

State of Delaware

Department of Health and Social Services

Health Insurance Exchange Planning

**Information Technology Gap Analysis and To-Be Vision of the
Exchange IT Systems Infrastructure**

September 12, 2011

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1. Executive Summary

In March 2010, the Patient Protection and Affordable Care Act (ACA) was passed by Congress and signed by the President. The ACA requires the creation of state-based Health Insurance Exchanges (“Exchange”) that will allow consumers to access information on qualified health plans offered by commercial insurers; apply for health subsidy programs (e.g., Medicaid, Children’s Health Insurance Program (CHIP), premium subsidies through the Exchange); and enroll in coverage. Individuals and families will be able to select a health plan that best meets their needs by submitting an application online, in person, through the mail, or over the phone. Based on recently released regulations by the Center for Consumer Information and Insurance Oversight (CCIIO), Exchanges will need to be operational by October 1, 2013 for coverage that will take effect January 1, 2014.

Information Technology (IT) readiness will play a critical role in establishing a streamlined and integrated “no wrong door” process for accessing both public and private health benefits under the ACA, a policy that also aligns with the Delaware Department of Health and Social Services’ (DHSS) strategic vision to provide centralized, easy access to affordable health care coverage for citizens. To that end, DHSS has requested that Public Consulting Group (PCG) develop a report to document the “To-Be” vision of the IT capabilities needed to implement the Exchange in the most effective and cost-efficient way that is also financially sustainable long-term.

The entirety of this report and PCG’s assessment of IT system gaps is based strictly upon Federal guidance and the vision articulated through U.S. Department of Health and Human Services (HHS) publications. It must be noted, however, that HHS’s vision for the Exchange and eligibility solutions is ambitious and far-reaching, and many areas of it have yet to be defined in detail. Therefore, significant uncertainty remains as to what the full and final federal requirements will be.

During the As-Is Assessment, PCG found that DHSS has a stable and secure IT infrastructure to support its core business needs, that its experience implementing the ASSIST tool presented a potential solution to what will be required of an Exchange, and that its integrated approach to eligibility across many programs and flexible approach to customer service were in good alignment with the goals and objectives of the federal health care reform law. On the flip side, it was clear that DHSS has many obstacles to overcome in order to develop a sufficient Exchange IT solution.

The results of PCG's gap analysis confirm this initial assessment and show that Delaware has some technical resources that could be leveraged in their current state to support the Exchange. The ASSIST application and some other existing infrastructure, such as oversight and noticing, represent areas where DHSS may have some flexibility to re-use existing resources, but many of the functions needed by an Exchange are either not currently supported by any DHSS system or may not have sufficient capacity. In addition, a lynchpin for the implementation of an Exchange is the development of a seamless, integrated, and largely real-time eligibility system. In such a solution, system modularity and flexibility are paramount, and portions of DHSS's current eligibility environment may not be well positioned to meet these demands.

This result should not be particularly surprising, however, since nothing analogous to a Health Benefit Exchange exists in the public sector. While Delaware's technical infrastructure had done a fair job of meeting DHSS's business needs, the advent of the ACA, in addition to the requirement to establish an Exchange or defer to the federal government to operate its Exchange, means that Delaware has many hard choices ahead on where to invest its resources, both to address the gaps identified in this report and to support its existing business needs.

To facilitate this process, PCG has identified a number of options DHSS has to address the technical needs of the Exchange. The technology solution design alternatives for establishing an Exchange are best separated into three categories as follows:

1. The options DHSS may consider to meet ACA requirements and guidance to integrate eligibility determination and enrollment for State sponsored programs with the Exchange.
2. The options to consider in satisfying the requirements and guidance necessary to implement an ACA compliant Exchange.
3. The technical infrastructure options to consider in deploying the Exchange IT systems.

While there are many interrelationships between these three areas, the decisions that Delaware faces for each are unique. For the eligibility solution, Delaware must decide to what extent its existing software solutions will play a role in the Exchange IT system. For the functionality needed to support the core Exchange business requirements, the choice is largely determining which source the State should use to obtain the needed technical solution. Lastly, as it pertains to infrastructure, Delaware needs to make clear how any eventual solution will be deployed and maintained within what kind of environment.

In order to facilitate this decision process, PCG recommends a closer examination of a subset of these options to fully understand and present to the State the opportunities, challenges, estimated costs, and estimated level of effort. To address eligibility, the most attractive option is a phased integration approach that could leverage an isolated rules engine that performs determinations to meet the immediate needs of the health care reform law and provide a foundation for improving the eligibility environment over time. To address the core Exchange business functions, PCG recommends a thorough assessment of external solutions that could be procured or transferred to meet these needs, be they from federal government, other states, or the private sector . Lastly, to tackle the deployment and infrastructure needs, PCG recommends either working with DHSS and DTI to determine the feasibility and desirability of hosting the eventual solution internally or looking for external ways to support it.

From this assessment and gap analysis, Delaware faces many difficult choices in a number of key areas with regard to the design and implementation of the IT infrastructure needed to support the Exchange. Each technical area, from eligibility, to Exchange business functionality, to the deployment and infrastructure options, presents resource, schedule, and strategy concerns that must be weighed against a variety of factors in order to determine the best fit for DHSS and the State. PCG looks forward to continuing to partner with DHSS to resolve these important questions and develop a solution that best meets the needs of Delaware residents and businesses.

2. Purpose, Scope, Approach

The purpose and scope of this phase of PCG's efforts to support Delaware's Health Benefit Exchange planning project includes the following:

- Provide a detailed assessment of federal requirements and guidance related to the ACA and the establishment of an Exchange;
- Provide an inventory and assessment of existing DHSS IT systems relevant to the Exchange, building upon the As-Is Assessment of the current environment;
- Determine DHSS systems' state of readiness and gaps for meeting ACA requirements and complying with federal guidance to determine functionality and potential for use in the Exchange (mapping systems against current federal IT systems guidance);
- Perform an IT Gap Analysis to identify differences between DHSS's current capabilities and the operational and technical requirements of an Exchange as detailed in federal documentation;
- Utilize the IT Gap Analysis to articulate and assess available options for implementing the technical components of an Exchange in Delaware, with the associated benefits and risks for each option; and,
- Prepare a report documenting the results.

PCG's approach to completing this deliverable was to:

- Analyze pertinent federal laws, regulations and guidance relating to the establishment of an Exchange;
- Utilize the results of the As-Is Assessment as a foundation to assess the functional and technical attributes of existing DHSS systems for their potential use or modification to meet the needs of the Exchange IT Solution;
- Meet with DHSS leadership and key stakeholders to obtain information and insights into Delaware's vision for the Exchange and how DHSS IT capability could support the Exchange;
- Document the IT Gap Analysis and identify options to address needed functionality; and,

- Assess potential options and document the positive and negative consequences of each, including their associated risks, compliance with federal requirements and guidance, likelihood to meet the mandate, and relative costs.

3. Assumptions

The following assumptions were used by PCG in the development of the To-Be Vision and IT Gap Analysis:

- PCG assumes there are no major changes planned for the programs and IT infrastructure researched other than those communicated during the research to develop the To-Be-Vision;
- PCG reviewed federal health care reform requirements and federal guidance issued as of July 21, 2011. Any material released after that date was not considered;
- Federal guidance has not been provided on all aspects of the Exchange at the time of this writing, therefore PCG made assumptions about needed functionality where noted based on our experience and knowledge of Exchange IT systems; and,
- Since detailed requirements for the upgrade to ASSIST have not been finalized, all future functionality is assumed from high-level design

4. Affordable Care Act Health Insurance Exchange Requirements and Gap Analysis

The establishment of a fully-functioning Exchange in Delaware will be a large and complicated effort. Through the ACA legislation and subsequent proposed regulation and guidance, HHS and the Center's for Medicare and Medicaid Services (CMS) has articulated a broad vision of what an Exchange must do, how it must operate, and the desired outcomes from its establishment in each state. Developing the appropriate IT infrastructure to support these functions and ensure the success of the Exchange will be a daunting task on its own, and yet the Exchange needs not only to function properly, but also seamlessly integrate into a State's existing environment if it is to provide the type of first-class consumer experience envisioned. These twin challenges will be addressed in this report through a thorough analysis of Delaware's existing infrastructure and the options that are available to the State to implement its Exchange.

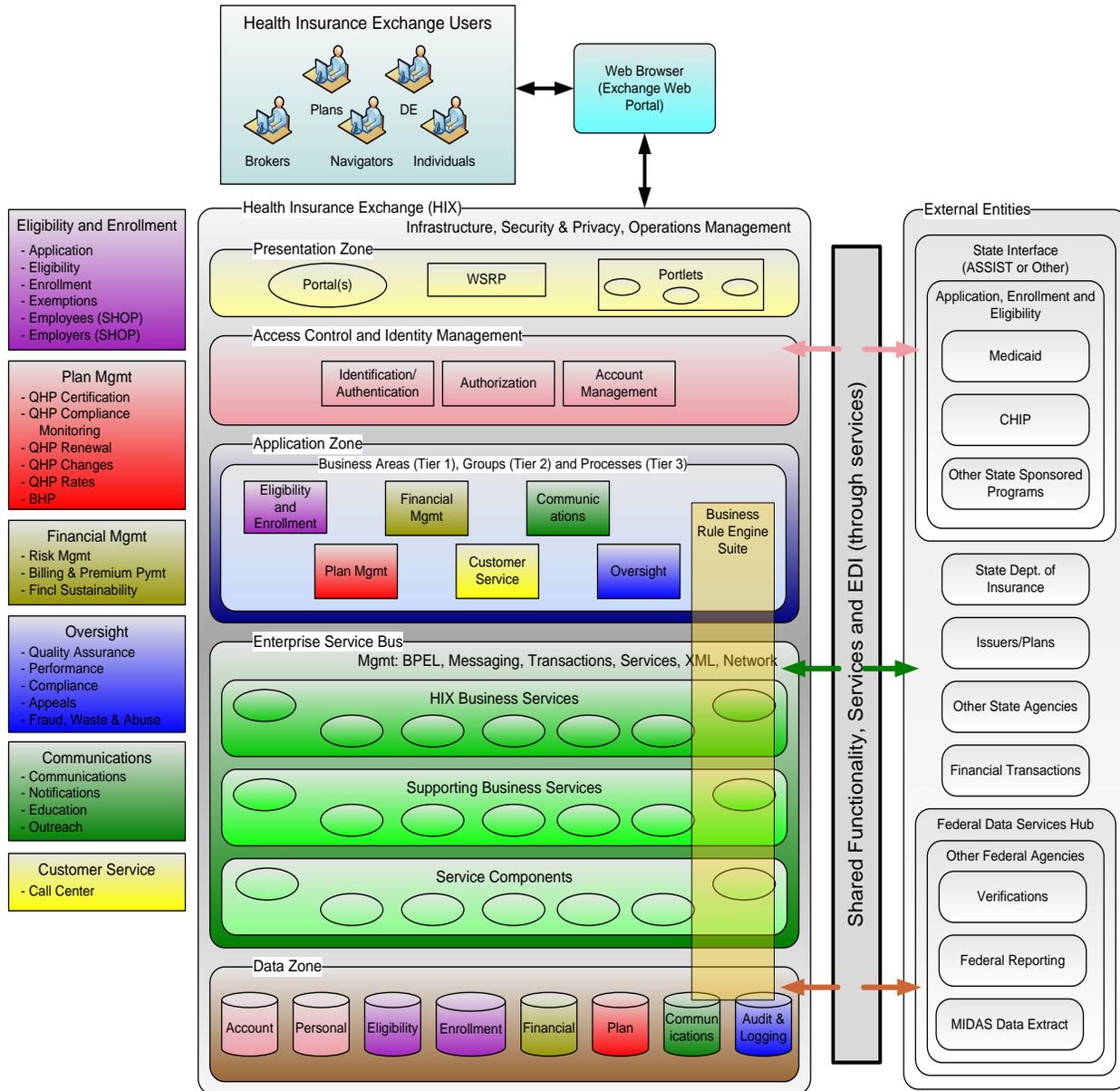
This section details the high-level functional and technical requirements of the Exchange and provides an assessment of DHSS's ability to support those requirements with existing IT systems. As required by the ACA and described in federal guidance, the Exchange must at a minimum carry out the following functions:

