

State of West Virginia

Offices of the Insurance Commissioner
Health Insurance Exchange (HIX)

Information Technology Strategic Plan

Version 1.1

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WEST VIRGINIA OFFICES OF THE INSURANCE COMMISSIONER

Health Insurance Exchange Information Technology Strategic Plan Version 1.1

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Version	Delivered Date	Update Reason
1.0	October 14, 2011	Initial Draft submitted to OIC for review.
1.1	December 9, 2011	Revised based on OIC comments.

Table i: Version History of the Plan



Executive Summary

This section of the report contains an executive level summary of the overall Information Technology Strategic Plan.

The Health Insurance Exchange (HIX, "Exchange") Information Technology (IT) Strategic Plan is intended to help the state's executive decision-makers prepare for the future by defining the action steps necessary to meet Exchange IT goals, business and system needs, and program priorities. In addition, this Plan is an important input to future funding requests for the Exchange and a key component of a Request for Proposals (RFP) for Exchange systems integration, hardware and software.

A highly collaborative approach involving stakeholders from numerous state agencies and the carrier and producer communities was taken in the preparation of this Plan. Based on review of over thirty state IT assets, collection of information from over sixty individuals in state government and the private sector, interviews with three Early Innovator grantees, and a comprehensive review of federal laws, regulations and guidance issued to date, this HIX IT Strategic Plan provides the state with a review of the current environment for West Virginia's Exchange, a gap analysis, a list of strategic IT issues, a list of recommended strategic IT initiatives to address gaps and issues, HIX IT cost considerations, and HIX IT design approaches.

The HIX IT Strategic Plan identifies:

- Nine state IT assets that could potentially be leveraged in the future Exchange IT environment.
 - RAPIDS, inROADS and SERFF offer the best opportunities for re-use in the future Exchange IT environment.
 - RAPIDS and inROADS would require significant enhancements and additional functionality in order to meet federal Exchange requirement.
- Eleven Technical Gaps and twelve Functional Gaps.
 - All of these gaps must be addressed prior to the Exchange launch in October 2013.
 - For two Technical Gaps and eight Functional Gaps, no IT assets exist in the West Virginia state current IT environment to potentially leverage.
- Forty-four strategic IT issues, 25 of which were prioritized as "Critical," or must be resolved prior to issuing Exchange IT RFP(s).
- Eight strategic IT initiatives to address the gaps and strategic IT issues.
- Four HIX IT design approaches for the future Exchange environment.

The Exchange may consist of a combination of existing state systems, Commercial-Off-the-Shelf (COTS) products, system components developed by other states and/or the federal government, and custom components. The four HIX IT Design Approaches presented in the table below and discussed in further detail in section 8.0 offer four viable frameworks for integrating multiple systems and components to create a cohesive Exchange IT environment.



Table 1: HIX IT Design Approaches

HIX IT Design Approach 1	Existing state IT assets drive the Exchange IT design.
HIX IT Design Approach 2	Newly-procured IT assets drive the Exchange IT design.
HIX IT Design Approach 3	Partnerships with other states to procure shared IT assets drive the Exchange IT design.
HIX IT Design Approach 4	A State-Federal Partnership or Federally-facilitated Exchange drives the Exchange IT design.

The most critical IT planning next steps for the Exchange are to validate the set of viable HIX IT design approaches described in this report with key Exchange business partners, and prepare a procurement strategy. This approach is action-oriented and mitigates the risk of experiencing IT planning delays due to the lack of an Exchange Board in place to make critical IT decisions by keeping all viable HIX IT design approaches on the table for several more months. This approach also allows the state to continue to gather important IT planning information through conversations with other states, CMS, and Exchange stakeholders before committing to a design approach.

OIC should closely collaborate with the Bureau for Medical Services (BMS) and other offices of the Department of Health and Human Resources (DHHR) to review and validate the HIX IT design approaches. The Exchange must coordinate effectively with Medicaid and other key HIX stakeholders to plan for Exchange IT in order to increase its chances of maximizing federal funding opportunities, and meeting federal deadlines with the required scope.



1.0 Introduction

This section of the report describes the purpose and background and objectives of the Current Environment Assessment, the work performed to develop the report, the project influences, and the format of the report.

1.1 Purpose and Approach

In June 2011, the West Virginia Offices of the Insurance Commissioner (OIC) contracted with BerryDunn to develop a Health Insurance Exchange (HIX, the Exchange) Information Technology (IT) Strategic Plan, including a gap analysis, as required for the Level Two Establishment Grant application process. The intended audience for the plan include: state decision-makers, the Exchange Board, the Centers for Medicare and Medicaid Services, and the vendor community. From June through October 2011, a BerryDunn team of IT specialists, business analysts, policy experts, and health insurance and Medicaid subject matter experts conducted key interviews and work sessions with state and private sector stakeholders in person and by phone, conducted research, and analyzed findings to prepare this plan. BerryDunn employed a proven IT strategic planning methodology to conduct this work, which is based on these major phases:

- Project Planning and Current Environment Assessment;
- Research and Development of Strategic IT Issues; and
- Development of Strategic IT Initiatives.

Development of IT Strategic Plan content has been an iterative and collaborative process with the OIC Health Policy team. Members of the OIC Health Policy team participated in current environment key informant interviews and reviewed a draft of the Current Environment Report; participated in the strategic IT issue stakeholder work sessions; and participated in the prioritization of strategic IT issues and initiatives.

1.2 Background

West Virginia is ahead of many states with respect to its HIX planning, due in large part to a \$36 million State Health Access Program (SHAP) grant received in 2009 from the Health Resources and Service Administration (HRSA). Part of this grant was designated for the OIC to research and develop a HIX. Through the SHAP grant, the OIC began planning for a HIX prior to the passage of the Affordable Care Act. With the help of the SHAP grant, the OIC was able to make significant strides in its Exchange planning, including engaging in discussions with stakeholders and other state agencies that will be impacted by the Exchange, researching other exchanges, holding discussions with the National Association of Insurance Commissioners (NAIC) and Federal Department of Health and Human Services (HHS), and serving as a NAIC Exchange Subgroup member.

The OIC also received a \$1 million Federal Planning Exchange Grant to assess the state's health insurance consumer and business markets, develop an economic assessment of the state's health insurance market, determine who will participate in the Exchange, develop education and outreach strategies, and assess the efficiency and effectiveness of the state's technical capacity to perform technical tasks for the Exchange.



As part of the Planning Exchange Grant, the OIC outlined the development of an IT Strategic Plan to guide the state's IT infrastructure planning for the Exchange. The grant also outlined the need for facilitation services. Accordingly, through the OIC's Request for Project-Based Services, the OIC competitively procured the services of an independent consultant to provide the following services in support of the state's HIX activities:

- Lead the development of West Virginia's HIX IT Strategic Plan;
- Provide coordination, facilitation, and project management services for IT-related Exchange activities; and
- Provide assistance in the development of grant applications for the Level Two Establishment Grant and other grants, as requested, as well as procurement documents (e.g., RFIs, RFPs, RFQs) for HIX IT needs.

Other recent planning activities include:

- Contracting with the Arnold Agency for Branding and Outreach;
- Development of an Actuarial Services RFP;
- Submission of a Level I Establishment Grant (June 30, 2011); and
- Planning for the submission of a Level II Establishment Grant (December 31, 2011).

1.3 Project Influences

Several assumptions and constraints impacted the development of this report.

"Assumptions" are premises about the business, policy and/or project environment that, for the sake of planning, are taken as fact. These may be events or trends which are occurring, are expected to occur, and/or are expected to continue during the life of the project and which may impact the project.

The following assumptions influenced the development of this report:

- Senate Bill 408 establishes a West Virginia Health Benefit Exchange within the Offices of the Insurance Commissioner as a governmental entity of the state. The state is therefore obligated by state law to create a Health Insurance Exchange, and new legislation would be required to abolish the Exchange.
- The proposed federal rules issued in July and August 2011 are being used for planning purposes in combination with the Affordable Care Act and the most current versions of federal guidance available.
- The state's Exchange IT planning approach aligns with the federal guidance that expects states to use a common or shared eligibility system or service to adjudicate placement for most individuals seeking Medicaid, CHIP or an Exchange health insurance subsidy program.
- The state's Medicaid Management Information System (MMIS) was not extensively evaluated as a key asset of the current West Virginia state Exchange IT environment as it is a proprietary, vendor-operated system that is currently in the re-procurement process, and therefore may not be in existence when the Exchange will be operational.



“Constraints” are known facts over which the project has limited or no control. These can affect the direction, planning, and implementation of the project. These include factors such as federal compliance deadlines.

The following constraints must be taken into account when reading this report:

- The Exchange Board has not been appointed.
- The federal government has not issued final rules implementing many provisions of the Affordable Care Act which are critical to the planning and design of the Exchange.
- The timing for the completion of this Plan is being driven by OIC’s aim to submit its Level Two Establishment Grant Application for the March 31, 2012 deadline.
- Estimates of the number Exchange users and their expected entry point into the Exchange (i.e., Call Center, website, by mail or in-person) over time have not been developed. The numbers of users of different components of the Exchange are an important factor in assessing the technical fit of current IT assets in terms of capacity.

1.4 Report Format

This HIX IT Strategic Plan consists of the following sections:

- **Section 2.0, Current Environment:** Presents the state’s business and technology environment that relate to the future Exchange IT environment.
- **Section 3.0, HIX IT Gap Analysis:** Identifies technical and functional gaps in the current environment that must be addressed by the future Exchange IT environment in order to meet business needs and achieve federal compliance.
- **Section 4.0, Strategic IT Issues:** Presents the gaps, open decisions, and other factors that might have a significant impact on the Exchange IT environment and are prioritized based on a multi-stakeholder collaborative process.
- **Section 5.0, Early Innovator States Research:** Describes the status of other states’ efforts to establish Exchanges, with detailed profiles of the five remaining Early Innovator grantees.
- **Section 6.0, HIX Cost Considerations:** Outlines key Exchange design-related decisions the state must resolve without delay, as well as information about estimated HIX IT costs and funding approaches.
- **Section 7.0, Strategic IT Initiatives:** Address the strategic IT issues that are described and prioritized in Section 4.0.
- **Section 8.0, HIX IT Design Approaches:** Identifies four viable HIX design approaches for the state to consider.
- **The Appendices** contain supporting information, details and sources to assist the reader in understanding this report.



2.0 Current Environment

This section of the report describes the current HIX organizational and technology environment for both the federal government and the State of West Virginia.

2.1 Work Performed

The information contained in this report is current as of September 29, 2011. To gather internal and external stakeholder feedback and information about the current business and technical environment in West Virginia related to HIX planning, a list of agencies and individuals to be interviewed was developed collaboratively between BerryDunn and the OIC. All individuals scheduled for interviews were invited to a kick-off meeting; on July 25, more than twenty individuals representing nine different entities attended the meeting. From July to September 2011, BerryDunn then conducted a series of on-site interviews, work sessions and follow-up communications with over 50 stakeholders representing over 25 entities that are part of the state's current HIX business and technology environments (see *Table 2 below*). In preparation for the meetings, BerryDunn prepared and distributed an Interview Outline (Appendix C). The complete list of individuals interviewed and/or contacted for information is included as Appendix B.

Table 2: Entities Contacted

<ul style="list-style-type: none"> • DHHR Office of Technology • DHHR Bureau for Medical Services • DHHR Bureau for Children and Families • Division of Corrections • Governor's Office of Healthy Enhancement and Lifestyle Planning (GOHELP) • Health Care Authority • OIC Consumer Services Division (CSD) • OIC Administrative Services, Personnel, and Purchasing • OIC Agent Licensing • OIC Executive, Chief Financial Officer • OIC Financial Conditions • OIC Health Policy Division • OIC Information Technology Department 	<ul style="list-style-type: none"> • OIC Legal Division, Fraud Prevention • OIC Market Conduct • OIC Office of Inspector General • OIC Rates and Forms • Public Employees Insurance Agency (PEIA) • WV CHIP • WV Health Information Network (WVHIN) • WV Office of Technology (WVOT) • WV Telehealth Alliance • Carriers: BCBS Highmark, Delta Dental, Hartford, The Health Plan, WellPoint, United Healthcare, Carelink/Coventry • Producers: Deacon & Deacon Insurance Agency, Commercial Insurance
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During these meetings, BerryDunn facilitated information gathering to gain an understanding of the current environment, including (but not limited to) the entity's current business functions, hardware/software environment and IT architecture, information on current/legacy systems that will interface with the Exchange, IT projects that are planned or underway that may impact the



Exchange, sources of funding, and privacy and security standards and policies that must be considered in HIX planning. Over thirty hardware and software assets from six state agencies or entities – the OIC, Department of Health and Human Resources (DHHR), Office of Technology, Department of Commerce, Health Care Authority, and Public Employees Insurance Agency – were identified and reviewed for this report.

2.2 Approach

The overall framework of the HIX IT Strategic Plan is that state and federal policies, regulations and guidance; organizational missions and goals; and market forces shape an organization's business, and business should drive technology. Technology is rarely an end in itself; it enables an organization to conduct its business more efficiently and/or more effectively. However, sometimes technology is required to comply with federal regulations (as is the case with HIX).

Figure 1: Framework for HIX IT Strategic Plan



It is impossible to assess the technology environment without first understanding the business processes it supports. Thus, to understand West Virginia's current HIX technology environment we must first define and examine the state's current business systems and infrastructure environment that can be leveraged by the HIX. Defining the parameters of the current environment is a challenge in the case of the HIX, as an Exchange is not currently in place in West Virginia; however, components of the future Exchange business and technology environments do exist.

West Virginia's Current HIX Business Environment consists of the sub-set of processes and functions required in the future HIX business environment that exists today.

The **Future West Virginia HIX Business Environment** at this point in time based on the federal laws, regulations, and guidance available, is comprised of the six core business areas and their key business functions outlined in the Center for Medicare and Medicaid Services (CMS) Exchange Reference Architecture (ERA) Foundation Guidance v0.99 March 16, 2011, plus the Exchange requirements and functions set forth in the Affordable Care Act (ACA) and the following Notices of Proposed Rule Making (NPRMs):

- 45 CFR Parts 155 and 156, Establishment of Exchanges and Qualified Health Plans;
- 45 CFR Part 153, Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment;
- 45 CFR 155 and 157, Exchange Functions in the Individual Market: Eligibility Determinations and Exchange Standards for Employers;
- 26 CFR Part 1, Health Insurance Premium Tax Credit; and
- 42 CFR Parts 431, 433, 435, and 457, Medicaid Program: Eligibility Changes Under the Affordable Care Act of 2010.



West Virginia's Current HIX Technology Environment is comprised of the existing technology assets that support the Current West Virginia HIX Business Environment.

The **Future West Virginia HIX Technology Environment** consists of the required technology functions and technical standards for HIX software, hardware, and infrastructure as adopted by the federal government and the technology solution the state chooses to meet the required business functions and technical standards.

It is important to point out that an Exchange is not a single system. A HIX has an organizational component – the people and processes that use and manage its business and systems; a mandatory public-facing Web component; and interfacing, administrative and back-end IT systems and business processes that enable a variety of transactions. In short, an Exchange consists of a set of business functions and the administration and technology to enable effective and efficient operations and meet federal requirements.

It is also important to note that the scope of Section 2.0 of this report is a Current Technology Environment Assessment. This section looks at current business processes, however, complete documentation and assessment of current business processes is outside of the scope of this deliverable.

2.3 Current HIX IT Environment

2.3.1 Current Federal HIX Planning Environment

The federal government plays several roles in shaping and supporting the development of a state's HIX. The ACA provides the legal framework for the development of the system. HHS plays a key role in interpreting and operationalizing the provisions of the ACA, by promulgating regulations, as well as providing additional guidance on both policy and technical implementation issues. Some proposed rule-making has occurred, however, much of the detail surrounding HIX implementation has yet to be articulated by the federal government. Funding is another important role, ranging from providing enhanced match for the development of Medicaid eligibility systems that must interact with the Exchange, to grants for the planning and development of the HIX itself. In addition, the HHS will be developing systems with which state systems must interact, for example, a data hub that will provide the basis of automated interfaces with the IRS, Homeland Security and the Social Security Administration which will provide income, citizenship/residency, and tax information.

2.3.1.1 Laws and Regulations

The Patient Protection and Affordable Care Act, together with the modifications included in the Health Care and Education Reconciliation Act of 2010 are collectively known as the ACA. One of the key reforms included in the ACA is the requirement that an Affordable Insurance Exchange be established for each state, and operated by the state itself, a consortium of states, or by the federal government.

An Exchange is an organized marketplace to help consumers and small businesses buy health insurance in a way that permits easy comparison of available plan options based on price, benefits, and quality. By pooling people together, reducing transaction costs, and increasing price and quality transparency, Exchanges create more efficient and competitive health insurance markets for individuals and small employers. Key values underlying the Exchanges are:

- Creating a more consumer-driven system;



- Providing transparency of health insurance information;
- Simplifying the process for consumers and administrators;
- Reducing redundancy for consumers and administrators;
- Coordinating public and private insurance offerings;
- Reducing costs;
- Sharing risk; and
- Ensuring privacy and security for enrollees.

The ACA also outlines specific tasks, characteristics, and functions of the Exchange necessary to implement these broad principles. New systems infrastructure will need to be developed and implemented to support these requirements, both for systems developed specifically for the Exchange and for interfaces with other systems. Significant areas include:

- Streamlining eligibility determination and enrollment for public health insurance subsidies (reduced cost sharing and tax credits) and programs, including Medicaid and Children's Health Insurance Program (CHIP). This includes providing a single point of entry for consumers by using a single application form that can be submitted online, through a call center, or in person to determine eligibility and for plan enrollment;
- Streamlining health insurance administration for consumers, employers, and carriers;
- Providing consumers with standardized, simplified plan descriptions and comparative data;
- Meeting specified privacy and security standards;
- Interfacing with related systems to obtain and provide information, including federal systems; and
- Certifying and de-certifying qualified health plans and assigning plan quality ratings.

HHS is in the process of making rules to implement provisions of the ACA. Many of the rules pertinent to the ACA provisions that address the Exchange are in the "proposed" status. One relevant rule that is final is "Federal Funding for Medicaid Eligibility Determination and Enrollment Activities," which was published in the Federal Register on April 19, 2011. This rule allows for enhanced federal financial participation (FFP) until December 31, 2015, for the design, development, and installation or enhancement of eligibility determination systems that meet certain new CMS standards. Cost allocation rules for Medicaid apply to integrated eligibility systems. This final rule includes the seven MITA standards and conditions discussed in Section 2.3.1.2 below.

On July 15, 2011, HHS promulgated proposed regulations which provide additional detail regarding the implementation of the Exchanges and the IT implications of those decisions. The Notice of Proposed Rule Making (NPRM) 45 CFR Parts 155 and 156 Establishment of Exchanges and Qualified Health Plans (QHPs) begins to operationalize parts of the ACA. Part 155 outlines the proposed approval process for state Exchanges and minimum functions of the Exchange and SHOP. Part 156 outlines the proposed standards for health insurance issuers with respect to participation in an Exchange including the minimum certification requirements for QHPs. Many of these issuer standards complement those for the Exchanges themselves. In Subpart B, the NPRM proposes that a state Exchange must be approved by HHS no later than January 1, 2013, in order to begin offering QHPs on January 1, 2014; outlines the state Exchange approval standards; and describes the option for states to operate an Exchange after 2014. It also describes the allowable sources of funding for state Exchanges beginning January 1, 2015, when federal funding will end.



West Virginia Senate Bill 408 signed into law April 4, 2011, has section 33-16G-6 regarding the Funding Structure, parts (a) and (b). Part (a) states that on or after July 1, 2011, the board is authorized to assess fees on health carriers selling qualified dental or health plans in West Virginia. Part (b) states that the Exchange shall publish costs associated with the Exchange on an Internet website to educate consumers.

2.3.1.2 IT Guidance and Standards

In addition to promulgating regulations, CMS has published a series of IT guidance documents for states, which inform the development of an Exchange. These documents provide technical guidance, and also emphasize the use of best practices in developing systems consistent with the principles underlying the formation of the Exchanges. CMS has advised states that guidance will be evolving and that states will need to adapt to these changes and be open to integrating newly available tools/system components. Several volumes of more detailed system architecture guidance have been made available to states in draft form. CMS has also stated its intent to try to ensure that guidance originating from different federal agencies aligns.

Following are summaries of key HIX-related IT guidance that has been released to date.

Guidance for Exchange and Medicaid IT Systems, v2.0

This guidance is meant to help states as they design, develop, and implement Exchange-related technology, and focuses on components of systems that are being addressed by early innovator grants and the final rule relating to federal funding for Medicaid eligibility systems. CMS sets forth business architecture, cost allocation, and technical architecture guidance for Exchanges in this document.

Business Architecture

The Business Architecture guidance emphasizes:

- High quality customer experience regardless of point of entry or program accessing;
- Seamless coordination between Exchanges, Medicaid, and CHIP and between the Exchange and business partners;
- Easy for individuals to explore health coverage options and quickly and accurately enroll into coverage; and
- Evaluation for individual eligibility in the Exchange, tax credits, Medicaid, and CHIP will be determined using a coordinated set of rules. As a result, BerryDunn expects the use of a common or shared eligibility system or service to adjudicate placement for most individuals.

Cost Allocation

In this document, CMS lays out important information about cost allocation among programs, specifically related to the use of 90/10 federal match for eligibility systems. States should allocate Exchange IT development and operations costs in accordance with OMB Circular A-87, between the federal Exchange-related grants and other Exchange users, such as Medicaid and CHIP. Exchange grants cannot be used as state match.

At a minimum, states must allocate the costs for the following services or functions among Exchange, Medicaid, and CHIP:

- Services or functions to adjudicate eligibility for premium tax credits and reduced cost sharing, Medicaid, or CHIP based on Modified Adjusted Gross Income (MAGI);



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- Health Care Coverage Portal (input and interface from other systems with single application);
 - Business Rules Management and Operations System (primarily eligibility determination related);
 - Interfaces to federal data services hub;
 - Interfaces to other verification sources;
 - Account creation and case notes (the electronic case file);
 - Notices (communications to applicants);
 - Customer service technology support; and
 - Interfaces to community assisters or other outreach organizations.

The services that may or may not be cost allocated include:

- The above functions for individuals whose eligibility is based on factors other than MAGI (e.g., disability);
- Member education, selection, and enrollment into plans;
- Member communications after the determination notice;
- Communicating and contracting with plans; and,
- Risk adjustment.

Additional guidance regarding cost allocation was provided in a letter to states from HHS and the U.S. Department of Agriculture on August 10, 2011. The guidance explains a time-limited, specific exception to the cost allocation requirements set forth in OMB Circular A-87 to allow federally-funded human services programs, such as Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF), to benefit from investments made in state eligibility systems to comply with the ACA. This exception allows states to reuse certain system enhancements for other programs and purposes without having to allocate those development costs to the other programs. This new guidance gives states like West Virginia with integrated eligibility systems more flexibility to enhance their eligibility systems as they will not have to require the other programs to fund their portion of the development costs.

Technical Architecture

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

- System Integration
 - High-level integration of process and information flow with business partners
 - Modular approach to system development, including the use of open interfaces, and exposed Application Programming Interfaces (APIs)
 - Seamless coordination between the Exchange, Medicaid, and CHIP and interoperability with Health Information Exchanges (HIEs) and public sector and community partners
- Service-Oriented Architecture
 - Web Services Architecture/Service-Oriented Architecture methodologies for system design and development
 - Common authoritative data sources and data exchange services
 - Open architecture standards
- Isolation of Business Rules
 - Standards-based business rules and technology-neutral business rule repository



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- Business rules expressed outside of transactional systems
 - Business rules accessible and adaptable by other states
 - Business rules submitted to federal repository
 - Security and Privacy
 - Apply appropriate controls to provide security and protect enrollee and patient privacy
 - Efficient and Scalable Infrastructure
 - Shared pool of configurable, secure computing resources (e.g., cloud computing)
 - Transparency, Accountability and Evaluation
 - Transaction data and reports for performance management, public transparency, policy analysis, and program evaluation
 - COTS business intelligence to support development of new reports and respond to queries
 - System Performance
 - Quality, integrity, accuracy and usefulness of functionality and information
 - Timely information transaction processing
 - Highly available systems that respond in a timely manner to customer requests

Exchange Reference Architecture (ERA): Foundation Guidance

This CMS document provides the business architecture, information architecture, and technical architecture for the Exchange and will be supplemented in the future with guidance containing the details of each component. This guidance is based on the CMS Medicaid Information Technology Architecture (MITA) Framework, and focuses on the key technology choices needed to create interoperable and coordinated Exchange services between the federal government and states, and continues to try to support best practice. The ERA has three components:

- **Business Architecture:** The Exchange is seen as having six key business areas: Eligibility and Enrollment, Plan Management, Financial Management, Customer Service, Communications, and Oversight. Each business area is broken into business processes used to determine the Exchange's high-level functional requirements.
- **Information Architecture:** The Information Architecture defines the mechanisms for exchanging information between Exchange stakeholders, and for such other functions as information/data management, analysis, reporting, etc. The primary focus of the information exchange mechanisms is the interface between the Exchanges and the Data Services Hub.
- **Technical Reference Architecture:** The Technical Reference Architecture ensures security, interoperability, portability, and operational requirements of the business services. It reinforces the shift to a "cloud first" policy for federal IT developments.

Office of the National Coordinator (ONC) Section 1561 Recommendations

Section 1561 of the ACA required HHS, in consultation with the Health Information Technology (HIT) Policy Committee and the HIT Standards Committee, to develop interoperable and secure standards and protocols that facilitate electronic enrollment of individuals in federal and state health and human services programs.



The recommendations include initial standards and protocols that should apply to the Exchange, and support the principles underlying the development of Exchanges:

- Transparent, understandable, and easy to use online process that enables consumers to make informed decisions about applying for and managing benefits;
- Accommodates various user capabilities, languages, and access considerations;
- Offers seamless integration between private and public insurance options;
- Connects consumers not only with health coverage, but also other human services; and
- Provides strong privacy and security protections.

The ONC recommendations contain ways to operationalize these goals, including use of current standards such as those related to the National Information Exchange Model (NIEM) and Health Insurance Portability and Accountability Act (HIPAA), isolation of business rules, encouraging maximum use of coordinated and consistent processes and data sources for Exchange-related verification and other uses, consumer access to data, and recommendations regarding privacy and security.

MITA Seven Standards and Conditions

As previously noted, CMS intends to maintain alignment between the architecture standards for the Exchange and other related systems. This is particularly critical for Medicaid eligibility, which will need to be integrated into one seamless system providing consumers with a single eligibility portal for public programs and subsidies.

This document builds on the work CMS, states, and private industry have done over the last six years under the MITA initiative. It follows up on the April 19, 2011, final rule containing new standards that must be met for Medicaid technology investments (including traditional claims processing systems, as well as eligibility systems) to be eligible for enhanced federal match funding. These standards are intended to foster better collaboration with states, reduce unnecessary paperwork, focus attention on the key elements of success for modern systems development, and help states ensure they are making efficient investments and ultimately will have successful system implementation.

The document provides more detail about the seven conditions and standards and the items the federal government will examine over the course of a systems development lifecycle to allow for enhanced funding. These standards are:

1. Modularity and flexibility;
2. States must increasingly conform to MITA standards;
3. States must conform to Industry Standards such as HIPAA;
4. States should share/leverage modules/development among and within states;
5. States must have appropriate Business Results;
6. States must have accurate data for Reporting and analysis; and
7. Interoperability.

Collaborative Application Lifecycle Tool and Gate Review Process

HHS has instituted the use of the Collaborative Application Lifecycle Tool (CALT) among states for HIX application lifecycle management, including the Gate Review process, as well as collaboration among states. CALT is a web-based platform that supports the entire software life cycle, from requirements and release management, to code review and defect tracking, to build



management, test and file releases. CALT is built on CollabNet's TeamForge application lifecycle management (ALM) platform and provides the capabilities to facilitate communication, collaboration, development, management, and governance within a project and across projects. The CALT environment is centralized; its features and functions are accessible to all users, regardless of geographic location, via the Internet.

HHS has proposed the establishment of the Gate Review Process to create a unified review process; promote sharing and interoperability between the Exchange and Medicaid systems as well as between the state and federal services hub, and between the states; and assist states in meeting the aggressive timeline and strict system requirements. The Gate Review process looks at the entire program and objectives of the HIX. It adapts the standard software development lifecycle to fit the Exchange lifecycle (ELC).

The proposed Gate Review process consists of four formal Stage Gate reviews: Architecture Review, Project Baseline Review, Final Detail Design Review, and Operational Readiness Review. It also consists of four Stage Gate reviews delegated to states: Project Start-up, Preliminary Design Review, Detailed Design Review, and Pre-Operational Readiness Review. Templates for each gate review will be available on CALT, and the dates for reviews will be arranged through the states' CMS project officer.

2.3.1.3 Federal HIX IT Initiatives

The federal government is taking the lead in several areas to develop Exchange-related IT infrastructure and model Exchange components and services for states. Four initiatives led by the federal government are described below.

Data Services Hub

To ensure reliable, efficient, and standardized information is available to Exchanges, Medicaid, and CHIP, HHS will establish a data services hub. HHS plans to work with states on the design of and specifications for this data services hub. They plan for the data services hub to verify citizenship, immigration, and tax information with the Social Security Administration, Department of Homeland Security, and Internal Revenue Service. They are also looking into whether the hub can help identify a consumer's other available coverage, such as through an employer or the Department of Veterans Affairs, if information is available. CMS has been working with the HIT policy committee and plans continued consultation with that group, states, and other stakeholders and will continue to explore potential additional functions that the data services hub might serve including information needed to pay advance premium tax credits and cost-sharing subsidies.

User Experience Project (UX2014)

Enrollment User Experience (UX) 2014 project is a public-private partnership working to deliver design specifications to support a best-in-class user experience to help ensure that large numbers of eligible consumers successfully enroll in and retain insurance coverage. The project goal is to provide a vision, core design, and interactive design elements for the federal government and states to adopt and execute a "first class" user experience for enrollment under ACA, in order to increase the number of eligible consumers who could more easily and efficiently enroll. Eight national and state foundations have formed a public-private partnership with CMS to sponsor this project. The intended clients are state-based Exchanges and CMS. Outcomes of the project include user screen templates for the single, streamlined Exchange application the federal government is developing. The project team is considering expanding the project to include screen templates for the SHOP Exchange.



Federal Exchange

The Notice of Proposed Rule Making (NPRM) 45 CFR Part 155, Subpart B, 155.105 (f) addresses HHS operation of an Exchange. HHS must (directly or through agreement with a not-for-profit entity) establish and operate an Exchange within a state if a state does not have an approved or conditionally-approved Exchange by January 1, 2013. States may also opt for the federal government to operate its Exchange as a Federally-Facilitated Exchange (FFE).

State-Federal Partnership Model

In the Exchange rule published on July 15, 2011 and in a letter from Secretary Kathleen Sebelius to governors, HHS announced the State Partnership model. The model is intended to give states another option to tailor their Exchange, as well as to provide states a way to transition to fully operating their own Exchanges.

On September 19, 2011, HHS provided more information to states on Exchange Partnership Opportunities. The Partnership model describes Exchanges where both HHS and a state work together to operate different functions of the Exchange; however, a partnership may legally be considered a federal exchange. The State Partnership model is intended to be a temporary solution for states to meet federal deadlines, with the long-term goal for states to transition to a state-based Exchange in future years. The goal of the Partnership is to take advantage of the state's expertise and knowledge of their insurance markets to support a seamless consumer experience. States may use Exchange grant funding to support the functions they choose to operate under the Partnership that are related to establishing the Exchange.

Under the proposed Partnership model, the federal government would be responsible for performing the core Exchange eligibility, enrollment, and financial management functions, with states electing to operate the plan management and/or selected consumer assistance functions. If electing to operate the plan management function, states will help tailor health plan choices for their state's Exchange, including the collection and analysis of plan information, plan monitoring and oversight, and data collection and analysis. HHS will coordinate with the state regarding plan oversight, including consumer complaints and issues with enrollment reconciliation. Where appropriate, HHS will help to ensure that Exchanges meet all of the required standards. If electing the consumer assistance functions, a state would oversee in-person consumer assistance, manage the Navigator program, and conduct outreach and education. Other consumer assistance functions which can be more centralized— including call center operations, managing the consumer website, and written correspondence with consumers to support eligibility and enrollment – would be operated by HHS.

On November 29, 2011, CMS provided additional State Exchange Implementation guidance to states in the form of a Questions and Answers (Q&A) document. This Q & A document provides some advance insight to states regarding expected changes to the proposed Exchange rules including further clarification of roles, responsibilities and options in a state-federal Exchange partnership and a Federally-facilitated Exchange environment. Key points related to IT include:

- HHS is striving to preserve the traditional responsibilities of State insurance departments in the Federally-operated Exchange environment and will work through issues related to Plan Management business functions with states.
- HHS is planning to revise the options available to states for the responsibility for eligibility determination under a Federally-facilitated Exchange to include allowing states to retain the final eligibility determination decision for Medicaid and CHIP, and provide options for State-based Exchanges to leverage Federally-managed services for eligibility



determination for advance payments of the premium tax credit, cost-sharing reductions, and exemptions from the individual responsibility requirement.

- HHS is also exploring ways the Federal government could manage services for verification of employer-sponsored minimum essential coverage.

2.3.2 Current Public and Private Sector HIX IT Environments

The following sub-sections highlight some key public and private Exchange initiatives.

2.3.2.1 Current Public Sector HIX IT Initiatives

Two states, Massachusetts and Utah, have operating pre-ACA Exchanges. The Massachusetts Connector serves both the individual and small group markets; Utah Exchange operates in the small group market only. The current HIX IT environments of the Early Innovator grantee states (Oregon, Wisconsin, New York, Maryland, and New England Consortium [Massachusetts, Vermont, Maine, Connecticut and Rhode Island]) are documented in Section 5.3, Early Innovator State Profiles.

As the pioneer state in the area of health care reform, Massachusetts' plan served as a general model for the program enacted by the Affordable Care Act. The Commonwealth Connector, a quasi-public agency governed by a board, manages two programs, with its small group and individual markets merged:

- "Commonwealth Care," offering subsidized products to low income adults through the state's Medicaid managed care entities; and,
- "Commonwealth Choice," to provide access to standardized, unsubsidized plans at various levels of coverage for individuals without access to employer-based coverage, including Business Express for businesses with up to 50 employees.

Massachusetts' insurance regulations provides a enabling environment for a robust Exchange, including individual mandate, guaranteed issue, mandated employer contributions, minimum benefit levels, and community rating. The Connector was initially financed through a \$25 million state appropriation but is now supported by surcharges on premiums.

