% Federal Poverty Level)	Premium cap (as % of income)
0% - 138 % (Medicaid Expansion)	0
100% - 138% (Non-Medicaid Eligible)	2%
139% - 149%	3% - 4%
150% - 199%	4% - 6.3%
200% - 249%	6.3% - 8.05%
250% - 299%	8.05% - 9.5%
300% - <400%	9.5%
400% and above	No Cap

Under the ACA, individuals making up to 400% of the Federal Poverty Level (FPL) may be eligible for subsidies in the form of premium tax credits.

SILVER PLAN COSTS WITH SUBSIDIES

The "benchmark plan" for tax credit purposes is the second-lowest priced silver plan within a state exchange in a geographic region (HIOS Plan ID 75293AR0270001 for Arkansas). Tax credit amounts are derived on the cost of this "benchmark" silver plan and are then adjusted according to an enrollee's annual income. Therefore, the amount of the tax credit varies with income such that the premium a person would have to pay for the second lowest cost silver plan would not exceed a specified percentage of their income (adjusted for family size). Consumers who are eligible for premium tax credits are not required to purchase the benchmark plan in their region and will not lose out on their credits by choosing a different plan. However, they will face higher premium costs if they choose a more extensive/costlier option. Tables III-J and III-K provide examples for costs and tax credits for a 40-year-old non-smoker and a family of four.

TABLE III-J. PREMIUMS, TAX CREDITS, AND MONTHLY PREMIUM COST FOR A 40-YEAR-OLD NON-SMOKER

Percent of FPL	Annual Income	Max Annual Premium	Monthly Tax Credit	Monthly premium cost to consumer
100 % (non-Medicaid eligible)	$ 11,490	$ 230	$ 273	$ 19
139 %	$ 15,856	$ 476	$ 252	$ 40
150 %	$ 17,235	$ 689	$ 235	$ 57
200 %	$ 22,980	$ 1448	$ 171	$ 121
250 %	$ 28,725	$ 2312	$ 99	$ 193
300 – 400 %	$ 34,470-$ 45,960	$ 3275-$ 4366	$ 19 - $ 0.0	$ 273- $ 364

*Average base individual monthly premium is $292.00 in AR for the "benchmark" silver plan. Numbers are approximate.

TABLE III-K. PREMIUMS, TAX CREDITS, AND MONTHLY PREMIUM COST FOR A FAMILY OF FOUR (TWO ADULTS AGE 40 WITH TWO CHILDREN)

Percent of FPL	Annual Income	Max Annual Premium*	Monthly Tax Credit	Monthly premium cost to consumer
100 % (non-Medicaid eligible)	$ 23,550	$ 471	$ 835	$ 39
139 %	$ 32,499	$ 975	$ 793	$ 81
150 %	$ 35,325	$ 1413	$ 756	$ 181
200 %	$ 47,100	$ 2967	$ 627	$ 247
250 %	$ 58,875	$ 4739	$ 479	$ 395
300 - 400 %	$ 70,650-$94,200	$ 6712 - $ 8949	$ 315 - $ 128	$ 559 - $ 746

*Average base individual monthly premium is $874.00 in AR for the "benchmark" silver plan. Numbers are approximate.

To put it into perspective, for 2014, a single 40-year-old at 250% FPL in Little Rock, AR would pay an average monthly premium of $306 for the "benchmark" plan before subsidies. The amount of credit received would be $113 (8.1%% of $28,725), premium limit based on annual income for those at 250% FPL). So, the cost after subsidy would be $193. If this individual chooses the lowest cost bronze plan instead, the monthly premium would be $231 before subsidy and $118 ($231-$113) after tax subsidy.

COST SHARING

For individuals and families with income levels below 250% FPL, there are silver plan variations that reduce the maximum out-of-pocket expenses. The AV may further be increased by reducing cost sharing in the form of deductibles, copayments, and coinsurance. Cost-sharing reductions apply only to covered healthcare services and do not include care rendered by out-of-network providers. Only silver plans have cost-sharing reduction variations. The level of the silver-cost sharing reduction (CSR) plan variation that the individual is eligible for depends on the income level of the individual (Table III-L).

TABLE III-L. ACTUARIAL VALUE AND PLAN REQUIREMENTS IN THE ACA

Actuarial Value	Out-of-Pocket Maximum (2014)	Who it applies to
60 %*	$ 6,350 for Individual $ 12,700 for family	Bronze plan, available to all individuals and small businesses
70 %*	$ 6,350 for Individual $ 12,700 for family	Silver plan, available to all individuals and small businesses
73%	$ 5,200 for Individual $ 10,400 for family	Silver plan with cost-sharing subsidies for people with income 200-250% of poverty
80%*	$ 6,350 for Individual $ 12,700 for family	Gold plan available to all individuals and small businesses
87%	$ 2,250 for Individual $ 4,500 for family	Silver plan with cost-sharing subsidies for people with income 150-200% of poverty
90%*,**	$ 6,350 for Individual $ 12,700 for family	Platinum plan available to all individuals and small businesses
94%	$ 2,250 for Individual $ 4,500 for family	Silver plan with cost-sharing subsidies for people with income 100-150% of poverty

Note: Rows marked with * reflect coverage that is available to all participants in the individual or small group market. Other levels of coverage are available only to individuals eligible for subsidies in exchanges based on family income. Kaiser Family Foundation Fact Sheet last accessed October 2014 at http://kaiserfamilyfoundation.files.wordpress.com/2013/09/early-look-at-premiums-and-participation-in-marketplaces.pdf. The row marked with ** was an option that was available but not adopted in Arkansas.

The ACA sets limits on the out-of-pocket expenses, but there is no specification for deductibles, copayments, and coinsurances. Because the gold, silver, and bronze coverage tiers are defined based on AV, the cost-sharing structure can and does vary from plan to plan. Even within the same tier, a plan with a higher deductible may compensate by having a lower coinsurance percentage once the deductible is met.

The following scenario explores the premium and other cost-sharing for a 40-year-old individual living in region 1 (Central) in Arkansas (Tables III-M and III-N). The first table lists the premiums for the lowest-cost plans across the three metal tiers within the SPM.

TABLE III-M. PREMIUMS FOR THE LOWEST-COST PLANS ACROSS THE THREE METAL TIERS WITHIN THE ARKANSAS STATE PARTNERSHIP HEALTH INSURANCE MARKETPLACE FOR A 40 YEAR OLD INDIVIDUAL RESIDING IN REGION 1

Plan Type	Expected Premium
Bronze	$231
Silver	$294
Gold	$336

Using these lowest-cost plans for this region as reference, Table III-N compares the out-of-pocket costs for these plans.

TABLE III-N. OUT-OF-POCKET COST COMPARISON FOR THE LOWEST-COST GOLD, SILVER, AND BRONZE PLANS AVAILABLE TO A 40 YEAR OLD INDIVIDUAL IN REGION 1 OF ARKANSAS

Coverage Category	Gold	Silver	Bronze
Max out of pocket for medical and drug EHB benefits	$4,500 for single	$6,000 for single	$6,300 for single
Combined medical and drug EHB deductible	$1,000 for single	$3,500 for single	$6,300 for single
Default (medical and drug) coinsurance	20 %	20 %	0 %
Primary Care Visit Copay (for injury or illness)	$20 copay	$25 copay	No Charge
Preventive Care Visit (1 visit/year)	No Charge	No Charge	No Charge
Specialty Care Visit Copay	$40 copay	$50 copay	No Charge
Other Practitioner Office Visit Copay (Nurse, Physician assistant etc.)	$20 copay	$25 copay	No Charge
Routine eye exam (Adult)	No copay; 20 % coinsurance after deductible	No copay; 20 % coinsurance after deductible	No copay; 0 % coinsurance after deductible
Urgent Care Visit	No copay; 20 % coinsurance after deductible	No copay; 20 % coinsurance after deductible	No copay; 0 % coinsurance after deductible
Emergency Department services	No copay; 20 % coinsurance after deductible	$175 copay; No coinsurance	No copay; 0 % coinsurance after deductible

Coverage Category	Gold	Silver	Bronze
Inpatient Hospital Services (e.g., Hospital Stay)	No copay; 20 % coinsurance after deductible	$250 copay per day; no coinsurance	No copay; 0 % coinsurance after deductible
Lab Outpatient and Professional Services	No copay; 20 % coinsurance after deductible	No copay; 0 % coinsurance after deductible	No copay; 0 % coinsurance after deductible
X-rays and Diagnostic Imaging	No copay; 20 % coinsurance after deductible	No copay; 0 % coinsurance after deductible	No copay; 0 % coinsurance after deductible
Generic Medicine Copay	$10 copay	$20 copay	No Charge
Mental/Behavioral Health Outpatient Services	No copay; 20 % coinsurance after deductible	$20 copay; no coinsurance	No copay; 0 % coinsurance after deductible
Monthly premium, region 1 minimum, 40 y/o single	$336	$294	$231
Annual premium	$4,032	$3,528	$2,772

Note: All figures are for in-network coverage only and plan may pay differently for provider/services outside the network. 'No Charge' means no charge for the visit; coinsurance may still apply after deductibles are met. 'No Cost' means no charge for visit and no coinsurance after deductible is met.

In this base case scenario, the premium for the lowest-cost plans across the three metal tiers range from $2,772 to $4,032. The difference of annual premium between the Bronze and Silver is $756. An individual with the silver plan will pay up to $3,500 annually as a combined medical and drug deductible. Also, depending on the services received, the individual will pay between $25 to $50 more per visit (not including emergency room and inpatient hospital services) as copay and a 20% coinsurance for certain services such as urgent care visit. Similarly, an individual with the gold plan will have an annual combined medical and drug deductible of $1,000, and have a $20 to $40 copay per visit for certain medical services (not including emergency room and inpatient hospital services) and a 20% coinsurance after the deductible is reached for services such as an urgent care visit. In comparison, the individual with the bronze plan will pay up to $6,300 a year in the form of a combined medical and drug deductible, which is also the maximum out-of-pocket (MOOP) cost limit for the bronze plan. This amount is much lower on the silver plan and even more so for the gold plan.

To summarize, when comparing a gold and bronze plan, the individual pays higher premiums upfront on the gold plan but has a lower deductible. Out-of-pocket cost is incurred gradually in the form of copays and coinsurances. On the bronze plan the individual pays a

lower premium but covers initial costs out-of pocket until they are maxed out, after which the plan covers EHB services without any out-of-pocket charge.

In general, the MOOP costs for gold plans range from $3,500 to $6,350 for single and $7,000 to $12,700 for family depending on the issuer. Most of the silver and bronze plans have MOOP costs of $6,350 for single and $12,700 for family.

BARRIERS AND PROMOTERS TO PARTICIPATION, EASE OF THE CERTIFICATION PROCESS, AND PLAN MONITORING

In December 2012, Arkansas became the first state in the nation to designate a Federally Facilitated Marketplace/State Partnership for their Health Insurance Marketplace. The Health Care Independence Act of 2013, creating the Arkansas "Private Option", was signed into law on April 23, 2013. Also, during the 2013 Arkansas legislative session, the Arkansas Health Insurance Marketplace Board was created to begin planning for a state based marketplace in Arkansas. Responsibilities for plan management were given to AID to meet policy requirements.

To evaluate the barriers and promoters to participation, ease of the certification process, and plan monitoring for the SPM, AFMC reviewed the SPM Plan Management Business Operations and Process Manual and distributed a survey to carriers who were invited to participate in the newly established insurance exchange.

BARRIERS AND PROMOTERS TO PARTICIPATION

The 23 carriers invited to participate in the inaugural plan year for the SPM were sent a survey to determine perceived barriers and promoters to participating in plan year 2014 enrollment.

SURVEY RESULTS

A total of 16 (70%) carriers completed the online SurveyMonkey® instrument. Three of those responses included carriers who participated in the 2014 Plan Year (Figure III-1). The response from the AR BCBS representative was inclusive of experiences for both the in-state and multi-state carriers. The remaining 13 responses were from carriers who were invited to participate in the SPM but who chose not to be a part of the inaugural year.

FIGURE III-1. RESPONSE TO CARRIER SURVEY QUESTION ABOUT PARTICIPATION

Carriers who did not choose to enter the SPM were asked to note barriers that discouraged participation (Figure III-2). Ten of the thirteen carriers who did not participate in the SPM responded. Reasons given by carriers for not participating included the overall process, amount of effort to provide required paperwork/documents, participation requirements, limited staff capacity, cost to benefit, limited ability to comply with state regulations, and limited ability to comply with federal regulations. Four additional responses were captured through the carrier's ability to note other barriers not already outlined within the survey responses. An additional barrier noted by the carriers included changes in their health insurance offerings; four carriers stated they do not offer health insurance in the individual market anymore or no longer offer health insurance.

FIGURE III-2. BARRIERS TO PARTICIPATION IN THE 2014 ARKANSAS STATE PARTNERSHIP HEALTH INSURANCE MARKETPLACE

Barrier	Percent
The overall process	10%
Amount of effort to provide required paperwork/documents	20%
Participation requirements	10%
Limited staff capacity	10%
Cost to benefit	10%
Limited ability to comply with state regulations	10%
Limited ability to comply with federal regulations	20%
Other (please specify)	40%

All three carriers offering insurance in the 2014 plan year of the SPM (100%) indicated that already providing service in Arkansas influenced their participation. In addition, two of the three respondents (66.7%) stated involvement in the HCIP promoted their participation as well.

EASE OF THE CERTIFICATION PROCESS AND PLAN MONITORING

QHPs must meet federal and state requirements for certification in order to be offered through the SPM. AID assisted health insurance carriers who chose to enter the 2014 SPM plan year to review application submissions, evaluate plans and service areas, and provide recommendations and guidance to carriers while working with the CMS filing system. Federal and state requirements for SPM carrier participants included:

- Basic plan regulations
- Pricing
- AID's authority over the process
- Establishment of essential community provider (ECP) policies
- Carrier accreditation expectations and timelines
- Quality improvement activities
- Mandatory offerings
- Essential health benefit offerings
- Non-discrimination standards

Per federal guidance through bulletins, states were encouraged to choose an existing health plan to set a "benchmark" for services for EHBs. CMS provided the following recommendations for choosing a benchmark:

- Any of the three largest small group insurance products by enrollment in the State's small group market;
- Any of the three largest State employee health benefit plans by enrollment;
- Any of the three largest national Federal Employees Health Benefits Program plan options by enrollment; or
- The largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the State.

Of the options above, there were seven plan options for Arkansas's benchmark. If the state did not choose a benchmark plan, the default benchmark plan for Arkansas would be the largest plan by enrollment in the largest product in the state's small group market.

The AHCD involved stakeholders in their study to determine the appropriate benchmark plan for the Arkansas SPM. AID considered consumer benefits and cost as well as compliance with ACA and Arkansas Insurance Law. AID Rule 103 was published, detailing how the benchmark would be selected. Arkansas chose to use the following plan and supplementations for their benchmark standard:

Plan:

Arkansas Blue Cross Blue Shield Health Advantage Point of Service (POS)

Supplements:

QualChoice Federal Plan Mental Health and Substance Use Disorder Benefits

Arkansas Child Health Insurance Plan (CHIP), AR Kids First for Pediatric Dental

Arkansas Child Health Insurance Plan (CHIP), AR Kids First for Pediatric Vision benefit

The four carriers who participated in the SPM for the 2014 plan year were sent a survey to determine their perceived ease of the certification process and satisfaction with the plan monitoring process.

CERTIFICATION PROCESS SURVEY RESULTS

The three carriers representing the four distinct 2014 Marketplace participants were asked to rate the importance of financial feasibility, relevance to products or work, interest in participating in the Marketplace, and outreach from AID in their decision to undergo the certification process.

Financial feasibility and outreach from AID were rated low in importance by all three carriers (100%).

Relevance to products or work was considered “great” in importance for one carrier (33.3%) while viewed as not at all or only a little important by others (66.7%).

Interest in participating in the Marketplace was rated as great importance for two carriers (67.7%) and not at all important for the remaining carrier (33.3%).

All three carriers (100%) rated the ease of use of the certification process as neutral.

In addition, carriers were asked to rate their satisfaction with AID on several attributes. Ratings of the education provided by AID regarding the certification process, quality of the certification process training provided to staff, methods of communication by AID, quality of support during the certification process, and post-certification follow-up were either neutral or somewhat satisfied. Responses were either neutral or somewhat dissatisfied when carriers rated the time and effort to complete the certification process. A wide variation in the rating of the knowledge of AID staff occurred with responses ranging from somewhat satisfied to somewhat dissatisfied.

Carriers were either neutral or somewhat satisfied with how the plan management staff resolved concerns during the certification process. There was not a consensus among respondents regarding the ease of use of the System for Electronic Rate and Form Filing (SERFF) application process; ratings ranged from somewhat easy to use to somewhat difficult to use. In an open text response for recommended changes to the certification process, suggestions included “more timely notice of changes and updates to policies” and “orderly filing review” by AID (providing discrepancies in connection with a phase in filing all at once). It was suggested

that the “Department should review a filing, compile all its objections, and then submit these objections to the issuer” all at once.

PLAN MONITORING SURVEY RESULTS

All three carriers were contacted by AID regarding plan management activities such as needed changes within the plans submitted for certification, provider networks, additional bulletins, consumer complaints or additional guidance from CMS. Carriers offered a range of responses, from very easy to somewhat difficult, when asked to rate their experience with AID communications throughout the plan monitoring process. Two of the carriers felt that plan monitoring issues were explained clearly while one carrier did not. However, all three carriers felt that plan monitoring issues were resolved in a timely manner.

One carrier indicated that their company underwent the QHP certification process in another state. When asked to rate the ease of use of the certification process in other state(s) their response was neutral.

Carriers were either somewhat satisfied or neutral when asked about their satisfaction with the education and training they received on plan monitoring processes. Overall satisfaction with the plan monitoring process varied greatly among the carriers ranging from very satisfied to somewhat dissatisfied. One carrier recommended through an open-ended response option that AID state plan management standards more clearly. The issuer provided the following as an example: AID Bulletin 9-2114 states that “AID network adequacy standards are met if issuer has accreditation from a HHS approved accrediting organization that reviews network adequacy, yet even though this issuer had such an accreditation, we were required to respond to numerous network adequacy questions from the Department”.

BASELINE QUALITY INDICATORS

Two mechanisms used for the assessment of quality indicators were identified – CMS Health Insurance Marketplace Quality Initiative and the AID Quality Reporting Pilot.

- The CMS Health Insurance Marketplace Quality Initiative includes a Quality Rating System (QRS), Quality Improvement Strategy (QIS), and an enrollee satisfaction survey system (ESS). Data includes validated QRS clinical data as well as a subset of the ESS survey data. CMS designed a 1 to 5 star rating scale to aggregate and summarize data findings. A phased in approach for quality reporting begins in 2016.
- The AID Quality Reporting Pilot gained approval in September 2014. It also includes validated clinical data measures as well as measures collected through a consumer survey. The proposed pilot will include eight clinical and eleven survey measures for a

total of 19 measures. A Quality Pilot Bulletin 1-2015 was released in January 2015. The deadline for clinical and survey data submission is August 1, 2015.

Neither the CMS quality initiative nor the AID quality pilot was fully implemented at the time of this report thus limiting a complete assessment of quality indicators during the inaugural year of the SPM.

Additional data sources for quality indicators were explored although none were ideal for this evaluation. Claims analysis of measures proposed by CMS and the AID projects generally require a full 1-2 years of data; both access and timing limited this option. In addition, carriers are required to begin the accreditation process through National Committee for Quality Assurance (NCQA) or Utilization Review Accreditation Commission (URAC), which would allow for adequate procedures to be in place to access quality measures. Ambetter became accredited through NCQA. QualChoice and AR BCBS are accredited through URAC. However, Arkansas carriers are not required to report quality measures until 2016, limiting access to quality measures data. Future plans for Arkansas include an all payer claims database which could further facilitate quality indicator assessment but not in the current timeframe.

The importance of quality measures has been acknowledged by AID and the SPM Steering Committee. However, at this time, full evaluation is not possible. Given the limitations in timing noted previously, the baseline quality measures readily available for this assessment include those which can be accessed through a consumer survey and compared to National CAHPS® Benchmarking Database (NCBD) data. Composites calculated from the AID 2014 Consumer Health Survey align with the survey measures selected for the AID Quality Reporting Pilot.

When compared to the NCBD, the 2014 AID Consumer Health Survey scored lower in the Getting Care Quickly, Rating of Specialist Seen Most Often, Rating of all Health Care, Rating of Health Plan, Health Promotion and Education, and Coordination of Care. The Customer Service composite was higher compared to national data. Since the Cultural Competency composite is a new composite measure for CAHPS®, comparable data is not yet available. The comparison of 2014 survey responses to NCBD data for Aspirin Use and Aspirin Discussion were not conducted because data was not available through the NCBD database.

TABLE III-O. AID CONSUMER SURVEY COMPARISON TO NCBD

Composites/Components Rating Item	2014 Summary Rate (%)	NCBD 2014 National (%)	Significance Difference (Survey vs. NCBD)
Getting Needed Care	81.9	81.2	Not Significant
How often it was easy to get needed care, tests, or treatment (Q9)	83.9	83.6	Not Significant
Got appointments with specialists as soon as needed (Q32)	79.9	78.7	Not Significant
Getting Care Quickly	78.5	81.6	Significantly lower
Got urgent care for illness, injury or condition as soon as needed (Q2)	82.0	83.7	Not Significant
Got routine appointment at doctor's office or clinic as soon as needed (Q5)	75.1	79.5	Significantly lower
How Well Doctors Communicate	91.0	90.2	Not Significant
Personal doctor explained things clearly (Q15)	93.6	90.7	Significantly higher
Personal doctor listened carefully (Q16)	91.3	90.6	Not Significant
Personal doctor respected consumer comments (Q17)	91.1	92.0	Not Significant
Personal doctor spent enough time with consumers (Q18)	87.9	87.8	Not Significant
Customer Service	90.3	86.0	Significantly higher
Customer service gave necessary information or help (Q63)	85.1	79.7	Significantly higher
Customer service staff courteous and respectful (Q64)	95.4	92.2	Significantly higher
Cultural Competency	72.3		
Rating of personal doctor (Q25)	81.1	79.7	Not Significant
Rating of Specialist Seen Most Often (Q34)	76.1	79.9	Significantly lower
Rating of all health care (Q8)	67.4	71.8	Significantly lower
Rating of health plan (Q73)	62.1	74.8	Significantly lower
Health Promotion and Education (Q7)	66.7	71.9	Significantly lower

Composites/Components Rating Item	2014 Summary Rate (%)	NCBD 2014 National (%)	Significance Difference (Survey vs. NCBD)
Coordination of Care (Q24)	72.8	80.3	Significantly lower
Advising Smokers and Tobacco Users to Quit	60.2	55.8	Not Significant
Discussing Cessation Medication	27.4	29.3	Not Significant
Discussing Cessation Strategies	27.0	24.5	Not Significant

SUMMARY

Four insurance carriers participated in the initial 2014 plan year for Arkansas, which was just under the National average for numbers of participating carriers. Regional coverage within the state was similar across the state except for the Southeast and Southwest regions which have fewer participating carriers offering plans. Overall, the number of carriers, insurance plans involved and costs were appropriate to cover enrollees.

Barriers and promoters to participation, ease of the certification process and plan monitoring were assessed through a carrier survey. Barriers noted by carriers who chose not to enter the SPM included concerns regarding the overall process, amount of effort to provide required paperwork/documents, participation requirements, limited staff capacity, cost to benefit, limited ability to comply with state regulations, limited ability to comply with federal regulations, changes in their health insurance offerings, not offering health insurance in the individual market anymore or no longer offering health insurance. Existing service to Arkansas influenced participation by the three carriers offering insurance in the 2014 plan year of the SPM. Two of the three respondents indicated involvement in the HCIP promoted their participation as well. There was not consensus among participating carriers regarding factors that influenced decisions to undergo the certification process. There was not a consensus among respondents regarding the ease of use of the System for Electronic Rate and Form Filing (SERFF) application process; ratings ranged from somewhat easy to use to somewhat difficult to use. All three carriers felt that plan monitoring issues were resolved in a timely manner. Carriers were either somewhat satisfied or neutral when asked about their satisfaction with the education and training they received on plan monitoring processes.

Full assessment of baseline quality indicators was not possible at the time of the report, however survey data from the 2014 AID Consumer Health survey were available for partial assessment of quality indicators. The composite analysis indicated that the Customer Service composite was significantly higher for the Consumer Health Survey compared to national data –

an area for celebrated success. Respondents to the survey also indicated that their personal doctor explained things clearly at a significantly higher rate; another key achievement. The composite for Getting Care Quickly was significantly lower compared to national data. So although access to urgent care was not an issue as indicated by survey response, there is room for improvement for the timing of access to routine healthcare. Of the ratings, Rating of Specialist Seen Most Often, Rating of all Health Care, and Rating of Health Plan were significantly lower compared to national data. Health Promotion and Education and Coordination of Care were also significantly lower compared to national data. These comparisons offer a 'snapshot' in time, ideally, a trended look would demonstrate truer patterns.

LIMITATIONS

Where possible, data sources available directly from the Arkansas Insurance Department were utilized. However, there were variables in which the evaluation team relied on National data sources which may or may not have accurately reflected the unique environment that the Arkansas Medicaid expansion presents.

The carrier survey responses rely on self-report of past events which may introduce recall bias. While all carriers participating in the SPM responded, non-response by those carriers invited but not participating in the SPM may also introduce response bias.

Quality indicators were limited by the timing of the evaluation – neither the CMS Health Insurance Marketplace Quality Initiative nor the AID Quality Reporting Pilot were fully implemented with finalized data at the time of reporting. However, the AID consumer survey data portion of the AID Quality Pilot was helpful in partial. Caution should be taken when interpreting the national comparison to AID survey data. While the NCBD allowed for a national comparison, the database only includes Medicaid data while the AID survey responses were from both Marketplace participants and HCIP enrollees. Differences in demographics and health status were noted throughout survey analysis between Marketplace and HCIP enrollees.

RECOMMENDATIONS

- The evaluation team recommends the AHIM should continue to pursue and recruit insurance carriers to enter the market to expand options for enrollees, competition to increase quality of offered products, and reduce costs.
- Future evaluation among the carriers for continued feedback regarding barriers, ease of certification process and plan monitoring through qualitative or quantitative data collection to inform methods for these processes.

- Continued assessment of quality indicators through either the CMS Health Insurance Marketplace Quality Initiative or the AID Quality Reporting Pilot. Focus on measures that are similar between the two quality initiatives would be most valuable for comparison purposes.

IV. EVALUATE EFFECTIVENESS OF IN-PERSON ASSISTER GUIDE TRAINING

OVERVIEW

The AHCD was responsible for certifying and monitoring health insurance plans sold through the federal Health Insurance Marketplace, ensuring access, affordability, quality, and choice for Arkansans. The AHCD was also responsible for assisting Arkansans with questions about their health insurance options and connecting them to the federal Health Insurance Marketplace, which opened for enrollment October 1, 2013, with full coverage available January 1, 2014. The AHCD implemented the Arkansas In-Person Assister (IPA) Guide program to complement the federal Navigator Program with a workforce prepared to facilitate enrollment and licensure.

The program deployed over 500 certified IPAs to assist consumers across the state during open enrollment. IPAs were hired to educate people about the new system, help them understand their health plan choices, and facilitate their enrollment in a qualified health plan. Federal regulations and Arkansas Act 1439 stipulated that the state establish a set of training standards for all assisters (IPAs, Navigators, Certified Application Counselors, existing insurance agents and brokers) to ensure their expertise in understanding the needs of underserved and vulnerable populations, eligibility and enrollment rules and procedures, the range of QHP options and procedures, and privacy and security standards. (These state-regulated IPAs funded through ACA Section 1311 funds and contracted by AID, were in addition to Navigators directly funded by CCIIO.) The Health Connector Training Program was developed and implemented with the aim of training the assisters to help consumers navigate the new SPM in Arkansas. AID contracted with the Arkansas Department of Higher Education (ADHE) to provide the training, which was coordinated through the Arkansas Association of Two-Year Colleges (AATYC). Cossatot Community College of the University of Arkansas served as the lead institution to coordinate the training and worked with six other two-year colleges to develop, implement, and monitor the training. The other lead colleges included North Arkansas Community College in Harrison, Black River Technical College in Pocahontas, East Arkansas Community College in Forrest City, South Arkansas Community College in El Dorado, Pulaski Technical College in North Little Rock, and National Park Community College in Hot Springs.

The Health Connector Training Program began training assisters in June 2013 and continued through the open enrollment period (October 1, 2013-March 31, 2014). There were three phases of the training:

- Phase I-Outreach and Education;
- Phase II-Federal Training; and
- Phase III-State Specific Issues.

The curricula for Phases I and III were developed by a team of educators led by AATYC, who received direction for content from AID and the Department of Health and Human Services (HHS). The bulk of the curriculum content was focused on detailed information about how health insurance works, the requirements of the ACA and Arkansas' unique Medicaid expansion program (HCIP or Private Option), and confidentiality issues. HHS developed and delivered the online curriculum for Phase II. Both Phases I and III included classroom training and online training components for the assisters while Phase II involved federally mandated online training. The classroom components of the Phase I and Phase III training were eventually removed, leaving the training as a 100% online course.

EVALUATION BY BOYETTE STRATEGIC ADVISORS

Boyette Strategic Advisors (BSA) evaluated the Health Connector Training Program, surveying the four groups involved in the training: trainees, training instructors, IPAs, and employers. To gain an in-depth understanding of the Health Connector Training Program and stakeholder views of the program, BSA also conducted initial research that involved a series of interviews and group discussions with the AATYC staff, the AID staff and representatives of the seven lead colleges involved in the training.

BSA reviewed the training requirements contained in the ACA and identified the partner organizations involved with the training program. These partner organizations included the institutions that offered the training and the organizations that employed the trained participants. BSA also interviewed leadership at AID, AATYC, and representatives of the seven lead colleges involved in the training.

BSA conducted a quantitative analysis of the training program. One method used was to conduct surveys with trainees, instructors, and the employers of the trainees to gain an understanding of the effectiveness of the training program. Another method involved comparing the goals of the training program with the achieved results in terms of number of participants trained and number of training sessions held in the state.

Finally, BSA also conducted a qualitative analysis of the training program that involved a high-level review of the curriculum components for the training and an evaluation of the input from the seven lead colleges.

CURRICULUM

During the stakeholder interviews with the AATYC staff, the AID staff and representatives of the seven lead colleges involved in the training, all stakeholders acknowledged that development of the curriculum was a difficult and time-consuming task. They also

acknowledged that due to the compressed timeline curriculum development was rushed, particularly the components for Phase I of the training. Many of those interviewed mentioned that the Phase I curriculum required multiple reviews, with significant revisions made to the initial drafts. Some stakeholders expressed frustration that perhaps those stakeholders writing the curriculum did not always receive sufficient guidance prior to curriculum development, possibly because federal officials did not offer guidance about the curriculum. Additionally, some stakeholders stated that curriculum development was challenging due to continual changes related to the ACA at the federal level as well. Although there was concern that the lead college representatives did not always possess the appropriate expertise in specific curriculum modules, most stakeholders agreed that the strong collaboration among the colleges resulted in an effective and informative curriculum that met the needs of the program.

According to the stakeholders interviewed, the development of the Phase III curriculum was more efficient and effective, likely due to a better understanding by AATYC and the seven lead colleges of the content and the process of curriculum development, as well as a better communication system and review process that was developed as a result of challenges faced in creating the Phase I curriculum.

CHALLENGES

Several stakeholders noted issues with the process for assigning trainees to training sites as an issue. Some of the lead college representatives found that trainees in their area were sent to other sites (out of town) for training, which reduced the number of students at their institutions while some colleges reported they were assigned more students than they could accommodate. Several respondents specifically mentioned issues with the federal Health Insurance Marketplace website not being available for use during the training process, which resulted in trainees not understanding how the federal website functioned and how to assist consumers in using it. The lead college representatives also mentioned that each college had unique processes and requirements related to billing and that in the early stages of the program, specific financial procedures had not been developed and disseminated to the colleges which created some administrative challenges. The college representatives suggested the use of uniform financial reporting procedures that would fit within the accounting systems utilized by the colleges.

RECOMMENDATIONS

Virtually all stakeholders believed that a classroom component should be required as part of the Phase III training. The stakeholders mentioned that trainees liked being able to interact with each other and with the instructors, and the classroom interaction allowed those being

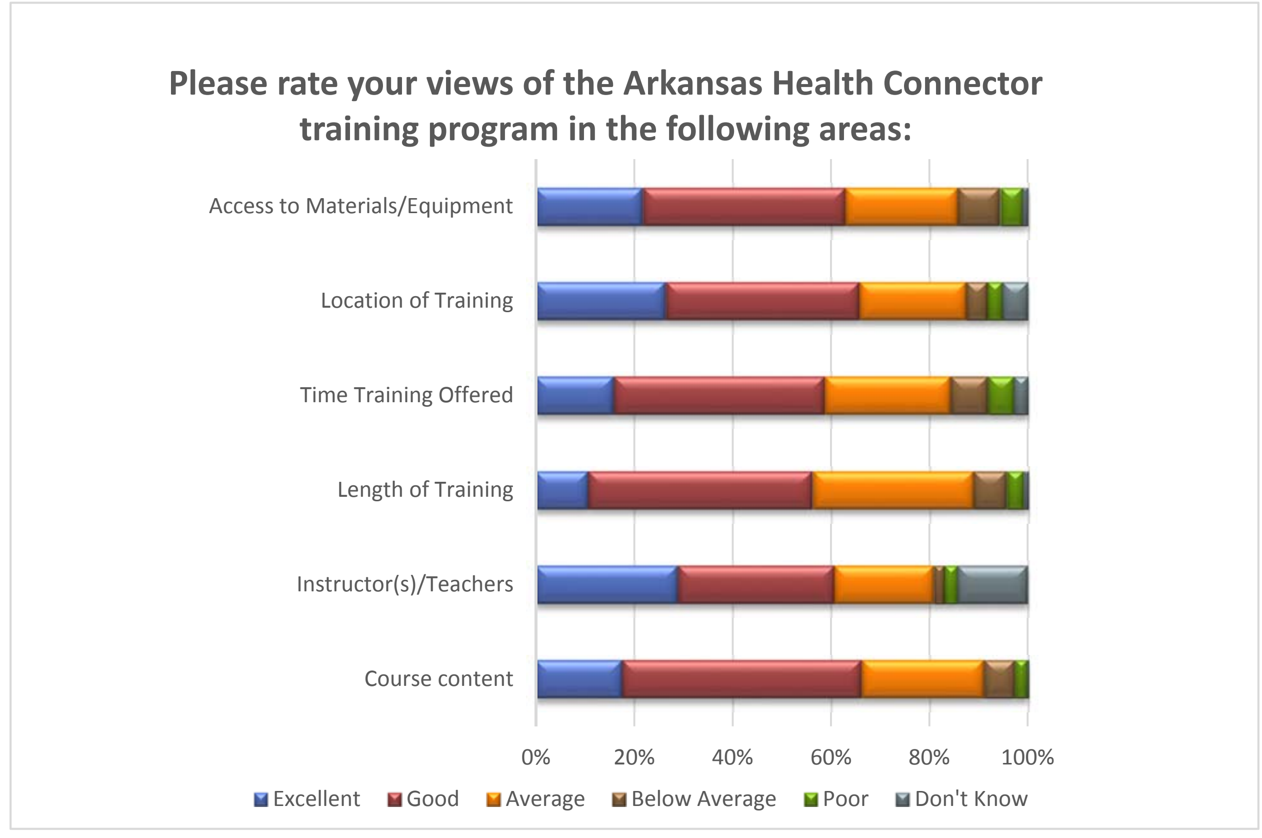
trained to get clarification on information, develop a sense of community, and share the challenges they encountered in their jobs. The lead college representatives indicated that they would have preferred to see a different approach to assigning trainees to a training location, since some colleges had excess capacity while others were at their maximum or beyond. They also suggested that trainees be assigned to the facility closest to their residence. The college representatives also indicated that the colleges should have collaborated to create standardized reporting forms and processes for more uniform financial reporting procedures that fit within the accounting systems utilized by the colleges.

TRAINEE SURVEYS

Between February 4, 2014 and February 18, 2014, BSA e-mailed survey links to the 2,657 individuals that completed training modules in the Health Connector Training Program. A total of 484 (18.2%) trainees completed the survey. Of those trainees, 73.9% (n=358) were female and 49.8% (n=241) were between 46 to 65 years of age. All responding trainees had a high school diploma or GED while 91.5% (n=443) had at least some college education and 45% (n=218) had a bachelor's degree.

Trainees were asked to rate their views of the Health Connector Training Program as excellent, good, average, below average, or poor in the areas of course content, instructors, length of training, time when training was offered, location of training, and access to materials (see Figure IV-1 below). Overall, trainees had a favorable view of all aspects of the Health Connector Training Program. Specifically, course content received the highest rating with 66.2% (n=320) of trainees viewing content as excellent or good followed by location of the training which was viewed as excellent or good by 65.7% (n=318). The length of training was rated lowest overall, with 42.7% (n=207) of trainees giving it a rating of average or lower.

FIGURE IV-1. TRAINEE SURVEY RESULTS



Training modules in the Health Connector Training Program included the course components: Arkansas Health Insurance Plans and Coverage; Diversity and Cross-Cultural Interactions; Ethics and Confidentiality; Customer Service and Communication; Roles and Responsibilities of Assisters; Health Insurance Marketplace Overview and ACA overview. When trainees were asked to rate the importance of each of these modules to their job performance, using a rating scale of very important, important, somewhat important, not very important and not at all important, the module addressing Arkansas Health Insurance Plans and Coverage was viewed as the most important with 93.4% (n=452) of trainees saying it was very important or important. In comparison, only 72.3% (n=350) of trainees thought the module on Roles and Responsibilities of Assisters was very important or important. Overall, trainees believed that all modules taught were very important or important to their job performance as assisters.

Regarding how effectively the training prepared the assisters for their job responsibilities, with a rating of 0 representing not at all prepared and 10 representing very prepared, the average rating was 6.8 with 63.4% (n=307) of trainees rating their preparedness at 7 or above. When asked to rate how easy it is to apply the training received in the Health Connector Training Program to the job requirements in their new position, 62.8% (n=304) of the trainees thought that it was very easy or somewhat easy. Of the 484 trainee survey respondents, 96.5%

(n=467) completed Phase I training and 45.8% (n=214) of those trainees completed Phase I in a classroom setting, the other 54.2% completed the training online. Phase II training was only offered online and was completed by 97.5% (n=472) of the trainees. Phase III training was completed by 93.2% (n=451) of the respondents and 46.7% (n=211), of those trainees received a portion of the Phase III instruction in a classroom setting, the remaining 53.3% completed the course online.

TRAINEE COMMENTS & RECOMMENDATIONS

Several trainees expressed the need for further training on Medicaid and insurance plans as well as further follow-up training to address system and regulatory changes. When asked about any additional comments trainees might have, a concern was expressed that the training did not include access to or training on the federal Health Insurance Marketplace portal and, as a result, trainees had to learn to navigate the enrollment website without post-training support. Although the average rating was 6.8 in terms of the training preparing the trainees for their job responsibilities, many trainees believed that the training did not fully prepare them to help clients navigate the overall program. Some trainees requested greater support while in the field to address problems encountered. Another common theme was that online only training was not as effective as classroom training since it did not provide opportunities for class discussions and interactions with other assisters and instructors.

INSTRUCTOR SURVEYS

There were 27 individuals that served as instructors in the program, 55.6% (n=15) of whom completed the survey that was emailed to them between February 4, 2014 and February 18, 2014. Respondents included 86.7% (n=13) females and all respondents held at least a bachelor's degree.

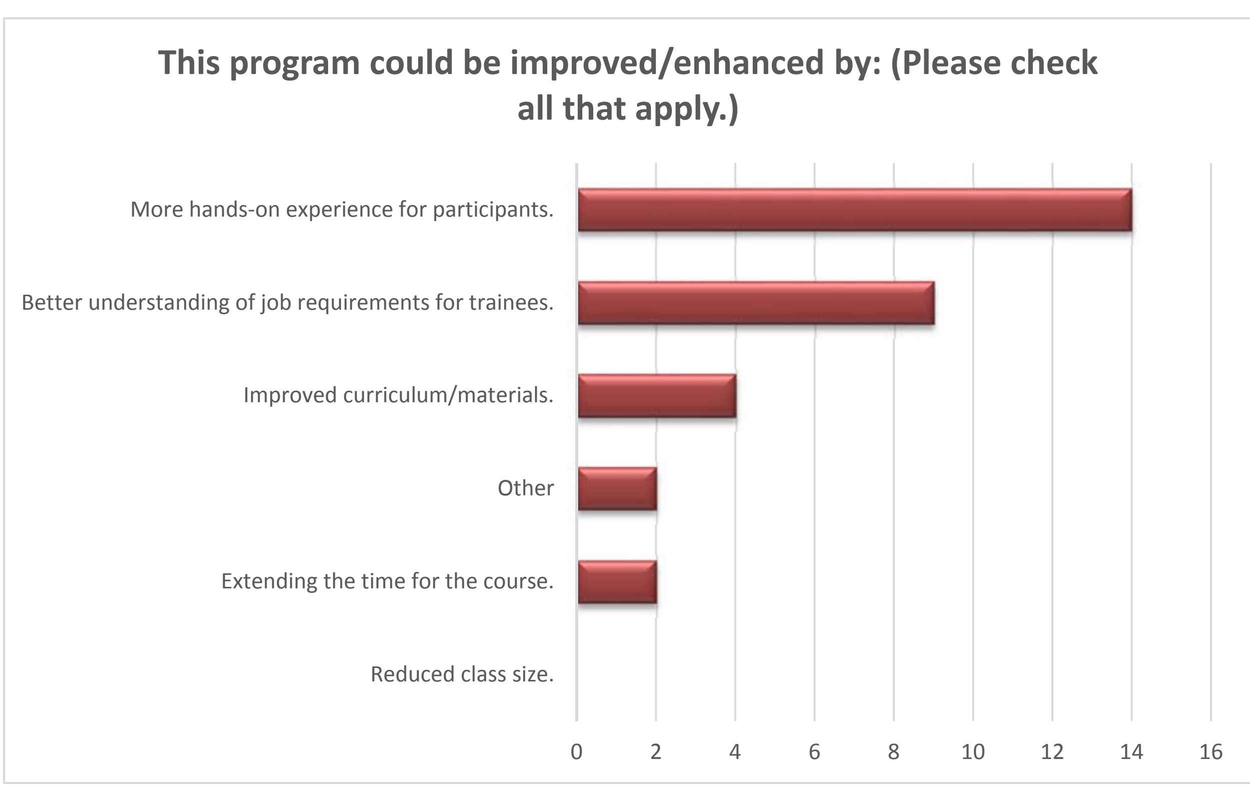
When rating the Health Connector Training Program in terms of the course content, length of training, location of training, time when training was offered, and access to materials, the program was deemed excellent or good, with length of training receiving the highest marks (all instructors rated the component as excellent or good). The location of training component received the lowest rating with 20% (n=3) of instructors rating it as average.

Instructors thought that all training modules that comprised the course components described previously were important or very important for the job performance of trainees. All instructors (n=15) said the Health Insurance Marketplace Overview was very important, and 93.3% (n=14) viewed the Arkansas Health Insurance Plans and Coverage content as very important.

Regarding how prepared the instructors were to deliver the curriculum provided, with a rating of 0 representing not at all prepared and 10 representing very prepared, instructors indicated a high level of preparedness with an average rating of 8.7 and all instructors rating preparedness at 7 or above.

When asked about possible improvements or enhancements to the training program, 93.3% (n=14) of the instructors responded that more hands-on experience for the trainees would improve the training. Sixty percent (n=9) of the instructors believed that a better understanding of the job requirements for trainees would improve the training program. Few instructors (26.7%, n=4) believed that the curriculum and materials could be improved. (See Figure IV-2 below.)

FIGURE IV-2. IMPROVEMENT/ENHANCEMENT RESULTS



INSTRUCTOR COMMENTS & RECOMMENDATIONS

Instructors believed that in-class training was important in order to share ideas and best practices as well as to have face to face discussions and allow trainee collaboration. Instructors also believed that trainees would benefit from better job descriptions and real-life scenarios, possibly referring to hands-on experience with navigating the Health Connector website and performing mock enrollment exercises. One instructor commented that the curriculum

development, as well as the train the trainer events, were rushed and the process of material review and feedback from AID was long, complicated, and cumbersome.

EMPLOYER SURVEY

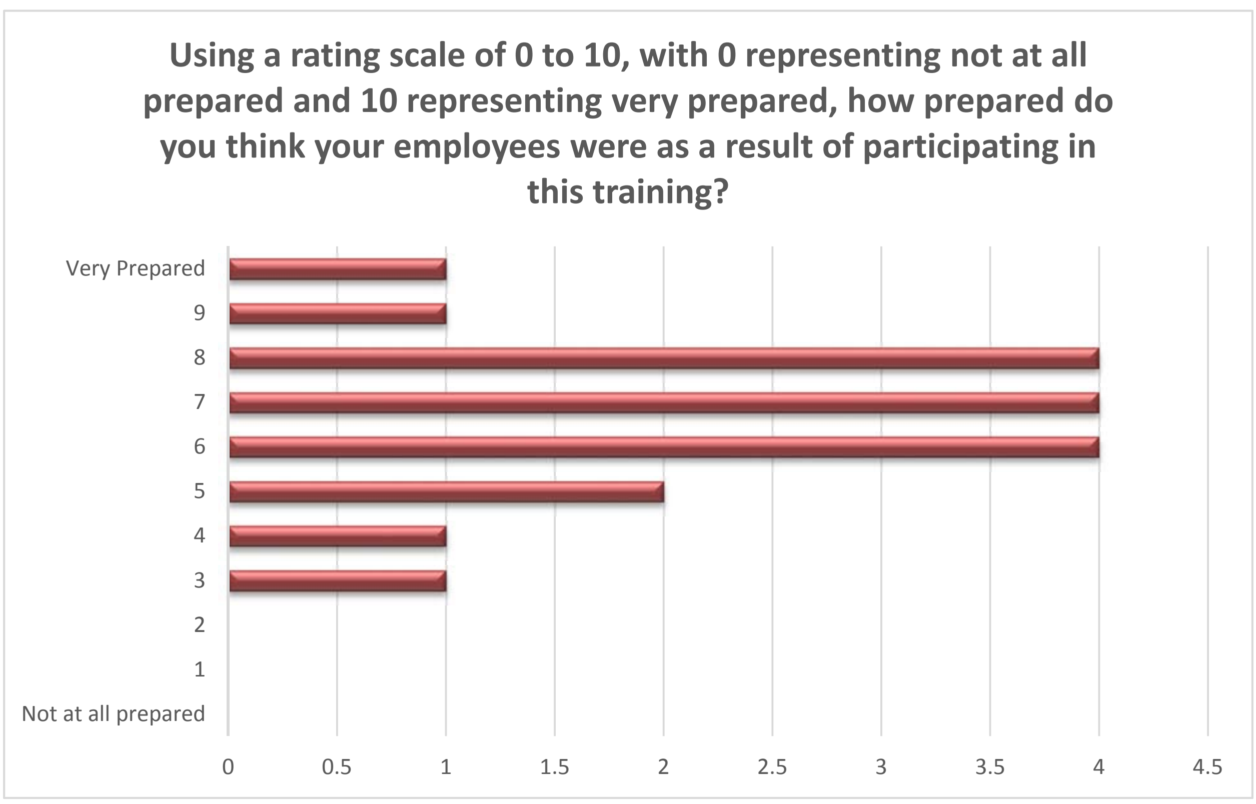
Between February 5 and February 24, 2014, the employer survey was emailed to 62 employers representing the 27 Community Based Organizations that hired Health Connecter Training Program trainees and 29% (n=18) of these employers responded to the survey. Trainees that were employed by the organizations that responded to the survey had received the classroom portion of their training at 18 different institutions. Seventy-two percent (n=13) mentioned that their employees were enrolled in training at Pulaski Technical College.

When rating the Health Connector Training Program in terms of course content, length of training, location of training, and time when training was offered, employers had a favorable view of most aspects of the training. However, ratings by employers were less favorable than the trainees' and instructors' ratings. Seventy-eight percent of employers (n=14) thought that the location of training was excellent or good, and 61.1% (n=11) believed that the length of training and course content was excellent or good. Training availability received the lowest positive rating with 50% (n=9) of employers giving it a rating of average or below average.

Employers believed that all of the course components taught in the training modules were important or very important in terms of the trainees' ability to carry out their job. All employers rated the training on Ethics and Confidentiality as important or very important and the next highest rated course component was the ACA Overview, with 94.4% (n=17) of employers rating it very important or important.

When asked to rate how prepared the employers thought their employees were to do their job as a result of participating in the training, with a rating of 0 representing not at all prepared and 10 representing very prepared, employers gave an average rating of 6.7, indicating that the trainees were generally prepared. Fourteen (77.7%) employers gave a rating of 6 or higher. (See Figure IV-3 below.)

FIGURE IV-3. PREPAREDNESS RESULTS



When asked about possible improvements or enhancements to the training program, most employers (83.3%, n=15) responded that increased focus on job-specific skills would improve the training program and 66.6% (n=12) of the employers thought that additional technical training was required. Forty-five percent of the employers (n=8) thought that the Health Connector Training Program could be improved by an enhanced curriculum while 33.3% (n=6) believed that better collaboration with employers would enhance the training program.

EMPLOYER COMMENTS & RECOMMENDATIONS

Employers commented that there was no training on the Health Insurance Marketplace website nor was there any training with regards to navigating the federal system ahead of it going live, so the trainees had to learn through trial and error. Employers also thought that the program should include more hands-on training with mock enrollments that simulated the day-to-day duties of the trainees. Multiple attempts by AID to secure online, hands-on training with the Healthcare.gov portal were unanswered due to technical difficulties with the portal and no such service was possible. Employers commented that there was no training on handling special cases such as American Indians, those above 65 years of age and those eligible for traditional Medicaid. Employers also believed that classroom training was more effective and

beneficial in teaching the content than on-line training, similar to comments by trainees and instructors.

CLASSROOM EVALUATIONS OBTAINED BY AATYC

AATYC distributed evaluation forms at the end of Phase I and Phase III training sessions to participants at the institutions where they received their training. Of the 362 evaluations that were received for Phase I training, the most frequent responses for the open ended question concerning what the trainees considered to be the best/strongest part of the class were the practice scenarios and class interaction. The weakest part of the class included changing guidelines, conflicting information in the material and the distance some participants had to travel to get to classroom training sessions.

For the Phase III training, 198 evaluations were submitted. Similar to Phase I training, classroom interaction with practice scenarios and open discussions between students and instructors were rated as the strongest part of the class. Conflicting and/or repetitive information, not having access to the Health Insurance Marketplace website, and travel time to reach training facilities were cited as the weakest part of the training.

OVERALL FINDINGS OF THE EVALUATION

After a thorough evaluation of the Arkansas Health Connector Training Program, BSA reported the following findings:

- While the curriculum development process was challenging for all parties involved, the resulting product was viewed as successful.
- Engaging earlier with experts at AID might have allowed for fewer revisions in the curriculum drafts. Initial expectations were not adequately communicated, and some of the college representatives did not possess the necessary expertise and understanding of the subject matter to effectively write the curriculum. Additionally, AID should rely more heavily on the educational expertise of AATYC and the lead colleges in decisions related to how material is presented and the teaching methods utilized.
- Both instructors and employers are concerned that the trainees did not receive exposure to the website. In addition, employers specifically said that trainees needed additional software training and the opportunity to complete mock enrollments prior to beginning work with consumers.
- Each phase of training should include some classroom instruction. Trainees, instructors, and employers all indicated this to be more effective and better in reinforcing learning objectives.

- The collaborative effort and project management expertise of AATYC and the lead colleges was a critical component in the success of this program.

LIMITATIONS

A limitation of BSA's evaluation is the lack of information related to the survey process for collecting quantitative information from all participants. The report identified a total of 2,657 trainees that completed the training and were sent a survey link by BSA to collect trainee perspectives regarding the Health Connector Training Program. Approximately 19% (n=484) completed the survey; however, BSA does not report the number of times the survey link was sent to each trainee. Assuming that the survey was sent only once, sending a reminder to the non-responders may have improved the low response rate. Based on the BSA report, the survey was administered via an online questionnaire that did not require multiple sessions. The amount of time required completing the survey and whether that acted as a barrier to participation that led to a low participation rate is unknown.

There is no information reported regarding follow-up efforts with survey non-responders. Follow-up after the original survey period may have been useful to identify whether responses of non-responders differed significantly from responders. The survey collected the responding trainee's demographic information which, if similar demographic information exists for the trainees, a comparison of demographics of responders and non-responders may be possible. However, views regarding the training program could only have been collected via the survey.

UTILITY OF THE GUIDE MANAGEMENT SYSTEM

The COPH also examined the Guide Management System (GMS) as part of the evaluation activities. The GMS is a browser-based application developed by Computer Aid Inc. (CAI), in collaboration with AHCD staff, to support contract facilitation and assist IPA organizations in tracking IPAs, monitoring training, invoicing, and meeting performance reporting requirements. The GMS had two primary components: .Net software application and the Moodle Learning Management System. The .Net component handled all work related to IPA Organizations and IPAs. The Learning Management System (or Moodle) handled all training needs of the IPAs.

The AHCD used the GMS to view the activities of IPA organizations and IPA organizations used the GMS to help meet contractual obligations and invoice AID for their services. The GMS was used to track expenditures of IPA organizations in the following categories: Salary/Benefits, Professional and Contractual, Travel, Supplies, Advertising, Equipment/Capital Purchases, and Other.

Information obtained through the GMS is categorized under the following headings, based on the tabs available for authorized personnel to access information: Organization, Assisters, Performance, Invoicing, Extracts, and Graphs.

ORGANIZATION TAB

The Organization tab contains information about organizations with which AID contracted to assist in health insurance outreach and enrollment. The available information within this tab includes:

- Organization name (e.g. Central Arkansas Library System, Future Builders, Tri-County Rural Health Network etc.)
- Organization identification number
- Contract monitor (i.e., the person from AID that has been assigned to the organization)
- Address of the Organization
- Authorized representative at the organization and contact information
- Federal identification number of the organization

For purposes of demonstrating the functionality of the GMS, we have chosen 'Future Builders' as a typical IPA organization and used screenshots from this organization for illustrative purposes. Figure 1 in Appendix IV-A shows the information available in the organization tab.

When the GMS was analyzed in July 2014, there were 31 organizations, (including organizations defined in GMS for the sole purpose of training and testing, 27 of the organizations employed IPAs Once a specific organization is selected within the Organization tab, the above mentioned information is available. Apart from this information, a link called "Contract Management" directs the user to the specific contract that the organization had with AID. Information contained within this link includes contract number, contract year, start date, end date, and description. An example is given as figure 2 in Appendix IV-A.

Within the "Contract Management" tab, various types of information for the organization are available for review. These include tabs for organizational Goals, Budget, Performance, Invoice, View Contract PDF, and CM Documents as the screenshot above shows.

Using the example of 'Future Builders', figure 3 in Appendix IV-A shows the contents in the Goals tab. The Budget tab for 'Future Builders' is shown as figure 4 in Appendix IV-A. The Performance tab within the Organizations tab give the performance reports by month in terms of the number of people assisted, the number of people served, the number of outreach activities, the number of full-time IPAs, the number of part-time IPAs, the number of full-time

supervisors, the number of part-time supervisors, and whether or not AID's Contract Monitor has reviewed the report. Figure 5 in Appendix IV-A gives an example of the GMS display for performance reports. It is possible to select a specific month and compare the performance measures against the organization's performance goals. As an example, the performance report for 'Future Builders' for the month of May, 2014 is displayed in figure 6 in Appendix IV-A.

The summary in figure 6 shows that the performance goals for the number of assisted and served were 7,200 and 18,000 respectively for the timeframe from June 2013 to June 2014. By the end of May 2014, 8,674 individuals were assisted, 58,357 were served and 2,251 outreach activities were conducted. It is possible to identify the individual IPAs that were involved in each of these efforts, once a specific monthly performance report is accessed. For example, the above performance report is for May, 2014. It shows that 936 individuals were assisted, 4,359 individuals were served, and 182 outreach activities were performed. Specific IPAs that performed these activities can be viewed by clicking on the tab titled "Detail" within the monthly performance reports. The screenshot in figure 7 in Appendix IV-A shows the relevant GMS display.

A snapshot of the contents of the Invoice tab for 'Future Builders' is given figure 8 in Appendix IV-A**.** The figure shows 15 of the 21 invoices submitted by the 'Future Builders' between August 27th, 2013 and June 18th, 2014. Each specific invoice can be clicked to view the invoice details. For example, the invoice submitted on June 18th, 2014 can be clicked to see the details as shown in figure 9 in Appendix IV-A. The invoice details show the overall budget for the organization, how much of that budget was paid for by AID at the time an invoice was submitted, how much the current invoice claims, and how much of the overall budget remains. While viewing the invoice details for a specific invoice (e.g. invoice submitted on June 18th, 2014), tabs allow access to pdf versions of the invoice and related documents as well as status histories for the specific invoice.

