Project Narrative

Vermont Level One Establishment Cooperative Agreement

The State has made significant progress in establishing a Health Benefit Exchange for individuals and small businesses in Vermont. The State's Health Benefit Exchange, *Vermont Health Connect*, has been successful in meeting grant requirements and engaging diverse stakeholders throughout Vermont. Vermont Health Connect will allow individuals and small businesses to compare and purchase qualified private health insurance plans, determine eligibility for and enroll individuals in public health insurance plans, and access federal tax credits. To date, Vermont has successfully received three grants from the Department of Health and Human Services (HHS): (i) Planning Grant (2010), (ii) Level One Exchange Establishment Grant (September 2011), and (iii) Level Two Exchange Establishment Grant (August 2012). Vermont continues to meet the federal requirements established within the Affordable Care Act (ACA), and is on target to begin open enrollment in October 2013.

The Vermont Health Connect mission is to provide all Vermonters with the knowledge and tools needed to compare easily and choose a quality, affordable and comprehensive health plan. In support of this mission, the State of Vermont seeks a second Level One grant to operate an In-Person Assistance (IPA) program and enhance support to individuals, families, employees, and small businesses using the Exchange. The scope of the present grant is limited to activities that were not included in the Level Two Establishment grant that Vermont was awarded in August 2012.

Vermont is developing multiple channels for Vermonters to find, compare, and enroll in qualified health plans. The primary channel is intended to be self-enrollment through the website. Individuals will also be able to access support on the phone through the customer support center, either facilitating their ability to self-enroll on the website or allowing them to complete the entire application process on the phone. Yet a large number of individuals will require individual in-person assistance to learn about Vermont Health Connect and complete the enrollment process.

Vermont intends to develop an in-person consumer support function that will provide education about the Exchange and individual enrollment assistance. The purpose of Vermont's overall consumer support program, composed of both the State-funded Navigator and the federally-funded IPA program, is to ensure that all Vermonters have access to enrollment assistance. Vermont's IPA program will be consistent with the applicable requirements of 45 CFR 155.20 (c), (d), and (e). The State is committed to providing resources for the Navigator program and will seek up to $400,000 in the State 2014 budget and on an ongoing basis in future years. Because Vermont Health Connect is part of a state agency, the budget proposal will be reviewed and debated by the Vermont legislature as part of the State's annual budget process. We anticipate that funding over the above amount will be challenging for the legislature to meet, and that the additional

funding requested here will ensure that Vermont is ready to meet the demand for enrollment assistance in the first year of Exchange implementation, particularly for those Vermonters facing unique challenges in using the Exchange successfully.

a. Discussion of Exchange Planning and Establishment Progress

Key Findings of Background Research

Over the past two years, Vermont has conducted extensive research and investigation into establishing Vermont Health Connect. This has included broad exploration of the current insurance market and issues such as churn and the characteristics of the uninsured and underinsured. These surveys and studies lay the groundwork for Vermont's Exchange implementation efforts, and a summary of these areas is described below.

Uninsured and Underinsured: Vermont contracted with Bailit Health Purchasing to better understand the characteristics of the uninsured and underinsured. Data from the 2009 Household Health Insurance Survey, which provides data on sources of coverage and individual demographics, were used to help Exchange staff better understand who the uninsured were and possible ways to reach them. Key findings from the report, posted online, included (these numbers were updated in the spring using 2010 census data):

- 47,460 residents, or 7.6% of the Vermont population, were uninsured;
- 160,400 residents, or 27.9% of all Vermont residents, were underinsured; and
- More than half (53%) of the uninsured adults aged 18 to 64 were eligible for coverage through a state health care program.

Current Insurance Market: Bailit also conducted a study that focused on how the commercial health insurance market currently operates in Vermont and what changes would be needed to comply with the federal requirements of the Exchange. This study found that the private commercial insurance market in Vermont is dominated by a small number of insurers and that these same insurers have consistently been part of the insurance market for many years. In 2009, the largest insured market segment was associations. The full report is available online.

Churn Analysis: The University of New England (UNE), Bailit's subcontractor, provided Vermont an analysis and assessment of options related to the issue of churn using the total number of individual episodes of eligibility for Catamount Health with premium assistance (a program that assists residents paying for commercial insurance) for four years, 2007-2010. UNE also reviewed existing literature on the issue of churn and interviewed officials in other states that have taken steps to mitigate churn. The report recommends improving the process for recertification, and standardizing the benefit packages between Exchange plans and Medicaid, and the full report is available online.

Administrative Simplification: The State engaged with a contractor, Pacific Health Policy Group (PHPG), to assess current efforts to promote administrative simplification and determine how these efforts relate to one another. This analysis included polling providers to determine areas of greatest complexity from their perspective and determining preferences and/or priorities for simplification. The PHPG is currently paused in draft form, and they will compile recommendations to be presented this winter and spring.

In addition to these broad research efforts, Vermont Health Connect also conducted a number of interviews, focus groups and surveys to inform the development of the outreach and education plan, the shape and scope of consumer support options, and the issues and concerns of small businesses and their employees. A summary of research to date is highlighted below.

Target Audience	Activity	Date Published
Brokers and Small Business Owners (Focus Groups)	Wakely Consulting conducted four focus groups. Each focus group was comprised of a broker and seven to eight small business owners who the broker currently assists. The purpose of the discussions was to explore the choices and decisions the owners will need to make about enrolling in the Exchange.	October 2012
Individuals and Small Business Owners (Eight Focus Groups)	Focus groups were conducted in Rutland and Burlington to gain insights on a number of proposed names and visual identities for Vermont Health Connect. A report outlining final recommendations on Vermont Health Connect's name, logo, and identity can be found online.	July 2012
Small Business Owners (Interviews)	Interviews were conducted with 50 small businesses to learn about broker services.	May 2012
Statewide Public (Phone Survey)	Interviews with 1,004 adult Vermonters were conducted to learn about their overall awareness of Vermont Health Connect and perceived barriers to access. Findings were used as a benchmark.	March 2012
Uninsured Vermonters (Four Focus Groups)	Focus Groups were conducted in Rutland, Colchester, and St. Johnsbury with a total of 32 participants. Topics covered knowledge of the ACA, access to enrollment information, and the Navigator program.	May 2011
Insurance Brokers (Interviews)	Nine insurance brokers and the Executive Director of the Vermont Insurance Agents Association were asked questions about the ACA, potential role of Brokers in exchange enrollment, and the Navigator program.	May 2011
Small Business Owners (Survey)	One hundred and seven small businesses were asked about their current health insurance offerings, knowledge of the ACA, and enrollment needs.	April 2011
Non-Profit Organizations (Interviews)	In-depth Interviews were conducted with 14 non-profit organizations. Topics included the role of Navigators, potential Navigators, and how best to serve the uninsured and underinsured.	April 2011

Request for Information (RFI) on In-Person Assistance Program: In October 2012, a RFI was posted to gather information from individuals and organizations interested in

providing enrollment assistance, outreach and education to individuals and small businesses. The goal of the RFI was for the State to obtain a better understanding of (i) populations who might need enrollment assistance, (ii) the overall interest of Vermont individuals and organizations to provide enrollment assistance, (iii) the current capacity of individuals and organizations to provide enrollment assistance, and (iv) the potential capacity to provide enrollment assistance.