Utah's Exchange is generally viewed as being much less interventionist than Massachusetts'. The Utah Health Exchange currently has over 100 small employer groups participating, insuring more than 3,000 covered lives. The Exchange is designed to connect consumers to the information they need to make informed health care choices, and in the case of health insurance, to execute that choice electronically. It is envisioned as a clearinghouse for the state's insurance markets which provides:

- Information about health care and health care financing;
- Ways for consumers to compare and choose an appropriate policy; and
- A standard electronic application and enrollment mechanism.

In addition to these communication-focused functions, its mission includes development of a defined contribution plan for employers. There is a board that manages the risk sharing for the defined contribution plan. The defined contribution program has had relatively low participation to date. There are no subsidies available and the Exchange does not set minimum plan standards or negotiate prices. Utah has focused on the small group market only. A broad array



of plans is offered within the Exchange, which some employers find difficult to navigate. The Exchange is run out of the Governor's Office of Economic Development, with two staff and a budget supported by small fees on employees. The Exchange also has an advisory board.

2.3.2.2 Current Private Sector HIX IT Initiatives

Sources estimate somewhere between twelve and a hundred "private exchanges" exist in the marketplace today, depending on the definition of private exchange. Some define a private exchange as a "defined contribution exchange," which simply stated, is an alternative to a group health benefit plan; rather than paying a portion or all of a premium, an employer sets a health insurance allowance for each worker and sends each to choose his or her plan, either openly or from a pre-determined set of plans through a third-party. Other private health exchanges look more like a web-based shopping experience within a clearinghouse of health insurance plans, allowing any individual to compare options and choose his or her own insurance. Exchanges use a variety of models; while most offer group plans, some send purchasers to the individual market. Most offer plans from different companies, but some offer a range of plans from a single issuer. Exchanges are financed by charging participating employers a monthly fee and/or receiving commissions from member insurers.

California has a well-established private exchange. Started in 1996, *CaliforniaChoice*[®], a defined contribution exchange, claims to be the nation's oldest health exchange for the small and mid-size employer market, involving Anthem Blue Cross, Health Net, Kaiser Permanente, Sharp Health Plan, Western Health Advantage, as well as dental, vision, chiropractic, and related ancillary benefit plans. *CaliforniaChoice*[®] works through brokers to serve both small and large employers, enabling employees in small groups to select from several health plans and benefit levels within one program.

Extend Health calls itself an Insurance Exchange, offering shop and compare services to individuals and employers seeking Medicare coverage and general health insurance since 2004. On its website, www.extendhealth.com, Extend Health claims it is the "industry's largest private Medicare Exchange and has helped more than 300,000 retirees find and choose the private Medicare plan that best meets their medical needs and budgets." Extend Health has extensive and proprietary defined contribution health care programs which serve all major markets, including large company group plans, large company working uninsured, retiree plans, and individual access plans.

HealthPass, a defined contribution program, is a taxable not-for-profit commercial exchange that was formed in 1999 with a little over \$1 million in seed money from the City of New York. More than 35,000 are enrolled through employers or as individuals. The exchange is marketed and sold exclusively through brokers. Brokers' commissions are about 6 percent of the premiums, which is the same commission they would receive for selling an employer any single plan. The exchange also provides employers an opportunity to offer other benefits such as dental, life, and accidental death and disability – products most small employers wouldn't consider. HealthPass collects 3.5 percent of premium dollars, and handles all the administrative issues normally involved in working with a plan – eligibility, enrollment, education, member advocacy, and billing – and presents employers with a single bill.

New York has mandatory community rating for the small-employer market which avoids adverse selection and helps the Exchange work. In New York, community-rating laws mean that health plans must offer the same rates to all employers with fewer than 50 employees. New York is



currently the only state in the country that has a pure community-rating requirement (meaning rates can't vary based on any factor).

The HealthPass website claims that nearly half of their employer members did not offer their employees healthcare coverage prior to joining HealthPass. Employers select the premium tier structure, set a defined dollar contribution, and designate which ancillary offerings – such as dental and a bundled security product for instance – will be made available to employees. Employees then choose their medical carrier, health benefit plan, and from the ancillary products made available by their employer.

Private exchanges such as eHealthInsurance.com and GoHealthInsurance.com, fit the clearinghouse model, and are licensed in all 50 states and are active in at least 20. Founded in 1997, Ehealthinsurance.com offers 13,162 health plans through 180 carriers and claims to be “responsible for the nation’s first Internet-based sale of a health insurance policy.” These two tools allow the user to complete all transactions on-line, whereas the private exchanges described above, which grew out of the group insurance brokerage industry, are driven less by technology. For example, ehealthinsurance.com allows an individual to complete an on-line application and receive an electronic approval “in 11 minutes!” according to its website, whereas Extend Health does not allow for on-line enrollment.

2.3.3 Current West Virginia HIX Governance and Program Structure

The following sub-sections describe the governance for the West Virginia Exchange, as well as the proposed program structure.

2.3.3.1 West Virginia Organizational Mission, Vision, and Goals

Future Exchange initiatives should be consistent with, or at a minimum, should not conflict with, existing mission and vision statements and goals of oversight entities: the State Office of Technology, the Offices of the Insurance Commissioner, and the HIX Board. The current missions, visions, and goals of these entities are presented below.

Table 3: Office of Technology, OIC and Exchange Mission, Vision and Goals

	State Office of Technology
Mission	The Office of Technology (OT) will provide cost effective leadership, guidance and support to the Governor, the cabinet, and all other executive branch agencies in achieving their specific goals and objectives through the creative and innovative use of technology.
Vision	Be recognized as a leader in the transformation of West Virginia State government through the modernization and innovative use of technology, enabling customers and citizens, through technology, to effectively conduct business with the state at any time, from anywhere and through any computing device in a secure and efficient manner.
Guiding Principles	The core of OT’s strategic planning process, operational philosophy, and management decisions center on the following foundational beliefs: <ol style="list-style-type: none"> 1. We value our customers and will always treat them with professionalism and respect. 2. We will be a catalyst for change and continually look for opportunities to consolidate, centralize, and standardize technology when the outcome will provide better security, more reliability, or lower costs. 3. We will meet our customer commitments as defined in our service level agreements and will measure our progress in order to achieve higher service levels in the future. 4. We will always pursue the highest quality solution at the lowest possible cost without



State Office of Technology	
	<p>regard to personal bias or self-preservation.</p> <ol style="list-style-type: none"> 5. We will not walk away from an issue when customers are without service until the issue is resolved or a mutually acceptable solution is achieved. 6. We are a trusted custodian of highly confidential and sensitive information and will protect the citizen and business information entrusted to us. 7. We will focus on solutions that meet the needs of the state, not necessarily those that satisfy the wants or desires of a specific agency. 8. We will enable the state to continue servicing the critical needs of citizens in times of disaster through the proper planning and deployment of technology.
Source	West Virginia Office of Technology, Statewide Strategic Plan: 2010 – 2013
Offices of the Insurance Commissioner	
Mission	The West Virginia OIC regulates the state's insurance industry, focusing on consumers' needs for available and affordable insurance products offered by financially viable companies directly or through knowledgeable producers.
Vision	None stated.
Goals	None stated.
Source	www.wvinsurance.gov
West Virginia Health Insurance Exchange	
Mission (DRAFT)	<i>The West Virginia Health Benefit Exchange will maximize the number of insured West Virginians, provide consumers with reliable health insurance information, and promote a competitive marketplace that allows individuals, families, and businesses to choose the health plan that provides them the best value.</i>
Vision (DRAFT)	<i>The West Virginia Health Benefit Exchange will be a trusted and easy-to-use guide for the health insurance marketplace that allows West Virginians to understand, compare, and enroll in available health insurance plans based on benefits, quality, and cost.</i>
Guiding Principles	<ol style="list-style-type: none"> 1. Protect viability of health insurance market. 2. Increase access to health insurance coverage options. 3. Increase portability and choice for health insurance. 4. Increase transparency in the purchase of health insurance. 5. Facilitate payment for coverage from assorted sources. 6. Standardize and simplify health insurance purchase. 7. Standardize method by which health insurance eligibility is determined. 8. Standardize method by which health insurance enrollment takes place. 9. Increase continuity of care through consumer payer source transitions. 10. Encourage value-based competition and plan innovation. 11. Achieve sustainable financial model for health insurance Exchange operations.
Source	WV OIC Office of Health Policy

2.3.3.2 West Virginia HIX Governance

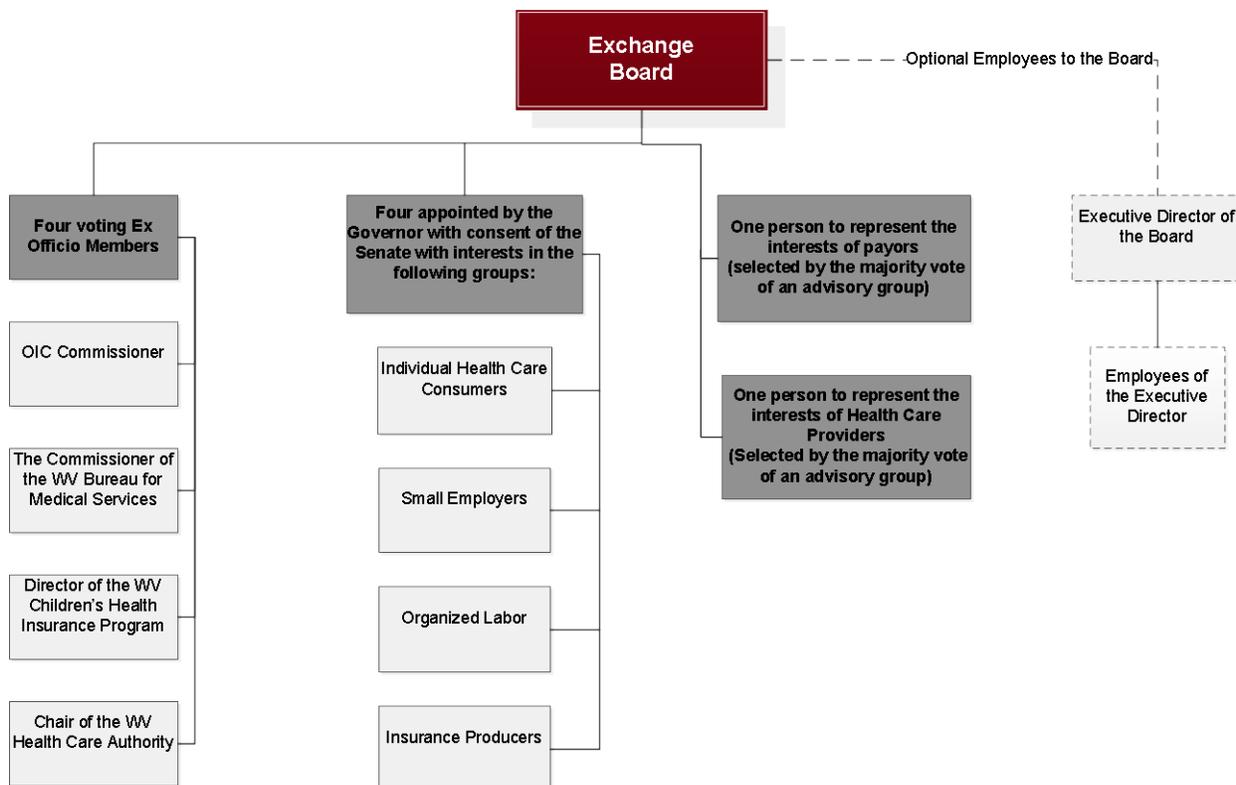
In March 2011, the West Virginia Legislature passed Senate Bill 408, which was introduced as a modified version of the National Association of Insurance Commissioners (NAIC) Exchange model legislation, creating a new article in the WV Code, 33-16G, to establish a Health Benefit Exchange. This bill authorized the establishment of the Exchange within the OIC as a government agency. It also established the need for an Exchange Board, which will have legislative and emergency rule-making authority. The Exchange is exempted from the rules of



State Purchasing and State Personnel and is expressly permitted to enter into contracts with state or federal agencies as well as other state exchanges. The legislation also created the West Virginia Health Benefit Exchange Fund in the State Treasury, which is created for the purpose of paying for the operations of the Exchange.

The Exchange Board created by the bill will be comprised of 10 seats as follows: the heads of four state agencies (OIC, Health Care Authority (HCA), Medicaid and CHIP); four appointed by the Governor who are to represent individual consumers, small employers, labor and producers; and two selected by advisory committees of the group, one by the Provider Advisory Committee and one by the Payer Advisory Committee. The Governor appoints the Chairperson.

Figure 2: West Virginia HIX Governance



Data Source: WV Senate Bill No. 408

According to Senate Bill No. 408, the governing rules of the Exchange Board include the following:

- Governor-appointed members will serve staggered terms and after the first series of terms will serve four-year terms. Board member appointments are to be made with advice and consent of the State Senate.
- Members of the Board are not entitled to compensation for services performed as members but are entitled to reasonable reimbursement for costs incurred while performing Board duties.
- Seven members of the Board constitute a quorum, and the affirmative vote of six members is necessary for any action taken by vote of the Board.



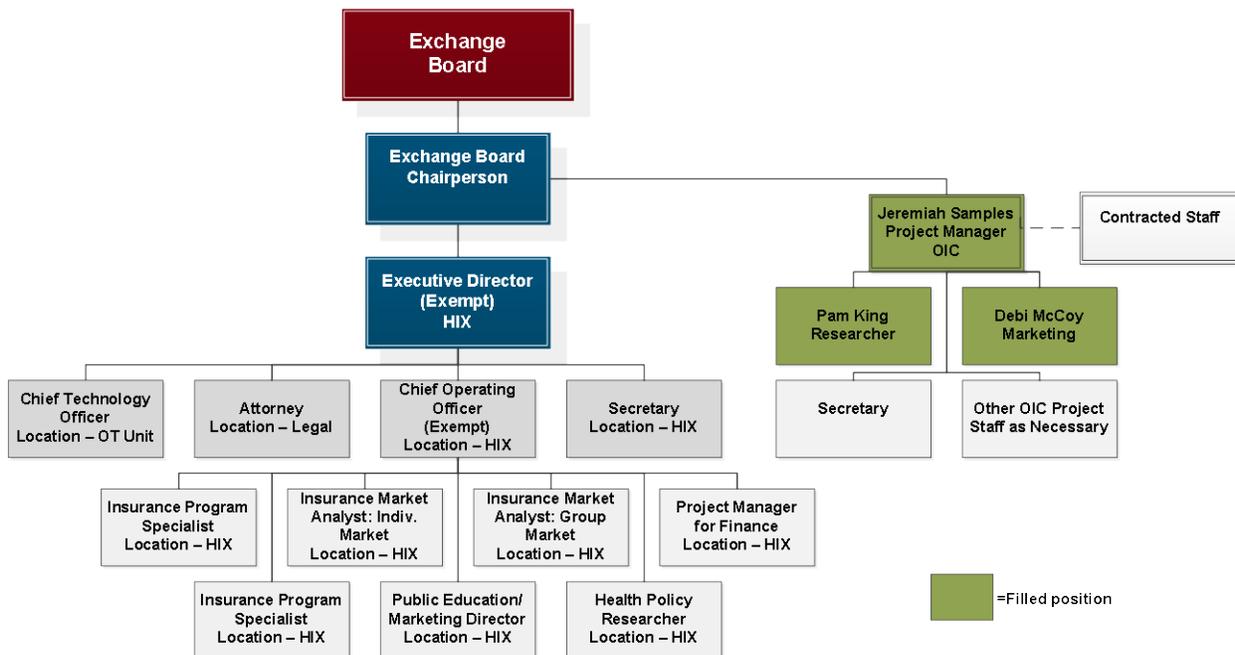
- Board members must undergo ethics training within six months of appointment and every two years thereafter.

As of the writing of this report, the Board has not yet been appointed.

2.3.3.3 West Virginia HIX Program Structure

The Exchange has been established as an entity within the OIC, thus the OIC has administrative and financial responsibility for it. The proposed program structure for the Exchange when the Board is in place is below.

Figure 3: West Virginia HIX Program Structure



Data Source: West Virginia Level 1 Establishment Grant

2.3.4 State Procurement Environment

State procurement rules and business processes are an important aspect of the current and future environments for HIX technology. They directly influence the timeline for acquiring the resources necessary to develop and implement technology projects necessary for the future HIX IT environment. The table below identifies the key features of the current procurement environment that impact the future environment for HIX IT.

Table 4: Key Features of the State Procurement Environment Related to HIX IT

Feature of Procurement Environment	Description
Senate Bill 408 Purchasing Exemption	Senate Bill 408 exempts the Exchange from certain provisions of state code related to the Department of Administration’s Purchasing Division as long as the contracts are awarded on a competitive basis.



Feature of Procurement Environment	Description
ITECH (Office of Technology, WVOT)	<p>Pre-Approved vendors compete for agency staffing needs based upon criteria developed by the agency and the WVOT. The agency completes a Statement of Work (SOW) explaining the basic training and skill sets required. The bid request is posted on the WVOT Bulletin Board for 5-10 business days. Supplemental Staffing requests are good for up to 1,000 hours during a twelve-month period. Project-based requests are good for up to twenty-four months and a maximum of \$2,000,000. A project is defined as having a pre-determined set of deliverables and expectations along with a set time period. Currently, there are nearly fifty IT vendors on ITECH.</p> <p>The SOW is submitted to the pre-qualified vendors in the appropriate category. Vendor responses are evaluated based on the factors provided in the SOW. The agency evaluates the bids using the vendor's proposal as well as interviews, either via telephone or in person.</p>
Existing Contracts	<p>Existing contracts for vendors currently providing services or solutions that could be leveraged for the Exchange may be able to be accessed through the contract change order or amendment process.</p>

2.3.5 Current West Virginia Insurance Market Environment

This section describes the key characteristics of the state's uninsured population, private insurance market, and subsidized insurance programs.

2.3.5.1 Uninsured Population

The Exchange will be a source of information available to all West Virginians. According to U.S. census data provided by the Kaiser Family Foundation, West Virginia has a population of approximately 1.8 million; just over one million are adults aged 19 to 64.

The uninsured are a primary target group of Exchange consumers. Kaiser estimates about 258,000 people are uninsured in West Virginia. This figure is probably a low estimate of potential Exchange consumers as it does not include individuals who are "underinsured," that is, individuals with very basic coverage such as catastrophic only. About 15% of the state's total population is uninsured; about 5% of children in West Virginia are uninsured.

The ACA also requires states that choose to operate an Exchange to establish a SHOP to enable small employers to offer affordable health plans to their employees and to qualify certain small employers to receive a small business tax credit for a portion of the employer's premium contributions toward employee coverage. Kaiser estimates that about 47% of insured individuals in West Virginia receive their insurance through their employer, which is slightly lower than the national rate of 49%.

Early assessments from the federal government estimated that over 22,000 small businesses in West Virginia could benefit from the tax credit. Health Care for America Now reports data from the Robert Wood Johnson Foundation indicating that about 140,000 non-elderly adults in West



Virginia hold jobs that don't offer health insurance benefits, comprising just over 60% of all non-elderly uninsured people. Recent data shows that about 32% of West Virginia businesses with fewer than 50 employees currently offer health insurance to employees, compared to 39% of businesses of the same size nationally, and 96% of large employers in the state. Nearly 70% of the state's private sector establishments have fewer than 50 employees.

2.3.5.2 Private Health Insurance Market

Commercial Individual and Group

Health insurance sales in West Virginia are concentrated to a few major private carriers, which may have implications for how the state chooses to operate the Exchange (i.e., will West Virginia adopt an "active purchaser" or an open marketplace model). According to the most recent Accident and Health Insurance Market Report completed in 2008 by the OIC, the state's top five companies for large group sales accounted for nearly 90 percent of covered lives in 2007. The situation was similar for the small group market (the top five companies covered 86 percent of lives; the top two covered 69 percent) and the individual market (the top three companies covered 86 percent of lives). Highmark BlueCross BlueShield West Virginia was the dominant player in the marketplace, covering 45 percent of individuals receiving major medical insurance (commonly referred to as "health insurance") in the commercial group and individual markets. Although the carrier make-up covering the small and large group markets was similar, with the exception of Highmark, the individual market was comprised of a different group of carriers, likely due to the special underwriting and marketing strategies required for that market segment. Please see the following tables for the top 10 carriers in the small group and individual markets.

Table 5: Top 10 Carriers of Small Group Major Medical Coverage

Earned Premium (\$)	Company Name	Covered Lives
\$162,029,170	Highmark BlueCross BlueShield West Virginia	40,152
\$41,868,043	Coventry Health and Life Insurance Company	12,878
\$25,376,798	Carelink Health Plans, Inc.	5,490
\$13,814,190	UnitedHealthcare Insurance Company	5,083
\$9,277, 927	Principal Life Insurance Company	2,367
\$8,929,211	The Health Plan of the Upper Valley	2,227
\$5,551,645	Union Security Insurance Company	1,106
\$5,319,156	First Health Life and Health Insurance Company	1,033
\$5,096,802	Consumers Life Insurance Company	1,530
\$5,031,363	Medical Benefits Life Insurance Company	1,445
\$14,662,570	Others (17)	3,730
\$296,956,875	Totals (27)	77,041

Data Source: West Virginia Offices of the Insurance Commissioner, Accident and Health Insurance Market Report for 2008, November 2008.



Table 6: Top 10 Carriers of Individual Major Medical Coverage

Earned Premium (\$)	Company Name	Covered Lives
\$36,437,253	Highmark BlueCross BlueShield West Virginia	8,910
\$5,664,108	Time Insurance Company	2,887
\$2,779,807	John Alden Life Insurance Company	1,480
\$945,894	The Health Plan of the Upper Ohio Valley	264
\$658,975	Continental General Insurance Company	86
\$330,659	Aetna Life Insurance Company	125
\$247,126	American Republic Insurance Company	43
\$162,771	Metropolitan Life Insurance Company	148
\$117,562	American National Life Insurance Company	30
\$107,794	Prudential Insurance Company of America	397
\$449,889	Others (28)	1,025
\$47,901,838	Totals (38)	15,395

Data Source: West Virginia Offices of the Insurance Commissioner, Accident and Health Insurance Market Report for 2008, November 2008.

The report also indicates that the private market for health insurance is “relatively stable by the measures of carrier entry and exit, premium volume, and number of covered lives”. According to the report, major medical health insurance resulted in earned premium revenues of \$786 million in 2007 and covered approximately 215,166 lives in West Virginia. The OIC reports major medical insurance sold by commercial providers in the state to large groups (employers with over 50 eligible employees) represents 53% of the covered lives, to small groups (employers with 2 to 50 eligible employees) represents 39% of covered lives, and to individuals represents 8% of covered lives.

2.3.6 Subsidized and State Insurance Programs

Nearly 50% of individuals in West Virginia receive their health insurance through a subsidized or state-run Public Employees Insurance Agency (PEIA) insurance program. The major programs are described below.

Medicaid

The West Virginia Medicaid program is managed by the Bureau for Medical Services (BMS), a bureau within the DHHR. The total Medicaid expenditures for SFY2010 were approximately \$2.5 billion. The Medicaid program provides health care benefits to just over 411,000 people annually in 55 counties, using a network of approximately 24,000 active providers.

Approximately 165,000 Medicaid members (families with dependent children, low-income children, and pregnant woman) are enrolled in three managed care organizations (MCOs). Fifty percent are enrolled in Unicare Health Plan of WV, Inc.; 32% in Carelink Health Plans; and 18% in the Health Plan of the Upper Ohio Valley. The other Medicaid members are enrolled in the Primary Care Case Management (PCCM) program – the Physician Assured Access System (PAAS). Certain Medicaid eligible individuals are not eligible for the MCO or PAAS programs –



Home and Community Based Services (HCBS) waiver clients, long-term care clients, foster care children, and Medicaid dually-eligible individuals (i.e. those eligible for both Medicaid and Medicare). Their services are paid according to a fee-for-service schedule.

In addition, M-WIN is a Medicaid-funded work incentive program that allows working West Virginians with disabilities or chronic health conditions to pay a monthly premium to keep or obtain Medicaid health care coverage. M-WIN eliminates a major barrier to employment – losing current healthcare benefits when you return to work. This program offers Personal Care Employment Support, hands-on assistance with daily activities related to personal hygiene, dressing, eating, environmental support functions, as well as health-related tasks during job-seeking activities and employment.

The ACA extends Medicaid eligibility to all adults under 65 under 138% of the federal poverty level (FPL), based on new income calculation requirements (known as MAGI). West Virginia's new Medicaid population will likely largely consist of uninsured non-disabled adults as currently Medicaid eligibility for adults is limited in West Virginia, covering working parents up to about 33% of FPL. The state projects a one-time 40% increase in Medicaid members, and the Kaiser Family Foundation estimates a 30% increase. The state has not released projections in Medicaid enrollment as a result of health care reform to the public as of the writing of this report.

Children's Health Insurance Program (CHIP)

WVCHIP was created to help working families who do not have health insurance for their children. CHIP offers three benefit programs to children in West Virginia, CHIP Gold for children less than 150% of FPL, CHIP Blue for children between 150% and 200% of FPL, and CHIP Premium (requires a monthly premium be paid) for children between 200% and 300% of FPL. Approximately 200,000 children are currently enrolled in CHIP. West Virginia CHIP provides coverage to children 18 or younger who live in West Virginia, meet the income guidelines, do not have health insurance and have not had coverage in the prior six months (for the Basic CHIP Plans) or the past twelve months for the CHIP Premium Plan, and are not eligible to receive West Virginia State Employee Health Insurance – PEIA or West Virginia Medicaid.

AccessWV

AccessWV, the state's high risk insurance pool, guarantees that all West Virginians who qualify can purchase health insurance through the plan, regardless of their current and past health circumstances such as pre-existing, severe or chronic medical conditions. Coverage through AccessWV is also available to persons with portability rights through HIPAA and to persons eligible for the Health Coverage Tax Credit (HCTC). The program is authorized by the "Model Health Plan for Uninsurable Individuals Act", which is Article 48 of Chapter 33 of the State Code. The program was launched in July 2005 and operates through the Offices of the Insurance Commissioner. The program currently covers over 700 lives. On July 1, 2011, AccessWV began offering premium subsidies of 15% to 60% based on a sliding scale for households with incomes up to 400% of the Federal Poverty Level.

AccessWV contracts with the PEIA for Plan Administrator services. PEIA in turn subcontracts with Wells Fargo Third Party Administrators for eligibility, billing, customer service and medical claims administration. PEIA subcontracts with Express Scripts, Inc. for pharmacy benefit management.



West Virginia Small Business Plan

The West Virginia Small Business Plan was created as a result of Senate Bill 143, passed in March 2004, with the goal of making more affordable health insurance available to working adults through employer-sponsored plans. The Small Business Plan is a partnership between insurance companies, PEIA and health care providers. The Plan advertises expected premium cost reductions ranging between 17-22% compared with similar commercially available policies; these reductions are primarily achieved by leveraging lower PEIA provider reimbursement rates. To help keep rates low, carriers also receive reduced administrative fees for plan contracts. The program received a multi-year \$1.3 million grant through 2007 from the Robert Wood Johnson Foundation to support creation and promotion of the Small Business Plan, but the program is unique from similar ones offered by other states in that no West Virginia state budget funds are dedicated to underwriting the costs of the Small Business Plan (Source: www.wvsbp.org).

To participate, small businesses must: have 2-50 employees; have been without a company-sponsored health plan for the prior 12 consecutive calendar months; pay at least 50 percent of the individual premium costs; have 75 percent participation from eligible employees; and been in existence for at least the past 12 consecutive months. Participation by small business groups has been lower than expected; as of March 2010, 1,732 West Virginians from 360 businesses were covered through the plan. Participation averaged 34 months, and the majority of groups employed 2-9 people (Source: WV Health Care Authority: A Report on West Virginia's Demonstration Projects for Covering the Uninsured, February 2011.)

Although all insurance carriers licensed to sell major medical insurance in West Virginia can issue policies for the Small Business Plan, Highmark BlueCross BlueShield was the first and remains the only participating carrier.

Public Employees Insurance Agency (PEIA)

PEIA was established under the Public Employees Insurance Act of 1971, to provide hospital, surgical, group major medical, prescription drug, group life, and accidental death and dismemberment insurance coverage to eligible employees; and to establish and promulgate rules for the administration of these plans. PEIA insures the state's approximately 150,000 employees, 50,000 retirees, as well as 4,000 Medicaid/CHIP dual eligible individuals. Benefits are made available to all active employees of the State of West Virginia and various related state agencies and local governments.

2.4 Current West Virginia HIX Business Environment

West Virginia's current HIX business environment consists of the sub-set of features required in the future HIX business environment that exist today. Thus in order to define the Current West Virginia HIX Business Environment, the Future HIX Business Environment must be defined. The Future HIX Business Environment, as we know it at this point in time based on the federal laws, regulations, and guidance available, is described by the six core business areas and their key business functions outlined in the CMS ERA: Foundation Guidance v0.99 March 16, 2011, plus the Exchange requirements and functions set forth in the ACA and the NPRM 45 CFR Parts 155 and 156, Establishment of Exchanges and Qualified Health Plans.

The table below presents the six core business areas and key business processes, functions and requirements as defined by CMS in the ERA Guidance, ACA and NPRM, and then describes the current status of the related business processes and functions existing in West Virginia today.



Table 7: Functional Characteristics of the Future and Current HIX Business Environments

Business Area	Reference (All are Proposed Rules)	Future HIX Business Environment	West Virginia Current Statewide HIX Business Environment
Eligibility and Enrollment	45 CFR 155 Subpart H	Exchange Functions: SHOP	<p>The West Virginia Small Business Plan offers qualifying small business discounted rates. Plan eligibility and enrollment is accessed through brokers who offer the Plan. The Plan has a website that is out-of-date; it contains information only, it does not allow for any on-line transactions.</p> <p>To provide required SHOP Eligibility and Enrollment functions, West Virginia will need to develop new business processes.</p>
	45 CFR 155.200 (b)	Determine eligibility for exemption from the individual responsibility requirement	This HIX function will require new business processes for West Virginia.
	45 CFR 155.200 I	Eligibility determinations for advance premium tax credits, cost-sharing reductions, and other applicable state health subsidy programs such as Medicaid and CHIP using a coordinated set of rules	Extensive business processes are in place to support eligibility determination and enrollment in state benefit programs including Medicaid and CHIP, and state insurance programs such as PEIA and AccessWV, however, they are not currently compliant with modifications necessary by ACA. Eligibility determination for premium tax credits, cost-sharing subsidies, and QHP enrollment will require new business processes for West Virginia.
	45 CFR 155.200 (d)	Appeals of individual eligibility	Medicaid and CHIP have business processes in place to handle eligibility appeals. RAPIDS sends an appeal form with the eligibility determination letter. Appeal hearings are handled through the state's Fair Hearing process, which is part of the state's Office of the Inspector General (OIG).



Business Area	Reference (All are Proposed Rules)	Future HIX Business Environment	West Virginia Current Statewide HIX Business Environment
			Appeals processes for eligibility for premium tax credits, cost-sharing subsidies, and QHP enrollment will require new business processes for West Virginia.
	45 CFR 155.400	Enrollment of qualified individuals into QHPs	Functionality for QHP enrollment does not exist and will require new business processes for West Virginia. In the private sector, existing enrollment capabilities vary by carrier and producer. Some (e.g., large multi-state plans) allow for enrollment through a variety of means including paper, the carrier's and/or private exchange websites, and via brokers/agent. Some carriers also have online portals for employers to upload batch employee data for enrollment, make changes to employee enrollment, etc.
	45 CFR 155.405 (a)	Single streamlined application for QHPs, advance payments of the premium tax credit, cost-sharing reductions, and Medicaid, CHIP or the BHP where applicable	Medicaid and CHIP utilize a common application; however, a single streamlined application for all insurance affordability programs (eligibility determination for tax credits and cost-sharing subsidies) and QHPs does not exist and will require new business processes for West Virginia.
	45 CFR 155.205 I	Premium calculator (to determine monthly premium after subsidies)	This HIX function will require new business processes for West Virginia.
	45 CFR 155.405 I(2)	Provide the tools to allow for applicant to file an application via an Internet portal; by telephone through a call center; by mail; and in person	Citizens of West Virginia can file Medicaid and CHIP applications via an Internet portal (inROADS), by mail and in person (county offices), however this functionality does not exist for all Exchange insurance affordability programs and will require new business processes for the state.



Business Area	Reference (All are Proposed Rules)	Future HIX Business Environment	West Virginia Current Statewide HIX Business Environment
Plan Management	45 CFR 155 Subpart K	Plan certification, recertification, and decertification Plan monitoring and review	<p>The existing processes most analogous to plan certification, monitoring and review functions are currently performed at the carrier level by several OIC departments. Financial Conditions licenses and performs ongoing financial monitoring and analysis of carriers. The Rates and Forms Filing Department reviews and approves any rate or form changes such as benefits changes. Market Conduct assures carriers are complying with consumer-oriented insurance laws by monitoring business affairs through data analysis and examinations. Review of network adequacy, a requirement under the ACA, is included as part of comprehensive examinations.</p> <p>New ACA plan certification, recertification, and decertification and monitoring and review requirements may require additional new business processes for West Virginia.</p>
	TBD	Plan quality rating	<p>West Virginia Legislative Rule 114CSR53 dictates the standards for Health Maintenance Organization (HMO) quality assurance; the rule indicates HMOs accredited by nationally recognized accreditation and review organizations (e.g., NCQA, URAC) are deemed in compliance with West Virginia rules. According to Market Conduct, plans are required to submit proof of accreditation every three years, however no formal process exists to validate the accreditation and new business processes will likely be required for this HIX function.</p> <p>HMOs under contract to provide services to Medicaid members are</p>



Business Area	Reference (All are Proposed Rules)	Future HIX Business Environment	West Virginia Current Statewide HIX Business Environment
			<p>required to have an independent, external review of the quality of services annually. BMS currently contracts with Delmarva for this service.</p> <p>New ACA plan quality rating requirements may require additional new business processes for the state.</p>
Financial Management	45 CFR Part 153	Plan assessment, reinsurance, risk adjustment, and risk corridors	<p>The reinsurance program will be operated by a separate entity and the risk corridor program will be federally-administered and therefore should not require new processes.</p> <p>Risk adjustment functions will require new business processes for West Virginia. Although some states have developed risk adjustment models for their Medicaid programs, West Virginia has not and may choose to adopt a federally-certified risk adjustment methodology or submit an alternative methodology for federal approval. Carriers participating in Medicare Part C or Part D are familiar with the methodology used for those programs, and to minimize carrier burden the federal government is considering leveraging existing processes from those programs when developing its methodology.</p>
	TBD	Reconciliation of reductions in enrollee out-of-pocket costs	This HIX function will require new business processes for West Virginia.
	TBD	Determination of issuer credits	This HIX function will require new business processes for West Virginia.
	TBD	Premium tax credit and cost-sharing reduction administration	This HIX function will require new business processes for West Virginia.