The 'View Documents' tab allows access to pdf documents related to the invoice. An example is given in figure 10 in Appendix IV-A. The 'View Invoice' tab allows access to a pdf copy of the invoice. The 'Status History' tab makes it possible to track the status of an invoice in terms of its submission date, review date, and approval date as shown in figure 11 in Appendix IV-A. The View Contract PDF tab allows access to a pdf copy of the contract between the organization (e.g. Future Builders, Arkansas Guide Organization etc.) and AID. It contains the details of the agreement between the two parties which include, among other details: Method of procurement of contract, Term dates, Contracting parties, Contract purpose, Costs and Distribution, Source of Funds, Goals and Objectives, Certification of vendor, and Signatures.

ASSISTERS TAB

The assisters tab provides information about the assisters, either individually or by the 27 organizations that hired licensed assisters. The information about the assister does not vary, whether the information is viewed for the assister as an individual assister or an assister hired by an organization as shown in figure 12 in Appendix IV-A. Once a specific assister is selected, the first screen gives the assister's general information. An example is given in figure 13 in Appendix IV-A.

The Assister Information page includes tabs for further information, including:

- Counties/Availability – This includes the counties served by the assister.
- Training log – This tab includes information about the phase 1 – 3 training for each assister, the dates when the assister took the exams, their score, the pass/fail status on the exam and the number of attempts on the exam. Figure 14 in Appendix IV-A shows the display in GMS.
- View Upload Documents – This tab contains the assister-related documents. The training transcript, i.e., all the modules completed by the assister, are contained in this tab as a pdf document. Also, documents uploaded by the organization are available in this tab. An example can be seen in figure 15 in Appendix IV-A.
- Upload Consumer Consent form: This tab allows the assister to upload the consent forms for consumers that they assisted.
- License – This includes the assister's details regarding the license to practice as an IPA. A screenshot is shown below. The view tab allows access to the pdf forms for the Arkansas Health Connector License Application and the Background Check report. Figure 16 in Appendix IV-A shows the display in GMS.

PERFORMANCE TAB

The Performance tab gives the performance for each organization by month. The information obtained through the performance tab is the same as that obtained through the Organization tab previously described. An example can be seen in figure 17 in Appendix IV-A.

INVOICING TAB

Although this tab is present, it is not functional and does not give the invoices for the organizations. However, invoices can be obtained directly through the organization tab as described previously, so there is no lack of information due to the inactivity of the invoicing tab.

EXTRACTS TAB

The Extracts tab allows the retrieval of excel format documents for the following information

- All assisters
- Assisters by organization
- Training/License status
- Licensed assister maps
- Login extract
- Outreach by organization
- Outreach by County by month
- Training log

The screenshot in figure 18 in Appendix IV-A shows how the information is displayed in the GMS.

GRAPHS TAB

The Graphs tab allows the extraction of charts as well as excel sheets for assisters by licensure status, by assister type, and assistance metrics by county, organization, and by county/organization. The GMS display can be viewed in figure 19 in Appendix IV-A. An example for a chart extract is given in figure 20 in Appendix IV-A.

IN-PERSON ASSISTER GUIDE AND NAVIGATOR INTERVIEWS

As part of its evaluation of the SPM, the COPH assessed the effectiveness of the training and ongoing support that IPA and Navigator organizations received from the AHCD.

The COPH evaluation team developed an interview guide with open-ended questions that focused on the IPA and Navigator organization's experiences and their perceptions of AID's support in the following areas:

- Promotional materials
- Recruitment
- Phase I-III and ongoing training
- Other support activities
- Communication
- Guide Management System
- Invoicing/Payment

- Impact of Political Context
- Additional Feedback

Staff from AFMC with formal interview training conducted telephone interviews with representatives of the IPA and Navigator organizations. Between May 27, 2014 and July 11, 2014, 28 IPA and/or Navigator organizations were contacted for interviews. AFMC conducted interviews with 21 organizations; 7 organizations declined or were unable to participate. The interviews, which lasted between 15 and 35 minutes, were audio-recorded and then transcribed verbatim.

FINDINGS

The transcriptions were reviewed to identify common, recurrent, or emergent themes. Broad patterns and recurring issues were identified within each interview guide subject area. The analysis is presented below with quotes from respondents to support analysis.

PROMOTIONAL MATERIALS

Most of the organizations (62%, n=13) received recruitment and promotional brochures from AID about the IPA and Navigator programs. However, the materials largely did not influence the organization's decision to participate in the program. Only two organizations indicated that the promotional materials influenced their decision to participate in the IPA program. The most common factor in an organization's decision to participate was that the project fit with the mission and values of the organization. Respondents described how the need was so great and that the ACA provided a "once in a lifetime opportunity." Many organizations noted that they were already rooted in the community and serving the hard-to-reach populations the IPA and Navigator programs were designed to serve.

> *"Our current capacity that we had as far as serving the community because we're a community action agency, so we kind of had some infrastructure already in place to run a program similarly and also our location. Where we were, we were just in a location that was in high demand and it didn't look like there was going to be a lot of guides in Northwest Arkansas, so we felt like it was a good opportunity for us to better serve the community."*

The following quotes capture many of the organization's motivations for participating:

“We were motivated by the desire to provide information to the people in our community about the Affordable Care Act. Basically, we took it on as a civic project so that our citizens would be informed and have a local person they could go to ask questions and learn about the Affordable Care Act.”

“We believe in the purpose of the project. We believe in the work. We understood the need. We live in the Delta so we know that this is important.”

RECRUITMENT

Respondents described the many challenges that their organization faced in recruiting IPAs/Navigators for the program. These challenges were described across all subject areas and reflected the fact that this program was developed and implemented within a short window of time with little precedent or prior AID experience. There were several issues that stood out. The limited amount of time that organizations were given to recruit IPAs/ Navigators was a major recurring issue.

“Well I think the challenges were not getting notification that the grant was approved until June 9, retroactive to June 1. The challenge was getting people hired as quickly as possible in the month of June and it wasn’t really until the end of the month that we had all 5 IPA Guides on staff. I know other agencies that were also awarded grants and it took them even longer to get people hired.”

The fact that the contract was for only one year was unattractive for many potential hires and limited many organizations’ recruitment pool. Additionally, the salaries did not reflect the amount of work expected of the IPAs/ Navigators, and organizations described the difficulty in balancing pay and experience. Many organizations, even after receiving the contract from AID, were unclear about exactly what duties and tasks for which they were recruiting the IPAs. Many did not initially realize the program’s heavy emphasis on “outreach, community work and on-the-ground work”. Other challenges included: high turnover, the politicized nature of the position, and size issues (for example, the Arkansas Department of Health (ADH) was expected to hire 280 IPAs while other organizations were very limited in the number of IPAs they could hire).

Almost every organization reiterated the importance of recruiting from the community in which they would be serving and relying on existing community and institutional partnerships. Several organizations recruited from within their organization or from volunteers or affiliates.

Many organizations described 'word of mouth' as the most effective recruitment tool. The flexible schedule of the position was an attractive feature for many applicants. Some organizations described how the people who responded to their recruitment efforts were already advocates and energetic about the issue.

TRAINING

Due to the changing dynamics at the operational and at the policy levels, IPA/Navigator organization contracts began at different times resulting in inconsistency in the locations and order of trainings thus creating difficulty in coordination of trainings for every organization. This resulted in challenges evaluating the training process because different organizations experienced significantly different trainings depending on where and at what time trainings were conducted. The Phase I training was a week-long commitment and for most organizations required their IPAs/Navigators to sometimes travel long distances due to the limited locations available for specific modules. Many organizations expressed frustration with the lag time between trainings, particularly between Phases II and III.

As one organization described,

> *"The online trainings, particularly in Phase II, were clunky and often crashed. The trainings were very intensive and there was a lot of material to cover. The online trainings provided no support, guidance or instruction."*

Overall, respondents felt that Phase I provided a good overview of health insurance, the ACA, and customer service. The strengths of the training included the face-to-face classroom instruction and role playing exercises. The classroom instruction brought together IPAs from different organizations which supported networking and collaboration. The materials (slides, informational packets) IPAs received were considered very relevant and used on a daily basis.

Respondents described several ways training could be improved, and reiterated the need for more face-to-face instruction and more role-playing and real world experiences. Respondents also requested:

- "A mock website, more simulations where you take someone through the process, practical stuff"
- More peer to peer interaction, connecting with other IPA organizations
- An overview of the many programs offered at Arkansas Department of Human Services (DHS) and other state agencies; overview of the other governmental and nongovernmental actors
- More locations and more date options

- “The test questions should be more content specific rather than kind of a trick question”
- Improve problems with online training and include some kind of support line for trainees to call for help
- More resources for continuing education (webinars, etc.)

AID SUPPORT

Organizations described many forms of support that they received from CMS and AID throughout the contract, including:

- Webinars, emails from CMS, continuing education resources
- Timely technical support—provided support with training, contract support, billing, etc.
- Helpline
- Contract monitor who regularly communicated with organization, including in-person site visits
- Insurance representative
- Brochures, materials, toolkits
- Support with news media

Organizations expressed that the most useful AID support came from the contract monitors, who were regarded as particularly supportive. Overall, the organizations lauded all AID staff for their availability and accessibility. Organizations received other useful support from AID that included national resources (emails, webinars) from CMS and others, health educators hired to speak at public events, and in-person site visits from the contract monitors.

Organizations also described forms of support that would have been helpful. Several indicated the need for a more concise and practical manual for IPA/Navigators. Many organizations also noted the lack of communication between AID and DHS and indicated that better communication would have strengthened the enrollment process. Some organizations felt that more guidance initially regarding the types of materials and expenses organizations might encounter should have been provided.

COMMUNICATION

Many organizations described that communication with AID during the first several weeks of the program was poor, but that it improved dramatically as the program progressed. Beyond the initial logistical hurdles, almost every organization described AID’s communication as excellent. Overwhelmingly, organizations indicated that the level of communication was sufficient. Some organizations noted that, although AID was always very receptive and accessible, they would have preferred AID to have been proactive and contacted them instead.

Similarly, many organizations expressed a desire for AID's communication to be tailored to the organization's particular needs rather than being inundated by emails.

Several organizations indicated that they received mixed messages from different levels of AID regarding continuing funding, recording outreach activities, etc. Suggestions for improved communication included:

- Bridging the gap between AID and local DHS offices
- Improving the webinars to be more responsive to changing issues
- Improving brochures/promotional materials by personalizing them for specific health issues

GUIDE MANAGEMENT SYSTEM

The Guide Management System (GMS) is the online portal that supported contract facilitation and assisted IPA organizations in tracking IPAs, training, monitoring performance, invoicing, and meeting performance reporting requirements. Access to this resource was authorized through AID. Although there was a learning curve for many, overall the GMS was user-friendly and effective as a data entry tool. However, many experienced obstacles in attempting to run reports and a common theme was that confusion around the service definitions (outreach/ assistance/ referral) complicated the reporting process. Further, once data were entered, it was difficult to edit and revise. Many were frustrated by how often the GMS seemed to go offline.

"The problem was when you do a serve, because of the glitches; you would have several contacts from the person before the application went through. After that, there would be glitches. We are talking about talking to someone 7 or 8 times before they get the Private Option part. That's just not understood. Is it 7 or 8 serves? Is it 7 or 8 serves in a contact? I don't think we ever understood that. When you have a problem and are trying to get someone enrolled, you are talking about 5 visits, 10 visits, 15 visits, sometimes. There are 5 minutes a visit, but even 15 minutes sometimes. Then you try to go on InsureAR and can't get through to the federal Marketplace. Those definitions go out the window when you do that."

INVOICING/ PAYMENT

Overall, the invoicing/payment process was positive however some organizations experienced difficulty with invoicing and receiving reimbursements in a timely manner. Some requested invoice backup documentation files were too large to upload and users experienced

technical difficulties. Several organizations also received inconsistent answers from AID regarding the purchasing restrictions for outreach events.

"The biggest problem I had was when open enrollment closed I received a phone call that told me not to spend any money advertising or promoting in any way, shape, or form[for] the Medicaid Private Option, which the Medicaid Private Option is just a sidebar to promotion basically of special enrollment events. I mean they go together. You can't be doing one or the other basically. So basically the only financial issues I had was that I felt the political environment was so sensitive that we basically didn't need to spend any money on advertising after open enrollment closed and I already had a number of outreach events planned, at that point in time my IPAs were super engaged and when that phone call happened, everything changed. I was later told that that was not the case and that we could spend the money but it was too late essentially by that point."

Organizations advised that, in the future, AID should provide improved GMS training, support for invoicing and payment, increased communication (specifically confirmation that invoices are received), and an improvement of the GMS automation system.

POLITICAL CONTEXT

Organizations described many ways in which the political uncertainty of the ACA impacted their work. The uncertainty related to contract renewal was stressful for IPA and impacted motivation and morale. The IPAs, especially in public events and forums, were met with resistance from community members opposed to the ACA. Several organizations described how staff quit because of uncertainty and fear which significantly impacted their relationship with clients and bred mistrust. It affected outreach as well.

"A lot of agencies would not allow the IPA guides to come in to do the enrollment at the agency due to political reasons. We were able to reschedule and go elsewhere to conduct outreach."

"It was just because of current political structure in Arkansas didn't allow for some long-term or even short-term planning. Throughout the whole process of while we were enrolling people, people were hearing this wasn't going to be going on next year, so I thought it had a huge impact on both our interactions with the public and just us planning our jobs as well."

"The refusal of the legislature to accept the federal funds for the PR for the program, that presented a lot of challenges because even though we were doing some good outreach events we weren't able to post to the website to have those events publicized because the website wasn't being populated."

FEEDBACK

Describing outreach efforts:

"The best way to capture people's interest was to have some type of an event, like a fair where they can stop by and pick up a brochure. A big part of being a guide was helping people get through the next step, and telling them to go home and then come back once something else happened. It took a lot of perseverance for people to get enrolled. That was difficult to lower their expectations about what exactly could be done in a single setting for some people."

"This kind of outreach needs to be ongoing. Even after people are enrolled, this is a population that has never used health insurance before and ongoing education about accessing care will be critical"

"[M]any of these people that have never had coverage before, they have no clue what choosing a plan means, what copays mean, what deductibles mean, all of that's pretty foreign. So more information about the differences, a better tool for them to compare the differences in the plans, rather than just hearing the information and them being pretty much pushed within 30 days to choose a plan, not really knowing what they're choosing."

Describing Assisters' work:

"Some of our guides were really good and some guides never got with the swing of things. The best guide we had was a community activist, in a small town, who felt passionately about the ACA, knew people in town, and got in with a free clinic to enroll people under the Private Option part of it. It's worth finding that specific type of guide. If you are not involved in a community, it's difficult to get a foothold and provide good services to your community."

RECOMMENDATIONS

- The findings from all of the surveys (trainees, instructors, and employers) and stakeholder interviews indicate that while the curriculum development and dissemination processes were challenging, the resulting product was viewed as largely successful by all parties. The Arkansas Health Connector Training Program met most of the goals and objectives for the program. The most glaring exception was that the curriculum was not translated into Spanish or Marshallese, as had been planned. Going forward it is the recommendation of the evaluation team that all the training materials be translated into Marshallese and Spanish.

- It is the evaluation team's recommendation that there be more classroom instruction and role-play/ interactive activities that allow trainees to engage more meaningfully with the materials and resources available (i.e. the Marketplace website)

V. EVALUATE EFFECTIVENESS OF IN-PERSON ASSISTERS AND FEDERAL NAVIGATORS

OVERVIEW

The ACA requires that consumers have access to in-person and on-call assistance to understand their choices and navigate the complexities of the new health insurance marketplaces. The SPM elected to implement the In-Person Assister (IPA) program to operate alongside the federally funded Navigator program. Although supported by separate funding streams, the Navigator and IPA programs were similarly designed to educate consumers about the Marketplace, help them understand their health plan choices, and facilitate plan selection. Both programs were required to conduct public education to raise awareness about the availability of qualified health plans (QHPs); distribute fair and impartial information; provide referrals to the appropriate entity or agency for consumers with a grievance question or complaint; and provide culturally and linguistically appropriate information to meet the needs of the population being served by the Marketplace.

The AID facilitated various consumer assistance and outreach activities supporting the SPM. Specifically, in 2012, AID established a Consumer Assistance Advisory Committee (CAAC) — comprised of a variety of stakeholders representing consumers, hospitals and other health care providers, insurance carriers, and community organizations—which oversaw the development of guidelines for the IPA program. The CAAC supported the development of the program objectives, structure for implementation, certification/ decertification requirements, training requirements, performance metrics and monitoring, and recruitment plans.

Both the IPA and Navigator programs were focused on uninsured and hard-to-reach populations, although IPAs served all those interested in enrolling in QHPs. Outreach efforts were focused on both individuals and small groups who would be eligible to use the SPM. In June 2013, AID awarded contracts to 27 organizations to hire and deploy more than 500 IPAs. AID identified the number of IPAs needed based on the uninsured rates per county and funded organizations based on the organization's capacity and its service area. Additionally, federal Navigator funds supported more than 30 Navigators in Arkansas, hired through two organizations (University of Arkansas Partners for Inclusive Communities and Southern United Neighborhoods of New Orleans, Louisiana).

In addition to the Navigator and IPA Programs, a number of organizations, using outside non-Marketplace funding, hired individuals to serve as Certified Application Counselors (CACs) in Arkansas. Created in 2013 by CCIIO, CACs provide assistance to consumers free of charge; but under federal rules, the duties and training requirements of CACs are less extensive than those of Navigators or IPAs. In particular, CACs are not required to engage in outreach, though

many do. CAC Programs must register with the federal Health Insurance Marketplace and must ensure that their CACs follow applicable standards. States are given flexibility in terms of additional standards for CACs. Arkansas Act 1439 of 2013, the Arkansas Health Insurance Marketplace Navigator, Guide, and Certified Application Counselors Act, mandated that the newly created CACs complete the Arkansas Health Connector Licensure requirements--just as IPA and Navigators do.

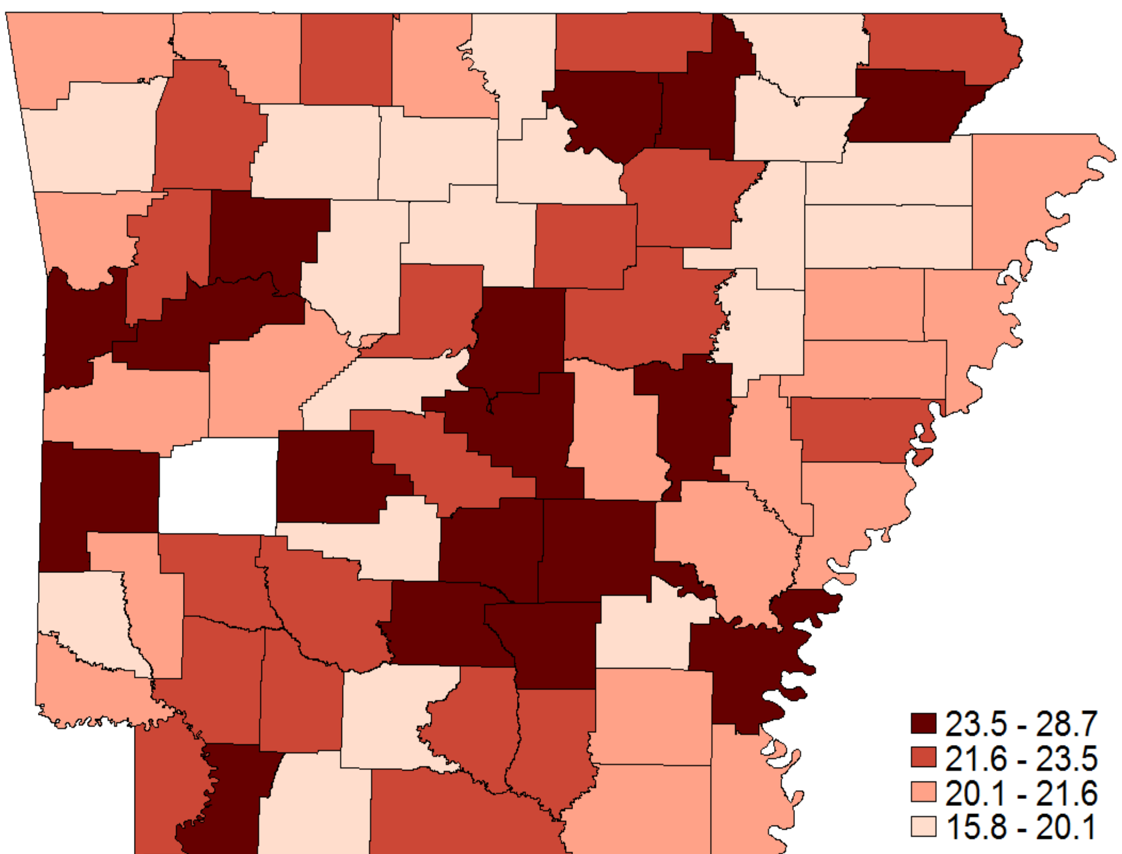
WHAT WE DID

Descriptive statistics were used to characterize the activities and outcomes of the IPAs (e.g. number of individuals assisted with enrollment, overtime and by county and region). The effectiveness of the IPAs was evaluated based on the likelihood of increased enrollment as a result of their activities. Regression models were used to assess the effect of IPA reported outcomes on actual enrollment in insurance plans as reported by AID. Overall performance of the IPAs was identified with data from AID's GMS, AID contracts and documents, characteristics of organizations employing IPA, and estimates from the consumer survey. Data from the AHCRC was also examined though the information found was more applicable to the outreach and education efforts as shown in Section II above.

WHAT WE FOUND

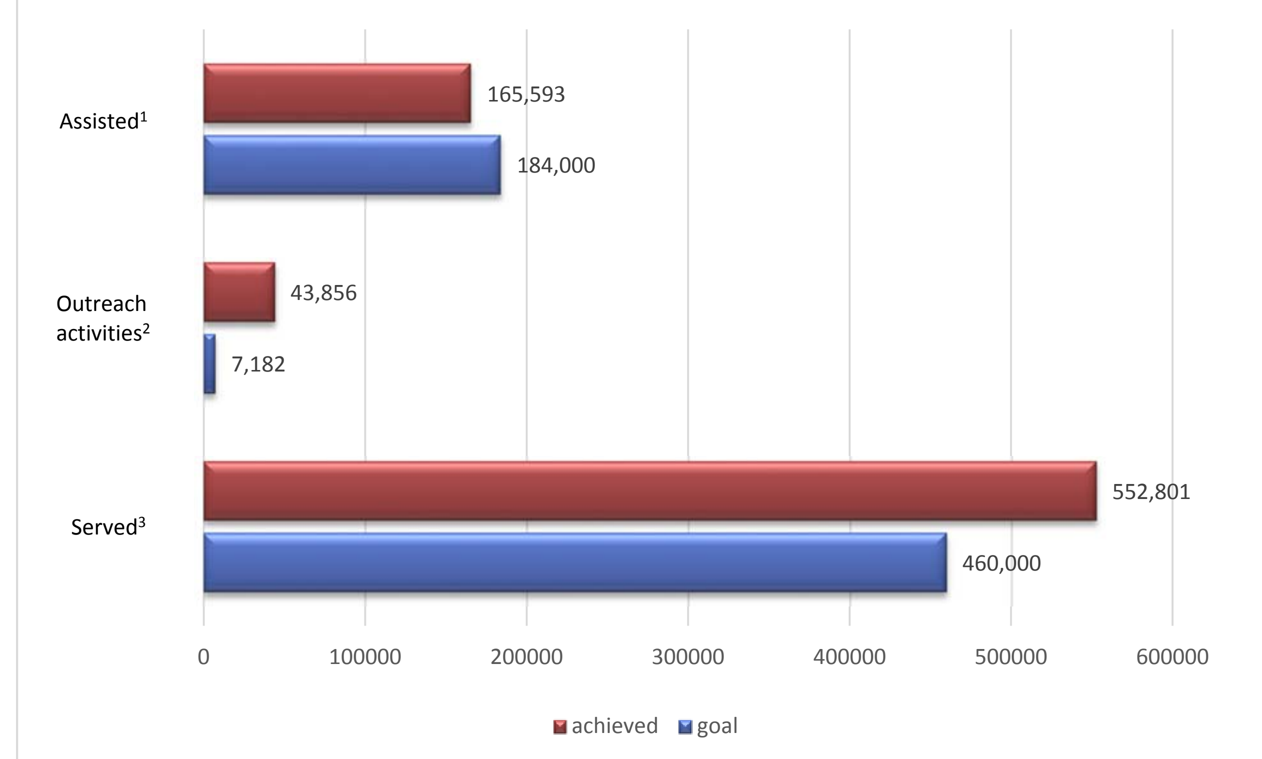
The IPA program proposed the allocation of 537 IPAs across the state based on each county's uninsured rate. AID used the US Census Bureau estimated population number for Arkansas for 2013 of 2,930,594. AID's original estimate of the number of uninsured <65 years for 2013 was 587,000 and was based on the best data available at the time. After conducting the analysis for this evaluation, the evaluation team was informed that these market size estimates were based on flawed assumptions and methods that overestimated the market by from 38.4% to around 50%, depending on which of the more recent data sources are used. Original estimates included: 234,000 newly Medicaid eligible under the expansion of Medicaid to 138% of the FPL, 273,000 individuals eligible at 139%-400% FPL and 80,000 group eligible. The total number of non-Medicaid eligible was estimated at 353,000 or 60%. AID estimated utilization of Marketplace services for the non-Medicaid eligible at a rate of 60%. It was estimated that IPAs would serve 211,000 consumers at an average of 2.25 hours per consumer, or 475,000 total hours with consumers. Assuming an FTE resource for six months of Open Enrollment at 85% utilization, 884 hours were available per FTE. The total hours of 475,000 divided by 884 hours per FTE equated to an estimated number of 537 IPAs.

FIGURE V-1. PERCENT OF UNINSURED ARKANSANS BY COUNTY, 2013



AID granted contracts to 27 organizations, apportioning the IPAs based on, the organization's capacity and service delivery area (See Appendix V-A). Performance metrics were determined for each organization based on their number of IPAs. All together, the goal of the IPA program was to assist 184,000 consumers with enrollment (out of a targeted 211,000 uninsured individuals in the state), and serve 460,000 individuals at over 7,000 outreach activities over the course of open enrollment (Figure V-2).

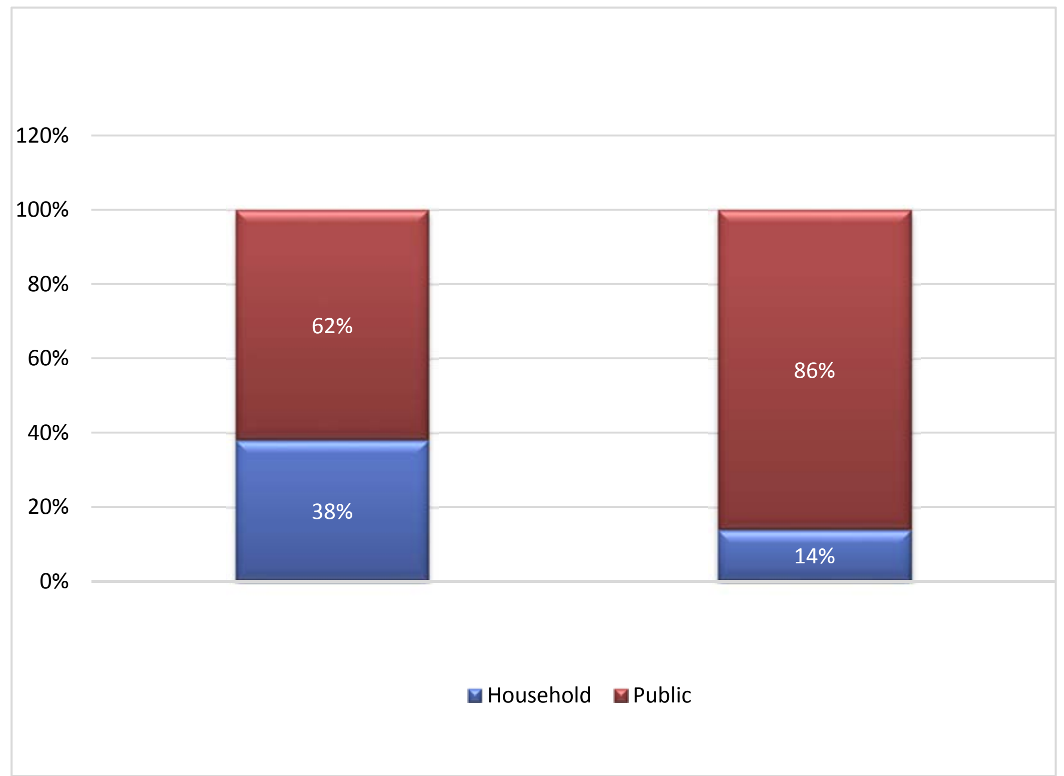
FIGURE V-2. OVERALL IPA PERFORMANCE METRICS: GOALS VS. ACHIEVEMENTS



[1]Assisted – The number of people assisted with enrollment
[2]Outreach activities – The number of outreach activities (in public and household)
[3]Served – The number of people at the outreach location or event

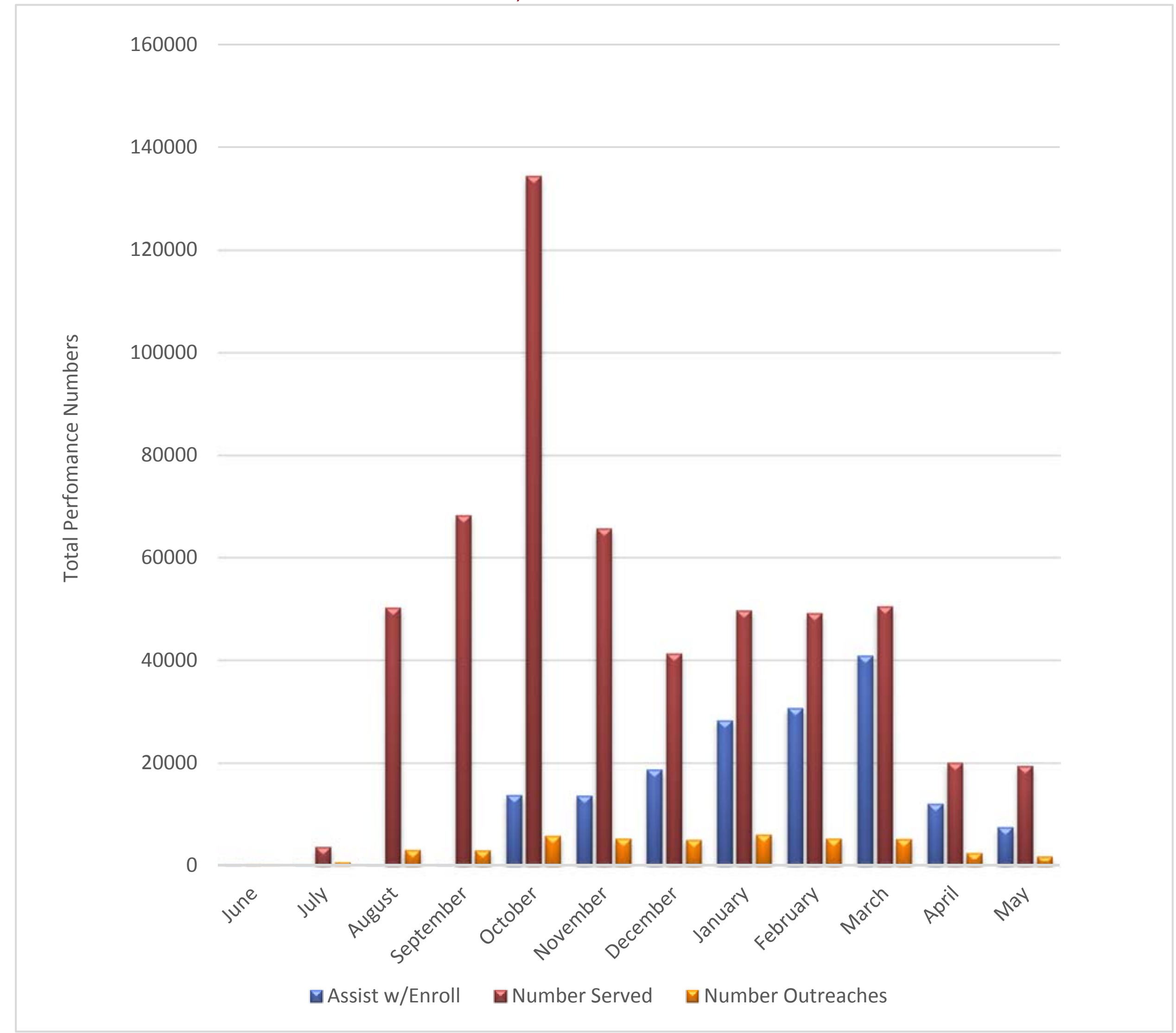
Statewide, the IPA program fell short of its goal for number of assists by 10% while exceeding its goals for number of consumers served and the number of outreach activities completed by 120% and 611%, respectively (see Figure V-2 above). Of the nearly 44,000 outreach activities, over 60% were completed at public events or locations, and almost 90% of all those served by the IPA program were served at public events/locations (see Figure V-3 below).

FIGURE V-3. PERCENT OF OUTREACH ACTIVITIES AND INDIVIDUALS SERVED IN PUBLIC VENUES AND HOUSEHOLDS



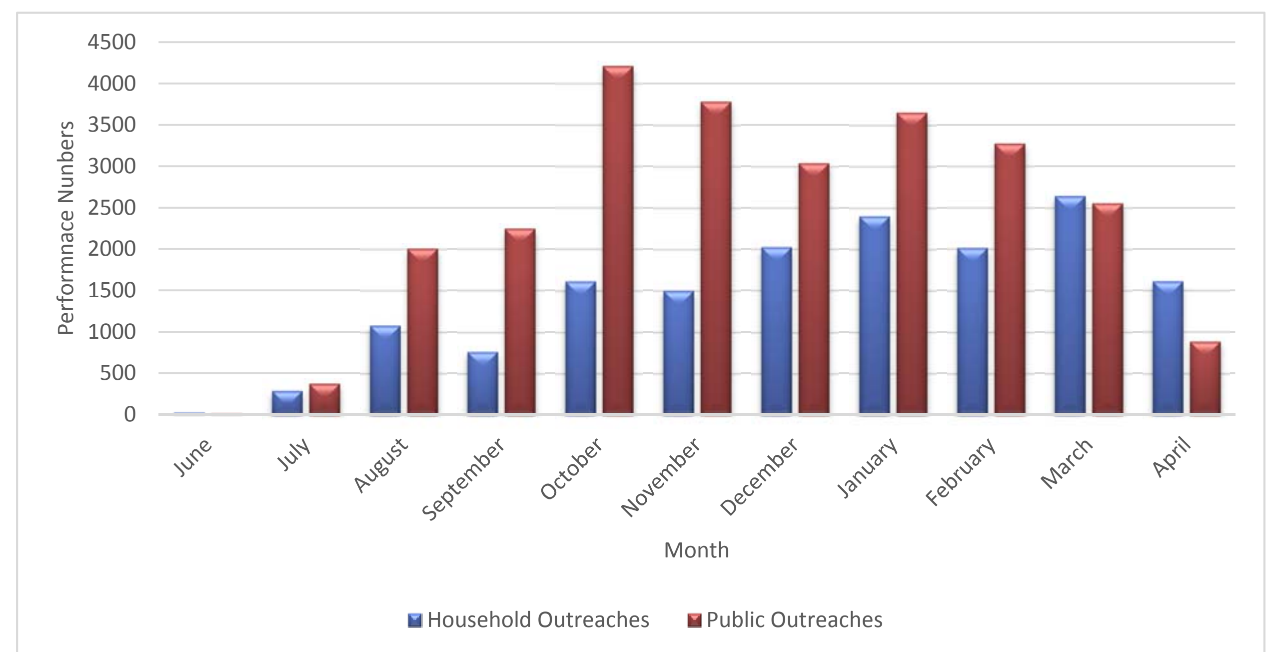
The IPA program was designed to facilitate consumer outreach beginning in the summer of 2013 leading up to the Marketplace's six-month open enrollment period from October 2013 through March 2014. Following open enrollment it was expected that the need for IPAs would drop by 75%. Initially, the IPA training program encountered some technical and logistical hurdles (see section IV) prior to open enrollment which delayed IPA outreach activities. (See Figure V-4 below).

FIGURE V-4. IPA PERFORMANCE METRICS, JUNE 2013-MAY 2014



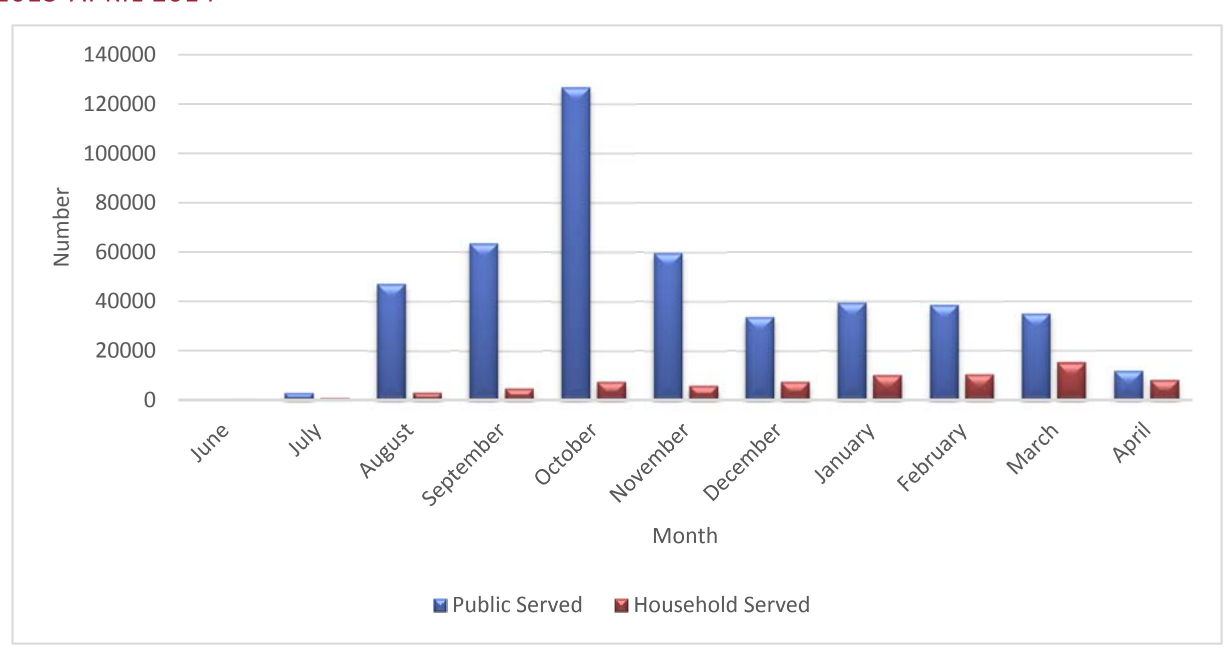
The IPA performance numbers spiked immediately following the start of open enrollment. While public outreach activities reached their peak in October, household outreach steadily increased through March of 2014 (see Figure V-4 above).

FIGURE V-5. HOUSEHOLD OUTREACH ACTIVITIES VS. PUBLIC EVENTS, JUNE 2013-APRIL 2014



There was a similar pattern in the number of individuals served by IPAs over the course of open enrollment (see Figure V-5 above).

FIGURE V-6. NUMBER OF INDIVIDUALS SERVED, HOUSEHOLD VS. PUBLIC EVENTS, JUNE 2013-APRIL 2014



The IPA program exceeded its outreach goal in October 2013 and exceeded its total number served goal in February 2014 (see Figures V-6 and V-7).

FIGURE V-7. CUMULATIVE NUMBER OF IPA OUTREACH ACTIVITIES

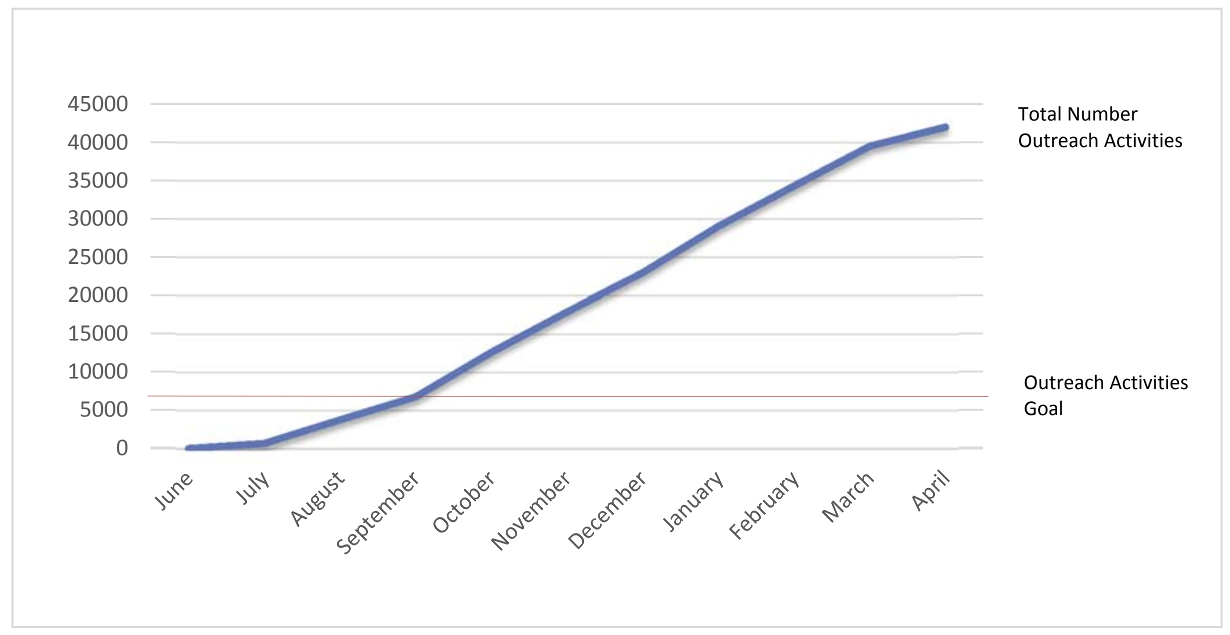
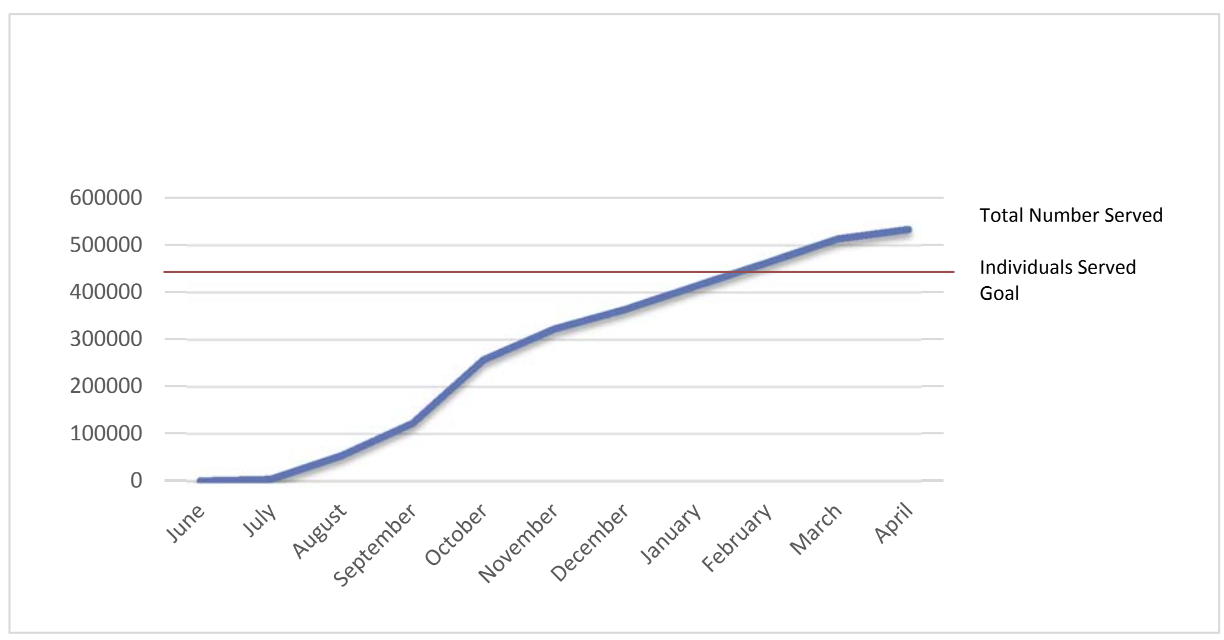
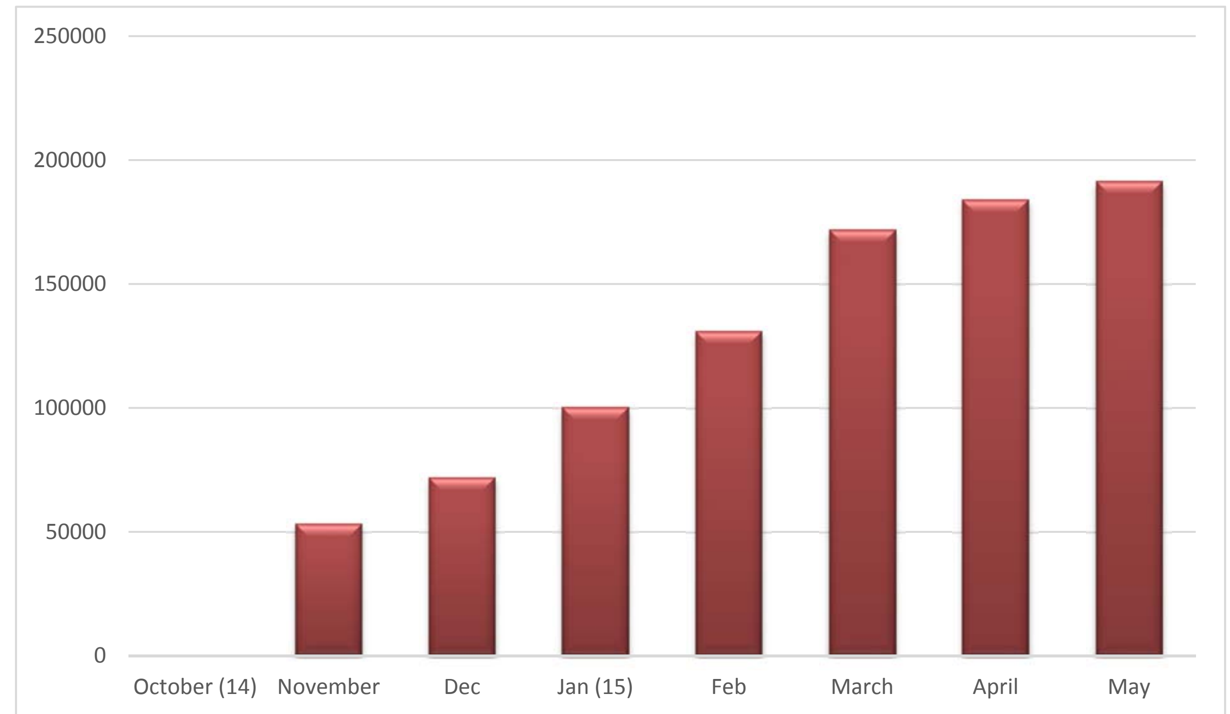


FIGURE V-8. CUMULATIVE NUMBER OF INDIVIDUALS SERVED BY IPAS



Based on GMS data, the greatest amount of reported assistance by IPAs was provided in March 2014, after a steady increase in the number of reported individuals assisted starting in October 2013 (see Figure V-8). However, the IPAs were unable to meet their goal for the total number of individuals to be assisted with enrollment; but according to their self-reported data, they fell short by only a small margin: 10% or 18,407 individuals (see Figure V-9).

FIGURE V-9. CUMULATIVE NUMBER OF PERSONS ASSISTED WITH ENROLLMENT



The number of individuals served at outreach events and assisted with enrollment by IPAs by county as reported in the GMS was compared to actual number of individuals enrolled for insurance by county as reported by AID. Overall, a substantially higher number of individuals were served compared to the number of individuals who actually enrolled. In about half of the state's counties, 1.5 to 10 individuals were served for every individual who actually enrolled for insurance. However, "served" was defined as the number of persons who attended outreach activities not the number of individuals who needed insurance, and it is likely that many of the individuals who attended outreach activities did not have insurance needs. They may also have been accompanying family and/or friends with insurance needs.

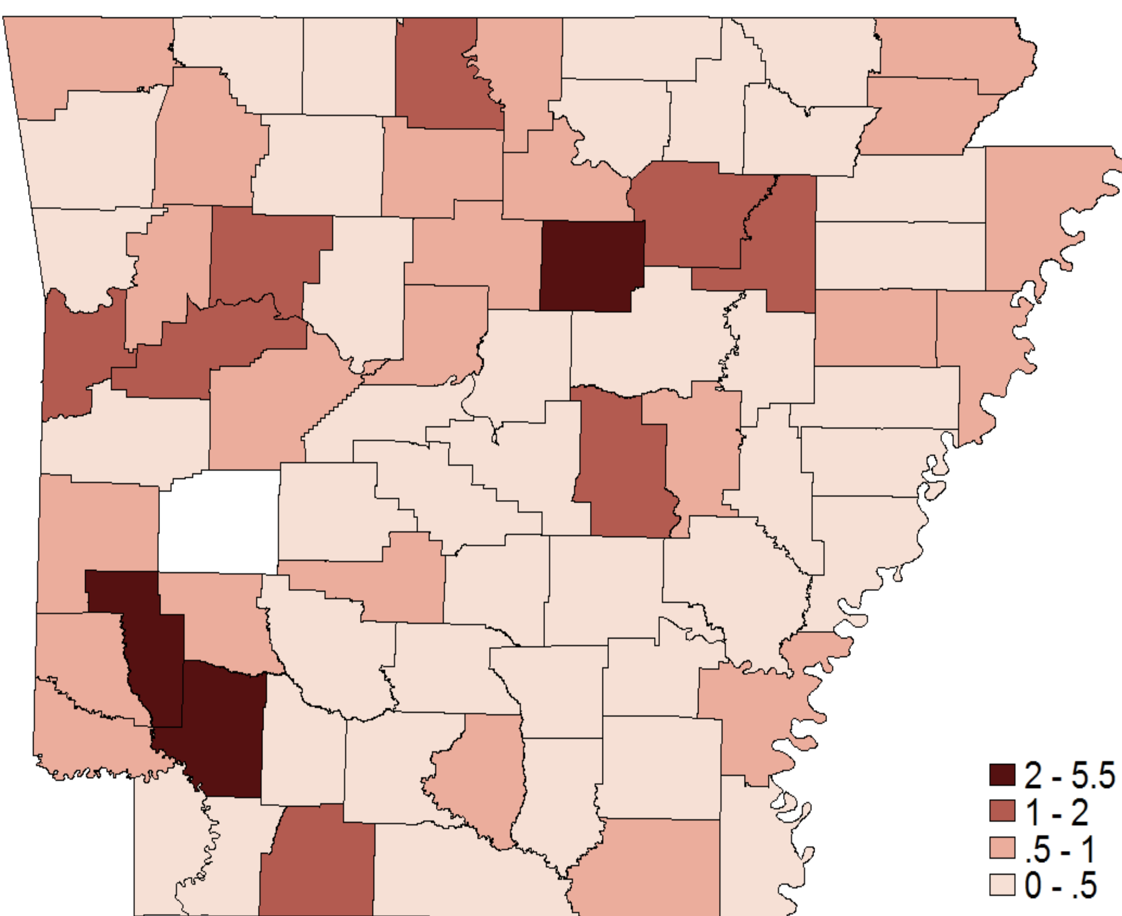
IPA PERFORMANCE BY COUNTY

The average number of IPAs per county was seven with an average of three IPA organizations per county. The average number of IPAs per organization was 19, though without including ADH, the average was 11. There were nine counties which only had IPAs from ADH.

A comparison of IPA reported assists with enrollment to actual enrollment showed a considerable gap, with the number of individuals who actually enrolled for insurance being substantially higher than the number of individuals who were assisted by IPAs. However, many individuals were likely able to enroll for insurance without the direct assistance of the IPAs or with assistance by a navigator or CAC or on their own. Nevertheless, in one-third of the

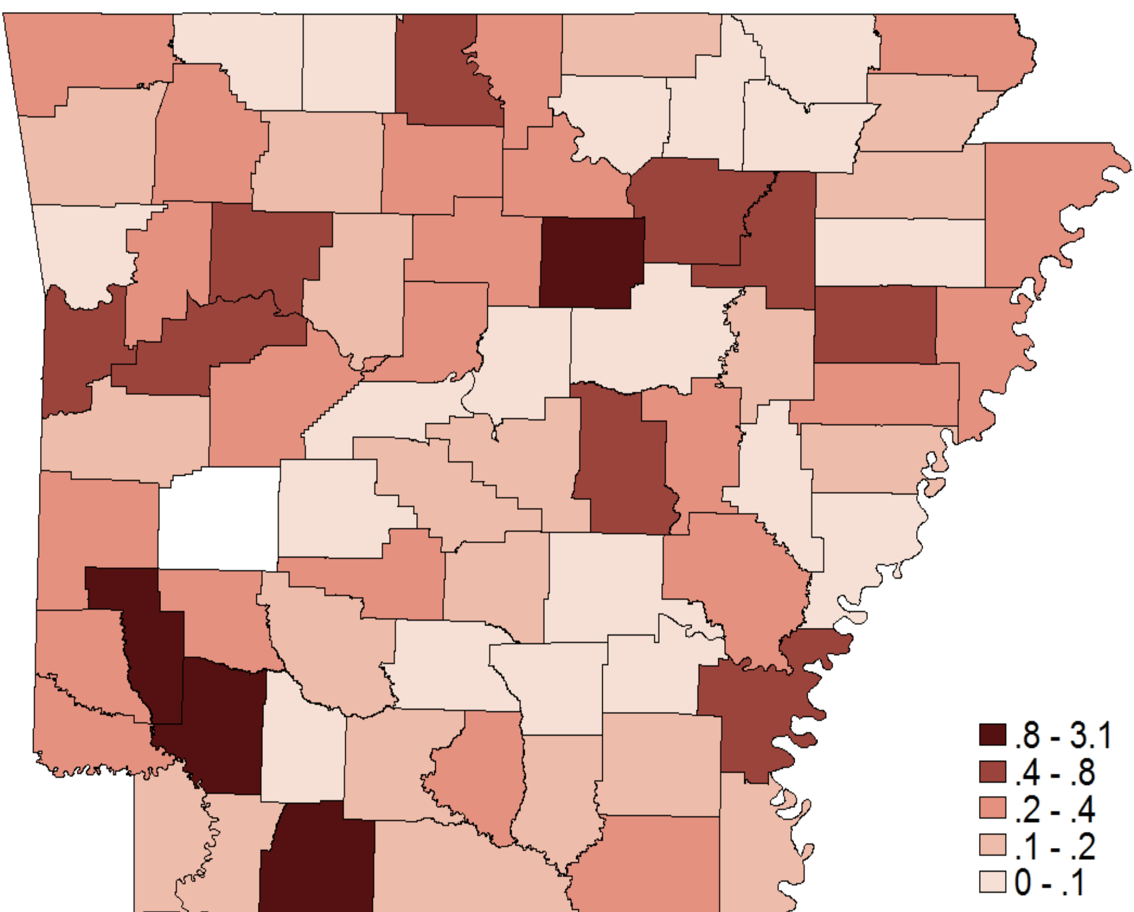
counties in the state, the number of individuals assisted by IPAs were nearly equal to the number of individuals who actually enrolled in an insurance plan (0.5 to 1.0). There was no pattern as to the location of these counties across the state (see Figure V-10).

FIGURE V-10. RATIO OF IPA ASSISTED WITH ENROLLMENT TO ACTUAL ENROLLMENT BY COUNTY.



In nine counties, the number of individuals the IPAs reported assisting represented almost one-half to three-fourths (0.4 to 0.8) of the number of individuals within the county who were estimated to be uninsured. There was no pattern as to the location of these counties across the state (see Figure V-11).

FIGURE V-11. RATIO OF IPA ASSISTED INDIVIDUALS TO UNINSURED INDIVIDUALS BY COUNTY



A regression model, which accounted for county population, indicated that a 10% increase in the number of individuals served by IPAs was associated with less than a one-half percent increase in the number of individuals who actually enrolled into an insurance plan and that a 10% increase in the number of individuals the IPAs reported assisting with enrollment was associated with just under a one percent increase in the number of individuals who actually enrolled in an insurance plan.