In total, 150 individuals and organizations responded. This included brokers, non-profit organizations (regional, state-wide, and population specific), and a few for-profit health services organizations. Respondents served a variety of regions within Vermont and a variety of populations that are relevant to Vermont Health Connect's enrollment eligible population. Only 21% of respondents felt that their populations would be likely or highly likely to self-enroll. The largest perceived barriers to self-enrollment included lack of computer/internet access, language barriers, and difficulties understanding the enrollment options and procedures.

The RFI respondents also demonstrated an in-depth understanding and knowledge of Vermont's enrollment eligible population. A majority of RFI respondents currently offer relevant in-person assistance services including outreach and education (90%), subsidized medical enrollment assistance (66%) and other enrollment assistance (e.g., fuel assistance, 80%). When asked what type of support they would need to offer Exchange enrollment assistance, respondents indicated that they would need additional financial resources for more staff and receive adequate training. Findings from the RFI have been used to inform the proposed design of the assistance programs, and will subsequently inform the criteria and training components of Assisters.

Enrollment Eligible Population & Estimated Assistance Need: DVHA estimates that approximately 266,500 individuals will be eligible to enroll through the Exchange: 36,500 employees from small businesses and 65,000 individuals into qualified health plans and 165,000 into Medicaid. (This number updates the estimate in our Level Two Grant application and will be further modified in early 2013, with the latest results of the Vermont Household Health Insurance Survey.) Of those eligible to enroll in the Exchange, the State estimates that approximately 1/3 of consumers may need in-person assistance. For Vermont, the population with income between 133% and 300% of FPL will require special attention; this group includes individuals currently enrolled in VHAP and Catamount, programs that are being replaced by Medicaid expansion and the development of the Exchange. The transition to the Exchange will require enrollees to choose from a much larger array of plans. This group is going to need a higher level of personal attention, because in addition to choosing insurance, they have to sign up for federal and state assistance/subsidies, which add a layer of complexity. In addition, Vermont's small business population will need significant assistance, as they decide whether to maintain or drop coverage when they enter the Exchange. The Exchange anticipates needing to provide supplementary assistance to those employees whose employer has dropped coverage.

Legal Authority and Governance

Vermont benefits from strong support for health care reform at the highest levels of State government. Act 48 of 2011 authorizes Vermont's Exchange, Vermont Health Connect. Act 48 established Vermont Health Connect within the existing Department of Vermont Health Access (DVHA), the state's Medicaid agency. Act 48 provides a framework for Vermont Health Connect and articulates goals, governance structure, and functions. The defined purposes of Act 48 are as follows:

- to facilitate the purchase of affordable, qualified health benefit plans in the individual and group markets in Vermont in order to reduce the number of uninsured and underinsured;
- to reduce disruption when individuals lose employer-based insurance;
- to reduce administrative costs in the insurance market;
- to contain costs;
- to promote health, prevention, and healthy lifestyles by individuals; and
- to improve quality of health care.

Act 48 also created the Green Mountain Care Board (GMCB). Members of the GMCB are responsible for controlling the rate of growth in health care costs and expanding the State's health care payment and delivery system reforms by building on Vermont's Blueprint for Health and implementing policies that move away from a fee-for-service payment system to one that is based on quality and value. The GMCB has authority over the approval of the Vermont Essential Health Benefit package and qualified health plan designs for Vermont Health Connect. They also have oversight in the State's rate review process. The State has worked closely with the GMCB and processes are in place to facilitate frequent input on important health policy issues.

In May 2012, Act 171 was signed by Governor Shumlin (i.e., H. 559, "An Act Relating to Health Care Reform Implementation"). This law further prepares the State for the implementation of Vermont Health Connect, with the following components:

- Merging the individual and small group markets;
- Eliminating an "outside-Exchange" market by permitting health issuers to sell insurance for individuals and small employers only through Vermont Health Connect;
- Retaining the current Vermont definition of a small employer as an employer with 50 or fewer employees until January 1, 2016;
- Mandating Vermont Health Connect to offer Bronze plans (initially removed through Act 48);
- Separating broker commissions from health plan premiums, and requiring them to be charged directly as a separate, transparent fee; and
- Allowing the State to compensate brokers for assisting with qualified health plan enrollment and application for premium tax credits and cost-sharing reductions through Vermont Health Connect.

Consumer and Stakeholder Consultation, Engagement and Support

A State priority is to engage stakeholders and elicit stakeholder feedback throughout the Vermont Health Connect planning and implementation process. The State of Vermont recognizes that the success of Vermont Health Connect depends on the involvement of stakeholders and their understanding of health reform and the Exchange. Since passage of Act 48 in 2011, stakeholder consultation has involved identification of and communications with relevant groups to gain an in-depth understanding of the nuances that shape Vermont's population. Various activities have been conducted to increase awareness and build trust among Vermonters about Vermont Health Connect. Below is a summary of consumer and stakeholder engagements that have taken place to date.

By Invitation Events: Since the summer of 2011, state officials responsible for implementation of Act 48 have appeared by invitation before more than fifty community or business organizations to explain Vermont Health Connect.

Forums: In the late summer and fall of 2012, Vermont Health Connect hosted five public forums in major locations around the state, four of which were dedicated to the general public and one targeted small businesses. Each forum garnered between twenty and eighty attendees as well as local media and public access stations coverage. Our community partners and advocates assisted with the promotion of these forums, which were facilitated by leadership at DVHA, the Agency of Administration, and the Department of Financial Regulation (DFR). The forum discussions provided rich insights into the issues that matter most to individuals and small businesses, including assistance. Regular forums will continue throughout 2013 for both individual and small business audiences with the use of Level Two funding.

Medicaid and Exchange Advisory Board (MEAB): Created by Act 48, the Medicaid and Exchange Advisory Board advises DVHA on policy development and program administration for the state's Medicaid-funded programs and the Exchange. The MEAB is comprised of consumer advocacy organizations, health care professionals, self-employed individuals and representatives of small businesses eligible for enrollment, and the thirty members bring diverse perspectives. In compliance with Act 48, the State of Vermont merged the Health Benefit Exchange Advisory Group with the Medicaid Advisory Board on July 1, 2012 to comply with ACA. The monthly MEAB meetings are open to the public. DVHA staff help the MEAB chairs set the agenda, and regularly present on the development of Vermont Health Connect components in order to obtain feedback relevant to the development of Vermont Health Connect. Meeting agendas and meeting documents are available online. Remaining meetings for 2012 will be held November 19 and December 10. Collectively, the members provide a wealth of expertise to inform the design and implementation of the Exchange, including assistance.

Outreach Working Group: DVHA has assembled an outreach working group consisting of both internal and external stakeholders. All representatives offer a unique perspective on conducting outreach to Vermonters and/or providing health coverage support services. This group aids with strategic development and outreach implementation to support successful enrollment in the Exchange. Examples of stakeholders include non-profit organizations and business associations currently serving Exchange-eligible populations.