Business Area	Reference (All are Proposed Rules)	Future HIX Business Environment	West Virginia Current Statewide HIX Business Environment
Customer Service	45 CFR 155.205 (a)	Call center	<p>Medicaid has member and provider call centers that provide customer support related to program eligibility, enrollment and services. Medicaid contracts with Automated Health Systems (AHS) to handle the Medicaid managed care customer support, which includes outreach and education to Medicaid consumers, application assistance, and enrollment for a variety of health programs, comprehensive health assessments, care coordination, linkages with medical homes, complaints resolution, and appointment scheduling and referral to other services (such as disease management, transportation, dental care, child care, etc.).</p> <p>The Bureau for Children and Families operates two “Change Reporting” benefit call centers (one for the Northern part of the state and one for the Southern) for members to report changes to their Medicaid and CHIP information. About 46 Economic Service Workers staff the two centers. An additional “Client Services” call center, located in Charleston, is a “catch-all” customer service line with seven Health and Human Resource Specialists. CHIP outsources its Call Center to the Jackson County Development Center Call Center to handle CHIP client and provider inquiries.</p> <p>OIC/CSD (see more below) has a call center staff of 16, with four dedicated to healthcare.</p> <p>All carriers have call centers to service members; some also have more advanced functionality such as “click to chat” and “click to call” from their websites. Carriers who responded to</p>



Business Area	Reference (All are Proposed Rules)	Future HIX Business Environment	West Virginia Current Statewide HIX Business Environment
			<p>requests for information during the current environment assessment indicated they in-source call center functions at local campuses; some use custom CRM tools, and one uses an application called Navigator.</p>
	<p>45 CFR 155.205 (b)</p>	<p>Internet Website</p>	<p>DHHR maintains inROADS which is a public-facing self-service web portal that allows individuals to apply on-line and determine eligibility for many state benefit programs including Medicaid and CHIP.</p> <p>The Exchange has launched bewv.com to provide information to the public about the West Virginia HIX.</p> <p>AccessWV and PEIA have applications and other forms available for download in .pdf format on their websites.</p> <p>PEIA and inROADS have some self-service benefits management functionality through their websites.</p> <p>Carriers maintain their own websites and online self-service functionality varies for enrollment and benefits management.</p>
	<p>(1)</p>	<p>Provides standardized comparative information on each available QHP</p>	<p>This HIX function currently does not exist within the state processes/ systems and will require new business processes. Some functionality does exist within the private sector as described in this report. Producers are a source of comparative information about plans, but this information is not standardized. Some carrier websites provide comparison tools for their various plans, (e.g., one carrier indicated they have a custom-built, seamless, online assistance tool that provides individual quotes and allows for plan comparison and enrollment).</p>



Business Area	Reference (All are Proposed Rules)	Future HIX Business Environment	West Virginia Current Statewide HIX Business Environment
	(2)	Is accessible to people with disabilities	This HIX function will require new business processes for West Virginia.
	(3)	Publishes [certain] financial information	This HIX function will require new business processes for West Virginia.
	(4)	Provides information about Navigators, etc	Consumers currently may seek information about licensed producers on the Internet homepage of the Agent Licensing Division by producer name, agency or NPN number but not by zip code to find a local producer for assistance. This HIX function will require additional business processes for West Virginia.
	(5)	Allows for an eligibility determination	See above.
	(6)	Allows for enrollment in coverage	See above.
	45 CFR 155.205 (d)	Consumer Assistance including the Navigator program	<p>OIC's Consumer Services Division (CSD) provides the initial point of contact for all citizens and businesses that have insurance-related inquiries, complaints, and information requests and assists them with identifying the proper channels within the state agencies.</p> <p>OIC's Agent Licensing Division is responsible for initial licensing and renewals of resident and non-resident producers selling insurance in West Virginia. The Division's responsibilities also include assuring producers are compliant with the continuing education requirements.</p>
	Communications	45 CFR 155.205 (e)	Outreach and education



Business Area	Reference (All are Proposed Rules)	Future HIX Business Environment	West Virginia Current Statewide HIX Business Environment
			<p>benefit programs.</p> <p>OIC performs a number of education and outreach efforts for private health insurance.</p>
		Applications and notices	<p>Medicaid, CHIP and the carriers are responsible for the production of numerous notices related to eligibility and member benefits.</p> <p>RAPIDS prepares over 450,000 correspondences per month, including notifications of Medicaid eligibility, paper member ID cards on a monthly basis, and redetermination letters. RAPIDS passes eligibility data to the MMIS for additional member communications. BMS generates and mails eligibility notifications for some state-funded programs.</p>
		Measurement/reporting of communication effectiveness	This HIX function will require new business processes for West Virginia.
Oversight	<p>45 CFR 155.200 (e)</p> <p>45 CFR 155.200 (f)</p>	Oversight and financial integrity	<p>The ACA requires GAO Oversight of the Exchange; not later than 5 years after Exchanges are operational, the Comptroller General will conduct a comprehensive study of the Exchange. At this time it is unclear what business processes will be required to support this function.</p> <p>The OIC Chief Financial Officer is responsible for the financial integrity of OIC operations. As the HIX is planned to exist within the OIC, it is likely the OIC will be responsible for these functions. This HIX function may require new business processes for West Virginia.</p>



Business Area	Reference (All are Proposed Rules)	Future HIX Business Environment	West Virginia Current Statewide HIX Business Environment
		Quality activities	<p>Medicaid healthcare quality activities are planned to be enhanced in the near future with implementation of the DW/DSS, WVHIN and APCD, to keep up with new federal regulations and state goals.</p> <p>The Health Care Authority compiles some quality data from Medicaid and PEIA claims and presents it to the public on comparecarewv.com.</p>

2.5 Current West Virginia HIX Technology Environment

Leveraging assets in the current IT environment could help the state meet the demanding federal timelines for establishing the Exchange in a cost-efficient manner. As noted previously, Exchange leaders in West Virginia have expressed the goal of creating a financially efficient Exchange. Thus, a scan of the state technology environment was performed to identify existing state IT assets and future planned technology efforts that may be leveraged to support required Exchange business functions, as outlined in Table 7.

Through a series of interviews and meetings with key government and private sector stakeholders over the course of three months, the team identified over thirty IT software and hardware assets used by six state agencies or entities to assess to determine their potential role in the future HIX IT environment. The key characteristics of these IT assets are summarized in the table below, described in further detail in the following sub-sections, and further assessed for their functional fit in the future Exchange IT environment in section 2.6.

Table 8: Key Assets of the Current West Virginia HIX Technology Environment

Current WV HIX State Technology Asset to Assess for Leveraging Potential	User Agency	Primary Functions	Key Technical Features	Status
Office of Technology (OT)				
State Data Center Enterprise Server (State's Mainframe)	DHHR et al	Hosts RAPIDS, OSCAR, FIMS, PEIA applications and other state systems	IBM server	New November 2010
Cisco Call Manager/ Contact Center	Multiple agencies, including southern BCF Change	<ul style="list-style-type: none"> - Call routing - Call treatment - Network to desktop computer telephony 	No data	In use and undergoing expansion



Current WV HIX State Technology Asset to Assess for Leveraging Potential	User Agency	Primary Functions	Key Technical Features	Status
	Call Center	integration - Call center reporting		
CHIP Online Eligibility Application	CHIP	- CHIP Premium Enrollment - Data management	Developed by OT on the state's mainframe with data tables residing in DB2	In use
Department of Commerce				
Broadband	Department of Commerce and other implementing parties	Provide access to telecommunications resources such as the Internet	Contracts with various service providers	Implementation in progress
Department of Administration				
West Virginia Financial and Information Management System (WVFIMS)	OIC and DHHR, et al	General ledger	State mainframe IBM server	New November 2010
CHIP Call Center	CHIP	- Eligibility look-up - Member and provider support - Call tracking	Hosted by vendor Jackson County Development Center	In use; upgrade to Cisco hardware and software planned
Department of Health and Human Resources (DHHR)				
RAPIDS Suite - eRAPIDS - RAFT	DHHR/BCF	- Eligibility Determination - Benefits Issuance	State-owned system hosted on state's mainframe, vendor supported	Implemented in 1996; incremental modernization in progress
inROADS	DHHR/BCF	Public-facing self-service web portal evaluates for possible eligibility, allows for on-line benefit application,	Vendor-developed and maintained; powered by eRAPIDS	Release 11+ in use; initial release implemented in 2003



Current WV HIX State Technology Asset to Assess for Leveraging Potential	User Agency	Primary Functions	Key Technical Features	Status
		renewal and checking for Medicaid, CHIP, SNAP, TANF and other state benefit programs.		
FACTS	DHHR/BCF	Case management	State-owned system hosted on state's mainframe, state supported	System transferred and enhanced by Deloitte in 1997.
DHHR Change Reporting and Client Services Call Center	DHHR/BCF	Respond to consumer inquiries regarding eligibility and benefits.	OT Cisco software (Southern Change Reporting Call Center) Nortel system (Northern Change Reporting Call Center)	In use
Medicaid Management Information System (MMIS) and Fiscal Agent Services	DHHR/BMS	<ul style="list-style-type: none"> - Claims adjudication - Member and Provider Call Center - Communications - Reporting 	Proprietary system, hosted remotely, developed and maintained by Molina	Implemented in 2003; system re-procurement in progress
Managed Care Customer Support Call Center	DHHR/BMS	<ul style="list-style-type: none"> - Managed care enrollment - Customer Service 	No data on call center. Enrollment system is primarily manual.	In use
Medicaid Data Warehouse and Decision Support System (DW/DSS)	DHHR/BMS	Program reporting, performance monitoring and decision-making.	TBD	Procurement in progress



Current WV HIX State Technology Asset to Assess for Leveraging Potential	User Agency	Primary Functions	Key Technical Features	Status
Master Data Management (MDM) Solution	DHHR	Unite business objects across agency applications to provide a single view of data across the breadth of the organization	TBD	Procurement planning; the first three systems to be tied into the MDM are intended to be RAPIDS, OSCAR, and FACTS
Health Care Authority (HCA)				
Comparecarewv.com	HCA	Public-facing website presenting provider and hospital cost and quality information and comparison tools	Web-based, developed and hosted by HCA	Enhancements recently completed and live
All Payer Claims Database (planned)	HCA DHHR OIC	Collect and store health care claims data from multiple payers.	TBD	Procurement in progress
WVHIN (planned)	WVHIN	Collection and exchange of clinical data.	TBD	Thomson Reuters selected to develop the solution
Offices of the Insurance Commissioner (OIC)				
Servers	OIC -IT	Supports SQL2000, Exchange, document/file storage, application hosting environments, Oracle, FileNet, and applications development	Operating systems on 15 of 19 servers is Microsoft Windows Server 2003; operating system on remaining servers is HPUX11	19 in use; 5 additional spare servers
IVUE	OIC – Multiple Departments	Image system for scanning documents into databases.	Vendor product administered by the OIC	In use



Current WV HIX State Technology Asset to Assess for Leveraging Potential	User Agency	Primary Functions	Key Technical Features	Status
FileNet	OIC – Multiple Departments	Image system for scanning, storing, and retrieving documents.	Vendor product administered by OIC	In use
Bewv.com	OIC – Health Policy	Public-facing website providing public with information about the West Virginia Health Insurance Exchange planning process.	Web-based, developed by Arnold Agency under contract to OIC – Health Policy	In use
Consumer Assistance Program (CAP) Call Center	OIC – CSD	Respond to consumer inquiries and complaints.	Case tracking is primarily manual and paper-based	Recent integration with SBS completed
State Based Systems (SBS)	OIC – CSD and ALED, Financial Conditions, Market Conduct	Support producer and company licensing, support market regulation, and consumer services.	Web-based; managed and hosted by the NAIC.	West Virginia implemented SBS in February 2011
System for Electronic Rates and Forms Filing (SERFF)	OIC – Rates and Forms	Electronic filing of industry rates and forms	Web-based; hosted by the NAIC	West Virginia implemented mandatory usage January 1, 2009
Online Premium Tax For Insurance (OPTins)	OIC – Financial Conditions	Carriers can pay taxes/fees securely via online portal.	Web-based; hosted by NAIC	In use
Market Analysis Review System (MARS)	OIC – Market Conduct	Allows for automation, documentation, and sharing of Level 1 Analysis Reviews.	Web-based, hosted by NAIC	In use
I-SITE	OIC – Agent Licensure and Market Conduct	Online interface for state insurance departments to obtain comprehensive financial, market conduct, producer	Web-based; hosted by NAIC	In use



Current WV HIX State Technology Asset to Assess for Leveraging Potential	User Agency	Primary Functions	Key Technical Features	Status
		licensing, and securities information; integrated with SBS.		
Market Analysis Prioritization Tool (MAPT)	OIC – Market Conduct	Provides a quick glance of the overall market, used to determine which companies to examine more closely.	Web-based, hosted by NAIC	In use
Market Conduct Annual Statement (MCAS)	OIC – Market Conduct	Online form for insurers to submit uniform annual statement data elements to multiple states simultaneously; not used by health insurance carriers at this time.	Web-based, hosted by NAIC	In use
Health Insurance Oversight System (HIOS)	OIC – Rates and Forms	Rates and Forms validates rate changes entered into SERFF and uploads to CMS using HIOS; carriers use HIOS to submit rate increases >10% directly to CMS.	Web-based; hosted by CMS	Developed after PPACA to meet new reporting requirements; new module recently released to support direct reporting from carrier to CMS
Human Resources Information System (HRIS)	OIC – Administrative Services	Human Resource functions (e.g., employment history, salary, tenure, personal identifiable information)	State-owned system hosted on state’s mainframe IBM server	Implemented in 1999; expected to be replaced by ERP
National Insurance Producer Registry (NIPR)	OIC- Agent Licensing	Support producer license application and renewal	Web-based; hosted by NAIC	In use; all renewals must be completed electronically



Current WV HIX State Technology Asset to Assess for Leveraging Potential	User Agency	Primary Functions	Key Technical Features	Status
Public Employees Insurance Agency (PEIA)				
PEIA IT Systems	PEIA	<ul style="list-style-type: none"> - Eligibility and Enrollment - Customer Service Call Center (Microsoft Dynamics) - Benefits Management (BAS) 	SQL server housed at state Data Center	In use

The following sections provide summary information about each of these current environment technology assets.

In order to further assess the potential of these components of the Current West Virginia HIX Technical Environment to be leveraged for the Future West Virginia HIX Environment, they must be evaluated against the technical guidance, standards and requirements established to date by the federal government. This exercise was conducted as part of Deliverable 3: Prioritized List of Strategic Issues.

2.5.1 State-wide Technology Resources

The state owns and maintains a state Data Center, which hosts the state’s mainframe and other state applications. In addition, the state has invested significant state and federal resources to expand broadband access throughout the state.

State Data Center and Mainframe

The state’s OT hosts applications at centralized facilities and coordinates the support, maintenance, upgrades, and administration of the software with the various application development groups throughout the executive branch. Through an ASP model, OT has combined over 1,000 hardware, software, and networking devices as part of an overall server and storage consolidation initiative. This approach has resulted in superior performance, increased security, and enhanced 24/7 support at an overall lower operating cost. The Data Center houses the state’s mainframe as well as other windows servers, PEIA’s SQL server environment and the state-wide Microsoft Exchange server. The Data Center is statement on Auditing Standards (SAS) 70 compliant, and has redundant cooling, heat, and detection systems as well as fire suppression systems.

The state has a mainframe IBM server that is new as of November 2010 and located in the OT state Data Center. This is a server with plenty of space for expansion, and there are off-site backups taking place daily. OT is in the process of upgrading from a tape system to a virtual tape system to streamline the backup processes. The following three major systems run on state’s mainframe: West Virginia Financial Information Management System (WVFIMS),



Recipient Automated Payment and Information Data System (RAPIDS), and Online Support Collections and Reporting System (OSCAR).

Cisco Contact Center

OT has deployed Cisco's Contact Center, which provides better call routing, call treatment, network-to-desktop computer telephony integration and multichannel contact management over an IP infrastructure. Cisco Supervisor Desktop provides performance metrics at individual staff and aggregate level and has other extensive call center reporting and communications capabilities. Several state agencies have availed themselves of this OT service offering, including BCF's southern Change Reporting Customer Service Call Center.

Broadband

West Virginia, located in the heart of Appalachia, has mountainous terrain that creates challenges for broadband deployment, which is reflected in the broadband build out rate. It is critical that West Virginia have a complete and robust middle mile in order to facilitate the efficient delivery of critical public services in healthcare, education, and public safety. Reliable and accessible Internet connectivity is essential for the state's citizens living in rural areas of the state to be able to utilize the HIX, and currently, a major part of the state's households have limited or no access to broadband. Coverage cannot be extended due to the cost of deployment and population scarcity. The most challenging parts of the state both demographically and topographically remain un-served.

There are approximately 750,000 households in the state. Currently, approximately 670,000 have access to broadband, leaving 80,000 households without access. All of the remaining households have access to dial-up. Approximately 400,000 households subscribe to broadband. There are about 220 wire centers in the state and all of them have access to broadband, at least those in communities with a population 50 and above. The unserved areas are principally the outlying rural areas of each wire center. Many businesses have access to broadband and high capacity services, but cost is a barrier to connection for many small businesses.

The Department of Commerce (DOC) leads and oversees the state's Broadband Initiative to expand broadband into West Virginia's rural areas. The DOC, in concert with Governor's Executive Office, received a federal Broadband Technology Opportunities Program (BTOP) grant that was fully funded for over \$126 million. Recognizing that broadband is imperative in serving its citizens and bringing economic development, former West Virginia Governor Joe Manchin, III, signed legislation creating the Broadband Deployment Council (BDC), an entity designed to facilitate innovative, quality, affordable broadband to all West Virginians; the BDC is working directly with the BTOP grant project. The Council has \$4 million to give out as grants to facilitate last mile access in unserved areas.

According to the state's Broadband Infrastructure Application Submission, West Virginia's broadband deployment strategy begins with the build out of an open network middle mile solution that will provide fiber to critical community anchor tenants. Distribution of the bandwidth to support private, public, and individual connectivity will then occur through switching, routing, and leadership. This high quality middle mile is essential to last mile completion of broadband deployment, and will provide a full range of interconnect possibilities to meet provider, carrier, and end user requirements. West Virginia's strategy is designed to foster competition generated by built-in multiple accesses, with the foreseeable reduction in costs for service for actual end



users. To address demand and sustainability issues, the state, through the selection of the anchor tenants for the build out, designed the broadband deployment strategy to enhance critical services to citizens, which is paramount to building demand for robust broadband service.

Direct work on the BTOP grant began in November 2010. The grant work must be substantially complete in two years (February 2012) and fully completed in three years (February 2013). The middle mile portion of this open access grant provides a backbone facilitating any entity in West Virginia access to broadband. The anchor tenant portion fully connects 1064 entities to receive broadband services. Each county in the state will receive some level of connectivity from the grant.

Frontier, which covers 99% of access lines and 90% of the geographic area of the state, has a commitment to reach 85% of its customers with broadband coverage. When this goal is achieved, there will still be about 50,000 households without broadband, which will be scattered around the state in the service area of virtually every wire center. These remaining unserved customers will present a significant challenge, but there are some promising technological fixes on the horizon, such as small pole mounted boosters that can extend the reach of broadband for an additional two to three miles. The remaining 1% of access lines is served by six small telephone companies and virtually all have broadband.

In addition, the West Virginia Telehealth Alliance (WVTA) received an \$8.9 million grant to expand broadband across the State of West Virginia as participants in the FCC's Rural Health Care Pilot Program. In addition, the Alliance received nearly \$1 million in state funds. This funding is being used by the WVTA to enhance broadband connections among healthcare providers; educate hospitals and rural clinics about telehealth applications; and help facilitate possible telehealth interlinkages.

As part of the FCC's Rural Health Care Pilot Program, the WVTA is working to enhance broadband connectivity to over 96 distinct locations (hospitals, rural clinics, free clinics, etc.) across the State of West Virginia. This improved broadband connectivity will provide a number of benefits, including but not limited to: enabling greater use of telehealth services and connections that will enable improved diagnostic capabilities and specialty treatment options; enabling better group purchasing power and enhanced reliability and quality of service; fostering tele-training and educational opportunities; and establishing virtual private networks to ensure security, reliability and connectivity. Connectivity is being extended through subsidies, group purchasing and a Hub model. Through group purchasing, the sites have access to 10-30% better pricing. Combined with the subsidy funded through the grant, sites are responsible for about 15% of the costs of the connectivity. Individual sites can decide how they want to use their bandwidth. This program will end sometime in 2014 or 2015, when funding is depleted. In addition to the designated sites that are receiving the subsidy, additional locations have been able to benefit from the discounted rates thus further increasing broadband access.

West Virginia Financial Information Management System (WVFIMS)

West Virginia FIMS is the state's general ledger system, which is maintained at the State Auditor level and utilized across all state agencies for accounting functions. A legislative change would be required for a state entity to utilize a different system. As long as the HIX is part of the OIC, it will need to use WVFIMS (or its replacement) as its financial system of record. WVFIMS has limited Accounts Payable functionality. The State Treasurer's Office controls all payments. Planning is in process to develop Oasis, an Enterprise Resource Planning (ERP) system, to



replace WVFIMS and other state administrative systems such as Human Resources Information Systems (HRIS), which supports personnel management functions. The current hardware environment for WVFIMS is a mainframe IBM server that is new as of November 2010 and located in the data center at the Office of Technology. The software environment consists of a Linux environment on the mainframe as well as Oracle and DB2. Integration capabilities for the current WVFIMS mainframe system consist of DB2 connect capabilities on the Linux mainframe, which provide for the ability to establish connections to other systems.

FIMS enables agencies to evaluate actual expenditures against their annual budgets. Reports provide the ability to compare current timeframe expenditures against similar previous time periods. They also provide the basis for making sound estimates of future financial requirements that will meet the needs of anticipated growth. Key reports include Cash Worksheets and financial reports that monitor administrative expenditures. Agencies update accounting information in FIMS on a daily basis.

CHIP Systems

RAPIDS handles CHIP eligibility determination. CHIP outsources member and provider customer service activities to the Jackson County Development Center Call Center. CHIP contracts with Wells Fargo Third Party Administrators for billing and medical claims administration and with Express Scripts, Inc. for pharmacy benefit management. Through Wells Fargo, CHIP members can pay premiums on-line. CHIP uses Health Data and Management Solutions (HDMS), along with AccessWV and PEIA, for its data warehouse.

A special database was developed by the state's OT to manage benefits issuance for the CHIP Premium program, which has about 1300 participants. The CHIP On-line Eligibility Application, developed and operated by the state's OT, is an interactive application that was developed on the state's Enterprise Server (mainframe), with all the data tables residing in DB2. The online portion of the application was developed in CICS, and the batch programs are COBOL and SAS.

RAPIDS generates a list of CHIP applicants between 200% and 300% of FPL and sends the list to the CHIP On-line Eligibility Application. These children are identified in RAPIDS as "denied" with exception code 714 in RAPIDS. The OT system receives the list of applicants and generates a letter to the guardian explaining the child is eligible and the process for paying the required premium. The OT system receives a nightly feed from Wells Fargo with a report of premium payments made. Eligibility is open for twelve months; OT generates and sends the redetermination letters for program participants.

2.5.2 Offices of the Insurance Commissioner (OIC)

The OIC utilizes an array of products and systems to facilitate its daily operations. The following are described in further detail below: state-based Systems (SBS), National Insurance Producer Registry (NIPR), System for Electronic Rates and Forms Filing (SERFF), Human Resources Information System (HRIS), IVUE and FileNet, I-SITE, Market Analysis Prioritization Tool (MAPT), Market Analysis Review System (MARS), and Market Conduct Annual Statement (MCAS). The OIC also uses WVFIMS, described above, for financial management.

The OIC hardware environment consists of a combination of servers ranging in purchase date from 2001 through 2005. The operating system on the majority of the servers (15 out of 19 servers in use) is Microsoft Windows Server 2003, which supports SQL2000, Exchange,



document/file storage, and application hosting environments. The Windows 2003 servers consist of a combination of Dell Model 1850, 4600, 6850, PV770N, OP240, as well as an HP PL server. The operating system on the remaining servers is HPUX11 (Hewlett-Packard's proprietary implementation of the UNIX operating system), and support Oracle, FileNet, and development of applications in these systems. The HPUX11 servers were purchased approximately in 2004 and are HP RISC servers, model RP8400. There are also additional spare servers (4 Dell 1850 servers, and 1 Dell 6850 server) that were purchased approximately in 2005.

The OIC IT Department provides IT support for all OIC operations which includes working with vendors and state-wide systems to support the OIC business processes. While the OIC houses several consumer advocacy and customer assistance functions, no automated or electronic call center customer relationship management or call-tracking capabilities are in place.

In February 2011, the OIC began using **State-Based Systems (SBS)**, a National Association of Insurance Commissioners (NAIC) system maintained by NAIC and used by 21 states, to support many aspects of insurance regulation. SBS software leverages Licensing Environment Online (LEO), a proprietary web-based system developed by Aithent and licensed for use by the NAIC. The goal for SBS is to enable state insurance departments to more efficiently and effectively process license applications, renewals, inquiries, complaints, enforcement actions, etc. with a minimum of effort and remain compliant with national uniformity initiatives. The core SBS product is available to states for free, and states can pay for customizations and enhancements. SBS is managed by an NAIC steering committee, available resources are fixed, and changes require that other state users be consulted. OIC is currently using SBS for its producer and company licensing functions, market regulation and consumer services processes.

The OIC's Agent Licensing Division uses the **National Insurance Producer Registry (NIPR)**, which is an electronic database provided and maintained by the NAIC, to accept initial license and renewal applications from producers. The NIPR hits against the Producer Database (PDB), which is a central repository of producer licensing information, to determine if there have been any actions taken against the producer in other states. After applications have gone through the review process – which may include being sent to the Legal Department for further investigation if needed- and are approved, the information is sent from NPIR to the SBS system, which allows producers to view and print their licenses online within minutes. Producers can also submit initial applications via paper, however all renewals must be completed electronically.

Part The OIC's Rates and Forms Filing unit handles the review and approval of all insurance plans and agents (approximately 10,000) and rates; a sub-department handles life and health insurance submissions (approximately 3,000). It is assumed that all filings for insurance plans to be offered in the Exchange will follow the current process, with the HIX board of directors having final approval. The State of West Virginia is one of 28 states that require companies to use the **System for Electronic Rates and Forms Filing (SERFF)** that is maintained by the NAIC. SERFF is a decentralized, point-to-point, web-based electronic filing system designed to enable companies to send and states to receive, comment on, and approve or reject insurance industry rate and form filings. As of January 1, 2009, West Virginia carriers must submit their applications for certification, which are PDF files, using the SERFF system and utilize EFT to make payments. NAIC is planning on developing SERFF capabilities to fully support federal plan certification requirements, as well as state-specific needs, with the main goal of streamlining the QHP certification process for regulators and carriers. They intend to have some



components, documentation, etc. ready by mid-2012 as they know states must submit their Exchange plans for certification by January 2013. The NAIC has requested funding for the enhancements, and they expect states will pay NAIC back through grant funds. The NAIC plans to send out a framework of expected deliverables and estimated cost soon for states to use in their grant applications.

As required by the ACA, as of September 1, 2011, carriers that submit a rate increase in SERFF equal to or above 10% for the individual and small group market must also submit the proposal to CMS for review through the **Health Insurance Oversight System (HIOS)**. The potential to leverage HIOS for Exchange-related plan management functions requires further research, although OIC staff interviewed indicated SERFF was more likely to be leveraged than HIOS.

The OIC's Administrative Services Division uses **Human Resources Information System (HRIS)**, a state-developed system that exists on the state mainframe, to manage all personnel functions such as tracking employment history, salary, and tenure. Although the Exchange is exempt from the rules of State Purchasing and State Personnel, the OIC Director of Administrative Services envisions HRIS will be used to manage Exchange personnel matters. The Administrative Services Division also uses WVFIMS (previously described) for procurement purposes. Both HRIS and WVFIMS are expected to be replaced by the ERP system.

Two document imaging systems, **IVUE** and **FileNet**, are currently supported by the OIC's IT Department and are used across OIC departments. IVUE is a vendor product administered by the OIC that provides basic storage and retrieval of images. FileNet is also a vendor product with more robust capabilities than IVUE; the application's code is managed by the OIC, providing more programming flexibility, providing the potential to be leveraged to support Exchange functions.

Market Conduct uses several web-based tools supported by the NAIC to perform its main responsibility of identifying non-compliant business practices of regulated entities through examinations and data analysis. **I-SITE** is an online interface designed for state insurance departments to obtain comprehensive company financial, market conduct, producer licensing, and securities information. I-SITE offers regulators seamless access to NAIC database information and is often the first place Market Analysts start when seeking information on companies, followed by SBS or SERFF. Market Conduct also uses the **Market Analysis Prioritization Tool (MAPT)**, which provides a quick glance of the overall market and is used to identify companies to examine more closely, and the **Market Analysis Review System (MARS)**, which allows for automation, documentation, and sharing of Level 1 Analysis Reviews. Although not currently used for health insurers, companies selling Life, Annuity, Homeowners, and Personal Property Auto insurance in West Virginia submit data via the **Market Conduct Annual Statement (MCAS)**, which was developed by NAIC to assist states in the collection of uniform data elements for use in monitoring, benchmarking, and regulating insurance company conduct. The MCAS is a web-based online application tool that supports manual and electronic data entry from carriers. As a data collection tool used by several states, it is possible the MCAS may be leveraged to collect common data elements required by the ACA for plan monitoring and review of carriers providing major medical insurance in West Virginia.

The OIC Consumer Services Division (CSD) serves as the initial point of contact for all citizens and businesses that have inquiries, complaints, and information requests and assists them to identify the proper channels within the state to handle their request. CSD also assists consumers to enroll in Medicare Part C, Medicare Part D, and AccessWV, the state's high risk



pool. CSD currently has 16 people in the call center with 4 staff handling healthcare. CSD also has a walk in service and fields inquiries via email but they do not have online chat capabilities or a web portal. In 2009, CSD opened 2,322 new files (for all lines of insurance business) and handled over 30,000 phone calls, averaging 135 consumer inquiries per day (for all lines of insurance business).

All-Payer Claims Database (APCD)

The All-Payer Claims Database (APCD) is a large-scale database that systematically collects health care claims data from a variety of payer sources. APCD systems collect data from the existing transaction systems in place to pay health care claims, which leverages data from within the insurance claims and reimbursement system. Per Executive Order No. 2-10, the creation of an All-Payer Claims Database task force was ordered. The APCD Act creates three MOU parties in state government – the OIC, BMS (Medicaid) and the Health Care Authority (HCA). These entities are tasked with developing collection; storage and retention; release; and analytical rules that must be approved by West Virginia Legislature. Currently in West Virginia, state public payer claims data are collected, maintained, and analyzed by the West Virginia Health Care Authority (HCA). Limited data was also voluntarily reported by three major private carriers, Mountain State Blue Cross Blue Shield, Coventry, and The Health Plan of the Upper Ohio Valley. This data was offered on a one time basis. The data are collected and processed by a private vendor. A standardized data file that has been scrubbed to remove identity information is securely transferred to the Health Care Authority (HCA) for analysis.

The hardware and software environment for an APCD has not been determined. Integration capabilities of the APCD will be determined as part of the process of developing the APCD. Current integration considerations will depend on the rules and regulations established within the state regarding the APCD. What model is chosen also has a factor in what integration will need to take place, so what information needs to be pulled into the APCD and from who/what entities? What are the types of data elements will be included in the APCD? How will the data be submitted and processed? How often will the data be required to be submitted? These are all factors in consideration when developing the APCD.

2.5.3 Department of Health and Human Resources (DHHR)

DHHR programs utilize a number of systems that are part of the Current West Virginia HIX Exchange Environment. RAPIDS is the state's integrated eligibility system; FACTS and the CHIP On-line Eligibility Application also perform eligibility functions. The state's MMIS and planned Medicaid DW/DSS are the source of critical healthcare claims and utilization data for the state's Medicaid population of over 400,000. Each of these systems is described in further detail below.

Recipient Automated Payment and Information Data System (RAPIDS Suite)

RAPIDS is the state's mainframe IV-A integrated eligibility and benefits issuance system. The RAPIDS Suite consists of RAPIDS, inROADS, eRAPIDS and RAFT, each of which is described further below. RAPIDS is maintained by the DHHR Bureau for Children and Families; it was developed in 1996 by and is supported by Deloitte Consulting. The Deloitte contract is currently in option years and will be rebid in 2013-2014. Consumers, state, and county workers, community partners and providers, and call center staff use the RAPIDS Suite to conduct eligibility and service authorization; program, screening, intake and registration; and manage notifications and correspondence, payments and collections; and case management for over



260,000 West Virginia households consisting of over 600,000 individuals. RAPIDS generates approximately 13,000 notices per day.

inROADS is the public-facing self-service portal for applying for, renewing and managing state benefits including TANF, SNAP, Medicaid and CHIP. inROADS can determine eligibility for about one-fourth of the state's 44 Medicaid categories. The remainder requires submission and validation of documents which must be completed manually (mailed by the applicant and reviewed by an eligibility worker). inROADS does not have the ability to upload documents. Moreover, many programs require original documentation with a wet signature for eligibility to be completed and therefore eligibility must be completed in-person. Some data can be directly exported from inROADS to RAPIDS so that an individual can initiate the application on inROADS and complete it in-person. inROADS also has a "mybenefits" account functionality that allows consumers secure access to certain benefits information on-line.

eRAPIDS is the result of the RAPIDS "incremental modernization" initiative to upgrade and enhance the RAPIDS mainframe system. Consisting of 22 sub-systems and 812 DB2 tables, RAPIDS, now eRAPIDS, contains the business logic and ancillary systems to adjudicate eligibility and issue benefits. It is browser-based, has a Graphical User Interface, is based on SOA for future reuse and replacement, and consolidates many screens, improving efficiency of the eligibility process. Many of the RAPIDS enhancements have been achieved by reusing transferable assets; for example, inROADS was a transfer from Pennsylvania and the eRAPIDS framework was transferred from Wisconsin. Each eRAPIDS component is designed to be modular and reusable. As an example, one of the Web Inquiry services is being extended to provide a web service in support of the state's WIC System. Also, the Work Programs component and the Worker Scheduler components of eRAPIDS have been demonstrated to other states with the intent of transferring those independent components.

eRAPIDS is used by over 2,000 Family Support/Income Maintenance Workers and supervisors, Client Service Workers, Customer Service Center workers and supervisors, hospital workers, and BCF staff throughout the state. Approximately 50 unique worker profiles exist to manage access and data security. eRAPIDS receives application information from inROADS, from data exchange from the Social Security Administration (SSA), in person at 54 county offices, and through paper applications received through the mail. About 10% of initial applications are submitted through inROADS. The West Virginia Bureau for Children and Families processes the benefit applications and conducts verifications to determine eligibility, notifies customers, exchanges data with appropriate agencies such as MMIS, and issues appropriate benefits. eRAPIDS has the ability to make a real-time eligibility decision if the individual is present with proper documentation. Constraints to real-time eligibility adjudication are policy and business-related: the need for a wet signature and manual review of supplemental documentation.