IPA PERFORMANCE BY REGION

The average number of IPAs per region was 108 with an average of three IPA organizations per region. Although the state was divided into seven regions for SPM premium rate purposes, for the IPA program, the state organized into five regions by county – Southeast, Southwest, Northeast, Northwest, and Central. There was regional variation across the performance metrics. The Southeast region (Jefferson, Arkansas, Ashley, Bradley, Chicot, Cleveland, Desha, Drew, Lee, Lincoln, Monroe, Phillips, Prairie, and St. Francis counties) performed significantly better than all other regions across all metrics, including exceeding its goals for the number

assisted (by 199%) and total number served (by 196%). The only other region to exceed the goal for number served was the Central region (Faulkner, Garland, Grant, Lonoke, Perry, Pulaski, and Saline counties). The Southwest region performed significantly worse than the other regions based on the low number of assists (Table V-A).

The five regions also experienced different Marketplace enrollment rates (Table V-A). Regionally, there was a positive association between IPA performance metrics and Marketplace enrollment rates. The Southwest region, which had the lowest IPA performance metrics, also had the lowest enrollment rate of the five regions. The Southeast region, with the highest IPA performance metrics, also had the highest enrollment rates.

TABLE V-A. IPA PERFORMANCE METRICS AND HEALTH INSURANCE COVERAGE BY REGION

Region	# of IPAs	% of state	% of state Assist w/ Enroll	% assist goal achieved	% of state number served	% served goal achieved	% of state number outreached	Estimated % of target covered from state avg. FFM (April)
Southeast	63	12%	29%	199%	23%	196%	21%	+4%
Southwest	65	12%	6%	38%	11%	91%	12%	-3%
Northeast	100	19%	19%	82%	18%	98%	26%	0%
Northwest	179	33%	22%	51%	18%	53%	21%	-1%
Central	133	25%	24%	77%	31%	127%	20%	+1%

Note: Blue and red fonts for percentages denote those that were above and below the goal, respectively.

IPA CHARACTERISTICS AND ORGANIZATION PROFILE

African American women were overrepresented as IPAs. Over 80% of all hired IPAs were women and nearly 40% were African American. Over 90% of the IPAs held a high school diploma, and 11% of all hired IPAs were fluent in Spanish.

A wide variety of entities served as IPA and Navigator organizations, reflecting AID's recognition that the success of assisters would depend on the extent to which they are trusted by the people using the Marketplace.

Of the 27 IPA organizations, 17 met or exceeded the total served goal; 10 met or exceeded the assisted goal; and all but one exceeded its outreach activity goal.

The organization with the highest outreach percentage was Covenant Medical Benefits (Table V-B). The organization with the highest assisted percentage was Tri County Rural Health Network. The organization with the highest served percentage was Future Builders.

TABLE V-B. IPA ORGANIZATION PERFORMANCE METRICS

Entity	Outreach Pct. (%)	Assisted Pct. (%)	Served Pct. (%)
Arkansas Department of Health	719	57	57
Arkansas Guide Organization	258	21	40
Arkansas Health Care Access Foundation	1017	46	120
Arkansas Minority Health Commission	6955	95	245
Arkansas Voices for the Children Left Behind	38	38	33
Better Community Development, Inc.	125	88	157
Central Arkansas Volunteers in Medicine Clinic	3950	37	65
Central Arkansas Library	2326	141	316
Choccross, LLC	439	134	128
Community Health Centers of Arkansas	460	51	72
Covenant Medical Benefits, Inc.	10,904	138	393
East Arkansas Enterprise Community	698	62	103
Economic Opportunity Agency of Washington County	582	23	98
Friendship Community Care, Inc.	938	120	324
Future Builders	546	95	453
Harbor House	161	26	30
Hope Restoration	263	103	218
In Affordable Housing	190	142	452
Mental Health Council of Arkansas	323	75	197
Options for Life Services	367	24	94
Quapaw House	465	143	243

Entity	Outreach Pct. (%)	Assisted Pct. (%)	Served Pct. (%)
Southeast Arkansas Behavioral Healthcare System, Inc.	363	16	37
The Hispanic Women's Organization of Arkansas	5721	88	178
The Living and Affected Corp.	165	125	209
Tri County Rural Health Network	2759	368	214
UAMS Medical Center	596	14	7
Women's Council on African American Affairs	974	133	149

Note: Pink highlight denotes top five performing organizations in specified category.

SUMMARY OF FINDINGS

The ACA requires that consumers have access to in-person and on-call assistance to understand their choices and navigate the complexities of the new health insurance marketplaces. The Arkansas State Partnership Health Insurance Marketplace elected to implement the In-Person Assister program to operate alongside the federally funded Navigator program.

The main findings related to the IPA and Federal Navigators are based on data from AID's GMS, AID contracts and documents, and characteristics of organizations employing IPA/Navigators.

AID contracted with 27 organizations to employ 540 IPAs across the state based on each county's estimated uninsured rate. The IPAs were primarily African-American women with a high school education and 1 in 10 were fluent in Spanish. Statewide, while the IPA program assisted 165,593 persons, it fell short of its goal for number of assists of 184,000 by 10%. Despite technical and logistical hurdles that delayed IPA outreach, the program exceeded its goals of serving 460,000 consumers and conducting 7,000 outreach events by 120% and 611%, respectively. There was regional variation in performance across the state with the Southeast region performing significantly better than other counties on number assisted and number served. Regionally, there was a positive association between IPA performance metrics and Marketplace enrollment rates.

CONSUMER HEALTH CARE SURVEY

The COPH contracted with the Arkansas Foundation for Medical Care (AFMC), a National Committee for Quality Assurance (NCQA) Certified Health Plan Employer Data and Information

Set (HEDIS®) Survey Vendor, to conduct the 2014 Consumer Health Care Survey with enrollees in the SPM health insurance plans. The survey instrument included questions from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0H Adult Commercial Survey, Centers for Medicare and Medicaid Services (CMS) Health Insurance Marketplace Survey and CMS Adult Qualified Health Plan Enrollee Experience Survey and additional questions designed to address specific evaluation needs. After conducting a simultaneous mail and SurveyMonkey® survey administration, AFMC received 1,216 surveys from the eligible beneficiary population from November 2014 through February 2014, resulting in an analyzable response rate of 27.6%.

GETTING INFORMATION IN-PERSON

Nearly 28% of survey respondents met in-person with anyone from an organization that helps people get health insurance through the SPM. Insurance agents were the most commonly reported assistance (43.5%) followed by certified application counselors (28.6%). Fewer respondents reported help from IPAs or navigators (12.4%) or other help (16.2%). However, it was noted that individuals may not have fully understood the assistance categories because many of the other assistance indicated by survey respondents were actually organizations employing IPAs or certified application counselors. The majority of respondents (71.9%) indicated they always received the information they needed when they met with in-person assisters. Of those who did not receive the help they needed, over 39% indicated the assister did not have the information they needed. Some other reason was the next most common response (36%) and over 1/3 of those comments were related to computer issues.

Overall, the majority of respondents felt that information from in-person assisters was easy to understand, assisters were helpful, and treated the respondent with respect. It is important to note that respondents who received help from agents, IPAs, or navigators were more likely to indicate that choosing a health plan was "definitely" easy (28.7 %) than those who did not receive in-person assistance (18.5%).

LIMITATIONS

Our analysis was based on the best data available at the time when it was conducted. We are aware of two data-related limitations worth noting. We have based our reporting of the number of people served at outreach events on the GMS. Insofar as the GMS contains duplicated reports, our analysis of numbers of people served at outreach events may be overestimated. On the other hand, our estimates of the ratio of IPA assisted individuals to uninsured individuals may be underestimated, because AID's original estimate of the number of

uninsured <65 are now considered to have overestimated the market by up to 50%, based on more recent data sources.

VI. ASSESS OUTCOME OF OPEN ENROLLMENT

NUMBER OF ARKANSANS DETERMINED ELIGIBLE

In November 2013, the Kaiser Family Foundation used the 2012 and 2013 Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC) to estimate the national and state-level populations eligible for premium tax credits after Marketplace enrollment.[2] Analysis included individuals with incomes between 100-400% FPL who were either uninsured or who purchased non-group insurance. Notable exclusions from analysis were as follows:

- Individuals covered by public program or employers
- Uninsured adults and children eligible for Medicaid or CHIP (for Arkansas this included individuals up to 138% FPL that are eligible for Medicaid expansion)
- Non-legal residents of the U.S.
- 16% of potential eligible assuming that this percentage usually has access to employer-based coverage, either from their own employer or through a spouse/parent.

According to their estimates, in 2014 over 17 million U.S. residents were eligible for the tax credits. The total population eligible for tax credits varied greatly between states. The District of Columbia had the lowest estimate of individuals eligible for the tax credits, only 9,000. The state with the highest estimate of tax credit eligible citizens was Texas (2,049,000). In Arkansas, the estimate was 150,000 residents who can enroll in the Marketplace and be eligible for the tax credits, based on income and other criteria.

[2] The Henry J. Kaiser Family Foundation. State-by-state estimates of the number of people eligible for premium tax credits under the Affordable Care Act. November 2013 Issue Brief. Last accessed October 2014 at http://kaiserfamilyfoundation.files.wordpress.com/2013/11/8509-state-by-state-estimates-of-the-number-of-people-eligible-for-premium-tax-credits.pdf.

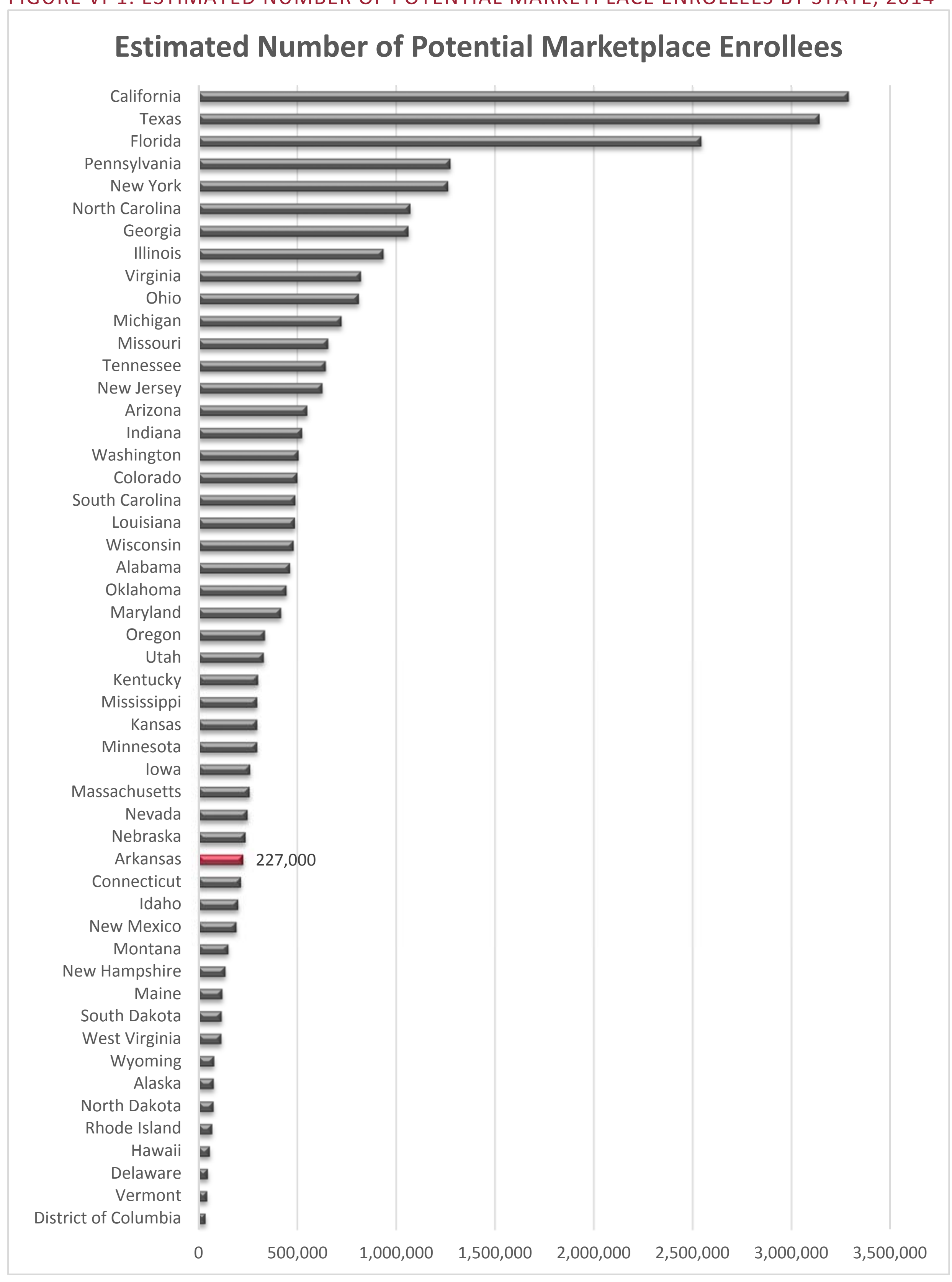
The potential Marketplace size was estimated by Kaiser analysts as well. Analysis began with the current non-group purchasers and uninsured legal U.S. residents not eligible for Medicaid or CHIP. The following groups were identified as ineligible for financial assistance and were excluded from analysis:

- Incomes above Medicaid eligibility but below the poverty level
- Uninsured individuals living in a household with a full-time employed family member

A total estimate of 29 million people nationwide might have considered enrollment through the Marketplace in 2014. Trends in the potential population who would consider enrollment were similar to the estimates of residents eligible for tax credits (Figure VI-1). The District of Columbia was estimated to have the lowest potential market size (36,000) and California was estimated to have the highest potential market size (3,291,000). Based on data from Kaiser, in Arkansas the estimated number of people who were purchasers of non-group insurance or uninsured at the time of analysis and could potentially purchase insurance through the Marketplace was 227,000 individuals (also seen in Figure VI-1 below).[3]

[3] The Henry J. Kaiser Family Foundation. Health Reform Indicators. Last accessed October 2014 at http://kff.org/state-category/health-reform/.

FIGURE VI-1. ESTIMATED NUMBER OF POTENTIAL MARKETPLACE ENROLLEES BY STATE, 2014



NUMBER OF ARKANSANS OBTAINING INSURANCE

Open enrollment for consumers with incomes greater than 138% FPL was scheduled to end on March 31, 2014. However, the federal government allowed individuals to request an extension if they had an unsuccessful attempt at signing up for health insurance prior to the March 31st deadline. Consumers were allowed until mid-April to submit a request for an extension. The decision to grant extensions was attributed to the many issues consumers encountered with Healthcare.gov and the enrollment process during the initial implementation in fall 2013 as well as avoiding a system overload as consumers rushed to meet the March 31st deadline. Consumers did not incur tax penalties if they met the enrollment deadline or requested an extension.

States varied widely in the percentage of the eligible Marketplace population they successfully enrolled by April 19, 2014 (Figure VI-2).[4] The total percentage of the US marketplace population who enrolled in exchanges was 28%. Iowa enrolled the lowest percentage, 11.1%, of their potential marketplace population while Vermont far exceeded the rest of the nation by enrolling 85.2%. Based on data obtained from Kaiser, by April 19, 2014 Arkansas enrolled 43,446 (19.1%) of the 227,000 individuals eligible for Marketplace insurance.

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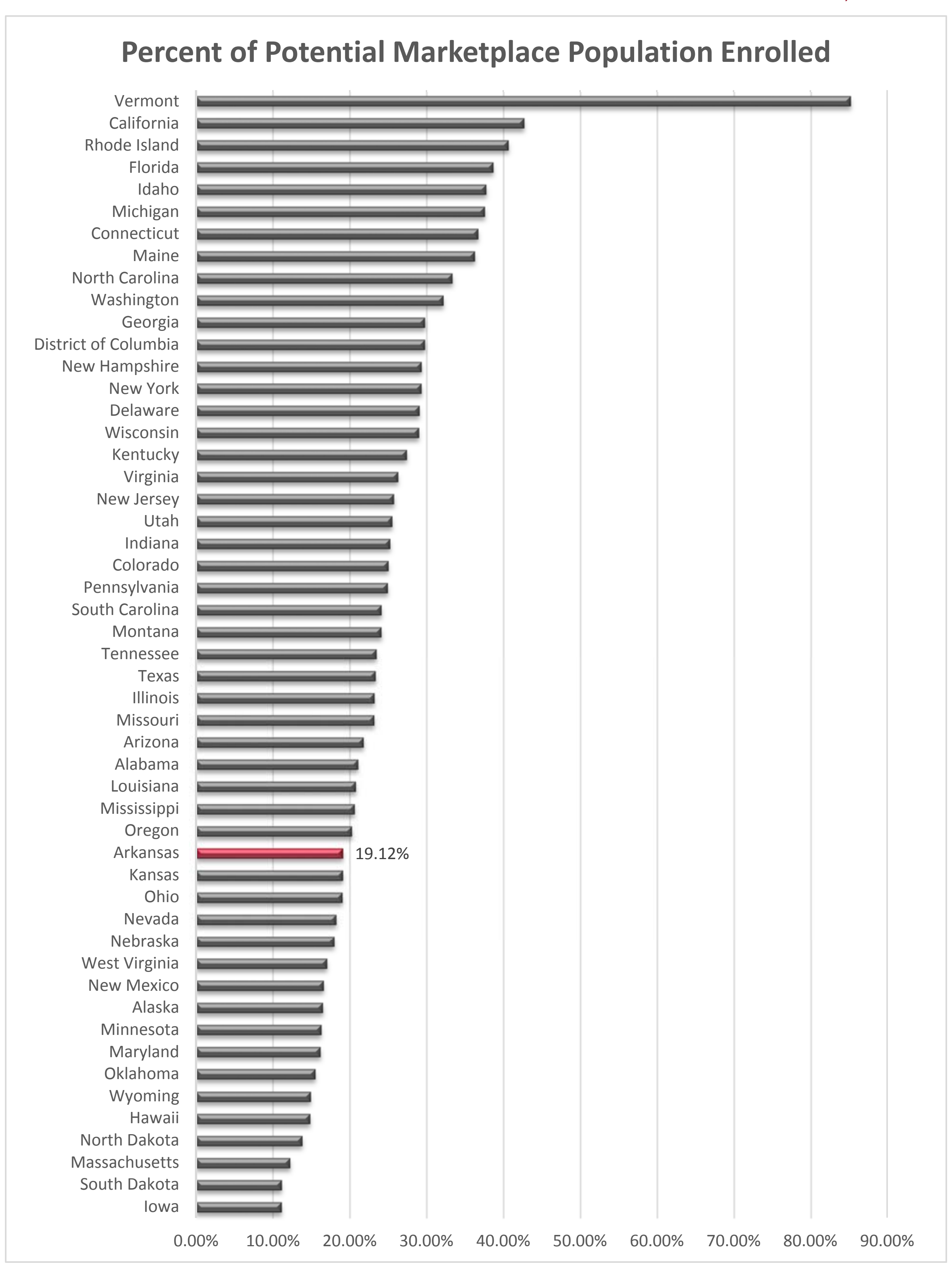
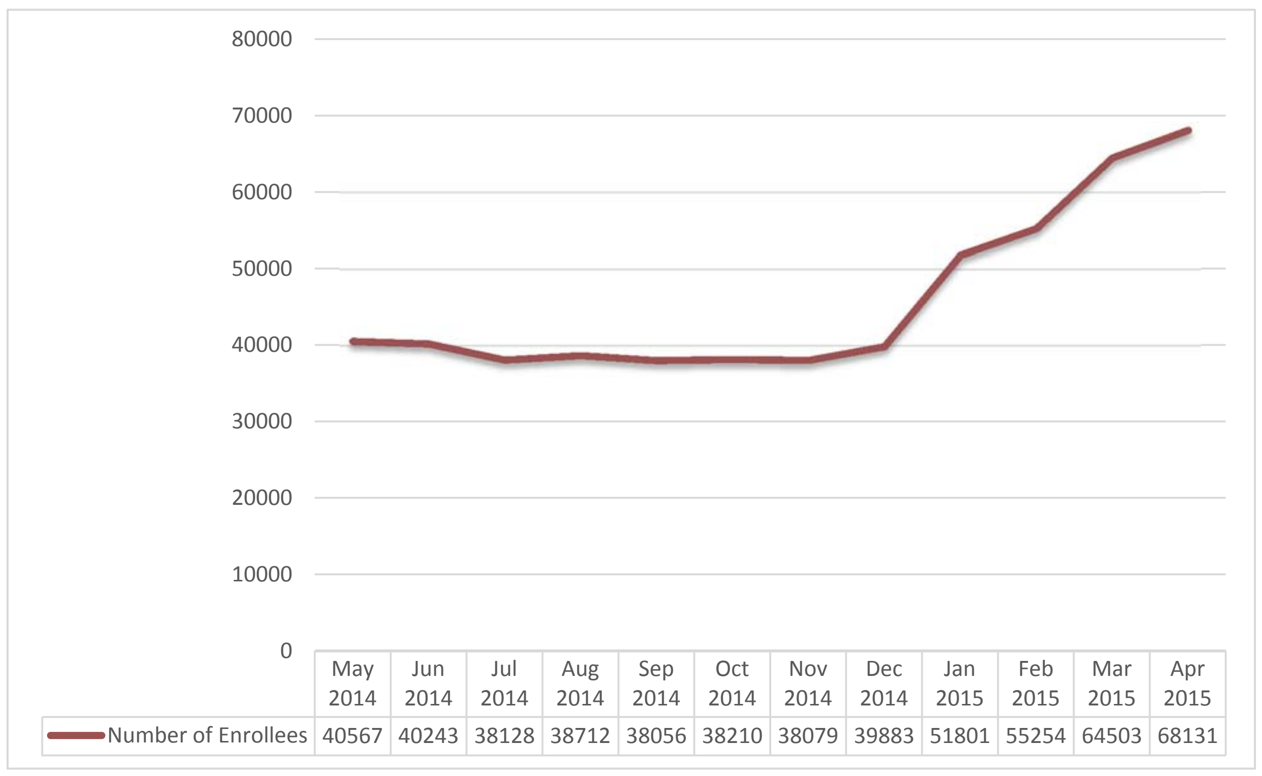
[4] The Henry J. Kaiser Family Foundation. Health Reform Indicators. Last accessed October 2014 at http://kff.org/state-category/health-reform/.

FIGURE VI-2. POTENTIAL MARKETPLACE POPULATION ENROLLED THROUGH APRIL 19, 2014



Since May 2014 the number of enrollees in the SPM has increased (Figure VI-3). Current Marketplace enrollee counts as of April 1, 2015 were 68,131 enrollees.

FIGURE VI-3. NUMBER OF ENROLLEES ON ARKANSAS MARKETPLACE PLANS[5]



	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015
Number of Enrollees	40567	40243	38128	38712	38056	38210	38079	39883	51801	55254	64503	68131

The percentage of females (55%) was slightly higher than the percentage of males (45%) who enrolled in SPM plans through April 19, 2014.[6] This trend was similar for the majority of states. Enrollee counts by metal plans were also reported by AID through July 2014. The

[5] AID, Arkansas Health Connector Division (AHCD). .

[6] The Henry J. Kaiser Family Foundation. Health Reform Indicators. Last accessed October 2014 at http://kff.org/state-category/health-reform/.

majority of enrollees selected silver plans (70%), followed by bronze (16%), gold (14%), and catastrophic (0%).

Ages of SPM enrollees with family incomes over 138% FPL were tracked by AID monthly through September 1, 2014. Enrollees 44 years of age and younger accounted for 44% of the SPM population while enrollees 45 years of age and older accounted for 56%. Age of enrollees remained relatively stable between May and September 2014.

PRIOR INSURANCE STATUS

The consumer survey data was used to examine prior health insurance status of enrollees in the HCIP and the Marketplace. Enrollees were asked about their health insurance coverage in the past six months and whether they had health insurance since turning 18 years of age and enrolling in the SPM. Table VI-A below provides the results of the two questions by HCIP and Marketplace enrollees, findings for the percent that reported being in excellent health, and the average age of respondents who reported having health insurance for the first time since turning 18 years of age.

In all of the questions, there were significant differences between HCIP and Marketplace enrollees. The percentage of enrollees reporting that they had health insurance in the past six months in the HCIP was 26.9% compared to 52.5% in the marketplace. For HCIP enrollees, 45.1% said they were obtaining health insurance for the first time as an adult compared to 20.1% of Marketplace enrollees. Of those who reported receiving health insurance for the first time as an adult, 7.0% of HCIP enrollees reported being in excellent health compared to 34.6% of marketplace enrollees. The sample average for being in excellent health status was approximately 9% for the entire sample indicating a substantial proportion of healthy enrollees in the Marketplace who never had health insurance as an adult. Finally, the average age of enrollees in the HCIP who obtained coverage for the first time as an adult was 36 years of age compared to 42 years of age in the Marketplace.

TABLE VI-A PRIOR INSURANCE STATUS

	HCIP		Marketplace	
Survey Measure	**n**	**Mean**	**n**	**Mean**
Health Insurance in Past 6 Months (%)	556	26.9	599	52.5
No Health Insurance Since Turning 18 (%)	556	45.1	599	20.1
Percent Excellent Health (%)	238	7.0	86	34.6
Average Age (mean)	238	36	86	42

ENROLLEE SATISFACTION WITH THE ENROLLMENT PROCESS

Enrollee satisfaction with the enrollment process was assessed through the 2014 AID Consumer Health Survey. Eight questions measured enrollee experience with choosing a health plan. Roughly 86% of Marketplace respondents and 62.9% of HCIP respondents indicated that they were looking for health insurance for themselves or for another family member through the Marketplace.

Over half of participants responded that they considered the services covered by the available health plans and how much they would have to pay. There is a large difference in the way the two groups responded to this question. While 83.3% of the Marketplace participants responded that they considered the services covered by the available health plans and cost of plan, only 49.1% in the HCIP group responded similarly. A total of 72.5% of Marketplace respondents and 67.3% of HCIP respondents reported that it was usually or always easy to understand the services covered by the health plans available. Over 78% of Marketplace respondents and roughly 75% of HCIP respondents reported that it was usually or always easy to understand the cost of the plan. Less than half of the respondents tried to find out which plans in the Health Insurance Marketplace had the doctors or hospitals they wanted. However, more Marketplace respondents (56.5%) than HCIP respondents (39.8%) attempted to find the doctors or hospitals they wanted. Roughly 75% of Marketplace respondents and 73% of HCIP respondents reported that it was usually or always easy to understand which health plans had the doctors or hospitals they wanted. More Marketplace (88.8%) than HCIP (52.9%) respondents chose a plan through the Marketplace. Only 16.9% of Marketplace and 10% of HCIP respondents indicated that it was not easy to choose a health plan. Over half of Marketplace and 52.7% of HCIP respondents indicated that it was somewhat easy to choose a health plan while 26.8% of Marketplace and 37.3% of HCIP respondents indicated that it was definitely easy to choose a plan.

TABLE VI-B ENROLLEE SATISFACTION WITH ENROLLMENT PROCESS

Questions about choosing a health plan between October 1, 2013 and September 30, 2014		Overall		HCIP		Marketplace	
	Answers	n	%	n	%	n	%
Looked for health insurance (Q46)	Yes	920	67.6	369	62.9	551	85.9
	No	271	32.4	207	37.1	64	14.1
Considered services covered and cost of plan (Q47)	Yes	813	56.2	287	49.1	526	83.3
	No	361	43.8	274	50.9	87	16.7
Often easy to understand services covered (Q48)	Never	49	6.7	22	7.9	27	4.0
	Sometimes	233	24.4	78	24.8	155	23.6
	Usually	345	42.7	104	38.5	241	52.1
	Always	177	26.2	80	28.8	97	20.4
Often easy to understand cost of plan (Q49)	Never	53	6.5	27	8.0	26	3.1
	Sometimes	156	17.7	54	17.4	102	18.2
	Usually	292	32.8	88	29.2	204	40.8
	Always	303	43.0	116	45.3	187	37.8
Tried to find which plan covered desired providers (Q50)	Yes	624	43.3	247	39.8	377	56.5
	No	546	56.7	314	60.2	232	43.5
Often easy to understand which plan covered desired providers (Q51)	Never	45	5.8	13	5.9	32	5.6
	Sometimes	143	21.1	60	21.6	83	19.7
	Usually	230	37.1	78	33.7	152	46.1
	Always	194	36.0	88	38.8	106	28.5
Chose health plan through marketplace (Q52)	Yes	838	60.4	280	52.9	558	88.8
	No	325	39.6	273	47.1	52	11.2
Easy to choose a health plan (Q53)	Yes, definitely	230	34.1	98	37.3	132	26.8
	Yes, somewhat	464	53.8	151	52.7	313	56.3
	No	126	12.2	25	10.0	101	16.9

STUDY OF WHETHER THOSE WHO INITIALLY PURCHASE INSURANCE TERMINATE AFTER A FEW MONTHS OR CONTINUE TO BE INSURED

Prior to the full implementation of the ACA, churn or shift between Medicaid and insurance exchanges was estimated for consumers with incomes below 200% of the FPL. One group of researchers estimated that up to 35% of adults living below 200% of the FPL would experience a change in eligibility within 6 months and nearly 50% would experience a shift between Medicaid and insurance exchanges within one year.[7] The Arkansas HCIP includes individuals living below 138% FPL, so although these previous estimates of churning are not fully applicable, the estimates do suggest there is a potential for transition between the Marketplace to Medicaid and termination of policies is a concern.

An extensive study of the transition between Medicaid and insurance exchanges was not feasible for the initial 2014 plan year without full access to insurance claims data; however, data was collected and presented by AID which addressed payment status of consumers over 138% FPL between June and September of 2014. Figure VI-4 represents active enrollees and cancellation status of policies for individuals with family incomes over 138% FPL. From June 2014 to April 2015, the percentage of SPM enrollees current on payments has varied somewhat from month to month with a range of 82-96%. At the same time, the percentage of cumulative cancellation percentage has shown a steady increase from 4% in June to 18% in April 2015. The totals are aggregated from carriers since the start of the Marketplace. Duplications may occur if an individual moves from one carrier and then enroll with another. Although the percentage of canceled plans has increased over time, the total number of enrollees has surpassed May 2014 totals (Figure VI-2). The net effect of cancellations is minimal presumably due to new enrollees entering the SPM through the Special Enrollment Period (discussed further in the following section).

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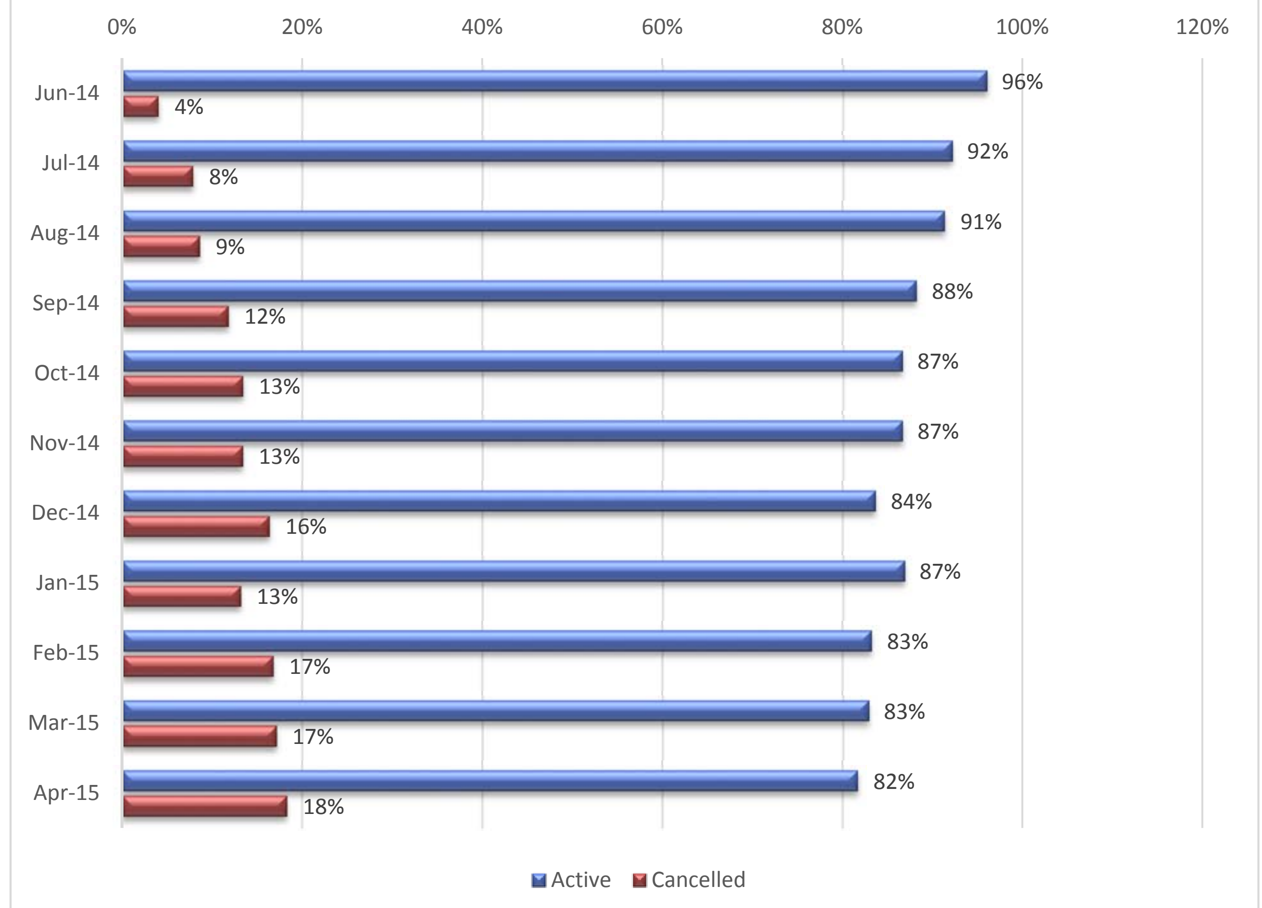
[7] Sommers, B.D., & Rosenbaum, S. Issues in health reform: How changes in eligibility may move millions back and forth between Medicaid and insurance exchanges. Health Affairs, 30, no. 2 (2011): 228-236. doi: 10.1377/hlthaff.2010.1000

FIGURE VI-4. PAYMENT STATUS OF MARKETPLACE ENROLLEES WITH INCOMES OVER 138% FPL



Note: "Active" includes those current on payment, first payment pending and individual in a grace period.

STUDY OF TRANSITION/ENROLLMENT DURING SPECIAL ENROLLMENT PERIODS

The 2014 plan year Special Enrollment Periods were available for individuals who had a qualifying life event after March 31, 2014. Qualifying life events included marriage, divorce, birth or adoption, death, loss of health care coverage, changes in income or citizenship, and release from incarceration. In Arkansas, an additional group of consumers were granted a Special Enrollment Period extension through Healthcare.gov. The DHS cancelled policies for 700 consumers with incomes over 138% of FPL who were inadvertently enrolled in the HCIP in error. The original deadline for these individuals to complete enrollment in the Marketplace was August 11, 2014. However, AID worked with CCIIO to extend the Special Enrollment Period to October 10, 2014 for these consumers to address concerns regarding the effect of a short notification timeline on consumer ability to enroll.

Data was available on the cumulative enrollment from October 2013 through the end of July 2014. Enrollment continued to grow after the March 31, 2014 deadline. Between April 15, 2014 and July 31, 2014 the average number of enrollees per week was 264 consumers. This was calculated on enrollment irrespective of status. The same increase in enrollment was observed when consumers with cancelled payment status were excluded from the calculations. Therefore, even when churning is taken into consideration, enrollment grew during the Special Enrollment Period.

SUMMARY

According to analysis of Kaiser data, overall Arkansas was successful at enrolling 19.1% of eligible individuals into the Marketplace by April 14, 2014. While cancellation of plans did occur throughout the evaluation study period, growth within the Marketplace population continued through special enrollment periods and through the 2015 plan year with a total of 68,131 current enrollees by April 1, 2015. The percentage of female enrollees was slightly higher than the percentage of males and the majority of enrollees selected silver plans. Enrollee satisfaction with choosing a health plan varied between Marketplace and HCIP enrollees; a higher percentage of Marketplace enrollees considered services covered and the doctors and hospitals they wanted when searching for a health plan. High proportions of both Marketplace and HCIP enrollees responded that it was usually or always easy to understand both services covered and costs of available health plans.

LIMITATIONS

National comparisons were solely through Marketplace data. The Arkansas Medicaid expansion through the HCIP was not reflected through national datasets. Also a full evaluation of the churn between the Marketplace, HCIP and Medicaid was not possible without access to claims data.

The consumer survey responses rely on self-report of past events which may introduce recall bias. Consumer survey responses were weighted for non-response limiting issues with response bias.

RECOMMENDATION

- Future efforts to reduce political barriers and secure additional funding to educate the general population on insurance plan options and how to access aid for enrollment may further increase Marketplace enrollee numbers.
- The evaluation team recommends gaining access to the Arkansas All-Payer Claims Database (APCD) for the evaluation of churn between various insurance types.

VII. EVALUATE IMPACT ON CONSUMER HEALTH CARE

The 2014 AID Consumer Health Survey was used to assess access to care, affordability of services, use of preventive services, utilization of emergency departments, consumer sense of well-being, and overall quality of care for enrollees in the SPM. As the SPM includes enrollees from both the HCIP and the Marketplace, both types of enrollees were included in the sampling. The methodology used in fielding the survey and resulting findings are presented in this section.

SURVEY OVERVIEW & METHODOLOGY

BACKGROUND

The AFMC served as the consumer survey subcontractor for the SPM 2014 Plan Year evaluation conducted by COPH. AFMC and COPH developed the AID Consumer Health Survey instrument which included questions from:

- Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0H Adult Commercial Survey
- Centers for Medicare and Medicaid Services (CMS) Health Insurance Marketplace Survey
- CMS Adult Qualified Health Plan Enrollee Experience Survey
- Additional questions designed to address specific evaluation needs

This report summarizes results derived from the AID Consumer Health Survey as applied to a random sample of Marketplace and HCIP beneficiaries. The five composite measures and four rating questions covered by the CAHPS® survey are: Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, and Cultural Competency composites; and Personal Doctor, Specialist Seen Most Often, Health Care, and Health Plan ratings. In addition, the CAHPS® survey covers two summary questions and five effectiveness of care measures where applicable. These are Health Promotion and Education, Coordination of Care, Aspirin Use, Aspirin Discussion, Advising Tobacco Users to Quit, Discussing Tobacco Cessation Medications, and Discussing Tobacco Cessation Strategies. For CAHPS® questions, satisfaction is presented as the percentage of respondents who chose the most positive question responses as specified by NCQA.

CMS designed two surveys as part of the Quality Rating System (QRS) for consumers to utilize when selecting plans from marketplaces. The CMS Health Insurance Marketplace Survey captures consumers' perspective on the services provided by marketplaces while the CMS Adult Qualified Health Plan Enrollee Experience Survey measures the enrollees' perspective on the services provided by the Qualified Health Plans offered through the Marketplace. The AID

Consumer Health Survey included additional questions covering cultural competence, coordination of care, and cost and access to care from the CMS Adult Qualified Health Plan Enrollee Experience. Eighteen questions covering two sections (Getting Information in Person and Choosing a Health Plan) came directly from the CMS Health Insurance Marketplace Survey.

RESPONSE RATE

The sample was designed anticipating 400 completed surveys from each population, HCIP and Marketplace, in order to achieve a 5% margin of error/95% confidence level. Anticipating a 20% response and factoring in a 30% oversampling, the sample consisted of 2,600 from each population. The HCIP and Marketplace samples received 588 and 624 responses respectively. Consequently at 95% confidence level, the survey achieved a 2.8% overall margin of error, a 3.9% margin of error for HCIP respondents, and a 4% margin of error for Marketplace respondents. Although this was a disproportional sample, which poses some disadvantages, the adopted sampling methodology ensures adequate representation from smaller carriers. AID randomly selected stratified sample from their data management system. Each stratum consisted of a combination of channel (Marketplace or HCIP) and insurer (A, B, C, or D) for a total of eight strata. A random sample of 650 individuals was taken from each stratum for a total sample size of 5,200. This design was taken into account in determining sampling weights in the calculation of survey items response rates. The sampling design weights are inverses of selection probability, which weigh the sample to the full finite population. Hence, the sampling design weights enable the calculation of valid estimates that pertain to the finite target population by accounting for the sampling design variability. When n (fixed) units are selected from a finite population of size N, the selection probability of each unit is n/N. This means the design weight is N/n. In this design, the population was divided into $j = 1, 2\ldots, 8$ mutually exclusive strata. A simple random sample of size $n_j = 650$ was selected from each stratum of size N_j. Therefore, the selection probability of a unit in stratum j is n_j/N_j, while its design weight is respectively N_j/n_j. This weight is then multiplied by each corresponding sample member's response to produce population estimates.

After eliminating two survey recipients who failed to meet survey eligibility criteria, the HCIP survey sample size was 2,599 and the Marketplace sample size was 2,599. A total of 589 HCIP surveys and 627 Marketplace surveys were received, resulting in response rates of 22.7% and 24.1%, respectively. After further adjusting for incorrect addresses, the analyzable sample sizes were 2,099 for HCIP and 2,286 for Marketplace beneficiaries. After eliminating surveys without any valid responses and those not meeting enrollment criteria, 588 (28%) HCIP surveys and 624 (27.3%) Marketplace surveys were available for analysis.

TABLE VII-A. RESPONSE RATE

Channel	HCIP					Marketplace					Overall
Insurer	A	B	C	D	Total	A	B	C	D	Total	
Survey sample size	650	649	650	650	2,599	650	650	649	650	2,599	5,198
Total surveys returned	145	150	155	139	589	100	200	172	155	627	1,216
Response rate (%)	22.3	23.1	23.8	21.4	22.7	15.4	30.8	26.5	23.8	24.1	23.4
Analyzable sample size*	523	540	527	509	2,099	537	588	571	590	2,286	4,385
Analyzable surveys	145	149	155	139	588	100	200	170	154	624	1,212
Analyzable rate (%)	27.7	27.6	29.4	27.3	28.0	18.6	34.0	29.8	26.1	27.3	27.6

*Excludes bad addresses

TABLE VII-B. ANALYSIS OF SAMPLE BY GENDER

Gender	Beneficiaries Surveyed	Percent of Total	Analyzable Responses	Percent of Total	Response Rate
Female	2,602	59.3	787	64.9	30.2
Male	1,783	40.7	425	35.1	23.8
Total*	4,385	100.0	1212	100.0	27.6

TABLE VII-C. ANALYSIS OF SAMPLE BY AGE

Age	Beneficiaries Surveyed	Percent of Total	Analyzable Responses	Percent of Total	Response Rate
18 - 24	381	8.7	50	4.1	13.1
25 - 34	1,022	23.3	172	14.2	16.8
35 - 44	964	22.0	196	16.2	20.3
45 - 54	948	21.6	297	24.5	31.3
55 - 64	1,029	23.5	481	39.7	46.7
65 - 74	41	0.9	16	1.3	39
75 or older	0	0	0	0	0
Total*	4,385	100.0	1,212	100.0	27.6

TABLE VII-D. ANALYSIS OF SAMPLE BY REGION

Geographic Region	Beneficiaries Surveyed	Percent of Total	Analyzable Responses	Percent of Total	Response Rate
Central	1,704	38.9	455	37.5	26.7
Northeast	622	14.2	194	16.0	31.2
Northwest	1,017	23.2	280	23.1	27.5
South Central	217	4.9	54	4.5	24.9
Southeast	256	5.8	72	5.9	28.1
Southwest	191	4.4	56	4.6	29.3
West Central	378	8.6	101	8.3	26.7
Total*	4,385	100.0	1,212	99.9	27.6

*Totals may not equal 100% due to rounding.

The tables above describe the demographic distribution of the survey sample and the survey respondents. Table VII-B shows that the sample consisted of 59.3% females and 40.7% males while the survey respondents consisted of 64.9% females and 35.1% males, somewhat different distributions of gender values. Similarly, Table VII-C describes departures in distribution values for age brackets 25-34, 35-34, and 55-64 between the beneficiaries surveyed and those who responded the survey. However, the distribution of geographic regions seem to coincide between the survey sample and survey respondents. Indeed, tests for goodness of fit confirm that the distributions of gender and age differ between the survey sample and respondents with p-values of 0.0002 and less than 0.0001 respectively.

These differences brought on by non-respondents may raise the concern of potential bias. To mitigate this nonresponse bias, the respondents were reweighted to better reflect the target population. Within each of the eight sampling strata, the subsample was partitioned into 12 mutually exclusive groups. The partitions consisted of the combinations of the levels of gender and age. Within each group, the sampling weights of non-respondents were shifted proportionally to respondents by multiplying the sampling weights of each respondent by a group specific adjustment factor. The factor is determined by dividing the sum of the sampling weights of all sampled units within a mutually exclusive group by the sum of the sampling weights of all respondents within the corresponding group. In this scheme, within each stratum, 12 mutually exclusive groups were created by combining the two levels of gender, male and female, with the six levels of age, 18-24 through 75 or older, $c = 1, 2, 3, \ldots, 12$. If N_c represents the subset of sampled units within group c and R_c represents the subset of respondents within group c, then the adjustment factor can be written as $f_c = \sum_{i \varepsilon N_c} w_i / \sum_{i \varepsilon R_c} w_i$ where w_i

represents the sampling weight of unit *i*. In turn, the adjusted weight for respondent *i* in group *c*, $w_{adjuste,c,i}$ can be written as $w_{adjusted,c,i} = f_c \times w_i$.

SURVEY PROCEDURE

An advance letter (Appendix VII-A), written on AID letterhead and signed by the Commissioner of AID, was mailed to each selected adult beneficiary. The letter explained the purpose of the survey, informed the beneficiary of its confidential and voluntary nature, and gave information on requesting a Spanish-language version of the survey. Approximately two weeks later a packet containing a questionnaire (Appendix VII-B (Spanish), VII-C (English)), a postage-paid return envelope and a cover letter was sent to each beneficiary. The cover letter, on AID letterhead and signed by the Commissioner, reiterated the information in the advance letter and gave specific instructions on completing and returning the survey. A reminder postcard (Appendix VII-D) was mailed twelve days later to those beneficiaries who did not respond. Eighteen days after the initial survey was sent, a second survey was mailed to any beneficiary who had not returned a survey. Ten days after the second survey, a second reminder postcard was mailed.

All mail was sent bulk rate with return receipt and address correction requested, and letters and surveys that were returned as undeliverable to AID with an address correction were re-mailed.

TABLE VII-E. SURVEY TIMETABLE

Survey Mailings	Date of Mailing
Advance letter	November 4, 2014
First survey	November 19, 2014
First reminder postcard	December 1, 2014
Second survey	December 19, 2014
Second reminder postcard	January 6, 2015
Data cutoff	February 10, 2015

A unique number was assigned to each survey for tracking purposes only. This tracking number was used so that a second survey could be mailed to non-responders but not to those who had already completed and returned the survey. Beneficiary confidentiality was never compromised. Surveys received after the February 10, 2015 cut-off date were excluded from the survey analysis. Fewer than 10 surveys were excluded due to receipt after the cut-off date. A total of 3,988 surveys were not returned or available for analysis. AFMC tracked the reasons

why these surveys were not returned or were ineligible for analysis following NCQA guidelines. AFMC translated the survey into Spanish and provided the Spanish-language version to beneficiaries by request. Of the 1,216 surveys that were returned, none was completed in Spanish.

TABLE VII-F. DISQUALIFIED SURVEYS

Non-Returned Surveys	Number Returned
Incorrect address	813
No response after maximum attempts	3,171
Beneficiary refusal	2
Beneficiary deceased	1
Beneficiary mentally incapacitated	1

SURVEY QUESTION DOMAINS AND CATEGORIZATION

The majority of questions included in the 2014 AID Consumer Health survey came from the CAHPS® 5.0H Adult Commercial Survey instrument including five composite measures, four rating questions, two question summary rates and five effectiveness of care measures. Cultural competency is a new composite measure from the CAHPS® 5.0H Adult Supplemental instrument. The composite measures represent the percentage of beneficiaries who responded favorably and include:

- Getting Needed Care — measures the beneficiary's ease of seeing a specialist and getting any care, tests or treatment.
- Getting Care Quickly — measures a beneficiary's access to urgent and non-urgent care in a timely manner.
- How Well Doctors Communicate — measures how well doctors listen, explain, spend enough time with and show respect for what beneficiaries have to say.
- Customer Service — measures how often beneficiaries got the help they needed and were treated with courtesy and respect by Medicaid's customer service.
- Cultural Competency — measures the patient's perspective on the responsiveness of health care providers to cultural factors that can affect health and health care, such as language and communication styles.

The four global rating questions included responses scaled from 0 to 10 in the CAHPS® 5.0H survey, where zero represents the "worst possible" and 10 represents the "best possible." The ratings represent the percentage of beneficiaries who rated the question an 8, 9 or 10 and

include the Rating of Personal Doctor, Rating of Specialist Seen Most Often, Rating of Health Care, and Rating of Health Plan.

The two question summary rates indicate the proportion of beneficiaries that selected "Always" or "Usually" for the following questions:

- Health Promotion and Education: Measures how often the beneficiary and their doctor talk about specific things they could do to prevent illness.
- Coordination of Care: Measures how often the beneficiary's personal doctor seems informed and up-to-date about the care they got from another doctor or health care provider.

The effectiveness of care measures specifically defines criteria for the numerator and denominator in that measure. These measures are described in detail below.

- Aspirin Use: Represents the percentage of beneficiaries who are currently taking aspirin. A single rate is reported, where the denominator includes:
    - Women age 56 – 79 years of age with at least two risk factors for cardiovascular disease
    - Men 46 – 65 years of age with at least one risk factor for cardiovascular disease
    - Men 66 – 79 years of age, regardless of risk factors
- Aspirin Discussion: Represents the percentage of beneficiaries who discussed the risks and benefits of using aspirin with a doctor or other health provider. A single rate is reported, where the denominator includes:
    - Women 56 – 79 years of age
    - Men 46 – 79 years of age
- Advising Smokers to Quit: Represents the percentage of beneficiaries 18 years of age and older who were current smokers or tobacco users and who received advice to quit.
- Discussing Cessation Medications: Represents the percentage of beneficiaries 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medications.
- Discussing Cessation Strategies: Represents the percentage of beneficiaries 18 years of age and older who were current smokers or tobacco users and who discussed or were provided cessation methods or strategies.

The 2014 AID Consumer Survey also includes the following questions, which will require analysis by topic and possibly demographics. Standardized composite rating scores are not available at this time for questions from the CMS Health Insurance Marketplace Survey and CMS Adult Qualified Health Plan Enrollee Experience Survey, but they may be available for future plan years. National and regional data are not available for comparisons for the

additional questions. However, regions within the state could be compared, especially for getting information in person, ER utilization, and health insurance status prior to plan year.

- 18 questions from the Centers for Medicare and Medicaid Services (CMS) Health Insurance Marketplace Survey
  - Getting information in person
  - Choosing a health plan
- 24 questions from the CMS Adult Qualified Health Plan Enrollee Experience Survey
  - Cultural competence
  - Additional questions related to coordination of care
  - Cost and access to care
- 5 additional questions designed to address specific evaluation needs
  - ER utilization
  - Who respondents consider as their personal doctor
  - Ever had health insurance
  - Had health insurance in the last 6 months
  - Delay doctor's visit due to missing work

COMPARISON TO NATIONAL CAHPS DATABASE

AFMC used the National CAHPS® Benchmarking Database (NCBD) to access 2014 National Adult Medicaid 5.0 scores for comparison. The following pages show the demographics of the samples compared to the 2014 NCBD. The comparison to the national benchmark shows how similar or different the Arkansas survey samples are from the other states' Medicaid programs. However, the Arkansas samples differ from the national benchmark data in that the Marketplace enrollee portion of the respondents do not qualify for Medicaid or the HCIP. AFMC also highlights if the Arkansas survey samples differ significantly from the national benchmark. A z-test was used to determine any significant differences.

In demographic comparisons to the national benchmark, 2014 AID Consumer Health survey respondents show statistically higher percentages in the "45 – 54" and "55 - 64" age categories, the "White" race category, the "No" Hispanic category, the "4-year college graduate" and "More than 4-year college degree" education categories, the "Good" and "Very Good" health status categories, and the "Excellent" and "Very Good" mental health status categories. 2014 survey respondents also show statistically lower percentages in the "18-24", "25-34", "65-74" and "75 or older" age categories, the "Asian", "Native Hawaiian/Pacific Islander", "Other" and "Multi-racial" race categories, the "Yes" Hispanic category, the "8th grade or less" and "Some high school, but did not graduate" education categories, the "Fair" and "Poor" health status categories and the "Fair" and "Poor" mental health status categories.

TABLE VII-G. PROFILE OF CONSUMER HEALTH CARE SURVEY RESPONDENTS: COMPARISON TO NCBD

Demographic	Category	2014 (%)	NCBD (%)	Significance Difference (2014 vs. NCBD)
Gender	Male	35.1	34.7	Not Significant
	Female	64.9	65.3	Not Significant
Age	18 - 24	4.1	14.9	Significantly lower
	25 - 34	14.2	18.1	Significantly lower
	35 - 44	16.2	16.0	Not Significant
	45 - 54	24.5	19.3	Significantly higher
	55 - 64	39.7	20.0	Significantly higher
	65 - 74	1.3	6.7	Significantly lower
	75 or older	0.0	5.0	Significantly lower
Race	White	73.0	56.4	Significantly higher
	African American/Black	18.7	19.8	Not Significant
	Asian	1.9	6.0	Significantly lower
	Native Hawaiian/Pacific Islander	0.1	1.5	Significantly lower
	American Indian/Native Alaskan	0.9	1.2	Not Significant
	Other	2.4	7.1	Significantly lower
	Multi-racial	3.1	8.0	Significantly lower
Hispanic	Yes	3.7	15.6	Significantly lower
	No	96.3	84.4	Significantly higher
Education	8th grade or less	2.5	8.3	Significantly lower
	Some high school, but did not graduate	12.4	17.7	Significantly lower

Demographic	Category	2014 (%)	NCBD (%)	Significance Difference (2014 vs. NCBD)
	High school graduate or GED	37.4	37.5	Not Significant
	Some college or 2-year degree	30.7	28.3	Not Significant
	4-year college graduate	10.4	5.2	Significantly higher
	More than 4-year college degree	6.6	2.9	Significantly higher
Health Status	Excellent	9.7	11.1	Not Significant
	Very Good	26.0	22.1	Significantly higher
	Good	37.6	33.5	Significantly higher
	Fair	21.6	24.6	Significantly lower
	Poor	5.1	8.6	Significantly lower
Mental Health	Excellent	23.9	19.9	Significantly higher
	Very Good	28.5	23.0	Significantly higher
	Good	26.9	29.0	Not Significant
	Fair	15.6	21.2	Significantly lower
	Poor	5.1	6.9	Significantly lower

In composite/component and rating item comparisons to the national benchmark, 2014 AID Consumer Health survey respondents show statistically higher percentages for "Personal doctor explained things clearly (Q15)," the customer service composite, "Customer service gave necessary information or help (Q63)," and "Customer service staff courteous and respectful (Q64)". The 2014 survey respondents also show statistically lower percentages for the getting care quickly composite, "Got routine appointment at doctor's office or clinic as soon as needed (Q5)," rating of specialist seen most often, rating of all health care, rating of health plan, the health promotion and education component and the coordination of care component.

TABLE VII-H. COMPOSITE MEASURES AND COMPONENTS COMPARISON TO NCBD

Composites/Components Rating Item	2014 Summary Rate (%)	NCBD 2014 National (%)	Significance Difference (Survey vs. NCBD)
Getting Needed Care	81.9	81.2	Not Significant
How often it was easy to get needed care, tests, or treatment (Q9)	83.9	83.6	Not Significant
Got appointments with specialists as soon as needed (Q32)	79.9	78.7	Not Significant
Getting Care Quickly	78.5	81.6	Significantly lower
Got urgent care for illness, injury or condition as soon as needed (Q2)	82.0	83.7	Not Significant
Got routine appointment at doctor's office or clinic as soon as needed (Q5)	75.1	79.5	Significantly lower
How Well Doctors Communicate	91.0	90.2	Not Significant
Personal doctor explained things clearly (Q15)	93.6	90.7	Significantly higher
Personal doctor listened carefully (Q16)	91.3	90.6	Not Significant
Personal doctor respected consumer comments	91.1	92.0	Not Significant
Personal doctor spent enough time with consumers	87.9	87.8	Not Significant
Customer Service	90.3	86.0	Significantly higher
Customer service gave necessary information or help (Q63)	85.1	79.7	Significantly higher
Customer service staff courteous and respectful (Q64)	95.4	92.2	Significantly higher
Cultural Competency	72.3		
Rating of personal doctor (Q25)	81.1	79.7	Not Significant

Composites/Components Rating Item	2014 Summary Rate (%)	NCBD 2014 National (%)	Significance Difference (Survey vs. NCBD)
Rating of Specialist Seen Most Often (Q34)	76.1	79.9	Significantly lower
Rating of all health care (Q8)	67.4	71.8	Significantly lower
Rating of health plan (Q73)	62.1	74.8	Significantly lower
Health Promotion and Education (Q7)	66.7	71.9	Significantly lower
Coordination of Care (Q24)	72.8	80.3	Significantly lower
Advising Smokers and Tobacco Users to Quit	60.2	55.8	Not Significant
Discussing Cessation Medication	27.4	29.3	Not Significant
Discussing Cessation Strategies	27.0	24.5	Not Significant

COMPOSITES AND RATINGS BY INSURER AND LEVEL OF COVERAGE

INSURER

Of the composites, the cultural competency composite had the greatest difference of 24.5 percentage points; of the ratings, the overall rating of health plan had the greatest difference of 27.1 percentage points; of the summary questions, the coordination of care measure had the greatest difference of 11.2 percentage points; and of the effectiveness of care measures, aspirin use had the greatest difference of 48.4 percentage points.

