## Project Narrative

Vermont will be leveraging Level Two funding in conjunction with its approved Advance Planning Document (APD) to complete the necessary work to provide a marketplace for the transparent choice and purchase of individual and small group health insurance, interoperability with other state health care programs, and an active platform for future evolution of the single-payer health care system envisioned in Vermont statute. Vermont successfully submitted a request for Level One Establishment funding in September 2011 and has since made significant progress toward establishing a Health Benefit Exchange (Exchange) for its residents. Based on progress to date, Vermont has met the requirements and milestones for Establishment Level Two funding. Level Two funding will help ensure Vermont is able to demonstrate operational readiness within the timeframes set by the Department of Health and Human Services (HHS).

### a. Demonstration of Past Progress in Exchange Planning Core Areas

**Background Research**

Using Planning and Level One Establishment funds, Vermont completed several surveys and studies to lay the groundwork for its Exchange implementation efforts. Vermont is committed to ongoing monitoring of the data 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;
- More than half (53%) of the uninsured adults aged 18 to 64 were eligible for coverage through a state health care program; and
- Likely Exchange and Medicaid utilization by population, insurance status, health status, and income level.

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 on the Exchange website. As a result of this study and other research, Vermont drafted legislation that was ultimately passed as part of Act 171 mandating the following changes:

- Vermont will merge its individual and small group markets;
- Vermont will retain its definition of small employer to include those employers with 50 or fewer employees until January 1, 2016; and
- Vermont will require all individual and small group health plans to be offered and purchased through the Exchange.

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 final report presented recommendations that might reduce the negative impacts of churn on families and the State. Vermont will continue to seek innovative ways to manage this problem. 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. PHPG's final recommendations will be completed in September 2012. Vermont plans to begin design and implementation of the recommended administrative simplification solutions as part of this grant.

**Stakeholder Consultation**

To create a collaborative and transparent environment for Exchange implementation, Vermont established an Exchange Advisory Group (EAG). This group had its first meeting in March 2011. The EAG has met monthly since that time to discuss and provide input to all aspects of Exchange planning and development. Both the Exchange Advisory Group and the Vermont Medicaid Advisory Board (MAB) have served as key discussants of and respondents to Exchange planning and design work. Per Act 48, Vermont's health care reform law, these groups will be replaced by a joint Medicaid and Exchange advisory committee in July 2012. The Medicaid and Exchange Advisory Committee is scheduled to meet at least ten times over the course of the next year and will assure Vermont meets program integration goals of both the ACA and Act 48. The commissioner of the Department of Vermont Health Access (DVHA) appoints members of the Medicaid and Exchange Advisory Committee, including a co-chair from both the former MAB and EAG. Committee members are comprised of representatives from multiple stakeholder groups, including a representative of health insurers licensed to do business in Vermont; beneficiaries of Medicaid or Medicaid-funded programs; individuals or small businesses eligible for enrollment through the Exchange; advocates for consumer organizations; and health care professionals. Meetings are open to the public and materials are posted online.

Stakeholder Analysis: Funds from the Planning grant were used to conduct a formal study of stakeholders and their preferences related to Exchange design and services. Input from this study and subsequent focus groups have been invaluable to Vermont's Exchange development process. For example, consumer advocates were unanimous in their opinion that too many plan choices would be confusing to consumers; as a result, Vermont has decided to ensure the number of plan design options available on the Exchange offers a range of meaningful plan choices without offering so many as to be confusing. In addition, the state chose to define "small employer" as 50 employees or less as a result of concerns from the business community. Other important areas where Vermont has relied on stakeholder response to inform policy decisions include the Navigator and Outreach programs.

Using Level One funding, GMMB Consulting was hired to conduct 15 in-depth interviews with community organizations, businesses, providers, brokers, insurance carriers, and consumer advocacy organizations in Vermont. These interviews lasted between 30-60 minutes, and covered several topics, including: important qualities to the Exchange; challenges and opportunities to development and implementation; lessons learned from existing enrollment practices; key audiences and how to reach them; and characteristics and roles of Navigators. Through these one-on-one conversations, the Exchange has been able to identify recurring themes arising around Navigators, the enrollment process, outreach strategies, and educational communications. The results of these interviews have been posted online. These interviews, when combined with the stakeholder study, will serve as the baseline against which the Exchange can measure stakeholder support and knowledge throughout the implementation process.

Public Meetings: Maintaining stakeholder relationships and fostering a robust, meaningful communications feedback loop with Vermont residents is of vital importance to Exchange staff. Vermont contracted with GMMB to hold six public meetings throughout the state to ensure that stakeholder feedback is inclusive of all regions and voices. Six employer meetings are also being scheduled to educate and inform small employers about the Exchange.

**State Legislative and Regulatory Actions**

Act 48, which authorizes Vermont's Exchange, was passed and signed into law in 2011. Act 48 provides a framework for the Health Benefit Exchange and articulates goals, governance structure, and functions. Act 48 establishes the Exchange within the existing Department of Vermont Health Access (DVHA), the state's Medicaid agency, and defines its purpose as follows:

- 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 171 was signed by Governor Shumlin on May 16, 2012. The Act requires individuals and small groups to purchase health insurance through the Exchange. By bringing more people into the Exchange, Vermont will be able to establish a more stable rating group and may be able to lower administrative expenses across the health care landscape. Other important aspects of Act 171 include:

- Merging the individual and small group markets;
- Retaining definition of a small employer as an employer with 50 or fewer employees until January 1,2016;
- Mandating the Exchange offer Bronze plans (formerly excluded in Act 48);
- Allowing large employers (over 100 employees) to buy plans on the Exchange in 2017; and
- Allowing the Exchange to compensate brokers for assisting with enrollment in a QHP and applying for premium tax credits and cost-sharing reductions through the Exchange.