RAPIDS produces 52 financial reports and 250 management reports. Thirteen different entities have different levels of system access, including the SSA and the Jackson County Development Center, which houses the CHIP Call Center.

RAFT (RAPIDS Analysis and Formatting Tool) is the Cognos RAPIDS reporting repository and Data Warehouse that contains historical integrated eligibility data that is used specifically for reporting and analytical purposes. RAFT is for internal DHHR users.



RAPIDS is funded through a combination of state and federal funds. The amount of federal funding is determined by a federal cost allocation methodology. Based on transaction volume, about 50% of RAPIDS funding comes from TANF, 25% from Medicaid (which is then split 50-50 federal and state), and 25% from SNAP (which is split 90-10 federal and state).

In terms of plans for the future, the RAPIDS team is contemplating ways to increase consumer use of inROADS to submit applications on-line, including creating out-stationed kiosks. In addition, a DHHR work group, the Medicaid Eligibility Gap and Alternative Analysis (MEGAA) Project has been formed to assess the feasibility of using RAPIDS to handle the Medicaid expansion beginning January 1, 2014, when the qualifying FPL is raised to 138% for all adults under 65 (also known as the "MAGI" population). The state expects an additional 140,000 to 160,000 individuals to become eligible for and enroll in Medicaid after 2014.

BCF Customer Service Centers

The BCF Office of Customer Services operates two "Change Reporting" customer service call centers during standard business hours Monday-Friday, one serving the Southern region of the state, and one in Fairview, West Virginia, and is staffed with 18 Economic Service Workers, 2 office assistants and 2 supervisors, and the Southern center is located in Charleston and is staffed with 28 Economic Service Workers, 2 office assistants and 3 supervisors. The call centers handle 15-16,000 calls per month on average, however in busy months as many as 20-25,000 calls may come in. Amongst other things, Economic Service Workers determine eligibility and process changes for Medicaid, CHIP, and SNAP and help with case reviews. Clients also have the option to enter eligibility change information in an online form on the BCF website; information is automatically e-mailed to call center staff for entry into RAPIDS and other appropriate systems. Additionally, the Office of Customer Services operates a "Client Services" call center, which is located in Charleston and is staffed with 7 Health and Human Resource Specialists, 2 support staff, and 1 supervisor. Specialists handle questions about benefits -including eligibility- send consumers Medicaid applications, manage client complaints, and serve as a "catch-all" for consumer questions/comments.

The Northern call center uses an old Nortel telephone system to manage call center functions. In May 2010 the Southern call center was migrated to the **Cisco system** (discussed above) supported by the Office of Technology. Members of the call center management team report dramatically improved efficiency and customer service as a result of transitioning to Cisco. Change Reporting staff do not use a Customer Relationship Management tool to log and track calls, however, they enter information directly into RAPIDS and other systems. Health and Human Resource Specialists in the Client Services call center do not enter information directly into RAPIDS, but they currently use a Microsoft Access tool to log and track client calls. Interviewed staff indicated the tool was inefficient, cumbersome, and antiquated and should not be leveraged elsewhere.

Families and Children Tracking System (FACTS)

The Family and Children Tracking System, or "FACTS" is a comprehensive customized statewide Automated Child Welfare Information System (SACWIS) established by DHHR for the administration of Title IV-E Child Welfare Programs, including child protective services, foster care services, Adult Protective Service programs, independent living services, family preservation services, and adoption services. FACTS was transferred to West Virginia and enhanced by Deloitte in 1997 but has been maintained internally since implementation.



FACTS is the program that all social service staff use to document and manage their casework process. The payment processes for providers of services are also managed through FACTS. Caseworkers and Supervisors utilize tablets (portable hand-held computers) in the field. The tablet, when connected to the State network, allows caseworkers to download their relevant case files to the tablet, and locks the files in the central database until the caseworker checks them back in.

The application is hosted on HP-UX v11.1 servers, and utilizes Oracle 10 database systems for data processing and storage. The Office of Technology is responsible for access controls over the HP-UX servers.

Medicaid eligibility for children in foster care is categorical. By being in foster care, a child is categorically eligible for Medicaid. No further eligibility review is required. FACTS does not adjudicate eligibility determinations. On a daily basis, FACTS sends a flat file to the MMIS with a list of newly-eligible children. On a monthly basis, FACTS sends the MMIS a file of all children eligible for the next month.

Medicaid Management Information System (MMIS) and Fiscal Agent Contract

The West Virginia MMIS and Fiscal Agent contract supports the state's \$2.5 billion a year Medicaid program with services and technology including claims processing, pharmacy point-of-sale (POS) and benefit manager (PBM) services, provider enrollment, and call centers for provider and member services. The Medicaid program provides health care benefits to just over 411,000 people annually in all 55 counties, using a network of approximately 24,000 active providers. The MMIS, known as HealthPAS, processes about 17.7 million claims per year: 9.5 million medical/dental claims and 8.2 million pharmacy claims. About 93% of claims are received electronically, of which about 53% are pharmacy claims. The Bureau's MMIS processes claims for two Home and Community Based Services (HCBS) waiver programs and several state-funded eligibility programs. It also functions as a third party administrator for other state agencies.

The MMIS and POS systems are web-enabled solutions built on a foundation of integrated public domain and COTS software products and are loosely coupled as sets of independent processes. The current system middleware layers are centered on Microsoft.NET™, COM and DCOM sets of libraries and services. The system is installed on an n-tier client/server computing platform from a variety of locations. The Fiscal Agent provides a local and wide area network to support the system, its users, and the customer interfaces. The Fiscal Agent also provides secure Internet Service Provider services for West Virginia's MMIS Web users.

The MMIS vendor sub-contracts with three vendors who operate Medicaid Eligibility Verification Systems (MEVS), a system that enables providers to verify client eligibility prior to providing Medicaid services, and provides an Automated Voice Response System (AVRS) which accesses the MEVS information. In West Virginia, MEVS is the system of record for 270/271 eligibility inquiry transactions and the AVRS. It is kept in sync with the member data in the MMIS. It is updated daily when the MMIS receives and processes the eligibility feeds from RAPIDS and FACTS.

The MMIS-Fiscal Agent vendor maintains a member and provider call center, and multiple toll-free telephone lines to receive and respond to various inquiries from members, providers, health plans, and other stakeholders. The Call Center has the ability to create call flows and allows callers to request to speak with a representative or to leverage self-service. The system has the



ability to route calls from within the call flow into call queues. The Call Center is built using the Syntellect (formally Apropos) CIM Suite and the solution is integrated with an Avaya Lucent Definity G3V6 hardware. There are AG4000 2T1 1600 MIPS PCI voice cards within the Syntellect servers that manage the call center voice integration. Current hardware utilization for this system is at 80%.

BMS is also looking into expanding its Personal Health Record initiative that began under a CMS transformation grant. A team from Shepherd University is currently conducting a pilot program called "Healthy Mountaineer" in Clay County.

BMS is in the process of re-procuring the contract for the MMIS and Fiscal Agent services. BMS is currently reviewing vendor responses and expects to make a decision by October 2011. In the interim, the current MMIS vendor, Molina, will be conducting a system "refresh" in December 2011 to bring the system into compliance with 5010 and ICD-10 standards. In addition, the MMIS vendor is in the process of developing an on-line provider enrollment portal.

BMS contracts with Automated Health Services to serve as the enrollment broker for approximately 165,000 members who receive their care through a managed care plan. The vendor is responsible for outreach (written and phone) to members already enrolled in managed care, PAAS and Mountain Health Choices, and provides training regarding managed care options. Automated Health Services also operates the state's Medicaid Hotline to handle member inquiries.

Medicaid Data Warehouse/Decision Support System (DW/DSS)

BMS is in the process of evaluating proposals from vendors to implement a DW/DSS to help the state to achieve its strategic Medicaid goals and move toward its vision of a future MITA-oriented Medicaid Enterprise. The data warehouse developed is expected to contain finalized MMIS claims data that is reconciled to payment and clinical data, as well as eligibility data, provider data, and MCO encounter and reference data, and data from other state agencies. Future enhancements of the DW/DSS may include the ability to add data from additional state agencies and potentially enable data access for additional state and external entities.

DW/DSS business capabilities are expected to provide the following benefits:

- Enhanced reporting capabilities;
- More efficient and effective performance monitoring;
- Improved data access, analysis and reporting to support decision-making;
- Ability to link outcomes and dollars for purposes such as pay-for-performance programs and what-if analyses;
- Enhanced integration with other entities to further reduce the potential for redundancy of services and payment;
- Improved access and integration of lab result data including the expanded use of clinical values as available and encounter data with reconciled claims and payment data;
- Access to appropriate data for other covered entities;
- Reports used by BMS, vendors and other state entities are run from a reconciled data store and the results are consistent;
- Reconciled MMIS claims data, eligibility data, provider data, reference data, encounter data and lab result data including the expanded use of clinical values as available are easy for BMS staff to access for program and operations management and decision-making in one place; and



- Improved tools and training for data analysis to improve healthcare decision-making.

Master Data Management (MDM) Solution

DHHR has initiated the process of procuring a Master Data Management (MDM) solution. The vision is to provide a single view of data across the breadth of the organization. Management of the Master Data includes clients, providers of services to clients, and many other business objects. In order to unite these business objects across the applications used by the Department, the business objects have to be consolidated, standardized, and cleansed. This requires one- or two-way communications between the various applications and the MDM solution. The first three systems to be tied into the MDM are intended to be RAPIDS, OSCAR, and FACTS.

2.5.4 Health Care Authority (HCA) IT Systems

Using data from Medicaid and PEIA hospital transactions, the HCA has developed CompareCareWV™, an online consumer resource for comparing hospital charges and quality indicators for common procedures, services, and diagnostic tests. The goal of CompareCareWV™ is to provide information that will help patients and their families become more involved in choosing the right hospital appropriate for their need.

West Virginia Health Information Network (WVHIN)

The WVHIN, a public-private partnership, is being developed as the state's HIE, and will enable the sharing of clinical data in the state, primarily between providers of care. This is a new capability for the state with development beginning August 15, 2011. The West Virginia HIN is charged with building a secure electronic health information system for the exchange of patient data amount physicians, hospitals, diagnostic laboratories, other care providers, and other stakeholders. Citizens will need to opt out of the program. Those that do participate will have a portal where they will be able to view their medical information as well as other capabilities. The HIN is to be web-based and the solution will be developed by Care Evolution. It will be similar to the solution they developed for the South Carolina HIN. The HIN will integrate with Microsoft's HealthVault system. At this time there does not appear to be any integration requirements with the HIX, but possibilities of the HIN being the Master Client Index for other systems, such as the HIX, as well as other possible integration opportunities have been discussed.

2.5.5 Public Employees Insurance Agency (PEIA) IT Systems

PEIA performs the processes of enrolling and billing using Benefits Administration System (BAS), a mainframe eligibility system, and payment using the state's financial management system, WVFIMS. Claims processing is outsourced to three third party administrators (TPAs) and medical management is outsourced as well. PEIA utilizes the Customer Relationship Management (CRM) system Microsoft Dynamics to support its sixty employees including, sixteen call center representatives (eight for eligibility and eight for enrollment). The CRM system provides imaging, workflow, integrated voice response (IVR) integration, screen pops, letter generation, and hot links to Express Scripts and Wells Fargo. PEIA also has a data warehouse and reporting system. The CRM system is integrated with BAS, WVFIMS, IVR and hot links to other external systems. PEIA's SQL server is housed at the state data center. PEIA uses HDMS to provide their data warehouse services.



2.5.6 West Virginia Private Sector HIX IT Environment

West Virginia's carriers and producers will be key participants in the Exchange. Some of the key characteristics of their IT environments as they pertain to the future Exchange are discussed below. Carriers and producers use an array of customer relationship management and other tools to manage and automate administrative processes.

Online Capabilities

Carriers have varying levels of existing ability to perform online functions such as member enrollment, claims review and explanations of benefits, premium payment, and provision of provider directories through member, provider, broker, and small group administrator portals. Some carriers provide members the option to complete the full spectrum of activities online, while other carriers have more limited functionality – particularly around enrollment – since a large portion of their commercial business is with employer groups. Some producers use online quoting tools such as Norvax and Quotit, and general agency services such as BenefitMall to find and compare rates between carriers.

Data Interface and Exchange

As mandated by federal law, all carriers comply with the HIPAA Electronic Data Interchange Health Care Claim Transaction sets for transmitting and handling of data, such as: the 834, which is used by employers, unions, government agencies, associations or insurance agencies to enroll members to a payer; the 837, which is used to submit health care claim billing information; the 270, which used to send an eligibility inquiry; and the 271 which is used to respond to eligibility inquiries.

Carriers all currently exchange data with various other external partners such as brokers, quality rating and health care organizations, and the federal government (for those who participate in Medicare Part C and Medicare Part D plans) using these and other standards such as Fair Information Practices for privacy and security when dealing with personally identifiable information. Carriers can handle sending and receiving both batch and real-time data.

Previous Exchange Experience

One carrier interviewed has experience exchanging data with the Utah Health Exchange for small businesses. The carrier is sent an enrollment file with member information from the Utah Health Exchange several times a day, and reconciliation files are sent several times a month. The carrier creates a member ID card for new members and sends the plan-issued member ID back to the Exchange so the systems are in sync. Changes to member enrollment and personal information are managed through the Exchange, which sends updates to the carriers.

2.6 Role of Existing State IT Assets in the Future HIX IT Environment

The state does not currently perform many of the business functions required in the future HIX environment, therefore there are a limited number of IT assets in the West Virginia HIX technology environment that may be leveraged to perform HIX functions. However, given the limited timeframe for HIX implementation and limited budget for HIX development and operations, it is important to assess the role of existing applications, systems, and technical infrastructure components in the future Exchange environment.

This section identifies the role the thirty-three state IT assets described in Table 8 above might play in the future Exchange IT environment according to the definitions provided in the table



below. The assets were evaluated for their potential to fulfill the business requirements in Table 7 and therefore close a gap between the current and future HIX environment. No IT assets exist in the current environment that meets future functionality as-is. Any IT asset identified as having a potential to be leveraged in the future HIX IT environment would require modification or enhancement to meet ACA requirements.

Table 14 in Section 3 further analyzes the level of fit for the future HIX environment for those systems identified in Table 10 as having a Potential for Leveraging.

Table 9: Definitions of Potential for Leveraging Categories

Category	Definition	# Assets Identified
Potential for Leveraging	Depending on state HIX design decisions, this system could potentially be leveraged with enhancements to perform core Exchange functions or provide core Exchange infrastructure.	10
Interface/Data Exchange	This existing system will likely be a necessary component of the future HIX IT environment through an interface or other form of data exchange with an HIX component.	9
Supporting	This is an ancillary or supporting system that should continue to or could be used to support existing and/or new business processes in the future HIX IT environment. It is not likely to require modifications.	12
None	There is no potential to leverage this IT resource in the future HIX environment.	2

Table 10: Assessment of Future Role of Existing West Virginia IT Assets

Current West Virginia HIX State IT Asset	Primary Functions	Role in Future HIX IT Environment
State Data Center Enterprise Server (State's Mainframe)	Hosts RAPIDS, OSCAR, FIMS, PEIA applications and other state systems	Potential for Leveraging
OIC Servers	Supports SQL2000, MS Exchange, document/file storage, application hosting environments, Oracle, FileNet, and applications development	Potential for Leveraging
Cisco Call Manager/Contact Center (OT)	<ul style="list-style-type: none"> - Call routing - Call treatment - Network to desktop computer telephony integration - Call center reporting 	Potential for Leveraging
RAPIDS Suite - eRAPIDS - RAFT	<ul style="list-style-type: none"> - Eligibility Determination - Benefits Issuance 	Potential for Leveraging



Current West Virginia HIX State IT Asset	Primary Functions	Role in Future HIX IT Environment
inROADS	Public-facing self-service web portal evaluates for possible eligibility, allows for on-line benefit application, renewal and checking for Medicaid, CHIP, SNAP, TANF and other state benefit programs.	Potential for Leveraging
DHHR Change Reporting and Client Services Call Center	Respond to consumer inquiries regarding eligibility and benefits.	Potential for Leveraging
Master Data Management (MDM) Solution (<i>Asset doesn't currently exist but is planned</i>)	Unite business objects across agency applications to provide a single view of data across the breadth of the organization	Potential for Leveraging
FileNet	Image system for scanning, storing, and retrieving documents.	Potential for leveraging
Consumer Assistance Program (CAP) Call Center	Respond to consumer inquiries and complaints.	Potential for leveraging
System for Electronic Rates and Forms Filing (SERFF)	Electronic filing of industry rates and forms	Potential for leveraging
CHIP On-line Eligibility Application	<ul style="list-style-type: none"> - CHIP Premium Enrollment - Data management 	Interface/Data Exchange
West Virginia Financial and Information Management System (WVFIMS)	General ledger	Interface/Data Exchange
CHIP Call Center	<ul style="list-style-type: none"> - Eligibility look-up - Member and provider support - Call tracking 	Interface/Data Exchange
FACTS	Case management	Interface/Data Exchange
Medicaid Management Information System (MMIS) and Fiscal Agent Services	<ul style="list-style-type: none"> - Claims adjudication - Member and Provider Call Center - Communications - Reporting 	Interface/Data Exchange
Managed Care Customer Support Call Center	<ul style="list-style-type: none"> - Managed care enrollment - Customer Service 	Interface/Data Exchange
Medicaid Data Warehouse and Decision Support System (DW/DSS)	Medicaid program reporting, performance monitoring and decision-making.	Interface/Data Exchange
All Payer Claims Database (Planned)	Collect and store health care claims data from multiple payers.	Interface/Data Exchange



Current West Virginia HIX State IT Asset	Primary Functions	Role in Future HIX IT Environment
WVHIN (Planned)	Collection and exchange of clinical data.	Interface/Data Exchange
Broadband	Provide access to telecommunications resources such as the Internet.	Supporting
Human Resources Information System (HRIS)	Human Resource functions (e.g., employment history, salary, tenure, personal identifiable information).	Supporting
Comparecarewv.com	Public-facing website presenting provider and hospital cost and quality information and comparison tools.	Supporting
Bewv.com	Public-facing website providing public with information about the West Virginia HIX planning process.	Supporting
State Based Systems (SBS)	Support producer and company licensing, support market regulation, and consumer services.	Supporting
Online Premium Tax For Insurance (OPTins)	Carriers can pay taxes/fees securely via online portal.	Supporting
Market Analysis Review System (MARS)	Allows for automation, documentation, and sharing of Level 1 Analysis Reviews	Supporting
I-SITE	Online interface for state insurance departments to obtain comprehensive financial, market conduct, producer licensing, and securities information; integrated with SBS.	Supporting
Market Analysis Prioritization Tool (MAPT)	Provides a quick glance of the overall market, used to determine which companies to examine more closely	Supporting
Market Conduct Annual Statement (MCAS)	Online form for insurers to submit uniform annual statement data elements to multiple states simultaneously; not used by health insurance carriers at this time.	Supporting
Health Insurance Oversight System (HIOS)	Rates and Forms validates rate changes entered into SERFF and uploads to CMS using HIOS; carriers use HIOS to submit rate increases >10% directly to CMS.	Supporting
National Insurance Producer Registry (NIPR)	Support producer license application and renewal.	Supporting



Current West Virginia HIX State IT Asset	Primary Functions	Role in Future HIX IT Environment
IVUE	Image system for scanning documents into databases.	None
PEIA IT Systems	Eligibility and Enrollment, Customer Service Call Center (Microsoft Dynamics), Benefits Management (BAS)	None

2.7 Opportunities for Leveraging in the State Procurement Environment

Section 2.6 above identified three features of the state’s current procurement environment relevant to the future HIX IT environment. These three features are listed below, with an assessment for their potential role in the future HIX IT environment.

Table 11: Role of State Procurement Environment Features

Feature of the State Procurement Environment	Description	Comments	Potential for Leveraging
Senate Bill 408	Senate Bill 408 exempts the Exchange from certain provisions of state code related to the Department of Administration’s Purchasing Division as long as the contracts are awarded on a competitive basis.	This exemption from state purchasing requirements may shorten the RFP approval process and may provide additional flexibility in the RFP contents. The Exchange Board must be in place in order for the Exchange to exercise this exemption.	Potential for Leveraging
ITECH (Office of Technology, WVOT)	Pre-Approved vendors compete for agency staffing needs based upon criteria developed by the agency and the WVOT.	This procurement tool shortens the time to procure vendors and eliminates the RFP development process for smaller IT projects. Use of this contract is mandatory for all agencies under the Governor’s jurisdiction requiring IT services above and beyond those available within state government, regardless of the dollar amount. The CTO may grant a waiver to this requirement. Depending on the procurement strategy selected by the Exchange, this contracting	Supporting



Feature of the State Procurement Environment	Description	Comments	Potential for Leveraging
		mechanism may be a useful vehicle to efficiently procure vendors for smaller HIX IT components.	
Existing Contracts	Existing contracts for vendors currently providing services or solutions that could be leveraged for the Exchange may be able to be accessed through the contract change order or amendment process.	<p>Using this approach could eliminate the need to use the RFP process to undertake certain IT development and implementation activities. However, it does present certain risks to the Exchange:</p> <ul style="list-style-type: none"> - Vendor management would be owned by another agency, which could impact OIC's ability to hold the vendor accountable to its timeline, budget and scope. - Contract terms have already been negotiated and factors such as existing rates and contract expiration date may impact the Exchange. 	Potential for Leveraging



3.0 HIX IT Gap Analysis

This section of the report identifies the technical and functional gaps in the current West Virginia IT environment, and identifies IT assets in the current environment that may be able to be leveraged to address them for the future HIX IT environment.

The Gap Analysis identifies and describes HIX IT gaps based on the information and analysis contained in the current environment report. A gap is identified by comparing the core functionality and technical requirements of the future environment to the resources and assets of the current environment (see Table 10). A gap results when no or partial functionality or technology exists in the current environment to meet the needs of the future environment.

No IT assets exist in the current West Virginia IT environment that meet ACA requirements as-is. Therefore, all ACA-required functionality and technology represent gaps in the current West Virginia IT environment. However, some of them may be “partial gaps” as some IT assets do exist in the current environment that have the potential to be leveraged to at least partially address the gaps.

This Gap Analysis groups gaps into two categories: Technical and Functional Gaps. Technical Gaps are gaps in the IT hardware and software required for the Exchange, and Functional Gaps are gaps in required system functionality to meet business needs. The report identified eleven Technical Gaps and twelve Functional Gaps. The HIX IT Gaps identified are summarized in the table below and further described and assessed in the following two sub-sections. All Gaps identified are “critical” gaps that must be addressed by the HIX system design and resolved prior to system implementation.

Table 12: List of Technical Gaps

ID #	Technical Gap
T-GAP-1	Server Infrastructure
T-GAP-2	Call Center & Customer Relationship Management (including efficient distribution and management of requests across phone, web, paper and face-to-face)
T-GAP-3	Internet Web site
T-GAP-4	Business Rules Engine
T-GAP-5	Correspondence and Notifications
T-GAP-6	Interface with Federal Data Hub
T-GAP-7	Interfaces with Existing Systems
T-GAP-8	Business Intelligence & Reporting
T-GAP-9	Document Management System
T-GAP-10	Security (Logical and Physical)
T-GAP-11	Unique Identifier



Table 13: List of Functional Gaps

ID #	Functional Gap
F-GAP-1	Determine eligibility for exemption from the individual responsibility requirement
F-GAP-2	Single streamlined application for QHPs, advance payments of the premium tax credit, cost-sharing reductions, and Medicaid, CHIP or the BHP where applicable.
F-GAP-3	Eligibility determinations for advance premium tax credits, cost-sharing reductions, and other applicable state health subsidy programs such as Medicaid and CHIP.
F-GAP-4	Enrollment of qualified individuals into QHPs
F-GAP-5	Seamless eligibility and enrollment process with Medicaid and other state health subsidy programs (Shared Eligibility Service)
F-GAP-6	Exchange calculator (premium and subsidy)
F-GAP-7	Appeals of individual eligibility
F-GAP-8	Plan Management
F-GAP-9	Risk Adjustment
F-GAP-10	Provide standardized comparative information on each available QHP (Carrier Menu)
F-GAP-11	SHOP
F-GAP-12	Financial Management System

Both functional and technical gaps can be addressed in several ways:

- Buying new COTS products and using as-is or customizing;
- Building new products from scratch;
- Transferring re-usable IT assets from other environments;
- Sharing IT assets and services through partnerships with other states or the federal government;
- Outsourcing; and
- Leveraging existing assets through modifications or enhancements.

Federal guidance recommends HIX IT approaches that promote program and inter-agency coordination, reduce redundancy, promote efficiency, and are cost-effective. Moreover, cost, resources and time are real constraints for the Exchange. Leveraging existing systems is one approach to address these federal recommendations and state constraints.

The following two tables, one for Technical Gaps and one for Functional Gaps compare the nine existing IT assets identified in Table 10 (Table 10 contains ten, including the Master Data Management (MDM) solution, however the MDM is not included in the Gap Analysis as it is in the planning phase) against the IT gaps listed in Tables 12 and 13 above and assess their “level of fit” to address each gap. Definitions of level of fit categories are provided in the table below.



Table 14: Level of Fit Definitions

Category	Definition
High 	Good potential to address an IT gap in the future Exchange environment.
Moderate 	Moderate potential to address an IT gap in the future Exchange environment.
Low 	Poor potential to address an IT gap in the future Exchange environment.

The “Findings” column provides a summary of the rationale for the level of fit determination.

It is assumed that all of the existing IT assets identified as having a potential to be leveraged for the future Exchange IT environment would require modification and/or enhancement in order to meet ACA requirements. Moreover, it is assumed that the vendor community will ultimately determine the level of fit of the state’s current IT assets and the technical feasibility of re-using them and/or integrating them into the future Exchange environment in their responses to the state’s RFP.

A constraint related to the Gap Analysis is that we have not sampled system users to determine how well existing functionality is meeting current business needs, including system performance. In addition, since we do not have projections of expected future system users, we cannot accurately determine if the current capacity of existing systems is adequate to meet future business needs.



Table 15: Assessment of Technical Gaps

ID #	Technical Gap	State Mainframe	OIC Servers	OT Cisco Call Center	OIC Call Center	DHHR Call Centers	RAPIDS	InROADS	FileNet	SERFF	Findings
T-GAP-1	Server Infrastructure	Low 	Low 								<p>The mainframe environment could be leveraged to build out the new business rules engine for eligibility determination as it is new as of 2010 and has capacity. However, although it is technically feasible to do so and meet ACA requirements, this approach does not result in the most flexible environment for simple modification of business rules. It is more likely that the mainframe environment will be integrated into the future Exchange environment in order for the Exchange to integrate and/or interface with RAPIDS, depending on the design approach selected.</p> <p>OIC hardware is six to ten years old and was not originally bought or developed to support the projected number of users expected to utilize Exchange IT systems.</p> <p>The Exchange and its scale will require robust hardware that is selected based on its ability to support the scale and type of functionality required by the exchange.</p>



ID #	Technical Gap	State Mainframe	OIC Servers	OT Cisco Call Center	OIC Call Center	DHHR Call Centers	RAPIDS	InROADS	FileNet	SERFF	Findings
T-GAP-2	Call Center & Customer Relationship Management (including efficient distribution and management of requests across phone, web, paper and face-to-face)			High 	Low 	Mod. 					<p>From a business perspective, the OIC Call Center presents an opportunity for leveraging because it already handles incoming consumer calls to the OIC related to health insurance. However, it is integrated with consumer services for other insurance lines, and is small. From a technology perspective, it does not use modern Call Center and CRM hardware and software for call tracking, routing, reporting and logging.</p> <p>The DHHR Call Centers (3 total) offer an opportunity for leveraging. In particular, the Charleston Change Reporting Center has effectively migrated to the state's Cisco hardware and software. The DHHR Call Centers use RAPIDS.</p> <p>OT has invested in a Cisco Contact Manager call center solution that provides call tracking, call routing and call logging functionality to state agencies. This may be a very cost-effective and time-efficient component of the Exchange's Call Center design approach, depending on the nature of the Exchange Call Center specifications to be developed.</p> <p>An approach to integrate the business of these existing call centers will need to be factored into the Exchange Call Center design to ensure a high-level of customer service to the public regardless of the "door" they enter through.</p>



ID #	Technical Gap	State Mainframe	OIC Servers	OT Cisco Call Center	OIC Call Center	DHHR Call Centers	RAPIDS	InROADS	FileNet	SERFF	Findings
T-GAP-3	Internet Web site							Mod. 			<p>DHHR's inROADS self-service benefits application portal may be leveraged if the state opts to leverage the RAPIDS platform. It currently performs eligibility screening for Medicaid, CHIP and other human services programs based on a single set of data elements entered by the user, and exchanges data with RAPIDS. It also has other functionality that the Exchange web portal will need such as consumer benefits management.</p> <p>OIC's bewv.com website is for posting information to the public. There is no functionality or technology to be leveraged. The URL may be used for the Exchange web portal.</p> <p>In addition, the state can utilize the application screen templates being developed by the UX2014 project.</p> <p>New web portal technology and functionality will be required, even if existing West Virginia assets can be leveraged.</p>
T-GAP-4	Business Rules Engine						Low 				<p>As described in T-GAP-1 above, it is feasible that the existing RAPIDS mainframe eligibility system could be leveraged to develop a new ACA-compliant business rules engine (BRE), but it is not the most technically strong approach to BRE development.</p>



ID #	Technical Gap	State Mainframe	OIC Servers	OT Cisco Call Center	OIC Call Center	DHHR Call Centers	RAPIDS	InROADS	FileNet	SERFF	Findings
T-GAP-5	Correspondence and Notifications						Mod. 				RAPIDS produces numerous standard notices and letters, and has recently purchased the Adobe LiveCycle product as a foundation for reengineering their current client notices. This functionality could potentially be leveraged in the future Exchange environment if RAPIDS is used to build out the Exchange.
T-GAP-6	Interface with Federal Data Hub										The federal data hub is a new system; new technology needs to be developed or procured to interface with it.
T-GAP-7	Interfaces with Existing Systems						Mod. 				<p>RAPIDS supports 27 interfaces with external state and federal systems for data exchange. These interfaces can be leveraged if RAPIDS is leveraged for the build out of the Exchange.</p> <p>In addition, new data sources will need to be incorporated, some interfaces/integration with existing sources/systems will need to be upgraded to “real time”, and some data exchanges may need to be modified to meet ACA-required transaction and security standards.</p> <p>New interfaces will also be needed to exchange data with other federal and state agencies and private entities in order to meet ACA requirements.</p>



ID #	Technical Gap	State Mainframe	OIC Servers	OT Cisco Call Center	OIC Call Center	DHHR Call Centers	RAPIDS	InROADS	FileNet	SERFF	Findings
T-GAP-8	Business Intelligence & Reporting						Mod. 				<p>RAFT is the Cognos internal reporting repository and Data Warehouse associated with RAPIDS. If the state opted to build the Exchange out on RAPIDS, this functionality could be leveraged to become the Data Warehouse for the Exchange.</p> <p>Additional reports and data exchanges would need to be developed in order to meet ACA reporting requirements.</p>
T-GAP-9	Document Management System						Mod. 		Mod. 		<p>OIC maintains FileNet, an image system for scanning, storing, and retrieving documents. Because OIC manages the application's code, it has potential to be leveraged to support the Exchange.</p> <p>RAPIDS also contains document management capabilities to handle eligibility verification documentation if RAPIDS is leveraged for the build out of the Exchange.</p>



ID #	Technical Gap	State Mainframe	OIC Servers	OT Cisco Call Center	OIC Call Center	DHHR Call Centers	RAPIDS	InROADS	FileNet	SERFF	Findings
T-GAP-10	Security (Logical and Physical)						Low 	Mod. 			<p>Since most of the eligibility determination functionality will likely be new (Business Rules Engine) even if RAPIDS is leveraged as the Exchange platform, there is probably little of the security features that are able to be leveraged for the future Exchange environment. If inROADS is leveraged as part of the Exchange build out, some components of the security for this existing consumer-facing system may be able to be leveraged however, based on federal regulations, we anticipate there will be a significant gap in the future environment.</p> <p>All application architecture is required to be compliant with the State of West Virginia's Information Security Policies and Procedures.</p>
T-GAP-11	Unique Identifier										<p>This is not a mandated component of the Exchange, but a highly recommended component to manage consumer information across multiple systems and entities. DHHR is planning to procure a Master Data Management (MDM) solution. Further discussion with DHHR about the status of this system development procurement is necessary in order to determine whether or not it can be leveraged for the Exchange.</p>



Table 16: Assessment of Functional Gaps

ID #	Functional Gap	State Mainframe	OIC Servers	OT Cisco Call Center	OIC Call Center	DHHR Call Centers	RAPIDS	InROADS	FileNet	SERFF	Findings
F-GAP-1	Determine eligibility for exemption from the individual responsibility requirement						Low 				The new business rules engine could potentially be developed to include the eligibility rules for the individual responsibility requirement exemption, but no IT assets exist in the current environment to address this required business function. RAPIDS' existing mainframe business rules engine could not be leveraged for this business function as it is not ACA-compliant.
F-GAP-2	Single streamlined application for QHPs, advance payments of the premium tax credit, cost-sharing reductions, and Medicaid, CHIP, or the BHP where applicable.										The application screen templates that result from the Enroll UX 2014 project could be leveraged by any vendor. Even though West Virginia currently has a combined Medicaid and CHIP application, the federal government is designing a new single streamlined application for all insurance subsidy programs – the Exchange, Medicaid and CHIP. The UX2014 project is the web version of the required federal single application. The federal government is working on the paper version.
F-GAP-3	Eligibility determinations for advance premium tax credits, cost-sharing reductions, and other applicable state health subsidy programs such as Medicaid and CHIP.						Low 				RAPIDS' existing mainframe business rules engine could not be leveraged for this business function as it is not ACA-compliant. Eligibility will need to be determined in “real time” through the Exchange portal using an ACA-compliant business rules engine. This is a shift from the current RAPIDS process that leverages COBOL-based protocols on the mainframe. Some existing RAPIDS databases may be able to be



ID #	Functional Gap	State Mainframe	OIC Servers	OT Cisco Call Center	OIC Call Center	DHHR Call Centers	RAPIDS	InROADS	FileNet	SERFF	Findings
											leveraged for the Exchange eligibility determination, and the mainframe could be used to develop the new business rules engine, however, that is not a technically-strong approach.
F-GAP-4	Enrollment of qualified individuals into QHPs										There is no existing functionality in the state's current IT environment that could be leveraged to address this HIX business requirement. Some components from other states may be able to be leveraged, but further investigation is necessary.
F-GAP-5	Seamless eligibility and enrollment process with Medicaid and other state health subsidy programs						Low 				While RAPIDS is an integrated eligibility system that allows for eligibility determinations to be made for multiple programs based on a single input of eligibility data, it does not currently include an ACA-compliant business rules engine to determine eligibility for the new insurance affordability subsidies or plan enrollment functionality.
F-GAP-6	Exchange calculator (premium and subsidy)										There is no existing functionality in the state's current IT environment that could be leveraged to address this HIX business requirement. Some components from other states may be able to be leveraged, but further investigation is necessary.