TABLE VII-I. COMPOSITES BY INSURER

Insurer	A		B		C		D		Range
Composites and Ratings	n	%	n	%	n	%	n	%	%
Getting Needed Care		83.3		89.0		69.7		86.7	19.3
Getting Care Quickly		79.4		81.7		73.6		78.3	8.1
How Well Doctors Communicate		92.8		93.6		85.9		91.6	7.7
Customer Service		91.7		90.3		90.6		69.7	22.0

Insurer	A		B		C		D		Range
Composites and Ratings	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**%**
Cultural Competency		94.8		70.3		91.2		76.3	24.5
Rating of personal doctor	183	82.8	274	86.1	262	71.9	210	83.6	14.2
Rating of Specialist Seen Most	96	83.6	138	83.3	138	61.0	121	82.7	22.6
Rating of all health care	183	72.4	253	75.2	242	51.8	222	63.5	23.4
Rating of health plan	239	66.1	342	64.6	316	56.6	288	39.0	27.1
Health Promotion and Education	184	68.6	252	63.3	242	71.3	220	65.8	8.0
Coordination of Care (Q24)	78	68.1	119	78.2	126	67.0	97	71.8	11.2
Aspirin Use	19	5.8	51	46.7	47	43.1	30	54.2	48.4
Aspirin Discussion	54	34.6	121	39.5	97	51.9	76	43.5	17.3
Advising Smokers and Tobacco	60	68.7	94	53.8	106	65.0	77	65.0	14.9
Discussing Cessation Medication	61	36.1	94	21.1	105	31.9	77	35.9	15.0
Discussing Cessation Strategies	60	24.6	94	23.5	105	32.5	77	36.8	13.3

LEVEL OF COVERAGE

Of the composites, the cultural competency composite had the greatest difference of 25.4 percentage points however, the number of respondents indicating that their level of coverage was "bronze" or "gold" on this composite was small (<25), and caution should be exercised; of the ratings, the overall rating of health plan had the greatest difference of 26.9 percentage points; of the summary questions, the coordination of care measure had the greatest difference of 15.6 percentage points; and of the effectiveness of care measures, aspirin use had the greatest difference of 47.2 percentage points. Estimates for the "catastrophic" level of coverage are not available because the number of responses in this category is less than five. All "gold" level respondent composite scores were higher than "bronze" or "silver" level respondent scores with the exception of customer service which "silver" level respondents rated highest and how well doctors communicate which "bronze" level respondents rated highest.

TABLE VII-J. COMPOSITES BY LEVEL OF COVERAGE

Level of Coverage	Bronze		Silver		Gold		Range
Composites and Ratings	**n**	**%**	**n**	**%**	**n**	**%**	**%**
Getting Needed Care		88.0		81.3		90.3	9.0
Getting Care Quickly		88.8		77.8		90.7	12.9
How Well Doctors Communicate		99.0		90.5		96.3	8.5
Customer Service		67.1		92.0		72.5	24.9
Cultural Competency		97.0		73.4		98.8	25.4
Rating of personal doctor	108	90.1	713	80.4	105	88.7	9.7
Rating of Specialist Seen Most Often	46	78.4	380	75.7	64	81.5	5.8
Rating of all health care	89	72.0	706	67.2	102	70.1	4.8
Rating of health plan	142	36.6	920	63.5	119	45.4	26.9
Health Promotion and Education (Q7)	90	73.0	703	66.3	102	72.4	6.7
Coordination of Care (Q24)	45	87.2	318	71.6	56	84.3	15.6
Aspirin Use	30	44.6	103	37.3	14	84.5	47.2
Aspirin Discussion	59	51.8	243	40.8	45	45.2	11.0
Advising Smokers and Tobacco Users to Quit	29	52.9	300	60.5	8	49.1	11.4
Discussing Cessation Medication	29	21.3	300	27.9	8	1.8	26.1
Discussing Cessation Strategies	29	15.8	299	27.6	8	0.0	27.6

STATE REGIONAL ANALYSIS

Overall mean ratings and utilization of services are further reported by geographic regions of the state. The map below shows the seven regions and the counties that lie within them.

GEOGRAPHICAL REGIONS

Northwest: Baxter, Benton, Boone, Carroll, Madison, Marion, Newton, Searcy, and Washington counties.

Northeast: Clay, Craighead, Crittenden, Cross, Fulton, Greene, Independence, Izard, Jackson, Lawrence, Mississippi, Poinsett, Randolph, Sharp, Stone, St. Francis and Woodruff counties.

Central: Cleburne, Conway, Faulkner, Grant, Lonoke, Perry, Pope, Prairie, Pulaski, Saline, Van Buren, White and Yell counties.

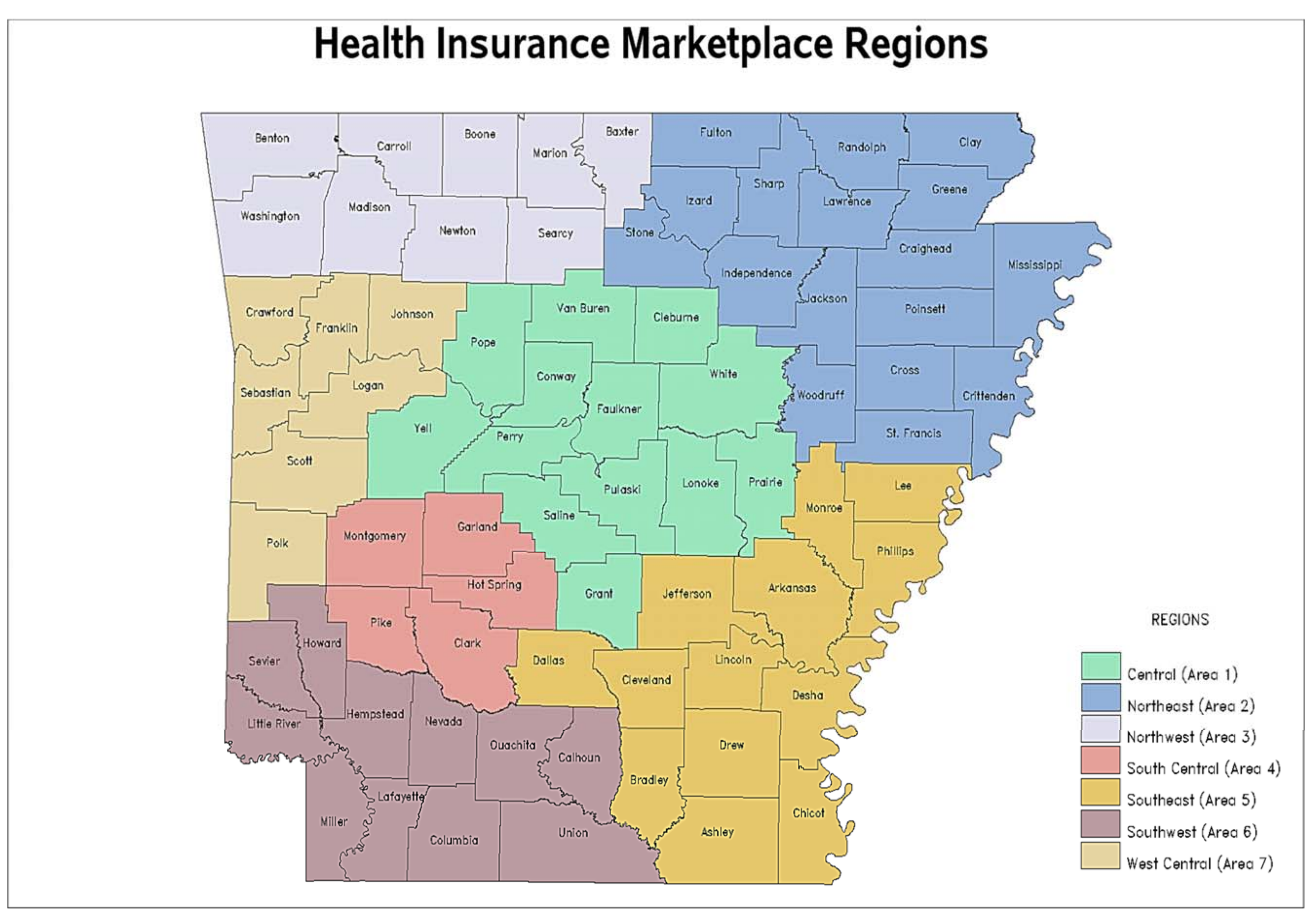
South Central: Clark, Garland, Hot Spring, Montgomery, and Pike counties.

Southeast: Arkansas, Ashley, Bradley, Chicot, Cleveland, Dallas, Desha, Drew, Jefferson, Lee, Lincoln, Monroe, and Phillips counties.

Southwest: Calhoun, Columbia, Hempstead, Howard, Lafayette, Little River, Miller, Nevada, Ouachita, Sevier and Union counties.

West Central: Crawford, Franklin, Johnson, Logan, Polk, Sebastian and Scott counties.

FIGURE VII-1. HEALTH INSURANCE MARKETPLACE REGIONS



Looking at composites by region, the cultural competency composite had the greatest difference of 37.9 percentage points; the Central region had the lowest composite score for cultural competency (62.1%) while the Northeast, Southwest, and South Central regions had the highest composite score (100%). However, the number of respondents included in the cultural competency composite was small (<25) in most regions, and caution should be exercised. Of the ratings, the rating of specialist seen most often had the greatest difference of 35.1 percentage points; ratings of specialist seen most often were lowest for the South Central region (49.3%) while the Northwest region had the highest rating (84.4%). Of the summary questions, the coordination of care measure had the greatest difference of 52.6 percentage points; the South Central region (32.4%) had the lowest score for coordination of care while the Northeast (85%) had the highest score. Of the effectiveness of care measures, aspirin use had the greatest difference of 66.1 percentage points; the Southwest region (10.5%) had the lowest percentage while the South Central (76.6%) had the highest. However, caution should be taken with interpreting results for cultural competency, rating of specialist seen most often, and aspirin use due to low numbers within regional analysis of these measures.

TABLE VII-K. COMPOSITES AND RATINGS BY REGIONS

Region	NW		NE		Central		SW		SE		South		West		Range
Composites and Ratings	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	
Getting Needed Care		83.8		81.7		80.8		95.7		74.1		70.9		81.6	24.8
Getting Care Quickly		80.9		77.4		72.7		77.0		85.5		73.5		94.4	21.7
How Well Doctors Communicate		94.0		85.6		92.5		93.6		83.3		94.4		95.7	12.4
Customer Service		89.3		87.7		93.2		85.9		99.4		81.6		87.2	17.8
Cultural Competency		83.7		100.0		71.2		100.0		78.7		100.0		62.1	37.9
Rating of personal doctor	212	82.3	146	72.8	359	86.6	44	83.5	52	77.9	41	86.3	75	76.7	13.8
Rating of Specialist Seen Most Often	116	84.4	70	72.0	198	77.7	22	79.9	23	64.1	20	49.3	44	79.7	35.1

Region	NW		NE		Central		SW		SE		South		West		Range
Composites and Ratings	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	
Rating of all health care	206	71.6	141	66.4	347	66.6	42	60.7	50	70.1	32	44.9	82	77.8	32.9
Rating of health plan	276	62.3	190	65.3	448	63.7	54	46.9	67	60.0	52	65.2	98	61.9	18.4
Health Promotion and Education	206	67.7	142	63.9	344	65.0	41	64.2	50	72.9	33	76.0	82	69.7	12.1
Coordination of Care (Q24)	94	77.9	70	85.0	157	74.8	17	72.9	26	56.5	20	32.4	36	71.5	52.6
Aspirin Use	29	37.4	21	32.6	52	43.8	8	10.5	6	54.8	12	76.6	19	43.5	66.1
Aspirin Discussion	92	32.9	50	32.4	124	40.4	13	45.7	14	48.3	24	89.6	31	40.9	57.2
Advising Smokers and Tobacco Users	57	62.7	63	50.4	114	66.2	15	49.2	33	51.0	17	83.3	38	78.4	34.1
Discussing Cessation Medication	57	29.8	63	21.6	116	44.0	15	20.7	32	10.1	17	27.3	37	19.2	33.9
Discussing Cessation Strategies	57	23.7	63	28.2	115	34.5	15	28.9	32	17.9	17	24.1	37	18.2	16.6

UTILIZATION OF SERVICES

The questionnaire contained several questions asking whether or not beneficiaries used various health care services and how often in the previous six months. The following table shows the percentage of respondents that used different services for the entire state and by the seven regions. The final column shows the range in values across the seven regions with higher numbers representing more variation.

At the state level, 73.3% of SPM enrollees reported visiting a doctor at least once, but there was considerable variation across regions. Enrollees in the southeast and south central regions reported much lower rates, while respondents in the west central region reported much higher rates. The percentage of respondents who reported seeing a doctor three or more times was over 40.6% at the state level and variation across the state was low. While comparative data is lacking, this high rate of utilization raises

some concerns and should be monitored with alternative data sources such as paid claims. Rates of specialist utilization varied with a 20.6 percentage point spread across regions. Overall, 38.4% of enrollees reported visiting a specialist in the past six months.

The percentage of enrollees that had at least one emergency department visit in the last six months was 18.1% at the state level. While there was some variation, four of the seven regions had rates between 18-20%. The southeast region had the highest rate of emergency department utilization and one of the lowest rates of utilization at a doctor's office. A total of 27.5% of enrollees in the southeast had an emergency department visit in the past six months. In contrast, enrollees in the northwest region had a low rate of emergency department utilization (13.4%) and a higher than average rate of visits to the doctor (76.9%).

TABLE VII-L. UTILIZATION OF SERVICES

	State		NW		NE		Central		SW		SE		SC		WC		Range
Utilization of Services	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**%**
Visiting the doctor at least once	1,194	73.3	276	76.9	192	72.0	448	75.2	54	81.4	72	59.8	52	54.4	100	84.6	30.2
Three or more visits to doctor	1,194	40.6	276	35.2	192	44.1	448	43.9	54	38.9	72	34.8	52	34.6	100	44.5	9.9
Visiting personal doctor at least	930	62.9	214	63.4	147	61.0	358	67.5	43	68.9	52	47.1	41	55.8	75	67.1	21.8
Three or more visits to personal	930	31.2	214	23.6	147	35.9	358	33.1	43	31.5	52	27.2	41	31.1	75	31.1	12.3
Seeking routine medical care	1,186	64.4	274	63.6	189	66.7	447	61.3	53	76.8	72	58.7	52	50.5	99	81.0	30.5
Seeking medical care for	1,188	41.8	276	37.1	190	43.0	443	43.8	55	41.1	72	51.8	52	28.5	100	37.2	23.3
Visiting a specialist	1,187	38.4	277	35.5	189	35.0	443	44.2	54	41.5	71	28.3	53	29.1	100	48.9	20.6
Visiting three or more	513	4.4	120	8.8	77	1.9	204	3.1	23	4.0	24	8.7	20	1.9	45	2.6	6.8
Visiting the ER at least once	437	18.1	90	13.4	75	20.4	169	18.2	20	9.9	30	27.5	15	19.8	38	18.8	17.7
Three or more visits to the ER	437	2.5	90	0.1	75	5.0	169	2.3	20	5.2	30	2.3	15	0.5	38	2.4	5.0

PLAN TYPE

Of the composite measures, the cultural competency composite had the greatest difference of 24.9 percentage points; of the ratings, the overall rating of all health care had the greatest difference of 12.5 percentage points; of the summary questions, the coordination of care measure had the greatest difference of 15.5 percentage points; and of the effectiveness of care measures, aspirin use had the greatest difference of 12.3 percentage points. All Marketplace respondent composite scores were higher than HCIP composite scores with the exception of customer service. Marketplace respondents rated their personal doctor, specialist and healthcare higher than HCIP respondents while HCIP respondents rated their health plan higher.

TABLE VII-M. PLAN TYPE COMPOSITES

Plan Type	HCIP		Marketplace		Range
Composites and Ratings	**n**	**%**	**n**	**%**	**%**
Getting Needed Care		79.4		91.0	11.6
Getting Care Quickly		76.8		86.9	10.1
How Well Doctors Communicate		89.2		97.0	7.8
Customer Service		91.5		86.6	4.9
Cultural Competency	70	68.7	72	93.6	24.9
Rating of personal doctor	419	78.9	510	88.4	9.5
Rating of Specialist Seen Most Often	230	73.5	263	84.4	10.9
Rating of all health care	442	64.9	458	77.4	12.5
Rating of health plan	569	63.9	616	55.3	8.6
Health Promotion and Education (Q7)	440	68.4	458	60.1	8.3
Coordination of Care (Q24)	202	69.5	218	85.0	15.5
Aspirin Use	50	36.0	97	48.3	12.3
Aspirin Discussion	110	39.4	238	45.6	6.2

Plan Type	HCIP		Marketplace		Range
Composites and Ratings	n	%	n	%	%
Advising Smokers and Tobacco Users to Quit	226	60.3	111	59.5	0.8
Discussing Cessation Medication	225	27.0	112	30.6	3.6
Discussing Cessation Strategies	225	27.0	111	26.2	0.8

SILVER COVERAGE

Of the composites for the silver coverage plan respondents only, the cultural competency composite had the greatest difference of 31.0 percentage points between the HCIP and Marketplace enrollees; of the ratings, the overall rating of all health care had the greatest difference of 15.3 percentage points; of the summary questions, the coordination of care measure had the greatest difference of 14.9 percentage points; and of the effectiveness of care measures, the discussing cessation medication composite had the greatest difference of 11.0 percentage points. All Marketplace respondent composite scores were higher than HCIP respondent scores. Marketplace respondents rated their personal doctor, specialist and healthcare higher than HCIP respondents while HCIP respondents rated their health plan higher.

TABLE VII-N. COMPOSITE OF SILVER COVERAGE PLAN RESPONSES

Silver Coverage					
Plan Type	HCIP		Marketplace		Range
Composites and Ratings	n	%	n	%	%
Getting Needed Care		79.4		91.8	12.4
Getting Care Quickly		76.8		85.3	8.5
How Well Doctors Communicate		89.2		96.7	7.5
Customer Service		91.5		94.1	2.6
Cultural Competency		68.7		99.7	31.0
Rating of personal doctor	419	78.9	294	87.8	8.9

Silver Coverage					
Plan Type	**HCIP**		**Marketplace**		**Range**
Composites and Ratings	**n**	**%**	**n**	**%**	**%**
Rating of Specialist Seen Most Often	230	73.5	150	86.6	13.1
Rating of all health care	442	64.9	264	80.2	15.3
Rating of health plan	569	63.9	351	61.7	2.2
Health Promotion and Education (Q7)	440	68.4	263	54.4	14.0
Coordination of Care (Q24)	202	69.5	116	84.4	14.9
Aspirin Use	50	36.0	53	40.7	4.7
Aspirin Discussion	110	39.4	133	44.0	4.6
Advising Smokers and Tobacco Users to Quit	226	60.3	74	63.0	2.7
Discussing Cessation Medication	225	27.0	75	38.0	11.0
Discussing Cessation Strategies	225	27.0	74	33.5	6.5

VIII. EVALUATE IMPACT ON HEALTH CARE PROVIDERS

ASSESSMENT OF UNCOMPENSATED CARE AND CHANGES IN SERVICES

According to The Kaiser Commission on Medicaid and the Uninsured, over 72 million nonelderly people were uninsured for part or all of 2013.[8] The cost of uncompensated care provided for uninsured U.S. residents is substantial, $84.9 billion in 2013 alone. The burden of uncompensated care falls on hospitals, community based providers such as clinics and health centers, and office-based physicians. The majority of uncompensated care was provided by hospitals nationwide in 2013.

The ACA allowed millions of uninsured Americans to obtain coverage through health care marketplaces in 2014. Those states that chose to expand Medicaid, like the establishment of the HCIP in Arkansas, further increased insurance coverage for uninsured populations. Additional insurance coverage, in theory, should reduce uncompensated care for health care providers. This in fact was the case based on recent studies by the Arkansas Center for Health Improvement (ACHI)/Arkansas Hospital Association (AHA) and the Colorado Hospital Association (CHA). In Arkansas, ACHI and AHA reported a 35.5% reduction in uninsured emergency department use and a 46.5% reduction in uninsured hospital admission through the second quarter of 2014. CHA collects monthly financial and volume data from hospitals throughout the nation. The CHA team reported preliminary data which showed a 30% drop in average charity care per hospital in states that elected to expand Medicaid services in 2014.

Through this evaluation, physician offices, hospitals, and mental health providers were surveyed to determine changes in uncompensated care. Changes in provider services due to

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[8] The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation. Uncompensated care for uninsured in 2013: A detailed examination. May 2014. Last Accessed October 2014 at http://kff.org/uninsured/report/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination/ .

the establishment of the Marketplace were also evaluated through provider surveys distributed to physician offices, hospitals, and mental health providers. Surveys addressed changes in the proportion of Medicare, newly-enrolled Marketplace or HCIP, traditional Medicaid, and other (non-Marketplace) private insurance patients. Staffing and/or capacity changes, time and cost constraints, and changes in patient volume were also assessed.

METHODS

Lists of hospital, clinic and behavioral health provider contacts are maintained by AFMC for regular communication and outreach activities. Each list was obtained by the Analytics department and prepared for e-blast communication and survey distribution through SurveyMonkey®. An initial email was sent to each participant to introduce the survey directly from AFMC (Appendices VIII-A and VIII-B). Survey distribution and reminder emails were generated through SurveyMonkey® (see Appendices VIII-C, VIII-D, and VIII-E). Reminder emails were sent once a week or every other week for each survey up to 12 times total (Appendix VIII-F). Dates of advance emails, open date of the survey and closing date of the survey is shown in Table VIII-A below.

TABLE VIII-A. SURVEY SCHEDULE BY GROUP

Group	Advance email	Open date	Closing date
Hospital	August 26, 2014	September 3, 2014	October 31, 2014
Clinic	October 7, 2014	October 21, 2014	December 20, 2014
Behavioral Health	August 26, 2014	September 3, 2014	October 31, 2014

OVERVIEW OF RESULTS

Samples for each group included 76 hospitals, 757 clinics, and 118 behavioral health facilities. Initial response to the survey was good: 51.3% for hospitals, 32.4% for clinics, and 42.4% for behavioral health facilities. However, analysis revealed that many respondents started the survey but fewer completed the entire instrument. Although still resulting in at least an 11% completed survey rate, this was an issue that affected the hospital analysis in particular as the number of completed surveys dropped considerably.

TABLE VIII-B. SURVEY RESPONSES BY GROUP

Group	Sample	Responded to survey	Completed entire survey
Hospital	76	39	8
Clinic	757	245	116
Behavioral Health	118	50	30

Surveys indicated that uncompensated care was reduced in the hospital setting for both inpatient and the ER visits. Changes were not as definitive in the clinic or behavioral health settings – the majority of respondents indicated no change. Although, if clinics or behavioral health respondents indicated a change in uncompensated care, more respondents reported a reduction in uncompensated care than those who reported an increase.

The majority of facilities did not indicate changes in patient volume. Those who reported changes in patient volume were more likely to report increases rather than decreases for all three settings (hospital, clinic and behavioral health). Categories of patients shifted in each setting after the Marketplace was established: as private/Marketplace/HCIP beneficiaries increased, self-paying and indigent patient levels decreased. Identifying Medicare and traditional Medicaid patients was easier for facilities while newly enrolled Marketplace/HCIP or patients with other private insurance was seen as more difficult.

As facilities prepared for changes in patient volume, the trend in overall responses indicated increased staff or structural capacity to accommodate additional patient loads. The majority of clinics or behavioral health facilities indicated they were taking new patients. And a large proportion of hospital, clinic and behavioral health providers indicated that they were able to service all groups of patients.

Behavioral health facilities (75%) referred patients to licensed Marketplace Assisters to aid with health insurance applications and enrollment most often followed by clinics (61.1%) and then hospitals (50%). Only three of the eight responding hospitals has become a Certified Application Counselors (CAC) organization. Based on the satisfaction ratings and open comment responses regarding education, more education is warranted for both provider facility staff and patients.

LIMITATIONS

Caution should be taken when interpreting these results. Providers began surveys but the participants who completed all questions was much lower; for the hospital survey 39 facilities started the survey while only 8 completed it, for the clinic survey 245 facilities began the survey but only 116 completed it, and for the behavioral health survey 50 facilities began the survey while only 30 completed it. Several factors, outlined below, may have played a role in the survey completion rates.

TIMING OF THE SURVEY

The provider surveys were conducted during the end of the first plan year for the Marketplace. A previous assessment of uncompensated care in Arkansas hospitals captured

larger reductions, however the timing of those surveys and methods for collecting the data may differ from the current survey. To our knowledge, changes in uncompensated care have not been assessed in the clinic and behavioral health settings prior to this survey.

ONLINE FORMAT

While an online format for the survey initially generated a strong response from providers, failure to complete the entire survey lead to issues with the response rate overall. This may be due to settings for the survey link, inability of respondents to complete the survey at one time, and detailed questions regarding costs and patient volume that required additional research by respondents.

SURVEY FATIGUE

The provider surveys were distributed at a time when Arkansas providers are already participating in multiple state-level and national health care initiatives. Health care initiatives involving providers include multiple assessments and survey fatigue is a concern in the provider setting. Although the online format was designed to limit the amount of time needed to distribute and respond to the survey, it may still have required more intense follow-up to ensure full completion of the surveys.

RECOMMENDATIONS

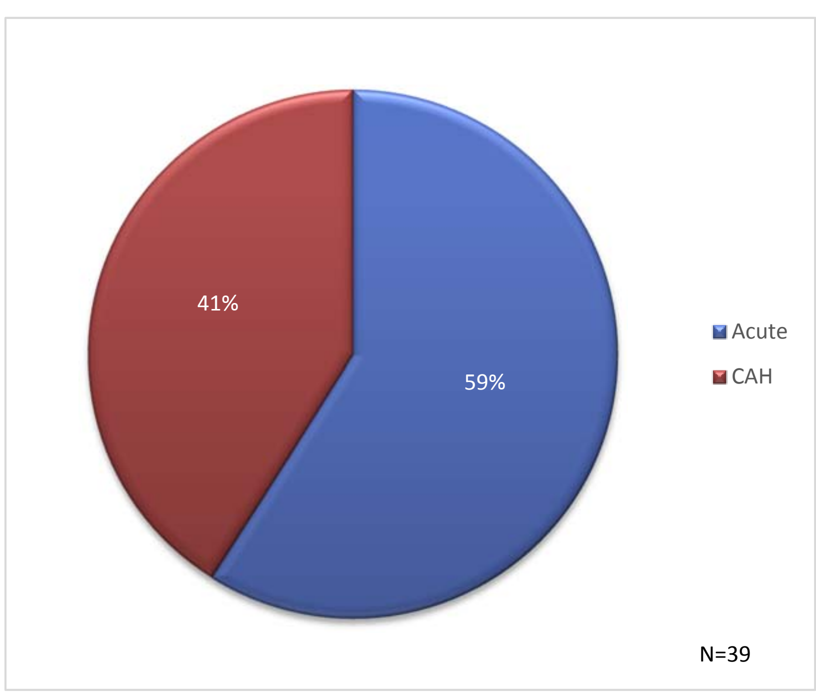
- Future assessment through provider surveys may benefit from in-person data collection options by way of interviews or other means to ensure completion of the survey.
- Additional education regarding the Marketplace and changes in health insurance is warranted for both provider facility staff and patients.

AID HOSPITAL SURVEY SUMMARY

RESPONDENT CHARACTERISTICS

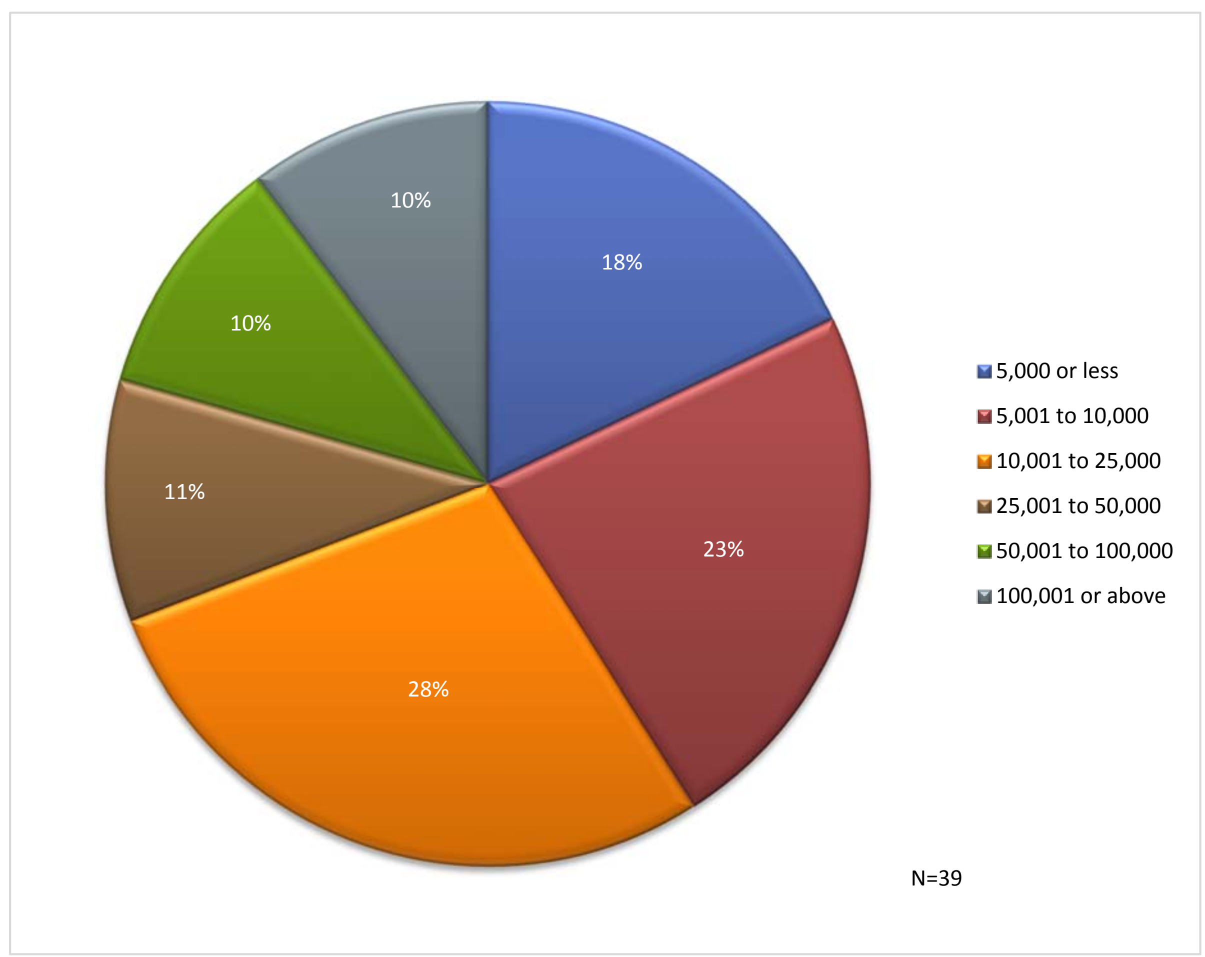
A total of 39 out of 76 hospitals contacted responded to the survey distributed by AFMC. Fifty-nine percent of the facilities were acute care facilities paid through a prospective payment system (PPS) or a teaching hospital (Figure VIII-1). Forty-one percent were critical access hospitals (CAH).

FIGURE VIII-1. HOSPITAL TYPES



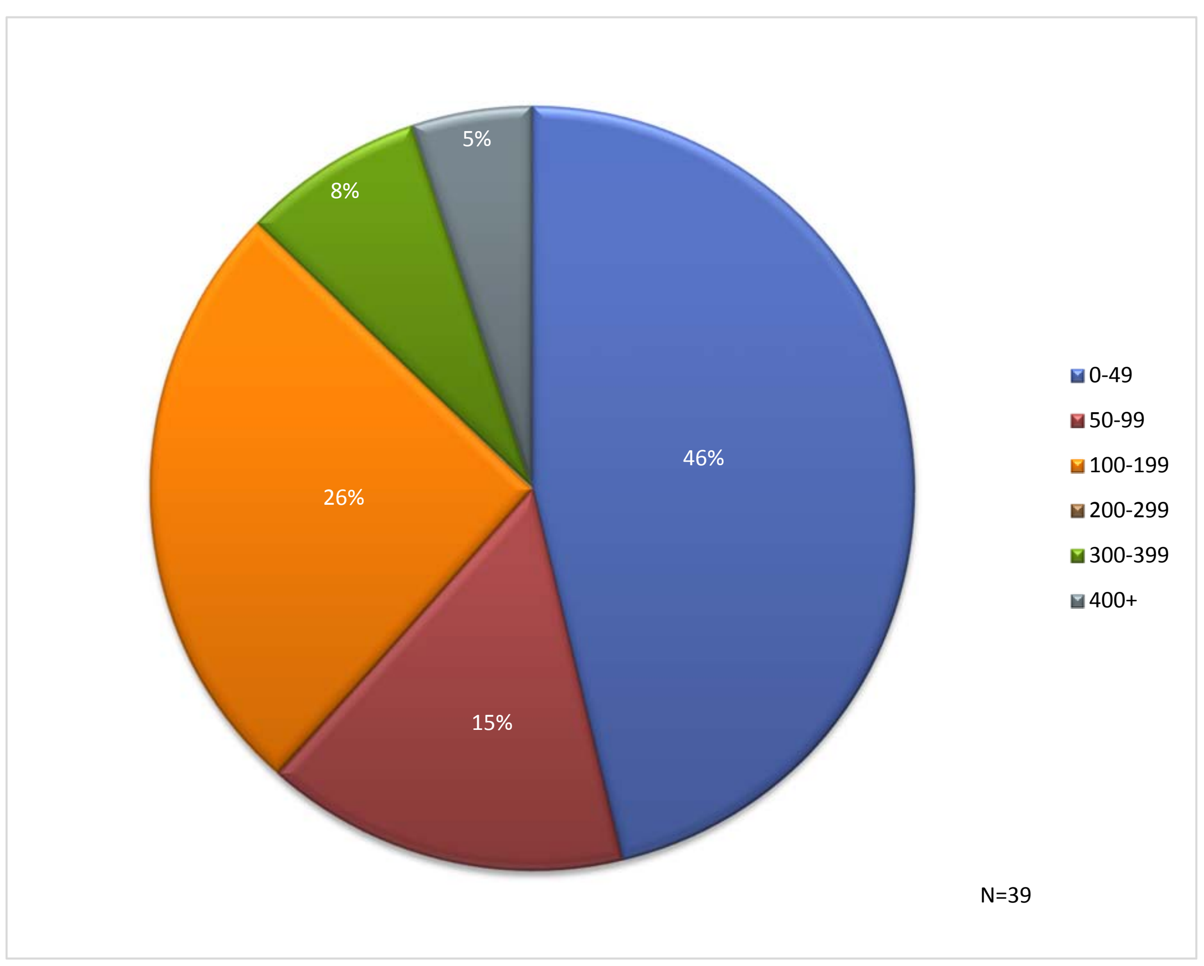
The size of the community serviced by respondent hospitals was also captured through the survey (Figure VIII-2). A total of 30.9% of responding hospitals served communities with 25,001 or more residents. Areas with 10,001 to 25,000 community members were served by 28.2% of responding hospitals. A number of hospitals indicated they served smaller, rural communities; 23.1% served 5,001 to 10,000 community members and 17.9% served communities with 5,000 or fewer residents.

FIGURE VIII-2. COMMUNITY SIZE CHARACTERISTICS



Hospital size was also assessed among survey respondents (Figure VIII-3). Hospitals with fewer than 49 beds represented 46.5% of the total. A quarter of hospitals participating in the survey had 100-199 beds and 15.4% of respondents had 50-99 beds. No participating hospitals indicated that they had 200-299 beds. Larger hospitals, those with 300 or more beds, represented a smaller proportion of respondents (12.8%).

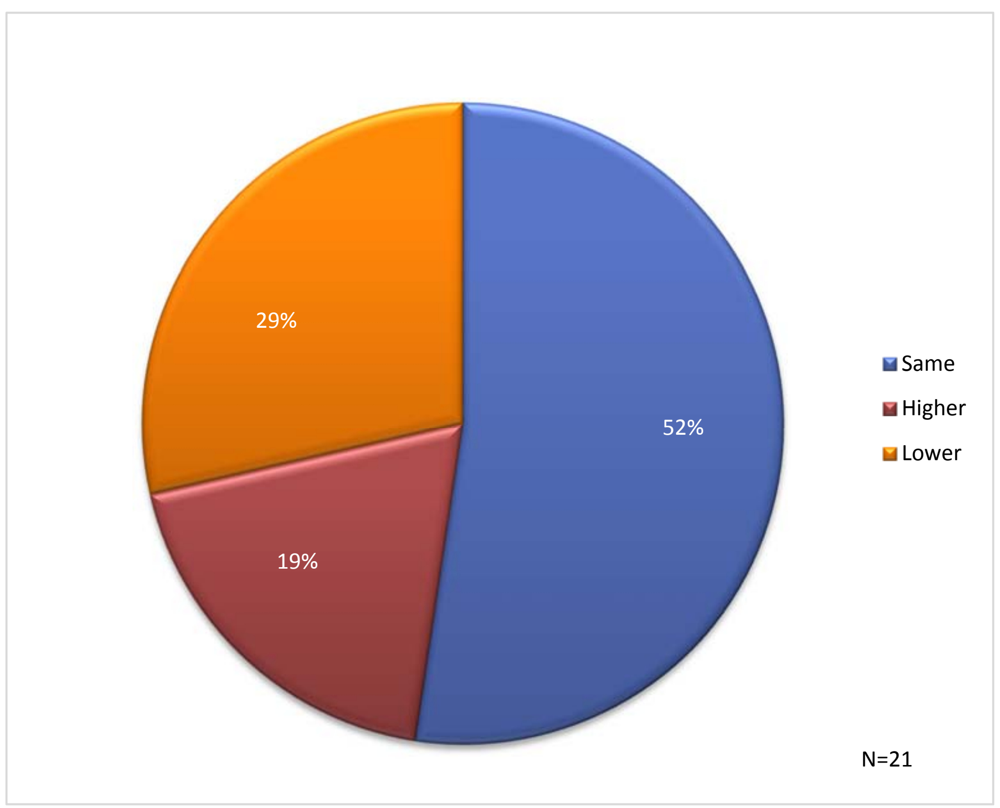
FIGURE VIII-3. HOSPITAL SIZE



CHANGES IN PATIENT VOLUME

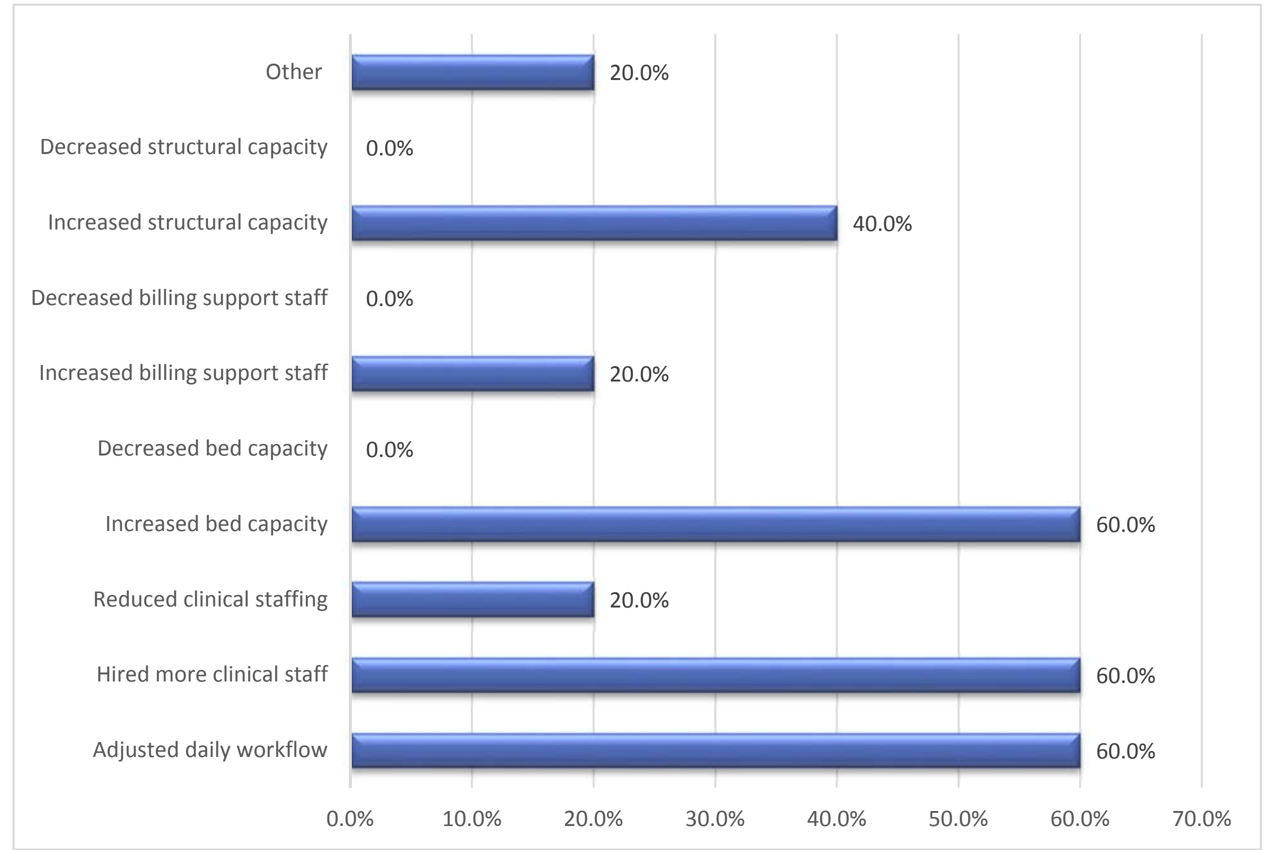
Hospitals were asked the average number of inpatient admits per week for the time periods before and after the Marketplace was established (Figure VIII-4). Over half of responding hospitals stated no change in inpatient admission volume (52.4%). Nineteen percent of the hospitals reported an increase in patient volume while 28.6% reported a decrease in volume. Relative increases in inpatient admission volumes ranged from 9.1% to 50% while relative decreases in inpatient admission volumes ranged from -40.0% to -4.8%.

FIGURE VIII-4. PATIENT VOLUME



Hospitals were also asked if they made adjustments to accommodate changes in patient load since the implementation of the Marketplace. Five (23.8%) of the 21 who responded to this question indicated that they made changes to accommodate new patient loads. Changes included adjustments to daily workflow, hiring more clinical staff, reducing clinical staffing, increasing bed capacity, increasing billing support staff, and increased structural capacity (Figure VIII-5). One respondent noted they added more staff in the emergency department under the "Other" category.

FIGURE VIII-5. CHANGES HOSPITALS MADE TO ACCOMMODATE NEW PATIENT LOADS



Two distinct questions were asked to determine the effect of time and cost constraints on the ability of hospitals to service Medicare beneficiaries, newly-enrolled Marketplace/HCIP recipients, traditional Medicaid enrollees and individuals with existing insurance. Responses were the same to both questions; eight of the nine respondents (88.9%) were able to service all patients regardless of coverage while one respondent (11.1%) indicated both time and cost constraints limited their ability to service traditional Medicaid enrollees.

UNCOMPENSATED CARE AND UNINSURED VISITS

The percentage of uncompensated care costs were assessed for Q2 (April-June) 2013 and compared to Q2 2014. Reported uncompensated care for hospitals ranged from 2% to 33% for Q2 2013 and 0% to 25% for Q2 2014. Of the nine hospitals responding to uncompensated care questions, 22.2% had no change in uncompensated care levels between Q2 2013 and Q2 2014 while 77.8% had a decrease in uncompensated care levels for the same time period (Figure VIII-6). The relative decreases in the percentage of uncompensated care reported by hospitals ranged from -100% to -22.2% (Figure VIII-7).

FIGURE VIII-6. UNCOMPENSATED CARE

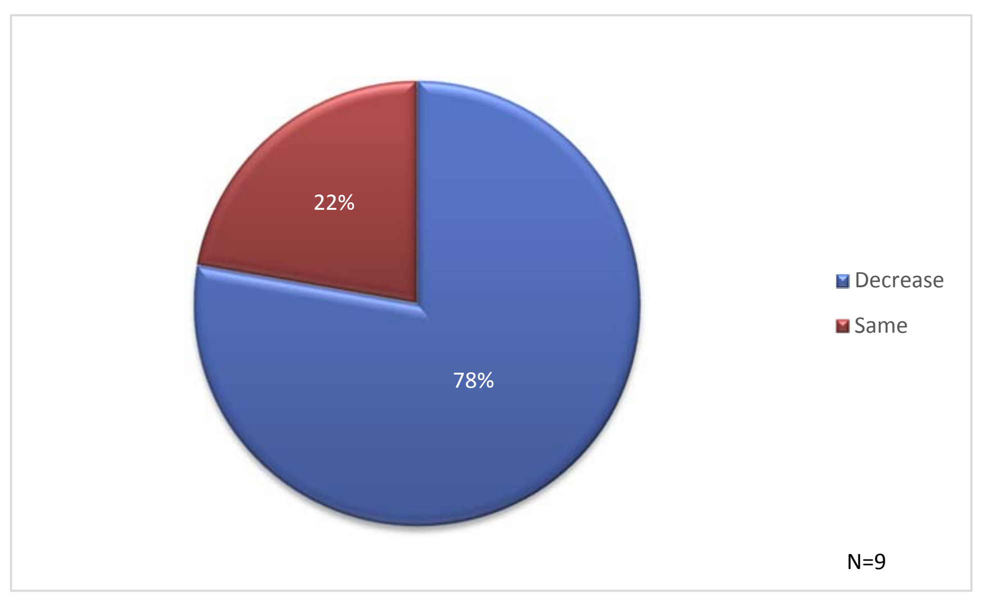
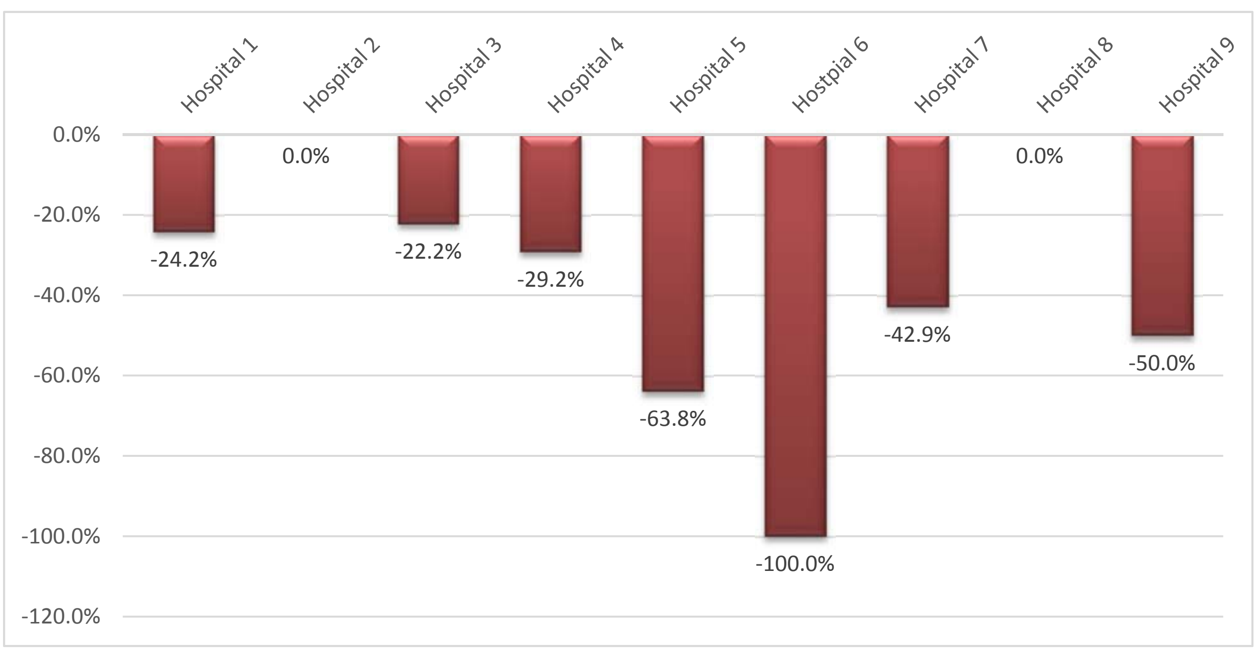


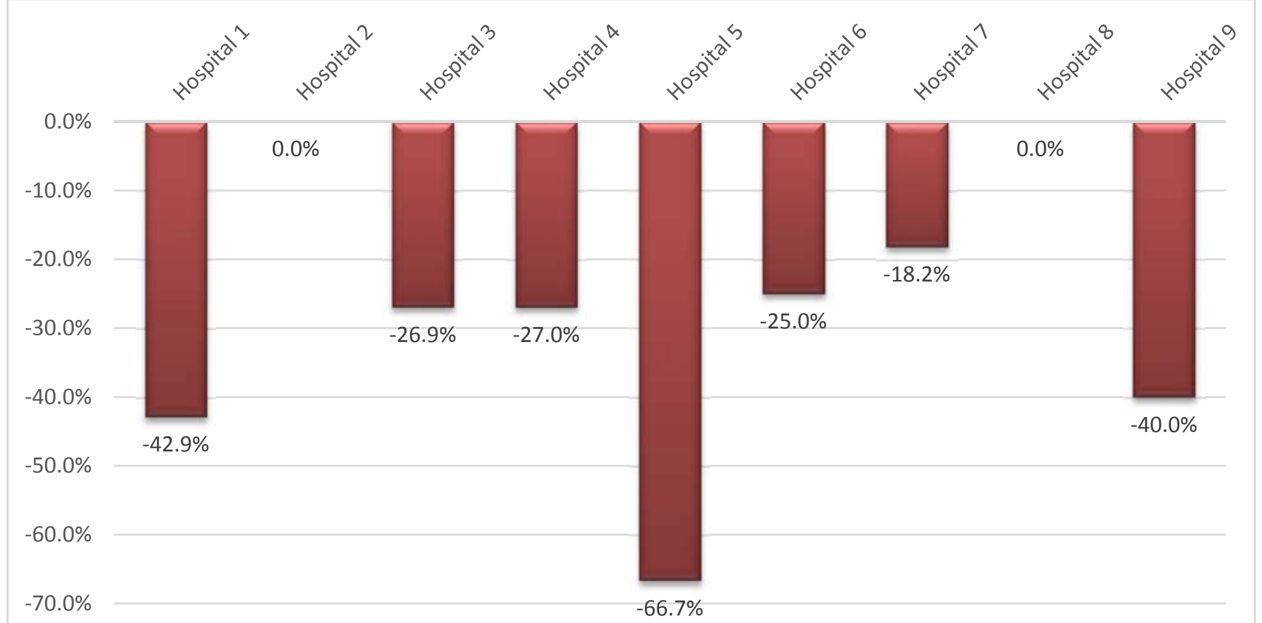
FIGURE VIII-7. RELATIVE DECREASES IN UNCOMPENSATED CARE



Respondents were also asked what percentage of uninsured visits were made to their Emergency Departments before and after the Marketplace was implemented. The percentage of uninsured visits to the Emergency Department for the nine responding hospitals ranged from 1% to 35% before the Marketplace was established and 1% to 25% after the Marketplace was established. The proportion of responding hospitals that indicated a decrease in uninsured

Emergency Department visits after implementation of the Marketplace was 77.8% while 22.2% indicated no change. The relative decreases in the percentage of uncompensated care reported by hospitals ranged from -66.7% to -18.2% (Figure VIII-8).

FIGURE VIII-8. RELATIVE DECREASES IN UNCOMPENSATED ER VISITS

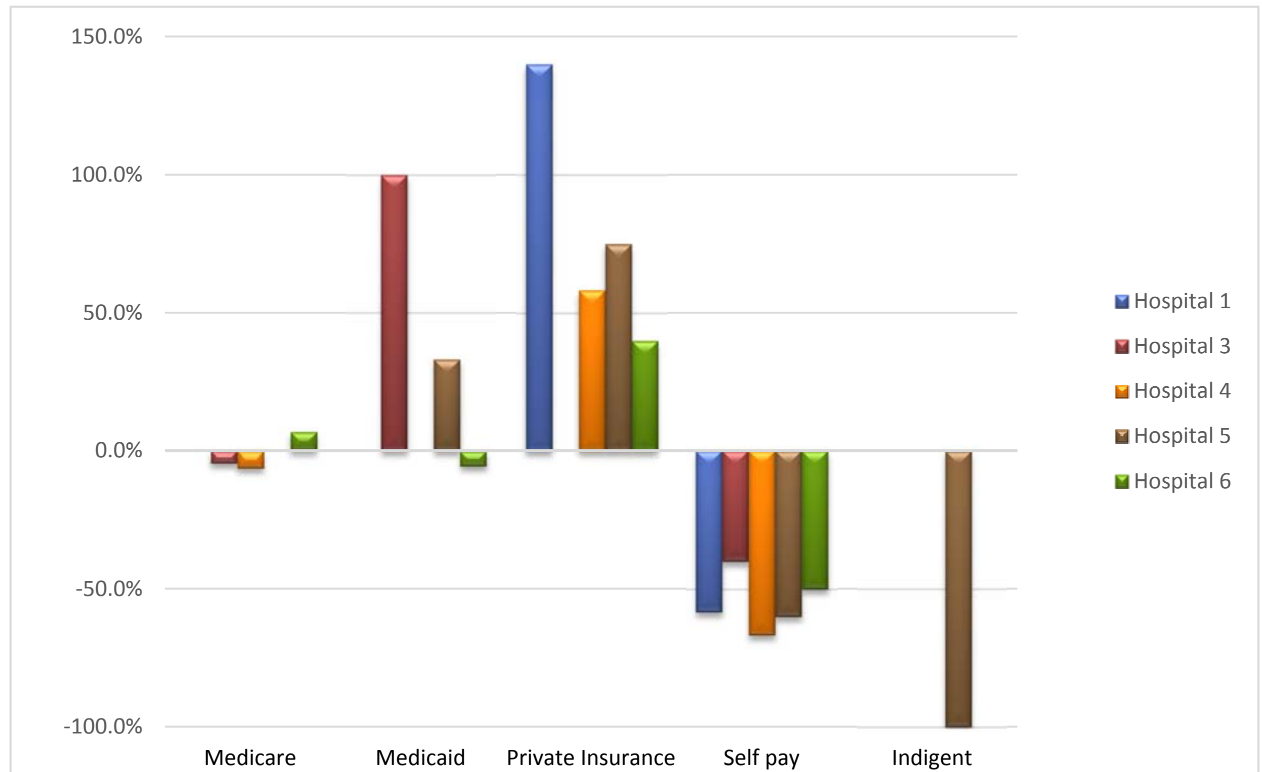


CHANGES IN CATEGORIES OF PATIENTS

A total of eight participating hospitals responded with the percentage of in-patient patients before and after the Marketplace was established. Categories of patients included Medicare, Medicaid, private insurance (including those newly-insured through the Marketplace/HCIP), self-pay, indigent or other types not included in the list. Five (62.5%) of the hospitals indicated there were differences in the make-up of the patients seen through in-patient services. Relative changes for the hospitals that indicated differences ranged from -4.3% to 140%.