Stakeholder Training: DVHA has contracted with consultant group GMMB to develop a training curriculum for stakeholders and to educate them on how to conduct Vermont Health Connect outreach. Stakeholders will be able to attend a training session in person or take the training on their own by following the presentation materials available on the website. In the coming months, this training will be promoted throughout DVHA's networks to reach as many stakeholders as possible.

Building Stakeholder Partnerships: For the past year, Vermont Health Connect staff has engaged stakeholders across the state. This has come in the form of hosting introduction and brainstorming engagement meetings, asking for review of documents and plans including the outreach plan, and attending conferences and public meetings hosted by stakeholder groups. Vermont Health Connect staff acknowledge that each stakeholder offers something important and distinct in terms of adding to the development and successful launch of the Exchange.

Outreach and Education Plan

In addition to summarizing the consumer and stakeholder engagement initiatives highlighted above, the Outreach and Education Plan also provides direction on the Exchange's target audiences, outreach strategies, materials development, media, and state employee communications. The target audiences detailed in the plan address the populations identified in 45 CFR 155.130. The plan does add sub-populations to the primary audiences list, including young adults (18-34), as they make up the largest portion of the uninsured population in Vermont, and Catamount Health beneficiaries, as they are currently in a State program and will transition to the Exchange in 2014. Additionally, the underinsured population is a priority for the State. The plan explores a variety of tactics for reaching these populations with the goal of engaging them and driving them to the Exchange website or an in-person assistor where they can learn more about the Exchange and get assistance enrolling. The plan includes the following components:

- Materials development
- Earned media
- Paid media (advertising)
- Social media
- Stakeholder engagement
- Partnerships and grassroots engagement
- State employee communications

Navigators

The ACA created the Navigator function to educate individuals and families about the availability of qualified health plans, provide them with fair and impartial information regarding plans that best fit their needs, and help them enroll in their plan of choice. Vermont's Act 48 confirms the five duties of Navigators required by the ACA, and also requires Navigators to facilitate enrollment in Medicaid, Dr. Dynasaur, VPharm, VermontRx, and other public health benefit programs.

Using the guidelines and standards noted above, the State will use an RFP process to select at least two Vermont entities to serve as Navigators. Using previous grant funding, Vermont has identified the Navigator Program's certification criteria and process. Criteria for Navigator entities includes, but is not limited to:

- Experience with enrollment-eligible populations (e.g., uninsured, under 400% FPL, individuals with private insurance, and small businesses);
- Experience with the health care system in Vermont;
- An organizational mission that is consistent with providing outreach, education, and enrollment assistance;
- Existing infrastructure in place to reach a broad range of Exchange-eligible populations; and
- Services accessible in person and over the phone, and have computer and internet skills to assist populations in the state who are less familiar with computer technology and might not have access to the internet.

Using previous grant funding, Vermont contracted with GMMB to develop a Navigator training program that meets federal guidelines and ensures that individuals are appropriately trained, including material on Vermont Health Connect's conflict of interest, accessibility, and privacy and security standards. The proposed training components for Navigators are presented below in Table 1.

Table 1. Navigator Training Curriculum

Component	Content
Train-the-Trainer	1. Overview of the Program 2. Trainer Essentials 3. Review of Content using Leaders' Guide 4. Demonstrations 5. Post Course Evaluation
Navigator training	1. Pre and Post Tests before each content area 2. Principles of Customer Service 3. Use of "Plain Language" 4. Affordable Care Act 5. Vermont Health Connect structure 6. Vermont's Blueprint 7. Needs of underserved and specific populations 8. Eligibility and enrollment rules and procedures 9. The range of QHP options and insurance affordability programs

	10. Privacy and security standards 11. Digital literacy and website navigation 12. Financial assistance 13. Outreach and education 14. Conflicts of interest 15. Sources of information and referral 16. Scenarios 17. Post Course Evaluation
Refreshers & Updates	1. Changes to the program or approach 2. Exchange Updates 3. Experiences, Problem Solving, & Trouble Shooting

DVHA staff consulted with DFR, the department that manages Vermont's licensing of agents and brokers, on their conflict of interest language. DVHA is reviewing this language and will assess what components can be carried over to the Navigator program and if any additional language needs to be developed. Vermont is also awaiting the arrival of the CMS conflict of interest standards. State staff have been working on privacy and security compliance across Vermont Health Connect and within the Navigator program. Vermont is committed to ensuring compliance with 45 CFR 155.210 and 45 CFR 155.260 and is exploring the ways current privacy practices meet these standards.

To identify the amount of enrollment assistance that may be needed across the State, Wakely Consulting completed a geographic resource allocation assessment. The analysis helped determine how Vermont should disperse consumer assistance resources geographically to ensure Vermonters receive the support they need. Utilizing the data from the 2010 ACS and 2009 Vermont Health Insurance Survey, Wakely Consulting derived two indices to analyze how enrollment assistance resources should be distributed. Specifically, the Simple Needs Based Index and Broad Need Based take into account the percentage of the population in the county that is below 401% FPL, uninsured, and underinsured. The analyses showed that the need index measures did not differ much from a population measure. As a result, the State has made a decision to estimate the need for consumer assistance based on county population, and details of this analysis can be found in the Consumer Support Proposal section below.

Long-Term Operational Costs

Vermont has housed Vermont Health Connect within the State's Medicaid agency, DVHA, and thus the Vermont Health Connect budget will be developed and approved within the DVHA budget. The budget period that includes January through July 2014 will proceed through the Vermont legislature beginning in January 2013. Because of this, the financing of Vermont Health Connect, unlike other states with an independent Exchange entity, must be done in conjunction with the state budget process. The benefit, however, is that the Exchange is part of a larger state agency with existing revenue sources and may not need an entirely separate or unique revenue stream.

The State has worked with CMS to create a cost-allocation process to ensure that costs are allocated appropriately between existing publically-funded programs and Vermont Health Connect. Due to the State's relatively small population size and similarly modest expected exchange enrollment, a per person enrollment fee, as discussed in larger states, will not be a viable mechanism to meet the organization's funding needs. The State is examining a wide range of financing options from claims assessments (new or increasing existing assessments) to revenue from advertising on the Vermont Health Connect website.

As required under the ACA, Vermont is planning for the financial self-sustainability of Exchange operations by January 1, 2015. The State is in the process of developing a mechanism for financing the ongoing operations of Vermont Health Connect (assuming revenue is needed outside of the usual state revenue sources) and will submit a financing plan to the Vermont general assembly on January 15, 2013, as required by Act 48 (2011).

Program Integration

The development of the Exchange within DVHA has been closely integrated with the work of other Vermont state agencies in order to carry out all of the responsibilities involved in planning for Vermont Health Connect. During the initial planning stages, there were several state workgroups that focused on discrete topics such as health insurance operations, insurance market planning, administrative simplification, eligibility, technology, and integration of public health, quality initiatives, and wellness programs into Vermont Health Connect. In addition, there were monthly core-team meetings of workgroup leaders to ensure coordination among the different workgroups. Workgroup activities have been documented in a report posted on Vermont Health Connect's website.