ID #	Functional Gap	State Mainframe	OIC Servers	OT Cisco Call Center	OIC Call Center	DHHR Call Centers	RAPIDS	InROADS	FileNet	SERFF	Findings
F-GAP-7	Appeals of individual eligibility										There is no existing functionality in the state's current IT environment that could be leveraged to address this HIX business requirement. Some components from other states may be able to be leveraged, but further investigation is necessary.
F-GAP-8	Plan Management									High 	<p>SERFF currently fulfills several ACA requirements for plan certification, recertification, decertification; plan monitoring and review; plan selection; plan submission; and rate review. NAIC has indicated SERFF may be enhanced to meet other ACA plan management requirements that are not currently supported. SERFF is a mature system that has been used by insurers and state regulators for approximately 15 years. It is considered sustainable as it is supported by NAIC and likely to be utilized by several states.</p> <p>Using SERFF capitalizes on existing process and information flows between carriers and the OIC and maximizes system integration and use of shared resources. SERFF also has an existing Application Programming Interface (API) which can serve as the central component for SERFF/Exchange data exchange and integration. NAIC expects the cost to states to range between \$30,000 – \$40,000 (depending on the number of states participating), although additional costs may be incurred for state-specific customizations.</p>



ID #	Functional Gap	State Mainframe	OIC Servers	OT Cisco Call Center	OIC Call Center	DHHR Call Centers	RAPIDS	InROADS	FileNet	SERFF	Findings
											<p>NAIC expects to have modifications and supporting documentation ready by mid-2012 to prepare states for HHS approval by January 2013. West Virginia has an existing service agreement with NAIC for using SERFF; when changes were recently required due to ACA non-Exchange related requirements, the OIC was able to revise the service agreement since NAIC was considered a sole source vendor.</p> <p>Risks include the potential that SERFF is unable to accommodate West Virginia-specific needs, or the costs to accommodate those needs are high. In addition, using SERFF provides West Virginia less control over changes and timelines since major revisions or enhancement to SERFF are managed through the SERFF Consortium, a group of several states and companies. Another potential drawback is that the ACA Plan Management requirements will necessitate functionality beyond that which than SERFF can provide, so additional plan management functionality will need to be procured and integrated with SERFF and other Exchange IT systems and applications.</p>



ID #	Functional Gap	State Mainframe	OIC Servers	OT Cisco Call Center	OIC Call Center	DHHR Call Centers	RAPIDS	InROADS	FileNet	SERFF	Findings
F-GAP-9	Risk Adjustment										West Virginia has a legislative mandate to develop an All Payer Claims Database (APCD). Claims data collected from issuers could be used in a post-claim formula for risk adjustment. Depending on the development timeline, the APCD could provide some of the data the state will need to perform Exchange risk management functions. No IT systems exist to support risk analysis.
F-GAP-10	Provide standardized comparative information on each available QHP (Carrier Menu)										There is no existing functionality in the state's current IT environment that could be leveraged to address this HIX business requirement. Provision of this business function will require a business rule engine. Some components from other states or relationships with private exchanges may be able to be leveraged, but further investigation is necessary.
F-GAP-11	SHOP										There is no existing functionality in the state's current IT environment that meets this HIX business requirement. Some components from other states or relationships with private exchanges may be able to be leveraged, but further investigation is necessary. The state needs to decide if it wants to create two separate Exchanges, one Individual and one SHOP, or combine their functions in a single Exchange. The new eligibility business rules engine may be able to be utilized to perform some of the required SHOP eligibility functions.



ID #	Functional Gap	State Mainframe	OIC Servers	OT Cisco Call Center	OIC Call Center	DHHR Call Centers	RAPIDS	InROADS	FileNet	SERFF	Findings
F-GAP-12	Financial Management System										<p>The SHOP Exchange will require a Financial Management module for billing, collections and distribution of premiums to issuers. The Individual and SHOP Exchanges will both need to interface with the state's financial system WVFIMS to report transactions involving state funds, but this system does not contain the functionality such as Accounts Receivable, to address this Gap.</p>

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4.0 Strategic IT Issues

This section of the plan summarizes and prioritizes strategic IT issues developed throughout the strategic planning effort in collaboration with internal and external stakeholders.

For the purposes of the IT Strategic Plan, a strategic IT issue is defined as an open/unresolved decision, concern, requirement (i.e., regulation), gap or other factor that has a significant impact on the IT environment of the Exchange. The purpose of the list of strategic IT issues is to identify and prioritize IT issues that need to be addressed as part of the IT Strategic Plan.

4.1 Work Performed

Based on the information gained through the current environment assessment and gap analysis, reviews of background documentation, and research on other states' Exchange initiatives, a list of strategic issues related to the Exchange technology environment was developed.

The strategic IT issues list was reviewed in work sessions for confirmation and to provide the opportunity for stakeholder feedback and refinement of the issues list. Thirty-nine individuals representing 25 entities from state government and the private sector, as listed in Table 17 below, attended the work sessions. A complete list of the work session participants is contained in Appendix B.

Table 17: Entities Represented in Strategic IT Issues Work Sessions

Name of Entity	
The Arnold Agency	Independent Insurance Agents of WV
BerryDunn	Molina (Medicaid MMIS)
Children's Health Insurance Program (CHIP)	Office of Technology
City Insurance Pro	OIC – Consumer Services
Coventry & NAHU	OIC – Finance
Deacon & Deacon Insurance Agency	OIC – Health Policy
Deloitte (RAPIDS)	OIC – IT
Delta Dental	OIC – Licensing
DHHR – OT	OIC – Market Conduct
DHHR/BCF RAPIDS	The Health Plan
GO HELP	WesBanco Insurance Services
Health Care Authority	WV School of Osteopathic Medicine
Highmark	

Six work sessions were conducted, one for each of the six business areas (Customer Service and Communications were combined into one meeting) listed in Table 18.



Table 18: Exchange Business Areas

Business Area	Primary HIX Functions	Business Area	Primary HIX Functions
Eligibility & Enrollment	Determine eligibility for exemption from the individual responsibility requirement	Customer Service	Call center
	Single streamlined application for QHPs, advance payments of the premium tax credit, cost-sharing reductions, and Medicaid, CHIP or the BHP where applicable.		Internet Web site
	Eligibility determinations for advance premium tax credits, cost-sharing reductions, and other applicable state health subsidy programs such as Medicaid and CHIP.		Manage responses to information requests and requests for services
	Enrollment of qualified individuals into QHPs		Efficient distribution/management of requests across phone, web, paper and face-to-face
	Seamless eligibility and enrollment process with Medicaid and other state health subsidy programs		Provide standardized comparative information on each available QHP (Carrier Menu)
	Exchange calculator (premium and subsidy)		Preparation and distribution of applications and notices
	Appeals of individual eligibility		Consumer Assistance including the Navigator program
	Tools to allow for the filing an application via an Internet portal; by telephone through a call center; by mail; and in person	Communications	Outreach and education
			Content and Messaging
Plan Management	Plan certification, recertification, and decertification	Oversight	Oversight and financial integrity, Exchange oversight of management and operations
	Plan monitoring and review		Quality activities.
	Plan quality rating	SHOP	Manage employer eligibility and enrollment in a SHOP Exchange
Financial Management	Plan assessment, reinsurance, risk adjustment, and risk corridors		Manage employee eligibility determination and enrollment in QHP through the SHOP
Reconciliation of reductions in enrollee out-of-pocket costs	Premium aggregator		
	Determination of issuer credits		

4.2 Prioritized List of Strategic IT Issues

This list of 44 strategic IT issues was reviewed and discussed in the “prioritization work session” that included Office of the Insurance Commissioner (OIC) Health Policy staff. As a result of this work session, the strategic issues were prioritized to provide high-level guidance from the OIC’s perspective about when each issue should be addressed. The team used the definitions in Table 19 below to prioritize the issues. The table also shows the number of issues assigned to each priority level.



Table 19: Definitions of Priority Levels

Priority	Definition	# Issues Identified
CRITICAL	Issue must be resolved prior to issuing RFP(s) for Exchange IT systems.	25
HIGH	Issue must be resolved prior to request for HHS certification of the Exchange.	4
MEDIUM	Issue must be resolved prior to Exchange Go-live.	9
LOW	Issue can be resolved after Exchange Go-live.	4
N/A	Issue not prioritized as the resolution is outside of OIC control.	2

The resulting list of strategic issues, documented and grouped according to priority level below, assisted in the development of strategic IT initiatives. For additional supporting details about each issue, including comments and business areas it impacts, please see Appendix D.

Table 20: Prioritized List of Strategic IT Issues

ID#	Strategic IT Issue Description
1	A plan for how the HIX will seamlessly coordinate with the state's existing Eligibility and Enrollment systems and what existing functionality can be leveraged has not been developed.
2	A decision on what entity will be responsible for enrollment of Medicaid and CHIP members has not been made.
5	From an IT planning perspective, the Exchange needs to estimate how many people will be entering the Exchange through the phone/call center.
7	Consumers may be uncomfortable with the amount of personal information accessible through the HIX. The technical design of the HIX must include a strong focus on security and compliance with federal regulations related to the security/privacy concerns for consumers.
10	Eligibility and enrollment systems will need to distinguish "newly eligible" Medicaid enrollees (i.e., "the MAGI population") from those who are new to Medicaid but would have been eligible under the existing rules for the purposes of determining the appropriate federal match rate.
11	HIX systems need to support paper, in-person, telephonic, and Internet eligibility and enrollment functions, for example document management.
12	A premium tax credit and cost-sharing subsidy calculator doesn't exist in the current environment and will need to be developed for the HIX.
13	A process for capturing data from carriers and creating standardized comparative information on each available QHP (i.e., a carrier menu) for display to consumers needs to be developed.



ID#	Strategic IT Issue Description
16	Eligibility and enrollment systems need to support households whose members are eligible for different plans/programs.
17	Consumers will move between subsidy programs and on and off subsidies; system will need to be designed to manage this "churn" and make movement between programs seamless and ensure continuity of benefits.
18	The HIX must coordinate customer service activities of agents, CHIP, Medicaid, and QHPs and assure efficient distribution/management of consumer inquiries/requests and responses/outcomes via phone, web, paper and face-to-face interactions.
21	Can existing rates and forms software used by the state (e.g., SERFF/SBS) be modified to support QHP certification/recertification/decertification and ongoing compliance?
23	Can existing rate and forms software be used to manage and distribute new rate/benefit information that is required to be sent to the HIX, OIC, and HHS from carriers?
24	To remain certified, QHPs must make available a range of data to the public, HIX, OIC, etc. What HIX systems will collect this information and make it available to the consumer?
25	The HIX must be able to monitor QHP marketing practices, e.g., issuers can't discourage unhealthy members from enrolling.
26	A plan for establishing, monitoring and enforcing provider network adequacy standards for QHP certification, including making the network information available to the consumer, will need to be developed.
29	A plan for business processes and IT systems needed to support the state's risk adjustment program needs to be developed.
30	A plan for how the All Payer Claims Database (APCD) will be created and utilized for the HIX has not been developed.
31	The state will need to decide if one HIX portal will serve the individual and small business (SHOP) markets or whether two portals will be used.
32	A plan for how data (including employer EIN, employee names and SSN) exchange will occur between the HIX and small employers needs to be developed.
33	A plan for how the SHOP HIX will manage premium collection, aggregation, and transmission needs to be developed.
37	A plan for the federal HIX, including components that may be available as part of a state partnership model, has not been developed.
38	Will the HIX do any premium aggregation in the individual Exchange and/or allow individuals to pay their QHP premiums through the HIX?
41	The HIX must create a system to identify and track consumers across systems and associate their data with them.
44	Will the Exchange need to have a financial component that is potentially outsourced or will the State Treasury be able to accommodate all Exchange financial functions?



ID#	Strategic IT Issue Description
3	The Exchange will be trying to reach a population that has limited experience with IT and with the health care system.
6	An IT system/process for handling exemption from the individual mandate responsibility requirement needs to be developed.
22	Issuers of QHPs must be accredited; what HIX systems will be needed to support the accrediting process?
28	Current IT environment does not support quality data collection and assessment of QHP issuer quality improvement strategies.
4	From an IT planning perspective, the Exchange needs to estimate how many people will be entering the Exchange through the website, paper, and in person.
8	The Exchange will need to consider what consumer information will be allowed to be viewed by different parties based on user access rules and the emphasis on "no wrong door".
9	Existing state systems currently do not support appeals processes for determining eligibility for insurance affordability subsidies and QHP enrollment.
14	Preparation and distribution of applications and notices needs to be coordinated with carriers, the HIX, Medicaid and CHIP, including the existing IT systems that currently support such functionality.
34	A plan for how access to the HIX will be provided to rural areas with limited access to broadband or to populations unable to afford broadband connectivity has not been developed.
39	How will the fees the Exchange assesses on participating carriers for HIX operations be collected?
40	How will the grants to the Navigators be processed?
42	HIX must allow for the pairing of QHPs and QDPs (Qualified Dental Plans) as per the ACA provision that requires the HIX to allow the selection of a stand-alone dental carrier in the exchange to provide just the essential pediatric oral services separate from the other benefits in the EXBP (Essential Health Benefits Package).
43	When QDP and QHP are selected in tandem as provided under the ACA, HIX must calculate and allocate federal subsidies (when eligible) between the two carriers selected, and also calculate and route the balance owed by the Plan enrollee making such selection.
15	Cost of paper mailings is high. Electronic delivery of required notices to a consumer's HIX account would be more cost effective. Can the state offer an opt-in option to consumers for paper mailings?
19	The HIX must determine what types of organizations it will allow to be "Navigators", what the licensing criteria will be, if existing IT systems can be leveraged to support the licensing process (NIPR, PDB, SBS), and what IT systems will be needed to support the role of the Navigator.



ID#	Strategic IT Issue Description
20	Will the Exchange compensate producers and Navigators? If so, how will the payments be made?
27	A plan needs to be developed for the Exchange to monitor brokers and Navigators.
35	The Exchange Board and executive sponsorship for the HIX is not in place.
36	The HIX must be operational by the fall of 2013, leaving approximately 24 months to hire a software vendor, design the system, develop the system, test the system, train state staff, and roll-out into production.

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5.0 Early Innovator States Research

This section of the plan summarizes the research conducted on the status of and lessons learned from other states' HIX planning and implementation.

5.1 Introduction

Through document review and telephone interviews, research was conducted on the five remaining Early Innovator grantees to learn how those states that are farthest along with their Exchange planning are addressing IT issues and gaps, and identify lessons learned and opportunities for collaboration. Profiles of New York, Oregon, the UMass Consortium, Wisconsin and Maryland are included below. The questionnaire that was used to guide the interviews is contained in Appendix E.

As of the Final Draft of this report, New York and Maryland have issued RFPs for core Exchange IT software and hardware, Oregon has procured a software and hardware vendor through a sole source and plans to issue an RFP for a systems integrator, Wisconsin competitively procured a vendor to enhance its eligibility system and is planning a separate procurement for the rest of the core Exchange IT components, and Massachusetts has not issued procurement documents for Exchange IT. New York, Maryland, and Oregon plan to issue separate RFPs for their Call Centers.

5.2 Early Innovator Profile: New York Department of Health

State	New York
Lead Agency(ies)	<ul style="list-style-type: none"> • Department of Insurance (received Planning Grant) • Department of Health – State Medicaid Agency (received \$27,431,432 Early Innovator Grant)
HIX IT Approach & Status	<p>State-operated, combination of leverage and build new components</p> <ul style="list-style-type: none"> • Build onto eMedNY, the state's Medicaid Management Information System (MMIS) • Individual and SHOP Exchanges expected to be integrated • PMO running Joint Application Development (JAD) sessions on six core Exchange functional areas • Conducted initial requirements gathering; selected vendor will do validation
IT Assets being Leveraged	<ul style="list-style-type: none"> • eMedNY, the state's Medicaid Management Information System (MMIS) • Plans to use NAIC's SERFF for Plan Management • Participant in Enroll UX2014
Planning & Governance Approach	<ul style="list-style-type: none"> • No Exchange legislation in place • Governor's Office is serving in coordination role
IT Procurement	<ul style="list-style-type: none"> • RFP for solution developer and all hardware and software issued July



Approach & Status	15, 2011. Proposals received and under review <ul style="list-style-type: none"> • Anticipating bids for Quality Assurance and Project Management Services in early November.
Cost and Funding Approach	<ul style="list-style-type: none"> • Early Innovator Grant • Level One Grant, Level Two Grant (planned) • 90/10 Match for Medicaid share
Staffing	<ul style="list-style-type: none"> • Estimating +/- 82 FTEs for fully-operational Exchange
Opportunities for Collaboration	NY expects to produce Exchange IT components fully extensible and scalable to any other jurisdiction.

HIX IT Approach

New York plans to use its Early Innovator grant to build products for the Exchange using its eMedNY MMIS to serve all New York health insurance purchasers. The MMIS processes payments for approximately one third of the state’s health care dollars and is the main source of Medicaid data for financial reporting, program analysis, auditing, and quality measurement. The state expects to produce Exchange IT components fully extensible and scalable to any other state.

New York decided to build the Exchange off its MMIS rather than its Welfare Management System (WMS) eligibility system based on the technology used in each of the systems. WMS is an older system that the state eventually wants to replace. Although mainframe-based, EMedNY allows the state to start-up quickly, as it already has some advanced MMIS components that are SOA-based and enterprise service-based. The specific build-out approach and plan will depend on the vendor selected.

In addition to leveraging the state’s MMIS, New York expects to use NAIC’s SERFF system for plan management, and the Enroll UX2014 project for the subsidy application user interface. Most of the non-Medicaid social service eligibility determination functions performed by the WMS will be integrated later.

New York, encouraged by the primary role the DOH is playing, sees the exchange functionality tightly integrated with Medicaid. Eligibility and enrollment has been and is expected to continue to be the primary focus of the Exchange IT. They have not yet decided how call center functionality will be handled. The current model is that local districts do a lot of eligibility determination, but New York is centralizing, and is building an enrollment center. There is a chance that this initiative could be leveraged to become the call center. New York anticipates using the federal data hub but does not expect to sign on for any of the currently offered federal-state partnership models. The state expects to continue to have to do some of their own verification.

With respect to plan management, the state is hoping to be able to use SERFF, with insurers filing material for QHP into SERFF. The entity responsible for qualifying plans will be able to see the filings and decide if a plan is qualified, assuming SERFF would have all the data the Exchange would need. SERFF would interface with the Exchange so that QHP data would be



available for viewing by the consumer. In the areas of financial management, communication and oversight the state still has major decisions to make and is awaiting further federal guidance.

Although not yet final policy, the SHOP functionality will probably be integrated with the individual exchange.

Planning and Governance Approach

New York does not have Exchange legislation in place. In the absence of a legislatively-designated governance structure, the Governor's Office has taken on a coordinating role. Currently, the primary coordination is occurring between the Department of Insurance and the Department of Health.

Three main public partners are working together to plan and develop the Exchange:

- Department of Insurance (DOI); applied for and received the \$1 million planning grant;
- Department of Health (DOH); runs the state's MMIS (eMedNY) and the Medicaid program; applied for and received the Early Innovator grant; and
- Office of Temporary and Disability Assistance; houses the Welfare Management System (WMS), which is used for eligibility determination.

The DOH now has a project management office (PMO) running joint application design sessions on the six core functional areas of the exchange.

The Department of Insurance has been primarily responsible for external coordination under the planning grant, working with a variety of stakeholders.

IT Procurement Approach and Status

State staff originally thought they could leverage their existing MMIS fiscal agent contract for the Exchange build-out, but the legislature mandated a competitive bid for the project. The [RFP](#) is currently out. New York decided against bidding system components separately, but bidders can use subcontractors or propose plans to re-use existing components. The state is currently also evaluating responses from bidders for an integrated quality assurance and project management services.

Cost and Funding Approach

The state has a \$10.7 million Level One grant, and expects to supplement grant funds with 90/10 match for the Medicaid portion of the system. They are not yet eligible to apply for a Level Two grant because they do not have an established governance structure.

The state is working with Wakely Consulting to develop cost projections for ongoing exchange operations. The ongoing funding source for the Exchange has not been determined. An assessment on the premium is the most likely option, supplemented by federal support for the allocable Medicaid portion.

Staffing

New York has a number of staff spread among different offices, funded under different grants and did not have an aggregate number available to share. Wakely Consulting developed an operations plan for the Exchange, once it is functional. They expect that 82 FTEs will be



needed, assuming that the governance structure that is ultimately adopted is similar to that being discussed in the legislature. In addition, the Quality Assurance and Project Management RFP requires 4 FTEs, with a state option for an additional 8 FTEs for the four-year duration of the contract.

Risks Identified

New York feels it is basically on track with its expected timeline, although there are significant risks to accomplishing its goals in a timely manner. The PMO is following CMS’ recommended system development life cycle approach. The Early Innovator grant requires New York to have regular meetings with CMS, each with specific deadlines that have thus far been met.

Key risks identified to date include:

- Compressed design, development and implementation timeframes;
- No governance structure in place;
- Lack of adequate guidance from CMS;
- Limited subject matter expertise;
- Specific technical issues, including the lack of an authentication mechanism, no decisions on the platform the state will use and concerns about the federal data hub; and
- A vendor different from the current fiscal agent means that solutions may not integrate as closely as originally presumed.

Suggestions/Implications for West Virginia

- Consider using SERFF for plan management.
- In theory states should be able to share business rules engines.
- New York is involved in Enroll UX 2014 and recommends that West Virginia consider using/customizing the user interface developed as part of that project. New York believes it will be generic enough for any state to use and that the group is making good progress.

5.3 Early Innovator Profile: Oregon Health Authority

State	Oregon
Lead Agency(ies)	<ul style="list-style-type: none"> • Exchange Corporation • Oregon Health Authority (OHA) • Insurance Division • Department of Human Services
HIX IT Approach & Status	<ul style="list-style-type: none"> • Buying COTS modules and customizing • Not using legacy eligibility system • Integrated eligibility determination system
IT Assets being Leveraged	<ul style="list-style-type: none"> • Plan to build on current insurance system for plan management • Participant in Enroll UX2014
Planning & Governance Approach	<ul style="list-style-type: none"> • Oregon passed legislation creating the Oregon Health Insurance Exchange Corporation
IT	<ul style="list-style-type: none"> • Oregon issued RFP and selected Oracle to develop the non-financial



Procurement Approach & Status	<ul style="list-style-type: none"> components of the software Integrator RFP planned
Cost and Funding Approach	<ul style="list-style-type: none"> Development funding a combination of grants, enhanced match Maintenance funding will be from fees on insurers and state programs ranging from 3-5% of the premium for each enrollee
Staffing	<ul style="list-style-type: none"> 21 staff now at Exchange Corporation; expected to double Additional staff at OHA and contractors
Opportunities for Collaboration	<ul style="list-style-type: none"> “Single brain” integrated eligibility system Use of COTS products UX2014

HIX IT Approach

Oregon is using commercially available, off-the-shelf software to create the Exchange. The Exchange Early Information Technology Innovation Grant is intended to help Oregon create a modular, reusable IT solution that will provide the Exchange’s customers with seamless access to information, financial assistance and easy health insurance enrollment, with no gaps in coverage for anyone with income up to 400% of the federal poverty level.

Oregon chose not to use its existing legacy Medicaid eligibility system, opting for a single interface for various programs, all supported by a “single brain”. An integrated system, rather than the current systems which are “cobbled” together, will be available for determining eligibility for health insurance and other social service programs such as TANF and SNAP. However, eligibility determination for other social service programs will not go through the Exchange.

Oracle, with whom the state had no previous relationship, will be doing state-specific configuration on the COTS products on the Oracle “cloud”. The state will leverage existing hardware. They plan to use an enterprise solution, partnering with social services, which was already underway when their innovator grant was submitted.

Oregon is participating in Enroll UX 2014 to develop its public interface.

Oregon plans to have the Insurance Division coordinate all plan information, including information the Division does not currently collect. The state thinks it has a solid system upon which to build and does not want to require carriers to send duplicative information to the Insurance Division and the Exchange. Staff have considered using SERFF but are unlikely to pursue it as a solution for handling plan management functions; they view it as a static document system and are not certain it will be the best solution to provide the functionality required by the Exchange.

Oregon is hopeful that CMS will develop a premium calculator as they believe that would be an excellent federal role. They will interface with the federal hub, however they will still need state-level verification and ways to process people who don’t file taxes, etc.

The SHOP will be merged with the individual exchange, although different products will be available to each group. Risk pools will be kept separate for now. A number of decisions



regarding call center functions and staffing, potential relationships with other states, how to handle Independent Verification and Validation (IV&V), etc. remain outstanding.

Planning and Governance Approach

Before legislation passed in June establishing the Oregon Health Insurance Exchange Corporation, Exchange-related activities were performed within the Oregon Health Authority, which runs the state's Medicaid program. The original Steering Committee established to oversee planning grants had representation from the OHA, Insurance Division, and Department of Human Services. The Department of Human Services has responsibility for TANF and SNAP, as well as the field offices with caseworkers that enroll applicants into Medicaid. After the Corporation was established, this Steering Committee turned into an interagency advisory group which meets monthly.

There are also biweekly meetings of "the big 4": the Directors of the Insurance Division, the Exchange Corporation, OHA and the Department of Human Services, which are used to discuss high level policy issues. Some eligibility functions for non-health care social service programs will need to be integrated into the system later due to time constraints.

In addition to collaboration among public entities, an advisory group composed of carriers exists, and another one for producers is planned. There have been some challenges working with consumer groups who support the Exchange concept but were opposed to certain design features.

IT Procurement Approach and Status

The RFP process for software development has been completed. Oregon has contracted with Oracle for a software solution encompassing eligibility determination, enrollment, shopping experience, identity management – basically the non-financial management functions. These functions are modular, and so can be purchased separately. They are still trying to determine what is needed for financial management (e.g., they have not determined whether to use a third party administrator).

They will be issuing an additional RFP for a systems integrator. All previous products were state-owned so there were no related contractual issues.

Cost and Funding Approach

Oregon has budgeted almost \$55 million for development of the Exchange IT components, \$48 million of which comes from their Early Innovator grant with an additional \$7 million anticipated from enhanced 90/10 match for the Medicaid component of the system. They may request more funds as part of a Level Two grant application. The vast majority of the funds (\$43 million) are budgeted for hiring a vendor, with almost \$6 million allocated for staff.

There has also been some discussion that innovator states may be able to develop components for federal use, which could generate more funding.

The legislature has already determined that the Exchange will establish fees on insurers and state programs ranging from 3-5% of the premium for each enrollee, depending on the total number of enrollees in the plan. If there is a surplus exceeding the amount of six months' operational expenses, the money will be applied to reduce fees.



Oregon is talking with the Center for Consumer Information and Insurance Oversight (CCIIO) about the possibility of sharing costs of IT development for carriers.

Staffing

Like other states, Oregon has staff spread throughout various agencies who are working on Exchange-related tasks, including staff working on Exchange IT at OHA. In addition to these staff, the state has a contract with Oracle for software development and a short term contract with KPMG to prepare for Oregon’s third gate review with CMS in early November, required under the Early Innovator grant. In their IT grant they budgeted for 48 FTE state staff, 30 local contractors and 21 system integrator/vendor staff.

Risks Identified

To date, Oregon has met its deadlines. Oregon will perform its own project management and believes the project will take 24-28 months. It has had two on-time IT-related federal gate reviews but acknowledges that “time, cost and scope” are all risks. It has proved difficult to get fully staffed.

Oregon is trying to mitigate risks by working on multiple pieces of the project concurrently to speed the development process. The state will also be using an iterative approach to development, and is planning to have an early prototype by early December so people can see what modifications are needed before too much work has been done. The state expects to follow a similar development pattern in the future.

Suggestions/Implications for West Virginia

Oregon recommended adopting the “single brain” integrated eligibility approach that they pursued. Other areas with potential for further review include:

- Use of COTS modules, potentially using some modifications developed for Oregon
- Building on current insurance systems
- Enroll UX 2014 project
- Iterative development process

5.4 Early Innovator Profile: University of Massachusetts – New England Consortium

State	Massachusetts
Lead Agency(ies)	<ul style="list-style-type: none"> • Commonwealth Health Insurance Connector Authority • Executive Office of Health and Human Services (EOHHS)
Collaborating States	<ul style="list-style-type: none"> • All New England states (Connecticut, Maine, Massachusetts, Vermont, New Hampshire, Rhode Island) • Open to collaboration with other states, being encouraged to do so by CMS
Interstate Collaborative Approach	<ul style="list-style-type: none"> • Not developing a regional Exchange • Primary goal is to build Massachusetts Exchange, but have other states leverage what they have done • Collaboration planned with partners ranges from information exchange, to sharing modules to providing services



HIX IT Approach & Status	<ul style="list-style-type: none"> • Build on existing Exchange capability • Simultaneously build Exchange and replace Medicaid eligibility system resulting in an integrated eligibility determination system
IT Assets being Leveraged	<ul style="list-style-type: none"> • Plan to build on Connector to make it ACA compliant and take it to the next level • Participant in Enroll UX 2014
Planning & Governance Approach	<ul style="list-style-type: none"> • Already had planning and governance infrastructure in place • Working very closely with Medicaid
IT Procurement Approach & Status	<ul style="list-style-type: none"> • Plan to issue a Request for Response (RFR) very shortly
Cost and Funding Approach	<ul style="list-style-type: none"> • Development funding a combination of grants, enhanced match • Declined to discuss development budget because of ongoing procurement process • Connector now funded by percentage of premiums
Staffing	<ul style="list-style-type: none"> • Declined to discuss development staffing because of ongoing procurement process
Opportunities for Collaboration	<ul style="list-style-type: none"> • UMass is eager to work with states outside of New England to review possibilities for shared modules, services

HIX IT Approach

The New England States Collaborative Insurance Exchange Systems project is a multi-state consortia project led by the University of Massachusetts Medical School. The approach being used is to create and build a flexible Exchange information technology framework in Massachusetts and share those products with other New England states. The project hopes to learn from the Massachusetts Exchange implementation and gain efficiencies so it can accelerate Exchange development for participating New England states. This project is unique in multiple ways: it is the only project being run out of a university, the only project actively involving other states in system design with the goal of possibly sharing components and the only project building on an existing Exchange.

The primary goals of the project are to modify the Connector IT infrastructure to meet the ACA requirements and to eventually use that modified structure to replace the Medicaid and CHIP eligibility system, creating a single integrated eligibility system. A goal is to build the rules engine so that eligibility determination for various social services can be migrated to the new rules engine over time. The Connector already vets health insurance plans to ensure they meet Massachusetts criteria for inclusion and determines exemptions from the individual mandate. The state, along with the rest of the collaborative partners, is participating in Enroll UX 2014.

Potential for Interstate Collaboration

The New England States Collaborative Insurance Exchange Systems (NESCIES) project was created to allow New England and possibly other states to leverage HIX components developed in Massachusetts. Massachusetts is putting special emphasis on creating components that are cost-effective, reusable, and sustainable for this purpose. The project has established a learning collaborative, led by a multi-state steering committee, where participating states can share



information and work together to develop system components and identify best practices. Despite the varying levels of sophistication and commitment to health reform of participating states, the goal is to work with all collaborators.

The group is not building a regional Exchange; each state will have its own. It may be possible however, that one or more states may purchase components or services from another. Massachusetts has identified 3 levels of “re-usability”

- Tier 1 – knowledge sharing, e.g. lessons learned, business rules and processes, reference architecture and project and risk management methodologies
- Tier 2 – joint procurements, states may be able to join together to develop/purchase a software and/or hardware or cloud based data centers. Once the development phase is completed each state typically owns and maintains the product separately.
- Tier 3 - joint applications, e.g. a rules engine related to MAGI eligibility determination hosted in a cloud that multiple states could potentially use. States would typically continue to coordinate after the development phase.

Massachusetts has identified components they think are highly reusable for other states. The state will be asking the winning vendor to focus on these areas during the development process to try to insure maximum flexibility. These areas are tied to the eligibility function and include:

- Standardized interfaces with federal and carrier hubs;
- The portal;
- Eligibility rules engine;
- Eligibility business process management; and
- Eligibility data management.

Planning and Governance Approach

Massachusetts already has a planning and governance infrastructure in place because of its work developing and implementing the Connector. The Connector is an independent quasi-governmental agency, with its own board. The Connector, EOHHS which runs the Medicaid program and the University are the executive sponsors of this project.

External stakeholders are represented on the Connector's board. Connector staff also meet regularly with insurance representatives. While these meetings include some discussion of IT issues, industry representatives have not been brought into the initial design phase – design has primarily been driven by the ACA requirements. There may be a role for interested parties in future JAD sessions.

IT Procurement Approach and Status

As noted, Massachusetts is treating HIX development and Medicaid eligibility update as a single project (HIX-IES) leading to an integrated eligibility system. Staff have broken tasks into work orders, some of which are specifically aimed at achieving HIX functionality, some specifically for Medicaid functionality and some for joint projects that cannot be easily divided, e.g. the web portal. CMS appears to be pleased with this approach. There are state staff and consultants working aggressively with the planning vendor.

Massachusetts plans to put out an RFR by the end of the month, and is hoping to have a vendor on contract at the beginning at 2012. Reflecting the importance of interstate collaboration to this project, the state is developing MOUs with some collaborating states regarding the project and



will include contract requirements mandating that the vendor work with those states. They expect to have the system functional by the 2013 ACA deadline.

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Cost and Funding Approach

Massachusetts’ early innovator grant is approximately \$35 million. After an initial infusion of \$25 million in state appropriations, ongoing Connector operations are funded by revenues obtained through retention of a percentage of premiums collected on both the subsidized and nonsubsidized insurance products administered by the Connector. Massachusetts wanted to wait until the release of its RFR before discussing expected budget and staffing.

Risks Identified

Massachusetts feels it can be ready for implementation in a timely manner given its substantial head start. However, it recognizes that the timelines are very tight and there may not be adequate vendors or money to do the necessary development as quickly as hoped. The state hopes to be in a position to help mitigate these risks for other states, but notes that collaborative development takes additional upfront time and that states vary greatly in “HIX Maturity”, IT capacity, political willingness, and policy direction.