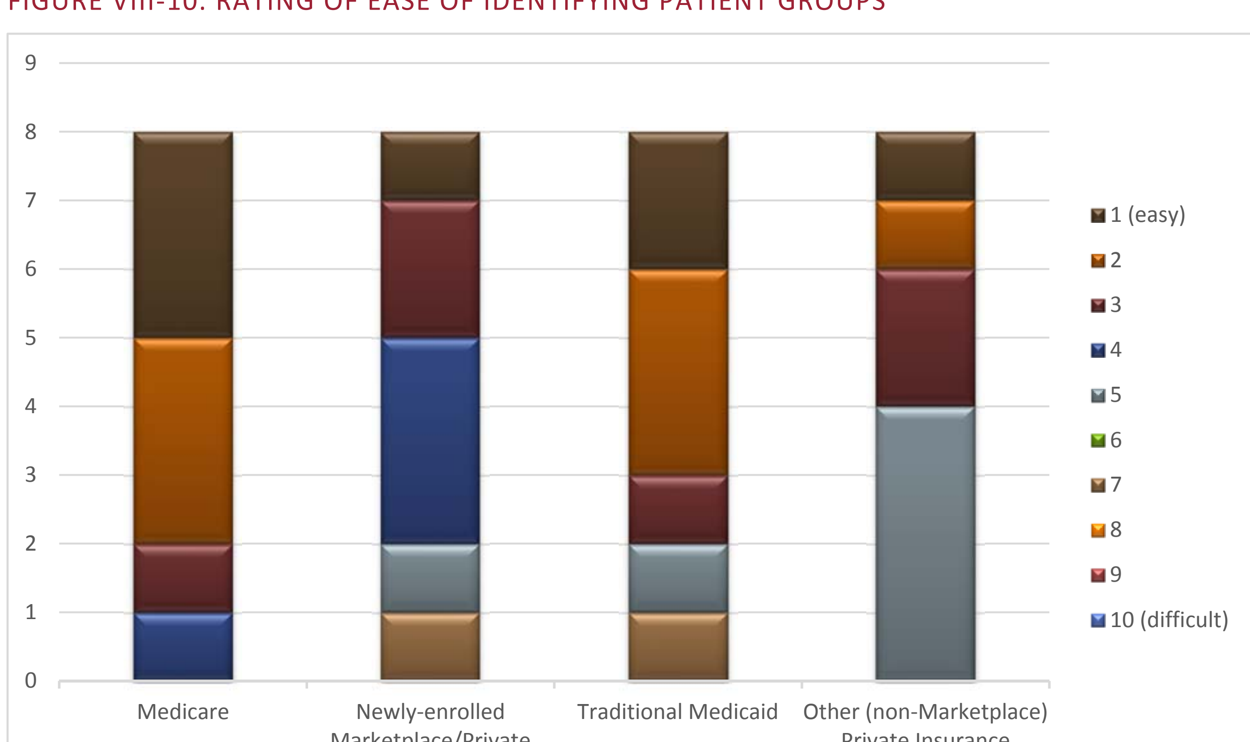
All five (100%) hospitals that stated a change indicated that there was a decrease in self-pay. Relative decreases of self-pay for the hospitals that experienced changes ranged from -66.7% to -40% (Figure VIII-9). Eighty percent of hospitals that experienced a change indicated an increase in private insurance (including those newly-insured through the Marketplace/HCIP). Relative increases of private insurance (including those newly-insured through the Marketplace/HCIP) ranged from 40% to 140%. Other changes included both increases and decreases in Medicare and Medicaid, but those changes were not consistent among hospital responses.

FIGURE VIII-9. RELATIVE CHANGES IN PATIENT POPULATIONS



Participating hospitals were asked to indicate their ease or difficulty in identifying patients with health insurance from Medicare, newly-enrolled Marketplace/HCIP, traditional Medicaid, or other (non-Marketplace) private insurance (Figure VIII-10). Medicare was noted as the easiest group to identify by hospitals. Fewer hospitals ranked identifying newly-enrolled Marketplace/HCIP, traditional Medicaid, or other (non-Marketplace) private insurance as "easy." Newly-enrolled Marketplace/HCIP and other (non-Marketplace) private insurance were ranked more difficult compared to the various insurance types. Two hospitals did rank traditional Medicaid more difficult compared to rankings for Medicare.

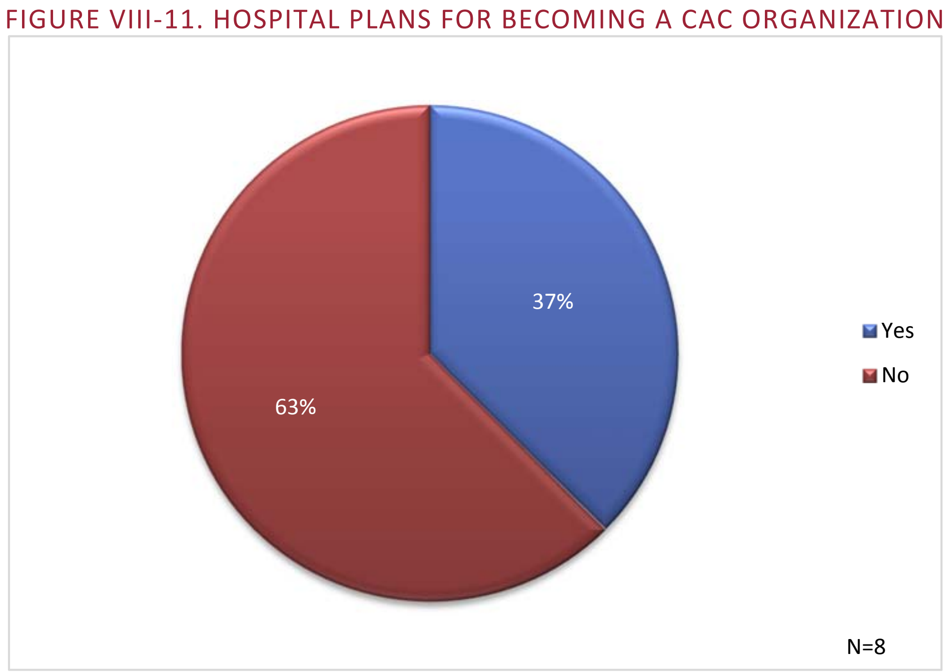
FIGURE VIII-10. RATING OF EASE OF IDENTIFYING PATIENT GROUPS



MARKETPLACE ASSISTANTS AND CERTIFIED APPLICATION COUNSELORS

The survey also evaluated whether hospitals referred patients to Marketplace Assisters or became Certified Application Counselors (CAC) organization. Half (4 of 8 hospitals) of the hospitals responding to this question indicated that they referred patients to licensed Marketplace Assisters to aid with health insurance applications and enrollment. Only 3 (37.5%) of the responding hospitals had become a CAC organization (Figure VIII-11). None of the hospitals that were not currently a CAC organization planned to become one.

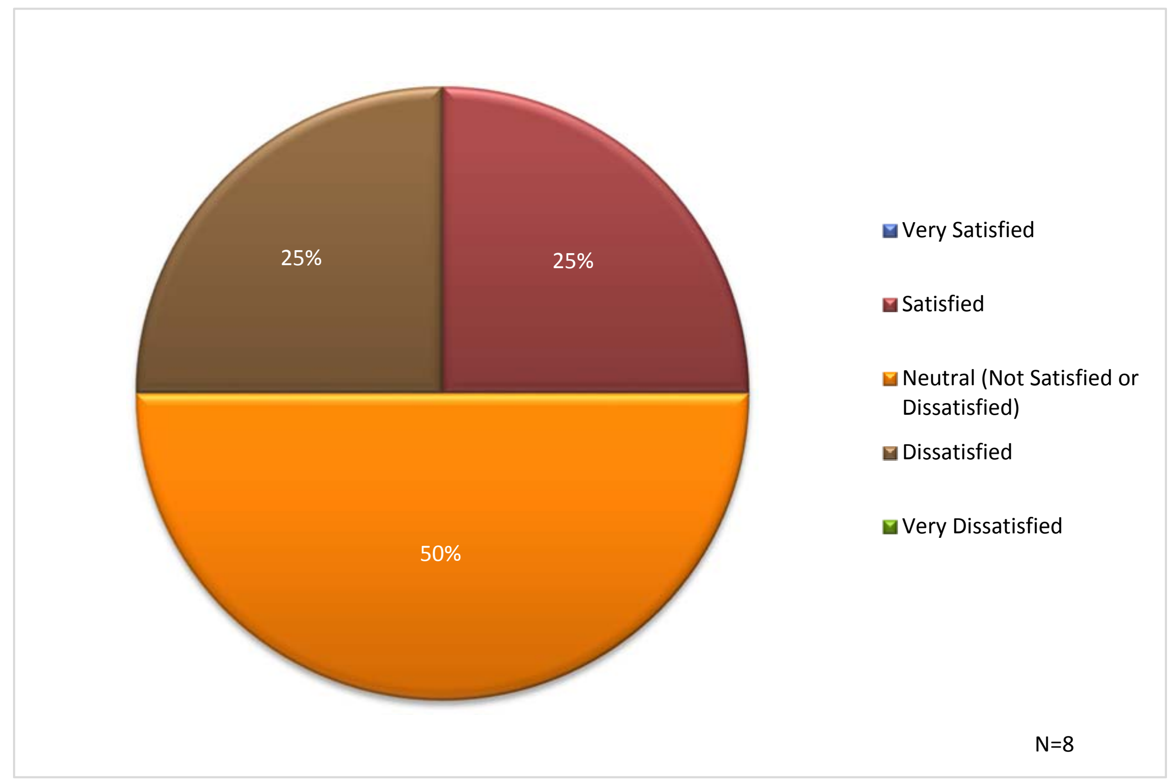
FIGURE VIII-11. HOSPITAL PLANS FOR BECOMING A CAC ORGANIZATION



EDUCATION

The responding hospitals rated their overall satisfaction with education provided to hospital staff regarding the implementation of the Health Insurance Marketplace (Figure VIII-12). Half of the respondents indicated they were neutral with training. One quarter of the respondents were satisfied with training and the final quarter of respondents were dissatisfied. Identified training needs included help with verification of eligibility forms, traditional Medicaid questions, educational worksheets for facilities, clarification of secondary insurance definitions, education on claim submission and plan coverage, and general improvements in education. One respondent requested hands on training through a mock sign-up site and allowing counselors to go through the whole application process before working with recipients. Based on the ratings and responses, improvements in the education for hospital staff is warranted.

FIGURE VIII-12. HOSPITAL SATISFACTION WITH HEALTH INSURANCE MARKETPLACE EDUCATION



OTHER COMMENTS

Additional input was requested through an open-ended response option. The following comments were provided by two different Hospitals:

> *"The way the private option enrollment was set up was confusing for both the community and providers."*

> *"The expansion has not really impacted our inpatient census. The impact has been in ER and outpatient services."*

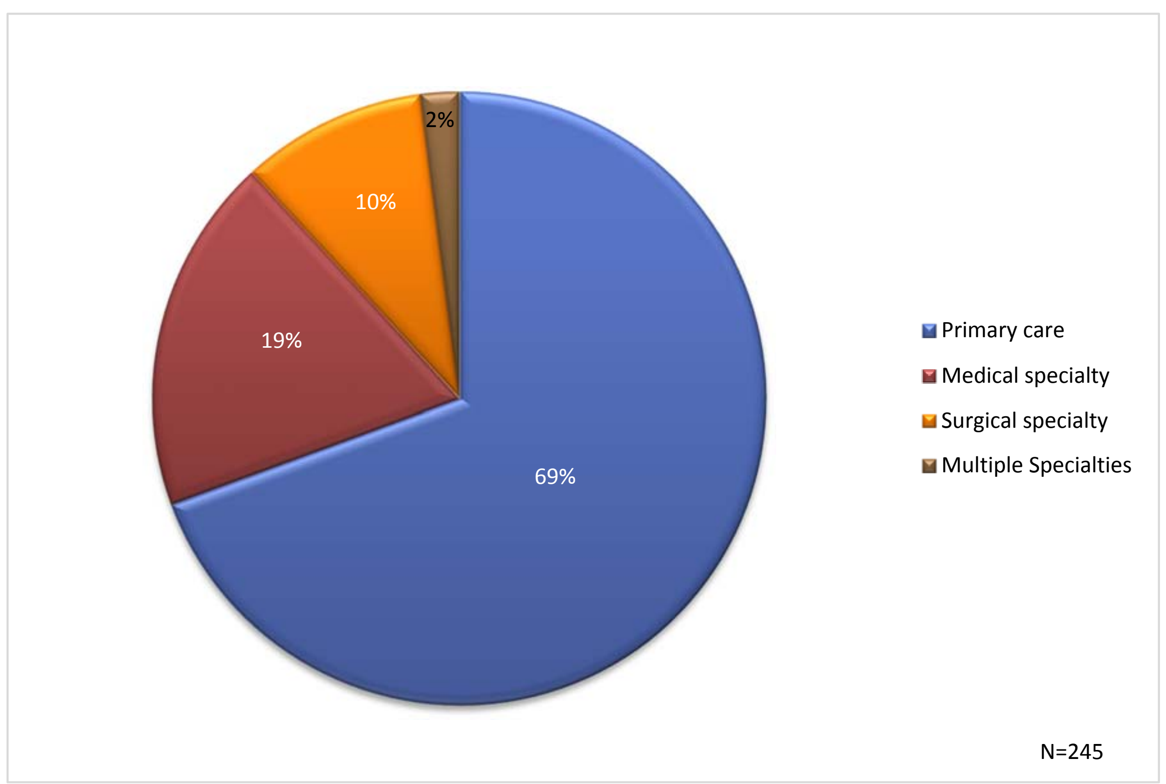
AID CLINIC SURVEY SUMMARY

RESPONDENT CHARACTERISTICS

A total of 245 clinics contacted responded to the survey distributed by AFMC (32.4% response rate). A total of 69.4% of the clinics practiced primary care (Figure VIII-13). Medical specialties accounted for 18.8% of respondents while surgical specialties accounted for 9.8%.

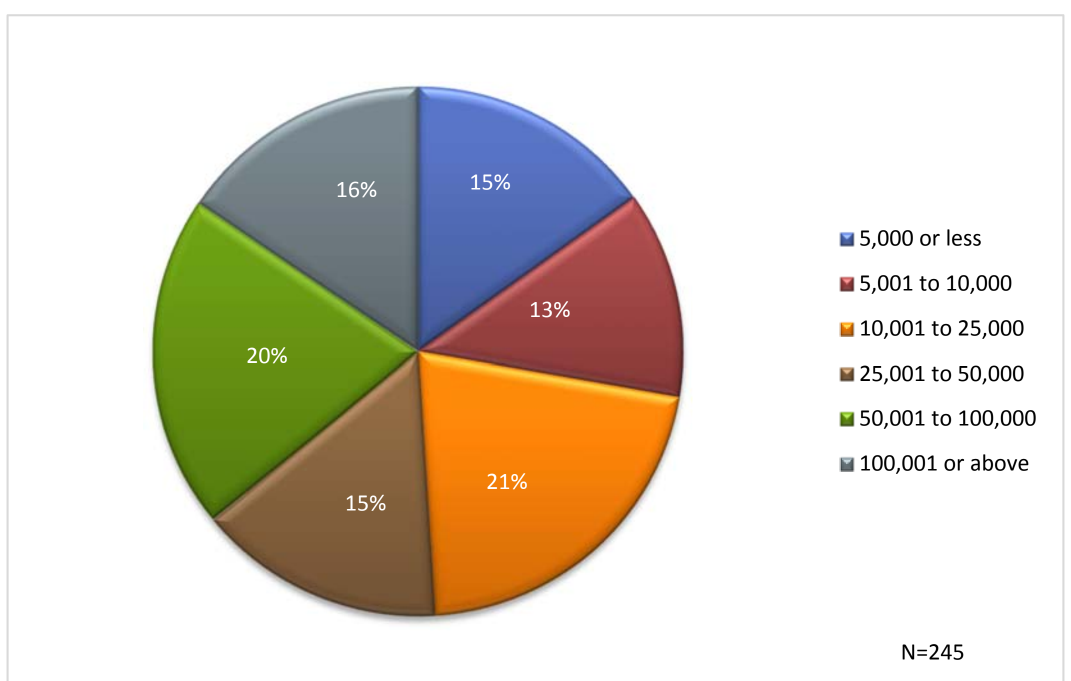
Another 2% of responding clinics indicated they practiced other types of care including multiple specialties.

FIGURE VIII-13. CLINIC TYPE



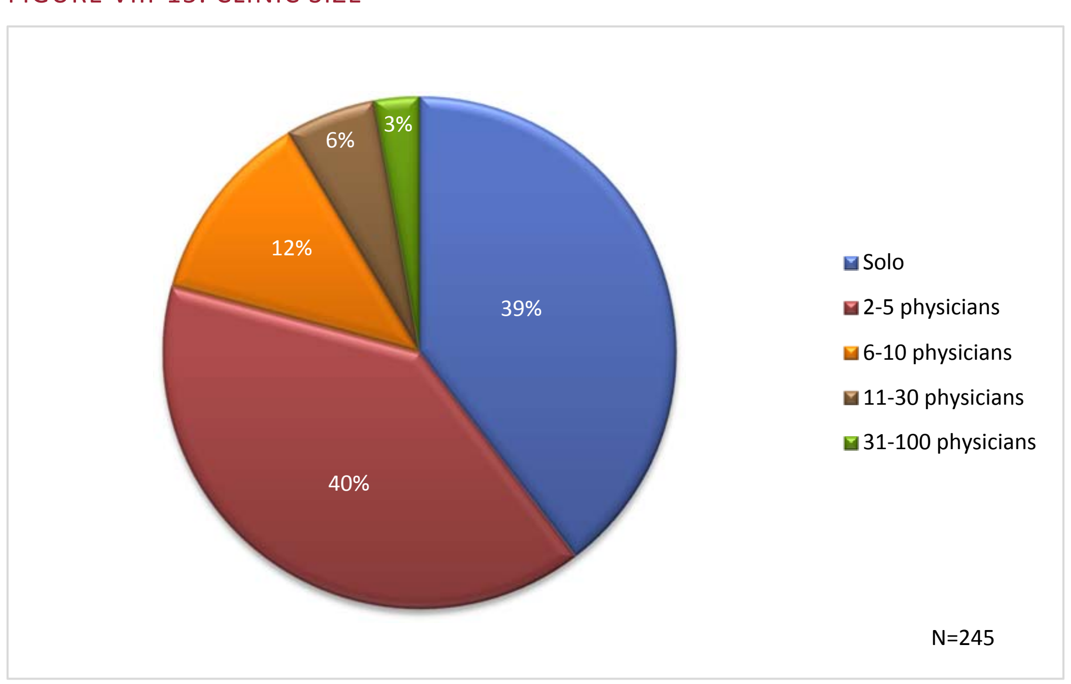
The size of the community serviced by responding clinics was also assessed through the survey (Figure VIII-14). Roughly half of responding clinics served communities with 25,001 or more residents. The other half of survey participants were located in communities with 25,000 or less residents. Approximately 15% of clinics served communities with over 100,001 residents. The same was true of the smallest communities; a total of 15.1% served communities with 5,000 or less residents.

FIGURE VIII-14. COMMUNITY SIZE CHARACTERISTICS



Survey respondents were asked to describe clinic size through the assessment (Figure VIII-15). Solo practices and clinics with 2-5 physicians accounted for the majority of respondents; 39.6% of responses were solo practices and 39.6% were clinics with 2-5 physicians. Roughly 12% of clinics had 6-10 physicians while 5.7% had 11-30 physicians. Larger clinics, those with 31-100 physicians, represented a much smaller proportion of respondents (2.9%).

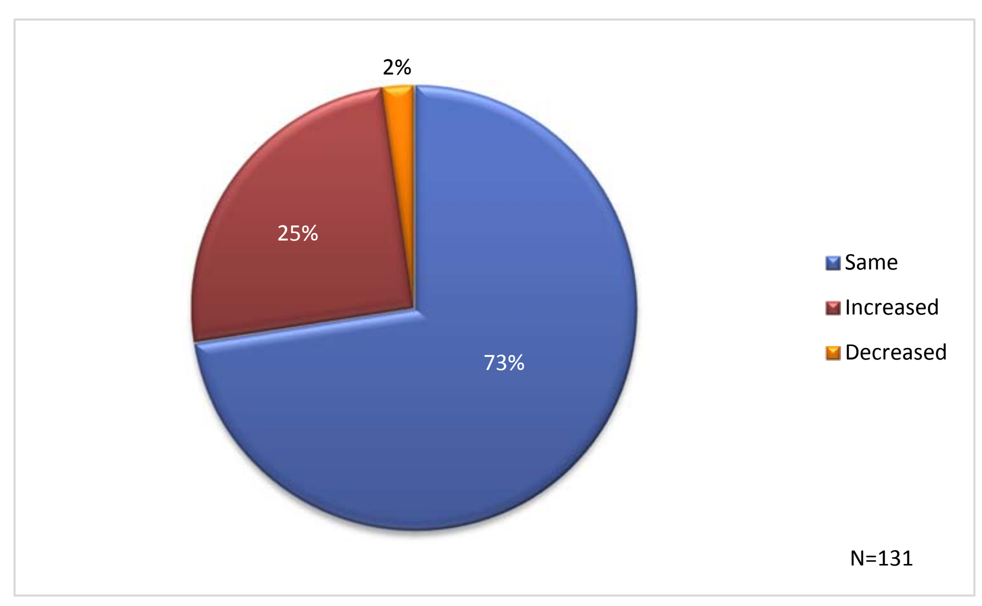
FIGURE VIII-15. CLINIC SIZE



CHANGES IN PATIENT VOLUME

Clinics were asked the average number of patients who visited their clinic per week for the time periods before and after the Health Insurance Marketplace was established (Figure VIII-16). A total of 131 clinics responded to the changes in patient volume questions. The majority of responding clinics stated no change in patient volume (72.5%). A quarter of the clinics reported an increase in patient volume while only 2.3% reported a decrease in volume. Categories of average weekly patient volume included: 1-75, 76-150, 151-200, 201-250, 251-350, and 351 or above. Only five of the 36 clinics (13.9%) who reported a change had a substantial increase or decrease that moved patient volume across 2 or more categories of average weekly patient volume. Thirty-one clinics (86.1%) increased or decreased patient volume by one category.

FIGURE VIII-16. PATIENT VOLUME



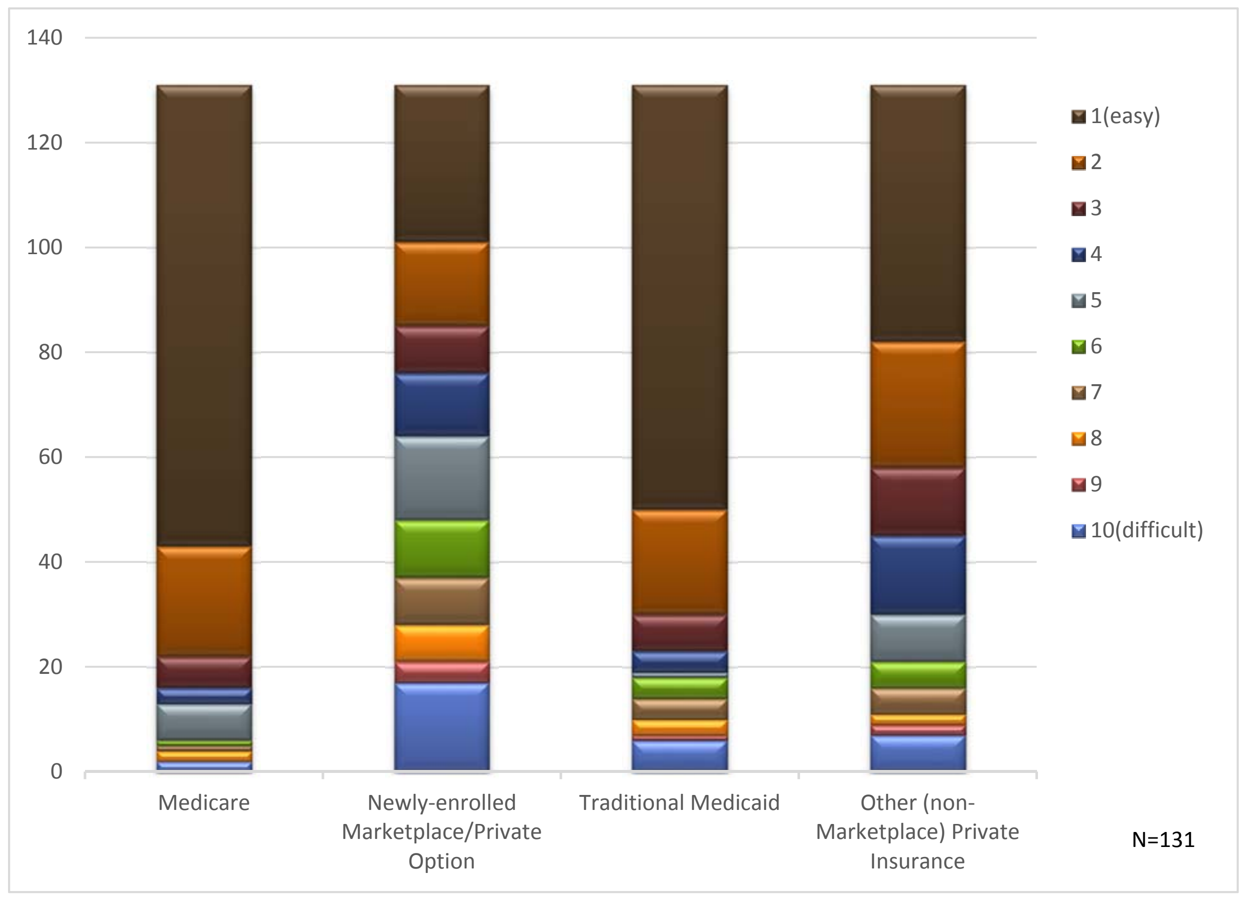
A total of 131 participating clinics responded with the percentage of patients before and after the Marketplace was established (Table VIII-C). Categories of patients included Medicare, Medicaid, private insurance (including those newly-insured through the Marketplace/HCIP), self-pay, indigent or other types not included in the list. Eighty-one (61.8%) of the clinics indicated there were differences in the make-up of the patients seen in the clinic setting. Overall, fewer changes were noted in Medicare, indigent and other patient populations; however, less patients were noted by providers more often for both indigent and other payment types. During the same time period, clinics noted more private insurance, Marketplace, and HCIP patients, and fewer self-pay patients. Over half of the clinics noted no change in Medicaid patient populations while 24.4% indicated more patients and 19.1% indicated fewer patients after the Marketplace was established.

TABLE VIII-C. CHANGES IN THE PERCENTAGE OF CLINIC PATIENTS

	Medicare	Medicaid	Private Insurance/ Marketplace/ HCIP	Self-pay	Indigent	Other
More patients	5.3%	24.4%	48.9%	3.8%	0.8%	0.8%
Less patients	7.6%	19.1%	7.6%	45.8%	11.5%	6.1%
No change	87.0%	56.5%	43.5%	50.4%	87.8%	93.1%

Participating clinics were asked to indicate their ease or difficulty in identifying patients with health insurance from Medicare, newly-enrolled Marketplace/HCIP, traditional Medicaid, or other (non-Marketplace) private insurance (Figure VIII-17). Medicare and traditional Medicaid were noted as the easiest groups to identify by clinics. Fewer clinics ranked identifying newly-enrolled Marketplace/HCIP or other (non-Marketplace) private insurance as “easy.”

FIGURE VIII-17. RATING OF EASE OF IDENTIFYING PATIENT GROUPS



Clinics were asked if they made adjustments to accommodate changes in patient load since the implementation of the Marketplace. Fifty-five (42%) of the 131 respondents indicated that

they made changes to accommodate new patient loads (Figure VIII-18). Changes indicated by responding clinics included adjustments to daily workflow or office hours, hiring or reducing clinical staff, hiring or reducing office staff, increased structural capacity, and other changes. The most common change was adjustments to daily workflow; 81.8% of clinics indicated adjustments to daily workflow. Larger proportions of clinics stated they hired additional clinic (32.7%) or office (29.1%) staff compared to those who stated a reduction in clinic (3.6%) or office (1.8%) staff. The trend in responses overall indicated increased staff or structural capacity to accommodate additional patient loads. "Other" changes noted by respondents through open text included the following:

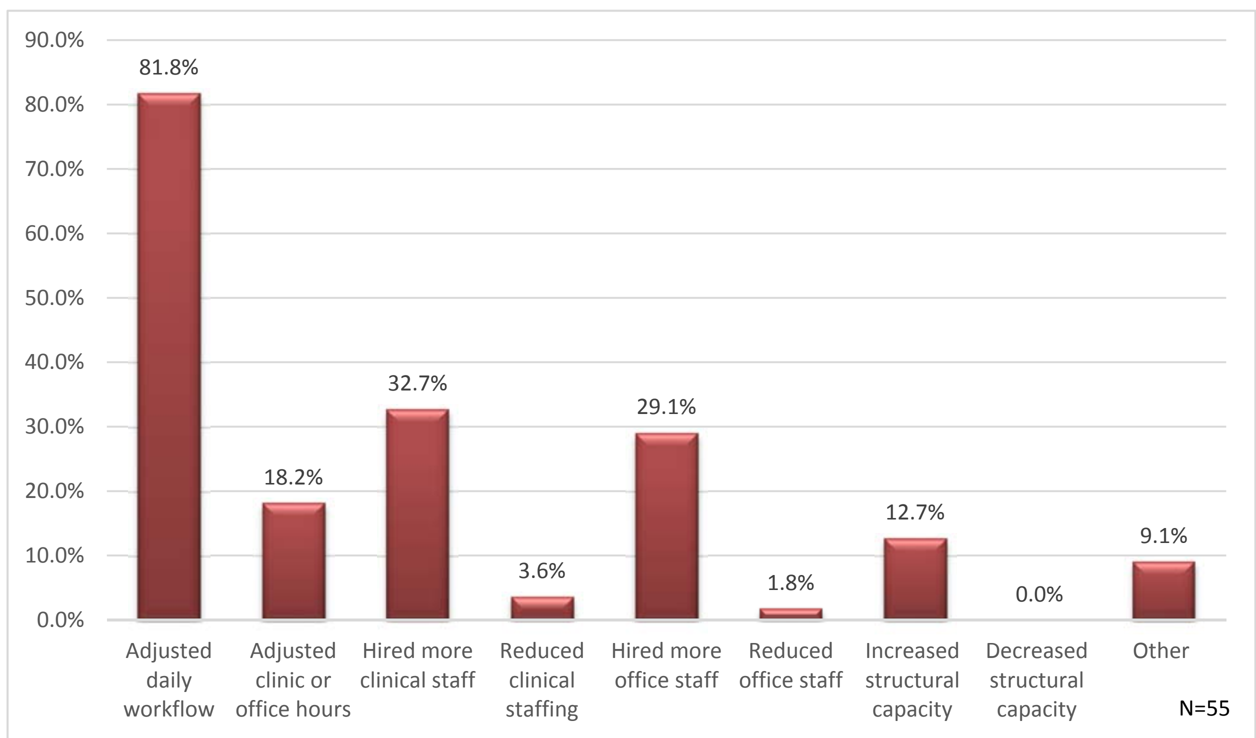
> *"Workload increased for everyone but cannot afford to hire anymore employees!"*

> *"Due to government help for insurance premiums we are less likely to accommodate a free exam."*

> *"Excessive time on government regulations."*

> *"Had to educate patients regarding what their insurance will pay - having to be more aggressive collecting copays and deductibles because patients are ill informed regarding what their insurance covers."*

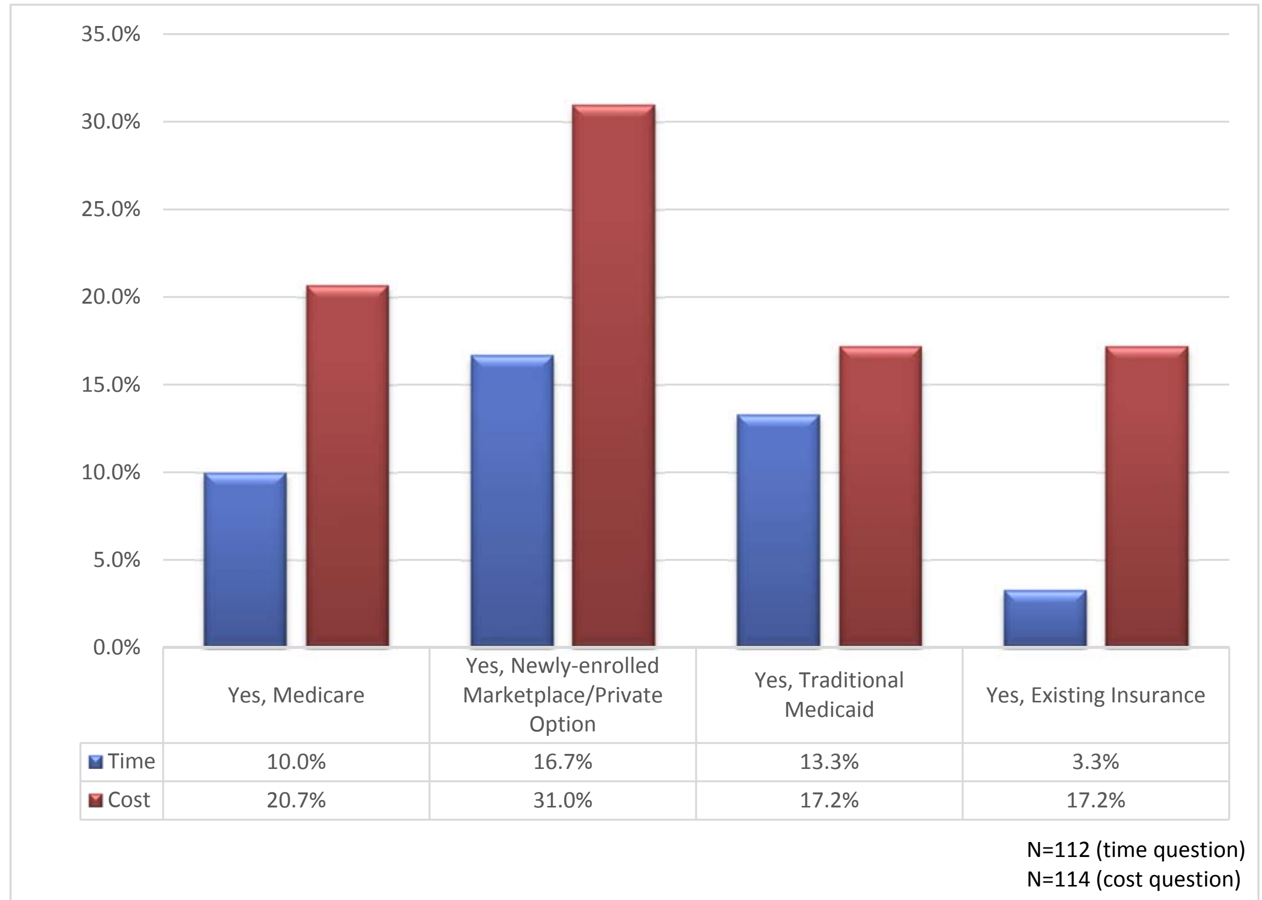
FIGURE VIII-18. CLINIC ADJUSTMENTS TO ACCOMMODATE CHANGES IN PATIENT LOAD



An additional question asked survey respondents to select whether they were at full capacity or taking new types of patients. Only 11.2% of the 116 respondents who answered the question were at full capacity. The largest proportion of clinics indicated they were accepting patients with existing insurance (85.3%). A total of 79.3% of clinics indicated they were taking new Marketplace/HCIP patients while fewer clinics indicated they were accepting traditional Medicaid (69%) or Medicare (68.1%) patients.

Two distinct questions were asked to determine the effect of time and cost constraints on the ability of clinics to service Medicare beneficiaries, newly-enrolled Marketplace/HCIP recipients, traditional Medicaid enrollees and individuals with existing insurance. Based on the responses, cost constraints was more of a limiting factor than time to service all types of patients except those with existing insurance (Figure VIII-19). However, the majority of clinics responded that they were able to service all groups of patients; 78.6% when asked about time and 73.7% when asked about cost.

FIGURE VIII-19. EFFECT OF COST AND TIME CONSTRAINTS TO SERVICE PATIENT GROUPS



	Yes, Medicare	Yes, Newly-enrolled Marketplace/Private Option	Yes, Traditional Medicaid	Yes, Existing Insurance
Time	10.0%	16.7%	13.3%	3.3%
Cost	20.7%	31.0%	17.2%	17.2%

UNCOMPENSATED CARE

The percentage of uncompensated care costs were assessed for Q2 (April-June) 2013 and compared to Q2 2014 (Figure VIII-20). Categories of estimated amounts of total uncompensated care each clinic included: $0 - $5000, $5,001 - $15,000, $15,001 - $25,000, $25,001 - $35,000, $35,001 - $50,000, and $50,001 or more. Of the 116 clinics responding to this question, 67% stated no change in uncompensated care. Increases in uncompensated care were reported by 10.3% of the respondents while 22.4% reported decreases in uncompensated care. All increases in patient volume were noted as moving from one category to the next category above it. The majority of clinics reported decreases in uncompensated care which moved across one category or two categories. One clinic reported a decrease in uncompensated care that moved across three categories - from $50,001 or more in Q2 2013 to $15,001-$25,000 in Q2 2014.

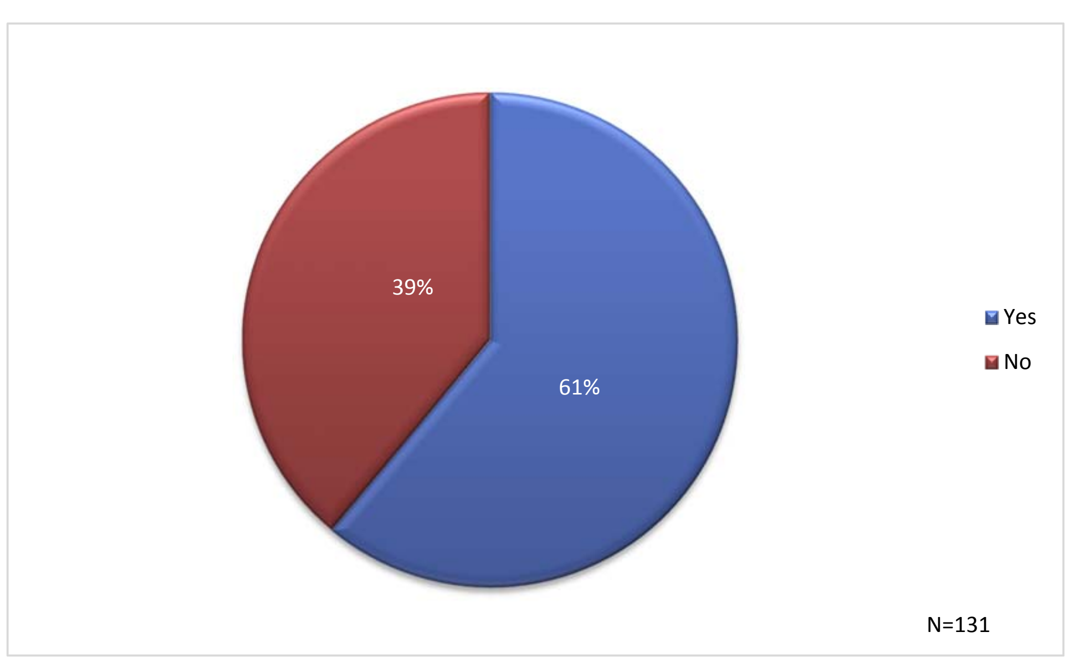
FIGURE VIII-20. UNCOMPENSATED CARE

23%
10%
67%
No change
Increase
Decrease
N=116

MARKETPLACE ASSISTERS

The survey also evaluated whether clinics referred patients to the Marketplace or licensed Marketplace Assisters. Over 60% of the respondents indicated that they referred patients to the Marketplace or licensed Marketplace Assisters to aid with health insurance applications and enrollment. Only 51 of the 131 (38.9%) responding clinics indicated they did not make referrals (Figure VIII-21).

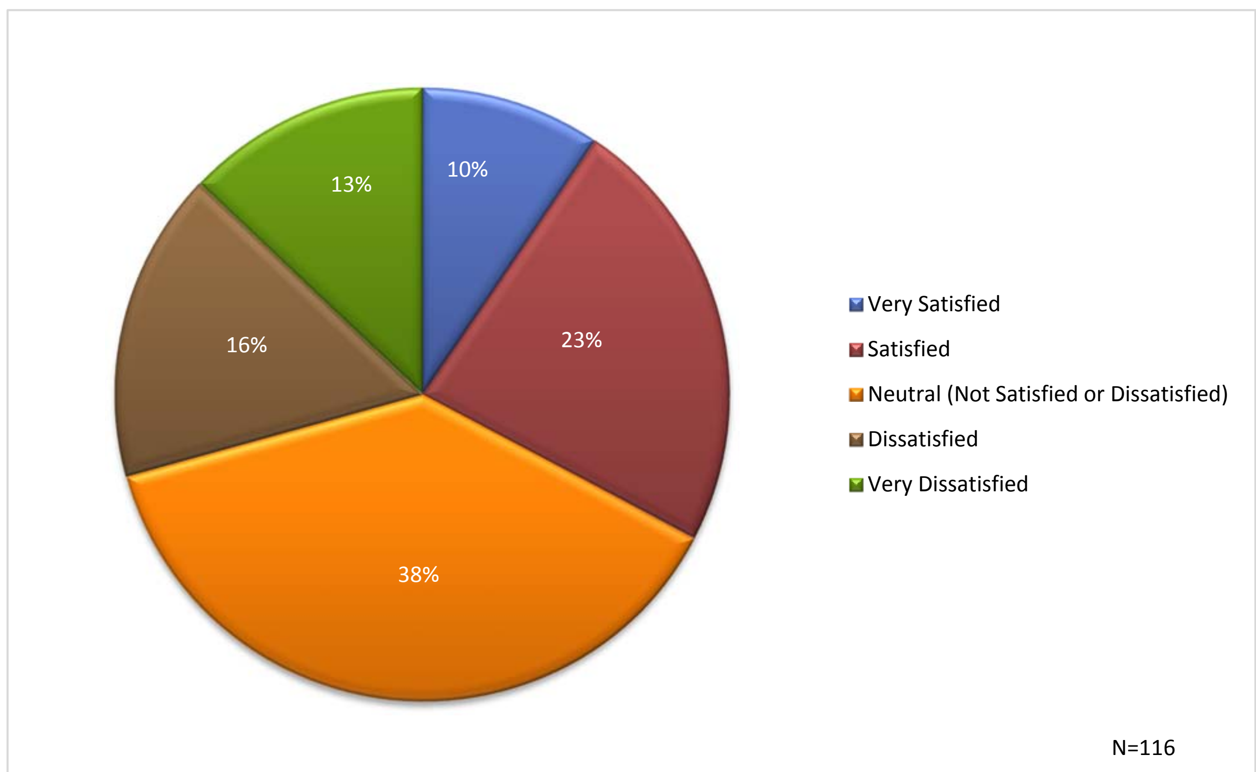
FIGURE VIII-21. CLINICS REFERRING TO THE MARKETPLACE OR LICENSED MARKETPLACE ASSISTERS



EDUCATION

The responding clinics rated their overall satisfaction with education provided to clinic staff regarding the implementation of the Marketplace (Figure VIII-22). A total of 44 of the 116 respondents (37.9%) indicated they were neutral with training. Over 32% of respondents were satisfied or very satisfied and 29.3% were dissatisfied or very dissatisfied.

FIGURE VIII-22. CLINIC SATISFACTION WITH HEALTH INSURANCE MARKETPLACE EDUCATION



Sixty-one clinics provided comments regarding education needs (Table VIII-D). Comments fell within the following categories/themes: general education; eligibility, access, and benefits for the patient and clinic; and billing. Overall, responses indicated more education is warranted and that confusion regarding coverage and access continues.

TABLE VIII-D. EDUCATION COMMENTS

General Education Comments	
Comment 1	Easier access, less confusing.
Comment 2	How to get it, what it covers.
Comment 3	Health Partners
Comment 4	Education would be great to have an organized meeting with presenters. Not webinars or paper mail outs.
Comment 5	We are still not familiar with all of the structure of how the program works.

General Education Comments	
Comment 6	People need to realize that this not affordable for the majority of the working low-income population. It basically covered the college students and unemployed adults that are not disabled.
Comment 7	There needs to be more educational tools in print format for physicians and patients. Also needs to be more meetings on the services.
Comment 8	We starting to see a lot of new patients referred by PCP that are sicker, CKD 3 and up.
Comment 9	Still difficult to get patients enrolled. I'm about the only one in my area that knows what to do and it is because I sought it out; no one came to me with info and I had to dig to get what I did.
Comment 10	It would be helpful to understand exactly what would be covered.
Comment 11	Resources for people to contact who are waiting for cards/coverage; Resources for providers to contact with questions.
Comment 12	Too much to list.
Comment 13	Not sure what you are asking. There was no education done that we are aware of for clinics as a whole. If you mean the general public they are lacking in knowledge as well.
Comment 14	The clinic personnel and public need more education about the Marketplace insurance.
Comment 15	I think people planning and the masses should get real and understand that nothing is free, nothing is free of consequences and realize how much this hurts ourselves. It all sounds good but there has not been real information about true cost -- not about the cost to the individual, not about cost to the business that are actually paying for real insurance that now has increased cost and decreased services while increasing cost sharing, the cost, to the family that now cannot get insurance and does not qualify for any subsidies and may have to pay a penalty. EDUCATION on this subject will be impossible since even the planners and directors have a moving target and we developed a plan that is dependent on another federal level bureaucratic process that also is not based in reality that the state has no control over.
Comment 16	None...have learned from implementation with program
Comment 17	Not much now, unless changes are coming. Then it is critical that all changes are known well in advance to both providers and patients.
Comment 18	All healthcare staff need to be educated

Eligibility, Access, and Benefits (Patient)	
Comment 19	We are a Pediatric office, parents are not willing to give up Medicaid and pay any amount of money when they can receive health care through Medicaid. We only had 2 parents sign up for insurance through the Marketplace because they did not qualify for Medicaid.

Eligibility, Access, and Benefits (Patient)	
Comment 20	People do not realize that if they go directly to the company they may not be eligible for the premium tax credit. People also do not realize that enrollment is at a specified period and you cannot enroll the rest of the year if not enrolled during open enrollment.
Comment 21	Explanation of benefits to patients, ability to verify benefits on date of service.
Comment 22	Where patients can go to apply - we hear that they have been kicked off system when trying to apply thru the exchange. Patients give up because they do not understand.
Comment 23	Education needed to determine what particular plan a patient might have and resources for patient's locally to get help with the marketplace besides the internet.
Comment 24	Most people try the marketplace and cannot get their enrollment finished. Patients receive letters of coverage when in fact, no coverage is in place. We are a small clinic and try to assist as needed but the needs in our area for education in the general population are great.
Comment 25	The public needs to be more informed from the right people (i.e. government officials, assisters, etc.). They are hearing horror stories about the Marketplace from people who had trouble with the first roll-out.
Comment 26	Patients think that they have Obamacare Insurance and that it pays for everything and that we have to see them.
Comment 27	The public needs to be more aware of how the marketplace affects their children's insurance coverage when they turn one year old. Currently they cannot submit an application until the first of the month after their first birthday leaving some children uninsured.
Comment 28	Patients need to know more about the coverage and providers available. ID cards need to indicate if it is a Marketplace policy. Providers need to know if they are in or out of network.
Comment 29	Patients are unclear what coverage they have and therefore, it is almost impossible for us to determine.
Comment 30	More education for the patients. They are not informed enough.
Comment 31	Patients are sometimes unsure what type of coverage they have.
Comment 32	Patients do not understand that they have co-pays and deductibles. Oftentimes they don't know if they have private Marketplace insurance or Medicaid. They are not educated very well.
Comment 33	More education for the person enrolling in the Marketplace for exact benefit coverages and copays.
Comment 34	It would be helpful to have information about the Arkansas Partnership Marketplace to patients that don't have insurance.
Comment 35	Public needs easy access to sign up. For the common person it seems to be overwhelming to even begin. Simply getting started sources would be great.

Eligibility, Access, and Benefits (Patient)	
Comment 36	More education that tests such as MRI, CT are not ordered by the patient because they now have insurance and just want it. The physician must be able to decide what is best for the patient and that they cannot run to the ER or Urgent Care Centers as soon as they leave the office to change what the physician has ordered or the way the patient has been treated. If no antibiotic is ordered they cannot expect to go to either the ER or the UCC and get them.
Comment 37	Detail instructions to enrollee on accessing care.
Comment 38	Realistic expectations for the enrollees; understanding that providers may not be paid for care if the enrollee does not pay their premium --- this is totally unfair to the providers.
Comment 39	Educate the patients as to what their insurance covers.
Comment 40	Most do not understand that they may have a deductible/co-insurance/copay. And many do not understand that there are premiums that must be paid in order to keep their coverage. They are also unaware that the "Private Option" could also require pre-authorizations for testing or other services.
Comment 41	More education for patients regarding what their insurance does and does not cover - patients need to understand that they may be out of pocket still for what their insurance does not cover - they need to understand the difference between Medicare and Medicare advantage programs.
Comment 42	There needs to be consistency in regards to interrupting the benefits as well as education to the patients.

Eligibility, Access, and Benefits (Clinic)	
Comment 43	I don't know where to start. The Marketplace and the ACA were thrown at physicians with the expectation that physicians had plenty of time to take on the new patients and would know how to handle their new insurance. Neither is the case.
Comment 44	There is confusion regarding the "expansion" and regular Medicaid. Several patients have come to us with both Medicaid and expansion coverage or two Medicaid numbers leaving us unsure about what number to file with.
Comment 45	A better explanation of what each plan covers.
Comment 46	More education....attending Medicaid conference on 11th.
Comment 47	More instructions on which insurances and what procedures need pre-certification.
Comment 48	No marketplace education was provided for private specialty practices. Since enrollment was a disaster and covered individuals may or may not have been appropriately identified, financial obligation was difficult to determine. Websites are not updated with correct information in a timely manner and the provider, as well as the patient, is left with unacceptable financial issues.

Eligibility, Access, and Benefits (Clinic)	
Comment 49	More onsite provider visits to explain the changes
Comment 50	How and when children will be covered by insurance on the exchange.
Comment 51	The content is good; the frequency needs to be expanded. It is much better for the education to be coming from a central organization rather than from our clinic. It appears to be self-serving, plus it takes away from our ability to care for patients.
Comment 52	It is almost impossible to identify the Private Option patients when they get the commercial card...then the trouble really starts...it is a mess.
Comment 53	Started poorly. No one knew what to do. Has settled down, but hard to find what benefits for wellness and other information, if not standard office visit. Must have card number to find. No other information will help.
Comment 54	More information as to what plans are out there, who the major company is that is writing the plans, fee schedule, and better way to verify insurance that patient states they have, how to tell traditional Medicaid from marketplace.
Comment 55	Need to find a better/faster way to do eligibility checks on insurances.
Comment 56	Not enough information provided to providers to advise their patients on what to do or where to go to get signed up on the Marketplace for insurance.
Comment 57	Education on the ability to identify insurance. We have had patients with as many as three Medicaid ID numbers. One patient started out on Medicaid and unbeknownst to the patient he had Ambetter. Everyone needs educated.
Comment 58	Notification of upcoming changes would be great. Would also appreciate being able to easily identify those who are in a "grace period."
Comment 59	We need to educate PROVIDERS into the benefits of the private option!!
Comment 60	Education on what is covered and what is not.

Billing	
Comment 61	There needs to be education as far as billing and what the Marketplace options pay for and what they don't. The education that we received last year was very inadequate. NO one knew anything until after everything was in place. Our offices have to bill codes in order to find out that they will not be paid for and then we have to write them off.

OTHER COMMENTS

Additional input was requested through an open-ended response option. Comments were provide by clinics and noted in Table VIII-E. Three comments were not included in this summary which were specific to the process of filling out the survey.

TABLE VIII-E. ADDITIONAL COMMENTS

Comment 1	Additional Insurance is great for the patients that qualify but we are starting to see a trend where patients have not paid their premiums or like Medicaid is not retroactively covering-such as newborn not picking up at birth, etc.
Comment 2	We have had a few problems with premiums not being paid and services not being paid because of that issue. (Respondent is referring to a previous comment given under education: "There is confusion regarding the "expansion" and regular Medicaid. Several patients have come to us with both Medicaid and expansion coverage or two Medicaid numbers leaving us unsure about what number to file with.")
Comment 3	Workshops for any individual need training. Go to Clinics Go to Hospitals. Sometimes these seminars do not get filtered to the people that really need to know. All your front line staff need to know
Comment 4	This insurance is anything but affordable.
Comment 5	Maybe information in a provider's office to hand out to patients.
Comment 6	There is now an additional burden of getting prior authorizations for patients needing diagnostic procedures.
Comment 7	People with Private Option are abusing the privilege of FREE medical care. I believe if they had to pay a co-pay this would stop.
Comment 8	It has improved our census and patients see their outpatient doctors now rather than going to ER
Comment 9	This worked out poorly. I tried to amp my practice up to capitalize on this but there was NO information available for practice planning. As it worked out it wasn't necessary. The patient interest did not respond like I thought it would. There was only a trickle of patients that didn't amount to anything of significance. Now we have to watch closely to make sure they paid their premium. If the government didn't pay the premium we saw no one pay out of pocket for this. Pretty much a high priced failure. The only ones sticking with this are the dopers.
Comment 10	Patients need more education on what they will have coverage for.
Comment 11	Need to make the cards more recognizable so the front desk will know to check AHIN to make sure premiums have been paid.
Comment 12	Need to educate the patients about what their insurance covers.
Comment 13	Not a fan of the marketplace. We lost many of our private insurance patients to self-pay because they can't afford their plans. The marketplace took middle class patients' insurance away and gave us more Medicaid patients, which of course takes away revenue not to mention the fact that many hardworking people no longer have

	insurance.
Comment 14	The patient load and the compensation are relatively the same, but some of those that had insurance have lost it, and others have gained it which balanced it all to be about the same. And those that lost it, may have new insurance, but their deductibles are outrageous and we are the brunt of their anger that they now have more to pay out of pocket than they had before. We have several who do not have insurance, state that they don't qualify for the Marketplace and Medicaid. And they can't afford any other insurance. And many are very apprehensive about the coming changes in the new year.
Comment 15	Good job. We love Private Option.
Comment 16	I am a firm believer of a FREE marketplace. Having this government funded marketplace is not just another "Private Option". THIS has regulations in it tied with the federal enforcement of regulations and taxes that automatically cripple the competition-- real Private Options. IF you note the real private insurance groups are still around, still making money as it is all passed on to the consumers at the individual and corporate level. Good business will stay in business and the poor ones will fail. The false belief that federal money is "free" money is just that ...FALSE. It all costs someone and usually the people that pay taxes. We have over 50 percent of our country that are takers only. The tax payers are in decline and having to pay more and more at and ever unsustainable rate will eventually break us as a nation. Arkansas cannot continue down this road and should back up, be responsible and work within our means to pay our bills. Put in better incentives for people to work and get paid. Then they will spend their money to pay other people and that will stimulate our economy and actually help. As a small business owner the last person out of work at my company will be me. The first to go will be "extra services" like the person that helps clean my house, the crew I pay to keep my lawn, the people I pay to teach my kids dance, piano, guitar. The city baseball and soccer teams I sponsor corporately, the individual fees to play those same sports. The new car for the older kids that are starting to drive, the extra payment to the insurance companies on the cars that I may not drive. No more vacations, spending money to have people in a job to provide services for people to be entertained. When we get closer to having only enough to survive -- there is less money for other services and let's face it, we become another nation or state that is unattractive. This extra cost to the working only creates more "working poor" and actually takes more jobs. Maybe not directly but the point of the "extra" things listed above are the indirect costs associated with making everything cost more with more regulatory burden and oversight.