The establishment of Vermont Health Connect within DVHA has facilitated close coordination and integration with Vermont's Medicaid program. DVHA has established Memoranda of Understanding with DFR and the Department for Children and Families (DCF). These MOUs ensure on-going cooperation and delineation of roles and responsibilities. DVHA used Level One funds to contract with Pacific Health Policy Group (PHPG) to develop new MOUs to cover Vermont Health Connect development through 2013 and for operations in 2014. These are under development and will be finalized when the Exchange business requirements development and workflows are completed. As part of this project, PHPG identified and analyzed all areas of functional overlap between Exchange-related processes and the processes of other agencies. This report is posted online. Vermont is committed to avoiding duplication and lowering administrative costs across state government.

Business Operations of the Exchange

Vermont is currently working with Wakely Consulting and their subcontractor, KPMG, on the development of Business Requirement Documents (BRD) for Vermont Health Connect. KPMG's facilitated requirements workshops are covering the following topics:

- Plan Management
- Enrollment Issuer
- Premium Processing (Issuer)
- Customer Service
- Premium Processing (Individual)
- Individual and Employee Anonymous Browsing
- Enrollment (Individual) & Premium Tax Credit
- Employer Eligibility, Employee Enrollment, Cost Sharing
- Premium Processing (Employer)
- Financial Management

The State of Vermont is in the process of expanding this work to include work streams on Communications, Oversight & Reporting, and Brokers/Navigators (which would include the IPA program).

The KPGM BRD development sessions began in late July and are running through early 2013. Additionally, we have brought on Oracle staff experienced with Oregon Exchange development. KPMG is working with Oracle to modify the BRD development process to include systems requirement specifications. These, when combined with a reuse methodology, will position the State well to transition this work to a systems integrator once a contract is finalized.

IT Gap Analysis and Exchange IT Systems

Vermont worked with Wakely Consulting on the initial planning and coordination of the Vermont Health Connect IT development. Wakely, through its subcontractor KPMG, has completed the following core planning activities for the IT System:

- IT Gap Analysis: Defined specific current state functional and system gaps; identified system and implementation options to close identified gaps and realize the technical roadmap.
- IT Budget Analysis and Assessment (included in our Level Two grant application): Analyzed the financial impact of a health insurance exchange solution; consulted with the State personnel and reviewed existing IT purchases made to date by the State to help quantify projected costs and potential budget risks.

Despite timing challenges, the State is considering the lessons learned, timelines, and decisions of other States like Massachusetts in planning for the establishment of the Vermont Health Connect. Vermont has collaborated with Oregon to reuse as much of their Exchange architecture, requirements, and design assets as possible. Like Oregon, Vermont procured elements of an end-to-end Oracle technology package as its core solution platform. In addition, the State procured Service Oriented Architecture (SOA) core components in early 2011. The State's procurement approach is to leverage its pre-purchased components and other technology needs identified through additional solution

design activities to build an integrated exchange platform that will leverage data from the existing legacy systems. Similar to Oregon, Vermont plans to deploy the Oracle stack in a cloud hosted environment, which will enable the State to accelerate its DDI environment deployment, and enable it to meet Exchange IT service levels that the State data center cannot currently support.

DVHA engaged and solicited feedback from internal and external stakeholders, policy and technology resources, and external subject matter experts to identify both existing and new capabilities that the State may need to support new processes emerging from the Exchange functions. Vermont took part in a CCIIO Planning Review in May, 2012, and the Detailed Design Review in October, 2012.

KPMG is working with Oracle to modify and expand the BRD development process to also include systems requirement specifications. Vermont is working closely with our project officer and CCIIO partners to ensure the state has a finalized systems integrator contract to build a fully-functional state-based Exchange for 2014.

Reuse, Sharing, and Collaboration

DVHA's Division of Health Reform supports collaboration across the State's extended portfolio of health IT and health reform IT projects, including eligibility modernization, health information exchange, and enterprise shared services which the Exchange will leverage. The Division of Health Reform ensures that all Exchange development integrates and coordinates with the other IT infrastructure currently in development to maximize internal leverage and reuse, consistent with CMS' Seven Standards and Conditions. The Division also coordinates the external-facing IT modernization efforts, such as administrative simplification through the statewide provider directory and master persons index projects, which provide additional venues for engagement and coordination with insurance carriers, providers, and brokers.

Vermont is actively exploring options for reuse and collaboration. The main focus of our reuse strategy has been to work with Oregon, as they have committed to using the Oracle platform, as well as the New England Collaborative for State Insurance Exchange Systems (NECSIES). To date, the State has had the opportunity to leverage the following in support of this reuse initiative:

- MA, RI and CT RFR content for various procurement activities;
- Use Cases and System demonstrations from Oregon in support of Vermont's Business requirements definition process;
- Architectural reuse opportunities through collaborating with MA's vendor, CGI; and
- Informational website design artifacts from Cover Oregon's User Interface work with Deloitte Consulting LLP.

In addition to consuming content in support of reuse, Vermont and Rhode Island have established a regular channel for Rhode Island to leverage the State's business requirement approach and documentation.

Organizational Structure

Noted earlier, as per Act 48, the Vermont Health Benefit Exchange is located within DVHA, the State agency that administers Medicaid as well as other State health benefit programs. Locating the Exchange within State government allows Vermont to leverage existing state resources for certain Exchange functions. The Exchange can look within DVHA for expertise in financial management and call center operations; DFR for risk leveling, plan management, and QHP certification; the Department for Children and Families for eligibility support; and the IT department of the Agency of Human Services for IT project management.

Using Level One funding, Vermont filled the position of DVHA Deputy Commissioner, as the Director for the Exchange in December, 2011. Throughout 2012, Vermont has been filling other Level One and now Level Two funded positions, within the Exchange itself and also within our partner agencies and departments in State government. In preparation for applying for a Level Two Establishment Grant in June, 2012, the Exchange tasked Wakely Consulting with examining the total staffing and resource needs for Vermont Health Connect. This included recommendations about staffing capacity and hiring sequences, estimated staffing costs, as well as a staffing plan with job descriptions and organizational charts.

Program Integrity

The breadth of Vermont Health Connect and Vermont's reform efforts overall makes even more imperative the establishment of detailed policies and procedures to combat waste, fraud, and abuse within its financial management system, as well as within the processing of data, information, and funds that flow through Vermont Health Connect. Vermont has instituted policies to ensure the proper use of state and federal funds. These policies include a process for regular reporting to HHS and state oversight entities. These procedures meet HHS' audit requirements.

The Exchange used Level One funds to contract with Wakely to develop an Internal Control Blueprint for management of the Exchange as it designs, builds, and implements the administrative infrastructure of the Exchange. Wakely has conducted an inventory of the internal control and program integrity features of currently existing state programs. Using these established controls as a guide, the Exchange has begun to plan for the internal resources needed to accurately monitor the proper use of resources and funds. The Blueprint and implementation plan was completed in August 2012. Vermont has instituted policies to ensure the proper use of state and federal funds. These policies include a

process for regular reporting to HHS and state oversight entities. These procedures meet HHS' audit requirements.