Suggestions/Implications for West Virginia

Massachusetts emphasized the importance of looking into the options for purchasing/obtaining at least some system components from other entities. They expect multiple potential sources for such components: other states, including Massachusetts; the federally facilitated Exchange (for which the contract was just awarded); and private vendors who will develop potential solutions. As discussed above they believe there are a number of components that lend themselves to sharing among states or purchase from outside sources. CMS has specifically asked that they work with a small number of non-New England states, which could prove to be an opportunity for West Virginia.

5.5 Early Innovator Profile: Maryland

State	Maryland Department of Health and Mental Hygiene
Lead Agency(ies)	<ul style="list-style-type: none"> • Department of Health and Mental Hygiene • Department of Human Resources • Governor’s Office • Health Benefit Exchange
HIX IT Approach & Status	<ul style="list-style-type: none"> • Starting by developing the MAGI eligibility component, see also Procurement • Using “sprint” approach
IT Assets being Leveraged	<ul style="list-style-type: none"> • Replacing current Medicaid eligibility system in phases
Planning & Governance Approach	<ul style="list-style-type: none"> • Independent Exchange established by law currently hiring staff • Contracted project management team • Workgroups developing detailed requirements • 4 legislatively mandated committees working on broad policy areas
IT Procurement Approach & Status	<ul style="list-style-type: none"> • Did an RFI to determine the state of the market • Issued an RFP for phased system development: core exchange functions and MAGI eligibility, non-MAGI eligibility, and other social service programs
Cost and Funding	<ul style="list-style-type: none"> • \$6 million Early Innovator Grant • \$27 million Level One Grant



Approach	<ul style="list-style-type: none"> • Use 90/10 match • Advisory Committee reviewing sustainable funding options
Staffing	<ul style="list-style-type: none"> • Soon the Exchange will have about half a dozen employees • The contracted PM team has about the same number
Opportunities for Collaboration	<ul style="list-style-type: none"> • Maryland has posted its RFP and other information on its Exchange web site. • Its JAD session notes and other materials are posted on CMS' CALT website. • They have been conducting presentations to other states on how they run their JAD sessions.

HIX IT Approach

Maryland is planning a phased implementation approach that is described in more detail in the procurement section. The first mandatory phase is to develop selected Exchange and MAGI eligibility functions. As Maryland finalizes its policy and design decisions additional parts of Exchange functionality will be added. For example, one important outstanding decision is whether to integrate the individual and SHOP markets – operationally and/or in terms of risk pools. When that decision is made development can proceed. After these core functions are completed, non-MAGI eligibility processing and then functions related to other social service programs such as SNAP and TANF will be added. As it develops its new Exchange and eligibility functionality it will phase out the legacy eligibility system.

Maryland is using sprint IT development methodology (a time limited period of work, with a well-defined and agreed-upon output) which they believe keeps the process moving. They do not think “sprints” necessarily need to be sequential, they can often be done in parallel despite some interdependency.

Independent verification may be done by a different state agency, rather than an outside entity.

Planning and Governance Approach

Legislation has been passed in Maryland establishing the Exchange. The Maryland Health Benefit Exchange is an independent, public corporation with a Board comprised of the Secretary of Health and Mental Hygiene, the Insurance Commissioner, the Executive Director of the Maryland Health Care Commission, and six gubernatorial appointees representing various stakeholder groups. The Executive Director has been hired and the Board appointed.

Within the State there are strong relationships among the Department of Health and Mental Hygiene (responsible for Medicaid), Department of Human Resources (responsible for Medicaid enrollment), the Governor’s office and the Exchange. Representatives of all these groups participate in JAD sessions and help review strategic direction. The Maryland Insurance Agency is also a partner, as is the Department of Information Technology.

There are now ongoing workgroups which were instituted in late May when a contracted project management team began. The groups began their work by looking at the broad question: What does the ACA mean for Maryland and then used their findings to produce relatively high-level needs requirements for an RFP. Now that the RFP has been released, the work of the groups has shifted to developing more detailed requirements. The team has identified 15 functional areas, such as pre-screening and verification, which correspond with the subject areas assigned to the workgroups. These 15 areas map to federal functional areas. Each group has an



executive champion, end users, and technical representatives working together, although not all members are involved in each JAD session. There are federally developed guidance documents that were used as a basis for or in coordination with some of the JAD output.

Maryland plans to engage the public in its planning but has not really started that process yet.

Maryland has just started its work in developing a plan management solution and has not yet engaged issuers. Maryland has a small number of TPA's that, taken together, work with a large share of the small group and individual markets, and intends to use them as key informants.

There are four advisory committees that are expected to report out at the end of this calendar year or early next year: Each committee is charged with developing at least one report to the legislature. A [table](#) on the Exchange website summarizes each committee's charge, the reports for which it is responsible and the vendor assisting it with its task. The committees are:

- Operating Model and Insurance Rules
- Small Business Exchange (SHOP)
- Navigator and Enrollment
- Finance and Enrollment

IT Procurement Approach and Status

To initiate its procurement process Maryland put out an RFI to learn about products available on the market. Based on the submissions it received, industry partners were invited to a market research session. Maryland developed a PowerPoint presentation outlining its findings. CMS has posted this on the CALT website. The summary does not single out products or vendors, but gives an overview of market readiness, specific to 17 different functional areas. Each functional area is scored on market readiness with respect to both technical and functional readiness, ranging from low scores for risk adjustment and reinsurance to very high scores for call center technology. Our contact noted that he believed the market is ready for health reform in those areas where there has been adequate federal guidance.

The Exchange issued an RFP to do a phased implementation of Exchange and eligibility functions. The RFP was issued through the Exchange because that entity has more flexibility with respect to procurement rules, e.g. it can do a sole source contracting more readily if appropriate.

Reflecting the tight timeline and the expansive scope of the work required Maryland chose to implement its new system in three phases, as described in Maryland's RFP:

- **Phase 1: Core Exchange Functions and MAGI Medicaid Eligibility Determinations.**
Most, but not all, of the functionality required to implement Phase 1 is being procured through this RFP
 - tools to compare qualified health plans
 - obtain information about those plans
 - enroll in an insurance product
 - establish eligibility for, and enroll in, all —applicable State health subsidy programs.

Phase 1 is broken into **Phase 1a** which encompasses creating the capacity for the HIX to perform the functions just described, and **Phase 1b** during which the Exchange may



issue Optional Task Orders for maintenance, hosting, operations and additional HIX functions not fully addressed in Phase 1a. The Exchange is still making decisions about how to address some ACA requirements, including the SHOP Exchange. After these decisions are made, the Exchange may issue related Optional Task Orders.

- **Phase 2: Integrating Non-MAGI Medicaid Eligibility Determination.**
Seniors, people with disabilities, and individuals needing long-term care services would also have their eligibility for Medicaid determined through the HIX.
- **Phase 3: Integrating Social Services Programs**
The HIX may add the capacity to conduct eligibility determinations for other social services programs, such as SNAP and TANF.

Maryland has also put out an RFP for an assessment of current call center functionality within the state. There are currently many different call centers and Maryland wants to determine whether it can and should build something based on an existing system.

Cost and Funding Approach

The State did not provide specific budget information. The State has two grants right now – a \$6 million Early Innovator grant and a \$27 million Level One establishment grant. Maryland expects to apply for the Level Two establishment grant in 2012. As noted above, there is an advisory committee currently developing recommendations for the legislature related to sustainable funding after 2014.

To date the Executive Director is the only Exchange employee, but she is being supported by a contracted project management team funded through the Early Innovator grant. She has been approved to hire directors of various departments: IT, policy, operations, communications and outreach and channel management (includes work with TPAs, brokers) and has an assistant Attorney General assigned. She also has some outsourced policy support which is supporting the work of the legislatively mandated advisory committees. The project management team has a director, a subject matter expert, a system architect and a business analyst. It will expand to 10-11 people when the vendor begins work.

Risks Identified

Maryland is concerned about whether the Federal Hub will be available as promised and is looking at possible alternate data sources as a backup.

Suggestions/Implications for West Virginia

Maryland is farther ahead in its procurement process than West Virginia. It has posted its RFP and other information on its Exchange web site [insert hyperlink](#). Its JAD session notes and other materials are posted on CMS' CALT website and are also available to West Virginia. Maryland also recommended using federal guidance as it did which can provide a head start on design discussions. They have also been doing presentations on how they run their JAD sessions for other states.



5.6 Early Innovator Profile: Wisconsin Department of Health Services

State	Wisconsin
Lead Agency(ies)	<ul style="list-style-type: none"> • Wisconsin Department of Health Services (DHS) • Office of the Commissioner of Insurance (OCI)
HIX IT Approach & Status	<ul style="list-style-type: none"> • Use Deloitte (existing eligibility system vendor procured competitively for eligibility system enhancements) to build out MAGI eligibility rules based on current Medicaid eligibility components. • Issue RFP for systems integrator and purchase and customization of COTS products for other parts of Exchange, e.g. plan management.
IT Assets being Leveraged	<ul style="list-style-type: none"> • Current integrated eligibility system.
Planning & Governance Approach	<ul style="list-style-type: none"> • No legislation in place. • Leadership shared between DHS and OCI, Governor's office oversees the project.
IT Procurement Approach & Status	<ul style="list-style-type: none"> • May 2010 issued RFP for maintenance and enhancement of current eligibility system and potential to develop entire Exchange. • With new administration did RFI and had numerous vendor presentations. • Modified RFP to limit it to eligibility. • Will competitively procure additional Exchange IT components.
Cost and Funding Approach	<ul style="list-style-type: none"> • \$37 million Early Innovator grant
Staffing	<ul style="list-style-type: none"> • Total FTE count including staff and contractors is about 120.
Opportunities for Collaboration	<ul style="list-style-type: none"> • Wisconsin has experience building on a Deloitte eligibility system and is willing to share expertise.

HIX IT Approach

Wisconsin's goal is a single, intuitive portal through which residents can access subsidized and non-subsidized health care and ultimately other state-based programs (e.g. Medicaid, CHIP, child care). The Exchange will integrate across health and human services programs to promote efficiency and lower overall administrative cost.

Wisconsin has largely divided the project into two sections: eligibility and enrollment, and all other functions. The State is looking at purchasing and customizing a more mature, commercial market product for the Exchange on the plan side, and is using Deloitte, its eligibility system vendor, to enhance and expand the current Medicaid and social service eligibility system it developed.

Deloitte will do the work related to MAGI eligibility determination business rules engine and integrating some other existing eligibility functions into the business rules engine. The eligibility system needs a lot of updating independent of the work needed to implement Exchange related functions – e.g. to integrate service oriented architecture. Wisconsin is purchasing some of the necessary tools to make these upgrades through the current procurement. Wisconsin will continue to use the existing consumer eligibility portal for the non-MAGI population. An applicant



will be routed to the correct site depending on his or her reason for potential eligibility. Wisconsin is also not planning to move SNAP and TANF eligibility determination into the new eligibility rules engine, at least for the time being, and possibly not at all.

Wisconsin intends to use the same plan management tools, portal and vendor to support both employer and employee plan choice. The State is doing some JAD sessions to design the product, but is limiting that work because of the plan to buy ready-made products that only need customization, rather than building from scratch. The procurement section discusses these plans in more detail.

Planning and Governance Approach

Wisconsin's Exchange planning was affected by a change in administration, slowing the development process. Additionally, the State changed course on its plan management approach, switching from an active purchaser model to a more open Exchange.

In January, the Office of Free Market Health Care was created, which is overseen by DHS and OCI with strong leadership from the Governor's office. There are MOU's between the two agencies and they work together closely on the project. There is a steering committee composed of work group leads. The work groups meet regularly to develop the requirements for the RFP. The workgroups are 1) screening and eligibility, 2) employer management, 3) plan management, 4) customer support and 5) program integrity and verification.

There has been some work with external stakeholders, but it has focused on policy rather than IT issues.

IT Procurement Approach and Status

In May 2010 Wisconsin issued a broad RFP for maintenance and enhancement of current eligibility system, which included eligibility determination for Medicaid, CHIP, SNAP and TANF, and the opportunity to develop the rest of the Exchange IT functionality.

The new administration was not confident that all of the shopping and small business portions of the Exchange could be built in the necessary timeframe and decided to change course. As a result, Wisconsin issued an RFI and held a series of scripted vendor presentations. Based on that input, Deloitte's work under the original RFP was limited to the eligibility system enhancements. Wisconsin will purchase COTS products for the other components of the system and then do necessary modifications. The RFP for those Exchange components is under development; target date for its release is not known at this time. Deloitte is currently working closely with the State on developing system requirements and so will not be eligible to bid on the RFP. Wisconsin has found that many of the bigger vendors are not interested in doing eligibility determination system development and are more interested in the more commercial plan side of the Exchange.

Cost and Funding Approach

Oregon received almost \$38 million for their Early Innovator grant.

DHS and OCI each have a small number of staff dedicated to the project, Deloitte has a large staff working on integration and Wisconsin has also hired additional contractors from HP for a total FTE count of about 120 people.



No decisions have been made with respect to sustaining Exchange operations after 2014. Under the prior administration staff developed a financing options paper. The paper recommended keeping exchange monies in a separate fund. It also presented 3 different financing options: a percentage of premiums paid through the Exchange, an assessment on all insurers, or a state appropriation. The paper recommended against the appropriation.

Risks Identified

Having sufficient time to create specifications, complete the procurement process and implement the system is the state's biggest current concern. Reflecting this concern, Wisconsin is working to determine how specific to make the RFP requirements. While increased specificity would be beneficial with respect to the contracting process, it will lengthen the RFP development process significantly. Wisconsin, like many other states, faces potential delays because of the political nature of health care reform. The State does not have Exchange legislation in place.

Suggestions/Implications for West Virginia

Wisconsin's situation is in many ways similar to West Virginia's. Deloitte supports its current legacy eligibility system. Staff are willing to talk with their West Virginia counterparts to share their approach and lessons learned as well as opportunities for using available software.

DRAFT



6.0 HIX IT Cost Considerations

This section of the Plan provides information from other states regarding estimated Exchange costs and funding approaches.

Cost is an important factor as the state considers its options to address identified IT gaps and issues. This section of the plan looks at how some other states are approaching estimating costs for Exchange planning, Design, Development, and Implementation (DDI) as well as operations. It also reviews the various federal funding options that are available to the state, and approaches other states are considering to generate revenue to sustain Exchange operations after federal funding ends in 2015.

6.1 Exchange Planning, Development, and Implementation Costs

West Virginia has made solid headway in its Exchange planning efforts to date, however key Exchange policy and design decisions remain outstanding. Additionally, important analyses and information-gathering to guide planning efforts, such as an Actuarial Assessment and Economic Modeling and a Request for Information (RFI) for Exchange IT component costs, are still in progress. It is only when more clarity about the set of factors unique to West Virginia's Exchange is gained that an accurate estimation of West Virginia's costs can be developed.

A review of available cost information for several states suggests it is difficult to make an "apples to apples" comparison between states, as well as to extrapolate to West Virginia's potential costs as each state is planning costs based on different timeframes, cost categories, and underlying assumptions such as state-specific consumer enrollment levels, adoption of a phased IT rollout, the ability to leverage existing technology, and decisions about outsourcing. However, bearing in mind those considerations, reviewing other states' estimates provides a preliminary approximation of expected cost ranges for West Virginia Exchange planners until more refined implementation cost estimates can be developed.

A review of four states' estimates for a state-run Exchange indicates costs ranged from \$18.3 million for a 12-month segment of the implementation period for Missouri (assumes leveraging of existing components when possible) to \$92 million for a 36-month implementation period for Illinois (includes a new eligibility system). The following sections offer additional insight by providing profiles of four states' estimated costs for various HIX design scenarios. These states were selected based on budget information available as of October 2011, the first draft of this report.

6.1.1 Oregon

As an Early Innovator, Oregon is further along in its IT planning and decision-making efforts than most other states. In February 2011, the state received \$48 million in funding from HHS through the Exchange Early Information Technology Innovation Grant to begin design, development, and implementation of its Exchange IT solution. Total costs of the system to cover the 24-month start-up period from February 2011-February 2013 were \$55 million with approximately 12% of that cost not allocated to OCIO¹ (see section 6.2.1 for more detail on cost allocation). As previously discussed in section 5, Oregon's approach is to build a state-run Exchange using commercially available off-the-shelf software, one primary product vendor, and

¹ Costs referenced in this profile include those allocated to Medicaid/CHIP.



a systems integrator. The State will also replace its legacy Medicaid eligibility system with a new integrated system. The combination of internal and external staffing resources that will design, develop, and implement Oregon's Exchange is summarized in the following table².

Table 21: Estimated Staff Resources for Oregon HIX IT Design, Development, and Implementation

Type	Internal Head Count	Internal* Cost	External Head Count	External Cost
Technical program leadership**	4	\$1,000,000	-	-
Management and support team	10	\$1,400,000	1	\$280,000
Project implementation teams				
<i>Procurement and Internal Portal</i>	5	\$630,000	4	\$1,600,000
<i>Exchange Service Delivery Model</i>	4	\$628,000	2	\$682,000
<i>Rules and Policies</i>	4	\$512,000	3	\$1,100,000
<i>Back Office Integration</i>	5	\$563,000	8	\$2,000,000
<i>Data Warehouse</i>	3	\$221,000	4	\$358,000
<i>External Portal</i>	4	\$467,000	7	\$1,600,000
<i>Telephony</i>	.2	\$11,000	1	\$125,000
<i>Implementation***</i>	9	\$241,000	-	-
Systems Integrator	-	-	13	\$8,400,000
Product Vendor	-	-	8	\$4,200,000
Expertise Consultancy	-	-	-	\$900,000
External Quality Control, Assurance, and Security Audit	-	-	-	\$3,800,000
Total	48.2	\$5,700,000	51	\$25,000,000

*Does not include fringe benefits, which add approximately \$1.8 million to internal staffing costs.

**Costs begin 90 days before grant award period of February 15, 2011

***Costs extend from February 15, 2012-February 14, 2013

The following is a summary of all costs included in the Oregon HIX IT budget:

- Salaries and wages: \$5.7 million;
- Fringe benefits: \$1.8 million;
- IT hardware: \$4 million;
- IT software: \$13.2 million;
- Contractual costs: \$25 million;
- Travel: \$144,576;
- Supplies: \$30,000;
- Equipment: \$675,000;
- Other costs: \$170,000;
- Office space and tenant improvement: \$1.5 million; and
- Contingency³: \$2.6 million.

² Exchange program leadership (e.g., Executive Director, Chief Financial Officer, Chief Operating Officer, Chief Information Officer) were not included in the IT grant budget.



6.1.2 Wisconsin

In December 2010, another Early Innovator state, Wisconsin, requested \$49.6 million to support a three-release, iterative plan for developing its Exchange beginning November 2010, with the final release being implemented November 2012 and post-implementation continuing through February 2013. The budget assumes the HIX will leverage Wisconsin's existing Medicaid and CHIP eligibility, enrollment, and management systems (CARES, ACCESS, and interChange) and that Wisconsin will purchase and modify COTS products for other components of the IT system. The State estimates that approximately 14% of the total budgeted costs will not be allocated to OCIO. The budget breaks down costs into the following eight overall categories:

- Salaries and wages: \$3.44 million;
- Fringe benefits: \$1.79 million;
- IT hardware: \$3,742,944;
- IT software: \$3,062,276;
- Contractual costs (project management and IT design, development, and implementation): \$36.6 million;
- Consultants (evaluation team): \$135,000;
- Travel: \$194,759;
- Supplies: \$50,680; and
- Other Costs (e.g., phone, business software): \$423,000.

6.1.3 Illinois

With the assistance of a consultant, the State of Illinois developed a start-up budget for a state-run Exchange spanning from October 2011-December 2013. Expense estimates were based on the consultant's experience with the Massachusetts Health Connector and operational and IT planning work for other state Exchanges under the ACA, factors unique to Illinois, and common available metrics for general and administrative cost. The budget, totaling \$93 million, is broken down into two main sections: Systems Development and Support (\$75 million) for the work required to develop and operate the Exchange's four major IT systems and Program Operations (\$18.9 million), which includes the remainder of administrative expenses to launch the Exchange. Costs are not allocated to other State programs in the budget presented. Please see the table below for a summary of estimated expenses.

³ All budgeted estimates were from Oregon's initial budget; with OCIO permission, funds may be re-allocated to meet emerging and shifting needs.



Table 22: Illinois HIX Start-up Costs

Systems Development and Support				
	Expenses			
	2011	2012	2013	Total
Eligibility & Enrollment	\$ 2,271,000	\$ 15,894,000	\$27,248,000	\$45,413,000
Website	\$ 791,000	\$ 5,539,000	\$ 9,495,000	\$15,825,000
Customer Service	\$ 482,000	\$ 3,372,000	\$ 5,780,000	\$ 9,634,000
Premium Billing	\$ 206,000	\$ 1,445,000	\$ 2,477,000	\$ 4,128,000
<i>Sub-Total</i>	\$ 3,750,000	\$ 26,250,000	\$45,000,000	\$75,000,000
Program Operations				
IT Infrastructure	\$ 123,000	\$ 70,000	\$ 79,000	\$ 272,000
Marketing & Advertising	\$ 20,000	\$ 80,000	\$ 100,000	\$ 200,000
Consulting & Professional	\$ 811,000	\$ 3,244,000	\$ 2,968,000	\$ 7,023,000
Salary & Benefits	\$ 296,000	\$ 2,976,000	\$ 5,097,000	\$ 8,369,000
General & Administrative	\$ 53,000	\$ 246,000	\$ 328,000	\$ 627,000
Facility & Related	\$ 88,000	\$ 287,000	\$ 436,000	\$ 811,000
<i>Sub-Total</i>	\$ 1,391,000	\$ 6,903,000	\$ 9,008,000	\$17,302,000
Total	\$ 5,141,000	\$ 33,153,000	\$54,008,000	\$92,302,000

6.1.4 Missouri

The State of Missouri worked with a consultant in early to mid-2011 to develop an implementation plan and cost estimates for the first Exchange start-up year spanning October 2011 to September 2012. Based on assumptions including a two-phase implementation approach and adoption of a hybrid strategy for IT system development (consisting of a combination of buying and configuring COTS products, leveraging solutions from other states, and building as a last resort), expenses for the first year total \$18,284, 271. Expense details are as follows:

- Salaries and wages: \$1,158,019;
- Fringe benefits: \$461,588;
- IT Hardware (annual lease costs): \$58,500;
- IT Software (licenses): \$5,461,262
- Consultants: \$7,135,338;
- Travel: \$1,218,000;
- Supplies: \$16,800;
- Other (facilities build and annual costs): \$393,750; and
- Contractual Costs (IT budget): \$2,381,014.



6.2 Funding for Exchange Planning, Development and Implementation

Section 1311 of the Affordable Care Act provides funding assistance to the states for the planning and establishment of Exchanges. Accordingly, since the ACA was passed HHS has made several grants available to states, including Exchange Planning Grants and Level One and Level Two Exchange Establishment Grants. In July 2010, West Virginia was awarded nearly \$1 million for initial planning activities related to the potential implementation of the Exchange; an extension was recently granted to allow the state to use the grant funds for continuing activities such as performing an Actuarial and Economic Assessment and Policy Model and Planning Assessment. In July 2011, West Virginia was awarded a one-year Level One Establishment Grant in the amount of \$9,667,694 to continue planning and development in core areas such as stakeholder consultation, legislative and regulatory action, governance, program integration, IT systems, financial management, oversight and program integrity, health insurance market reforms, consumer and small business assistance, and business operations.

West Virginia may choose to reapply for a second year of funding under the Level One Establishment Grant if additional time is needed to meet the criteria to apply for the Level Two Establishment Grant. To be eligible to apply for the Level Two Grant, the state must have: legal authority to establish and operate an Exchange that complies with federal requirements available at the time of the application, a governance structure for the Exchange, a budget and initial plan for financial sustainability by 2015, a plan outlining steps to prevent fraud, waste, and abuse, and a plan describing how consumer assistance capacity in the state will be created, continued, and/or expanded, including provision for a call center. Unlike the Planning Grant, the Establishment Grants will be used to fund all Exchange operations including personnel salaries and benefits through the end of 2014. States can apply for these grants on a rolling basis through June 2012; applications are processed quarterly by HHS and awards are made approximately 45 days after the application due date.

In addition to the Exchange Planning and Establishment Grants, the OIC's Rates and Forms Division recently received \$1,000,000 in funding under an HHS Premium Review Grant, \$150,000 of which is allocated for enhancing SERFF and developing an interface with the Exchange to assist with plan management functions. The OIC was also granted approximately \$205,000 from the Consumer Assistance Program Grant; a portion was used to enhance the Consumer Service Division's reporting functions to the federal government using SBS, as well as to conduct consumer outreach and education through statewide community forums, meetings, fairs and festivals and media spots.

6.2.1 Cost Allocation

As outlined in federal guidance and summarized in section 2.3.1.2 above, certain Exchange IT costs, including the web portal and eligibility determination, must be shared by all users of the Exchange, such as Medicaid and CHIP. Each state will estimate the portion of Exchange IT costs to allocate to Medicaid and CHIP based on projected Medicaid and CHIP use of Exchange IT services. The relevant federal-state cost-sharing percentage for IT Support would be then applied to that Medicaid and CHIP share based on OMB Circular A-87 and subsequent guidance outlining time-limited specific exceptions to these cost allocation requirements for new eligibility systems and enhancements, in order to determine the amount of federal funds to request through the Advanced Planning Document (APD) process and state funds needed.

Most states are in the process of preparing their Exchange budgets and determining their cost allocation formulas, based on actuarial and other data analysis. Two of the Early Innovator



states, Wisconsin and Oregon, have shared some of their cost allocation planning information. Wisconsin is estimating a cost allocation of 62% to the Exchange and 38% to Medicaid and CHIP for development of shared IT systems/functionality such as eligibility determination, and 100% of costs allocated to the Exchange for Exchange-only functionality such as the SHOP. For Exchange development activities that benefit Medicaid as well as non-Medicaid populations, Oregon is proposing to allocate 49.7% of costs to Medicaid and 51.3% of costs to the Exchange, based on projected Exchange enrollment. For development activities such as SHOP-specific functionality that benefit a single population group, all costs would be allocated to the Exchange.

6.3 Sustaining Exchange Operations

While the ACA provides for appropriation of funds from the Federal Treasury for Exchange development and implementation through 2014, it also requires states to “ensure that such Exchange is self-sustaining beginning on January 1, 2015....” To become self-sustaining, the Exchange must develop a sustainable source of administrative revenue that offsets operating costs, accounting for any financial surplus the Board may want to generate to assure the financial viability of the Exchange, particularly in the volatile first years of operation. Although the ACA does not prescribe how an Exchange must be self-sustaining, in WV Senate Bill 408 the State Legislature authorizes the West Virginia Exchange Board to “assess fees on health carriers selling qualified dental plans or health benefits in this state, including health benefit plans sold outside the Exchange, and shall establish the amount of such fees and the manner of remittance and collection of such fees in legislative rules. Fees shall be based on premium volume of the qualified dental plans or health benefit plans sold in this state and shall be for the purpose of operation of the Exchange.”

To determine the amount of revenues that must be generated to allow the Exchange to be self-sustaining, West Virginia must develop expense estimates for the first several years of Exchange operations. Fixed operational costs may include communications and outreach, management, internal IT costs, facilities, and other infrastructure costs; variable costs may include eligibility processing and enrollment, premium billing and customer service. Operational costs will also depend on policy decisions and design variables such as whether or not: the individual and small business Exchanges are combined; the definition of “small employer” for purposes of the SHOP is expanded from 1-50 to 1-100; a basic health plan is created; the Exchange acts as a market organizer versus an “active purchaser”; the Exchange performs the minimum required services for mandated Exchange functions or provides more robust services and support. The state should engage in actuarial and economic modeling to develop 3-5 year annual operating expense estimate scenarios based on the varying policy and design decisions, as well as consumer enrollment and Exchange participation scenarios to help determine costs and the premium base upon which fees may be leveraged. Exchange leadership will also need to decide whether or not to begin assessing fees in 2014 while Exchange operations are funded by federal grants to allow for generation of operational reserves, and if so, what a reasonable reserve amount may be.

Together, these analyses and decisions will help West Virginia determine the administrative revenues required to support Exchange operations on an ongoing basis and to make decisions such as whether or not fees should be assessed on health insurance sold both inside and outside of the Exchange (as authorized by WV Senate Bill 408) and whether or not additional revenue sources may be required to keep fee assessments on carriers within reason. In the Massachusetts Commonwealth Care and Choice experiences, administrative fees (based on



percentage of capitation payments and monthly premiums, respectively), ranged from a high of 5% in the first fiscal year to a low of 3.2% five years later. Oregon estimates its administrative fee will be 3.3% of premiums in 2014 based on combined individual and small group Exchange health insurance enrollment of 207,500, decreasing to 2.8% of premiums in 2016 for 327,500 covered lives. Greater enrollment (and associated premiums) as momentum within the Exchange is gained decreases administrative fees as a percentage of premiums because fixed costs are spread over more members, underscoring the importance of the Exchange adopting policies and practices that will increase consumer participation to create a financially efficient Exchange. In addition to assessing fees on carriers selling qualified health and dental plans in West Virginia, alternative funding sources under consideration by other states include:

Excise taxes on products or services (including those associated with unhealthy lifestyles such as tobacco);

- Revenue diversion from programs potentially phased out by health reform (e.g., high risk pools, public employee insurance);
- Funds from other public programs for which the Exchange may assume responsibility for certain functions (e.g., eligibility determination for Medicaid and CHIP);
- Carrier participation fees;
- Fees on health care providers;
- General revenues;
- Navigator licensing fees;
- Healthcare/wellness advertisers on the Exchange website; and
- Fees for individual users and/or small businesses.

6.4 Summary of Cost Considerations for West Virginia

A review of available estimates from other states provides a preliminary approximation of expected planning, design, and development cost ranges for West Virginia's Exchange until more refined estimates can be developed when key policy and design decisions are made and analyses and information-gathering is completed. A review of six states' estimates for a state-run Exchange indicates costs vary widely depending on state-specific decisions such as the degree to which existing IT components are able to be leveraged. Wisconsin – a state that will leverage its existing mainframe Medicaid and CHIP eligibility and enrollment system-projected design, development, and implementation costs for its Exchange will be \$49.6 million from 2010 through 2013. As appropriated for in Section 1311 of the Affordable Care Act, the federal government has provided funding assistance to states for these planning and establishment costs. West Virginia has already received approximately \$10.7 million in Planning and Level One Establishment Grant funding and is positioned well to apply for Level Two Establishment Grant funding in the near future to support ongoing implementation efforts. In addition to implementation costs, once operating expenses are determined West Virginia will need to develop an ongoing plan for financial sustainability of the Exchange, including determining the degree to which an operational surplus is required to assure Exchange viability during its volatile first few years. Finally, although Senate Bill 408 allows for the assessment of fees on carriers providing health insurance in West Virginia both inside and outside of the Exchange, a determination as to whether or not additional sources of revenue are required will need to be made.



7.0 Strategic IT Initiatives

This section of the Plan describes the strategic IT initiatives identified and prioritized to address strategic IT issues and gaps.

The purpose of the list of initiatives is to identify and prioritize IT initiatives that need to be addressed as part of the strategic plan to mitigate or alleviate previously reviewed strategic IT issues or Exchange technology gaps. Based on the state’s current environment, strategic IT issues and IT gaps identified, together with federal and state requirements and an understanding of the initiatives of the Early Innovators, we analyzed the needs and steps required for the state to prepare for its HIX IT functions and developed a list of proposed strategic IT initiatives, ensuring that all strategic IT issues are addressed by at least one strategic IT initiatives. This section contains a summary list of the prioritized IT initiatives. The full descriptions are contained in Appendix F.

7.1 Work Performed

An initiative description, critical tasks required for its completion, and anticipated benefits of doing so are included for each initiative identified. Additionally, a timeline with an associated priority ranking based upon each initiative’s urgency of completion was developed.

For the purposes of the IT Strategic Plan, a strategic IT initiative is defined as an activity or set of related activities that address a strategic IT issue or a technology gap related to the Exchange. The strategic IT initiatives list was reviewed in a work session with OIC Health Policy and IT Department personnel for confirmation and to provide the opportunity for feedback and refinement of the initiatives list, as well as to prioritize and develop a timeline for the initiatives. Work session participants are listed in Table 23 below.

Table 23: Individuals Involved in Strategic IT Initiatives Work Session

Name	Agency
Lisa Calderwood	OIC - Health Policy
Diana Hypes	OIC - IT
Debi McCoy	OIC - Health Policy
Jeremiah Samples	OIC - Health Policy
Jeff Wiseman	OIC - Health Policy

After several iterative discussions amongst members of the BerryDunn and OIC teams, the list was distilled to nine key initiatives deemed fundamental to overall timely and successful Exchange implementation. The first overarching initiative is development of an Exchange project work plan and Project Management Office, which will help create a shared framework and planning approach to the overall Exchange project and smaller initiatives and projects contained within. The next three initiatives relate to business and operational planning, including development of a business plan, operations plan, and detailed business process mapping- which will provide both high level and detailed roadmaps for how the Exchange will function. Initiatives 5 through 8 pertain to acquiring required Exchange IT components and integrating



them into an overall Exchange model, from gathering of requirements to developing a procurement strategy, completing the RFP process, and creating an integration strategy. The last initiative, forming a Medicaid/CHIP/OIC work group, will facilitate joint policy and process alignment across overlapping program areas for the different state entities, reducing redundancies, creating efficiencies, and facilitating a more seamless, user-friendly experience for consumers accessing insurance affordability programs through the Exchange.

7.2 Prioritized List of Strategic IT Initiatives and Timeline

In addition to confirming and refining the list of initiatives, the OIC work session participants validated the priority of the initiatives based on previous prioritization of the issues each initiative is intended to address, keeping in mind timelines for RFP issuance and federally- mandated milestones. Table 24 below summarizes the definitions used to prioritize the initiatives, as well as the number of initiatives assigned to each priority level.