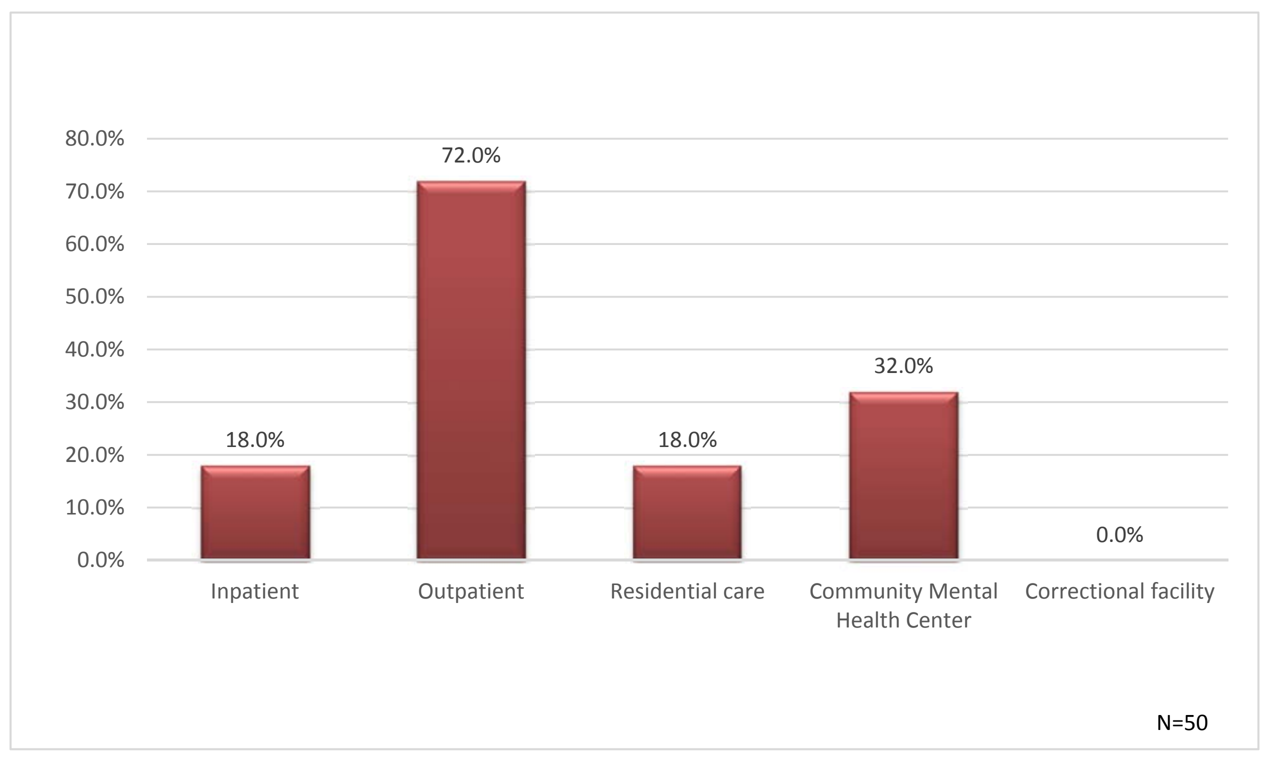
AID BEHAVIORAL HEALTH SURVEY SUMMARY

RESPONDENT CHARACTERISTICS

A total of 50 behavioral health facilities contacted responded to the survey distributed by AFMC. The majority of respondents, 72%, were outpatient facilities (Figure VIII-23). Community

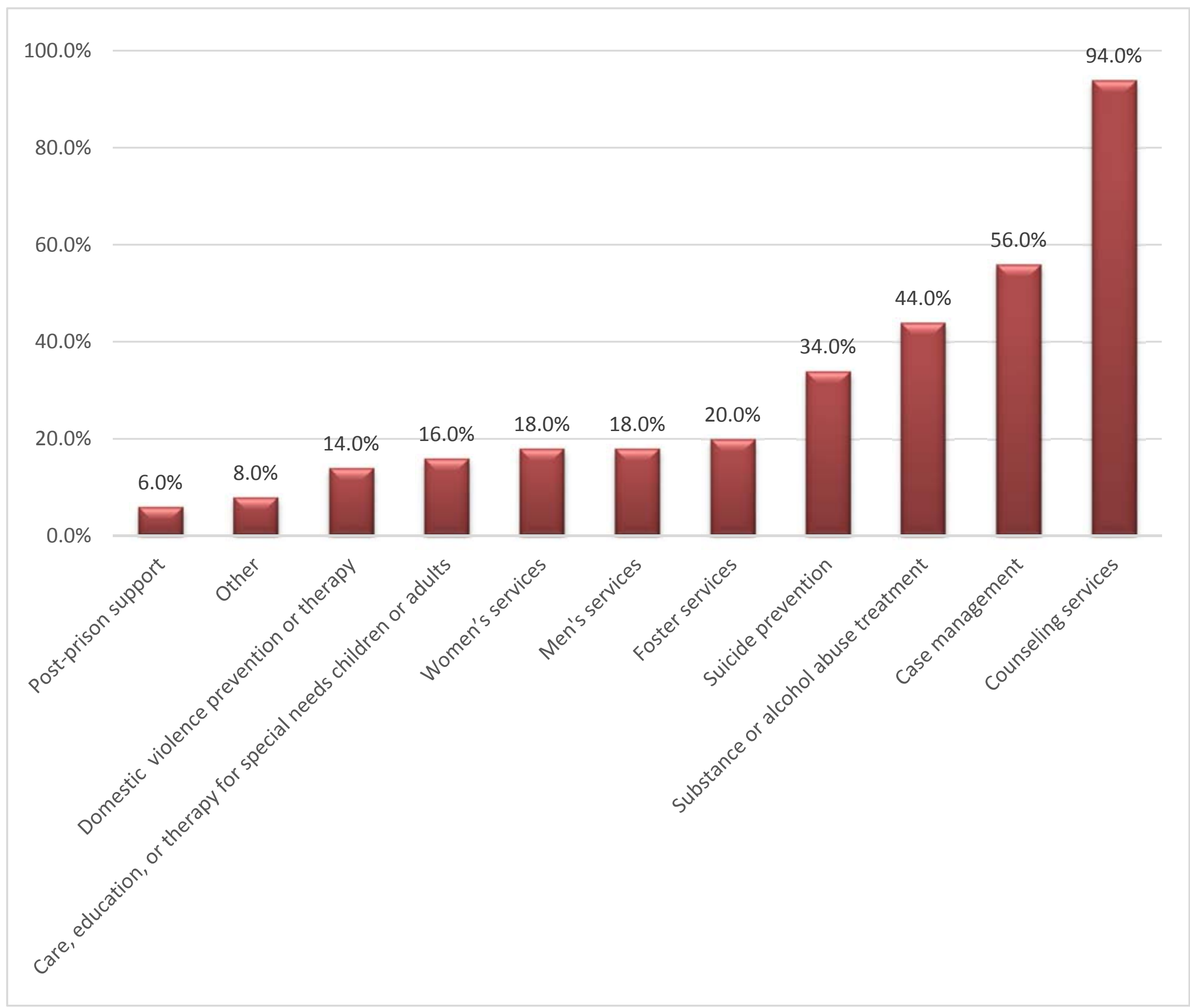
mental health centers (32%), residential care (18%) and inpatient facilities (18%) were also noted as facility types.

FIGURE VIII-23. FACILITY TYPE



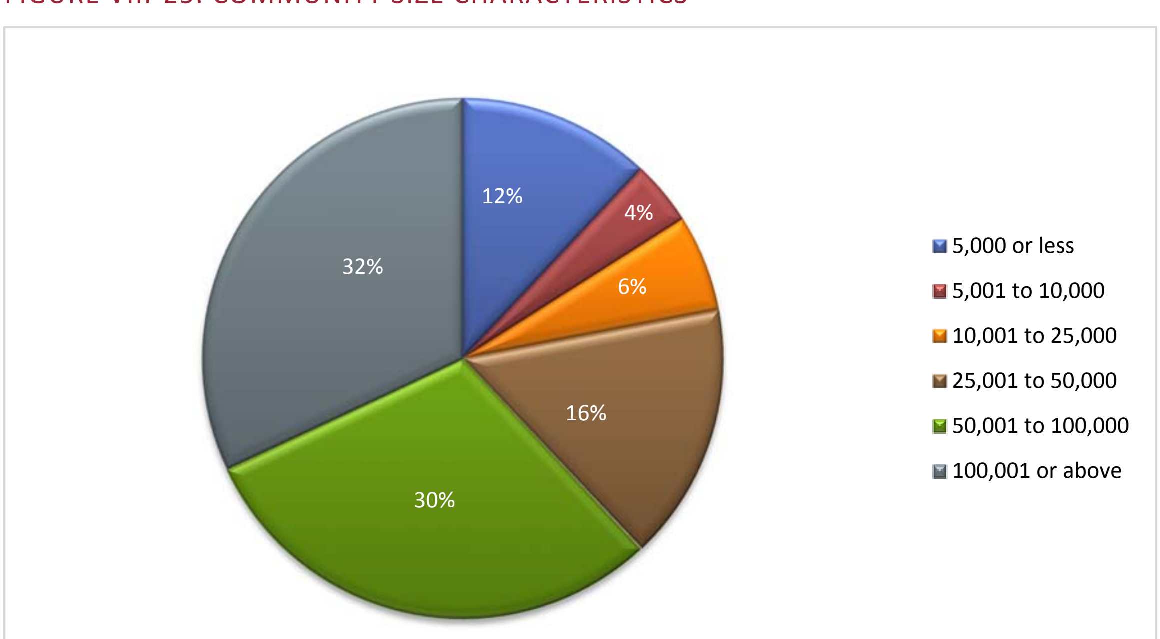
Facilities were asked to classify the majority of care they provide (Figure VIII-24). Ninety-four percent responded that they provide counseling services. Over half of the facilities provided case management services. There was also a focus among facilities on substance or alcohol abuse treatment (44%) and suicide prevention (34%). Various other services were noted by facilities including foster services (20%), men's services (18%), women's services (18%), services for special needs children or adults (16%), domestic violence support services (14%) and post-prison support (6%). Four facilities indicated "Other" and stated that the type of care provided was parent education, psychiatric care and medication maintenance, child and adolescent in-patient stabilization, and intensive day treatment services.

FIGURE VIII-24. TYPE OF CARE



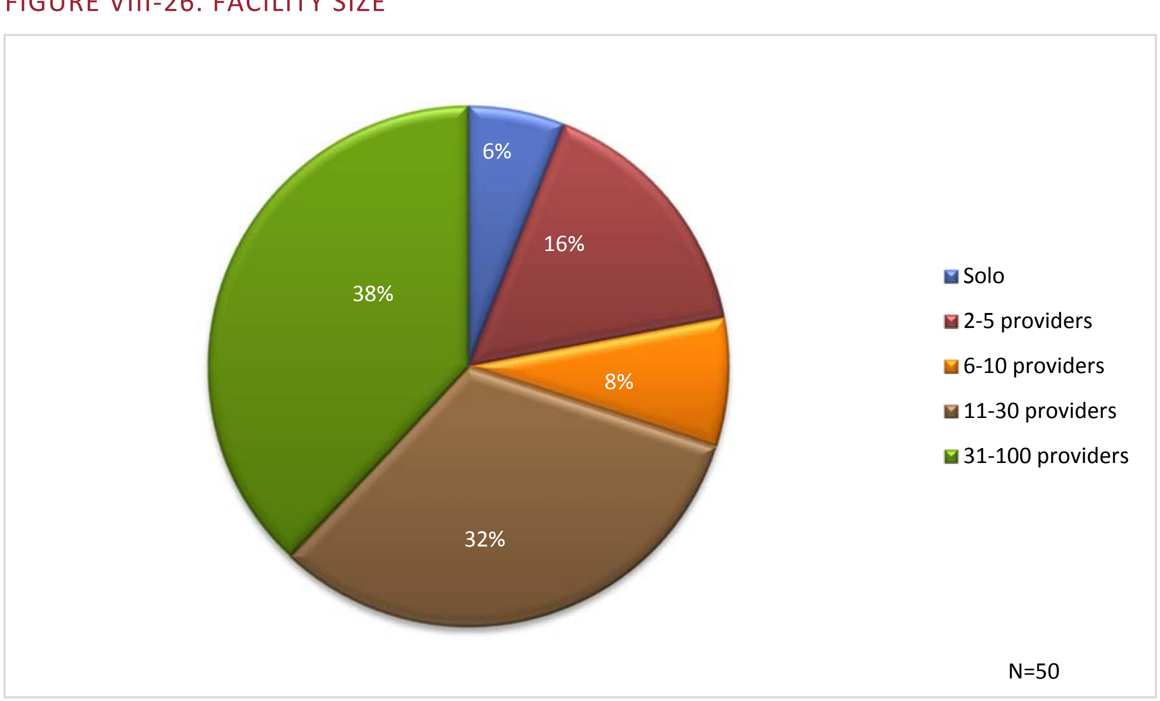
The size of the community serviced by respondent behavioral health facilities was also captured through the survey (Figure VIII-25). A total of 78% of responding facilities served communities with 25,001 or more residents. Fewer responding behavioral health facilities served smaller communities: six percent of facilities served areas with 10,001 to 25,000 community members, four percent served 5,001 to 10,000 community members and 12% served communities with 5,000 or less residents.

FIGURE VIII-25. COMMUNITY SIZE CHARACTERISTICS



Facility size was also assessed among survey respondents (Figure VIII-26). Behavioral health facilities that responded to the survey were larger in size; 38% reported 31-100 providers in their practice and 32% reported 11-30 providers. Facilities with 6-10 providers represented 8% of respondents while facilities with 2-5 providers represented 16%. Only 6% of behavioral health facilities responding to the survey were solo practices.

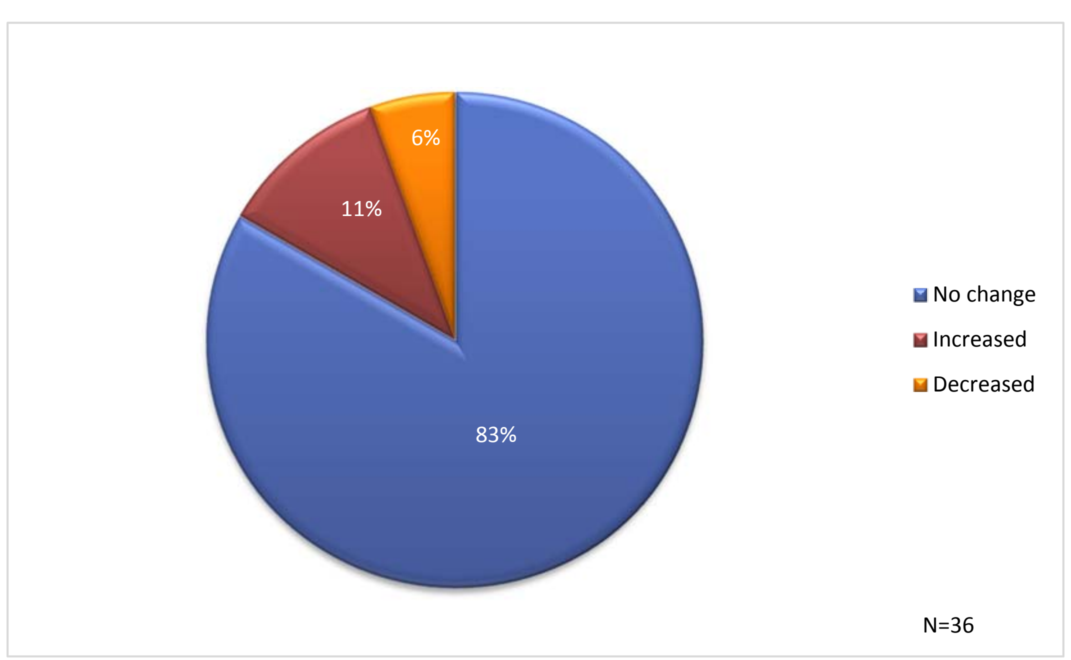
FIGURE VIII-26. FACILITY SIZE



CHANGES IN PATIENT VOLUME

Behavioral health providers were asked the average number of patients their practice services for the time periods before and after the Marketplace was established (Figure VIII-27). Categories of average weekly patient volume included: 1-75, 76-150, 151-200, 201-250, 251-350, and 351 or above. Of the 36 respondents, 83.3% stated no change in inpatient admission volume. Increases in patient volume was reported by 11.1% of the respondents while 5.6% reported decreases in patient volume. All increases in patient volume were noted as moving from one category to the next category above it. Of facilities that reported a decrease, one facility moved across three categories while the other facility moved across one category.

FIGURE VIII-27. PATIENT VOLUME



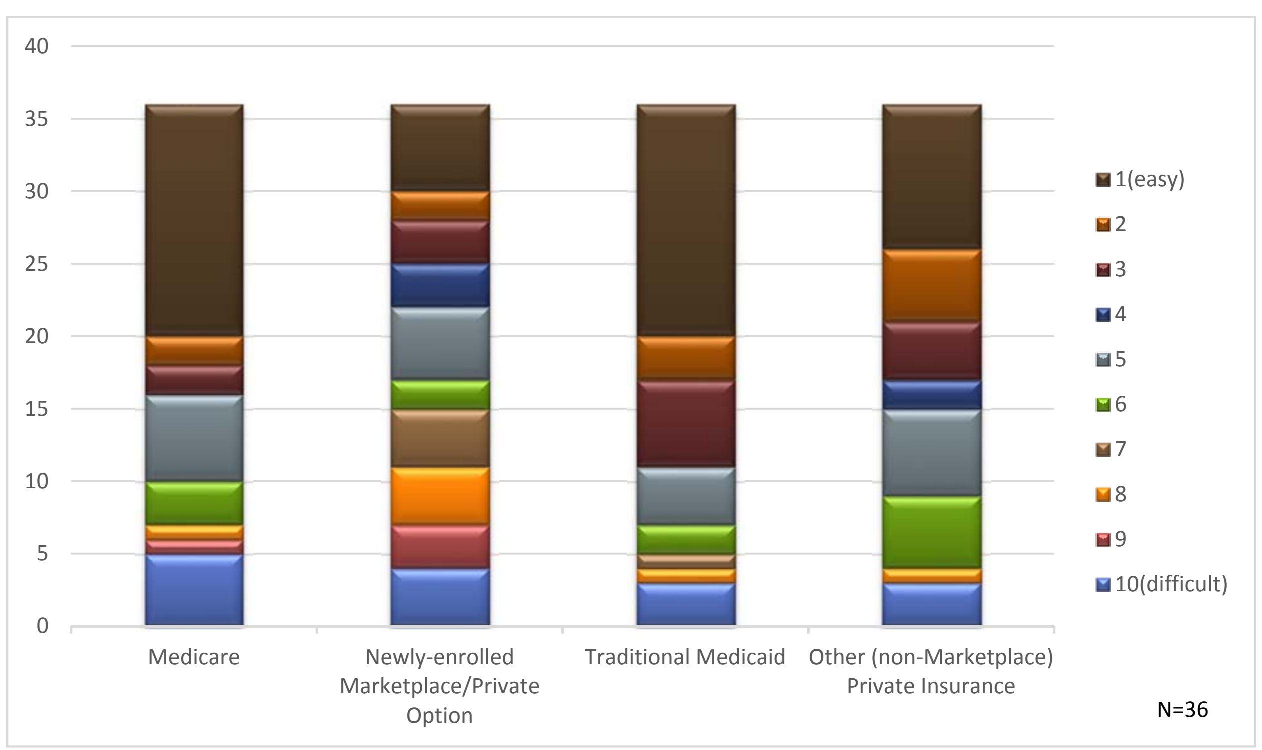
A total of 36 participating behavioral health providers responded with the percentage of patients before and after the SPM was established. Categories of patients included Medicare, Medicaid, private insurance (including those newly-insured through the Marketplace/HCIP), self-pay, indigent or other types not included in the list. Twenty-six (72.2%) of the providers indicated there were differences in the make-up of the patients seen at their facility. Overall, fewer changes were noted in Medicare, self-pay and other patient populations. During the same time period, 66.7% of respondents to this question indicated more private insurance, Marketplace, and HCIP patients after the establishment of the Marketplace. Providers also indicated that less indigent or Medicaid patients were seen at their facility.

TABLE VIII-F. DIFFERENCES IN PERCENTAGE OF PATIENTS AFTER SPM ESTABLISHED

	Medicare	Medicaid	Private/Market/PO	Self-pay	Indigent	Other
More patients	19.4%	11.1%	66.7%	11.1%	2.8%	0.0%
Less patients	8.3%	30.6%	0.0%	16.7%	36.1%	11.1%
No change	72.2%	58.3%	33.3%	72.2%	61.1%	88.9%

Participating behavioral health facilities were asked to indicate their ease or difficulty in identifying patients with health insurance from Medicare, newly-enrolled Marketplace/HCIP, traditional Medicaid, or other (non-Marketplace) private insurance (Figure VIII-28). Medicare and Medicaid was noted as the easiest groups to identify by providers. Fewer facilities ranked identifying newly-enrolled Marketplace/HCIP or other (non-Marketplace) private insurance as "easy."

FIGURE VIII-28. RATING OF EASE OF IDENTIFYING PATIENT GROUPS



Behavioral health facilities were asked if they made adjustments to accommodate changes in patient load since the implementation of the Marketplace. Over half of the 36 respondents indicated that they made changes to accommodate new patient loads (55.6%). Changes indicated by responding clinics included adjustments to daily workflow or office hours, hiring or reducing clinical staff, hiring or reducing office staff, increased structural capacity, and other changes (Figure VIII-29). The most common change was adjustments to daily workflow; 55% of

facilities indicated adjustments to daily workflow. Larger proportions of clinics stated they hired additional clinic (45%) or office (20%) staff compared to those who stated a reduction in clinic (10%) or office (5%) staff. The trend in responses overall indicated increased staff or structural capacity to accommodate additional patient loads. Additional changes behavioral health facilities noted as “Other” through comments are included in Table VIII-G.

FIGURE VIII-29. CHANGES TO CLINIC TO ACCOMMODATE CHANGES IN PATIENT LOAD

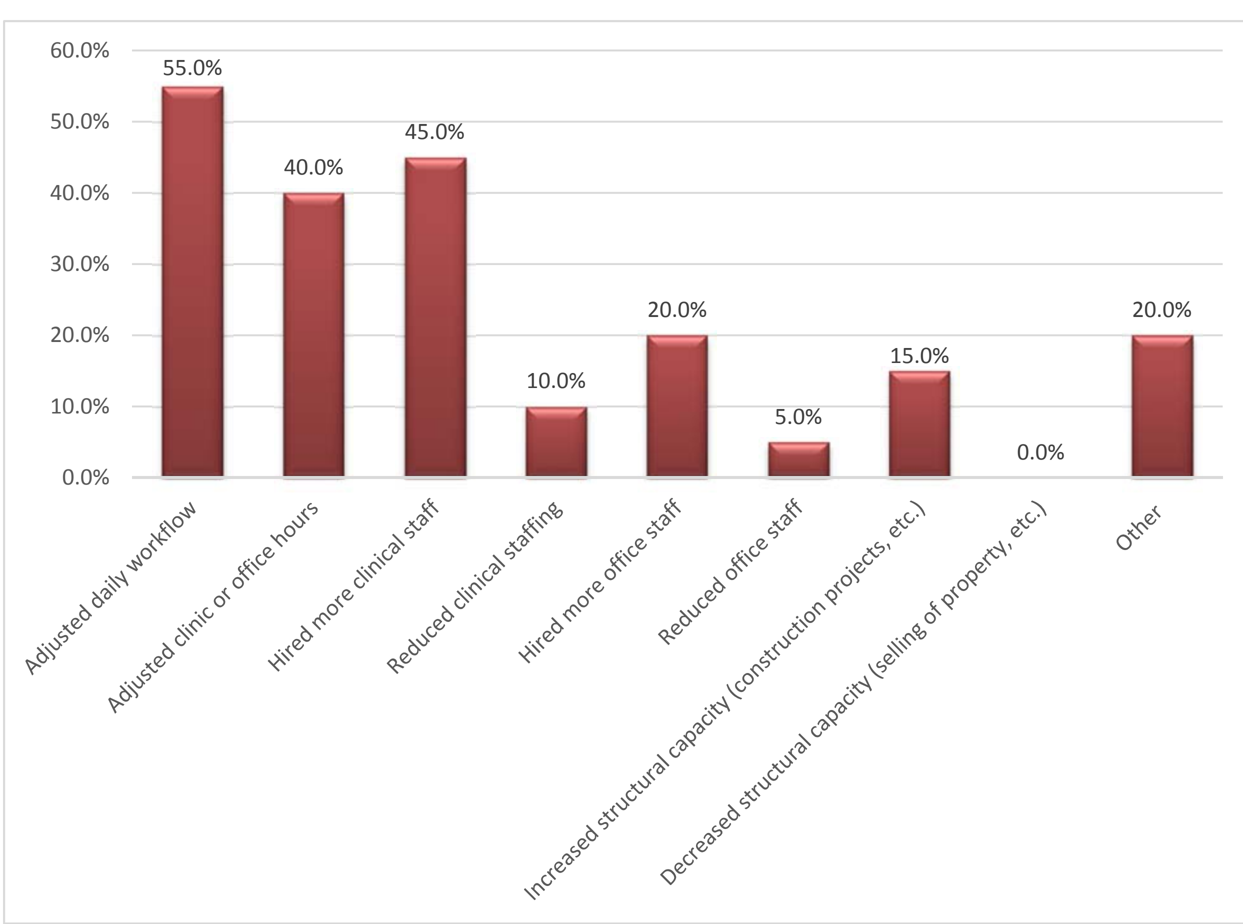


TABLE VIII-G. ADDITIONAL COMMENTS REGARDING FACILITY CHANGES

Comment 1	Terminated employment of some staff who did not meet the criteria of a provider and hired different staff who do meet this criteria.
Comment 2	Cannot find enough higher licensure clinicians who qualify to provide insurance coverage. We are also having shortages with psychiatrist coverage.
Comment 3	As director of emergency service we have been able to place clients that were previously indigent in private hospitals using Private Option.
Comment 4	Hired Someone with Private Billing Experience & Credentialing Specialist.

The survey also assessed whether respondents were at full capacity or taking new types of patients. Only 6.7% of the 30 respondents who answered the question were at full capacity. The largest proportion of behavioral health providers indicated they were accepting patients with existing insurance (96.7%). A total of 86.7% of providers indicated they were taking new Marketplace/ HCIP patients while fewer clinics indicated they were accepting traditional Medicaid (73.3%) or Medicare (43.3%) patients.

Two distinct questions were asked to determine the effect of time and cost constraints on the ability of behavioral health providers to service Medicare beneficiaries, newly-enrolled Marketplace/HCIP recipients, traditional Medicaid enrollees and individuals with existing insurance. Based on the responses, cost constraints was more of a limiting factor than time to service all types of patients (Figure VIII-30). However, a large proportion of behavioral health providers responded that they were able to service all groups of patients; 73.3% when asked about time and 48.3% when asked about cost.

FIGURE VIII-30. EFFECT OF COST AND TIME CONSTRAINTS TO SERVICE PATIENT GROUPS

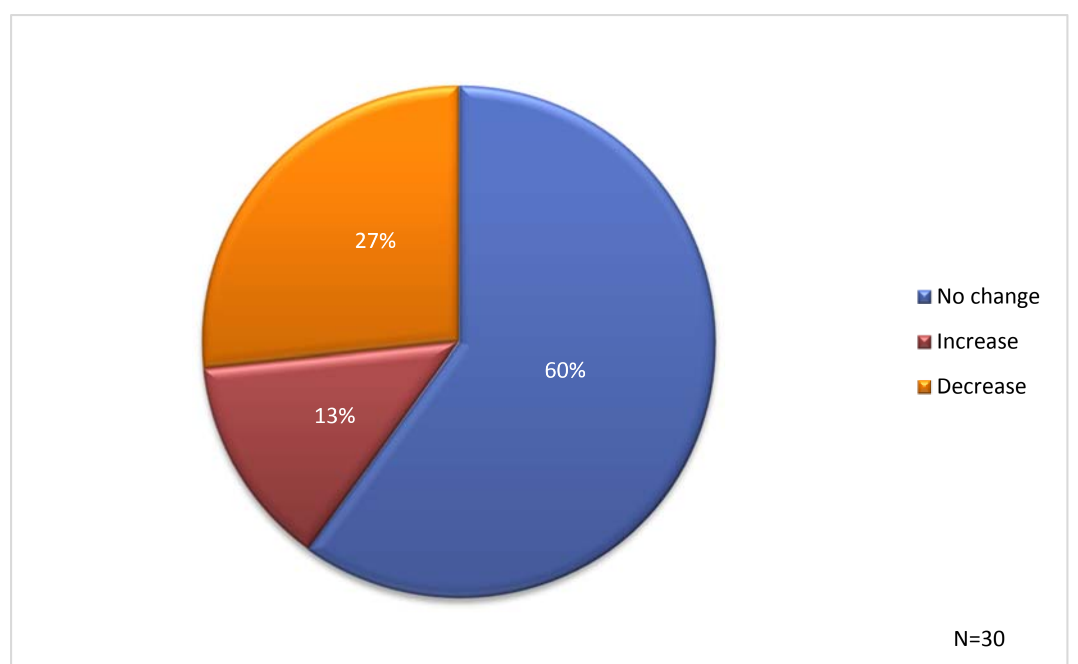
	Yes, Medicare	Yes, Newly-enrolled Marketplace/Private Option	Yes, Traditional Medicaid	Yes, Existing Insurance
Time	10.0%	16.7%	13.3%	3.3%
Cost	20.7%	31.0%	17.2%	17.2%

N=30 (time question)
N=29 (cost question)

UNCOMPENSATED CARE AND UNINSURED VISITS

The percentage of uncompensated care costs were assessed for Q2 (April-June) 2013 and compared to Q2 2014. Categories of estimated amounts of total uncompensated care each facility provided included: $0 - $5000, $5,001 - $15,000, $15,001 - $25,000, $25,001 - $35,000, $35,001 - $50,000, and $50,001 or more. Of the 30 providers who responded to this question, 60% stated no change in uncompensated care. Increases in uncompensated care were reported by 13.3% of the respondents while 26.7% reported decreases in uncompensated care. All increases in patient volume were noted as moving from one category to the next category above it. The majority of facilities that reported decreases in uncompensated care moved across one category; only one facility that reported a decrease in uncompensated care moved across two categories.

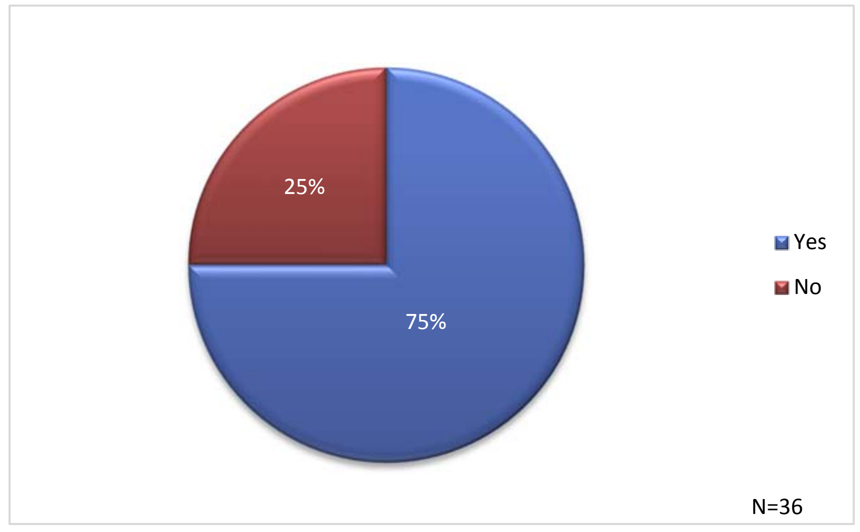
FIGURE VIII-31. UNCOMPENSATED CARE



MARKETPLACE ASSISTERS

The survey also evaluated whether behavioral health facilities referred patients to Marketplace Assisters. Seventy-five percent of the respondents indicated that they referred patients to licensed Marketplace Assisters to aid with health insurance applications and enrollment (Figure VIII-32).

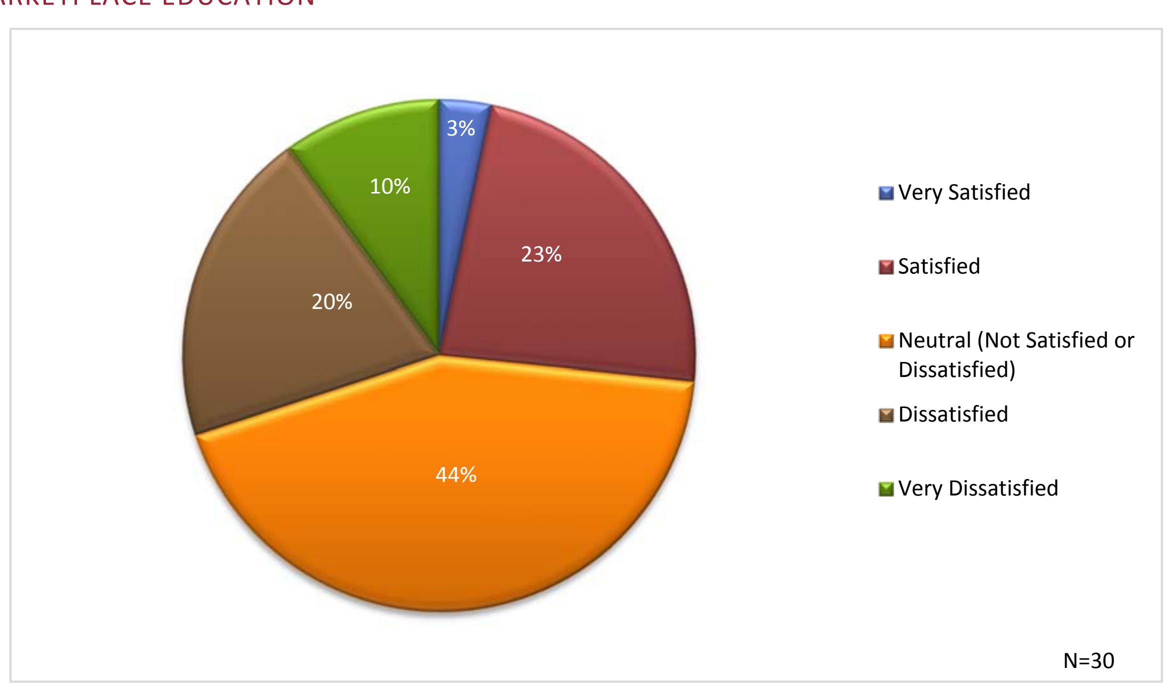
FIGURE VIII-32. BEHAVIORAL HEALTH PROVIDERS REFERRING TO THE MARKETPLACE OR LICENSED MARKETPLACE ASSISTERS



EDUCATION

The responding behavioral health providers rated their overall satisfaction with education provided to their facility regarding the implementation of the Marketplace (Figure VIII-33). Over 40% of the respondents indicated they were neutral with regard to education provided by AID. Just over one quarter of the respondents were very satisfied/satisfied with training and 30% of respondents were dissatisfied/very dissatisfied.

FIGURE VIII-33. BEHAVIORAL HEALTH PROVIDER SATISFACTION WITH HEALTH INSURANCE MARKETPLACE EDUCATION



Education comments addressed both provider concerns and needed education for patients. Participants provided overall general education comments; eligibility, access and benefits comment that applied to either the patients or the clinic; and requests for additional billing education. A full listing of the comments provided are included in Table VIII-H. Based on the ratings and responses, improvements in the education for behavioral health staff and patients is warranted.

TABLE VIII-H. EDUCATION COMMENTS

General Education Comments	
Comment 1	Training for facilities providing services.
Comment 2	Basic continuing education for providers and consumers
Comment 3	Continued education.
Comment 4	More education as to how this impacts service delivery in general, what this means for possible clientele, and how partnerships are anticipated to work.
Comment 5	Refresher course to help provide information to clients and their families.

Eligibility, Access and Benefits (Patient)	
Comment 6	That certain individuals can meet criteria for marketplace plans such as Blue Cross, QualChoice, or others and they don't necessarily have to go on Medicaid which can be restraining to choice of providers since we cannot take Medicaid.
Comment 7	Where to sign up, how to sign up and how to gain access to Private Option
Comment 8	I believe the education provided to service providers and service recipients is good but think it would be helpful to better educate the general public who seem unaware (admittedly political agendas are contributing to this) of the advantages of establishing standards for insurance or the advantages of a decrease cost to the public sector by having expanded coverage for substance abuse treatment which if left until later phases of pathology is extremely expensive.
Comment 9	Most clients found they could not apply on-line.
Comment 10	Recipients have huge deductibles that they can't afford to pay. They are not familiar with how private insurance works. Also, we are finding some recipients are being enrolled in market place insurance when they clearly meet eligibility for traditional Medicaid.
Comment 11	With regard to behavioral health care: New ACA insurance frequently does not cover behavioral health providers or services, and it sometimes has high deductibles that make care inaccessible. Individuals and legislators may benefit from education regarding the significant barriers to care the marketplace has created for access to outpatient behavioral health services for a low income population, especially in comparison to traditional Medicaid. With regard to access to other health care: ACA does provide

	improved access to hospital and some other outpatient care. Individuals would benefit from more overall exposure and education regarding the marketplace. In person assisters at points of service would also help with this.

Eligibility, Access and Benefits (Clinic)	
Comment 12	They need to fix how private insurance comes ups on the MCD site like its MCD coverage. Not the marketplace.
Comment 13	Education Needed: How do we know what insurance the client has, the benefits of that insurance, any copays etc. In the beginning we thought that all of the Medicaid expansion clients were going to be BCBS now we are finding that they can be different insurances which causes problems with assigning them to providers who are registered with that insurance. We have had to refer clients elsewhere because we are not in network with their providers. If they had all been given Medicaid instead of insurance it would have been much easier for the providers. We are very familiar with the Medicaid registration process and guidelines. We did not receive much information about the Market Place in reference to our business. We have had to call and get pieces of information as they were available. Patients came in with Medicaid cards but we later found out that they would be switching over to Private Insurance at "some point" which was a month by month thing. We billed regular Medicaid until it stopped paying claims and then we knew they were switched over to BCBS of Arkansas. Sometimes this would require a therapist change because not all Mental Health Professionals that are paid by Medicaid are also paid by BCBS. Within the past month we have learned that just because a patient has "Medicaid expansion" that doesn't necessarily mean they will be having BCBS they may be assigned to other insurance companies. This is a big problem because we do not have therapists that are registered with all insurances as each registration is a tedious process. While the Marketplace has benefits of providing care to people who previously did not have insurance coverage in my opinion we would have benefited more by putting the funds toward Traditional Medicaid.
Comment 14	Benefit amounts from differing plans, including deductibles, co-pays, etc. Also, what are the actual benefits for residential, outpatient, etc.
Comment 15	How to navigate through the system to verify benefits.
Comment 16	Better understanding of what the policy coverage actually means.
Comment 17	There are some concerns about which health care plan goes first if there are two differences in plan colors (silvers, metallics) that we sought out information for via conferences, workshops, etc...I noticed that many of the providers had the same questions.
Comment 18	The following areas need to be addressed with all providers: AHIN usage and time lines Private Option Insurance types and required service mix (silver, metallic, etc.) Co-payment options (if deferred process).

Billing	
Comment 19	Billing
Comment 20	Billing info
Comment 21	Reimbursement education, what is covered and not covered. Basically we knew nothing when we took these patients on. We have just had to figure it all out on our own.

OTHER COMMENTS

Participants were asked to provide additional comments or feedback not covered by survey questions. The six additional comments given by behavioral health providers are listed in Table VIII-I**.** Two of the six (33.3%) respondents indicated that the changes in insurance benefited both their clinic and/or patients while the remaining four (66.7%) participants indicated there are still barriers to address for behavioral health.

TABLE VIII-I. ADDITIONAL COMMENTS

Comment 1	The insurance changes have helped my facility immensely.
Comment 2	I feel it is a disparity because the same clinicians who can see Medicaid should be able to see clients in the Marketplace. All clinicians are governed by their licensure board and should be eligible. It has cause a barrier to services being provided.
Comment 3	Our clinic and clients have benefited from the Private Option insurance
Comment 4	We have discovered how to work with the changes but it was difficult. Our staff have struggled to make the changes to service more clients. The information given was too broad and not enough hands on training was given.
Comment 5	Behavioral health benefits through the Private Option marketplace are very limited in comparison to traditional Medicaid.
Comment 6	Marketplace needs to allow LAC's and LMSW therapists to provide services. Services need to be available in place of service. "Schools" - this is one of the best community service integrations that has happened in the past decade. Throttling outpatient services by severely restricting them in a state that is already mostly underserved is a mistake and will lead to more inpatient bed days.

IX. DEVELOP A YEAR TWO PLAN FOR ONGOING EVALUATION

Objective nine for the current evaluation was designed to use the lessons learned from the first-year evaluation in combination with the prior evaluation plans to make recommendations for future evaluation planning. The original evaluation plans for the SPM involved analysis of implementation activities, outcomes associated with implementation of the SPM, and cost-effectiveness of the different activities associated with implementation. The major activities included in the initial evaluation planning included the development and fielding of a large scale consumer survey, qualitative interviews to assess implementation activities, and identification and analysis of utilization and cost data. This section describes future evaluation planning in relation to the major activities and original goals outlined in prior plans.

CONSUMER SURVEY INFORMATION

The first year evaluation of the SPM relied on data from a consumer survey developed and fielded by the evaluation team. The information from the consumer survey was instrumental in understanding the characteristics of enrollees, their satisfaction with the enrollment process, and other measures specific to accessing health care following enrollment. We strongly believe that additional surveys of consumers should be conducted in future years as the SPM goes forward, but suggest that consideration be given to new questions and emphasis consistent with new approaches to engaging consumers.

The consumer survey for the current report focused heavily on questions concerning the use of navigators and IPAs in purchasing or obtaining health insurance on the SPM. Questions on all aspects of the navigators and IPAs were relevant because of their central role in assisting consumers. Indeed, several of the current overall evaluation objectives focused on the IPAs and navigators because of the central role they were to play in helping consumers obtain insurance. However, the use of IPAs and navigators to assist consumers was curtailed by the Arkansas state legislature. The consumer survey fielded in this evaluation found that a fairly small percentage (28%) of people used IPAs, navigators, agents, or other professionals for help in obtaining insurance. Of the 28% who used assistance, approximately 40% of people relied on a commercial agent. However, we did find evidence that enrollees who used in-person assistance were much more likely to believe it was “definitely easy” to choose a health plan and somewhat more likely to be satisfied with their overall plan.

Given the relatively low number of enrollees that used in-person assistance and the large percentage that used an agent to enroll, the consumer survey should reduce the number of questions related to navigators and IPAs. The role of IPAs and navigators remains important, but without full scale efforts to use IPAs and navigators for consumer assistance, other

questions should be prioritized. For example, information from a marketing approach may provide more useful information. Questions should focus on:

- How consumers navigated the SPM
- Why consumers obtained insurance in the first place – health concerns, issues with penalties for not having insurance, or other reasons
- Whether consumers are aware of SPM branding and other messages in support of the SPM
- Whether consumers need services currently provided or not provided by the SPM

Other questions with the survey should be retained, especially CAHPS items that can be compared to national benchmarks. Our survey data indicated that the SPM fared better on some items relative to national benchmarks and worse on others. For example, we were able to compare overall health of participants in the SPM to national benchmarks using a categorical measure of health that asks about both physical and mental health. The health status categories include: excellent, very good, good, fair, and poor health. Categorical measures of health, while frequently used, could be supplemented by more sensitive measures of health that are currently collected in large national surveys. Instruments such as the EQ5D have more sensitivity to clinical changes and should provide much better estimates of health over time in Arkansas and in comparison to the rest of the country.

HEALTH CARE UTILIZATION AND EXPENDITURES

The prior evaluation plans placed considerable emphasis on determining utilization of services and overall expenditures. In particular, concerns were raised about monitoring inappropriate utilization of emergency department services and inpatient hospitalizations with the intent of reducing utilization over time. The prior plans also called for monitoring health expenditures at the plan level, by issuers, and overall for the state. To achieve these objectives, evaluators were expected to obtain claims data, electronic health record information, or other sources of data that provide summary measures of expenditures and utilization.

The first year evaluation could not address all of the planned analyses because of the inability to obtain claims or other electronic data. We were able to assess variation in premiums at the plan level and across issuers and regions of the state. However, it was not possible to assess questions related to utilization of services and overall health expenditure patterns because of insufficient data infrastructure during the first year.

The recent passage of Arkansas Act 1233 to create the Arkansas Transparency Initiative of 2015 could lead to significant enhancements in data infrastructure for SPM evaluation activities that maintains data privacy. A major issue with obtaining claims data and other sources of patient information involves privacy issues and these issues could be a roadblock for many initiatives seeking to measure expenditures and utilization at the individual level. With

the data infrastructure available from the creation of an all payer claims database (APCD), evaluators would be able to study a number of metrics related to the SPM including:

- Trends in per capita emergency department use
- Trends in per capita hospitalization use
- Overall expenditures by public and private payers
- Prices for bundles of services provided by public and private payers
- Per member per month expenditures by public and private payers

With simple identifiers added to datasets maintained within the APCD, a number of questions concerning SPM enrollees can be addressed. Most importantly, the datasets need identifiers for plan type, broad income category designations consistent with current coinsurance regulations, and whether the individual is purchasing subsidized insurance or obtaining insurance through the HCIP. With these identifiers, it will be possible to address whether consumers are making rational choices with respect to insurance purchases, and whether care quality is similar across plan types and marketplaces. The creation of the APCD may also assist in understanding potential crowd-out effects from the creation of the SPM. It is possible and likely that the current structure of the SPM is generating enrollment from persons previously covered under employer-sponsored health insurance. Knowledge of the extent of crowd-out and the implications for SPM costs over time are an important consideration for future evaluations.

COST-EFFECTIVENESS OF IMPLEMENTATION ACTIVITIES

With the transition of SPM implementation from the AHCD at AID to the Arkansas Health Insurance Marketplace (AHIM), there will be considerable interest in understanding the cost-effectiveness of implementation activities. The transition to AHIM moves the SPM from a state/federal partnership program to a state-based exchange and creates a need to evaluate the cost-effectiveness of different activities. The current evaluation did not address cost effectiveness of the different activities as there was more interest in overall effectiveness in the first year.

Several issues related to the cost-effectiveness of implementation activities under the new management structure could be considered. One consideration is the potential for new branding activities to influence overall enrollment and guide consumers to cost-effective resources for navigating the SPM. This evaluation did not focus on branding as an implementation activity, although there is potential value from understanding the implications of branding on consumer enrollment. Consideration should be given to the creation of a new name for the SPM such as “ConnectAR” that emphasizes the connection to the state and raises awareness and procedures for enrolling in the SPM. If consumers are more aware of the SPM

and procedures for enrolling, it would reduce the need for other, and potentially more costly, methods for consumers to find information about enrolling in the SPM.

We believe in a renewed focus on increasing enrollment in the SPM as the pool of potential enrollees remains large and all of the subsidies for enrolling are paid by the federal government, not the state. As implementation of the SPM goes forward, it will be important to assess whether the benefits of implementing the SPM through increased access to health services, improved health outcomes and health security, exceed the costs to the state and the federal government.

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I-A. MASTER INTERVIEW GUIDE FOR EVALUATION OF GOVERNANCE PROCESSES

OVERALL PROJECT MANAGEMENT

- What roles have you had in the Arkansas Health Benefits Exchange (Arkansas Health Connector) Project?
- What have been the main successes of the project so far, in your opinion?
- What challenges have you personally faced in doing your work for this project?
- What have been the main challenges for the project overall?
- What is your opinion of the overall management of the project?
- (For AID only): Has the management contractor been effective? Can you provide examples?
- (For AID only): What have been the challenges you have faced in working with the management contractor?
- How would you characterize the quality of communication between AID and the contractor?
- Is there anything you think should be done differently in project management going forward?

STEERING COMMITTEE &/OR ADVISORY COMMITTEE MEMBERS:

- In your opinion, have all types of relevant stakeholders been involved in the committees? Are there any stakeholder types that are missing or inadequately represented?
- Did you feel that you had a “seat at the table” in your participation on the SC/AC? Have you felt engaged in the process overall?
- Did some stakeholders seem to have a greater voice in the committee? If so, what kinds of stakeholders?
- Who led the meetings?
- Was there adequate opportunity for you to voice your opinions, questions, or concerns? How were they received by the committee?
- Were your opinions or concerns taken into account in recommendations or final decisions? Can you provide an example?
- Did some individuals dominate meeting discussions (aside from those who had to present information to the group), or were discussions balanced between a variety of participants?
- Did you feel that decisions were driven by particular kinds of stakeholders, or did everyone have relatively equal input? Can you provide any examples?

- Is there anything that could be done differently to make you feel more engaged in committee activities going forward?
- Do you think the committee has been effective in conducting its mission? How could effectiveness be improved?
- What have been the primary successes of the committee thus far, in your opinion?
- What have been the main challenges in the committee's work so far, in your opinion?
- What are the remaining challenges as you see them?
- What recommendations do you have for improving the committee's work going forward?

POLICY MAKERS:

- What roles have you had in the planning, development, and/or implementation of the Arkansas State Partnership Health Insurance Marketplace?
- What is your overall opinion of the implementation of the Arkansas State Partnership Health Insurance Marketplace?
- What challenges still need to be addressed for optimal program performance?
- What suggestions do you have for resolving these issues?

AID DIVISIONS:

- What role did your division play in the planning, development, and/or implementation of the Arkansas State Partnership Health Insurance Exchange?
- What was your role in particular?
- How would you characterize the communication between your division and other divisions during these processes?
- How could communication be improved, if needed?
- What have been the primary successes of the program, as you see them?
- What have been the main challenges?
- What challenges remain, and how might they be addressed?
- What other suggestions do you have for improving the program going forward?

II-A. OUTREACH AND EDUCATION VENDOR AND CONSTITUENT INTERVIEW GUIDES

MASTER INTERVIEW GUIDE FOR OUTREACH AND EDUCATION VENDORS

OVERALL OUTREACH AND EDUCATION EFFORTS

- What role did you play in the planning, development, and/or implementation of the outreach and education efforts completed by your organization?
- What activities did your organization perform as a part of your outreach and education efforts?
- Did your organization perform activities or provide services to increase participation in outreach and education activities that were not a part of your contract with the Arkansas Insurance Department?
- Did your organization measure the effectiveness of your outreach and education activities? If so, how did you measure the effectiveness of an outreach and education activity?
- Which outreach and education activities do you feel were most effective?
- Why do you feel the _____________ activity was more effective? (List each activity)
- Which education and outreach activities were not effective? Why do you feel these education and outreach activities are not effective?
- Did your organization work with IPA to increase awareness of education and outreach activities?

COUNTY-BASED OUTREACH AND EDUCATION EFFORTS

- Were your organization's education and outreach activities more effective in some counties than other?
- If so, why do you feel your organization's outreach and education efforts were more effective in some counties than others?

AWARENESS OF THE ACA AND MARKETPLACE

- What activities did your organization perform to impact change in consumer awareness of the ACA and Marketplace?
- Did your organization measure pre and post outreach and education efforts implementation success of consumer awareness of the ACA and Marketplace?
- If so, how did you measure pre and post outreach and education efforts implementation success of consumer awareness of the ACA and Marketplace?

- Which activities do you feel were most successful in increasing awareness of ACA and the Marketplace?
- In your opinion, how do you feel the outreach and education efforts in Arkansas increased the awareness and knowledge of the ACA and Marketplace?

SUCCESSES AND CHALLENGES OF OUTREACH AND EDUCATION EFFORTS

- In your opinion, what were the main successes of your organizations outreach and education efforts?
- What challenges did your organization faced in conducting outreach and education efforts?
- What were the main challenges for the outreach and education efforts overall?
- In your opinion, what challenges did the communities in which you provided outreach and education activities face?
- Were there specific populations your organization was not able to reach? If so, why was your organization unable to reach these specific populations? How would you characterize the working relationship between your organization and AID? What successes and challenges did your organization experience working with AID?

OVERALL EXPERIENCES

- What do you think will be the overall impact of terminating the outreach and education efforts?
- Is there anything you think should have been done differently in implementing outreach and education efforts?
- Please provide any additional feedback on outreach and education activities.

MASTER INTERVIEW GUIDE FOR OUTREACH AND EDUCATION CONSTITUENTS

OVERALL OUTREACH AND EDUCATION EFFORTS

- Did your organization participate in any outreach and education activities?
- If so, which outreach and education activities did your organization participate in?
- Which outreach and education activities do you feel were most effective? Why do you feel the _____________ activity was more effective? (List each activity)
- Which education and outreach activities were not effective? Why do you feel these education and outreach activities are not effective?
- In your opinion, what were the primary successes of the outreach and education activities/training?
- In your opinion, what were the main challenges of the outreach and education activities/training?
- Is there anything you think should have been done differently in implementing and conducting outreach and education activities?
- Please provide any additional feedback on outreach and education activities.