- Exchange website
- Navigator program
- Applications and notices
- Eligibility determinations for the following:
 - Exchange participation,
 - Advance payment of premium tax credits,
 - Cost-sharing reductions,
 - Medicaid, and
 - CHIP
- Premium tax credit and cost-sharing reduction calculator
- Seamless eligibility and enrollment process coordinated with Medicaid, other State health subsidy programs, and ideally other human service programs (e.g., Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance to Needy Families (TANF) program)
- Individual responsibility determinations
- Enrollment in a Qualified Health Plan (QHP)

- Adjudication of appeals of eligibility determinations
- Small Business Health Options Program (SHOP)
- Notification and appeals of employer liability
- Health Plan quality rating system
- Certification, recertification, and decertification of qualified health plans
- Administration of premium tax credits and cost-sharing reductions
- Risk adjustment and transitional reinsurance
- Information reporting to Internal Revenue Service (IRS) and enrollees
- Outreach and education
- Call center

Figure 4-1 shows a functional grouping of the requirements listed above and how that functionality works together in the Exchange architecture. The figure will be followed by a description of each group and more detail on the capabilities each functional group supports.

Figure 4-1: Exchange Requirements Overview - Core Component Areas and Architecture



4.1. The Health Insurance Exchange Web Portal

The beginning point for all consumers of an Exchange will be the Exchange web portal. The Exchange will establish and maintain a website through which enrollees and prospective enrollees may obtain standardized comparative information on QHPs, apply for coverage, and enroll online. The Exchange web portal will also need to interact

with State eligibility and enrollment IT systems for individuals who may be eligible for Medicaid or CHIP. These individuals should be able to apply for State-sponsored coverage, have their eligibility determined and be enrolled, just like those applying for QHPs.

Exchange websites will also need to post required transparency information. In addition, the website must provide access to an electronic calculator that allows individuals to view a preliminary estimate of the total cost of their coverage once advanced premium tax credits have been applied, and the impact of cost sharing reductions have been considered, if applicable.

4.1.1. IT Gap Analysis Summary

DHSS IT systems are Health Insurance Portability and Accountability Act (HIPAA) compliant and follow Section 508 guidelines. DHSS IT systems also comply with CMS expectations for security, privacy, transparency, accountability and evaluation. Additionally, the IT systems involved in Medicaid and Delaware Healthy Children's Program (DHCP) eligibility determination also comply with CMS's expectations for system performance. DHCP is Delaware's CHIP program. The two primary IT systems supporting application data collection and eligibility determination and enrollment are the Application for Social Services and Internet Screening Tool (ASSIST) and the Delaware Client Information System (DCIS II).

The ASSIST tool is a public-facing, Web-based application that allows potential clients to self screen and/or apply for benefits online. While ASSIST operates as a screener for potential eligibility today, it is being modified in the near future to incorporate its eligibility screening business rules in a robust rules engine. These modifications will be complete the third quarter of 2012. The new platform, and ASSIST's compliance with Service Oriented Architecture (SOA) methodologies, will make it an efficient and highly scalable IT system.

DHSS believes ASSIST provides a good platform that can be integrated with the Exchange Web Portal and configured to support eligibility determination for the expanded Medicaid and DHCP population as well as eligibility determination for Exchange Qualified Health Plan (QHP) premium subsidies/tax credits and cost sharing reductions.

DCIS II supports eligibility determination and enrollment for all Delaware state-sponsored/administered programs except the Delaware Prescription Assistance Program (DPAP). The DCIS II Eligibility Determination and Benefit Calculation (EDBC)

subsystem can be accessed as a web service and may be utilized real-time to determine eligibility for state-sponsored programs based on rules other than MAGI and programs other than Medicaid and DHCP. DHSS plans to explore this in more detail in the coming months to determine how useful the EDBC subsystem may be as part of the Exchange solution.

In summary, DHSS does not believe there are any technical barriers to using components of ASSIST and DCIS II to support the eligibility determination and enrollment for state-sponsored programs as part of the Exchange. The rules engine may also be configured to support eligibility determination for QHP premium subsidies/tax credits and cost sharing reductions.

The sub-sections below provide more detail regarding specific technical requirements for the Exchange web portal.

4.1.2. System Architecture

In implementing ACA provisions, states need to develop modular, flexible systems that include open interfaces and exposed Application Programming Interfaces (APIs). The goal is that systems are built to permit a sharing of their components (in whole or in part) and to allow for ongoing and iterative updates and enhancements. To accomplish this feat, systems must be in alignment with the Medicaid Information Technology Architecture (MITA) framework and must follow the Standard Industry Lifecycle Framework (SDLC). It is expected that states will take advantage of Web Services Architecture (utilizing protocols and formats such as SOAP and XML) and SOA to leverage opportunities to share and to pool configurable resources.

Systems developed or enhanced to support functions of the Exchange should adhere to the following architecture principles to the fullest extent possible:

Systems Integration

- Provide high-level integration of process flow and information flow with business partners (i.e. Navigators, health plans, small businesses, brokers, employers, Medicaid, CHIP, etc.).
- Apply a modular, flexible approach to systems development, including the use of open interfaces and exposed APIs.
- Utilize APIs and separate business rules from core programming, available in both human and machine-readable formats.

- Ensure seamless coordination between the Exchange, Medicaid, and CHIP, and allow interoperability with health information exchanges, public health agencies, human services programs, and community organizations providing outreach and enrollment.

Service Oriented Architecture

- Employ Web Services Architecture/SOA methodologies for system design and development and to ensure standards-based interfaces to link partners and information at both federal and state levels.
- Employ common authoritative data sources and data exchange services, including, but not limited to, federal and state agencies or other commercial entities.
- Employ open architecture standards (non-proprietary) for ease of information exchanges.

Isolation of Business Rules

- Use standards-based business rules and a technology-neutral business rule repository.
- Stay consistent with the recommendations issued pursuant to Section 1561 of the ACA, clearly and unambiguously keeping business rules outside of transactional systems.
- Enable the business rules to be accessible and adaptable by other states.
- Submit business rules to a federally designated repository.

Security and Privacy

- Support the application of appropriate controls to provide security and protection of enrollee and patient privacy.

Efficient and Scalable Infrastructure

- Leverage the concept of a shared pool of configurable, secure computing resources (e.g., “Cloud Computing”).

Transparency, Accountability and Evaluation

- Produce transaction data and reports to support performance monitoring.
- Leverage commercial, off-the-shelf business intelligence functionality to support the development of new reports and respond to queries.

System Performance

- Ensure quality, integrity, accuracy, and usefulness of functionality and information.
- Provide timely information transaction processing, including maximizing real-time determinations and decisions.
- Ensure systems are highly available and respond in a timely manner to customer requests.

4.1.3. CMS - Technical Architecture and Standards

Standards help achieve and sustain secure interoperability among state and federal health programs and providers and community organizations that deliver care and promote access to coverage and benefits. It is CMS's intent to ensure that any IT system development projects supported through Exchanges, Medicaid, or CHIP funding comply to the fullest extent possible with standards in wide use within the U.S. health system and with standards endorsed or adopted by HHS.

- Federal Data Services Hub to verify citizenship, immigration, and tax information from Social Security Administration, Department of Homeland Security and Internal Revenue Service
- Relevant HIPAA standards, including those for protection of Protected Health Information (PHI)
- National Information Exchange Model (NIEM), including data standards defined for 11 core data elements (eligibility and enrollment related)
- Section 508 guidelines or guidelines that provide greater access to individuals with disabilities
- Security and Privacy (HIPAA Privacy and Security Rules specify privacy and security requirements that HIPAA covered business associates must follow)

4.2. Navigators, Brokers, and Other Users

There will be a great need for public outreach and education to help consumers understand how to access and use the Exchange, and to assist consumers with the purchase of health insurance that best meets their needs. The ACA envisions Navigators playing a central role in this process.

According to the ACA, an Exchange must establish a program under which it awards grants to entities, called Navigators, to perform the following duties:

- Conduct public education activities to raise awareness of the availability of qualified health plans
- Distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits and cost-sharing reductions in accordance with federal tax laws;
- Facilitate enrollment in qualified health plans;
- Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman, or any other appropriate state agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage; and
- Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange.

Navigators may include trade, industry, and professional associations, community and consumer-focused nonprofit groups, resource partners of the Small Business Administration (SBA), licensed insurance agents and brokers, and other entities that are capable of carrying out the required duties, meet the standards established by the Secretary of HHS, and provide information that is fair, accurate, and impartial.

To be eligible to receive a grant from the Exchange, a Navigator must demonstrate that it has existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to enroll in a qualified health plan. Grants must be made from the operational funds of the Exchange and not federal funds received by the State to establish the Exchange.

HHS has not published a detailed list of qualification standards or guidelines for Navigators or exactly how they envision Navigators will assist consumers. The recently issued Notice of Proposed Rulemaking (NPRM) concerning the Exchange, which was issued by CCHIO in early July 2011, suggests that each state-based Exchange will be provided the flexibility to determine standards, criteria, and any licensure by Navigators. The NPRM also leaves each state to decide the role of agents and brokers in its Exchange and does not impose any federal standards on their conduct. The proposed rule does provide some definition around the role of Navigators and suggests that producers (i.e. agents and brokers) may serve as Navigators provided they are not paid by health insurers and satisfy any other Navigator requirements that the state Exchange may adopt.

4.2.1. IT Gap Analysis Summary

If there is an IT component to Navigator and broker/agent support, it does not appear that DHSS currently supports any functionality in this area. For example, an IT component associated with the Navigator program might involve tracking which Exchange enrollees were assisted by a particular Navigator, or a means by which the Exchange can monitor the performance and activities of Navigators. Establishing and maintaining a “broker of record” system will also likely be necessary in order to track, and possibly pay a commission to, brokers and agents that assist individuals and employers enroll in coverage through the Exchange. While the DHSS systems do not have this functionality, “broker of record” systems are widely used in the commercial health insurance market.