ACA Requirements

Vermont has reviewed all rulemaking provided to date regarding health insurance market reforms. DVHA and DFR have taken the lead in planning, designing, and implementing all necessary market reforms. Previous laws and regulations have been revised to include these reforms including establishing minimum loss ratios, establishing dependent coverage to age 26, and removing cost-sharing for preventive services.

DFR has started to enhance the review of rate and form filings by enforcing the additional requirements dictated by the ACA as well as Vermont's Act 48. The Department enforces federal and state requirements when reviewing all forms for health insurance policies. Rate review enhancements include the collection of additional rate detail in a standardized format and making the overall rate review process more transparent to consumers. On September 1, 2011, the Department established a rate review website aimed at educating consumers on the rate review process. DFR continually posts all major medical filings received after January 1, 2012, and Medicare-Supplement filings received after May 16, 2012.

Small Business-Specific Components (SHOP)

The State is committed to ensuring that Vermont Health Connect will have robust features that are attractive and useful to small employers, that will reduce the administrative burden on the employer, and that will enable employee choice, increased portability, and continuity of coverage. In consideration for the State's small size, Vermont is not creating a separate SHOP Exchange but rather integrating small employers and their employees into the main portal and designing the Exchange to ensure simplicity and continuity as much as possible. Vermont's Act 171 established that a qualified employer is an entity which employees an average of no more than 50 employees on working days during the preceding calendar year. Beginning on January 1, 2016, the threshold will be 100. Vermont's statutes currently provide that part-time employees working less than 30 hours per week would not be counted in determining whether an entity is a qualified employer. Vermont would seek to comply with a final federal rule for determining employer size.

Wakely Consulting has been working on recommendations regarding the small business experience and functions within the Exchange. In July 2012, they produced a report entitled Operational Guide for Vermont's Small Business Exchange. The document describes the small business functions, dynamics of employee choices, tax considerations, and strategies for engaging brokers in the successful implementation of Vermont Health Connect. The report helped advance the development of the Vermont Health Connect design process. Since then, Vermont has made significant progress in a number of areas including compliance with 45 CFR 155 and premium aggregation.

In terms of broker services, the report provides three compensation models, which were presented to the Medicaid and Exchange Advisory Board on September 10, 2012. Vermont staff is meeting with brokers and other interested parties, including representatives of the Vermont Insurance Agents Association and the Vermont Chamber of Commerce, regarding the preferred strategy to utilize and compensate brokers in Vermont Health Connect.

While estimates vary on the specific percentage of Vermont's small group market that is brokered today, most estimates suggest it to be at least 70%. As noted above, Act 171 removes broker fees from premiums, requiring that small employers agree to pay this as a separate, transparent fee. Based upon stakeholder interviews and market research with small employers in Vermont, the State has ascertained that employers anticipate needing broker support during the first year of this market transition, but are unlikely to use a broker if faced with current broker fee levels (estimated at 4% of premium). Specifically, 78% of interview respondents indicated that they would not hire a broker if the cost is an additional 4% of premium while 57% will not hire a broker if the cost is an additional 2% of premium. If broker assistance is cost-prohibitive, a majority of small employers will be looking for the State to provide a level of expertise and individualized attention that is needed for successful exchange enrollment.

The State is committed to providing small businesses with the support needed to enroll their employees in Vermont Health Connect. The State has received Level Two funding to provide support to small businesses in making choices about coverage, including whether or not to continue to provide coverage. Vermont recognizes that the relationship that many small businesses have with their brokers is a valuable asset and would like to offset the cost of this service with these Level Two funds. The details of the compensation plan are still being developed. The State also recognizes that many small businesses do not currently use brokers, and that many who do may choose not to when faced with the separate broker fee. Additionally, many brokers are not accustomed to providing individual assistance to employees, which will likely be required whether or not an employer chooses to keep or drop coverage.

b. Proposal to Meet Program Requirements

Current Exchange Pathway

Based on the activities completed to date, including activities initiated and proposed under the State's Level Two funding, Vermont intends to establish a fully-functional state-based Exchange. Vermont will build a unified Exchange, inclusive of the needs of individuals and families as well as small employers and their employees. The full breadth of Vermont's Exchange plans can be found in the Level Two Exchange Establishment application. The focus of the current application is for consumer support funding that was not included in the Level Two application submitted in June, 2012, prior to the announcement of the In-Person Assistance funding opportunity.

Vermont is on a path to operate a state-based Exchange by October 1, 2013. Vermont has been working on Exchange development since being awarded a Planning Grant in October, 2010, and has made significant progress on the required Exchange activities for a state-based Exchange. Below is a summary of additional activities Vermont is engaging in to ensure the successful operation of the Exchange.

State Legislative and Regulatory Actions: Additional legislation will be necessary during the 2013 session to establish a financing plan for Vermont's Exchange, following a recommendation by the Secretary of Administration to the Legislature in January 2013 as required by Act 48. Exchange staff will continue to coordinate with the Governor's office on additional legislative priorities and/or regulatory action regarding Exchange operations. DFR will also continue to assess whether additional changes may be needed to comply with ACA market reforms.

Program Integration: Exchange staff will continue to use internal working groups and the Medicaid and Exchange Advisory Board to vet policy and technical decisions that impact both the Exchange and Medicaid. Using Level Two funding, Vermont will analyze the legal and policy issues that may arise between the Exchange and Medicaid. This analysis will include guidance identifying policy options and implementation assistance regarding transition planning for optional eligibility groups and waiver programs to Exchange and Medicaid coverage, alignment of benefits and cost-sharing between Medicaid and the Exchange, and streamlined coverage for Exchange and Medicaid-eligible pregnant women.

Many of the activities around coordination between the Exchange and other agencies will focus on the IT build, including the eligibility rules engine, master person index, and business flows for information sharing. Throughout the build process, IT staff will analyze all shared business functions. The Exchange team will coordinate with other state agencies and programs on developing detailed business processes and will create memoranda of understanding with all agencies and departments involved. The Exchange is actively collaborating with DFR on the QHP certification process, and the Exchange will obtain all necessary internal operating and data sharing agreements before the certification process begins. DFR will establish an effective plan management environment that supports a cohesive regulatory and certification process for QHPs. The Exchange will also continue to collaborate with and support DFR on important decisions that impact the individual and small group markets inside the Exchange.

Rate and Form Filing Review: DFR will continue to refine its rate and filing review process as Exchange implementation moves forward. The rates and forms team will work with the Exchange implementation team within the Department to advise them on new and current statutory requirements relating to essential health benefits and qualified health plans. Actuaries and policy analysts will establish standards to ensure that the review of plans contains a meaningful analysis based upon the essential health benefits. The establishment of those standards must also include actuarial, policy, and legal analysis to ensure that plans offered in the market do not create the risk of biased selection based on health status. The Department will use Level Two funds in conjunction with Rate Review grant funds to

prepare for implementation of market reforms set to take effect in 2014. The Green Mountain Care Board is also enhancing its tools for data collection. DVHA and GMCB are working closely to ensure that carriers provide the information necessary to support the evaluative measures described above.