IV-A. GUIDE MANAGEMENT SYSTEM FIGURES

FIGURE 1

FIGURE 2

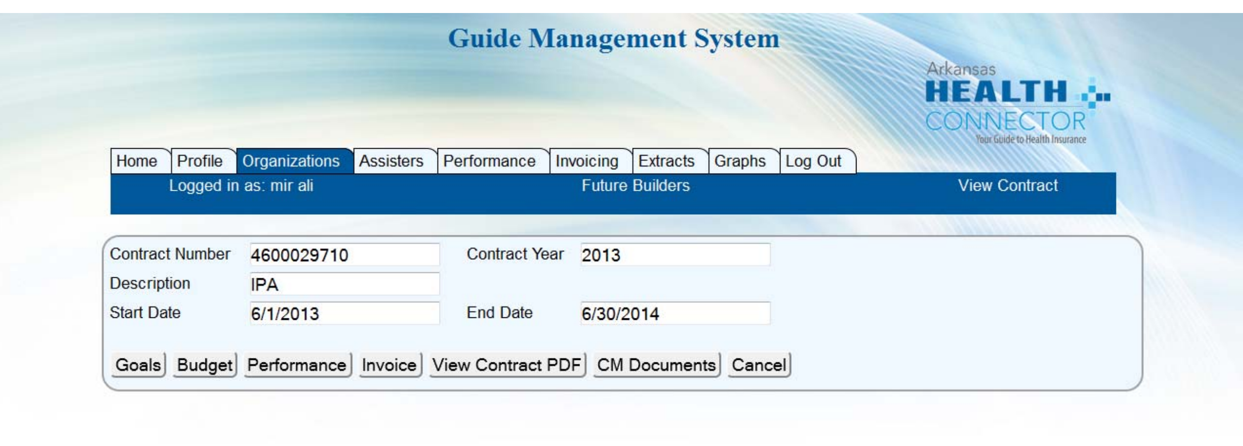


FIGURE 3

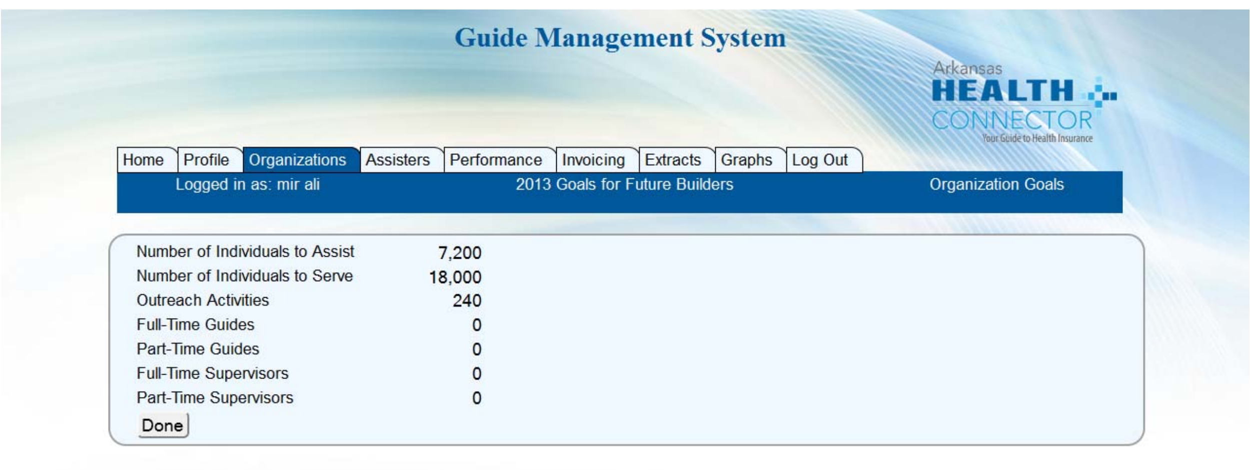
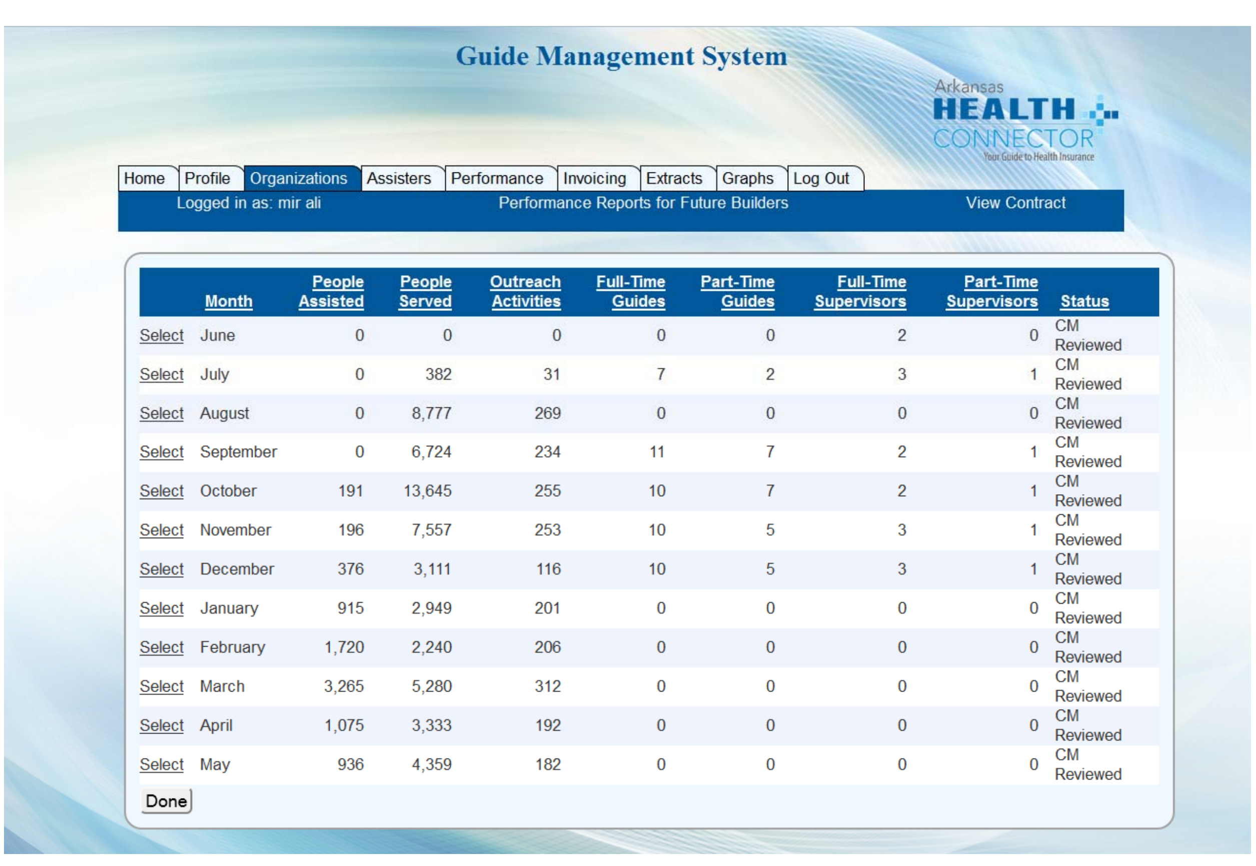


FIGURE 4

FIGURE 5



Guide Management System

Arkansas HEALTH CONNECTOR Your Guide to Health Insurance

Home | Profile | Organizations | Assisters | Performance | Invoicing | Extracts | Graphs | Log Out

Logged in as: mir ali   Performance Reports for Future Builders   View Contract

	Month	People Assisted	People Served	Outreach Activities	Full-Time Guides	Part-Time Guides	Full-Time Supervisors	Part-Time Supervisors	Status
Select	June	0	0	0	0	0	2	0	CM Reviewed
Select	July	0	382	31	7	2	3	1	CM Reviewed
Select	August	0	8,777	269	0	0	0	0	CM Reviewed
Select	September	0	6,724	234	11	7	2	1	CM Reviewed
Select	October	191	13,645	255	10	7	2	1	CM Reviewed
Select	November	196	7,557	253	10	5	3	1	CM Reviewed
Select	December	376	3,111	116	10	5	3	1	CM Reviewed
Select	January	915	2,949	201	0	0	0	0	CM Reviewed
Select	February	1,720	2,240	206	0	0	0	0	CM Reviewed
Select	March	3,265	5,280	312	0	0	0	0	CM Reviewed
Select	April	1,075	3,333	192	0	0	0	0	CM Reviewed
Select	May	936	4,359	182	0	0	0	0	CM Reviewed

Done

FIGURE 6

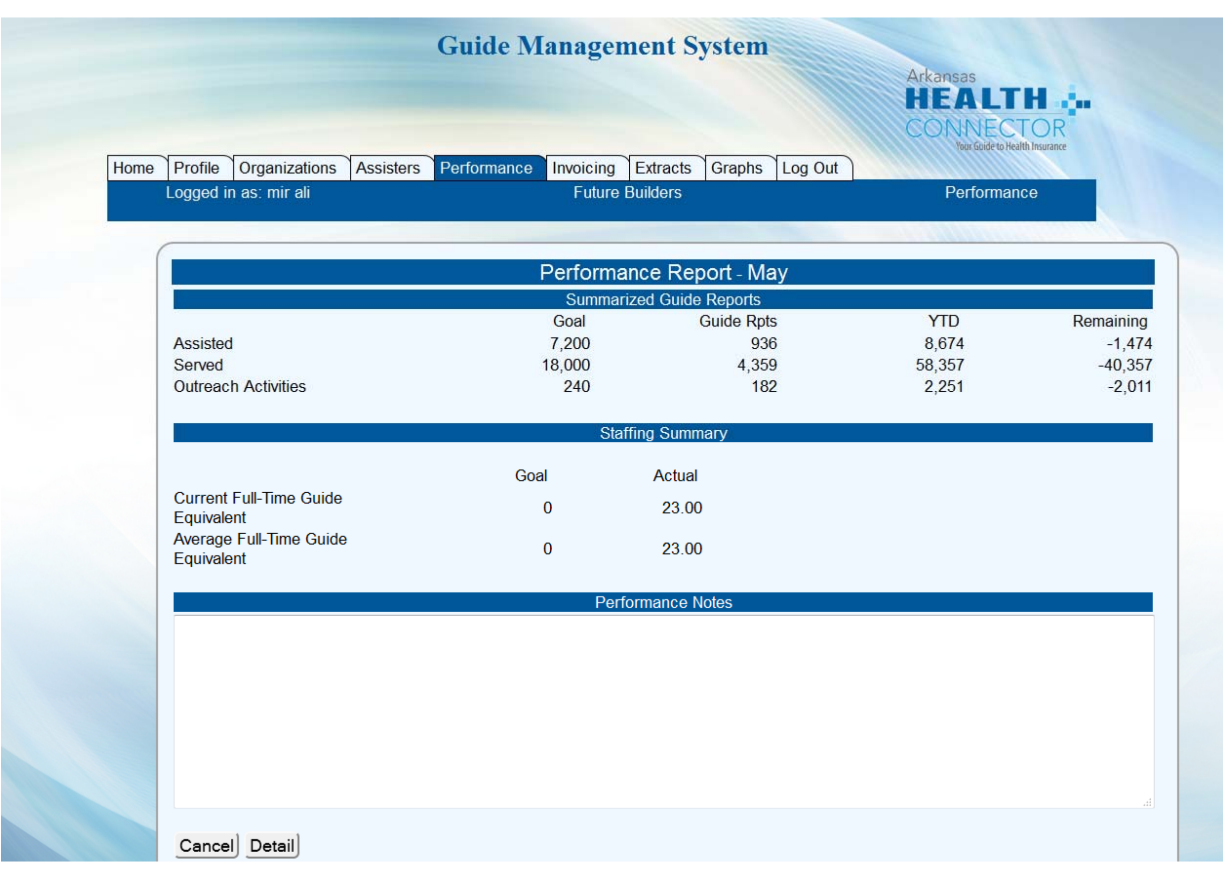
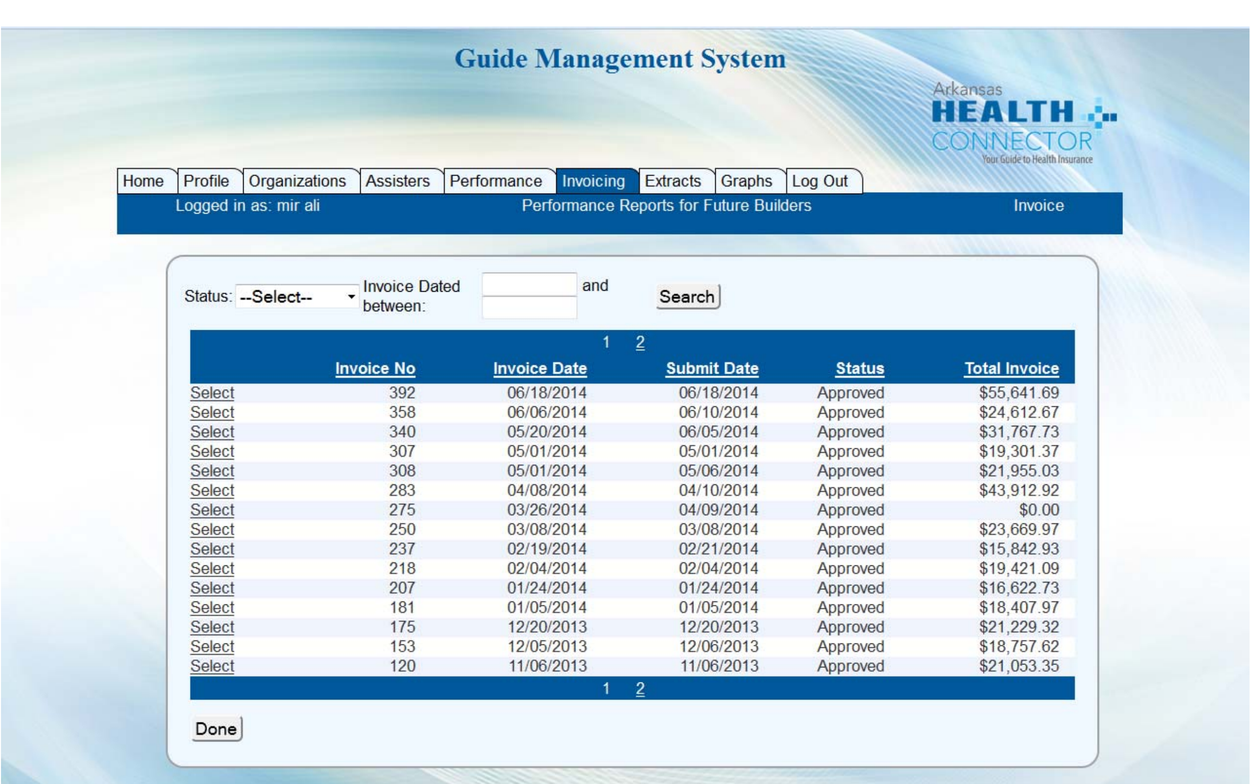


FIGURE 7

FIGURE 8



	Invoice No	Invoice Date	Submit Date	Status	Total Invoice
Select	392	06/18/2014	06/18/2014	Approved	$55,641.69
Select	358	06/06/2014	06/10/2014	Approved	$24,612.67
Select	340	05/20/2014	06/05/2014	Approved	$31,767.73
Select	307	05/01/2014	05/01/2014	Approved	$19,301.37
Select	308	05/01/2014	05/06/2014	Approved	$21,955.03
Select	283	04/08/2014	04/10/2014	Approved	$43,912.92
Select	275	03/26/2014	04/09/2014	Approved	$0.00
Select	250	03/08/2014	03/08/2014	Approved	$23,669.97
Select	237	02/19/2014	02/21/2014	Approved	$15,842.93
Select	218	02/04/2014	02/04/2014	Approved	$19,421.09
Select	207	01/24/2014	01/24/2014	Approved	$16,622.73
Select	181	01/05/2014	01/05/2014	Approved	$18,407.97
Select	175	12/20/2013	12/20/2013	Approved	$21,229.32
Select	153	12/05/2013	12/06/2013	Approved	$18,757.62
Select	120	11/06/2013	11/06/2013	Approved	$21,053.35

FIGURE 9

FIGURE 10

FIGURE 11

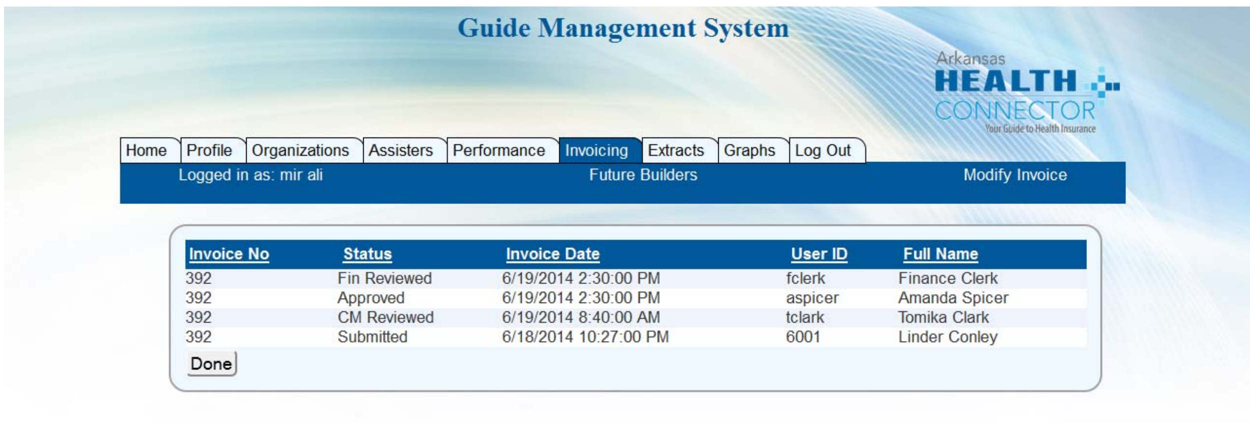


FIGURE 12

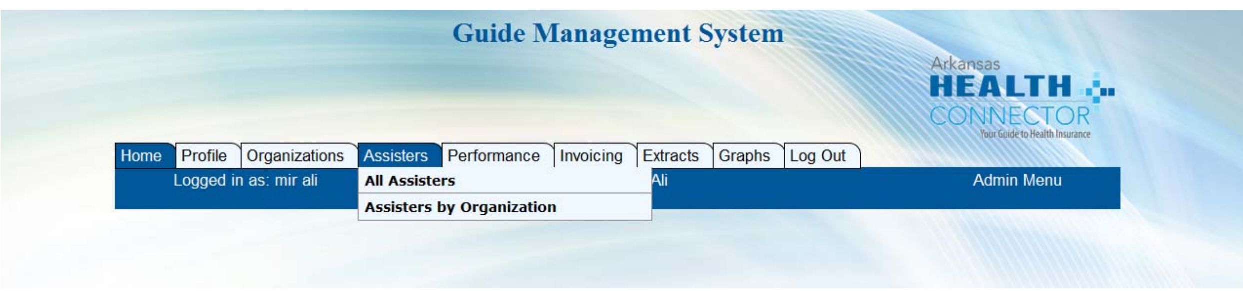


FIGURE 13

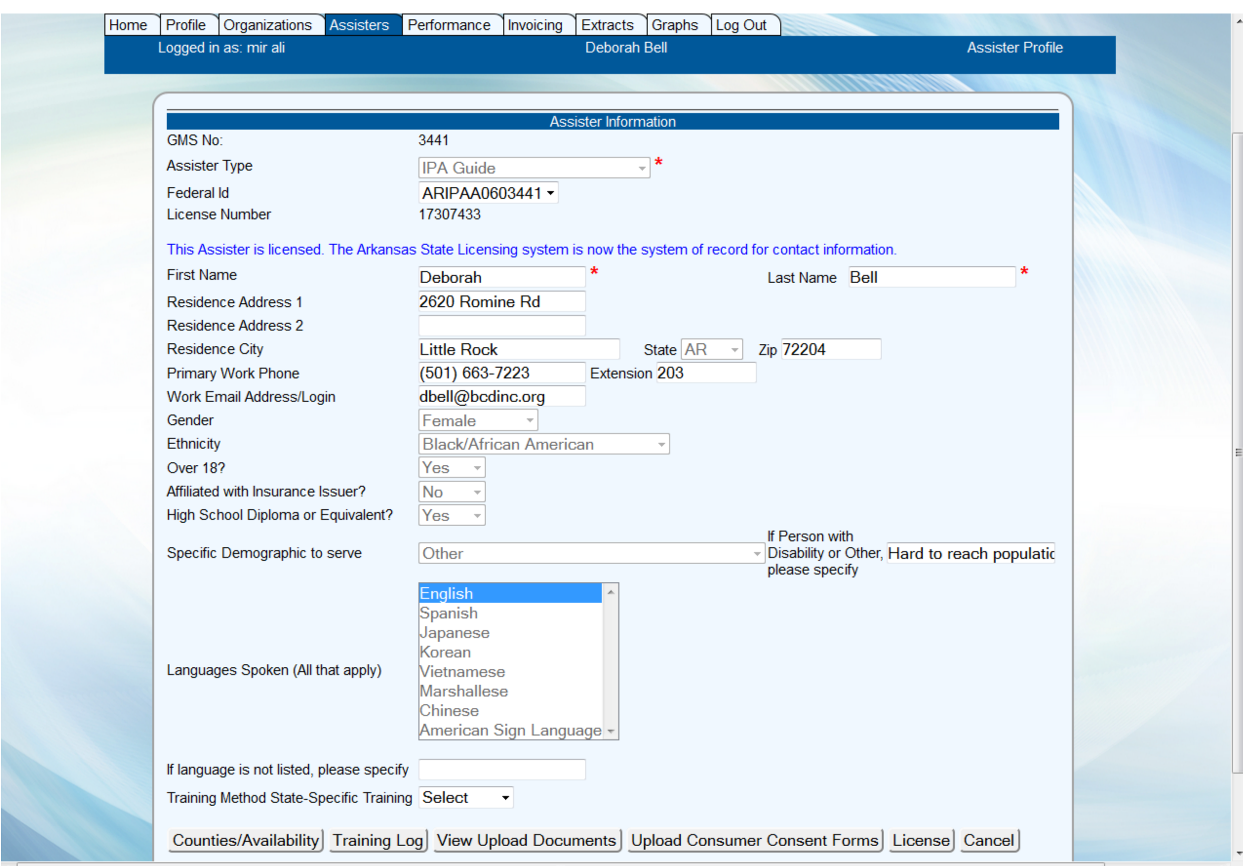
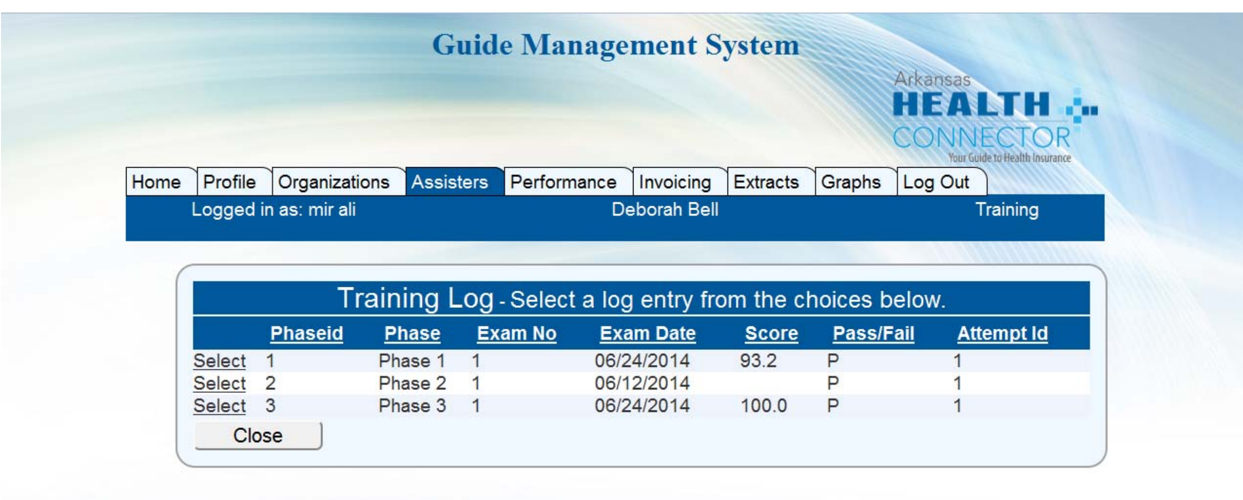


FIGURE 14

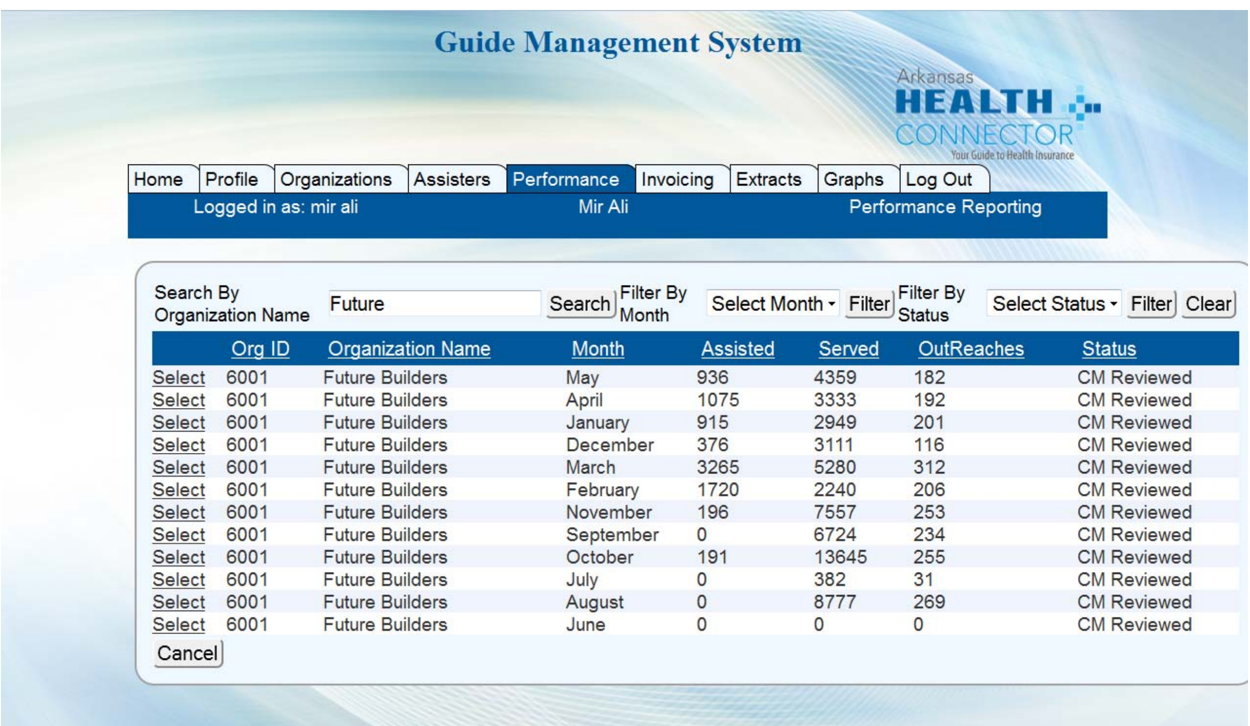


	Phaseid	Phase	Exam No	Exam Date	Score	Pass/Fail	Attempt Id
Select	1	Phase 1	1	06/24/2014	93.2	P	1
Select	2	Phase 2	1	06/12/2014		P	1
Select	3	Phase 3	1	06/24/2014	100.0	P	1

FIGURE 15

FIGURE 16

FIGURE 17



Guide Management System

Arkansas HEALTH CONNECTOR Your Guide to Health Insurance

Home | Profile | Organizations | Assisters | Performance | Invoicing | Extracts | Graphs | Log Out

Logged in as: mir ali — Mir Ali — Performance Reporting

Search By Organization Name: Future [Search] Filter By Month: Select Month [Filter] Filter By Status: Select Status [Filter] [Clear]

	Org ID	Organization Name	Month	Assisted	Served	OutReaches	Status
Select	6001	Future Builders	May	936	4359	182	CM Reviewed
Select	6001	Future Builders	April	1075	3333	192	CM Reviewed
Select	6001	Future Builders	January	915	2949	201	CM Reviewed
Select	6001	Future Builders	December	376	3111	116	CM Reviewed
Select	6001	Future Builders	March	3265	5280	312	CM Reviewed
Select	6001	Future Builders	February	1720	2240	206	CM Reviewed
Select	6001	Future Builders	November	196	7557	253	CM Reviewed
Select	6001	Future Builders	September	0	6724	234	CM Reviewed
Select	6001	Future Builders	October	191	13645	255	CM Reviewed
Select	6001	Future Builders	July	0	382	31	CM Reviewed
Select	6001	Future Builders	August	0	8777	269	CM Reviewed
Select	6001	Future Builders	June	0	0	0	CM Reviewed

Cancel

FIGURE 18

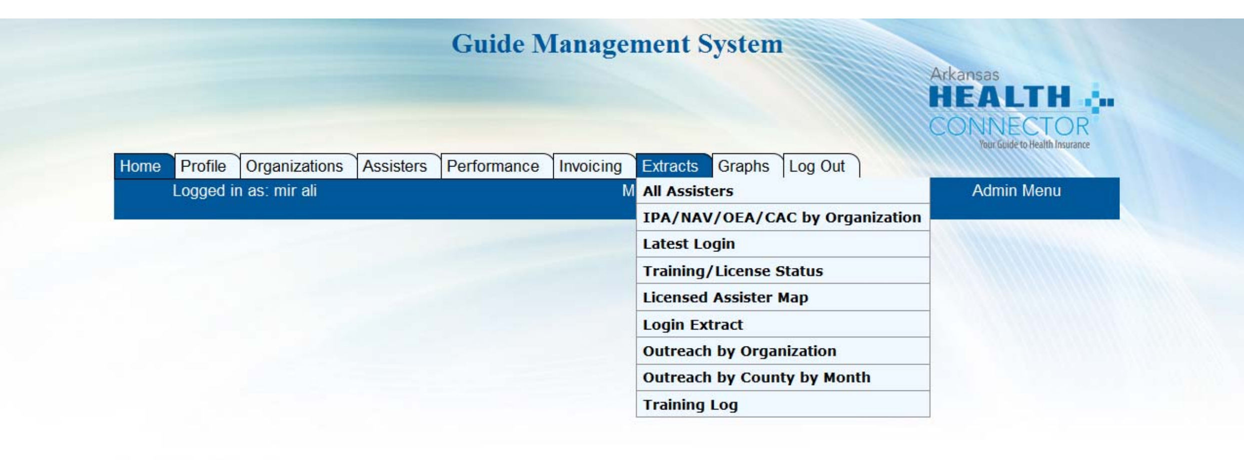
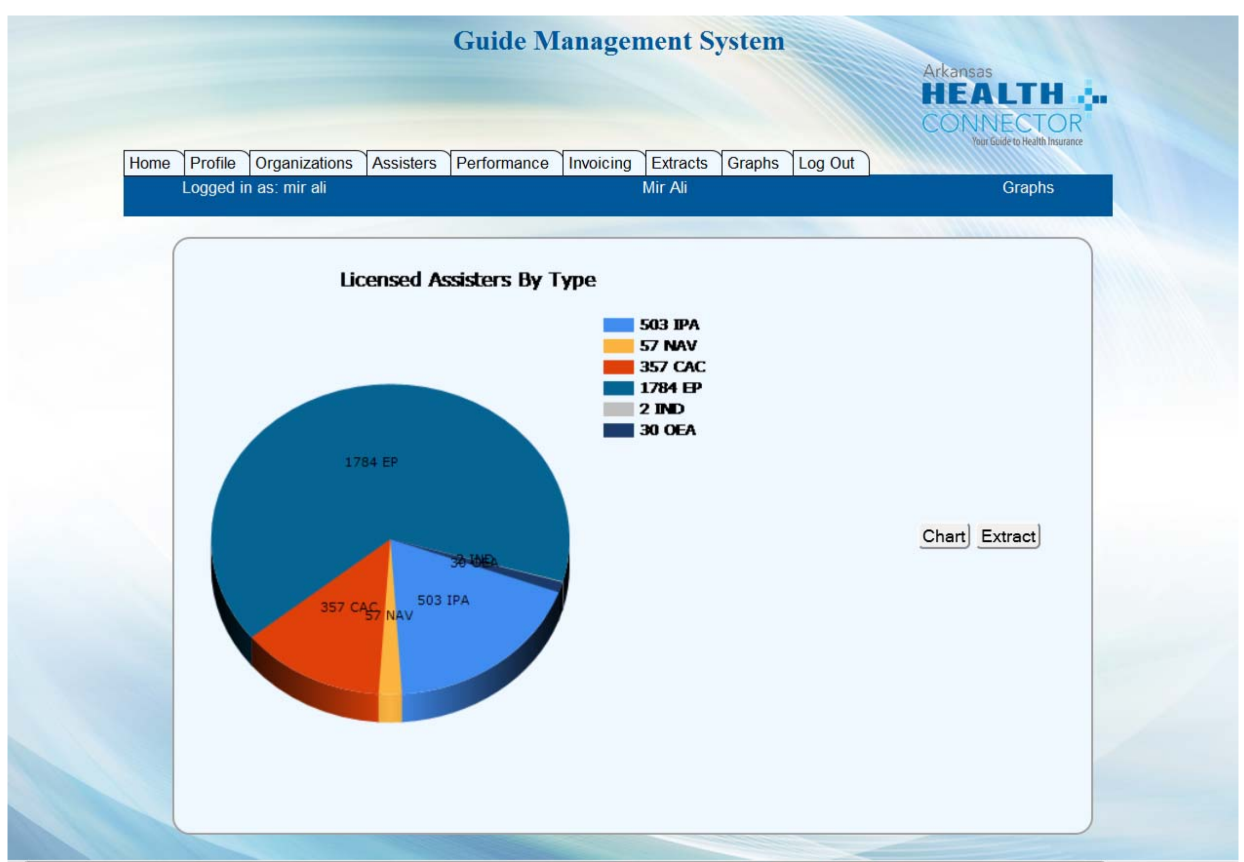


FIGURE 19

FIGURE 20



V-A. IN-PERSON ASSISTER AND NAVIGATOR ORGANIZATIONS

Vendor Name	AID counties	# of IPAs	# OF IPAs Awarded
Better Community Development, Inc.	Pulaski	4	4
Central Arkansas Volunteers in Medicine d/b/a Harmony Health Clinic	Pulaski	5	5
Community Health Centers of Arkansas, Inc.	Benton, Carroll, Clark, Cleveland, Crawford, Crittenden, Drew, Greene, Hempstead, Lawrence, Lincoln, Logan, Marion, Montgomery, Newton, Ouachita, Phillips, Poinsett, Polk, Pulaski, Randolph, Searcy, Sebastian, Sevier, Union, Van Buren, Washington	35	42
Covenant Medical Benefits, Inc.	Clay, Craighead, Cross, Greene, Jackson, Mississippi, Lawrence, Poinsett, Randolph, Sharp	22	32
Friendship Community Care, Inc	Boone, Pope, Washington, Stone	4	4
Future Builders, Inc.	Jefferson, Faulkner, Lonoke, Pulaski, Saline	11	20
Hope, Restoration & Wellness Learning Center	Pulaski	1	1
Southeast Arkansas Behavioral Healthcare System, Inc.	Arkansas, Jefferson, Grant	3	3
Arkansas Guide Organization	Boone, Carroll, Madison, Marion	6	9
Economic Opportunity Agency of Washington County, Inc. (EOA)	Washington	7	7
Harbor House, Inc.	Crawford, Sebastian, Polk	3	3
Mental Health Council of Arkansas	Miller, Sevier, Union, Cleburne, Craighead, Independence, White, Pulaski, Benton, Washington, Boone, Crawford, Sebastian	16	16
The Hispanic Women's Organization of Arkansas	Benton, Washington	10	10

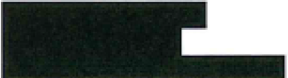
Vendor Name	AID counties	# of IPAs	# OF IPAs Awarded
The Living & Affected	Jefferson, Sebastian, Faulkner, Garland, Pulaski, Saline	7	7
Arkansas Health Care Access Foundation	Jefferson, Hot Spring, Pulaski, Faulkner	4	4
Arkansas Department of Health	All	234	0
Arkansas Voices for the Children Left Behind	Pulaski	1	1
Central Arkansas Library	Jefferson, Faulkner, Lonoke, Pulaski, Saline	8	8
CHOCCROSS, LLC	Lee, Monroe, Crittenden, and Cross	7	7
IN Affordable Housing, Inc.	Conway, Yell, White, Faulkner, Garland, Grant, Lonoke, Pulaski	9	15
Options for Life Services, LLC	Columbia, Dallas, Hempstead, Howard, Lafayette, Little River, Miller, Nevada, Union, Bradley, Jefferson	11	11
Quapaw House, Inc.	Garland	1	1
Tri-County Rural Health	Arkansas, Ashley, Chicot, Desha, Drew, Jefferson, Lee, Lincoln, Phillips, Crittenden, Mississippi	23	38
Women's Council on African American Affairs, Inc.	Pulaski	4	4
East Arkansas Enterprise Community (EAEC), Inc.	St Francis	6	8
Arkansas Minority Health Commission	Ouachita, Sevier, Union, Desha, Phillips, St. Francis, Crittenden, Pulaski	10	10

Arkansas Insurance Department

Mike Beebe
Governor

Jay Bradford
Commissioner

November 19, 2014



Dear *Consumer*:

You may recall receiving a letter from me a couple of weeks ago.

As **Insurance Commissioner**, I asked the **Arkansas Foundation for Medical Care, Inc.**, to conduct a survey of a small group of Arkansans who obtained new **health insurance** coverage in 2014. This survey asks about **how satisfied** you are with the services that your health insurance carrier and health care practitioner provide. **I am asking for your help.**

Please fill out the enclosed survey and return it by Date in the envelope provided. The postage has already been paid, so your participation will not cost you anything. It should take you less than 20 minutes to complete the survey.

To ensure your answers are **private and confidential**, do not place your name on the survey or the return envelope. The number on the survey is only used to help us follow-up when surveys are not returned. Neither AFMC nor your health insurance company or health care provider will ever know which number goes with you.

You can also choose to take the survey **on-line** by going to www.XXXXXXXXXXXXX. If you prefer to respond this way, add the number on the front of your survey in the space provided. More information can be found on the next page of this letter.

All information you provide is completely **confidential** and will not have any effect on your benefits. No one will know how you answered the questions. Your responses will be added to responses from other consumers to form a picture of how well consumers believe their current insurance carrier and other providers are meeting their health care needs. **Participation is voluntary and will not affect the services you receive.** If you are unable to complete the survey by yourself, someone else can help you.

Please call the Arkansas Foundation for Medical Care if you have questions about the survey or would like more information. Call 1-888-987-1200 (toll-free) anytime Monday through Friday between 8:30 a.m. and 5:00 p.m.

Si gusta recibir la versión en español de esta encuesta, favor llamar al 1-888-987-1200.

I hope you will decide to complete the survey because your experience is unique and cannot be replaced by anyone else.

Sincerely,

Jay Bradford,
Insurance Commissioner

1200 West Third Street, Little Rock, AR 72201-1904 · (501) 371-2600 · (501) 371-2618 fax · www.insurance.arkansas.gov
Information (800) 282-9134 · Consumer Services (800) 852-5494 · Seniors (800) 224-6330 · Criminal Inv. (866) 660-0888

Arkansas HEALTH CONNECTOR

2014 Encuesta Sobre Cuidado de la Salud para el Usuario

RECOPILACIÓN Y ANÁLISIS DE DATOS POR

Si gusta recibir la versión en español de esta encuesta, favor llamar al 1-877-650-2362.

ESTE CUESTIONARIO FUE ADAPTADO DE LA ENCUESTA DE PLAN DE SALUD DE CAHPS, QUE FUE DESARROLLADA Y FINANCIADA POR LA AGENCIA PARA LA INVESTIGACIÓN Y CALIDAD DE CUIDADO DE LA SALUD, ROCKVILLE, MD.

Instrucciones para la Encuesta

IMPORTANTE: ¡Por favor lea antes de responder las preguntas!

Responda a las preguntas marcando la casilla a la izquierda de su respuesta.

Se le puede pedir que omita algunas preguntas que no se aplican a Usted. Cuando esto ocurra, verá una flecha con una nota que le dice cual siguiente pregunta debe responder, así:

1☐ **Sí**
2☑ **NO → Pase a la pregunta 13**

<u>Su privacidad está protegida</u>. Toda la información que permitiría a alguien identificarlo a Usted o a su familia se mantendrá de forma privada. Sus respuestas a esta encuesta también son completamente **<u>confidenciales</u>**. Usted puede notar un número en la portada de esta encuesta. Este número se utiliza **<u>sólo</u>** para hacernos saber que ya envió su cuestionario y que no tenemos que enviarle recordatorios. Ni la Fundación de Arkansas para la Asistencia Médica (AFMC) ni su compañía de seguros verán su nombre u otra información. Todas las encuestas son anónimas.

Apreciamos su ayuda en completar la encuesta.
Si decide no hacerlo, sin embargo,
esto no afectará a los beneficios que usted obtiene.

Si tiene alguna pregunta sobre esta encuesta o quiere saber más acerca de este estudio, por favor llame a la línea gratuita 1-877-650-2362.

Si gusta recibir la versión en español de esta encuesta, favor llamar al 1-877-650-2362.

Su atención médica en los últimos 6 meses

Estas preguntas son acerca de su propia atención médica. No incluya la atención de salud que recibió cuando pasó la noche en un hospital. No incluya las veces que fue para visitas de atención dental.

1) En los últimos 6 meses, ¿tuvo usted una enfermedad, lesión o condición que requirió **atención inmediata** en una clínica, sala de emergencias o consultorio médico?

1 ☐ Sí
2 ☐ NO ➜ Pase a la pregunta 4

2) En los últimos 6 meses, cuando usted necesitó **atención inmediata**, con qué frecuencia lo atendieron tan pronto como lo necesitaba?

1 ☐ Nunca
2 ☐ A veces
3 ☐ A menudo
4 ☐ Siempre

3) En los últimos 6 meses, ¿cuántas veces ha ido a una sala de emergencia?

0 ☐ Nunca
1 ☐ 1 vez
2 ☐ 2
3 ☐ 3
4 ☐ 4
5 ☐ 5-9
6 ☐ 10 o más veces

4) En los últimos 6 meses, ¿hizo alguna cita para un **chequeo o una consulta regular** en el consultorio de un médico o una clínica?

1 ☐ Sí
2 ☐ NO ➜ Pase a la pregunta 6

5) En los últimos 6 meses, ¿con qué frecuencia consiguió una cita para un **chequeo o una visita de rutina en el consultorio** de un médico o clínica tan pronto como lo necesitaba?

1 ☐ Nunca
2 ☐ A veces
3 ☐ A menudo
4 ☐ Siempre

6) En los últimos 6 meses, **sin** contar las veces que fue a una sala de emergencia, ¿cuántas veces fue a un consultorio médico o clínica para recibir atención de salud para usted?

0 ☐ NINGUNA ➜ Pase a la pregunta 12
1 ☐ 1 vez
2 ☐ 2
3 ☐ 3
4 ☐ 4
5 ☐ 5-9
6 ☐ 10 o más veces

7) En los últimos 6 meses, ¿usted y su médico u otro proveedor de cuidado médico hablaron acerca de cosas específicas que usted puede hacer para prevenir una enfermedad?

1 ☐ Sí
2 ☐ No

8) Usando un número del 0 al 10, donde 0 es la peor atención médica posible y el 10 la mejor atención médica posible, ¿qué número usaría para calificar toda la atención de la salud recibida en los últimos 6 meses?

- 00 ☐ 0 La peor atención médica posible
- 01 ☐ 1
- 02 ☐ 2
- 03 ☐ 3
- 04 ☐ 4
- 05 ☐ 5
- 06 ☐ 6
- 07 ☐ 7
- 08 ☐ 8
- 09 ☐ 9
- 10 ☐ 10 La mejor atención médica posible

9) En los últimos 6 meses, ¿con qué frecuencia le fue fácil conseguir la atención médica, exámenes o tratamiento que necesitaba?

- 1 ☐ Nunca
- 2 ☐ A veces
- 3 ☐ A menudo
- 4 ☐ Siempre

10) Un intérprete es alguien que le ayuda a comunicarse con otras personas que no hablan su idioma. En los últimos 6 meses, ¿necesitó usted un intérprete para ayudarle a hablar con cualquier persona en el consultorio de su médico o clínica?

- 1 ☐ Sí
- 2 ☐ **NO ➜ Pase a la pregunta 12**

11) En los últimos 6 meses, cuando necesitó un intérprete en el consultorio de su médico o clínica, ¿con qué frecuencia usted consiguió uno?

- 1 ☐ Nunca
- 2 ☐ A veces
- 3 ☐ A menudo
- 4 ☐ Siempre

Su médico personal

Estas preguntas son acerca de su médico personal u otro profesional de la salud. Para esta encuesta, considere como su médico personal a cualquiera que usted visita para su atención médica de rutina, incluyendo enfermeras practicantes y asistentes médicos.

12) Un médico personal es el que usted vería si necesita un chequeo, quiere consejos sobre un problema de salud, o se enferma o lesiona. ¿Tiene usted un médico personal?

- 1 ☐ Sí
- 2 ☐ **NO ➜ Pase a la pregunta 31**

13) Marque a quien usted considera ser su médico personal.

- 1 ☐ Médico (MD o DO)
- 2 ☐ Enfermera practicante (APN)
- 3 ☐ Asistente médico (PA)
- 4 ☐ Otro (**Por favor especifique. En mayúsculas.**)

____

____

____

14) En los últimos 6 meses, ¿cuántas veces visitó a su médico personal para recibir atención para usted mismo?

- 0 ☐ **NINGUNA ➜ Pase a la pregunta 25**
- 1 ☐ 1 vez
- 2 ☐ 2
- 3 ☐ 3
- 4 ☐ 4
- 5 ☐ 5-9
- 6 ☐ 10 o más veces

15) En los últimos 6 meses, ¿con qué frecuencia su médico personal le explicó las cosas de una manera que fue fácil de entender?

1 ☐ Nunca
2 ☐ A veces
3 ☐ A menudo
4 ☐ Siempre

16) En los últimos 6 meses, ¿con qué frecuencia su médico personal le escuchó con atención?

1 ☐ Nunca
2 ☐ A veces
3 ☐ A menudo
4 ☐ Siempre

17) En los últimos 6 meses, ¿con qué frecuencia su médico personal mostró respeto por lo que usted tenía que decir?

1 ☐ Nunca
2 ☐ A veces
3 ☐ A menudo
4 ☐ Siempre

18) En los últimos 6 meses, ¿con qué frecuencia su médico personal pasó suficiente tiempo con usted?

1 ☐ Nunca
2 ☐ A veces
3 ☐ A menudo
4 ☐ Siempre

19) Cuando usted visitó a su médico personal para una cita programada en los últimos 6 meses, ¿con qué frecuencia él o ella tenían sus registros médicos u otra información sobre su atención de salud?

1 ☐ Nunca
2 ☐ A veces
3 ☐ A menudo
4 ☐ Siempre

20) En los últimos 6 meses, ¿ordenó su médico personal un análisis de sangre, rayos X o alguna otra prueba?

1 ☐ Sí
2 ☐ **NO → Pase a la pregunta 23**

21) En los últimos 6 meses, cuando su médico personal ordenó un análisis de sangre, rayos X o alguna otra prueba, ¿con qué frecuencia alguien del consultorio de su médico personal se comunicó con usted para darle los resultados?

1 ☐ Nunca
2 ☐ A veces
3 ☐ A menudo
4 ☐ Siempre

22) En los últimos 6 meses, cuando su médico personal ordenó un análisis de sangre, rayos X o alguna otra prueba, ¿con qué frecuencia le entregaron los resultados tan pronto como usted los necesitaba?

1 ☐ Nunca
2 ☐ A veces
3 ☐ A menudo
4 ☐ Siempre

23) En los últimos 6 meses, ¿recibió atención de un médico u otro proveedor de salud además de su médico personal?

1 ☐ Sí
2 ☐ **NO → Pase a la pregunta 25**

24) En los últimos 6 meses, ¿con qué frecuencia su médico personal parecía estar informado y al día sobre la atención que usted recibió de los médicos u otros profesionales de la salud?

1 ☐ Nunca
2 ☐ A veces
3 ☐ A menudo
4 ☐ Siempre

25) Usando un número del 0 al 10, donde 0 es el peor médico posible y 10 el mejor médico posible, ¿qué número usaría para calificar a su médico personal?

00 ☐ 0 Peor médico personal posible
01 ☐ 1
02 ☐ 2
03 ☐ 3
04 ☐ 4
05 ☐ 5
06 ☐ 6
07 ☐ 7
08 ☐ 8
09 ☐ 9
10 ☐ 10 Mejor médico personal posible

26) En los últimos 6 meses, ¿tomó usted algún medicamento recetado?

1 ☐ Sí
2 ☐ **NO ➜ Pase a la pregunta 28**

27) En los últimos 6 meses, ¿con qué frecuencia usted y su médico personal hablaron de todos los medicamentos recetados que estaba tomando?

1 ☐ Nunca
2 ☐ A veces
3 ☐ A menudo
4 ☐ Siempre

28) En los últimos 6 meses, ¿recibió atención de más de un tipo de proveedor de cuidado médico o usó más de un tipo de servicio de salud?

1 ☐ Sí
2 ☐ **NO ➜ Pase a la pregunta 31**

29) En los últimos 6 meses, ¿necesitó ayuda de alguien en el consultorio de su médico personal para administrar su cuidado de salud entre estos diferentes proveedores y servicios?

1 ☐ Sí
2 ☐ **NO ➜ Pase a la pregunta 31**

30) En los últimos 6 meses, ¿con qué frecuencia consiguió la ayuda que necesitaba de la oficina de su médico personal para administrar su cuidado de salud entre estos diferentes proveedores y servicios?

1 ☐ Nunca
2 ☐ A veces
3 ☐ A menudo
4 ☐ Siempre

Cómo obtener atención de salud de los especialistas

Al responder a las siguientes preguntas, no incluya las visitas al dentista o la atención que recibió cuando pasó la noche en un hospital.

31) Los especialistas son médicos como cirujanos, cardiólogos, alergólogos, dermatólogos y otros médicos que se especializan en un área de atención de la salud. En los últimos 6 meses, ¿hizo alguna cita para ver a un especialista?

1 ☐ Sí
2 ☐ **NO ➜ Pase a la pregunta 35**

32) En los últimos 6 meses, ¿con qué frecuencia consiguió una cita para ver a un especialista tan pronto como lo necesitaba?

1 ☐ Nunca
2 ☐ A veces
3 ☐ A menudo
4 ☐ Siempre

33) ¿Cuántos especialistas ha visto en los últimos 6 meses?

0 ☐ **NINGUNO ➜ Pase a la pregunta 25**
1 ☐ 1 especialista
2 ☐ 2
3 ☐ 3
4 ☐ 4
5 ☐ 5 o más especialistas

34) Queremos saber cómo califica al especialista al que fue con más frecuencia en los últimos 6 meses. Usando un número del 0 al 10, donde 0 es el peor especialista posible y 10 el mejor especialista posible, ¿qué número usaría para calificar ese especialista?

- 00 ☐ 0 Peor especialista posible
- 01 ☐ 1
- 02 ☐ 2
- 03 ☐ 3
- 04 ☐ 4
- 05 ☐ 5
- 06 ☐ 6
- 07 ☐ 7
- 08 ☐ 8
- 09 ☐ 9
- 10 ☐ 10 Mejor especialista posible

Obteniendo información personalmente

Las siguientes preguntas son acerca de sus experiencias cuando se reunió en persona entre el 1 de octubre de 2013 y el 30 de septiembre de 2014, con alguien de una agencia u organización que ayuda a las personas para obtener seguro de salud a través del mercado de Seguros de Salud.

35) Entre el 1 de octubre de 2013 y 30 de septiembre de 2014, ¿se reunió personalmente con alguien de una organización que ayuda a las personas para obtener un seguro de salud a través del mercado de Seguros de Salud?

- 1 ☐ **SÍ** ➜ **Pase a la pregunta 37**
- 2 ☐ No

36) Entre el 1 de octubre de 2013 y 30 de septiembre de 2014, necesitaba ayuda personal pero no pudo conseguirla porque el edificio no era accesible para las personas con discapacidades?

- 1 ☐ **SÍ** ➜ **Pase a la pregunta 46**
- 2 ☐ **NO** ➜ **Pase a la pregunta 46**

37) ¿Quién le ayudó a obtener un seguro de salud a través del mercado de Seguros de Salud? **Marque una o más.**

- A ☐ Un agente seguros
- B ☐ Guía o navegador
- C ☐ Consejero certificado de solicitudes
- D ☐ Otro (**Por favor especifique. En mayúsculas.**)

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38) Entre el 1 de octubre de 2013, y 30 de septiembre de 2014, ¿con qué frecuencia obtuvo la información o ayuda que necesitaba cuando se encontró en persona con alguien acerca de cómo obtener un seguro de salud del mercado de Seguros de Salud?

1 ☐ Nunca
2 ☐ A veces
3 ☐ A menudo
4 ☐ SIEMPRE ➜ **Pase a la pregunta 40**

39) ¿Alguna de las siguientes fue una razón por la cual usted no recibió la información o ayuda que necesitaba cuando se encontró en persona con alguien acerca de cómo obtener un seguro de salud del mercado de Seguros de Salud? **Marque una o más.**

No tuvimos la oportunidad de la información o ayuda porque:

A ☐ No hubo tiempo suficiente
B ☐ Ellos no tenían la información que necesitaba
C ☐ La información que ellos le dieron era difícil de entender
D ☐ La información que ellos le dieron estaba equivocada
E ☐ No pudo hablar o firmar en el idioma que prefiere
F ☐ Alguna otra razón (**Por favor, especifique. Por favor imprima.**)

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40) Entre el 1 de octubre de 2013 y 30 de septiembre de 2014, con qué frecuencia fue fácil de entender la información que obtuvo cuando se reunió en persona con alguien acerca de cómo obtener un seguro de salud del mercado de Seguros de Salud?

1 ☐ Nunca
2 ☐ A veces
3 ☐ A menudo
4 ☐ SIEMPRE ➜ **Pase a la pregunta 42**

41) ¿Qué tipo de información NO fue fácil de entender cuando se reunió en persona con alguien acerca de cómo obtener un seguro de salud del mercado de Seguros de Salud? **Marque una o más.**

NO fue fácil de entender:

A ☐ Cómo obtener ayuda para pagar su seguro médico
B ☐ Plazos importantes
C ☐ Beneficios y cobertura para visitas a un médico o especialista
D ☐ Beneficios y cobertura de medicamentos recetados
E ☐ Beneficios y cobertura de la atención prenatal y el parto
F ☐ ¿Cuánto tendría que pagar por cada plan de salud
G ☐ ¿Cuánto tendría que pagar de su bolsillo por los servicios de salud en cada plan de salud
H ☐ ¿Qué se incluye en una "visita de bienestar" y lo que tendría que pagar
I ☐ Cuales médicos están en cada plan de salud
J ☐ Lo que tendría que pagar si consulta a un médico fuera del plan de salud
K ☐ Cómo definir el tamaño de su familia o de los ingresos
L ☐ ¿Cuales médicos en cada plan de salud tienen oficinas que son accesibles para las personas con discapacidades
M ☐ ¿Cómo encontrar un plan de salud que satisfaga las necesidades de su familia
N ☐ Otra causa (**Por favor, especifique. En mayúsculas.**)

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42) Entre el 1 de octubre de 2013 y 30 de septiembre de 2014, ¿con qué frecuencia las personas que se reunieron con usted acerca de obtener seguro médico del mercado de Seguros de Salud, lo ayudaron tal como usted creía que debería ser?

1 ☐ Nunca
2 ☐ A veces
3 ☐ A menudo
4 ☐ Siempre

43) Entre el 1 de octubre de 2013 y 30 de septiembre de 2014, ¿con qué frecuencia las personas que se reunieron con usted acerca de conseguir un seguro de salud del mercado de Seguros de Salud, usaron palabras o frases que no entendió?

1 ☐ Nunca
2 ☐ A veces
3 ☐ A menudo
4 ☐ Siempre

44) Entre el 1 de octubre de 2013 y 30 de septiembre de 2014, ¿con qué frecuencia las personas que se reunieron con usted acerca de conseguir un seguro de salud del mercado de Seguros de Salud, lo trataron con cortesía y respeto?

1 ☐ Nunca
2 ☐ A veces
3 ☐ A menudo
4 ☐ Siempre

45) Queremos saber cómo califica la asistencia personal que recibió para ayudarle a utilizar el mercado de Seguros de Salud entre el 1 de octubre de 2013 y el 30 de septiembre de 2014. Usando un número del 0 al 10, donde 0 es el peor en asistencia personal posible y 10 la mejor asistencia personal posible, ¿qué número usaría para calificar la asistencia que recibió cuando se reunió en persona con alguien acerca de cómo obtener un seguro de salud del mercado de Seguros de Salud?

00 ☐ 0 Peor asistencia personal posible
01 ☐ 1
02 ☐ 2
03 ☐ 3
04 ☐ 4
05 ☐ 5
06 ☐ 6
07 ☐ 7
08 ☐ 8
09 ☐ 9
10 ☐ 10 Mejor asistencia personal posible

La elección de un plan de salud

Las siguientes preguntas son acerca de sus experiencias para elegir un plan de salud a través del mercado de Seguros de Salud entre el 1 de octubre de 2013 y 30 de septiembre de 2014.

46) Entre el 1 de octubre de 2013 y 30 de septiembre de 2014, ¿usted buscaba un seguro médico para sí mismo o para otro miembro de la familia a través del mercado de Seguros de Salud?

1 ☐ Sí
2 ☐ No

47) Entre el 1 de octubre de 2013 y 30 de septiembre de 2014, ¿consideró usted los servicios cubiertos por los planes de salud disponibles en el mercado del seguro médico y la cantidad que tendría que pagar?

1 ☐ Sí
2 ☐ **NO → Pase a la pregunta 50**

48) Entre el 1 de octubre de 2013 y 30 de septiembre de 2014, ¿con qué frecuencia le fue fácil entender los servicios cubiertos por los planes de salud disponibles para usted?

1 ☐ Nunca
2 ☐ A veces
3 ☐ A menudo
4 ☐ Siempre

49) Entre el 1 de octubre de 2013 y 30 de septiembre de 2014, ¿con qué frecuencia le fue fácil comprender cuánto tendría que pagar?

1 ☐ Nunca
2 ☐ A veces
3 ☐ A menudo
4 ☐ Siempre

50) Entre el 1 de octubre de 2013 y 30 de septiembre de 2014, ¿trató de averiguar cuáles planes en el mercado de Seguros de Salud tenían los médicos u hospitales que usted prefería?

1 ☐ Sí
2 ☐ **NO → Pase a la pregunta 52**

51) Entre el 1 de octubre de 2013 y 30 de septiembre de 2014, ¿con que frecuencia fue fácil entender los planes de la salud que incluían a los médicos u hospitales que usted prefería?

1 ☐ Nunca
2 ☐ A veces
3 ☐ A menudo
4 ☐ Siempre

52) ¿Usted eligió un plan de salud a través del mercado de Seguros de Salud?

1 ☐ Sí
2 ☐ **NO → Pase a la pregunta 54**

53) ¿Fue fácil elegir un plan de salud?

1 ☐ Sí, definitivamente
2 ☐ Sí, algo
3 ☐ No

Su plan de salud

Las siguientes preguntas son acerca de sus experiencias con su plan de salud.

54) Entre el momento de cumplir los 18 años de edad y el 31 de diciembre de 2013, ha tenido usted alguna vez algún tipo de seguro de salud?

1 ☐ Sí, plan de seguro individual
2 ☐ Sí, con el plan de sus padres
3 ☐ Sí, con el plan de sus padres y el plan de seguro individual
4 ☐ No, este es mi primer plan de seguro ➜ **Pase a la pregunta 56**

55) En los 6 meses **antes de inscribirse** en el mercado de Seguros de Salud, ¿tenía usted cobertura de seguro de **salud**?

1 ☐ Sí
2 ☐ No
3 ☐ No corresponde

56) En los últimos 6 meses, ¿usted buscó información en folletos o en la Internet sobre cómo funciona su plan de salud?

1 ☐ Sí
2 ☐ **NO** ➜ **Pase a la pregunta 58**

57) En los últimos 6 meses, ¿con qué frecuencia los folletos o la Internet le proporcionaron la información que necesitaba sobre cómo funciona su plan de salud?

1 ☐ Nunca
2 ☐ A veces
3 ☐ A menudo
4 ☐ Siempre

58) A veces la gente necesita servicios o equipos que no se brindan en una visita regular o rutina al consultorio, como la atención de un especialista, terapia física, un audífono, u oxígeno. En los últimos 6 meses, ¿usted buscó información de su plan de salud sobre la cantidad que tendría que pagar por un servicio o equipo de cuidado de la salud?

1 ☐ Sí
2 ☐ **NO** ➜ **Pase a la pregunta 60**

59) En los últimos 6 meses, ¿cuántas veces pudo averiguar a través de su plan de salud la cantidad que tendría que pagar por un servicio o equipo de cuidado de la salud?

1 ☐ Nunca
2 ☐ A veces
3 ☐ A menudo
4 ☐ Siempre

60) En algunos planes de salud la cantidad que paga por un medicamento recetado puede ser diferente para los distintos medicamentos, o puede ser diferente para los medicamentos con receta por correo en vez de en la farmacia. En los últimos 6 meses, ¿usted buscó información de su plan de salud sobre la cantidad que tendría que pagar por los medicamentos con receta antes de que los obtuviera?