4.3. Identity Access Management

While the ACA does not explicitly discuss Identity Access Management (IAM), CMS does describe the need for consumers that purchase insurance through the Exchange to be able to establish accounts, along with User IDs and passwords. This requirement, along with the previously stated privacy and security requirements, implicitly necessitates the integration of an IAM solution. The Exchange must be able to trust the identities of users requiring access and easily administer user identities in a cost-effective way. IAM solutions are based on the users and access rights management through an integrated, efficient and centralized infrastructure. This concept combines business processes, policies and technologies that enable organizations to:

- Provide secure access to any resource;
- Efficiently control this access;
- Respond quickly to changing relationships; and,
- Protect confidential information from unauthorized users.

When implementing any technology that provides access to protected information, and assessing how it must be used, Delaware should be prepared to ask the following questions:

- Have we identified the different use roles and are they included in the identity management process?
- How will identities be verified, ensuring they are who they claim to be, and evaluated for risk and access purposes?
- What level of authentication strength is required?

- Are there national or local regulatory requirements or technical standards that apply?
- After authentication, what is the process for credentialing these individuals?
- How often will credentialed individuals need to be re-authenticated, and how will we find out about critical changes in their identity (e.g. stolen identity, legal name changes, marriage, etc.) be determined?

4.3.1. IT Gap Analysis Summary

Delaware's Department of Technology & Information (DTI) has implemented an IAM solution from Oracle that is being integrated in ASSIST, the only public facing IT system supporting Medicaid and DHCP eligibility and enrollment for Delaware.

4.4. Enrollment and Eligibility

Determining eligibility and providing for efficient processes to enroll users in health plans are key functions of the Exchange. Exchange IT Systems need to integrate with the State Medicaid program in order to ensure seamless eligibility verification and enrollment processes. The Exchange should identify people who qualify for coverage through the Exchange, including eligibility for advanced premium tax credits and cost-sharing reductions, Medicaid and CHIP. The State should aim to provide the same customer experience to all individuals seeking coverage, regardless of the source or amount of financial assistance for which they qualify, or whether they enter the process through the Exchange, Medicaid, or CHIP. Because the ACA also addresses other health and human service programs, the complexity of enrollment will need to be addressed across the spectrum of human services programs.

CMS distributed two documents – *EE BA Supplement draft v1.0 2011-05-03* and *EE Activity Descriptions v43 2011-04-28* regarding enrollment and eligibility business processes. While these documents are not yet complete, they do provide insight into the enrollment and eligibility services the Exchange will need to provide.

4.4.1. IT Gap Analysis Summary

DHSS has the necessary system functionality to support eligibility determination and enrollment in State-sponsored programs. With ASSIST, DHSS already operates under a “No Wrong Door” policy, enabling a flexible, consumer-focused model that minimizes the navigational burden associated with multiple applications and eligibility processes.

DHSS believes that the ASSIST modifications being implemented in the third quarter of 2012 will make it an IT system that can be integrated with the Exchange Web Portal and configured to support eligibility determination for the expanded Medicaid and DHCP population as well as eligibility determination for Exchange Qualified Health Plan (QHP) premium subsidies/tax credits and cost sharing reductions.

DCIS II supports eligibility determination and enrollment for all Delaware state-sponsored/administered programs except the Delaware Prescription Assistance Program (DPAP).

Application information entered directly into DCIS II (not downloaded from ASSIST) comes from three different sources.

- Completing a paper application and submitting the application to any client service center;
- Visiting a client service center and apply in-person; or
- Calling a client service center to apply.

DCIS II verifies that all necessary data is collected based on the answers to questions. Once the application entry (AE) subsystem is complete the process flows to the Standard Filing Unit (SFU), which creates the appropriate assistance groups, and the Eligibility Determination and Benefit Calculation (EDBC) subsystem where the system evaluates the individual's benefit request and demographics to assign them to the correct family grouping, makes an eligibility determination based on technical and financial means tests and finally calculates the benefit level if the individual or filing group is eligible.

The DCIS II EDBC subsystem can be accessed as a web service and may be utilized real-time to determine eligibility for state-sponsored programs based on rules other than MAGI and programs other than Medicaid and DHCP. DHSS plans to explore this in more detail in the coming months to determine how useful the EDBC subsystem may be as part of the Exchange solution.

In summary, DHSS does not believe there are any technical barriers to using components of ASSIST and DCIS II to support the eligibility determination and enrollment for state-sponsored programs as part of the Exchange. The rules engine may also be configured to support eligibility determination for QHP premium subsidies/tax credits and cost sharing reductions. Below are more details on the Exchange

requirements in the Eligibility and Enrollment business area and how the IT gap analysis summary was devised.

4.4.2. Individual Eligibility & Enrollment Business Processes

Applications and Verifications

The ACA requires a standardized format for applications that will facilitate the enrollment of individuals into qualified health plans. CMS's expectation is that a state will establish a one-stop-shop for health coverage through the Health Insurance Exchange. It will also create a system known as a “no wrong door”, which will allow individuals and families to be connected with private insurance, Medicaid, or CHIP, no matter where they choose to apply. Additionally CMS's vision, which will likely be longer term and is not a requirement for 2014, is that an applicant will be evaluated and screened for all State-sponsored programs through a single application.

The ACA requires the following consumer-specific data be verified with government data sources through the Federal Data Services Hub (DSH).

- Citizenship, status as a U.S. National, or lawful presence
- Residency in the Exchange's service area
- Incarceration status
- Native American status
- Household income

The DSH is being developed by CMS as a set of re-usable web services that the Exchange Web Portal and the State's eligibility systems will have to utilize.

Business Process IT Gap Analysis

DHSS uses the ASSIST software package to collect information from applicants for Medicaid, the DHCP and many other State-sponsored programs. There are no technical barriers preventing Delaware from moving application for all applications for State-sponsored programs to ASSIST, fully supporting CMS's, “one-stop-shop” and “no wrong door” vision. ASSIST modifications will be implemented will provide a set of re-usable web services that the Exchange Web Portal can utilize

Seamless Eligibility Process with Medicaid, CHIP and Applicable State-Sponsored Programs

For states to maximize federal matching funds for modifications to Eligibility and Enrollment systems, the ACA requires seamless integration between the Exchange,

Medicaid and CHIP, and potentially with other State-sponsored programs. The ACA requires all states to offer Medicaid coverage to non-elderly residents with modified adjusted gross income (MAGI) at or below 133 percent (138 percent with the five percent income disregard) of the Federal Poverty Level (FPL), for coverage that will take effect on January 1, 2014. This income amount will be determined using the Modified Adjusted Gross Income rules, a new definition of income under ACA.

CMS envisions that Medicaid and CHIP eligibility, based on MAGI at or below 133% FPL, will be determined through a single, streamlined process. If a state wants to expand beyond the 133% FPL threshold, the Exchange will have to be able to account for that as well. An individual may also request a full eligibility determination for Medicaid or CHIP. If the State's modified eligibility rules are not available to the Exchange, it will have to transfer data with the State's eligibility determination system in a "real time" fashion. The following example details what a single session might look like:

1. The Exchange will transmit data to the State;
2. The State will determine eligibility "real time";
3. The State will transmit the determination back to the Exchange; and,
4. The Exchange will continue processing enrollment in a QHP.

Business Process IT Gap Analysis

The modifications being implemented in ASSIST coupled with the web services access supported by DCIS II will allow seamless eligibility and enrollment processing for Medicaid and DHCP, and potentially for other State-sponsored programs.

Eligibility Determinations for Exchange Participation in Qualified Health Plans, Premium Tax Credits, and Cost-Sharing Reductions

One component of the Exchange will be verification and determination of eligibility and enrollment of individuals in QHPs. This also includes eligibility determination for advance premium tax credits and cost sharing reductions. States may choose to perform these functions outside of the Exchange, for example utilizing another state agency's eligibility determination system.

Business Process IT Gap Analysis

DHSS does not currently support any commercial individual health coverage plans, such as QHPs. But, the rule engine used by ASSIST may also be configured to

support eligibility determination for Exchange Qualified Health Plan (QHP) premium subsidies/tax credits and cost sharing reductions.

Enrollment, Renewal, Disenrollment in Medicaid and CHIP

CMS envisions Medicaid and CHIP enrollment occurring real time once an individual is determined eligible. Real-Time transmission back to the Exchange from the State Medicaid and CHIP enrollment system should confirm enrollment for the user.

Business Process IT Gap Analysis

Under the same processes described earlier for eligibility determination and enrollment, ASSIST and DCIS II will be able to support renewals and disenrollment. In Medicaid and DHCP

Enrollment, Renewal, Disenrollment in a Qualified Health Plan

The Exchange will need to facilitate an eligible individual's selection of a QHP and subsequent enrollment in the plan. The Exchange will generate plan choice information that is customizable to the individual's eligibility and personal preferences. The individual will be able to compare QHPs from different health carriers offering a range of benefit plan options (e.g., platinum, gold, silver, bronze, and catastrophic) based on quality and price (taking into account any premium subsidies and cost-sharing reductions for which they may be eligible).

Enrollment activities include notifying the issuer of the selected QHP of the individual enrollment, facilitating payment of the first month's premium, notifying CMS to facilitate payments of advance premium tax credits and cost sharing reductions, and processing the issuer's response to the Exchange enrollment transaction.

Business Process IT Gap Analysis

DHSS does not currently support any functionality in this process for QHP. Enrollment in managed care plans is performed on a limited basis within the MMIS.

Eligibility Decision Appeals

The activities involved in appeals of eligibility determinations made by the Exchange, including receiving appeal requests, adjudicating appeals, implementing appeal decisions and providing notices to individuals.

Business Process IT Gap Analysis

DHSS currently has in place an appeals process for Medicaid and DHCP that could potentially be leveraged to support the Exchange.

4.4.3. Individual Responsibility Exemption Business Processes

The individual responsibility provision of the ACA will require most individuals to obtain and maintain health coverage or face a tax penalty. Exemptions to the individual responsibility requirement will be made based on affordability (i.e. premiums exceed 8.0% of an individual or family's MAGI), religious beliefs, and hardship. Exemptions from the penalty also will be allowed for taxpayers with income under 100 percent FPL, members of Indian tribes and individuals who are not covered for a period of less than three months during the year. Exemptions to the individual responsibility requirement may also be made for religious reasons, individual not lawfully present and incarcerated individuals.

Business Process IT Gap Analysis

DHSS does not currently support any functionality in this process.

Application

Collect and verify initial and updated application information from an individual necessary to determine eligibility for a certificate of from the individual responsibility requirement.

Eligibility Determination

Determine eligibility for exemptions from the individual responsibility requirement.

Eligibility Decision Appeal

The activities involved in appeals of denials of certificates of exemption made by the Exchange, including receiving appeal requests, adjudicating appeals, and providing notices to individuals and to the Internal Revenue Service.

4.4.4. Small Business Health Options Program Exchange Employer Eligibility & Enrollment Business Processes

Another feature required in the ACA is the requirement that each state must establish and operate a Small Business Health Options Program (SHOP) Exchange, which will provide access to qualified health plans to those employers with up to 50 employees. A state can expand eligibility to employers with up to 100 employees in 2014 or defer the expansion for the small group market until 2016.