Eligibility and Enrollment: Vermont seeks to use the process of design, development and implementation of the Exchange as a catalyst for and a partner in the modernization of the State's current eligibility system, yielding one system that will determine eligibility for the Exchange, CHIP, and Medicaid. Locating the Exchange within DVHA allows Vermont to leverage existing State work, in collaboration with the Department for Children and Families (DCF), with both Departments having access to the modernized eligibility system. The system will be designed to add future functionality for other benefit programs offered by DCF, such as SNAP, TANF, and LIHEAP.

For the Exchange, the system will allow Vermonters to compare health plans, enroll in a plan, and receive tax credits or public assistance, if eligible. The consumer-facing component of the Exchange will be a website portal that allows for anonymous browsing, plan comparison, eligibility determination, and plan enrollment, augmented by a customer support center and in-person assistance as needed. This portal will include real-time determinations and a single-session enrollment process.

Vermont currently uses a combined application for residents applying for health benefits and other benefits such as SNAP and TANF. In the first phases of Vermont's integrated eligibility systems development, healthcare applications will be de-coupled and updated to comport with all necessary changes under the ACA and Vermont's Medicaid expansion populations. Vermont is hoping to adopt the healthcare application that CMS is currently developing. Vermont's goal is seamless and streamlined processes for all Vermonters using the public system. Consistent with the ACA requirements, Vermont has begun to develop options to permit application submission online, by phone, fax, or paper form. Any paper applications or forms received will be indexed and scanned at the existing application and document processing center.

Evaluation Plan: Vermont has developed an Evaluation Plan for Vermont Health Connect with Wakely Consulting. The plan outlines key indicators, baseline data, methods for monitoring progress, plans for timely interventions when needed, and steps for ongoing evaluation once operational. The plan leverages existing Vermont data sources including Vermont Household Health Insurance Survey and the Health Disparities Report. The plan also includes recommendations on the staff needed to support data collection, a budget for ongoing evaluation, and suggested reporting templates and processes. The evaluation plan report can be found here and a report on baseline indicators can be found here.

An important step in designing the evaluation plan is indicating specific measures of success in each activity. The ultimate measure of success will be the number of eligible Vermonters who enroll in/purchase health coverage through Vermont Health Connect. Additional performance metrics for IPAs specifically may include consumer knowledge of

IPAs, number of individuals enrolled through assistance programs, and satisfaction in enrollment assistance services. Using previous grant funding, DVHA continues to solicit stakeholder input on the evaluative measures for assistance programs (Navigators and IPAs).

Exchange IT Systems

The State will leverage current technology infrastructure and procure additional infrastructure and resources as needed to ensure our ability to operate a federally-compliant Exchange by October 2013. The design, development, and implementation of the Exchange coincide with another enterprise-wide initiative to modernize the State's integrated eligibility system. The State will coordinate these efforts to ensure the ultimate development of one system to determine eligibility for Medicaid, CHIP, and the Exchange. The State seeks to reuse functionality and share data and logic across human services areas to improve efficiency and scalability.

The State of Vermont is committed to the DDI (Design, Development and Implementation) of a Health Benefit Exchange solution by 2014 that is based on a Service Oriented Architecture (SOA) and is presented in a customer-centric manner. Similar to Oregon, Vermont plans to have its Oracle software suite hosted in the cloud, which will enable Vermont to accelerate its DDI environment configuration process. To confirm a viable operations and maintenance model for the Exchange, an assessment will be conducted to identify the best value hosting option for the Exchange. The State's IT strategy is to closely follow Oregon's COTS (Commercial Off-The-Shelf) implementation and customize the architecture and configuration specific to Vermont requirements. For example, federal ACA or MAGI Medicaid business rules developed in the Oracle solution for Oregon are potentially re-usable. Vermont is currently evaluating its need for additional Oracle software component licenses to bring it in line with the Oracle stack that Oregon has procured, and the State is working closely with CCIIO to ensure a signed contract with a systems integrator.

Organizational Structure

Vermont received funding through the Level Two grant to fund the State-based and contracted positions required to establish Vermont Health Connect. Vermont is currently seeking to fill State-based positions through established recruiting and hiring procedures. Vermont intends to use those same procedures to fill positions described in this application.

Financial Integrity

The State is committed to developing and maintaining a financial management system for the Exchange that complies with state and federal requirements, supports a transparent and efficient accounting and reporting process, and leverages current State resources to the greatest extent possible. Housing the Exchange in an existing state agency created the

opportunity to leverage an established structure for the financial management functions of the Exchange. Vermont has developed or utilized existing financial procedures to provide control and reporting of all property, funds, and assets related to grants and cooperative agreements with the federal government. These policies and procedures meet the requirements of the state's existing financial oversight requirements, while still adhering to HHS monitoring needs for grant funding. These procedures include rules related to vendor oversight and quality assurance.

Vermont has identified two critical areas where additional work is needed: 1) financial management, and 2) premium processing and reporting. It has been determined that the level of effort and cost required to remediate the existing systems to support the billing/collection needs of the Exchange exceeds the benefits of enhancing the existing system. The Exchange has used Level Two funds to develop the requirements and design elements for premium processing, and is currently accepting proposals from premium processing vendors. Additionally, KPMG is working with the State to examine program integrity processes as associated with financial management and premium processing, and will identify gaps and provide recommendations.

Consumer Support Proposal

Approximately 266,330 individuals will be eligible to enroll in coverage—both private qualified health plans and Vermont's Medicaid programs—through Vermont Health Connect beginning in October 2013. A key ingredient to enrollment success will be providing assistance to those seeking coverage. Beyond the open-enrollment period, assistance will also be needed to ensure individuals stay enrolled and receive guidance during qualifying events (e.g., family and life changes). Additionally, Vermont is interested in taking advantage of the interactions that the Exchange will have with Vermonters to also educate them about Vermont health reform and other health care resources available to them, such as the state's "Blueprint for Health" reform initiative. The focus of the Blueprint has been to implement a model that organizes community systems of health despite the existence of independent providers, practices, organizations, and multiple insurers. The Exchange, therefore, needs to ensure a robust level of customer service, education, and enrollment assistance for all individuals and small businesses.

As noted above, the State is designing a website that encourages self-enrollment. In addition, individuals and small businesses will have access to the call center and in-person assistors: Navigators and Brokers. Through consumer consultations and the RFI process, the State estimates that adequately resourcing in-person efforts to accommodate the estimated number of individuals and small businesses who will seek enrollment assistance in the first year would require a much larger budget request than Navigators alone, as initially conceived. To address the gap between the amount that is likely to be approved in the state budget process to fund the State's assistance capacity and the demand for assistance, the State is seeking funding to augment the State's Navigator program with additional In-Person Assisters. The purpose of these IPAs will be to ensure all Vermonters

have needed access to in-person enrollment assistance, particularly during the first year of enrollment, when the Exchange will see the largest new volume.