1 ☐ Sí
2 ☐ **NO** ➜ **Pase a la pregunta 62**

61) En los últimos 6 meses, ¿cuántas veces pudo averiguar a través de su plan de salud cuánto tendría que pagar por los medicamentos recetados?

1 ☐ Nunca
2 ☐ A veces
3 ☐ A menudo
4 ☐ Siempre

62) En los últimos 6 meses, ¿pudo obtener información o ayuda del servicio al cliente de su plan de salud?

1 ☐ Sí
2 ☐ NO ➜ **Pase a la pregunta 65**

63) En los últimos 6 meses, ¿con qué frecuencia el servicio al cliente de su plan de salud le dio la información o ayuda que necesitaba?

1 ☐ Nunca
2 ☐ A veces
3 ☐ A menudo
4 ☐ Siempre

64) En los últimos 6 meses, ¿con qué frecuencia el personal de servicio al cliente del plan de salud lo trató con cortesía y respeto?

1 ☐ Nunca
2 ☐ A veces
3 ☐ A menudo
4 ☐ Siempre

65) En los últimos 6 meses, ¿su plan de salud le pidió llenar algún formulario?

1 ☐ Sí
2 ☐ NO ➜ **Pase a la pregunta 70**

66) En los últimos 6 meses, ¿con qué frecuencia fueron fáciles de llenar los formularios de su plan de salud?

1 ☐ Nunca
2 ☐ A veces
3 ☐ A menudo
4 ☐ Siempre

67) En los últimos 6 meses, ¿con qué frecuencia estaban los formularios que tuvo que llenar disponibles en el idioma que prefería?

1 ☐ Nunca
2 ☐ A veces
3 ☐ A menudo
4 ☐ Siempre

68) En los últimos 6 meses, ¿usted necesitó en un formato diferente, como letra más grande o Braille?

1 ☐ Sí
2 ☐ NO ➜ **Pase a la pregunta 70**

69) En los últimos 6 meses, ¿con qué frecuencia los formularios que había que llenar estaban disponibles en el formato que usted necesitaba, tal como letra más grande o Braille?

1 ☐ Nunca
2 ☐ A veces
3 ☐ A menudo
4 ☐ Siempre

70) Las peticiones de reembolso se envían al plan de salud para su pago. usted puede enviar las peticiones usted mismo, o los médicos, hospitales, y otros las pueden enviar a su plan de salud por usted. En los últimos 6 meses, ¿envió usted o cualquier otra persona alguna petición de pago por los costos de atención a su plan de salud?

1 ☐ Sí
2 ☐ NO ➜ **Pase a la pregunta 73**
3 ☐ No sabe ➜ **Pase a la pregunta 73**

71) En los últimos 6 meses, ¿con qué frecuencia su plan de salud tramitó sus peticiones rápidamente?

1 ☐ Nunca
2 ☐ A veces
3 ☐ A menudo
4 ☐ Siempre
5 ☐ No sabe

72) En los últimos 6 meses, ¿con qué frecuencia su plan de salud tramitó sus peticiones correctamente?

1 ☐ Nunca
2 ☐ A veces
3 ☐ A menudo
4 ☐ Siempre
5 ☐ No sabe

73) Usando un número del 0 al 10, donde 0 es el peor plan de salud posible y 10 el mejor plan de salud posible, ¿qué número usaría para calificar su plan de salud?

00 ☐ 0 Peor plan de salud posible
01 ☐ 1
02 ☐ 2
03 ☐ 3
04 ☐ 4
05 ☐ 5
06 ☐ 6
07 ☐ 7
08 ☐ 8
09 ☐ 9
10 ☐ 10 Mejor plan de salud posible

74) En los últimos 6 meses, antes de ir para una consulta o tratamiento, ¿con qué frecuencia su plan de salud le aclaró cuánto tendría que pagar?

1 ☐ Nunca
2 ☐ A veces
3 ☐ A menudo
4 ☐ Siempre

75) En los últimos 6 meses, ¿con qué frecuencia su plan de salud no pagó por un servicio que el médico dijo que usted necesitaba?

1 ☐ Nunca
2 ☐ A veces
3 ☐ A menudo
4 ☐ Siempre

76) En los últimos 6 meses, ¿con qué frecuencia tuvo que pagar de su propio bolsillo la atención que usted pensó que su plan de salud pagaría?

1 ☐ Nunca
2 ☐ A veces
3 ☐ A menudo
4 ☐ Siempre

77) En los últimos 6 meses, ¿se demoró o no visitó a un médico porque estaba preocupado por el costo? **No** incluya la atención dental.

1 ☐ Sí
2 ☐ No

78) En los últimos 6 meses, ¿se demoró o no visitó a un médico, ya que no podía permitirse el lujo de perder el tiempo libre del trabajo para ir a la consulta?

1 ☐ Sí
2 ☐ No

79) En los últimos 6 meses, ¿se demoró o no procuró una receta porque estaba preocupado por el costo?

1 ☐ Sí
2 ☐ No

Acerca de usted

80) En general, ¿cómo calificaría su salud en general?

1 ☐ Excelente
2 ☐ Muy buena
3 ☐ Buena
4 ☐ Pasable
5 ☐ Mala

81) En general, ¿cómo calificaría su **salud mental o emocional**?

1 ☐ Excelente
2 ☐ Muy buena
3 ☐ Buena
4 ☐ Pasable
5 ☐ Mala

82) ¿Actualmente fuma cigarrillos o consume tabaco todos los días, algunos días, o nunca?

1 ☐ Todos los días
2 ☐ Algunos días
3 ☐ **Nunca** ➜ **Pase a la pregunta 86**
4 ☐ **No sabe** ➜ **Pase a la pregunta 86**

83) En los últimos 6 meses, ¿le aconsejó un médico u otro profesional de la salud en su plan dejar de fumar o de consumir tabaco?

1 ☐ Nunca
2 ☐ A veces
3 ☐ A menudo
4 ☐ Siempre

84) En los últimos 6 meses, ¿con qué frecuencia un médico o proveedor de salud le recomendó medicación o discutió con usted ayuda para dejar de fumar o consumir tabaco? Los ejemplos de medicamentos son: el chicle de nicotina, parches, vaporizador nasal, inhalador, o medicamentos recetados.

1 ☐ Nunca
2 ☐ A veces
3 ☐ A menudo
4 ☐ Siempre

85) En los últimos 6 meses, ¿con qué frecuencia su médico o proveedor de salud discutió con usted o le indicó métodos y estrategias que no eran medicamentos para ayudarle dejar de fumar o usar tabaco? Ejemplos de métodos y estrategias son: servicio de atención telefónica, consejería individual o de grupo, o programa de deshabituación.

1 ☐ Nunca
2 ☐ A veces
3 ☐ A menudo
4 ☐ Siempre

86) ¿Toma usted aspirina todos los días o cada dos días?

1 ☐ Sí
2 ☐ No
3 ☐ No sabe

87) ¿Tiene usted un problema de salud o toma medicamentos que hace peligroso el tomar aspirina?

1 ☐ Sí
2 ☐ No
3 ☐ No sabe

88) Un médico o proveedor de salud ¿alguna vez discutió con usted los riesgos y beneficios de la aspirina para prevenir un ataque cardíaco o un derrame cerebral?

1 ☐ Sí
2 ☐ No

89) ¿Es usted consciente de que tiene alguna de las siguientes condiciones? **Marque una o más.**

A ☐ Colesterol alto
B ☐ Presión arterial alta
C ☐ Padre o hermano tuvo ataque al corazón antes de cumplir los 60 años

90) ¿Alguna vez un médico le ha dicho que usted tiene cualquiera de las siguientes condiciones? **Marque una o más.**

A ☐ Un ataque al corazón
B ☐ Angina o enfermedad coronaria
C ☐ Accidente cerebrovascular
D ☐ Cualquier tipo de diabetes o niveles altos de azúcar en la sangre

91) En los últimos 6 meses, ¿usted obtuvo atención de salud 3 o más veces por la misma enfermedad o problema?

1 ☐ Sí
2 ☐ **NO ➜ Pase a la pregunta 93**

92) ¿Es esta una condición o problema que ha durado al menos 3 meses? **No** incluya el embarazo o la menopausia.

1 ☐ Sí
2 ☐ No

93) ¿Usted ahora necesita o toma medicamentos recetados por un médico? **No** incluya el control de la natalidad.

1 ☐ Sí
2 ☐ **NO ➜ Pase a la pregunta 95**

94) ¿Es este medicamento para tratar una condición que ha durado al menos 3 meses? NO incluya el embarazo o la menopausia.

1 ☐ Sí
2 ☐ No

95) ¿Cuál es el grado o nivel de escuela que ha completado?

1 ☐ Octavo grado o menos
2 ☐ Algunos estudios secundarios, pero no se graduó
3 ☐ Graduado de escuela secundaria o GED
4 ☐ Un poco de universidad o título de 2 años
5 ☐ Graduado de universidad de 4 años
6 ☐ Graduado con más de 4 años de universidad

96) ¿Qué describe **mejor** su situación laboral? Es usted: **[Marque sólo UNO.]**

1 ☐ Empleado a tiempo completo
2 ☐ Empleado a tiempo parcial
3 ☐ Ama de casa
4 ☐ Estudiante a tiempo completo
5 ☐ Jubilado
6 ☐ Incapaz de trabajar por razones de salud
7 ☐ Desempleado
8 ☐ Otro

97) ¿Es usted de origen o ascendencia hispana o latina?

1 ☐ Sí, hispano o latino
2 ☐ No, no hispano o latino

98) ¿Cuál es su raza? **Marque una o más.**

A ☐ Blanca
B ☐ Negro o afroamericano
C ☐ Asiático
D ☐ Nativo de Hawái u otras islas del Pacífico
E ☐ Indio Americano o Nativo de Alaska
F ☐ Otro (**Por favor especifique. En mayúsculas.**)

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99) ¿Cuál es su idioma preferido?

1 ☐ Inglés
Si es inglés
➜ Vaya a la pregunta101
2 ☐ Español
3 ☐ Chino
4 ☐ Otro (**Por favor especifique. En mayúsculas.**)

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100) ¿Qué tan bien habla usted el inglés?

1 ☐ Muy bien
2 ☐ Bien
3 ☐ No muy bien
4 ☐ No del todo

101) ¿Le ayudó alguien a completar esta encuesta?

1 ☐ **SÍ ➜ Vaya a la pregunta 102**
2 ☐ **NO ➜ Gracias.**
Por favor devuelva la encuesta completada en el sobre con franqueo pagado.

102) ¿Cómo le ayudó esa persona?
Marque una o más.

A ☐ Me leyó las preguntas
B ☐ Escribió las respuestas que di
C ☐ Respondió a las preguntas por mí
D ☐ Tradujo las preguntas a mi idioma
E ☐ Me ayudó de alguna otra manera (**Por favor especifique. En mayúsculas.**)

____

____

____

¡MUCHAS GRACIAS!

Por favor devuelva la encuesta completada en el sobre con franqueo pagado.

ESTE MATERIAL FUE PREPARADO POR LA FUNDACIÓN DE ARKANSAS PARA LA ATENCION MEDICA INC. (AFMC) BAJO CONTRATO CON EL COLEGIO DE SALUD PÚBLICA.DE: LA UNIVERSIDAD DE ARKANSAS PARA LAS CIENCIAS MÉDICAS (UAMS).
LOS CONTENIDOS PRESENTADOS NO NECESARIAMENTE REFLEJAN LA POLÍTICA UAMS. MP2-AID.SVYS,1-1/15

Arkansas HEALTH CONNECTOR

2014 Consumer Health Care Survey

DATA COLLECTION AND ANALYSIS BY

Si gusta recibir la versión en español de esta encuesta, favor llamar al 1-877-650-2362.

THIS QUESTIONNAIRE WAS ADAPTED FROM THE CAHPS HEALTH PLAN SURVEY, WHICH WAS DEVELOPED AND FUNDED BY THE AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, ROCKVILLE, MD.

Survey Instructions

IMPORTANT: Please read before answering questions!

Answer the questions by checking the box to the left of your answer.

You may be asked to skip some questions that don't apply to you. When this happens you will see an arrow with a note that tells you what question to answer next, like this:

1☐ **Yes**
2☑ **NO → Go to question 13**

Your privacy is protected. All information that would let someone identify you or your family will be kept private. Your responses to this survey are also completely **confidential**. You may notice a number on the cover of the survey. This number is used **only** to let us know if you returned your survey so we don't have to send you reminders. Neither the Arkansas Foundation for Medical Care (AFMC) nor your insurance company will see your name or other information. All surveys are anonymous.

We appreciate your help in completing the survey.
If you choose not to, however, it will not affect the benefits you get.

If you have questions about this survey or want to know more about this study, please call toll-free 1-877-650-2362.

Si gusta recibir la versión en español de esta encuesta, favor llamar al 1-877-650-2362.

Your health care in the last 6 months

These questions ask about your own health care. Do not include care you got when you stayed overnight in a hospital. Do not include the times you went for dental care visits.

1) In the last 6 months, did you have an illness, injury, or condition that **needed care right away** in a clinic, emergency room, or doctor's office?

- 1 ☐ Yes
- 2 ☐ NO ➜ Go to Question 4

2) In the last 6 months, when you **needed care right away**, how often did you get care as soon as you needed?

- 1 ☐ Never
- 2 ☐ Sometimes
- 3 ☐ Usually
- 4 ☐ Always

3) In the last 6 months, how many times did you go to an emergency room?

- 0 ☐ None
- 1 ☐ 1 time
- 2 ☐ 2
- 3 ☐ 3
- 4 ☐ 4
- 5 ☐ 5 to 9
- 6 ☐ 10 or more times

4) In the last 6 months, did you make any appointments for a **check-up or routine care** at a doctor's office or clinic?

- 1 ☐ Yes
- 2 ☐ NO ➜ Go to Question 6

5) In the last 6 months, how often did you get an appointment for a **check-up or routine care** at a doctor's office or clinic as soon as you needed?

- 1 ☐ Never
- 2 ☐ Sometimes
- 3 ☐ Usually
- 4 ☐ Always

6) In the last 6 months, **not** counting the times you went to an emergency room, how many times did you go to a doctor's office or clinic to get health care for yourself?

- 0 ☐ NONE ➜ Go to Question 12
- 1 ☐ 1 time
- 2 ☐ 2
- 3 ☐ 3
- 4 ☐ 4
- 5 ☐ 5 to 9
- 6 ☐ 10 or more times

7) In the last 6 months, did you and a doctor or other health provider talk about specific things you could do to prevent illness?

- 1 ☐ Yes
- 2 ☐ No

8) Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?

- 00 ☐ 0 Worst health care possible
- 01 ☐ 1
- 02 ☐ 2
- 03 ☐ 3
- 04 ☐ 4
- 05 ☐ 5
- 06 ☐ 6
- 07 ☐ 7
- 08 ☐ 8
- 09 ☐ 9
- 10 ☐ 10 Best health care possible

9) In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?

- 1 ☐ Never
- 2 ☐ Sometimes
- 3 ☐ Usually
- 4 ☐ Always

10) An interpreter is someone who helps you talk with others who do not speak your language. In the last 6 months, did you need an interpreter to help you speak with anyone at your doctor's office or clinic?

- 1 ☐ Yes
- 2 ☐ **NO ➜ Go to Question 12**

11) In the last 6 months, when you needed an interpreter at your doctor's office or clinic, how often did you get one?

- 1 ☐ Never
- 2 ☐ Sometimes
- 3 ☐ Usually
- 4 ☐ Always

Your personal doctor

These questions are about your personal doctor or health care provider. For this survey, consider your personal doctor as anyone you see for your regular health care, including nurse practitioners and physician assistants.

12) A personal doctor is the one you would see if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor?

- 1 ☐ Yes
- 2 ☐ **NO ➜ Go to Question 31**

13) Check who you consider to be your personal doctor.

- 1 ☐ Physician (MD or DO)
- 2 ☐ Nurse practitioner (APN)
- 3 ☐ Physician assistant (PA)
- 4 ☐ Other **(Please specify. Please print.)**

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14) In the last 6 months, how many times did you visit your personal doctor to get care for yourself?

- 0 ☐ **NONE ➜ Go to Question 25**
- 1 ☐ 1 time
- 2 ☐ 2
- 3 ☐ 3
- 4 ☐ 4
- 5 ☐ 5 to 9
- 6 ☐ 10 or more times

15) In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

16) In the last 6 months, how often did your personal doctor listen carefully to you?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

17) In the last 6 months, how often did your personal doctor show respect for what you had to say?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

18) In the last 6 months, how often did your personal doctor spend enough time with you?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

19) When you visited your personal doctor for a scheduled appointment in the last 6 months, how often did he or she have your medical records or other information about your care?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

20) In the last 6 months, did your personal doctor order a blood test, x-ray, or other test for you?

1 ☐ Yes
2 ☐ **NO ➜ Go to Question 23**

21) In the last 6 months, when your personal doctor ordered a blood test, x-ray, or other test for you, how often did someone from your personal doctor's office follow up to give you those results?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

22) In the last 6 months, when your personal doctor ordered a blood test, x-ray, or other test for you, how often did you get those results as soon as you needed them?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

23) In the last 6 months, did you get care from a doctor or other health provider besides your personal doctor?

1 ☐ Yes
2 ☐ **NO ➜ Go to Question 25**

24) In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

25) Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?

- 00 ☐ 0 Worst personal doctor possible
- 01 ☐ 1
- 02 ☐ 2
- 03 ☐ 3
- 04 ☐ 4
- 05 ☐ 5
- 06 ☐ 6
- 07 ☐ 7
- 08 ☐ 8
- 09 ☐ 9
- 10 ☐ 10 Best personal doctor possible

26) In the last 6 months, did you take any prescription medicine?

- 1 ☐ Yes
- 2 ☐ **NO → Go to Question 28**

27) In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking?

- 1 ☐ Never
- 2 ☐ Sometimes
- 3 ☐ Usually
- 4 ☐ Always

28) In the last 6 months, did you get care from more than one kind of health care provider or use more than one kind of health care service?

- 1 ☐ Yes
- 2 ☐ **NO → Go to Question 31**

29) In the last 6 months, did you need help from anyone in your personal doctor's office to manage your care among these different providers and services?

- 1 ☐ Yes
- 2 ☐ **NO → Go to Question 31**

30) In the last 6 months, how often did you get the **help that you needed** from your personal doctor's office to manage your care among these different providers and services?

- 1 ☐ Never
- 2 ☐ Sometimes
- 3 ☐ Usually
- 4 ☐ Always

Getting health care from specialists

When you answer the next questions, do not include dental visits or care you got when you stayed overnight in a hospital.

31) Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, did you make any appointments to see a specialist?

- 1 ☐ Yes
- 2 ☐ **NO → Go to Question 35**

32) In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?

- 1 ☐ Never
- 2 ☐ Sometimes
- 3 ☐ Usually
- 4 ☐ Always

33) How many specialists have you seen in the last 6 months?

- 0 ☐ **NONE → Go to Question 35**
- 1 ☐ 1 specialist
- 2 ☐ 2
- 3 ☐ 3
- 4 ☐ 4
- 5 ☐ 5 or more specialists

34) We want to know your rating of the specialist you saw most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?

- 00 ☐ 0 Worst specialist possible
- 01 ☐ 1
- 02 ☐ 2
- 03 ☐ 3
- 04 ☐ 4
- 05 ☐ 5
- 06 ☐ 6
- 07 ☐ 7
- 08 ☐ 8
- 09 ☐ 9
- 10 ☐ 10 Best specialist possible

Getting information in person

The following questions ask about your experiences when you met in person with anyone from an agency or organization that helps people get health insurance through the Health Insurance Marketplace between October 1, 2013, and September 30, 2014.

35) Between October 1, 2013, and September 30, 2014, did you meet in person with anyone from an organization that helps people get health insurance through the Health Insurance Marketplace?

- 1 ☐ **YES → Go to Question 37**
- 2 ☐ No

36) Between October 1, 2013, and September 30, 2014, did you want in-person help but were unable to get it because the building was not accessible for persons with disabilities?

- 1 ☐ **YES → Go to Question 46**
- 2 ☐ **NO → Go to Question 46**

37) Who helped you get health insurance through the Health Insurance Marketplace? **Mark one or more.**

- A ☐ Insurance agent
- B ☐ Guide or navigator
- C ☐ Certified application counselor
- D ☐ Other **(Please specify. Please print.)**

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38) Between October 1, 2013, and September 30, 2014, how often did you get the information or help you needed when you met in person with someone about getting health insurance from the Health Insurance Marketplace?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ **ALWAYS → Go to Question 40**

39) Were any of the following a reason why you did **not** get the information or help you needed when you met in person with someone about getting health insurance from the Health Insurance Marketplace? **Mark one or more.**

Did **not** get the information or help because:

A ☐ There was not enough time
B ☐ They did not have the information you needed
C ☐ The information they gave you was hard to understand
D ☐ The information they gave you was wrong
E ☐ You could not talk or sign to someone in the language you prefer
F ☐ Some other reason **(Please specify. Please print.)**

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40) Between October 1, 2013, and September 30, 2014, how often was it easy to understand the information you got when you met in person with someone about getting health insurance from the Health Insurance Marketplace?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ **ALWAYS → Go to Question 42**

41) What kind of information was **not** easy to understand when you met in person with someone about getting health insurance from the Health Insurance Marketplace? **Mark one or more.**

Not easy to understand:

A ☐ How to get help paying for your health insurance
B ☐ Important deadlines
C ☐ Benefits and coverage for doctor or specialist visits
D ☐ Benefits and coverage for prescription drugs
E ☐ Benefits and coverage for prenatal care or childbirth
F ☐ How much you would have to pay for each health plan
G ☐ How much you would have to pay out-of-pocket for health care services in each health plan
H ☐ What is included in a "wellness visit" and what you would have to pay
I ☐ Which doctors are in each health plan
J ☐ What you would have to pay if you used a doctor outside of the health plan
K ☐ How to figure out your family size or income
L ☐ Which doctors in each health plan have offices that are accessible for people with disabilities
M ☐ How to find a health plan that meets your family's needs
N ☐ Something else **(Please specify. Please print.)**

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42) Between October 1, 2013, and September 30, 2014, how often were the persons you met with about getting health insurance from the Health Insurance Marketplace as helpful as you thought they should be?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

43) Between October 1, 2013, and September 30, 2014, how often did the persons you met with about getting health insurance from the Health Insurance Marketplace use words or phrases you did not understand?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

44) Between October 1, 2013, and September 30, 2014, how often did the persons you met with about getting health insurance from the Health Insurance Marketplace treat you with courtesy and respect?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

45) We want to know your rating of the in-person assistance you got to help you use the Health Insurance Marketplace between October 1, 2013, and September 30, 2014. Using any number from 0 to 10, where 0 is the worst in-person assistance possible and 10 is the best in-person assistance possible, what number would you use to rate the assistance you got when you met in person with someone about getting health insurance from the Health Insurance Marketplace?

00 ☐ 0 Worst in-person assistance possible
01 ☐ 1
02 ☐ 2
03 ☐ 3
04 ☐ 4
05 ☐ 5
06 ☐ 6
07 ☐ 7
08 ☐ 8
09 ☐ 9
10 ☐ 10 Best in-person assistance possible

Choosing a health plan

The following questions ask about your experience choosing a health plan through the Health Insurance Marketplace between October 1, 2013, and September 30, 2014.

46) Between October 1, 2013, and September 30, 2014, were you looking for health insurance for yourself or for another family member through the Health Insurance Marketplace?

1 ☐ Yes
2 ☐ No

47) Between October 1, 2013, and September 30, 2014, did you consider the services covered by the health plans available to you in the Health Insurance Marketplace and how much you would have to pay?

1 ☐ Yes
2 ☐ **NO ➜ Go to Question 50**

48) Between October 1, 2013, and September 30, 2014, how often was it easy to understand the services covered by the health plans available to you?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

49) Between October 1, 2013, and September 30, 2014, how often was it easy to understand how much you would have to pay?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

50) Between October 1, 2013, and September 30, 2014, did you try to find out which plans in the Health Insurance Marketplace had the doctors or hospitals you wanted?

1 ☐ Yes
2 ☐ **NO ➜ Go to Question 52**

51) Between October 1, 2013, and September 30, 2014, how often was it easy to understand which health plans had the doctors or hospitals you wanted?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

52) Did you choose a health plan through the Health Insurance Marketplace?

1 ☐ Yes
2 ☐ **NO ➜ Go to Question 54**

53) Was it easy to choose a health plan?

1 ☐ Yes, definitely
2 ☐ Yes, somewhat
3 ☐ No

Your health plan

The next questions ask about your experience with your health plan.

54) Between the time you turned 18 and December 31, 2013, have you ever had any kind of health insurance?

1 ☐ Yes, individual insurance plan
2 ☐ Yes, under parent's plan
3 ☐ Yes, under parent's plan and individual insurance plan
4 ☐ No, this is my first insurance plan
➜ Go to Question 56

55) In the 6 months **before you enrolled** in the Health Insurance Marketplace, were you covered by **health** insurance?

1 ☐ Yes
2 ☐ No
3 ☐ Not applicable

56) In the last 6 months, did you look for any information in written materials or on the Internet about how your health plan works?

1 ☐ Yes
2 ☐ **NO ➜ Go to Question 58**

57) In the last 6 months, how often did the written materials or the Internet provide the information you needed about how your health plan works?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

58) Sometimes people need services or equipment beyond what is provided in a regular or routine office visit, such as care from a specialist, physical therapy, a hearing aid, or oxygen. In the last 6 months, did you look for information from your health plan on how much you would have to pay for a health care service or equipment?

1 ☐ Yes
2 ☐ **NO ➜ Go to Question 60**

59) In the last 6 months, how often were you able to find out from your health plan how much you would have to pay for a health care service or equipment?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

60) In some health plans the amount you pay for a prescription medicine can be different for different medicines, or can be different for prescriptions filled by mail instead of at the pharmacy. In the last 6 months, did you look for information from your health plan on how much you would have to pay for specific prescription medicines before you got them?

1 ☐ Yes
2 ☐ **NO ➜ Go to Question 62**

61) In the last 6 months, how often were you able to find out from your health plan how much you would have to pay for specific prescription medicines?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

62) In the last 6 months, did you get information or help from your health plan's customer service?

1 ☐ Yes
2 ☐ NO ➜ Go to Question 65

63) In the last 6 months, how often did your health plan's customer service give you the information or help you needed?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

64) In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

65) In the last 6 months, did your health plan give you any forms to fill out?

1 ☐ Yes
2 ☐ NO ➜ Go to Question 70

66) In the last 6 months, how often were the forms from your health plan easy to fill out?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

67) In the last 6 months, how often were the forms that you had to fill out available in the language you prefer?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

68) In the last 6 months, did you need the forms in a different format, such as large print or braille?

1 ☐ Yes
2 ☐ NO ➜ Go to Question 70

69) In the last 6 months, how often were the forms that you had to fill out available in the format you needed, such as large print or braille?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

70) Claims are sent to a health plan for payment. You may send in the claims yourself, or doctors, hospitals, or others may send them to your health plan for you. In the last 6 months, did you or anyone else send in any claims for payment of your health care costs to your health plan?

1 ☐ Yes
2 ☐ NO ➜ Go to Question 73
3 ☐ Don't know ➜ Go to Question 73

71) In the last 6 months, how often did your health plan handle your claims quickly?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ Don't know

72) In the last 6 months, how often did your health plan handle your claims correctly?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ Don't know

73) Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?

00 ☐ 0 Worst health plan possible
01 ☐ 1
02 ☐ 2
03 ☐ 3
04 ☐ 4
05 ☐ 5
06 ☐ 6
07 ☐ 7
08 ☐ 8
09 ☐ 9
10 ☐ 10 Best health plan possible

74) In the last 6 months, before you went for care, how often did your health plan make it clear how much you would have to pay?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

75) In the last 6 months, how often did your health plan not pay for a service that your doctor said you needed?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

76) In the last 6 months, how often did you have to pay out of your own pocket for care that you thought your health plan would pay for?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

77) In the last 6 months, did you delay or not visit a doctor because you were worried about the cost? Do **not** include dental care.

1 ☐ Yes
2 ☐ No

78) In the last 6 months, did you delay or not visit a doctor because you could not afford to miss time off from work to go to the doctor?

1 ☐ Yes
2 ☐ No

79) In the last 6 months, did you delay or not fill a prescription because you were worried about the cost?

1 ☐ Yes
2 ☐ No

About you

80) In general, how would you rate your overall health?

1 ☐ Excellent
2 ☐ Very good
3 ☐ Good
4 ☐ Fair
5 ☐ Poor

81) In general, how would you rate your overall **mental or emotional health**?

1 ☐ Excellent
2 ☐ Very good
3 ☐ Good
4 ☐ Fair
5 ☐ Poor

82) Do you now smoke cigarettes or use tobacco every day, some days, or not at all?

1 ☐ Every day
2 ☐ Some days
3 ☐ **Not at all** ➜ **Go to Question 86**
4 ☐ **Don't know** ➜ **Go to Question 86**

83) In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

84) In the last 6 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

85) In the last 6 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

86) Do you take aspirin daily or every other day?

1 ☐ Yes
2 ☐ No
3 ☐ Don't know

87) Do you have a health problem or take medication that makes taking aspirin unsafe for you?

1 ☐ Yes
2 ☐ No
3 ☐ Don't know

88) Has a doctor or health provider ever discussed with you the risks and benefits of aspirin to prevent heart attack or stroke?

1 ☐ Yes
2 ☐ No

89) Are you aware that you have any of the following conditions? **Mark one or more.**

A ☐ High cholesterol
B ☐ High blood pressure
C ☐ Parent or sibling with heart attack before the age of 60

90) Has a doctor ever told you that you have any of the following conditions? **Mark one or more.**

A ☐ A heart attack
B ☐ Angina or coronary heart disease
C ☐ A stroke
D ☐ Any kind of diabetes or high blood sugar

91) In the last 6 months, did you get health care 3 or more times for the same condition or problem?

1 ☐ Yes
2 ☐ **NO → Go to Question 93**

92) Is this a condition or problem that has lasted for at least 3 months? Do **not** include pregnancy or menopause.

1 ☐ Yes
2 ☐ No

93) Do you now need or take medicine prescribed by a doctor? Do **not** include birth control.

1 ☐ Yes
2 ☐ **NO → Go to Question 95**

94) Is this medicine to treat a condition that has lasted for at least 3 months? Do **not** include pregnancy or menopause.

1 ☐ Yes
2 ☐ No

95) What is the highest grade or level of school that you have completed?

1 ☐ 8th grade or less
2 ☐ Some high school, but did not graduate
3 ☐ High school graduate or GED
4 ☐ Some college or 2-year degree
5 ☐ 4-year college graduate
6 ☐ More than 4-year college degree

96) What **best** describes your employment status? Are you: [**Mark only ONE.**]

1 ☐ Employed full-time
2 ☐ Employed part-time
3 ☐ A homemaker
4 ☐ A full-time student
5 ☐ Retired
6 ☐ Unable to work for health reasons
7 ☐ Unemployed
8 ☐ Other

97) Are you of Hispanic or Latino origin or descent?

1 ☐ Yes, Hispanic or Latino
2 ☐ No, not Hispanic or Latino

98) What is your race? **Mark one or more.**

A ☐ White
B ☐ Black or African American
C ☐ Asian
D ☐ Native Hawaiian or Other Pacific Islander
E ☐ American Indian or Alaska Native
F ☐ Other (**Please specify. Please print.**)

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99) What is your preferred language?

1 ☐ English
If English ➜ Go to Question 101
2 ☐ Spanish
3 ☐ Chinese
4 ☐ Other (**Please specify. Please print.**)

____

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100) How well do you speak English?

1 ☐ Very well
2 ☐ Well
3 ☐ Not well
4 ☐ Not at all

101) Did someone help you complete this survey?

1 ☐ **YES ➜ Go to Question 102**
2 ☐ **NO ➜ Thank you.** Please return the completed survey in the postage-paid envelope.

102) How did that person help you? **Mark one or more.**

A ☐ Read the questions to me
B ☐ Wrote down the answers I gave
C ☐ Answered the questions for me
D ☐ Translated the questions into my language
E ☐ Helped in some other way (**Please specify. Please print.**)

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THANK YOU!
Please return
the completed survey
in the postage-paid
envelope.

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Hello!

We recently sent you a survey.

If you have already returned it, please accept our thanks.
You do not need to call to see if it has been received.

If you have not returned your survey,
please take a few minutes to do so.

Because only a small number of people have been selected for the survey, it is extremely important that each person takes part. Even if you can only answer some questions, please return the survey.

If you did not get a survey, or if it was misplaced,
please call Arkansas Foundation for Medical Care toll-free at

1-877-650-2362,

and we will mail you another copy.

We appreciate your help!

Si gusta recibir la versión en español de esta encuesta o completarla por teléfono, favor de llamar al 1-877-650-2362.

Click here to view this message in a browser window.

Dear Provider,

Good afternoon from the Arkansas Foundation for Medical Care (AFMC). The Affordable Care Act led to several changes in Arkansas insurance plans for 2014 including Medicaid expansion via the Private Option and the creation of the Arkansas Partnership Marketplace. AFMC is part of an external evaluation for the Arkansas Partnership Marketplace. As part of the evaluation, we would like to send a brief survey to Arkansas health care providers regarding your experience before and after implementation of the Arkansas Partnership Marketplace. This survey will only take a few minutes of your time. We greatly appreciate your time and feedback.

Within the next two weeks, we will be sending a Survey Monkey link to each provider from the following email address: **ExternalEvaluation@afmc.org**. Let us know if you have updated contact information. Please send only one collective survey response, as this survey will be limited to one response per organization.

Please let me know if you have any questions. It is a pleasure working with you!

Yours very truly,

Amelia Rich-Elam, CPHIT
Manager, Provider Relations
Medicaid Managed Care Services
(A division of Arkansas Foundation for Medical Care)
1020 West 4th Street
Little Rock, AR 72201

501-212-8674
Fax: 501-375-0705

Click here to view this message in a browser window.

Dear Provider,

Good afternoon from the Arkansas Foundation for Medical Care (AFMC). The Affordable Care Act led to several changes in Arkansas insurance plans for 2014 including Medicaid expansion via the Private Option and the creation of the Arkansas Partnership Marketplace. AFMC is part of an external evaluation for the Arkansas Partnership Marketplace. As part of the evaluation, we would like to send a brief survey to Arkansas health care providers regarding your experience before and after implementation of the Arkansas Partnership Marketplace. This survey will only take a few minutes of your time. We greatly appreciate your time and feedback.

Within the next two weeks, we will be sending a Survey Monkey link to each provider from the following email address: **ExternalEvaluation@afmc.org**. Let us know if you have updated contact information. Please send only one collective survey response, as this survey will be limited to one response per organization.

Please let me know if you have any questions. It is a pleasure working with you!

Yours very truly,

Melanie Boyd
Manager, Program Evaluation
Analytics
Arkansas Foundation for Medical Care
mboyd@afmc.org
501-212-8718

URAC
In-Process
HEALTH UTILIZATION
MANAGEMENT
GOVERNOR'S
Quality Award
ACHIEVEMENT AWARD 2013

AID Hospital Marketplace Survey

The Affordable Care Act (ACA) led to several changes in Arkansas insurance plans in 2014 including Medicaid expansion/Private Option and the creation of the Arkansas State Partnership Marketplace. Arkansas's Partnership Marketplace was in place by January 1, 2014.

- Medicaid expansion involves individuals earning less than 138% of the federal poverty level (FPL) who qualify for Arkansas's Private Option coverage. Medicaid pays the monthly health insurance premium for those who qualify for private option coverage.

- Currently, those in the newly eligible Medicaid expansion population who qualify for traditional Medicaid are individuals who are deemed to have complex or costly health conditions not covered by their private insurance plan ("medically frail"). Applicants are asked a series of questions that assess medical usage, living situation, and state of health. Individuals who are considered to need additional services not provided by the private insurance plans are signed up for the traditional Medicaid plan.

- The government established a Health Insurance Marketplace so that individuals can compare health insurance plans to choose the one that best suits their needs and budget. Financial assistance on monthly health insurance premiums is available for individuals who earn between 138% and 400% FPL.

- The government also assists with cost-sharing reductions beyond premiums (co-pays; co-insurance) for individuals with incomes between 100% and 250% of the FPL and who are enrolled in a Silver Level Plan offered on the Marketplace. Beginning in PY 2015, individuals with incomes between 50% and 100% FPL will be responsible for modest cost-sharing on a sliding scale, although their cost sharing in 2014 was zero (completely paid by the government).

This survey is part of an evaluation to determine how health care services have been impacted by implementation of the Health Insurance Marketplace in Arkansas in plan year 2014. Participation is voluntary. All responses are confidential and will be stored in a secure database. Results will be de-identified and reported to the Arkansas Insurance Department for evaluation purposes and released in aggregate only.

Hospital Name: ______________________ Hospital Phone: __________________

Survey Respondent Name: _____________________ Date: ___________________

County of Hospital: ____

1. Which of the following describes your hospital?
   1☐ Critical access hospital (CAH)
   2☐ Prospective payment system (PPS)
   3☐ Psychiatric hospital
   4☐ Other _______________________________________

2. What size community does your hospital service?
   1☐ 5,000 or less
   2☐ 5,001 to 10,000
   3☐ 10,001 to 25,000
   4☐ 25,001 to 50,000
   5☐ 50,001 to 100,000
   6☐ 100,001 or above

3. How many acute care inpatient beds does your hospital have?
   1☐ 0-49
   2☐ 50-99
   3☐ 100-199
   4☐ 200-299
   5☐ 300-399
   5☐ 400+

Insurance plans purchased through the Arkansas Partnership Marketplace were effective beginning January 1, 2014.

4. On average, how many inpatient admits did you have per week before the Marketplace was in place?

   ___ ___ ___

5. On average, how many inpatient admits do you currently have per week?

___ ___ ___

6. Have you made changes in your hospital to accommodate changes in patient load since the implementation of the Partnership Marketplace?

1☐ Yes
2☐ No

7. If yes, what changes have you made? Please select all that apply:

A☐ Adjusted daily workflow
B☐ Hired more clinical staff
C☐ Reduced clinical staffing
D☐ Increased bed capacity
E☐ Decreased bed capacity
F☐ Increased billing support staff
G☐ Decreased billing support staff
H☐ Increased structural capacity (construction projects, etc.)
I☐ Decreased structural capacity (selling of property, etc.)
J☐ Other ____

8. Have time constraints affected your ability to service Medicare, newly-enrolled Marketplace (including Private Option), traditional Medicaid, or existing insurance patients? Mark all that apply.

1☐ Yes, Medicare
2☐ Yes, Newly-enrolled Marketplace/Private Option
3☐ Yes, Traditional Medicaid
4☐ Yes, Existing Insurance
5☐ No, we are able to service all four groups of patients

9. Have cost constraints affected your ability to service Medicare, newly-enrolled Marketplace (including Private Option), traditional Medicaid, or existing insurance patients? Mark all that apply.

1☐ Yes, Medicare
2☐ Yes, Newly-enrolled Marketplace/Private Option
3☐ Yes, Traditional Medicaid
4☐ Yes, Existing Insurance
5☐ No, we are able to service all four groups of patients

10. Please estimate the percent of uncompensated care costs for your facility during calendar year Q2 (April-June) 2013, before the Marketplace was in place?

____________________%

11. Please estimate the percent of uncompensated care costs for your facility in calendar year Q2 (April – June) 2014:

______________________________%

12. On average, what percentage of uninsured visits to your ER did you have per week before the Marketplace was in place?

_____________________%

13. On average, what percentage of uninsured visits to your ER do you currently see per week?

_____________________%

14. Before the Marketplace was in place, what percent of your in-patient patients were:

1______Medicare

2______ Medicaid

3______Private Insurance

4______Self pay

5______ Indigent

6______ Other

15. What <u>percent</u> of your in-patient patients <u>currently</u> are:

1______Medicare

2______ Medicaid

3______ Private Insurance, including newly insured through the Marketplace/Private Option

4______Self pay

5______ Indigent

6______ Other

16. Did your hospital refer patients to licensed Marketplace Assisters to assist with health insurance applications and enrollment?

1☐ Yes
2☐ No

17. Is your hospital a Certified Application Counselor (CAC) Organization?

1☐ Yes (Skip to 19)
2☐ No

18. If your hospital is not currently a Certified Application (CAC) Organization, does your hospital plan to become a CAC?

1☐ Yes
2☐ No

19. On a scale of one to ten, with one indicating most ease and ten indicating most difficult, how difficult is it for your hospital to identify patients with health care insurance from the following sources:

	easy	1	2	3	4	5	6	7	8	9	10	difficult
1	Medicare	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
2	Newly-enrolled Marketplace/Private Option	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
3	Traditional Medicaid	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
4	Other (non-Marketplace) Private Insurance	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

20. Please rate your overall satisfaction with education provided to your hospital staff regarding the implementation of the Marketplace.

1☐ Very Satisfied
2☐ Satisfied
3☐ Neutral (Not Satisfied or Dissatisfied)
4☐ Dissatisfied
5☐ Very Dissatisfied

21. Please indicate what education regarding Arkansas's Partnership Marketplace is needed.

____

22. Please provide any additional comments or suggestions you might have.

____

AID Physician Marketplace Survey

The Affordable Care Act (ACA) led to several changes in Arkansas insurance plans in 2014 including Medicaid expansion/Private Option and the creation of the Arkansas State Partnership Marketplace. Arkansas's Partnership Marketplace was in place by January 1, 2014.

- Medicaid expansion involves individuals earning less than 138% of the federal poverty level (FPL) who qualify for Arkansas's Private Option coverage. Medicaid pays the monthly health insurance premium for those who qualify for private option coverage.

- Currently, those in the newly eligible Medicaid expansion population who qualify for traditional Medicaid are individuals who are deemed to have complex or costly health conditions not covered by their private insurance plan ("medically frail"). Applicants are asked a series of questions that assess medical usage, living situation, and state of health. Individuals who are considered to need additional services not provided by the private insurance plans are signed up for the traditional Medicaid plan.

- The government established a Health Insurance Marketplace so that individuals can compare health insurance plans to choose the one that best suits their needs and budget. Financial assistance on monthly health insurance premiums is available for individuals who earn between 138% and 400% FPL.

- The government also assists with cost-sharing reductions beyond premiums (co-pays; co-insurance) for individuals with incomes between 100% and 250% of the FPL and who are enrolled in a Silver Level Plan offered on the Marketplace. Beginning in PY 2015, individuals with incomes between 50% and 100% FPL will be responsible for modest cost-sharing on a sliding scale, although their cost sharing in 2014 was zero (completely paid by the government).

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Clinic Name: ___________________________ Clinic Phone: _______________

Physician Name: ________________________ Date: _______________________

County of Practice: ____

Survey Respondent Name: ____

1. How would you classify the majority of care you provide?

1☐ Primary care
2☐ Medical specialty
3☐ Surgical specialty
4☐ Other ____

2. In what size community do you practice?

1☐ 5,000 or less
2☐ 5,001 to 10,000
3☐ 10,001 to 25,000
4☐ 25,001 to 50,000
5☐ 50,001 to 100,000
6☐ 100,001 or above

3. What is the size of your practice?

1☐ Solo
2☐ 2-5 physicians
3☐ 6-10 physicians
4☐ 11-30 physicians
5☐ 31-100 physicians

Insurance plans purchased through the Arkansas Partnership Marketplace were effective beginning January 1, 2014.

4. On average how many patients did your practice see per week before the Marketplace was in place?

1☐ 1-75
2☐ 76-150
3☐ 151-200
4☐ 201-250
5☐ 251-350
6☐ 351 or above

5. On average, how many patients does your practice currently see per week?

1☐ 1-75
2☐ 76-150
3☐ 151-200
4☐ 201-250
5☐ 251-350
6☐ 351 or above

6. Before the Partnership Marketplace was in place, what percent of your patients were:

1______Medicare

2______ Medicaid

3______Private Insurance

4______Self pay

5______ Indigent

6______ Other

7. What percent of your patients currently are:

1______Medicare

2______ Medicaid

3______ Private Insurance, including newly insured through the Marketplace/Private Option

4______Self pay

5______ Indigent

6______ Other

8. On a scale of one to ten, with one indicating most ease and ten indicating most difficult, how difficult is it for your practice to identify patients with health care insurance from the following sources:

	easy	1	2	3	4	5	6	7	8	9	10	difficult
1 Medicare		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
2 Newly-enrolled Marketplace/Private Option		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
3 Traditional Medicaid		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
4 Other (non-Marketplace) Private Insurance		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

9. Did your clinic refer patients to the Arkansas Partnership Marketplace or to an Assister to help with application for insurance?

1☐ Yes
2☐ No

10. Have you made changes in your clinic to accommodate changes in patient load since the implementation of the Marketplace?

1☐ Yes
2☐ No

11. If yes, what changes have you made? Please select all that apply:

A☐ Adjusted daily workflow
B☐ Adjusted clinic or office hours
C☐ Hired more clinical staff
D☐ Reduced clinical staffing
E☐ Hired more office staff
F☐ Reduced office staff
G☐ Increased structural capacity (construction projects, etc.)
H☐ Decreased structural capacity (selling of property, etc.)
I☐ Other ______________________________

12. Which of the following best describes your current practice? Please select all that apply:

A☐ We are at full capacity
B☐ We are taking new patients on Medicare
C☐ We are taking new patients from the Marketplace/Private Option
D☐ We are taking new patients on Traditional Medicaid
E☐ We are taking new patients with Existing Insurance

13. Have time constraints affected your ability to service Medicare, newly-enrolled Marketplace (including Private Option), traditional Medicaid, or existing insurance patients? Mark all that apply.

1☐ Yes, Medicare
2☐ Yes, Newly-enrolled Marketplace/Private Option
3☐ Yes, Traditional Medicaid
4☐ Yes, Existing Insurance
5☐ No, we are able to service all four groups of patients

14. Have cost constraints affected your ability to service Medicare, newly-enrolled Marketplace (including Private Option), traditional Medicaid, or existing insurance patients? Mark all that apply.

1☐ Yes, Medicare
2☐ Yes, Newly-enrolled Marketplace/Private Option
3☐ Yes, Traditional Medicaid
4☐ Yes, Existing Insurance
5☐ No, we are able to service all four groups of patients

15. Estimate the amount of total uncompensated care your entire group provided in the course of Q2 (April-June) 2013, before the Marketplace was in place:

1☐ $0 - $5000

2☐ $5,001 - $15,000

3☐ $15,001 - $25,000

4☐ $25,001 - $35,000

5☐ $35,001 - $50,000

6☐ $50,001 or more

16. Estimate the amount of uncompensated care your entire group provided in the course of Q2 (April-June) 2014:

1☐ $0 - $5000

2☐ $5,001 - $15,000

3☐ $15,001 - $25,000

4☐ $25,001 - $35,000

5☐ $35,001 - $50,000

6☐ $50,001 or more

17. Please rate your overall satisfaction with education provided regarding the implementation of the Marketplace.

1☐ Very Satisfied
2☐ Satisfied
3☐ Neutral (Not Satisfied or Dissatisfied)
4☐ Dissatisfied
5☐ Very Dissatisfied

18. Please indicate what education regarding Arkansas's Partnership Marketplace is needed.

____

19. Please provide any additional comments or suggestions you might have.

____

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Clinic Name: ___________________________ Clinic Phone: _______________

Physician Name: ________________________ Date: _______________________

County of Practice: ____

Survey Respondent Name: ____

1. Which of the following describes your facility? Mark all that apply.

A☐ Inpatient
B☐ Outpatient
C☐ Residential care
D☐ Community Mental Health Center
E☐ Correctional facility
F☐ Other (please specify) ____

2. How would you classify the majority of care you provide? Mark all that apply.

A☐ Counseling services
B☐ Case management
C☐ Substance or alcohol abuse treatment
D☐ Suicide prevention
E☐ Care, education, or therapy for special needs children or adults
F☐ Domestic violence prevention or therapy
G☐ Women's services
H☐ Men's services
I☐ Foster services
J☐ Post-prison support
K☐ Other (please specify) ____

3. In what size community do you practice?

1☐ 5,000 or less
2☐ 5,001 to 10,000
3☐ 10,001 to 25,000
4☐ 25,001 to 50,000
5☐ 50,001 to 100,000
6☐ 100,001 or above

4. What is the size of your practice?

1☐ Solo
2☐ 2-5 providers
3☐ 6-10 providers
4☐ 11-30 providers
5☐ 31-100 providers

Insurance plans purchased through the Arkansas Partnership Marketplace were effective beginning January 1, 2014.

5. On average how many patients did your practice see per week <u>before</u> the Marketplace was in place?

1☐ 1-75
2☐ 76-150
3☐ 151-200
4☐ 201-250
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6. On average, how many patients does your practice <u>currently</u> see per week?

1☐ 1-75
2☐ 76-150
3☐ 151-200
4☐ 201-250
5☐ 251-350
6☐ 351 or above

7. <u>Before</u> the Partnership Marketplace was in place, what <u>percent</u> of your patients were:

1______Medicare

2______ Medicaid

3______Private Insurance

4______Self pay

5______ Indigent

6______ Other

8. What percent of your patients currently are:

1______Medicare

2______ Medicaid

3______ Private Insurance, including newly insured through the Marketplace/Private Option

4______Self pay

5______ Indigent

6______ Other

9. On a scale of one to ten, with one indicating most ease and ten indicating most difficult, how difficult is it for your practice to identify patients with health care insurance from the following sources:

	easy	1	2	3	4	5	6	7	8	9	10	difficult
1 Medicare		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
2 Newly-enrolled Marketplace/Private Option		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
3 Traditional Medicaid		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
4 Other (non-Marketplace) Private Insurance		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

10. Did your clinic refer patients to the Arkansas Partnership Marketplace or to an Assister to help with application for insurance?

1☐ Yes
2☐ No

11. Have you made changes in your clinic to accommodate changes in patient load since the implementation of the Marketplace?

1☐ Yes
2☐ No

12. If yes, what changes have you made? Please select all that apply:

A☐ Adjusted daily workflow
B☐ Adjusted clinic or office hours
C☐ Hired more clinical staff
D☐ Reduced clinical staffing

E☐ Hired more office staff
F☐ Reduced office staff
G☐ Increased structural capacity (construction projects, etc.)
H☐ Decreased structural capacity (selling of property, etc.)
I☐ Other ____

13. Which of the following best describes your current practice? Please select all that apply:
A☐ We are at full capacity
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C☐ We are taking new patients from the Marketplace/Private Option
D☐ We are taking new patients on Traditional Medicaid
E☐ We are taking new patients with Existing Insurance

14. Have <u>time</u> constraints affected your ability to service Medicare, newly-enrolled Marketplace (including Private Option), traditional Medicaid, or existing insurance patients? Mark all that apply.
1☐ Yes, Medicare
2☐ Yes, Newly-enrolled Marketplace/Private Option
3☐ Yes, Traditional Medicaid
4☐ Yes, Existing Insurance
5☐ No, we are able to service all four groups of patients

15. Have <u>cost</u> constraints affected your ability to service Medicare, newly-enrolled Marketplace (including Private Option), traditional Medicaid, or existing insurance patients? Mark all that apply.
1☐ Yes, Medicare
2☐ Yes, Newly-enrolled Marketplace/Private Option
3☐ Yes, Traditional Medicaid
4☐ Yes, Existing Insurance
5☐ No, we are able to service all four groups of patients

16. Estimate the amount of total uncompensated care your entire group provided in the course of Q2 (April-June) 2013, <u>before</u> the Marketplace was in place:

1☐ $0 - $5000

2☐ $5,001 - $15,000

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5☐ $35,001 - $50,000

6☐ $50,001 or more

17. Estimate the amount of uncompensated care your entire group provided in the course of Q2 (April-June) 2014:

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2☐ $5,001 - $15,000

3☐ $15,001 - $25,000

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5☐ $35,001 - $50,000

6☐ $50,001 or more

18. Please rate your overall satisfaction with education provided regarding the implementation of the Marketplace.

1☐ Very Satisfied
2☐ Satisfied
3☐ Neutral (Not Satisfied or Dissatisfied)
4☐ Dissatisfied
5☐ Very Dissatisfied

19. Please indicate what education regarding Arkansas's Partnership Marketplace is needed.

____

20. Please provide any additional comments or suggestions you might have.

____

VIII-F. HEALTH CAREPROVIDER SURVEY REMINDER EMAIL

To:

From: [AFMC Evaluation Team]

Subject: Arkansas Insurance Department Provider Survey

Body: Hello from Arkansas Foundation for Medical Care (AFMC). As mentioned in our previous email, we are conducting a brief survey regarding your experiences before and after implementation of the Arkansas Insurance Department's State Partnership Marketplace. Your response is appreciated.

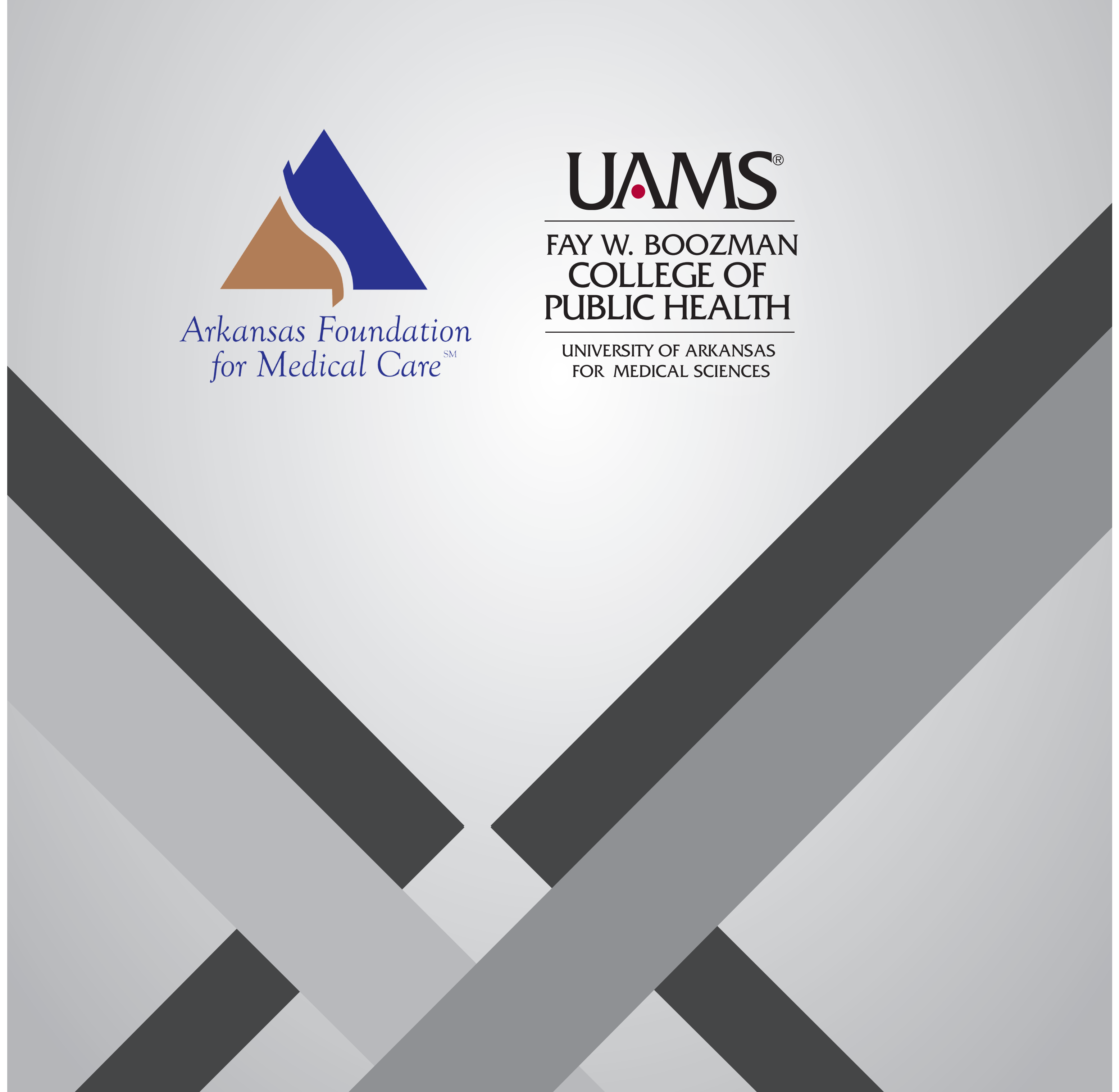
Name: [FirstName] [LastName]
Organization Name: [Name]

Here is a link to the survey: [Unique Survey Link]

This link is uniquely tied to this survey and your email address. Please do not forward this message.

Thanks for your participation!

Please note: If you do not wish to receive further emails from us, please click the link below, and you will be automatically removed from our mailing list.
https://www.surveymonkey.com/optout.aspx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