For coverage effective January 1, 2014, small employers can also qualify for Small Business Health Care Tax Credits if they purchase coverage for their employees through SHOP Exchange. The SHOP Exchange, like the individual market Exchange, will include a web portal to make comparing and purchasing health insurance easier for small businesses and their employees. States may choose to merge the operations of their SHOP Exchange with their individual market Exchange.

Business Process IT Gap Analysis

DHSS does not currently support any functionality in this process.

Application

Collect and verify initial and updated application information from an employer necessary to determine eligibility for participation in a SHOP Exchange. Application information includes the employer's name and address, employer identifier, and roster of employees. Employers must also provide an attestation that all full-time employees are offered coverage.

Eligibility, Renewal Determination

Determine or re-determine the employer's eligibility for participation in the SHOP Exchange.

Determine Employer Contribution

This process facilitates plan selection options for the employees in accordance with the selected enrollment timeframe. The employer also declares its contribution toward the cost of coverage and whether it elects to contribute through pre-tax payment of premiums. The employer communicates to the employee regarding the availability of coverage through the SHOP Exchange and guidelines for selecting and enrolling in a QHP.

Termination

Termination of an employer's participation in a SHOP Exchange initiated by the employer or by the Exchange if the employer is found to be negligent. Employees enrolled in QHPs are notified of their options. The QHP issuer and CMS are also notified.

Appeals

This business process involves the activities involved in appeals of eligibility determinations made by the SHOP Exchange, including receiving appeal requests, adjudicating appeals, implementing appeal decisions and providing notices to employees and employers.

4.4.5. SHOP Exchange Employee Eligibility & Enrollment Business Processes

Supports an employee's ability to apply, determine eligibility and enroll in health coverage offered through the SHOP Exchange.

Business Process IT Gap Analysis

DHSS does not currently support any functionality in this process.

Application

Collect initial and updated application information from an employee necessary to determine eligibility for enrollment through the SHOP Exchange.

Verification

Verify the existence of the employee's home and work addresses with trusted data sources and validate the identifier associating the employee with the employer.

Enroll, Renew, Disenroll an Employee in a Qualified Health Plan

Assess whether an employee meets the requirements for an enrollment period, and if so, generate plan choice information. Enrollment activities may include notifying the issuer of the employee's selected qualified health plan, facilitating payment of the premiums, and processing the issuer's response to the Exchange enrollment transaction. The Exchange notifies CMS of the employee's enrollment, renewal or disenrollment in a qualified health plan.

Appeals

The activities involved in the appeal of eligibility determinations made by the Exchange, including receiving appeal requests, adjudicating appeals, implementing appeal decisions and providing notices to employees and employers.

4.5. Plan Management

Each Exchange will need to have the ability to assess and monitor the insurance products that are to be offered on the Exchange to ensure they meet the standards of Qualified Health Plan and to ensure continued compliance with all applicable Exchange rules. As currently defined, the Exchange Plan Management function encompasses the following services:

1. Establishing and applying criteria and standards for certification, re-certification and de-certification of issuers and QHPs;
2. Ongoing compliance monitoring of issuers and QHP;
3. Development of issuer agreement and engagement of issuers;
4. Review justification in rate renewals and
5. Maintain ongoing operational data and reporting.

CMS distributed two documents entitled *PM BA Supplement draft v1.0 2011-05-03* and *PM Activity Descriptions v23 2011-04-25* regarding plan management business processes. While these documents are not yet complete they do provide significant insight into the plan management services the Exchange needs to provide. The details lead one to realize that, beyond the IT capability needed to support plan management, there will be significant manual processes to support coordination, management and governance between the entities involved.

In addition, the federal NPRM issued on July 11, 2011 provides further direction on the role and funding guidance of Navigators and brokers. A design consideration for the Plan Management function would be to expand the role and scope to include certification and oversight of brokers and Navigators. Today the State Department of Insurance (SDOI) regulates issuers, health plans, rates and rate renewal requests, as well as broker licensure. The solution design for Plan Management should consider how to best leverage those existing standards, processes and capabilities. Another key design consideration will be the frequency and resulting degree of interface and data exchange between the issuer of the QHP to the Exchange.

4.5.1. Basic Health Program

The ACA offers states the option to create a Basic Health Program (BHP) to provide coverage to legal residents with MAGI up to 200% FPL who are otherwise not eligible for Medicaid. This population represents the first income group that would receive subsidies through the State's Health Benefit Exchange and lawfully present immigrants with MAGI up to 133% FPL. Should the State choose to offer a BHP, individuals

eligible for the BHP would be ineligible to receive premium subsidies through the Exchange.

The ACA requires BHP enrollees to receive the same essential health benefits and the same or lower premiums and cost sharing that they would receive from an Exchange plan. To finance the BHP, the State would receive 95% of the federal subsidies that enrollees would have received through the Exchange for Silver level coverage.

At this time Delaware has decided not to pursue the establishment of a BHP so this review will not go into further details on this option. Delaware may choose to revisit this at a later date.

4.5.2. IT Gap Analysis Summary

DHSS does not currently support any functionality in this area. Below is more detail as to what the ACA Exchange requirements are for Plan Management.

Establish Issuer and Plan Initial Certification and Agreement

This process may be performed in order to accomplish the initial (first-time) certification and agreement for a QHP provided by an issuer. Components of this process may also be used for recertification.

The Exchange develops and issues a QHP solicitation. If the State is requiring services beyond the essential health benefits, the solicitation may specify these services. After the solicitation is issued, the Exchange may elect to hold a vendor conference to answer respondent questions, and issue a data book.

The Exchange evaluates the proposals submitted by the issuers. In evaluating the proposals, the Exchange may need to access information from the following sources:

- Information about the issuer from the Department of Insurance; and
- May include information about the issuer from CMS. Some of the required information in the proposal may be standardized and evaluated using electronic tools in such areas as network adequacy and benefit design. The Exchange may elect to request oral presentations or conduct site visits.

The Exchange may need or want to conduct negotiations with those issuers whose proposed QHPs meet the certification criteria. Based on the negotiations, the Exchange may accept the issuer's proposal or request revisions to the proposal. If the Exchange accepts the issuer's proposal, the Exchange certifies the offering as a QHP and notifies the issuer. The Exchange then may generate and send the QHP agreement.

If an Exchange uses an agreement, the Exchange sets up the QHP agreement information regarding the issuer and the QHPs in an automated system (e.g., a database), once the agreement has been accepted by the issuer. The Exchange may direct the issuer to upload the information into the system (either at the time of application or at agreement signing). The Exchange may also work with the issuer(s) during this period to ensure a successful transition to operations.

The Exchange assigns an initial plan quality rating. In assigning the rating, the Exchange uses the Plan Quality Rating Methodology provided by CMS.

Monitor Issuer and Plan Certification Compliance

This process may consist of administrative activities performed in order to monitor plan performance and certification compliance. Plan quality ratings are also updated as part of this process.

The Exchange reviews certification compliance data received from the issuers and monitors plan performance. The Exchange may establish a Performance Indicator Dashboard for tracking performance data. The Exchange also monitors issuer operations and financial reporting in accordance with the QHP agreement, if applicable.

The Exchange provides issuer and plan data to CMS.

The Exchange may update the plan quality rating. In assigning the rating, the Exchange uses the Plan Quality Rating Methodology provided by CMS which establishes common quality rating elements.

Establish Issuer and Plan Renewal and Recertification

This process may be performed after the initial certification process for QHPs. The process may include activities associated with the recertification of qualified health plan participation, including potential decertification of the QHP.

The Exchange may request that issuers of the QHP notify the Exchange of their intent to continue (renewal) or discontinue (non-renewal) offering QHPs through the Exchange.

The Exchange evaluates information provided by the issuer seeking renewal in the recertification process. This process may mirror many of activities in the initial certification process.

The Exchange updates the issuer and plan information in its automated system.

Maintain Operational Data

This process may be performed to maintain the currency of the operational data received from issuers, to analyze changes in the data, and to take appropriate actions based on changes in the data. The data may include: provider network data, issuer general information, transparency data, quality information, complaint data (from multiple sources), and marketing materials and notifications to members.

Process Change in Plan Enrollment Availability

This process may be performed when an issuer either closes or re-opens enrollment for a QHP during a plan year. The issuer may close enrollment of a QHP under certain conditions specified in section 2702 of the Public Health Service Act (i.e., service capacity limits).

The Exchange receives a notification of change in plan enrollment availability (close/re-open enrollment) from the issuer. The issuer also provides the notification to the Department of Insurance.

The Exchange updates the issuer and plan information in its automated system, updates the Exchange website, updates plan selection tools, and issues communications to stakeholders.

The Exchange notifies CMS of the plan change in availability.

Review Rate Increase Justifications

For rate/benefit data, the Exchange receives and analyzes justifications associated with rate increases.

This process may be performed to receive and review justifications for rate increases. The Exchange review also utilizes information received from the State Department of Insurance and/or CMS rate review processes. The July 2011 NPRM suggests the state Exchanges can leverage the rate review and approval process performed by the Department of Insurance.

4.6. Financial Management

To promote a viable and sustainable market, the ACA requires the development of a number of financial management capabilities and functions, including:

- Risk Management;
- Premium Payment Administration; and

- Exchange Financial Sustainability.

The Risk Management requirements are intended to develop solutions to “smooth out” or spread market risk. The primary processes will include the actuarial computation of, collection and administration of reinsurance premiums, the receipt, processing and payment of high risk claims that reach the assigned attachment point, and the measurement, reporting and analytics of financial performance across the commercial markets, for health plans sold inside and outside the Exchange.

The premium payment administration requirements include processes relating to the billing, collecting, aggregation, transmittal, reporting and reconciliation of insurance premium payments from multiple sources including individuals, employees, employers and the federal government.

The financial sustainability requirements relate to the need for each state-based Exchange to be financially self-sustaining by 2015.

CCIIO has not yet formally released Financial Management Business Architecture Supplement or Activity Design documentation but they have provided preliminary draft documentation that provides some insight regarding financial management business processes.

4.6.1. IT Gap Analysis Summary

DHSS does not currently support any functionality in this process. More detail regarding the Exchange requirements for financial management is provided below.

Risk Management Programs

The ACA provides for two transitional mechanisms (Reinsurance and Risk Corridors) that extend for the first three years of the Exchange that are intended to mitigate risk uncertainty in the market due to multiple factors including immaturity, insufficient data credibility, unpredictable user volumes and (high risk) cost patterns. Parallel with the establishment of these transitional programs, the ACA requires creation of a permanent Risk Adjustment mechanism to “smooth out” medical cost variability across insurers both inside and outside of Exchange markets. Medical cost variation at the individual issuer level can result from adverse selection, unit price differences under healthcare provider network contracts, and variances in medical management program effectiveness and high claims incidence rates. Adding to the business complexity and market risk distortion will be inconsistent participation of issuers on and off the Exchange.

The ability to successfully develop, implement, test and deliver these financial management services requires a deep understanding of the complex actuarial considerations, data management, financial accounting, commercial insurance billing and premium processing practices, technology development, financial reporting and reconciliation procedures.