To accomplish the activities necessary to ensure all eligible Vermonters have the assistance needed to enroll, IPA entities will be needed across the state to reach populations who will not self-enroll or use a Broker or Navigator. Vermont's dispersed population makes offering assistance challenging. For example, Vermont's population of just over 625,000 is spread over 9,615 square miles and dissected by the Green Mountains. Vermont's rural nature, geography, and lack of state-wide broad band and cellular coverage make the job of the assister difficult. Our challenge is to reach all Vermonters regardless of geographic location. With our network of state roads and limited federal highways, more consumer assisters are needed to cover the broadly dispersed, often hard-to-reach population in the time allotted before and during open-enrollment.

Due to these key barriers and the volume of potential enrollees, the State strongly believes that Vermont Health Connect and Vermonters would benefit from additional consumer assistance to ensure successful enrollment of Vermont's underserved and special populations as well as meet the needs of a dispersed population. The State anticipates approximately 16-17 IPA entities will need to be geographically dispersed around the state and three to five additional specialist organizations to ensure all Vermonters have access to enrollment assistance in this critical first year of enrollment.

IPAs by Region

As noted earlier, Wakely Consulting completed a geographic resource allocation assessment and determined the need for consumer assistance should be based on the population size in the region. In Table 2 below, the estimated number of IPAs by county is presented based on this analysis. When planning the regional distribution of IPAs, DVHA chose to use Vermont's Agency of Human Services' (AHS) 12 regional districts, which have created an efficient division of services. For example, AHS identifies one regional district to serve individuals and families in both Franklin and Grand Isle counties. As a result of AHS's model, Franklin County and Grand Isle County have been combined. Also mirroring AHS's districts, Essex County is separated into two; the northern region is combined with Orleans County and the southern region is combined with Caledonia County. And note that while 24% of the population resides in Chittenden County, individuals are geographically condensed and therefore easier to reach. Despite the larger population in this region, the State estimates that two or three IPAs will be sufficient.

Table 2. Estimated Number of IPAs by County

County	Portion of VT Population	Estimated Number of Needed IPA Organizations
Chittenden	24.0%	2-3
Rutland	10.3%	2

Windsor	9.7%	2
Washington	9.6%	2
Windham	7.6%	1
Franklin & Grand Isle	8.4%	1
Bennington	6.1%	1
Addison	5.5%	1
Caledonia & Essex (South)	4.9%	1
Orleans & Essex (North)	4.2%	1
Orange	4.7%	1
Lamoille	4.0%	1
TOTAL	100%	16-17

IPAs by Specific Populations

The State recognizes that additional IPA entities may be necessary to provide enrollment assistance to specific populations in the State. These groups may require special care, cultural competency, and understanding to bring them into the enrollment process. In virtually all cases, the populations are small, but difficult to reach and require targeted, specialized care and assistance. While the State recognizes that not all individuals within these populations will enroll in Vermont Health Connect, the majority will and the State is planning accordingly. In addition to the regional IPAs, the State estimates approximately three to five IPAs will be needed to meet the needs of these populations.

1) Abenaki People

While they are no tribes federally recognized by the United States Bureau of Indian Affairs, four tribes are recognized by the State of Vermont: The Nulhegan Abenaki Band, the Elnu Abenaki Band, the Koasek of the Koas Abenaki, and the Abenaki at Missisquoi. The largest tribe is Missisquoi with a population of about 2,700, followed by Nulhegan at 142. The other two tribes combine to about 50, bringing Vermont's total to nearly 3,000. These numbers may be underestimated because not all Abenaki are registered. While the Abenaki people themselves are hesitant to provide the State with accurate numbers, a local expert in Indian Affairs estimates that approximately 1,000 may need individual enrollment assistance. An association serving Abenaki members indicated in their RFI response that their population would be "not likely" to self-enroll in Vermont Health Connect. Identified barriers to self-enrollment included literacy and most likely confusion with enrolling through the call center.

2) Refugees and New Americans

Vermont's refugees and New Americans primarily live in the Burlington area, with additional concentrations in Washington and Windham Counties. This population

represents approximately 35 different countries and range of ages. Associations serving this population indicated in their RFI responses that their populations would be "not at all likely" to self-enroll in Vermont Health Connect. Barriers to self-enrollment included limited English proficiency, limited literacy, minimal experience using computers, limited computer access, and low familiarity with Vermont's health care system and program enrollments in general. In terms of language barriers specifically, the English Language Learner (ELL) population has doubled over the last decade in Vermont.[1] Chittenden County, Vermont's most populated county, has over 62 different languages and dialects spoken at the heart of the county where the bulk of the new American population resides. While the size of the non-English population in Vermont is small, the diversity of languages spoken is challenging. During the 2009 H1N1 pandemic, health information in Vermont was required to be communicated in 11 languages, in addition to English. The languages were: Arabic, Burmese, Chinese, French, Nepali, Russian, Serbo-Croatian, Somali, Spanish, Swahili, and Vietnamese. Approximately five percent of Vermont residents speak a language other than English. Overall, linguistic and cultural differences will make enrollment challenging for this very diverse group of citizens.

3) Deaf and Hard of Hearing

Vermont also has a large deaf and hard of hearing population, mainly located in Barre, Bennington, Brattleboro, and Burlington. The Vermont Center for the Deaf and Hard of Hearing (VCDHH) estimates approximately 20,000 individuals living in Vermont have hearing loss (3.2% of Vermont's population), including 2,000 being profoundly deaf. In comparison, the national average of individuals with hearing difficulties is 1.76% (ages 5 to 64). The VCDHH estimates approximately 50% of their population are enrollment-eligible and 2,000 would need enrollment assistance. Aside from deaf interpreter services, an understanding of deaf culture is essential for an in-person enrollment assister.

4) Small Business Community

Vermont's small group market, inclusive of small businesses currently in an association, is approximately 9,300 employers and 60,000 lives. Seventy percent of these employers currently use a broker to purchase health insurance, but that number is likely to decrease since broker fees are no longer included in premium payments and are charged as a separate, transparent fee. It is estimated that at least 30% and perhaps over 50% of these employers will choose to drop coverage for the 2014 insurance year. The State anticipates that a larger percentage of Vermont employers will drop coverage than in other states due to: the high percentage of very small businesses with lower-income employees and the state's 2017 vision of disassociating health insurance from employment. Therefore, we anticipate that many employers will need assistance grappling with the question of whether to maintain or drop coverage. Vermont will use Level Two funds to support small businesses that want to call upon their broker for assistance with these decisions, but there

[1] U.S. Census Bureau, 2005-2009, American Community Survey, Burlington, VT

will be many employers who will not seek this assistance through a broker. Many employees previously covered with employer-sponsored insurance may need additional help purchasing private coverage through the Exchange if their employer does decide to drop. Organizations or individuals familiar with the diverse needs of the Vermont small business population will be critical to filling this enrollment assistance gap.

Selection of Navigators and IPAs and Funding

A competitive Request for Proposals (RFP) process – combined for both "Navigators" and "In-Person Assisters" – will help identify the most qualified organizations to provide assistance functions across the State and for specific populations. The RFP will focus on needed skills and experience, and not specifically include or exclude any particular entity (consistent with the ACA requirements). One RFP will be issued, and the State will award organizations accordingly to best maximize assistance to enrollment-eligible populations. Contracts to provide assistance in 2013-2014 will be awarded in the spring of 2013.