Table 24: Definitions of Priority Levels

Priority	Definition	# Initiatives Identified
CRITICAL	Initiative must be addressed prior to issuing RFP(s) for Exchange IT systems.	6
HIGH	Initiative must be addressed prior to request for HHS certification of the Exchange.	1
MEDIUM	Initiative must be addressed prior to Exchange go-live.	1
LOW	Initiative can be addressed after Exchange go-live.	0

Table 25: List of Strategic IT Initiatives

#	Strategic IT Initiative	Description
1	Develop an Exchange project work plan and Project Management Office.	A project work plan and PMO should be developed for the implementation of the Exchange. The PMO initiative should identify and help support the use of effective and appropriately scaled project management principals, processes, tools and techniques within the OIC. The work plan should specify the approach to managing project scope, resources, communications, and risks, as well as what must be completed and by when to assure readiness for HHS certification by January 2013 and go-live by October 2013. During the course of the project, a Project Manager should maintain the project work plan and make it available to the stakeholders as part of project status meetings. The tasks within the project work plan must describe the specific steps to undertake for each specific phase of Exchange development and implementation and will inform the Exchange operations plan.
2	Develop an Exchange business plan.	A business plan is important to the success of any enterprise. Developing a plan will force those creating it to evaluate the Exchange in a critical and objective manner and will help create



#	Strategic IT Initiative	Description
		<p>consensus around key business aspects of the Exchange; the finished plan will serve as a road map and decision-making tool that will help the Exchange successfully perform its operations and plan for the future. The plan will also serve as a communication tool to stakeholders, providing insight into the Exchange's vision and purpose.</p> <p>The business plan may include:</p> <ul style="list-style-type: none"> • Executive summary; • Mission, vision, and goals; • Services and products; • Market analysis; • Communications/outreach strategy; • Operations plan; • Governance; • Organizational structure, management team and personnel; and • Financial plan including sustainability model, budget, and funding plans. <p>Although not all elements may be available immediately, the business plan should be augmented as additional information becomes available and decisions are made.</p>
3	Form a Medicaid/CHIP/ OIC joint policy/IT planning work group.	Achieving the federal government's vision of a simple, seamless path to affordable coverage in the Exchange will require enhanced and immediate collaboration between the OIC, Medicaid, and CHIP. Joint policy development/existing policy alignment and decisions about the technology needed to support new and existing policies and processes is required, including eligibility determinations and enrollment, customer service, and communications.
4	Develop a procurement strategy for the Exchange.	A strategy is required to successfully manage the procurement of all Exchange IT components given demanding implementation timelines, Exchange gaps, and the variety of sources from which IT components may be acquired including: existing state resources (upgraded or "as-is"); newly procured from the vendor community; leveraged from Innovator states and/or the federal government; and shared with other states in a Regional Exchange. Decisions to be made may include the scope and content of the RFP(s), the nature of the functional and technical requirements, and when RFP(s) should be issued, e.g. should West Virginia issue a full scope RFP in the near future and leverage change orders and sole source agreements as requirements are clarified or should the state issue multiple RFPs in stages? In addition, because the Exchange may be comprised of components from several sources, the strategy should



#	Strategic IT Initiative	Description
		<p>address working with the NAIC to acquire more concrete information on plans to expand/adapt NAIC systems to meet ACA requirements and communicating with states in the region about opportunities for collaboration. The strategy may include options for procuring:</p> <ul style="list-style-type: none"> • Eligibility determination module; • Web enrollment portal; • Plan management software (e.g., new/enhanced SERFF functionality); • Financial management tools; • Business rules engine; • Master Data Management tool; • Customer Relationship Management tool and call center software/hardware; • Systems integrator; • Components for SHOP functionality; • Virtual enrollment portals; and • All Payer Claims Database components.
5	<p>Complete the RFP process for the Exchange IT components.</p>	<p>Systems in the current state technology environment do not support all required Exchange functions, therefore procurement of new IT components to fulfill certain functions is required. Given demanding timelines for design, development, and implementation of the Exchange as imposed by federal deadlines, the state must soon engage in a streamlined procurement process which includes designing and issuing a/an RFP(s), reviewing vendor responses, inviting vendors for interviews and oral presentations, selecting finalists, and awarding the contract.</p>
6	<p>Develop an Exchange IT integration strategy with other state systems and applications and external business partners.</p>	<p>The Exchange IT integration strategy will consist of two main elements: 1) integration within the state's systems and technologies and, 2) integration with external business partners such as the federal government, carriers, producers, and small businesses. Integration strategy may include links with databases and other systems and website interfaces. Integration will allow for sharing of data and business processes among connected applications or data sources, increasing efficiencies and maintaining data integrity across systems.</p>
7	<p>Develop an Exchange operations plan.</p>	<p>An operations plan will define the resources and business processes necessary for the Exchange to provide services to consumers in West Virginia. It answers questions such as who is doing what? What are the day to day activities and processes? What personnel, equipment, and materials are required? How will suppliers (e.g., carriers), other business partners (e.g., producers), and vendors be used and involved? The Exchange's operations plan should include development of high level processes for the following key functions:</p>



#	Strategic IT Initiative	Description
		determination of exemption from the individual responsibility requirement and payment; eligibility determination; eligibility appeals; streamlined application and enrollment; enrollment via an Internet portal, telephone through a call center, mail, and in person; plan certification/recertification/decertification; plan monitoring and review; plan quality rating; plan reinsurance and risk adjustment; reconciliation of reductions in enrollee out-of-pocket costs; determination of issuer credits; administration of premium tax credit and cost-sharing reduction; call center functionality; provision of Exchange website and calculator; consumer assistance and Navigator programs; consumer outreach and education; distribution of applications and notices; oversight and monitoring of financial integrity; SHOP-specific administration; notification and appeals of employer liability for the employer responsibility payment; and information reporting to IRS and enrollee. The operations plan should also encompass privacy and security policies and procedures.
8	Complete business process mapping for core and supporting Exchange business operations.	Business process mapping and creation of flowcharts will define new and existing processes required by the Exchange. Process mapping will help identify areas where policies and procedures are needed as well as what, if any, underlying technology is needed to support those processes. In addition to detailed documentation of process steps, mapping should include who is responsible for each step, what standards should exist for each step (e.g., average time for a consumer to determine eligibility and enroll), and how process success is defined.

A timeline for beginning and completing the initiatives was developed based on their prioritization and urgency (see Table 26). The majority of issues were deemed “critical priority”, requiring immediate focus and attention in order to position the Exchange to meet federally-mandated milestones, gate reviews, and implementation dates; no initiatives were deemed “low priority” (i.e., able to be addressed after Exchange Go-live). The BerryDunn and OIC teams recognize that progress on several of the initiatives may continue after the slated completion date as known requirements evolve, new requirements are developed, and key decisions are made by the federal government, the Exchange Board, and other key stakeholders.



Table 26: Strategic IT Initiative Timeline

									HHS Approval		Exchange Go-Live					
#	Strategic IT Initiatives	2011			2012				2013				2014			
		Oct	Nov	Dec	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1	Project Work Plan and Project Management Office	Work Plan														
2	Business Plan															
3	Medicaid/CHIP/OIC Work Group															
4	Procurement Strategy															
5	RFP Process															
6	IT Integration Strategy															
7	Operations Plan															
8	Business Process Mapping															



8.0 HIX IT Design Approaches

This section of the report outlines the design approaches for the Exchange IT components.

The Exchange is a complex policy, technology and administrative undertaking that requires integrated planning and a holistic view of the multiple systems and business processes required for it to meet business goals and comply with federal regulations. Formulation of a clear Exchange IT strategy and development of an Exchange IT implementation road map are dependent upon the selection of an Exchange IT design approach. We have identified four viable HIX IT design approaches for the state to consider, listed in Table 27 below, based on the following assumptions:

- A decision about the Exchange IT design approach should be made before any decisions are made about the procurement of Exchange IT components.
- All four approaches meet all of the Technical and Functional Gaps identified in Section 3.0.
- All four approaches reflect compliance with the federal guidance to develop and utilize a single common business rules engine (BRE) for determining eligibility for the Exchange, Medicaid and CHIP populations whose eligibility will be determined by the new MAGI income standard.
 - This is the federal expectation.
 - This approach benefits the state Exchange because to the extent that Medicaid functions are consolidated in the Exchange, federal matching dollars will be available to support the Medicaid-allocated portion of Exchange operations starting in 2015, when the ACA mandates that Exchanges be self-sustaining and Exchange grant funding is no longer available.
- It is the state's goal to preserve horizontal integrated eligibility determination.
- The state's long-term goal is one integrated eligibility system/service for all state health insurance subsidy (Exchange, Medicaid and CHIP) and human services programs (SNAP, TANF, etc).
- It may be necessary to operate and integrate or interface two separate eligibility systems (new BRE and legacy RAPIDS) in order to meet the October 2013 deadline for the Exchange to be operational. Approaches 1, 2 and 3 have a "sub-option" to integrate all eligibility for all health and human services programs for the October 2013 go-live; take a phased approach and integrate the new ACA-required eligibility categories first, and the "legacy Medicaid categories" and other human services programs over time; or continue to determine non-MAGI eligibility in the legacy system.
- Eligibility business rules for Medicaid populations whose eligibility is not income-based and for other human services programs could be migrated to the BRE over time.
- The Exchange is responsible for making Medicaid determinations for the MAGI population only. It must screen for non-MAGI Medicaid eligibility and ensure seamless transition of those individuals who may be eligible for Medicaid on a basis other than MAGI to Medicaid for further eligibility assessment.
- In Approaches 1-3, the same business rules engine could potentially be used for plan comparison and SHOP functions in addition to MAGI eligibility.
- Each of the four approaches identified could be configured to meet all federal requirements and could meet federal timelines, though some approaches have a higher schedule risk than others.



- Any of the four approaches could take advantage of re-usable components developed by Early Innovator states.
- Any of the four approaches could utilize the application website screen design templates created by the UX2014 project.
- Any of the four approaches could be built out to include the SHOP Exchange. In addition to selecting an HIX design approach, the state should decide in a timely manner whether it will create a separate SHOP and Individual Exchanges or a single Exchange combining the two.
- SERFF and SBS can be incorporated into any of the four design approaches to supply some of the Plan Management functionality (SERFF) and customer assistance, licensing and oversight functionality (SBS).
- Regardless of the approach selected, the state can work with the Office of Technology to further assess the feasibility of leveraging and estimated costs associated with OT's Cisco Contact Center and Mailroom, and DHHR to determine the status of the Master Data Management solution procurement and whether or not there is an opportunity to leverage this project for the Exchange. These tasks can be conducted in parallel with the procurement process if the state structures the RFP in such a way that asks vendors to price IT components separately.

The Exchange may consist of a combination of existing state systems, Commercial-Off-the-Shelf (COTS) products, system components developed by other states and/or the federal government, and custom components. These four HIX IT Design Approaches offer four viable frameworks for integrating multiple systems and components to create a cohesive Exchange IT environment.

Table 27: HIX IT Design Approaches

HIX IT Design Approach 1	Existing state IT assets drive the Exchange IT design.
HIX IT Design Approach 2	Newly-procured IT assets drive the Exchange IT design.
HIX IT Design Approach 3	Partnerships with other states to procure shared IT assets drive the Exchange IT design.
HIX IT Design Approach 4	A State-Federal Partnership or Federally-facilitated Exchange drives the Exchange IT design.

The timing for selecting an approach is critical, given the applicable federal deadlines. A design approach must be selected in order to write the RFP(s).

- A State-run Exchange must be at least conditionally certified for operational readiness by January 2013.
- Plan Management functionality must be operational and ready to accept applications for QHPs from carriers by early 2013.
- The Exchange must be operational to begin to accept applications for the initial open enrollment period, October 2013.



- It will take at least two months to develop requirements and draft the RFP, even with leveraging RFPs from other states.
- If the Board is in place and the purchasing exemption can be exercised, time for the state to approve the RFP could be reduced to one month.
- The state should allow at least one month for vendor responses, and the state would need at least one month for vendor selection and negotiation.
- Given these schedule assumptions, the procurement process will take a minimum of five months. However, it could take several more months if the Board is not in place and the RFP must go through the normal state purchasing process.
- OIC should consider alternative procurement approaches, such as utilizing the state's Purchasing process, if it does not appear that the Exchange Board will be appointed in time to approve the RFP.

Key considerations related to each of the four HIX IT design approaches are discussed below.

HIX IT Design Approach 1	Existing state IT assets drive the Exchange IT design.
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Description and Related Assumptions

In this scenario, RAPIDS, the state's existing benefits eligibility determination system, is used as the platform to build out new IT functionality for the Exchange, including the Shared Eligibility Service for MAGI (income-based) eligibility determination for insurance subsidies, Medicaid and CHIP, by re-using and enhancing existing IT infrastructure and components (such as production of notices, data warehouse and business intelligence, and document management); other existing state systems such as SERFF and SBS are enhanced to meet ACA requirements and incorporated into the Exchange platform; and new components necessary to meet ACA requirements such as SHOP functionality are acquired through agreements with other states or purchase of COTS products and integrated. This approach would require very close collaboration between the Exchange and DHHR to ensure the new system meets the business needs of all system users - Medicaid, the Exchange, CHIP, and other state subsidy programs.

Key Considerations

The main advantages of this approach are:

- RAPIDS is a state-owned system that has been in place since 1996.
- This approach keeps all state eligibility determination functions within the existing state eligibility system, thus making it the least risky in terms of data conversion and system integration.
- RAPIDS already has several of the key business and technical components required by the Exchange, including relatively newer hardware, integrated eligibility determination, a data warehouse, a document management system, ability to produce correspondence, and many interfaces with external systems for eligibility data verification.
- The ability to re-use existing components that have a proven track record of functioning well together to meet business needs similar to the Exchange could save the state time and money.
- RAPIDS has a self-service consumer web portal (inROADS) that could be leveraged as the Exchange web portal. inROADS would require significant enhancements to meet ACA requirements, but its existence could save the state time and money.



- It retains the horizontally-integrated eligibility system.
- Under the revised cost allocation guidance, other benefit programs such as SNAP and TANF could benefit from the core system enhancements such as the business rules engine at no cost to those programs. These enhancements could be phased in over time in order to mitigate the schedule risk.
- Supports the federal vision of a “Shared Eligibility Service” between the Exchange, Medicaid and CHIP.
- All Exchange DDI is managed by a single vendor.
- Key IT systems – SERFF and SBS – that are being effectively utilized by OIC, a key Exchange business partner, are integrated into the Exchange.

Some of the primary challenges or disadvantages of this approach are:

- The ACA standards and requirements for a business rules engine are such that little of the existing RAPIDS mainframe eligibility determination functionality can be re-used.
- Pursuing this approach would require very close collaboration between the OIC and DHHR to ensure that vendor work, system work, and all users’ policy needs and program and business goals are effectively coordinated and achieved.
- RAPIDS was designed around the business needs of what is now an out-moded eligibility determination process – one that is based upon face-to-face contact with an eligibility worker and a complex eligibility cascade with over forty different Medicaid eligibility categories. The ACA’s simplification of Medicaid eligibility categories and the use of the MAGI eligibility determination process for most Medicaid and CHIP applicants calls for the consideration a new eligibility system design framework.

If the state did not pursue Approach 1, it would have three alternatives, discussed below as Approaches 2, 3 and 4: develop an Exchange “from scratch” using new infrastructure and a combination of existing state systems, COTS products and components from other states customized to meet West Virginia’s needs; partner with other states to develop shared Exchange infrastructure or create a regional partnership; or partner with the federal government for the development of the Exchange. There are no other existing platforms within the state to consider building the Exchange on. The state’s MMIS was not considered a viable platform for building out the Exchange because it is a vendor-owned and operated system that is currently up for re-procurement.

HIX IT Design Approach 2	Newly-procured IT assets drive the Exchange IT design.
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Description and Related Assumptions

In this approach, the Exchange is developed “from scratch,” with new infrastructure and software, including potentially a new eligibility system, and leverages existing systems when possible.

- All Exchange IT functionality, with the exception of that provided by state systems that can be leveraged, would be competitively procured. A systems integrator vendor would be procured to ensure the effective integration of all Exchange IT hardware and software, both existing and new.
- SERFF and SBS could be integrated with the new Exchange IT.



-
- A new Shared Eligibility Service could be developed to handle all MAGI eligibility determination for Medicaid, CHIP and insurance subsidies. It would integrate or interface with RAPIDS as necessary in the short-term, but RAPIDS could remain “as is” in the future Exchange environment from the perspective of ACA-related (i.e. MAGI) eligibility determination requirements. RAPIDS could continue to handle non-MAGI Medicaid eligibility determination and eligibility determination for other state subsidy programs.
 - RAPIDS could be enhanced to provide the Shared Eligibility Service functionality.

This approach has many variations and does not imply extensive custom development, but acquisition and customization of IT components that are “new” to West Virginia; they may be COTS products, shared services, re-usable components from Early Innovator states or the federal government, or otherwise acquired based on proposed vendor solutions.

Key Considerations

This approach also has advantages and disadvantages. The primary advantages of this approach are the ability to benefit from the latest technology and functionality in the marketplace while at the same time leveraging key existing state IT systems – SERFF and SBS – that are being effectively utilized by OIC, a key Exchange business partner. Moreover, as described in section 2.3.1.3, guidance provided by CMS in November 2011 suggests additional flexibility in the functions that may be shared with the federal government in a State-based Exchange environment. For example, a State-based Exchange could use Federally-managed services to make determinations for advance payments of the premium tax credit, cost-sharing reductions and exemptions from the individual responsibility requirement.

If a new eligibility system is procured, this approach requires agreement with DHHR to enable the Exchange to lead the procurement and development of the Shared Eligibility Service for Exchange, Medicaid and CHIP eligibility determination. If RAPIDS is leveraged to provide the eligibility functionality and another systems integrator is engaged to provide other core Exchange components, there is a potential for logistical and technical challenges related to the involvement of multiple vendors. In addition, this approach may be the riskiest in terms of cost; time to procure, design, develop and implement; impact on state resources; integration with the state’s existing eligibility system (although the extent to which this will be necessary has not been determined); and scope, as no existing ACA-compliant Exchange exists to learn from. However, COTS products from the private insurance marketplace and reusable IT components from Early Innovator states (such as the MAGI business rule engine) should be available in the near future and able to be integrated together and incorporated into a “new” Exchange environment, thus decreasing some of the risk. Moreover, even within a service-oriented architecture, it can be technically challenging to “cobble together” a holistic solution from numerous different components.



HIX IT Design Approach 3

Partnerships with other states to procure shared IT assets drive the Exchange IT design.

Description and Related Assumptions

This approach is a variation of Approach 2, with mostly new IT hardware and software being acquired and leveraging state systems such as SERFF and SBS when possible, but West Virginia shares the risk and cost of developing IT components that provide standard functionality required by all states, such as an eligibility business rules engine and a premium calculator, with other states. In this scenario, like in Approach 2, a new eligibility system would be developed and interfaced with RAPIDS, which would be phased out over time. In this scenario, the state could partner with any other state(s) in the country, not necessarily in its geographic region, to share IT components, or it could pursue a regional solution, which could entail more extensive integration of Exchange functionality and IT governance with selected neighboring states.

Key Considerations

This is the design approach we know the least about, as there is no operational precedent for a multi-state partnership or regional Exchange. The New England States Collaborative Insurance Exchange Systems (NESCIES), created as part of the commonwealth of Massachusetts' Early Innovator Grant, is the closest working model we have to consider. NESCIES states are participating in Exchange IT solution design discussions with Massachusetts, may participate in joint procurements with Massachusetts, and may re-use some IT components Massachusetts is developing, but it is not a regional exchange.

West Virginia is talking to neighboring states about forming a regional Exchange and/or joining together to procure common IT components. The advantages of this approach are shared risk, shared cost, and shared effort, which might help the state achieve the aggressive federal timeline for Exchange operation. Risks include poor client service and longer response time for state-specific requests and customization from a vendor who would be accountable to multiple parties. In addition, the formation and administration of this type of partnership could be time-consuming and a drain on limited state resources and the logistics of managing the procurement process across multiple states could be challenging.

HIX IT Design Approach 4

A State-Federal Partnership or Federally-facilitated Exchange drives the Exchange IT design.

Description and Related Assumptions

This approach has two variations: the transitional State Partnership Model and the Federally-facilitated Exchange (FFE). As discussed in Section 2, the federal government has proposed a model for a transitional partnership with states. In the proposed State Partnership Model, the federal government develops and operates core Exchange IT functionality including eligibility determination and the web portal as an interim solution for states who are not ready to meet federal deadlines. In this model, States have the option to operate the Plan Management functionality and/or some of the customer assistance services. The long-term goal is to transition States from the Partnership model to a fully State-operated Exchange. HHS has not clarified whether or not the State Partnership model constitutes a FFE.



States can also opt to have the federal government operate its Exchange as an FFE. As described in section 2.3.1.3, guidance provided by CMS in November 2011 suggests additional flexibility in the functions that may be shared with the federal government in a State-based Exchange environment, and may be provided by states when the FFE option is elected. In the FFE model, HHS intends to structure business processes so that participating states retain ownership of traditional insurance regulatory activities.

HHS has procured a vendor to develop the key IT components of the federally-run exchange.

Key Considerations

Based on what we currently know about the proposed federal models, the advantages of partnering with the federal government or choosing the FFE include:

- Potentially smoother federal certification;
- Less demanding on state resources for project management and technical oversight;
- Sharing risk;
- Potentially lower cost, depending on the number of states who participate;
- Allows the state to focus limited resources on the aspects of the Exchange that are most state-specific: customer service and plan management, and let the federal government handle the development of the functionality that is common to all states;
- Less intensive procurement process (less requirements development, smaller RFP);
- Less schedule risk as the vendor has already been procured; and
- Fewer state procurement needs.

The disadvantages include:

- The state would have limited control over and input on IT design decisions;
- May be challenging to interact with the federal project manager and/or selected vendor regarding system design and changes;
- May be challenging to integrate the FFE with existing and new state systems and business processes; and
- Making systems changes and state-specific customizations could be slow depending on the total number of states involved.

Further discussion with HHS about the details of the partnership model and the FFE is necessary in order to fully assess the pros and cons of this approach.





Appendix A: Glossary of Terms and Abbreviations

This section of the report contains a glossary of the common terms and abbreviations used throughout the deliverable.

Term	Definition
ACA	Affordable Care Act
AHS	Automated Health Systems
ALM	Application Lifecycle Management
APCD	All Payer Claims Database
API	Application Programming Interfaces
AVRS	Automated Voice Response System
BAS	Benefits Administration System
BDC	Broadband Development Council
BMS	Bureau for Medical Services
BRE	Business Rules Engine
BTOP	Broadband Technology Operations Program
CALT	Collaborative Application Lifecycle Tool
CAP	Consumer Assistance Program
CHIP	Children's Health Insurance Program
CMS	Center for Medicare & Medicaid Services
COTS	Commercial Off-the-Shelf
CRM	Customer Relationship Management
CSD	OIC Consumer Services Division
DDI	Design, Development, and Implementation
DHHR	Department of Health and Human Resources
DOC	Department of Commerce
DW/DSS	Data Warehouse/Decision Support System
EFT	Electronic Funds Transfer
ELC	Exchange Life Cycle
ERA	Exchange Reference Architecture
ERP	Enterprise Resource Planning
FACTS	Families and Children Tracking System



Term	Definition
FFE	Federally-Facilitated Exchange
FFP	Federal Financial Participation
FPL	Federal Poverty Level
GAO	Government Accountability Office
GOHELP	Governor's Office of Healthy Enhancement and Lifestyle Planning
HCA	Health Care Authority
HCBS	Home and Community Based Services
HCTC	Health Coverage Tax Credit
HDMS	Health Data & Management Solutions
HHS	Department of Health and Human Services
HIE	Health Information Exchange
HIN	Health Information Network
HIPAA	Health Insurance Portability and Accountability Act
HIT	Health Information Technology
HIX	Health Insurance Exchange
HMO	Health Maintenance Organization
HRIS	Human Resources Information Systems
HRSA	Health Resources and Services Administration
inROADS	Information Network for Resident Online Access and Delivery of Services
IT	Information Technology
IVR	Integrated Voice Response
IV&V	Independent Verification and Validation
JAD	Joint Application Development
JCDC	Jackson County Development Center
MARS	Market Analysis Review System
MAGI	Modified Adjusted Gross Income
MAPT	Market Analysis Prioritization Tool
MCAS	Market Conduct Annual Statement
MCO	Managed Care Organizations
MDM	Master Data Management
MEGAA	Medicaid Eligibility Gap and Alternative Analysis



Term	Definition
MITA	Medicaid Information Technology Architecture
MMIS	Medicaid Management Information System
NAIC	National Association of Insurance Commissioners
NCQA	National Committee for Quality Assurance
NIEM	National Information Exchange Model
NIPR	National Insurance Producer Registry
NPRM	Notice of Proposed Rule Making
OIC	Offices of the Insurance Commissioner
OIG	Office of the Inspector General
ONC	Office of the National Coordinator
OPTins	Online Premium Tax for Insurance
OSCAR	Online Support Collections and Reporting System
PAAS	Physician Assured Access System
PDB	Producer Database
PBM	Pharmacy Benefit Manager
PEIA	Public Employees Insurance Agency
PMO	Project Management Office
POS	Point of Sale
QHP	Qualified Health Plan
RAPIDS	Recipient Automated Payment and Information Data System
RFI	Request for Information
RFP	Request for Proposal
RFQ	Request for Qualifications
RFR	Request for Response
SBS	State-Based Systems
SERFF	System for Electronic Rates and Forms Filing
SHAP	State Health Access Program
SHOP	Small Business Health Options Program
SNAP	Supplemental Nutrition Assistance Program
SOW	Statement of Work
SSA	Social Security Administration



Term	Definition
TANF	Temporary Assistance for Needy Families
WMS	Welfare Management System
WVFIMS	West Virginia Financial and Information Management System
WVHIN	West Virginia Health Information Network
WVOT	West Virginia Office of Technology
WVTA	West Virginia Telehealth Alliance



Appendix B: Project Participant List

This section of the report lists all of the individuals who participated in the Current Environment and strategic IT issues phases of the Project and their organizational affiliation.

Name	Agency/Entity	Attended Kickoff	Interviewed	Contacted for Information	Attended Strategic IT Issues Work Session
Alan McVey	Independent Insurance Agents of WV				X
Alex Macia	For Delta Dental				X
Amy Wenmoth	Health Care Authority			X	
Arnold Hassen, PhD	WV School of Osteopathic Medicine				X
Bill Richardson	BerryDunn (for BMS)				X
Bob Roset	The Health Plan		X		X
Brandy Pierce	BMS – Managed Care		X		
Brenda Howell	FACTS			X	
Brian Pratt	Office of Technology - WVFIMS		X		
Bruce Martin	WesBanco Insurance Services; IIAWV				X
Cheri Harpold	OIC – Finance	X	X		
Chip Lucas	The Health Plan		X		X
Chris Bailes	OIC – Fraud Department		X		
Chris Budig	WV Telehealth	X	X		
Chris Clark	GOHELP	X		X	X
Christy Thomas	Molina (DHHR/BMS – MMIS)				X



Name	Agency/Entity	Attended Kickoff	Interviewed	Contacted for Information	Attended Strategic IT Issues Work Session
Dan Shriver	West Virginia Office of Technology			X	
Dan Soper	Coventry			X	
Darlene Thomas	DHHR -OT	X	X		X
David Gillespie	OIC – Finance	X	X		
Debi McCoy	OIC –Health Policy				X
Dena Wildman	OIC – Consumer Service	X	X		
Dennis Rinehart	OIC – Fraud Department	X	X		
Diana Hypes	OIC -IT	X	X		X
Ed Dolly	BMS	X	X		
Elizabeth Webb	OIC –Agent Licensing		X		X
Fred Earley	Highmark BCBS			X	
Gary Griffith	OIC – Fraud Department	X	X		
Gary McIntyre	Highmark BCBS				X
Geoff Christian	Producer		X		
Gray Marion	Producer		X		
Harriett Fitzgerald	Health Care Authority			X	
Heather Grzych	Delta Dental				X
James Myers	City Insurance Pro				X
Jason Haught	PEIA	X	X		
Jeff Album	Delta Dental			X	X
Jennifer Martin	UnitedHealthcare		X	X	



Name	Agency/Entity	Attended Kickoff	Interviewed	Contacted for Information	Attended Strategic IT Issues Work Session
Jeremiah Samples	OIC –Health Policy	X	X		X
Jill Miller	Molina (Medicaid MMIS)				X
Jim Pitrolo	Health Care Authority			X	
Jinny Moles	OIC – Consumer Service	X	X		
John Beane	OIC – IT	X	X		X
John Fleig	UnitedHealthcare			X	
John Grey	Health Care Authority			X	X
Joseph Deacon	Deacon & Deacon Insurance Agency		X		X
Joy Higa	UnitedHealthcare		X		
Kathy Beck	OIC – Consumer Service			X	X
Kathy Damron	OIC – Administrative Services		X		
Kathy Moore	WV HIN	X	X		
Keith Zalaznik	DHHR – RAPIDS (Deloitte Consulting)		X		X
Kelly Newhouse	Coventry and NAHU				X
Kim Covert	Coventry Health Care		X		
Kim Elkins	OIC –Rates and Forms				X
Kyle Schafer	West Virginia Office of Technology		X		
Laura Haines	Hartford			X	
Lester Thomas	Office of Technology - WVFIMS		X		



Name	Agency/Entity	Attended Kickoff	Interviewed	Contacted for Information	Attended Strategic IT Issues Work Session
Linda Zinn	Coventry Health Care		X		
Lisa Calderwood	OIC –Health Policy				X
Mark Coetzer	West Virginia Office of Technology		X		X
Mark Hooker	OIC – Market Conduct		X		X
Martha Boling	DHHR/BCF RAPIDS				X
Martha Morris	OIC – Market Conduct		X		
Melinda Kiss	OIC – Finance	X	X		X
Mike Farren	OIC – IT		X		
Mitch Collins	WellPoint			X	
Monroe Gillespie	OIC – IT		X		
Nancy Malacek	OIC –Health Policy	X		X	
Pam Mills	BCF –Office of Customer Services		X		
Pam King	OIC –Health Policy				X
Paul Shannon	DHHR Office of Technology		X		
Phil Weikle	WV HIN	X		X	
Phil Wright	The HealthPlan			X	
Richard Lemons	FACTS			X	
Richard Pickens	Office of Technology - WVFIMS		X		
Rick Dorman	Deloitte Consulting (RAPIDS)				
Rod Friend	DHHR - RAPIDS	X	X		X
Roger Neptune	DHHR - RAPIDS	X	X		X



Name	Agency/Entity	Attended Kickoff	Interviewed	Contacted for Information	Attended Strategic IT Issues Work Session
Sarah Young	BCF –Office of Customer Services		X		
Scott Drake	Arnold Agency				X
Scott Miller	OIC – IT		X		
Sharon Carte	CHIP	X	X		
Shelly Baston	Health Care Authority			X	X
Stacey Shamblin	CHIP	X	X		X
Susan McGill	Coventry Health Care		X		
Tammy Haynes	PEIA		X		
Ted Cheatham	PEIA	X	X		
Tom Whitener	Market Conduct		X		
Tonya Gillespie	OIC Rates and Forms		X		
Vinny Prasad	DHHR – RAPIDS (Deloitte Consulting)		X		
Wilma Garbett	Office of Technology - WVFIMS		X		



Appendix C: Interview Outline

Information Technology (IT) Strategic Plan

Interview Outline

State of West Virginia Office of the Insurance Commission
Health Insurance Exchange (HIX)

Objective: The purpose of the on-site interviews is to determine the current functionality and to identify assets that may be leveraged for accomplishing West Virginia's Health Insurance Exchange (HIX). Systems will be assessed for both functional attributes (what the user needs to do via the IT system) and technical attributes (system architecture and integration capabilities) to support all or part of West Virginia's Health Insurance Exchange systems requirements.

I. Introductions

II. Current Business Environment

Meeting participants should be prepared to discuss the business processes/functions that are supported by the system/agency.

- a) What types of transactions do you conduct?
- b) What systems currently support these transactions?
- c) If relevant, how long does a typical transaction take to process?
- d) What volumes of transactions are processed?

III. Current Technical Environment

Meeting participants should be prepared to discuss the software applications and technology that is currently used by the department to support existing business processes.

- a) Who are the users of the currently supported software programs?
- b) How many users?
- c) What information do you provide to internal stakeholder departments?
- d) What information is provided to external entities?
- e) What are the security measures for the current hardware environment? (i.e. – Monitoring Systems, Access Control Systems, etc.)



-
- f) What measures are in place for disaster recovery? (i.e. - Redundant Power Supply, Off-site backups, etc.)
 - g) How is the system/solution funded?

IV. Planned Future IT Initiatives

Meeting participants should be prepared to discuss any current IT Initiatives.

- a) Do you have any new IT Initiatives planned or under development? (i.e. – Planned Enhancements/Modifications, New Procurements, New Systems/IT Projects, etc.)
- b) If so, what is their status?
- c) If so, how are they being funded?

V. Integration Capabilities

Meeting participants should be prepared to discuss the integration capabilities of the software programs currently supported.

- a) Does the currently supported software program have the ability to integrate with different systems? If so, in what format?
- b) Does the currently supported software program have the ability for real-time verification from other systems?
- c) What systems do your current software programs interface with? What is the frequency of the data interface? (i.e. – real-time, monthly, weekly, etc.)

VI. Future Exchange Environments

Meeting participants should be prepared to discuss the capabilities of leveraging other systems with the West Virginia Health Insurance Exchange.

- a) In what ways do you envision the future West Virginia Health Insurance Exchange could leverage your systems environment?
- b) In what ways do you envision the future West Virginia Health Insurance Exchange could leverage other systems environments of the state?