Billing and Premium Payment Processing

The ACA (and the recently released NPRM dated 7/11/2011) establish the following requirements related to billing, collecting, and aggregating premiums. With regard to the individual market Exchange, an Exchange has three options as it relates to premium payment administration:

- No active role in premium processing,
- Facilitate the payment of premiums by enrollees by creating an electronic “pass through” without directly retaining any payments, or
- Establish a payment option where the Exchange collects premiums from multiple sources and pays a reconciled aggregated sum to the QHP issuers.

Additionally, regardless of the option elected, the Exchange must enable an individual purchaser to remit premiums directly to the QHP issuer.

For the SHOP Exchange, the primary premium payment requirements include:

- Accepting payment of an aggregated premium;
- Facilitating through electronic means the collection of premium payments. This could include the Exchange acting as a simple pass-through or the Exchange collecting and distributing premiums to QHP issuers;
- Developing a single monthly bill for all QHPs in which an employer’s employees are enrolled and processing a single monthly payment from the employer; and
- Provide a monthly bill to an employer that identifies the total premiums owned.

4.7. Oversight

Ensuring the quality of the QHPs offered through the Exchange and the Exchange customer experience will be critical to the Exchange’s success. The Exchange must continually track and manage the quality of the products being offered, manage the Exchange’s overall performance, and ensure compliance with federal rules and program mandates.

While many of the specific business processes required for oversight of an Exchange have yet to be defined by HHS, it is anticipated that the Exchange IT System will need to provide tools to facilitate the administration and oversight of Exchange operations, monitor health plan quality and compliance, and monitor health plan transactions and Exchange operations to detect fraud, waste, and abuse. The Exchange IT systems will also need to provide tools to allow compliance with the required functions related to oversight and financial integrity requirements to comply with Section 1313 of the ACA including federal reporting and annual federal audits. Lastly, the Exchange IT systems should provide an automated method to manage individual and employer complaints, appeals, and grievances.

4.7.1. IT Gap Analysis Summary

DHSS has a variety of processes and systems in place to administer and provide oversight for public assistance programs, including compliance with federal program reporting and rules, and systems and procedures to monitor fraud, waste, and abuse. However, since no program similar to an Exchange exists within the State, Delaware does may not have existing infrastructure that could be easily leveraged to support these activities.

The oversight activities specific to monitoring Exchange operations, and particularly the measurement and monitoring of plan quality metrics and enrollee satisfaction will require new sources of data, interfaces with the Exchange IT products, and additional human resources. While Delaware performs some measure of program oversight, it does not currently perform quality assessment and management for its existing health plans to the extent required by the ACA and recent regulatory guidance; and furthermore, DHSS does not have the ability to readily make quality information accessible to consumers in the required format.

Similarly, the operations of an Exchange will require additional federal reporting, monitoring for fraud, waste, and abuse, and handling new complaints, grievances and appeals to comply with the statute. DHSS does have some experience in these areas, however the additional demands in terms of volume and complexity from the Exchange will likely outstrip DHSS's capacity to perform these functions both operationally and technologically.

While the official business process blueprints for this area have not been issued, the section below provides details into anticipated functionality an Exchange IT system will need to support.

4.7.2. Exchange Operations and Quality Oversight Business Processes

These processes support effective management of Exchange business operations to ensure a satisfactory level of service; as well as measuring and monitoring health plan quality.

Exchange Operations Oversight

Provide tools and reports on Exchange operations such as transaction cycle times, consumer satisfaction, and other key metrics. Receive health plan quality data and make available to the Exchange web portal for display to users.

Business Process IT Gap Analysis

DHSS does not currently support any functionality for these processes.

4.7.3. Individual and Employer Compliant, Appeals, and Grievances Business Processes

Individual Appeal, Complaints, and Grievances

Provide tools to receive, track, and report on appeals, complaints, and grievances filed by individuals. Provide reports on processing and resolution.

Employer Appeal, Complaints, and Grievances

Provide tools to receive, track, and report on appeals, complaints, and grievances filed by employers. Provide reports on processing and resolution.

Business Process IT Gap Analysis

DCIS II has a hearing and appeals subsystem. Further analysis will be needed to determine if can be leveraged to support the Exchange.

4.7.4. Federal Compliance and Monitoring and Detection of Fraud, Waste and Abuse Business Processes

Federal Compliance

Provide reporting tools to comply with federal reporting and auditing requirements.

Monitoring and Detection of Fraud, Waste and Abuse

Provide tools to monitor health plan claims data and Exchange transactional data and detect potential fraud, waste, and abuse. Provide reports of potential targets. Track the progress and resolutions of investigations.

Business Process IT Gap Analysis

DHSS currently performs federal reporting and has resources and processes for the monitoring and detection of fraud, waste and abuse for its public assistance programs. However the systems may not be sufficient, or may require modifications to support the Exchange.

4.8. Communication

The communications demands that a fully-functioning Exchange will impose on an organization are great, even if their requirements have not been fully articulated by HHS at this time. The Exchange IT systems must support two major areas of consideration related to communication:

- Client Noticing – Provide a method to communicate verification of eligibility for Medicaid, CHIP, premium tax credits and cost sharing reductions, in addition to relaying final decisions on individual appeals. Notify employers of employees’ eligibility for advanced premium tax credits where the employer does not provide minimum essential coverage or coverage is deemed unaffordable. Notify carriers of premiums and tax credits to be applied to individual, rating of plans submitted to the Exchange, and the certification status of submitted plans.
- Marketing and Outreach – Effective marketing and outreach of the Exchange are critical considerations. To the extent it may be feasible in a given market, a complete Exchange IT system could include tools to support the planning, management, and measurement of education and outreach strategies, including the effectiveness of the web portal itself.

4.8.1. IT Gap Analysis Summary

Communications is another area where DHSS has some experience and infrastructure to perform a portion of what will be required by the Exchange, but may not support the full range of functions will be needed. In terms of noticing functionality, DHSS performs client noticing of eligibility decisions and case maintenance through DCIS II, but it does not have any noticing capability for employers or health plan carriers. Further, the DCIS II Client Noticing subsystem is used to support all programs where DCIS II is the system of record and may require significant modifications to address the

expanded noticing needs of an Exchange. Additionally, DHSS does not have any automated system or process to perform or manage ongoing, regular education and outreach to clients to provide information about the Exchange, however the scope of Delaware's ultimate Exchange may not necessitate such sophisticated tools.

4.8.2. Communication/Notification Business Processes

Individual Communication/Notification

Provide method of communication for individuals to learn about eligibility verification and benefits decisions for Medicaid, CHIP, advanced premium tax credits, and cost sharing reductions.

Business Process IT Gap Analysis

DCIS II has the potential to satisfy this process; however it may be difficult and costly to modify the system to address new noticing requirements and may not be flexible enough to respond to changes in noticing requirements.

Employer Communication/Notification

Provide method of communication to employers to inform them of employees' eligibility for advanced premium tax credits in instances which the employer does not provide minimum essential coverage or coverage is deemed unaffordable.

Business Process IT Gap Analysis

DHSS does not currently support any functionality for these processes.

Health Plan Carrier Communication/Notification

Provide method of communication to notify carriers of premiums and tax credits to be applied to individual coverage, rating of plans submitted to the Exchange, and the certification status of submitted plans.

Business Process IT Gap Analysis

DHSS does not currently support any functionality for these processes.

4.8.3. Administration of Education and Outreach Business Processes

Provide tools to create, manage, and monitor the effectiveness of education and outreach efforts.

Business Process IT Gap Analysis

DHSS does not currently support any functionality for these processes.

4.9. Customer Service

Ensuring a first-class consumer experience and easing the path for an individual to access health insurance products is a key goal of the ACA. As part of its plan to provide assistance to individuals and small businesses, each Exchange must operate a toll-free number to respond to requests for assistance from consumers. The call center must be able to respond to the specific needs of the individual as well as the small employer, such as inquiries related to eligibility, plan selection, premiums, tax credits, appeal status, and availability of primary care providers (as available), and enable callers to access the specific services of Navigators and brokers. Each Exchange will need to have a call center operational prior to open enrollment (October 1, 2013).

In addition to the call center, the Exchange may also operate an online help center, where individuals and employers may ask questions and receive answers through the Exchange website. The online help center should also provide specific guidance for Navigators and brokers when they have questions on behalf of the consumers they serve or need further clarification on product offerings or Exchange operations. There must also be a mechanism by which carriers may inquire about plan certification status and ratings, and premium information. The Exchange IT systems must provide tools to support these key Exchange functions for customer service in order to provide a first-class consumer experience.

4.9.1. IT Gap Analysis Summary

DHSS operates a decentralized model to providing customer service. Outside of a small group that provides front-line call center support to DSS and DMMA clients, DHSS does not utilize a centralized call center. These gaps, in addition to increased demands of supporting an Exchange, State-based consumer assistance programs, and additional Exchange website functionality for self-service represent significant obstacles DHSS would face to support the Exchange. DHSS also does not utilize automated call tracking or monitoring technologies for its existing customer support activities.

4.9.2. Call Center Business Processes

Establish a call center for consumer, employer, and carrier support. Provide tools to support call tracking, monitoring, and reporting for customer service support. Provide linkages between the call center and consumer assistance programs.

IT Gap Analysis

DHSS does not currently support any functionality for these processes.

4.10. Summary of IT Gap Analysis

The table below presents a summary of PCG’s findings during its gap analysis of DHSS’s current capabilities relative to the requirements of establishing a fully-functioning Exchange. Each major Exchange functional area was assigned a fit value (None, Low, Medium, High) to indicate the level to which an existing IT system or process could support the Exchange.

Table 4-1 Summary of IT Gap Analysis

| Exchange Function | As-Is Processes Support | Comment |
|----------------------------|-------------------------|---|
| Exchange Web Portal | High | <ul style="list-style-type: none"> • Supports CMS’s technical standards <ul style="list-style-type: none"> ○ New version of ASSIST isolates business rules ○ ASSIST complies with many CMS standards ○ Likely efficient and scalable distributed environment ○ DCIS II components are configured as re-useable web services. ○ Based on Service-Oriented Architecture • Low support for other |
| Navigator/Broker Program | None | <ul style="list-style-type: none"> • No functionality exists to support this area |
| Identity Management | High | <ul style="list-style-type: none"> • DTI has an IAM solution that is being integrated with ASSIST |
| Eligibility and Enrollment | Medium | <ul style="list-style-type: none"> • Support for State-sponsored programs • No support or interface with commercial carriers <ul style="list-style-type: none"> ○ Potential to configure rules in ASSIST rules engine |
| Plan Management | None | <ul style="list-style-type: none"> • No functionality exists to support this area |

| | | |
|------------------------------|-------------|--|
| Financial Management | None | <ul style="list-style-type: none"> No functionality exists to support this area |
| Oversight | Low | <ul style="list-style-type: none"> Current oversight systems and program unlikely to support expanded demands of an Exchange |
| Communications | Low | <ul style="list-style-type: none"> DCIS II noticing currently only focuses on clients DHSS has no established education and outreach resources |
| Customer Service/Call Center | Low | <ul style="list-style-type: none"> Current call center and customer service supports unlikely to support expanded demands of an Exchange |

As can be seen in the narrative and summary table above, DHSS has some existing technical resources that can be effectively leveraged to support an Exchange, but also lacks some key areas of system functionality. This result should not be particularly surprising, however, since nothing analogous to an ACA compliant Exchange exists in the public sector in Delaware. Furthermore, prior to the enactment of the ACA and the dramatic changes it has imposed on states to upgrade and enhance their IT solutions; Delaware’s technical infrastructure had done a fair job of meeting DHSS’s business needs. With the advent of the ACA and its requirements for all states to either establish an Exchange or defer to the federal government to operate its Exchange, however, Delaware will need to make many decisions on where to invest its resources, both State and federal, to address these identified gaps and other needs to satisfy the ACA requirements and continue to support its existing business needs.