To best accommodate the need for assistance across the state, DVHA plans to implement a tiered grant system. Having three tiers of assisters (Navigators plus IPAs) allows the State flexibility in the amount awarded to each qualified entity. Our approach was informed by what was proposed in Illinois; just as Illinois distinguished functions based on a tiered model, we intend to distinguish organizations based on the quantity and type of individuals they propose to reach. Dating back to 2006, Massachusetts also awarded different sized grants based on the capacity and responsibility of the designated organization.

In our approach, the size of the grant and the distinction between tier levels will reflect the organization's targeted population size and estimated volume of enrollment assistance they would provide. The RFP process will inquire about an organization's current capacity and potential need to add additional staff to address their targeted population. Tier 1 and 2 organizations will receive IPA funding, and will be distinguished based upon size of funding awarded. Tier 3 organizations will receive state-funded Navigator grants, and will be selected based in part on their ability to provide broad statewide coverage. The size of grants and the number of grantees are consistent with the model proposed in Illinois and used in Massachusetts, and the results of our RFI indicate that organizations in Vermont are prepared to fill this need. Through our knowledge of Vermont's organizations and the RFI process, we understand that organizations may be interested in a partnership model as well. This would allow two or more organizations to share a Tier 2 grant by combining resources to make their enrollment assistance capacities whole.

Below in Table 3, estimated grant amounts and number of grantees is presented. In order to determine the funding in each tier, we assessed the number of individuals each organization should reach in order to enroll all eligible people, based on the Wakely model which predicts a percentage of the population needing in-person assistance. The Wakely model, based on analysis conducted over the spring and summer, assumes that a range of 15% to 25% of the Exchange-eligible population will require in person assistance. Based

on additional input we have received over the summer and fall, including numerous public forums, stakeholder conversations, RFI survey responses and small employer focus groups, we believe that potentially more than 1/3 of Exchange consumers will require in-person assistance in the first year. This population includes:

- Individuals moving from VHAP and Catamount to a QHP who will require additional assistance facing an array of choices;
- Uninsured Vermonters moving to coverage in Medicaid or a QHP who will require targeted outreach and support; and
- Small businesses and their employees facing significant changes in coverage, or the potential to move away from employer-sponsored coverage.

With regard to the small business community, Wakely Consulting conducted focus groups with employers to explore the efficacy of decision-making "support tools" for small employers. The report recommends that support tools should be incorporated into website design and outreach materials, but also suggests, "these tools alone may not suffice for many employers, and it is likely that small employers will require considerable one-on-one assistance to understand and use these tools."[2] Given that there is no small group market in Vermont outside the Exchange, it is critical that small businesses and their employees receive the support they need to find coverage during this first year transition.

Table 3: Grant Levels

Grant Level	Grant Range	Consumer Assistance Type	Estimated Number of Grants	Funding Source	Total IPA Cost	Medicaid Allocation
Tier 1	Up to $40,000	IPA	8 -9	L1 Grant	$360,000	$93,420
Tier 2	$40,001 to $100,000	IPA	12 - 13	L1 Grant	$1,300,000	$337,350
Tier 3	$400,000 (total)*	Navigator	2 Statewide Organizations	State		Dependent on state appropriation
				Sub Total:	$1,660,000	
				Medicaid allocation:	$430,770	
				Grant Total:	$1,229,230	

**Contingent on receiving state funding. This number represents only the state share, and the full cost includes a Medicaid cost allocation.*

[2] http://www.greenmountaincare.org/sites/gmc/files/pdf/Implementing%20Employee%20Choice%20for%20Vermont%20Small%20Employers%20DRAFT.pdf

Training

A comprehensive training program for assisters was cited by RFI respondents as essential to Vermont Health Connect's success. Respondents noted that in order to offer valuable assistance to their populations, they need to be well trained and receive ongoing support from the State.

The Navigator program must provide a base level of training and/or certification of Navigators to ensure they are knowledgeable about all aspects of Vermont Health Connect, Vermont Blueprint for Health, and relevant aspects of the ACA and Vermont Acts 48 and 171. Vermont Health Connect's assistance program will be comprised of both Navigators and IPAs. In an effort to efficiently use resources, all organizations will go through the same certification process and training and be held accountable to the same standards of practice.

Noted earlier, the State received funding to design a preliminary Navigator training program, including the curriculum and certification process. Additional funding is needed to expand the training program to include IPAs and add ongoing training support for those offering assistance.

Vermont Health Care Ombudsman (HCO) office

The State of Vermont sees a growing role for the Health Care Ombudsman as essential for a successful Exchange, particularly in the first year or more of transition. The general statutory duties of the HCO required through Act 48 (2011) increase in complexity under the Exchange, well beyond those funded through the CAP grant. We also expect that there will be a significant increase in call volume and consumer issues, as approximately 266,330 Vermonters will use the Exchange portal in 2013-2014, new to health coverage or transitioning from existing public programs to the Exchange or to Medicaid benefits provided under the Affordable Care Act.

DVHA contracted with Vermont Legal Aid, under whose auspices the HCO's office is located, to help it prepare to implement the Exchange by analyzing the complaints and questions received by the HCO. This work included evaluating the likely consumer assistance needs once the Exchange is operational, and designing a process for addressing consumer complaints not resolved by other consumer assistance efforts within the Exchange itself. Since its inception more than a dozen years ago, the HCO has categorized and recorded data about the problems it has helped resolve and the consumer education it has provided. The HCO's Consumer Complaints Report, which analyzed that data, was completed and submitted to DVHA in August 2012 and lays the foundation on which our budgetary assumptions are based.

Specific new statutory duties include advising the Green Mountain Care Board regarding its health care reform policies, procedures, and rules. The ombudsman may also suggest policies, procedures, or rules to the Board in order to protect patients' and consumers'

interests.[3] The HCO will represent rate payers as a party in all health insurance rate review cases before the Green Mountain Care Board.[4] The HCO participates in the advisory group convened by the director of payment reform to advise the director in developing and implementing the pilot projects and the Green Mountain Care Board in setting overall policy goals for payment reform.[5] The HCO monitors, analyzes and comments on federal, state and local laws and regulations regarding the activities, policies, procedures and rules of the Green Mountain Care Board and recommends changes.[6] The HCO takes referrals from the Exchange and Navigators to assist consumers having problems related to the Exchange. [7]

These additional duties require a level of staffing that goes beyond what the HCO has had thus far, as well as training on the Exchange and any issues connected to it. The Exchange is requesting funding to support this work, critical to Vermont's transition to the Exchange.

[3] 18 V.S.A. § 9374(f).

[4] Green Mountain Care Board Expedited Rule 2012-01A §10(b). A similar provision is included in proposed GMCB Rule 2.000 §2.105.

[5] 18 V.S.A. § 722(b).

[6] 8 V.S.A. § 4089w(b)(5).

[7] 33 V.S.A. §§ 1805(16), 1807 (b)(4).