Appendix D: Prioritized List of Strategic IT Issues

ID #	Strategic IT Issue	Supporting Comments	Priority	Eligibility and Enrollment	Customer Service	Communications	Plan Management	Financial Management	Oversight	SHOP
1	A plan for how the HIX will seamlessly coordinate with the state's existing Eligibility and Enrollment systems and what existing functionality can be leveraged has not been developed.	Most individuals will be evaluated for eligibility to use the HIX, tax credits/cost-sharing, Medicaid, and CHIP using a coordinated set of rules. As a result, CMS expects the use of a common or shared eligibility system or service to adjudicate placement for most individuals.	C	X						
2	A decision on what entity will be responsible for enrollment of Medicaid and CHIP members has not been made.	Enrollment of Medicaid members - through the HIX or otherwise - will need to be coordinated with BMS. BMS has the responsibility to facilitate health plan selection for enrolled individuals, but may arrange with the HIX to undertake this function.	C	X						
5	From an IT planning perspective, the Exchange needs to estimate how many people will be entering the Exchange through the		C	X	X					



ID #	Strategic IT Issue	Supporting Comments	Priority	Eligibility and Enrollment	Customer Service	Communications	Plan Management	Financial Management	Oversight	SHOP
	phone/call center.									
7	Consumers may be uncomfortable with the amount of personal information accessible through the HIX. The technical design of the HIX must include a strong focus on security and compliance with federal regulations related to the security/privacy concerns for consumers.	Consider what functionality can exist outside of the secure portal, such as a subsidy eligibility calculator for screening, so that consumers who may not qualify for subsidies can figure that out without going through the full application.	C	X	X					
10	Eligibility and enrollment systems will need to distinguish "newly eligible" Medicaid enrollees (i.e., "the MAGI population") from those who are new to Medicaid but would have been eligible under the existing rules for the purposes of determining the appropriate federal match rate.	Is this an HIX issue or just DHHR? May be a DHHR-only issue. The question is will the MAGI-calculator need to have a field to identify individuals who qualify for Medicaid based on MAGI.	C	X						



ID #	Strategic IT Issue	Supporting Comments	Priority	Eligibility and Enrollment	Customer Service	Communications	Plan Management	Financial Management	Oversight	SHOP
11	HIX systems need to support paper, in-person, telephonic, and Internet eligibility and enrollment functions, for example document management.	Audit trail required, e.g., to determine how/if producers are compensated for enrolling members/groups in the Exchange? Need better estimates of volume of people expected to use different entry points, e.g., Internet vs. paper?	C	X	X					
12	A premium tax credit and cost-sharing subsidy calculator doesn't exist in the current environment and will need to be developed for the HIX.	Should a "paper-based" calculator, e.g. tax worksheets provided by IRS, be developed too? Should the calculator be outside secure portion of portal to facilitate use by navigators, etc?	C	X	X					
13	A process for capturing data from carriers and creating standardized comparative information on each available QHP (i.e., a carrier menu) for display to consumers needs to be developed.	Is there anything that can be leveraged from existing processes carriers have for submitting data to Medicare and private exchanges, e.g., eHealthInsurance.com? Does WebMD or other vendor already have a master provider index? Each carrier has its own provider	C	X	X					



ID #	Strategic IT Issue	Supporting Comments	Priority	Eligibility and Enrollment	Customer Service	Communications	Plan Management	Financial Management	Oversight	SHOP
		directory.								
16	Eligibility and enrollment systems need to support households whose members are eligible for different plans/programs.	Example: child eligible for CHIP, husband eligible for employer-sponsored insurance, and wife eligible for premium tax credit and QHP enrollment.	C	X	X					X
17	Consumers will move between and on and off subsidies; system will need to be designed to manage this "churn" and make movement between programs seamless and ensure continuity of benefits.		C	X	X	X				X
18	The HIX must coordinate customer service activities of agents, CHIP, Medicaid, and QHPs and assure efficient distribution/management of consumer inquiries/requests and responses/outcomes via phone,	Consider single point repository as part of future requirements to facilitate coordination of customer service activities. - OIC is moving to a new CRM tool, MS Dynamics, through the	C	X	X	X				



ID #	Strategic IT Issue	Supporting Comments	Priority	Eligibility and Enrollment	Customer Service	Communications	Plan Management	Financial Management	Oversight	SHOP
	web, paper and face-to-face interactions.	ACA grant.								
21	Can existing rates and forms software used by the state (e.g., SERFF/SBS) be modified to support QHP certification/recertification/decertification and ongoing compliance?	<ul style="list-style-type: none"> - Can carrier data captured for certification filing also be used for viewing by consumers? - Continue discussions with NAIC regarding SERFF and SBS. If NAIC is not going to modify their systems, then an alternative needs to be identified. - Currently only HMOs are required to be certified. This process will need to be extended to cover all plans. - Can NAIC's MCAS (Market Conduct Annual statement) be modified to capture data needed for QHP accreditation? Mark Hooker following up. Can Exchange inquire on this NAIC database for certifying QHPs? 	C				X			



ID #	Strategic IT Issue	Supporting Comments	Priority	Eligibility and Enrollment	Customer Service	Communications	Plan Management	Financial Management	Oversight	SHOP
23	Can existing rate and forms software be used to manage and distribute new rate/benefit information that is required to be sent to the HIX, OIC, and HHS from carriers?	Rate/benefit info must be submitted to HIX annually for rate approval and other operational reasons and also must be sent to HHS for risk corridor program. See Comments related to #15 above.	C				X			
24	To remain certified, QHPs must make available a range of data to the public, HIX, OIC, etc. What HIX systems will collect this information and make it available to the consumer?	Plans already have some responsibilities for reporting to the federal government for Medicare and collect data for HEDIS measures. Can existing processes be leveraged?	C				X		X	
25	The HIX must be able to monitor QHP marketing practices, e.g., issuers can't discourage unhealthy members from enrolling.	OIC-Market Conduct already monitors carrier marketing practices. Need to determine what data needs to be reported to the public and how existing business processes need to be modified.	C				X		X	



ID #	Strategic IT Issue	Supporting Comments	Priority	Eligibility and Enrollment	Customer Service	Communications	Plan Management	Financial Management	Oversight	SHOP
26	A plan for establishing, monitoring and enforcing provider network adequacy standards for QHP certification, including making the network information available to the consumer, will need to be developed.	Currently West Virginia only monitors network adequacy for managed care and standards are minimal. The NPRM give states flexibility in setting standards and monitoring them, and additional rules are being considered. The Exchange will need to set the standards and develop an oversight plan. This could necessitate some data analytics functionality. GeoAccess is a COTS product in use by managed care organizations to analyze provider networks.	C				X			
29	A plan for business processes and IT systems needed to support the state's risk adjustment program needs to be developed.	<ul style="list-style-type: none"> - The Reinsurance Program will be implemented by a separate entity. - Should the carriers take ownership of risk adjustment? It is a pool of money that they will contribute to and distribute amongst each other. 	C					X		



ID #	Strategic IT Issue	Supporting Comments	Priority	Eligibility and Enrollment	Customer Service	Communications	Plan Management	Financial Management	Oversight	SHOP
30	A plan for how the All Payer Claims Database (APCD) will be created and utilized for the HIX has not been developed.	The project is considering additional work activity (funded by the level 1 Grant) to develop a strategic plan that defines the activities that must be completed in order to develop the APCD and how the APCD would inform/integrate with the CompareCare tool. Additionally, the development of a business and operational plan is being considered to address how the HIX would leverage and utilize this APCD information operationally, as well as how the tool (and information) would be shared with other state agencies.	C					X		
31	The state will need to decide if one HIX portal will serve the individual and small business (SHOP) markets or whether two portals will be used.	<ul style="list-style-type: none"> - This will be a Board decision. - The state is considering contracting with a private Exchange entity to implement the SHOP Exchange. 	C							X



ID #	Strategic IT Issue	Supporting Comments	Priority	Eligibility and Enrollment	Customer Service	Communications	Plan Management	Financial Management	Oversight	SHOP
32	A plan for how data exchange will occur between the HIX and small employers needs to be developed.	E.g., can employers upload data to HIX using Quicken or other small business software? How will paper submittals be managed?	C							X
33	A plan for how the SHOP HIX will manage premium collection, aggregation, and transmission needs to be developed.	Business processes need to be developed.	C	X			X			X
37	A plan for the federal HIX, including components that may be available as part of a state Partnership model, has not been developed.	Currently HHS is entertaining the idea of a partnership model for the federal HIX, which would allow states to leverage certain modules/core functionality from the federal HIX. This is still in the exploratory phase, with HHS working to setup workgroups to discuss with the states to see what functionality makes the most sense to try this with, and if states be willing to take part in this type of model.	C	X	X	X	X	X	X	X
38	Will the HIX do any premium aggregation in the individual Exchange and/or allow individuals	Business processes and Exchange system functionality to address these transactions	C	X	X					



ID #	Strategic IT Issue	Supporting Comments	Priority	Eligibility and Enrollment	Customer Service	Communications	Plan Management	Financial Management	Oversight	SHOP
	to pay their QHP premiums through the HIX?	would need to be developed.								
41	The HIX must create a system to identify and track consumers across systems and associate their data with them.	ThomsonReuters was recently awarded the contract for development of the WVHIN.	C	X						
44	Will the Exchange need to have a financial component that is potentially outsourced or will the State Treasury be able to accommodate all Exchange financial functions?	E.g., premium collection and remittance, collection of fees from carriers, etc.	C					X		
3	The Exchange will be trying to reach a population that has limited experience with IT and with the health care system.		H	X	X	X				
6	An IT system/process for handling exemption from the individual mandate responsibility requirement needs to be developed.	WV interested in having federal government (IRS) assume responsibility for this functionality.	H	X						



ID #	Strategic IT Issue	Supporting Comments	Priority	Eligibility and Enrollment	Customer Service	Communications	Plan Management	Financial Management	Oversight	SHOP
22	Issuers of QHPs must be accredited; what HIX systems will be needed to support the accrediting process?	- Currently only HMOs need to be accredited in West Virginia. Will need to expand this process to all issuers. - Will NCQA and/or URAC be developing databases for states to access accreditation data?	H				X			
28	Current IT environment does not support quality data collection and assessment of QHP issuer quality improvement strategies.	Currently the state only looks at carrier quality improvement strategies for managed care.	H				X		X	
4	From an IT planning perspective, the Exchange needs to estimate how many people will be entering the Exchange through the website, paper, and in person.		M	X	X					
8	The Exchange will need to consider what consumer information will be allowed to be viewed by different parties based on user access rules and the emphasis on "no wrong door".		M	X	X					



ID #	Strategic IT Issue	Supporting Comments	Priority	Eligibility and Enrollment	Customer Service	Communications	Plan Management	Financial Management	Oversight	SHOP
9	Existing state systems currently do not support appeals processes for determining eligibility for insurance affordability subsidies and QHP enrollment.	The proposed rule regarding the appeals process requirement is forthcoming. Currently, OIC and DHHR have appeals processes for various programs, however none are automated.	M	X						
14	Preparation and distribution of applications and notices needs to be coordinated with carriers, the HIX, Medicaid and CHIP, including the existing IT systems that currently support such functionality.	Audit trail capabilities will be required to track originator of correspondence.	M	X		X				X
34	A plan for how access to the HIX will be provided to rural areas with limited access to broadband or to populations unable to afford broadband connectivity has not been developed.	The project is considering additional work activity (funded by the level 1 Grant) to provide access to "virtual enrollment portals" utilizing tablets in community settings to make eligibility determination and enrollment into health coverage programs more accessible to consumers.	M	X	X	X				X



ID #	Strategic IT Issue	Supporting Comments	Priority	Eligibility and Enrollment	Customer Service	Communications	Plan Management	Financial Management	Oversight	SHOP
39	How will the fees the Exchange assesses on participating carriers for HIX operations be collected?	Business processes and Exchange system functionality to address these transactions would need to be developed.	M						X	
40	How will the grants to the Navigators be processed?	Business processes and Exchange system functionality to address these transactions would need to be developed.	M		X				X	
42	HIX must allow for the pairing of QHPs and QDPs (Qualified Dental Plans) per the ACA requiring the HIX to allow the selection of a stand-alone dental carrier in the exchange to provide just the essential pediatric oral services separate from the other benefits in the EXBP (Essential Health Benefits Package).		M				X			
43	When QDP and QHP are selected in tandem as provided under the ACA, HIX must calculate and allocate federal subsidies (when eligible) between the two carriers selected, and also calculate and route the balance owed by the		M					X		



ID #	Strategic IT Issue	Supporting Comments	Priority	Eligibility and Enrollment	Customer Service	Communications	Plan Management	Financial Management	Oversight	SHOP
	Plan enrollee making such selection.									
15	Cost of paper mailings is high. Electronic delivery of required notices to a consumer's HIX account would be more cost effective. Can the state offer an opt-in option to consumers for paper mailings?	Does "in writing" in the rules mean paper? Follow-up with federal government required.	L		X	X				



ID #	Strategic IT Issue	Supporting Comments	Priority	Eligibility and Enrollment	Customer Service	Communications	Plan Management	Financial Management	Oversight	SHOP
19	<p>The HIX must determine what types of organizations it will allow to be "Navigators", what the licensing criteria will be, if existing IT systems can be leveraged to support the licensing process (NIPR, PDB, SBS), and what IT systems will be needed to support the role of the Navigator.</p>	<ul style="list-style-type: none"> - Look at licensing requirements for Medicare Advantage. - inROADS has "Community Partners" - have MOUs w DHHR - they can go in to RAPIDS and enter applications on behalf of a consumer - Consider different Navigator certification requirements for different Exchange populations, such as one for SHOP, one for subsidies, etc. - System will need to authenticate Navigators. - Navigators and brokers will need an HIX identification number. - Data about Navigator and broker licensing status will need to be passed to the Exchange. 	L	X	X	X			X	



ID #	Strategic IT Issue	Supporting Comments	Priority	Eligibility and Enrollment	Customer Service	Communications	Plan Management	Financial Management	Oversight	SHOP
20	Will the Exchange compensate producers and Navigators? If so, how will the payments be made?	<p>The NPRM says little about this subject.</p> <p>The HIX will need to be able associate an enrollment that is completed to a Navigator or broker in order to pay the Navigator/broker for the transaction.</p> <p>A new business process would need to be developed for this transaction.</p>	L		X				X	
27	A plan needs to be developed for the Exchange to monitor brokers and Navigators.	Includes monitoring broker and Navigator marketing practices.	L		X					X
35	The Exchange Board and executive sponsorship for the HIX is not in place.	<p>For many different reasons the political environment in West Virginia has been challenging to obtain executive sponsorship and establish a board responsible for the development of the HIX. Executive sponsorship at the Governor and Commissioner levels as well as establishment of the board will be critical in order to be successful with this project. This</p>	N/A	X	X	X	X	X	X	X



ID #	Strategic IT Issue	Supporting Comments	Priority	Eligibility and Enrollment	Customer Service	Communications	Plan Management	Financial Management	Oversight	SHOP
		issue would likely have impacts on the IT design of the HIX if left unresolved.								
36	The HIX must be operational by the fall of 2013, leaving approximately 24 months to hire a software vendor, design the system, develop the system, test the system, train state staff, and roll-out into production.	The timeline may have impacts on the IT design of the HIX.	N/A	X	X	X	X	X	X	X



Appendix E: Early Innovator State Questionnaire

INTERVIEW OUTLINE

State of West Virginia Office of the Insurance Commission
Health Insurance Exchange (HIX)

Objective: We have sent this interview outline to you because you were identified as one of five early innovator states for HIX. We will use the information you provide to help the State of West Virginia develop system requirements for the HIX and incorporate your lessons learned into the overall planning process. Your feedback will be valuable as the state undertakes this project.

I. Planning

- d) What partnerships have you formed with other state agencies for HIX IT planning? How are Medicaid and the Exchange working together?
- e) How are you working with issuers and producers on IT issues? Other external entities?
- f) Which partnerships have been most important during the planning process? What challenges have you faced? How have you addressed these challenges?
- g) Have you met key IT planning deadlines? If not, what have been the obstacles and how did you overcome them?

II. Current Procurement

- h) Are you procuring any IT components or services for the Exchange?
 - a. If not, why not? In-house development? Sole source? Existing vendor relationship?
 - b. If so, which HIX components and/or services? What is the status of the RFP (e.g., in development, on the street, reviewing proposals, vendor selected)? What challenges have you faced related to the procurement of IT components or services? How did you address them?

III. Design, Development, and Implementation Approach

- a) Are you buying, leasing, building, and/or customizing?
- b) What existing state and/or other IT systems/assets are you leveraging? What challenges has this presented? How have you addressed them?
- c) If not addressed in the previous question, how is the Exchange coordinating eligibility functions and requirements with the Medicaid eligibility system? Does your existing eligibility system include any other state programs besides healthcare? If so, how will these other eligibility determination be integrated into the Exchange?



- d) What IT functionality (if any) is planned for each of the six CMS HIX business areas (e.g., Eligibility and Enrollment; Plan Management; Financial Management; Communications; Customer Service; and Oversight)?
- e) Are you planning for a project management vendor? IV&V vendor? Single vendor or multiple?
- f) How many months are planned between project initiation and go-live? What risks have you identified?
- g) What components of your implementation approach (i.e., phased) could perhaps benefit West Virginia?
- h) Is the SHOP functionality integrated with the Individual Exchange or operating separately?
- i) How is Call Center functionality and staffing going to be provided?
- j) What are your expectations for leveraging federal technology resources/systems/solutions?

IV. Cost

- a) What is your planned budget for the Design, Development, and Implementation of Exchange IT components? What major categories does this break down into (i.e., personnel vs. hardware vs. software)?
- b) What is your estimated annual operating budget for IT related to the Exchange?
- c) What are your planned sources of funds for Exchange IT? (I.e., Establishment Grants - Level 1 and/or 2; CMS 90/10 eligibility systems, MMIS enhanced match, etc.)
- d) What models are you considering for financing the Exchange after 12/31/14?

V. Staffing

- a) How many state staff (FTE) are dedicated to Exchange planning and implementation?
- b) How many contracted staff (FTE) are dedicated to Exchange planning and implementation?



Appendix F: Strategic IT Initiative Descriptions

Each strategic IT initiative identified in Section 7.0 is presented utilizing the template below.

HIX Strategic IT Initiative	
This section of the template contains the initiative name. Each initiative is color-coded Blue , Green , Yellow or Red based on time-sensitivity	
Initiative Description	
This section of the template contains a description of the initiative.	
Initiative Source Information	
Functional Area:	This section of the template identifies the Business Area(s) the initiative is associated with: Eligibility and Enrollment, Customer Service, Communications, Plan Management, Financial Management, Oversight
Strategic Issue(s)	
#	List of the strategic issue(s) that this initiative or project addresses
Critical Tasks to Implement Initiative	
This section of the template lists the critical tasks required to implement the initiative.	
Anticipated Benefits	
This section of the template contains a checklist of the anticipated benefits that are expected from the initiative.	



HIX Strategic IT Initiative #1

Critical

Develop an Exchange project work plan and Project Management Office.

Initiative Description

A project work plan and Project Management Office (PMO) should be developed for the implementation of the Exchange. The PMO initiative should identify and help support the use of effective and appropriately scaled project management principals, processes, tools and techniques within the OIC. The work plan should specify the approach to managing project scope, resources, communications, and risks, as well as what must be completed and by when to assure readiness for HHS certification by January 2013 and go-live by October 2013. During the course of the project, a Project Manager should maintain the project work plan and make it available to the stakeholders as part of project status meetings. The tasks within the project work plan must describe the specific steps to undertake for each specific phase of Exchange development and implementation and will inform the Exchange operations plan.

Initiative Source Information

Functional Area:	Eligibility and Enrollment, Customer Service, Communications, Plan Management, Financial Management, Oversight
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Strategic Issue(s)

#	All
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Critical Tasks to Implement Initiative

- Establish an initiative owner and lead team.
- Develop a PMO Business Case and Charter document based on a strategic planning session.
- Present an overview of program and project management to provide team members with a common understanding of program and project management processes and knowledge areas.
- Conduct planning sessions to identify the methods, processes and tools for governance and management of the OIC's project portfolio, and conduct a series of work sessions to help the OIC select the initial project management practices, processes, tools and templates needed to achieve project benefits as soon as possible.
- Develop teams for projects in the Exchange project portfolio and initiate project management, including development of work plans.

Anticipated Benefits

- Creates a shared framework and planning approach to the overall Exchange project and smaller projects contained within.
- Establishes interdependencies between work streams, key milestones, and critical path activities; ensures the work plan is followed, vendors follow through with scope of works, and stakeholder meetings are conducted to stay on schedule with federally mandated milestones, gate reviews, and implementation dates.
- Implements governance processes to select, prioritize and monitor strategic business projects, assuring limited resources are being focused on the most important initiatives.
- Provides training, coaching and mentoring including the development and utilization of project management tools, templates and checklists.



HIX Strategic IT Initiative #2

Critical

Develop an Exchange business plan.

Initiative Description

A business plan is important to the success of any enterprise. Developing a plan will force those creating it to evaluate the Exchange in a critical and objective manner and will help create consensus around key business aspects of the Exchange; the finished plan will serve as a road map and decision-making tool that will help the Exchange successfully perform its operations and plan for the future. The plan will also serve as a communication tool to stakeholders, providing insight into the Exchange's vision and purpose. The business plan may include:

- Executive summary;
- Mission, vision and goals;
- Services and products;
- Market analysis;
- Communications/outreach strategy;
- Operations plan;
- Governance;
- Organizational structure, management team and personnel; and
- Financial plan including sustainability model, budget, and funding plans.

Although not all elements may be available immediately, the business plan should be augmented as additional information becomes available and decisions are made.

Initiative Source Information

Functional Area:

Eligibility and Enrollment, Customer Service, Communications, Plan Management, Financial Management, Oversight

Strategic Issue(s)

#	All
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Critical Tasks to Implement Initiative

- Establish an initiative owner and lead team.
- Create a framework for the business plan.
- Review existing information, research performed, and decisions that will inform the plan.
- Identify missing information, research gaps, and open decisions required to complete the plan.
- Define an approach to closing information, research, and decision-making gaps.
- Update the business plan as new information and research is gathered and as business decisions are made.

Anticipated Benefits



HIX Strategic IT Initiative #2

- Creates internal consensus on the business aspects of the Exchange and provides a shared vision to all stakeholders.
- Identifies planning and information gaps requiring further definition and exploration.
- Communicates existing components of the business plan to stakeholders and shares plans for closing any information, research, or decision-making gaps to internal and external stakeholders, alleviating uncertainty or concern.
- Establishes a roadmap for future planning and decision-making, reducing the risk of design, development, and implementation efforts diverging from the Exchange's intended purpose and goals.

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HIX Strategic IT Initiative #3

Critical

Form a Medicaid/CHIP/OIC joint policy/IT planning work group.

Initiative Description

Achieving the federal government's vision of a simple, seamless path to affordable coverage in the Exchange will require enhanced and immediate collaboration between the OIC, Medicaid, and CHIP. Joint policy development/existing policy alignment and decisions about the technology needed to support new and existing policies and processes is required, including eligibility determinations and enrollment, customer service, and communications.

Initiative Source Information

Functional Area:

Eligibility and Enrollment, Customer Service, Communications

Strategic Issue(s)

#1	A plan for how the HIX will seamlessly coordinate with the state's existing Eligibility and Enrollment systems and what existing functionality can be leveraged has not been developed.
#2	A decision on what entity will be responsible for enrollment of Medicaid and CHIP members has not been made.
#10	Eligibility and enrollment systems will need to distinguish "newly eligible" Medicaid enrollees (i.e. "the MAGI population") from those who are new to Medicaid but would have been eligible under the existing rules for the purposes of determining the appropriate federal match rate.
#14	Preparation and distribution of applications and notices needs to be coordinated with carriers, the HIX, Medicaid and CHIP, including the existing IT systems that currently support such functionality.
#17	Consumers will move between subsidy programs and on and off subsidies; system will need to be designed to manage this "churn" and make movement between programs seamless and ensure continuity of benefits.
#18	The HIX must coordinate customer service activities of agents, CHIP, Medicaid and QHP's and assure efficient distribution/management of consumer inquiries/requests and responses/outcomes via phone, web, paper and face-to-face interactions.
#41	The HIX must create a system to identify and track consumers across systems and associate their data with them.

Critical Tasks to Implement Initiative

- Determine initiative owner and work group membership.
- Identify if existing meetings (e.g. MEGAA) can be leveraged or if new meetings are required.
- Decide on meeting owners, frequency of meetings, scope of work and decision-making, etc.

Anticipated Benefits

- Aligns development of new policies arising from ACA; facilitates consumer continuity of coverage and care.
- Reduces redundancies and create cost efficiencies in development of IT systems and processes.
- Creates more consumer-friendly and coordinated eligibility determination, enrollment, customer service, and communications processes for public programs and the Exchange.



HIX Strategic IT Initiative #4

Critical

Develop a procurement strategy for the Exchange.

Initiative Description

A strategy is required to successfully manage the procurement of all Exchange IT components given demanding implementation timelines, Exchange gaps, and the variety of sources from which IT components may be acquired including: existing state resources (upgraded or "as-is"); newly procured from the vendor community; leveraged from Innovator states and/or the federal government; and shared with other states in a Regional Exchange. Decisions to be made may include the scope and content of the RFP(s), the nature of the functional and technical requirements, and when RFP(s) should be issued, e.g. should West Virginia issue a full scope RFP in the near future and leverage change orders and sole source agreements as requirements are clarified or should the state issue multiple RFPs in stages? In addition, because the Exchange may be comprised of components from several sources, the strategy should address working with the NAIC to acquire more concrete information on plans to expand/adapt NAIC systems to meet ACA requirements and communicating with states in the region about opportunities for collaboration. The strategy may include options for procuring:

- Eligibility determination module;
- Web enrollment portal;
- Plan management software (e.g. new/enhanced SERFF functionality);
- Financial management;
- Business rules engine;
- Master Data Management tool;
- Customer Relationship Management and call center software/hardware;
- Systems integrator;
- Components for SHOP functionality;
- Virtual enrollment portals; and
- All Payer Claims Database components.

Initiative Source Information

Functional Area:	Eligibility and Enrollment, Customer Service, Communications, Plan Management, Financial Management, Oversight
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Strategic Issue(s)

#36	The HIX must be operational by the fall of 2013, leaving approximately 24 months to hire a software vendor, design the system, develop the system, test the system, train state staff, and roll-out into production.
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Critical Tasks to Implement Initiative



HIX Strategic IT Initiative #4

- Establish an initiative owner and lead team.
- Review known and incomplete Exchange requirements, existing state IT components that may be leveraged in the Exchange, and existing vendor relationships that may be leveraged using change orders or sole source provisions.
- Clarify enhancements to NAIC-supported tools such as SBS and SERFF including cost, timeline, and ability to meet federal and state-specific requirements; determine which meet West Virginia's needs.
- Meet with representatives from Exchanges in the region to determine opportunities for collaboration.
- Determine opportunity to leverage components from Innovator states.
- For components that must be newly acquired, decide on approach to RFP process, e.g. multiple RFP's for each component, a single RFP for all, when/if an RFP for a systems integrator will be issued.

Anticipated Benefits

- Allows for planned, deliberate approach to acquiring required IT components including managing cost and reducing risk of overlooking key Exchange elements.
- Leverages existing resources and capitalizes on array of procurement strategies including enhancing existing assets, using change orders, and employing additional procurement flexibility provided for in Senate Bill 408.
- Streamlines the procurement process, minimizes unnecessary work and creates efficiencies.
- Positions the Exchange to meet federally mandated milestones, gate reviews, and implementation dates.
- Reduces the risk that IT components and the integrated solution will fall short of fulfilling all Exchange needs and requirements.



HIX Strategic IT Initiative #5

Critical

Complete the RFP process for the Exchange IT components.

Initiative Description

Systems in the current state technology environment do not support all required Exchange functions, therefore procurement of new IT components to fulfill certain functions is required. Given demanding timelines for design, development, and implementation of the Exchange as imposed by federal deadlines, the state must soon engage in a streamlined procurement process which includes designing and issuing a/an RFP(s), reviewing vendor responses, inviting vendors for interviews and oral presentations, selecting finalists, and awarding the contract.

Initiative Source Information

Functional Area:

Eligibility and Enrollment, Customer Service, Communications, Plan Management, Financial Management, Oversight

Strategic Issue(s)

#36	The HIX must be operational by the fall of 2013, leaving approximately 24 months to hire a software vendor, design the system, develop the system, test the system, train state staff, and roll-out into production.
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Critical Tasks to Implement Initiative

- Establish initiative owner and lead team.
- Draft RFP(s) based on established functional and technical requirements and procurement strategy.
- Issue RFP, review responses, and invite vendors for demonstrations.
- Select top vendors, complete finalist presentations, and begin contracting process.

Anticipated Benefits

- Allows for selection of vendor with best overall fit for West Virginia's Exchange needs based on objective criteria and a thorough, competitive vetting process.
- Reduces the risk that IT components and the integrated solution will fall short of fulfilling all Exchange needs and requirements.



HIX Strategic IT Initiative #6

Critical

Develop an Exchange IT integration strategy with other state systems and applications and external business partners.

Initiative Description

The Exchange IT integration strategy will consist of two main elements: 1) integration within the state's systems and technologies and 2) integration with external business partners such as the federal government, carriers, producers, and small businesses. Integration strategy may include links with databases and other systems and website interfaces. Integration will allow for sharing of data and business processes among connected applications or data sources, increasing efficiencies and maintaining data integrity across systems.

Initiative Source Information

Functional Area:	Eligibility and Enrollment, Customer Service, Communications, Plan Management, Financial Management, Oversight
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Strategic Issue(s)

#1	A plan for how the HIX will seamlessly coordinate with the state's existing Eligibility and Enrollment systems and what existing functionality can be leveraged has not been developed.
#13	A process for capturing data from carriers and creating standardized comparative information on each available QHP (i.e. a carrier menu) for display to consumers needs to be developed.
#14	Preparation and distribution of applications and notices needs to be coordinated with carriers, the HIX, Medicaid and CHIP, including the existing IT systems that currently support such functionality.
#18	The HIX must coordinate customer service activities of agents, CHIP, Medicaid and QHP's and assure efficient distribution/management of consumer inquiries/requests and responses/outcomes via phone, web, paper and face-to-face interactions.
#24	To remain certified, QHP's must make available a range of data to the public, HIX, OIC, etc. What HIX systems will collect this information and make it available to the consumer?
#32	A plan for how secure data (including employer EIN, employee names and SSN) exchange will occur between the HIX and small employers needs to be developed.
#41	The HIX must create a system to identify and track consumers across systems and associate their data with them.

Critical Tasks to Implement Initiative

- Decide if IT integration strategy development and implementation will be managed by state Agencies or if a systems integrator will be competitively procured.
- Develop integration plan including project ownership and team, scope of efforts, e.g. which components must be integrated in what timeline, schedule, etc.

Anticipated Benefits



HIX Strategic IT Initiative #6

- Aligns IT components to assure Exchange system delivers all functions and achieves optimal performance.
- Minimizes redundancies and creates efficiencies within state systems.
- Adds value by creating synergistic capabilities from combining separate components into a greater whole.
- Assures ability to interface and share data with external business partners.

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HIX Strategic IT Initiative #7

High

Develop an Exchange operations plan.

Initiative Description

An operations plan will define the resources and business processes necessary for the Exchange to provide services to consumers in West Virginia. It answers questions such as who is doing what? What are the day to day activities and processes? What personnel, equipment, and materials are required? How will suppliers (e.g. carriers), other business partners (e.g. producers), and vendors be used and involved?

The Exchange's operations plan should include development of high level processes for the following key functions: determination of exemption from the individual responsibility requirement and payment; eligibility determination; eligibility appeals; streamlined application and enrollment; enrollment via an Internet portal, telephone through a call center, mail, and in person; plan certification/recertification/decertification; plan monitoring and review; plan quality rating; plan reinsurance and risk adjustment; reconciliation of reductions in enrollee out-of-pocket costs; determination of issuer credits; administration of premium tax credit and cost-sharing reduction; call center functionality; provision of Exchange website and calculator; consumer assistance and Navigator programs; consumer outreach and education; distribution of applications and notices; oversight and monitoring of financial integrity; SHOP-specific administration; notification and appeals of employer liability for the employer responsibility payment; and information reporting to IRS and enrollee. The operations plan should also encompass privacy and security policies and procedures.

Initiative Source Information

Functional Area:

Eligibility and Enrollment, Customer Service, Communications, Plan Management, Financial Management, Oversight

Strategic Issue(s)

#	All
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Critical Tasks to Implement Initiative

- Establish an initiative owner and lead team.
- Define core and supporting business processes required for Exchange functions.
- Determine workgroups required to establish and address processes by functional area.
- Identify existing processes to be leveraged and new processes to be developed.
- Develop new processes, taking into consideration previously-made decisions and federal mandates.
- Define roles and responsibilities for Exchange processes and resources needed to support them (people, IT equipment).
- Incorporate operations plan into business plan.

Anticipated Benefits

- Provides detailed plan for how the Exchange carries out day to day activities.
- Clarifies relationships with business and community partners.
- Establishes roles and responsibilities and required resources, facilitating operational budgeting.



HIX Strategic IT Initiative #8

Medium

Complete business process mapping for core and supporting Exchange business operations.

Initiative Description

Business process mapping and creation of flowcharts will define new and existing processes required by the Exchange. Process mapping will help identify areas where policies and procedures are needed as well as what, if any, underlying technology is needed to support those processes. In addition to detailed documentation of process steps, mapping should include who is responsible for each step, what standards should exist for each step (e.g. average time for a consumer to determine eligibility and enroll), and how process success is defined.

Initiative Source Information

Functional Area:

Eligibility and Enrollment, Customer Service, Communications, Plan Management, Financial Management, Oversight

Strategic Issue(s)

#1	A plan for how the HIX will seamlessly coordinate with the state's existing Eligibility and Enrollment systems and what existing functionality can be leveraged has not been developed.
#6	An IT system/process for handling exemption from the individual mandate responsibility requirement needs to be developed.
#9	Existing state systems currently do not support appeals processes for determining eligibility for insurance affordability subsidies and QHP enrollment.
#11	HIX systems need to support paper, in-person, telephonic, and Internet eligibility and enrollment functions, for example document management.
#13	A process for capturing data from carriers and creating standardized comparative information on each available QHP (i.e. a carrier menu) for display to consumers needs to be developed.
#14	Preparation and distribution of applications and notices needs to be coordinated with carriers, the HIX, Medicaid and CHIP, including the existing IT systems that currently support such functionality.
#17	Consumers will move between subsidy programs and on and off subsidies; system will need to be designed to manage this "churn" and make movement between programs seamless and ensure continuity of benefits.
#18	The HIX must coordinate customer service activities of agents, CHIP, Medicaid and QHP's and assure efficient distribution/management of consumer inquiries/requests and responses/outcomes via phone, web, paper and face-to-face interactions.
#19	The HIX must determine what types of organizations it will allow to be "Navigators", what the licensing criteria will be, if existing IT systems can be leveraged to support the licensing process (NIPR, PDB, SBS), and what IT systems will be needed to support the role of the Navigator.
#21	Can existing rates and forms software used by the state (e.g. SERFF/SBS) be modified to support QHP certification/recertification/decertification and ongoing compliance?
#23	Can existing rate and forms software be used to manage and distribute new rate/benefit information that is required to be sent to the HIX, OIC, and HHS from



HIX Strategic IT Initiative #8	
	carriers?
#28	Current IT environment does not support quality data collection and assessment of QHP issuer quality improvement strategies.
#29	A plan for business processes and IT systems needed to support the state's risk adjustment program needs to be developed.
#32	A plan for how data (including employer EIN, employee names and SSN) exchange will occur between the HIX and small employers needs to be developed.
#33	A plan for how the SHOP HIX will manage premium collection, aggregation, and transmission needs to be developed.
#41	The HIX must create a system to identify and track consumers across systems and associate their data with them.
Critical Tasks to Implement Initiative	
<ul style="list-style-type: none"> • Identify initiative owner and lead team. • Using high level business processes developed in operations plan, determine business processes requiring mapping. • Develop required working groups based on process functional area (e.g. eligibility and enrollment versus plan management) and complete mapping. • Share maps with relevant business areas and develop required policy, procedures, and training. 	
Anticipated Benefits	
<ul style="list-style-type: none"> • Provides clarity on the who/how/what of Exchange functions. • Identifies areas where new policies and procedures are required. • Clarifies what technology is required to support processes. • Supports identification of best practices and benchmarks and development of performance measures. • Aids in solving problems and making decisions. • Serves as a training and communications tool. 	



Appendix G: Sources

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