In the areas where it has been noted that DHSS has some potential “As-Is” support for these processes, it must be noted that this assessment comes with important caveats. The ASSIST application presents an excellent example of both the opportunities and challenges that Delaware faces implementing an Exchange. Based on SOA architecture and with the forthcoming upgrade including a robust, isolated business rules engine, the ASSIST system could be well positioned to support eligibility determinations for the Exchange, but there are still many potential obstacles to overcome to design the complete eligibility solution needed to address Delaware’s business needs. Even with this opportunity, however, Delaware will need to address such as oversight and customer service where DHSS has current capabilities are more narrowly focused, thinly resourced and not especially sophisticated in their use of information technology. As a result, they

likely do not have sufficient capacity or capability to absorb the new activities required by the Exchange and upgrades or new solutions may be required.

Delaware still has a number of options to explore to establish the technical infrastructure for the Exchange and make sound improvements to its technology environment that can benefit its other programs and missions. The following section will present a discussion and assessment of the available options, including the pros and cons of each and the relative feasibility, difficulty, and costs associated with each utilizing a common set of criteria.

5. Discussion of Alternatives

The technology solution design alternatives for establishing an Exchange are best separated into three different categories as follows:

1. The options DHSS may consider to meet ACA requirements and guidance to perform eligibility determination and enrollment for Medicaid, CHIP, and the Exchange.
2. The options to consider in satisfying the requirements and guidance necessary to implement an ACA compliant Exchange.
3. The technical infrastructure options to consider in deploying the Exchange IT systems.

While there are many interrelationships between these three areas, the decisions that Delaware faces are unique for each area. For the eligibility solution, Delaware must decide to what extent its existing software solutions will play a role in the Exchange IT system and how these systems will need to integrate in the future environment. For the functionality needed to support the core Exchange business, the choice is largely what source should the State use to obtain the needed technical solution. Lastly, as it pertains to infrastructure, Delaware needs to make clear how any eventual solution will be deployed and maintained within what kind of environment.

In order to assess these options, this section has been structured to provide a description of the overall considerations, a listing of available options with their positive and negative attributes, and a diagram of what a solution utilizing the proposed option might look like.

5.1.1. State Sponsored Programs Eligibility and Enrollment Options

Regardless of the option chosen to implement the Exchange, DHSS will have to modify existing eligibility and enrollment IT systems for State-sponsored programs. This is required to integrate eligibility and enrollment into the Exchange. The following ACA criteria affect this integration.

- The Health Insurance Exchange Web Portal Architecture and Standards
 - Systems Integration
 - Service Oriented Architecture
 - Isolation of Business Rules
 - NIEM Information Exchange Compliance

- Individual Eligibility & Enrollment Business Processes
 - Applications and Verifications
 - Seamless Eligibility Process with Medicaid, CHIP and the Exchange
 - Enrollment, Renewal, Disenrollment in Medicaid and CHIP

All these items are described in more detail above. DHSS has four primary options to implement the new Eligibility and Enrollment rules and functionality that will interface with the Exchange, as follows:

1. Do the minimal work required to existing IT systems to interface with the Exchange, even if it is not compliant with CMS technical guidelines;
2. Modify existing IT systems to be CMS compliant, but implement in multiple phases with some phases occurring after October 1, 2013;
3. Modify existing IT systems to be CMS compliant, but implement all at once to meet the October 1, 2013 deadline; and
4. Replace existing IT systems with new systems and implement them to meet the October 1, 2013 deadline.

Option 1 – Minimal Integration

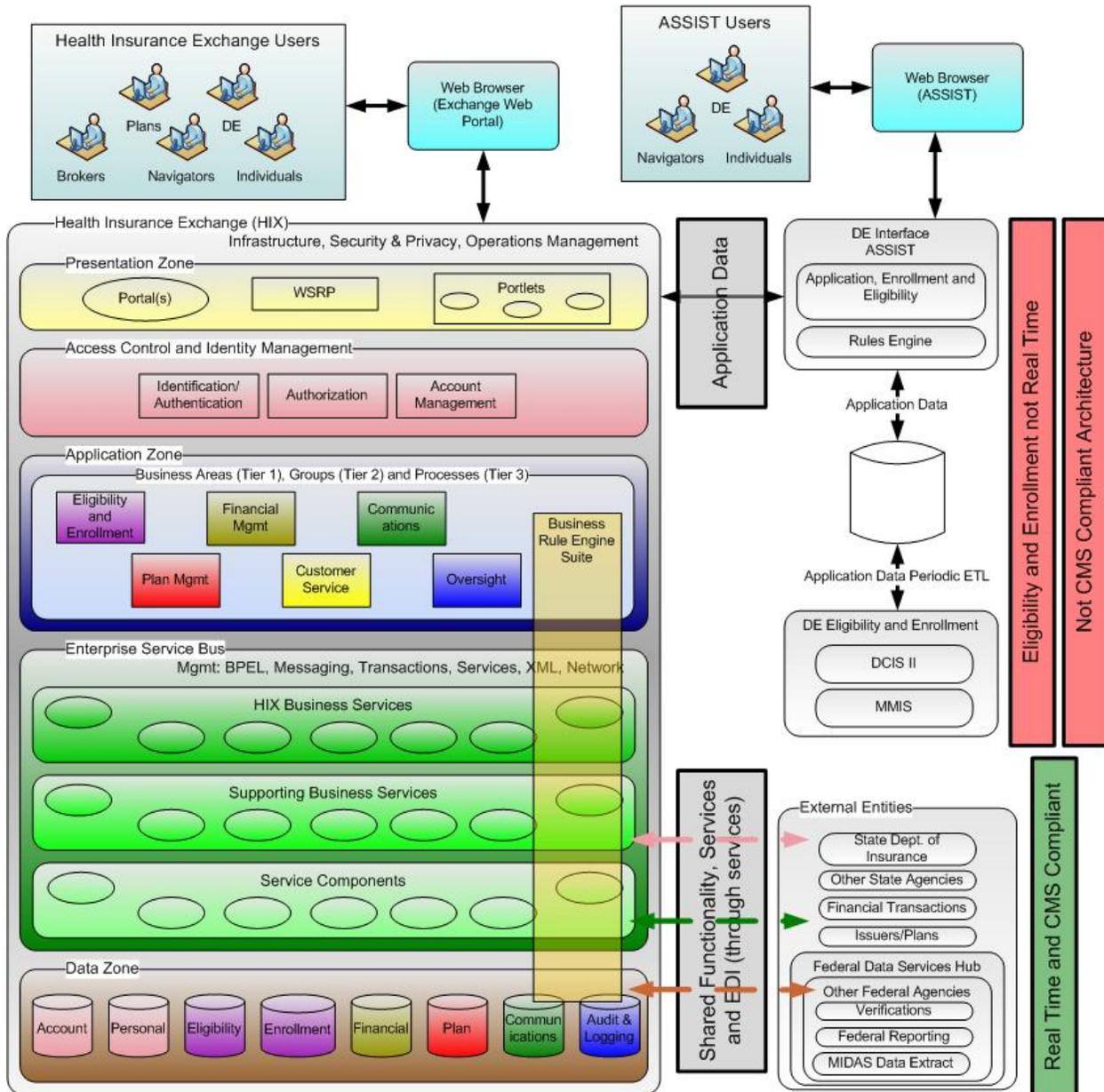
Make the modifications required to transfer application data between the Exchange and ASSIST, establishing ASSIST as the State-side portal. All other eligibility and enrollment business process flow would be the same as it is currently.

Under this option if a consumer enters through the Exchange and is determined Medicaid or CHIP eligible the consumer would be “transferred” to the ASSIST Graphical User Interface (GUI). All data the consumer entered in the Exchange web portal GUI would be mapped to ASSIST and be populated on the ASSIST GUI. Once ASSIST has control the existing DHSS business process flow would remain in place. ASSIST would do some eligibility screening using rules from a rules engine. Information for individuals passing the screening would be written to a database and the data would be extracted periodically and process in DCIS II. A DHSS eligibility worker would communicate with the individual to complete eligibility determination. Information for eligible individuals is passed to MMIS, where the enrollment process is completed.

Conversely, if a person enters ASSIST and is determined ineligible for Medicaid or CHIP, but potentially eligible for subsidized insurance through a QHP, that person’s information is “transferred” to the Exchange and the Exchange will manage the information.

The format and data requirements of the data exchanged between ASSIST and the Exchange will have to be defined and the data exchange will have to follow the NIEM model. ASSIST may also have to be modified to abide by the Exchange's IAM requirements once those requirements are defined.

Figure 5-1: Eligibility Option 1: Minimal Integration



Pros

- Offers the least risk of missing the October 1, 2013 deadline required by the ACA.
- The shortest implementation schedule.
- The least expensive option.

Cons

- The only Exchange Web Portal Architecture and Standards criteria followed would be NIEM.
- Does not meet CMS' vision of a seamless eligibility and enrollment process occurring real time.
- This plan may not be approved by CMS.

Option 2 – Phased Integration

Plan to support ACA requirements and guidelines in a phased implementation based on modifications to existing IT systems, with some phases occurring after October 1, 2013. DHSS may choose to focus only on Medicaid and CHIP to mitigate risk. Design, develop and implement in phases. Below is a high level first pass as to what the phases may be.

1. Upgrade ASSIST to comply with CMS Exchange Web Portal Architecture and Standards criteria and to satisfy CMS' visions of a seamless eligibility and enrollment process occurring "real time". Consider developing portlet web services that can be consumed by the Exchange web portal for application data collection.
2. Strip all eligibility determination business rules out of DCIS II and configure them in the Corticon rule engine being implemented for ASSIST.
3. Strip any remaining eligibility business processes out of DCIS II and implement it in ASSIST.
4. Strip all enrollment business rules out of MMIS and configure them in Corticon.
5. Strip any remaining enrollment business processes out of MMIS and implement it in ASSIST.

Pros

- Complies with the Exchange Web Portal Architecture and Standards criteria.
- Complies with CMS' vision of a seamless eligibility and enrollment process occurring real time.

- Modernizes Medicaid and CHIP eligibility processes.

Cons

- The longest implementation schedule.
- Large amount of development work to legacy systems likely required to isolate some business rules but not all – two bodies of work instead of one
- High risk of impacting other state-sponsored programs.
- Case management and where it resides has an impact on case management for redets, etc. – Functionality will be out of synch
- Might not fully meet CMS' implementation schedule.

Figure 5-2: Eligibility Option 2: Phased Integration – Prior to October 01, 2013

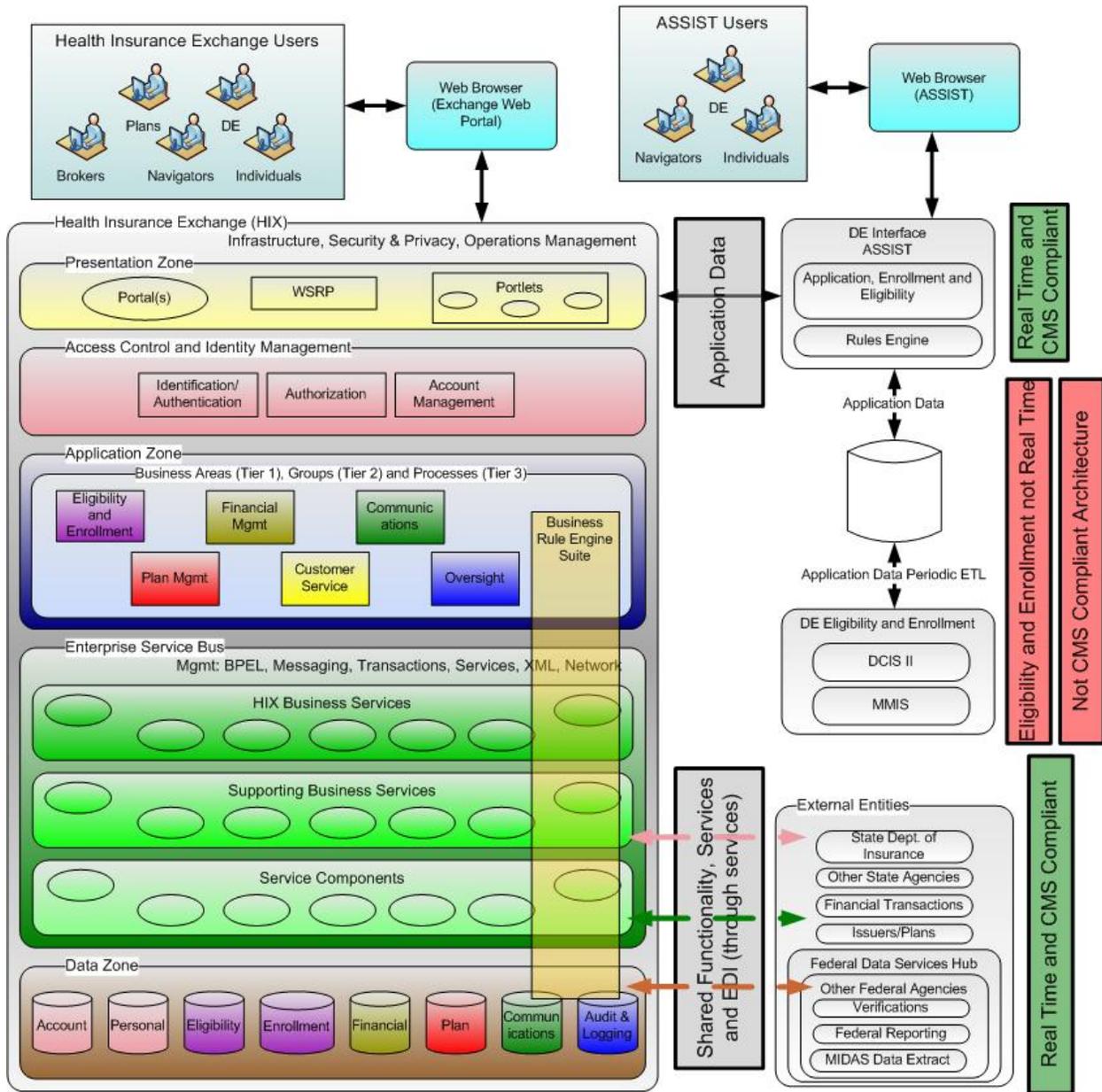
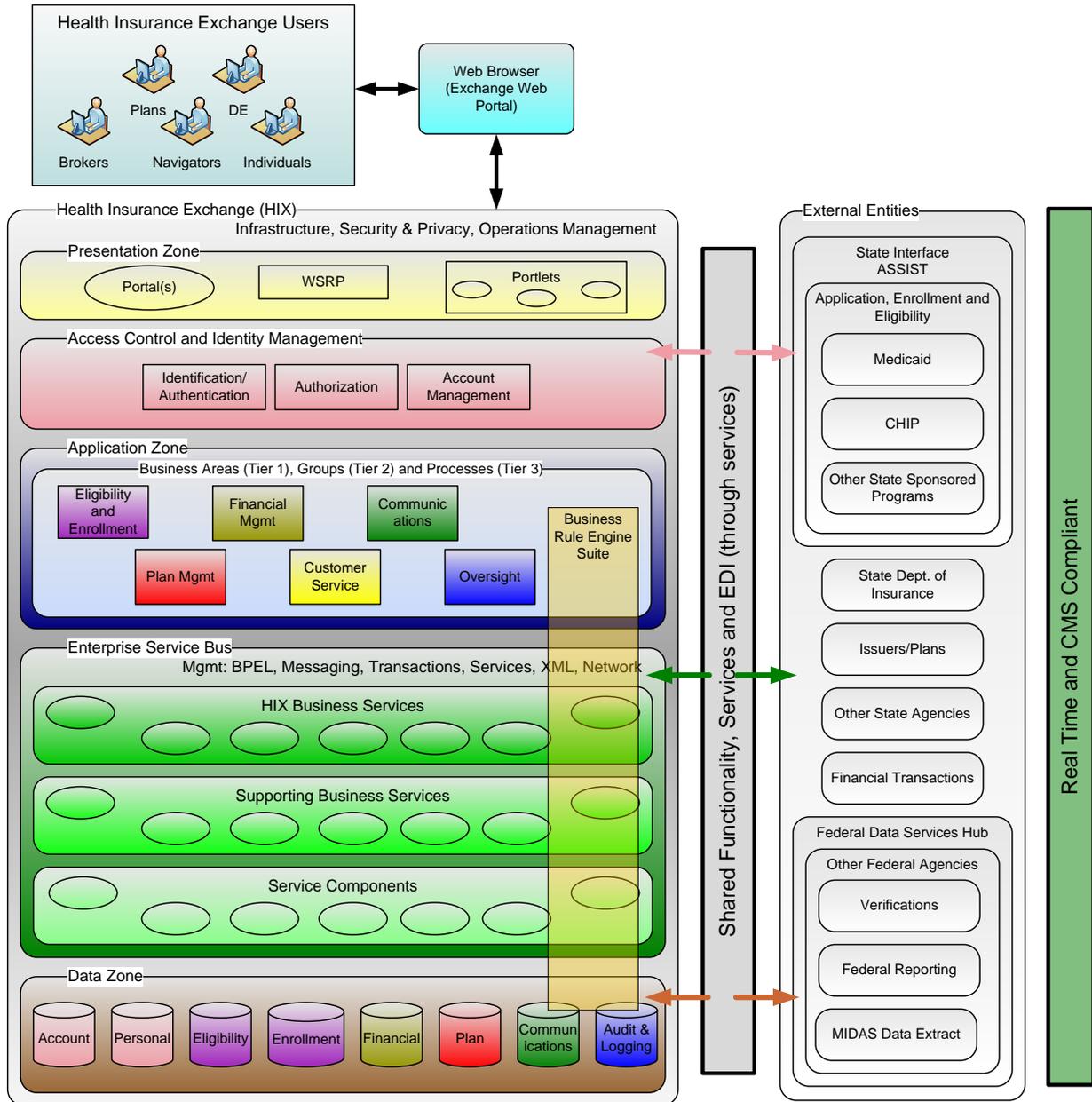


Figure 5-3: Eligibility Option 2: Phased Integration – Sometime After to October 01, 2013



Option 3 – Complete Integration

Plan complete support of ACA requirements and guidelines by October 1, 2013 based on modifications to existing IT systems. The same as described for Option 2 except for a compressed implementation schedule (Refer to Figure 5-3).

Pros

- All the Pros described under Options 2.
- Meet CMS' expected implementation schedule.

Cons

- This option suggests parallel phase schedules with more resources, making it more complex to manage.
- The compressed schedule increases the risk that nothing will be available by October 1, 2013.
- Large amount of development work to legacy systems likely required

Option 4 – Replacement

Replace existing IT systems supporting eligibility and enrollment with new IT systems that meet ACA requirements and guidelines. Evaluate vendor products as the replacement.

The advantage this option has is that it negates the need to enhance ASSIST. On the other hand, there would be the need to go through the procurement process. It is also a possibility that that any eligibility system replacement product can use the Corticon rules engine. A possible scenario for this option is as follows:

1. Replacement product procurement process.
2. Strip all eligibility determination business rules out of DCIS II and configure them in the Corticon rule engine being implemented for ASSIST.
3. Strip any remaining eligibility business processes out of DCIS II.
4. Strip all enrollment business rules out of MMIS and configure them in Corticon.
5. Strip any remaining enrollment business processes out of MMIS.

Pros

- All the Pros described under Options 3.
- A completely modernized eligibility and enrollment process with less design, development and integration effort.
- Takes full advantage of temporary federal funding opportunities

Cons

- Going through the procurement process.
- Vendor capacity unknown
- Likely highest cost

5.1.2. ACA Compliant Exchange Options

Based on the analysis of available Information System assets in Delaware and the gaps that need to be addressed to meet ACA requirements and guidance, five potential options were identified for the State to consider:

1. Allow the Federal Government to Operate the Exchange;
2. Leverage Government Developed Capability (Early Innovator Grantee states, the federal Exchange);
3. Purchase/Procure Commercially Developed Capability;
4. Join a Multi-State Solution; and
5. Build a Custom Exchange Solution.

Option 1 – Allow the Federal Government to Operate the Exchange

States are required under the ACA to create Exchanges for state residents. But there is no penalty to the individual states for failure to act. The ACA authorizes the federal government to step in and manage the Exchange functions should any individual state fail to act. Delaware needs to decide whether the creation of an Exchange by the State rather than the federal government is a critical issue.

Delaware has tabled this option. The Secretary of Health & Social Services, under the direction of Governor Jack A. Markell's Office, is leading the effort.

Pros

- Potentially the least expensive of the options.
- Potentially the lowest administrative burden of the options.

Cons

- Requires coordination with Medicaid and CHIP programs
- Churn of members across programs may be administratively burdensome if the Exchange is administered by non-State entity
- Loss of state self-determination.
- The federal government will choose a non-profit organization to administer the Exchange.
- The federal government would, at the very least, be involved in issues that are now the purview of the State and the SDOI.
- State regulation of insurers and products offered outside the Exchange and federal regulation of QHP products will add complexity and make it more difficult for the state to maintain regulatory control.

- Management, governance and coordination of State health insurance products will involve three entities, (DHSS, SDOI and HHS) instead of two.
- State would still have to figure out how to integrate Federal Exchange into their environment

Option 2 – Leverage Government Developed Capability (e.g., Early Innovator Grantee States, other States, and the Federal Exchange)

CMS is developing a suite of Exchange IT system modules to satisfy all Exchange requirements, except eligibility and enrollment processes for specific state Medicaid, CHIP and applicable State-sponsored programs. Processes to capture application information and a rules engine to house generic eligibility rules are included as part of the Federal Exchange (FX). It is not known at this time how flexible the FX will be in terms of implementing individual States' eligibility requirements.

CMS is requiring the Federal Exchange be composed of highly modular interoperable components interacting as Web Services in a SOA environment. The goal is to maximize interoperability, through open standards, and reusability of service components.

This option may allow DHSS the opportunity and flexibility to pick and choose FX components to meet some Exchange IT system requirements while satisfying other requirements in other ways. DHSS will still have to develop State-specific eligibility and enrollment processes that interface with the FX components of the Delaware Exchange.

Pros

- This option has the advantage of leveraging the Federal Exchange which, by default, will meet ACA requirements and Federal Guidance.
- This option may be a cost-effective solution, possibly the least expensive option that allows Delaware to implement a State-administered Exchange.

Cons

- Utilizing FX components is dependent upon whether they will be completed by the October 1, 2013 deadline required.
- Early Innovator States are not as far along as originally planned in terms of solutions development.
- An extensive integration effort is required, perhaps the highest of all options.

- The date upon which FX components are released and the integration effort required may put the ability to meet deadlines at risk.

Option 3 – Purchase/Procure Commercially Developed Capability

There are a number of vendors offering IT system components to satisfy different business subject area Exchange requirements. There are also vendors offering complete IT systems suites that satisfy all Exchange requirements. The offering range from software packages/suites that allegedly can be purchased and deployed on a State hosted or cloud environment, to Software as a Service (SaaS) offerings, and all the way up to fully outsourced IT and business process services.

It is hard to determine if the integration effort for this option is greater or less than Option 2 since the FX components have not even been designed yet. At this point, it may be safe to assume that this option's integration effort will be less.

Pros

- Assuming vendor offerings will be available before FX offering, the risk of missing the October 1, 2013 deadline is minimized.
- This option offers a wider range of choices than Option 2, making it easier to meet DHSS specific requirements.
- Integration effort will most likely be less than Option 2.

Cons

- There is the potential risk that vendor offerings are not fully developed. DHSS will want to be diligent in ensuring commercial products are operable and meet the State's specifications.
- This option requires closer scrutiny to ensure commercial products meet and federal guidance.
- Integration will become more and more complex as the number of vendors involved in the complete Exchange IT solution increases.
- There is likely a higher cost than under Option 2.

Option 4 – Join a Multi-State Solution

Delaware could join with another state or states in a Multi-State Exchange. All the Exchange IT system requirements could be satisfied by the Multi-State Exchange, except eligibility and enrollment processes for specific state Medicaid, CHIP and applicable State-sponsored programs. The Multi-State consortium could utilize options

2 and/or 3 to satisfy Exchange IT system requirements. Member states may also have existing IT systems that satisfy Exchange requirements.

Pros

- The “divide and conquer” concept of this option may lower the lowest risk of missing the October 1, 2013 deadline, if willing partners can be found in time.
- Spreading costs over multiple states should reduce the cost for any individual state. This option may be the least expensive to develop maintain and operate.

Cons

- This option will not give the State much control or flexibility, and would likely involve a lengthy and cumbersome process to obtain agreement on all requirements from participating States.
- The progress on this Exchange solution would only be as fast as the slowest State in the consortium.
- It may be difficult or impossible to come to agreement on a multi-state Exchange in time to meet the deadline

Option 5 – Build a Custom Exchange Solution

Option 5 requires Delaware to build the entire Exchange from scratch. All Delaware eligibility and enrollment functionality in IT systems (ASSIST, DCIS II, MMIS and their subsystems) would be replaced with new functionality. All Exchange IT systems will be built to State specifications. This solution will be the most expensive and time consuming solution. Given time and resource constraints PCG does not believe this solution is viable and should not be pursued.

Pros

- All functionality will meet Delaware State specifications.
- Delaware will have complete control of modifications.

Cons

- The most expensive and time consuming option.
- DHSS does not have experience in many of the core business areas. DHSS will have to rely on external subject matter experts to gain an understanding of the best way to implement the Exchange business requirements and design the IT systems to support the business processes.

- A high (almost guaranteed) risk of missing all of the Exchange deadlines.

5.1.3. Exchange IT Systems Deployment/Infrastructure Options

Depending on current capacity utilization and ability to support a SOA environment DHSS may need to consider its options in deploying, maintaining, administrating and operating the technical IT infrastructure required to support the Exchange IT system. DHSS basically has three options.

1. If there is the capacity to easily scale to meet the demands of the Exchange, DHSS and DTI may choose to host the Exchange IT systems. This assumes DHSS and DTI have the subject matter expertise and is willing to take on all of the responsibilities of hosting a SOA environment entails.
2. DHSS could choose to host the Exchange IT systems in a Cloud computing environment. The physical IT infrastructure responsibilities would be outsourced, but administration would still be the responsibility of the State.
3. Depending on the software products chosen, Delaware may be able to use the SaaS model, where all IT infrastructure responsibility is taken on by the vendor.

Developing a recommendation depends on a more detailed understanding of the State's IT environment.

6. PCG Recommendations and Proposed Next Steps to Develop a Delaware Health Insurance Exchange

Delaware faces many difficult choices in a number of key areas of how to design and implement the best IT infrastructure to support the Exchange. Each technical area, from Eligibility, to Exchange business functionality, to the deployment and infrastructure options, presents resource, schedule, and strategy concerns that must be weighed against a variety of factors to determine the best fit for DHSS and the State. In order to facilitate this process, PCG will present recommendations of options to pursue for further consideration based on this initial assessment as well as a description of the next steps that will be required to fully flesh out the costs and benefits of each selected option.

6.1.1. Eligibility/Enrollment Option Recommendations and Next Steps

As has been stated numerous times in this report, what to do to comply with the eligibility and enrollment requirements and standards is a fundamental consideration to designing an Exchange IT Solution. Eligibility and enrollment are areas where Delaware, like all states, has an infrastructure to support their existing programs and therefore must decide whether, and how much to leverage that infrastructure, the level of integration between any new solutions and the existing systems, and whether to scrap and replace those systems entirely and build a new eligibility system. Furthermore, any decisions regarding eligibility and enrollment are complicated by DHSS ongoing efforts to overhaul its MMIS system as well as by the other programs within the State that also rely on this same infrastructure.

As the assessment above shows, each option has distinct positive and negative aspects for Delaware moving forward, however Options 1: Minimal Integration, Option 2: Phased Integration appear to be the most attractive. A complete integration or system replacement at this time does not appear to be a feasible option to meet the mandate.

In order to fully flesh out these recommended options and provide the thorough analysis needed to decide on a course of action, PCG recommends the following next steps:

1. Perform further analysis into the capabilities of ASSIST and the Corticon rules engine
2. Assess the integration capacity of DCIS II and the level of effort required to extract business rules

3. Assess the potential for existing MMIS enrollment functionality to support Exchange needs
4. Research potential vendor solutions that could satisfy Delaware's needs
5. Estimate costs and level of effort for each option
6. Develop assessment report of the selected options
7. Meet with State leadership to decide a course of action

6.1.2. Exchange Business Functionality Recommendations and Next Steps

Meeting the technical needs to operate the Exchange is an area where Delaware has the most gaps between existing and needed functionality, however this is common situation for most states. Fortunately, because of the frenzied efforts to establish Exchanges in the tight timeframes of the ACA by the federal government, Early Innovator Grantees, other states, and vendors, there may be many solutions for Delaware to choose from that can provide the full range of functionality needed for the Exchange. Any potential technical solutions still present significant trade-offs that must be weighed and any solution, even an off-the-shelf product offering complete functionality must be successfully integrated into Delaware's IT environment.

From this analysis, Option 2: Government Developed Capability, Option 3: Commercially Developed Capability appear to be the most feasible and warrant further consideration. Coming to an agreement on a Multi-State Exchange in time to meet the mandate does not seem feasible at this time. Deferring all responsibility to the federal government does not appear to be an attractive option at this time because so little information is known about the Federal Exchange solution and how well it may be able to meet Delaware's needs or how any potential cost model may be structured. Lastly developing a custom solution to the Exchange is very costly, resource intensive, risky, and highly unlikely to meet to be completed in time to meet the mandate.

To form a more complete analysis of these recommended options and provide the information need to make an informed decision, PCG recommends the following next steps:

1. Develop Delaware's functional requirements for the Exchange
2. Compare government developed capabilities (including Early Innovator Grantees, federal government, and other state solutions) against Delaware's functional requirements to assess the level of fit, feasibility and risk
3. Compare possible Commercially Developed Capabilities against Delaware's functional requirements to assess the level of fit, feasibility and risk

4. Assess multi-state partnering opportunities and compare against Delaware's functional requirements to assess the level of fit, assess feasibility, and analyze risk
5. Estimate costs and level of effort for each option
6. Develop assessment report of the selected options
7. Meet with State leadership to decide a course of action

6.1.3. Infrastructure/Deployment Recommendations and Next Steps

Regardless of the solution that is chosen for either eligibility or the Exchange business functions, Delaware must still decide upon the desired approach to deploy and maintain the technical infrastructure supporting those solutions. In order to conclude these decisions, PCG recommends the following next steps:

1. Obtain more detailed information on DTI and IRM's infrastructure capacity, compatibility, and scalability
2. Review Delaware's functional requirements for the Exchange solution with key technical stakeholders to identify desired options
3. Estimate costs and level of effort for each option
4. Develop assessment report of the selected options
5. Meet with State leadership to decide a course of action

7. Glossary

7.1. Acronyms

| Acronym | Definition |
|---------|---|
| ACA | Patient Protection and Affordable Care ACT |
| API | Application Programming Interface |
| APTC | Advance Premium Tax Credits |
| ASSIST | Application for Social Services and Internet Screening Tool |
| BHP | Basic Health Plan |
| CHIP | Children’s Health Insurance Program |
| CMS | Centers for Medicare & Medicaid Services |
| CSR | Cost Sharing Reductions |
| DCIS II | Delaware Client Information System |
| DHCP | Delaware Healthy Children’s Program |
| DHSS | Delaware Department of Health and Social Services |
| DSH | Federal Data Services Hub |
| DTI | Delaware’s Department of Technology & Information |
| EDI | Electronic Data Interchange |
| FMAP | Federal Medical Assistance Percentage |
| FPL | Federal Poverty Level |

| Acronym | Definition |
|---------|---|
| HHS | U.S. Department of Health and Human Services |
| HIPAA | Health Insurance Portability and Accountability Act |
| HIX | Health Insurance Exchange |
| IAM | Identity Access Management |
| IRS | Internal Revenue Service |
| IT | Information Technology |
| MITA | Medicaid Information Technology Architecture |
| MMIS | Medicaid Management Information Systems |
| NIEM | National Information Exchange Model |
| PCG | Public Consulting Group |
| PHI | Protected Health Information |
| QHP | Qualified Health Plans |
| SBA | Small Business Administration |
| SDOI | State Department of Insurance |
| SOA | Service Oriented Architecture |
| SHOP | Small Business Health Options Program |
| SNAP | Supplemental Nutrition Assistance Program |
| TANF | Temporary Assistance to Needy Families |
| | |