Vermont continues to actively review federal guidance on Exchange implementation, as well as the political and legislative actions of other states.

**Governance**

Act 48 authorized the establishment of the Exchange within DVHA. Placing the Exchange within a state agency allows for easy leveraging of existing systems and, during planning stages, state personnel. It also helps build accountability and keep administrative costs low.

December 2011, Lindsey Tucker was hired as the Exchange Deputy Commissioner.[1] As of June 2012, five new Exchange unit staff have been hired, with an additional nine across other areas of state government, such as the insurance division. These hires have been focused on individuals who bring a blend of policy, operations, and technology expertise that directly benefit the integrated health reform visoon of Vermont. Under the Level One grant, the Exchange contracted with Wakely Consulting to assist in identifying other staffing and governance needs of the Exchange. Wakely will provide to Vermont in July 2012 a report that details organizational charts, sequence of hiring, estimated staffing costs, and job descriptions. Early deliverables for this project have informed this grant proposal.

Act 48 also created the Green Mountain Care Board (GMCB) to oversee health care cost-containment and other reform efforts in Vermont. 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 Exchange has worked closely with the GMCB and processes are in place to facilitate frequent input on important health policy issues that impact Vermonters, such as the Essential Health Benefits analysis.

**Program Integration**

The work of 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 the Exchange. 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 the Exchange. 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 the Exchange website.

[1] http://hcr.vermont.gov/sites/hcr/files/HIX_docs/1_Lindsey%20Tucker%20Resume.pdf

The establishment of the Exchange within DVHA has facilitated close coordination and integration with Vermont's Medicaid program. DVHA staff, working with other agency partners and the established workgroups, has produced high-level business process documentation of core Exchange functions. Coordination is currently underway to further detail the business rules needed for an integrated eligibility determination system and to analyze other ways the programs can work together to provide seamless health coverage for Vermont residents. The Exchange is working with KPMG to further asses and refine these requirements, as well as to finalize strategic planning for how Exchange efforts fit within the broader health IT systems development outlined in the State's IAPD.

DVHA has established Memoranda of Understanding with the Department of Financial Regulation (DFR)[2] and the Department for Children and Families (DCF).[3] 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 Exchange development through 2013 and for normal operations in 2014. 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.

DFR is the insurance regulatory agency within Vermont. Recognizing the integral role DFR plays in regulating the health insurance market, the Exchange regularly consults and coordinates with DFR on issues and decisions related to the market and carrier interaction. The Exchange has worked closely with DFR leadership to ensure that the agency has the appropriate resources to support the Exchange, particularly in regards to the QHP Certification process. Through December 2014, DFR will maintain four full-time positions under this grant specifically dedicated to implementing the Exchange. These positions include an Exchange Project Director, Qualified Health Plan (QHP) Certification Administrator, Data and Reporting Coordinator, and Administrative Assistant.

**Exchange IT Systems**

Vermont contracted with Wakely Consulting to assist with the initial planning and coordination of the Exchange IT development. Wakely, through its subcontractor KPMG, has completed the following core planning activities for the Exchange IT System:

- Gap Analysis: Defined specific current state functional and system gaps; identified system and implementation options to close identified gaps and realize the technical roadmap; and
- IT Budget Analysis and Assessment: 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.

The Vermont Exchange team also 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.

The State of Vermont is seeking to engage outside vendors to assist with developing requirements for Exchange IT systems that comply with standards endorsed or adopted by the Secretary of Health and Human Services (HHS) pursuant to Sections 1104 and 1561 of the ACA (Affordable Care Act), HIPAA (Health Insurance Portability and Accountability) transaction standards to ensure accessibility, and security, and privacy standards consistent with federal law.

As previously stated in the IAPD (Implementation Advance Planning Document) V4.0, "Through the CCIIO (Center for Consumer Information and Insurance Oversight) early innovators grant, Vermont is engaged with NESCIES (New England States Collaborative for Insurance Exchange Systems) to leverage (the Commonwealth of) Massachusetts' transformational work. Vermont has been able to take some advantage of select document sharing and other forms of knowledge transfer but recent activities have resulted in the decision that the Massachusetts' status time-line would not allow Vermont to meet its goals."[4] The Level One and Level Two grants are not separate projects but rather integral pieces of the

**2** http://hcr.vermont.gov/sites/hcr/files/HIX_docs/2_DFR%20MOU.pdf

3 http://hcr.vermont.gov/sites/hcr/files/HIX_docs/3_DCF%20MOU.pdf

[4] Vermont Health Enterprise, Implementation Advance Planning Document (IAPD),Version 4.0, April, 2012

Vermont Health Enterprise IAPD which was submitted, reviewed and approved by all of our federal partners including CIIO and CMS. Vermont has been proceeding with the build out of its health care enterprise and the Level One and Level Two grants have been built into the IAPD (in particular the 'jumbo' IAPD) process to ensure appropriate and correct cost allocation.

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 Benefit Exchange. Vermont has also begun to collaborate with Oregon with the intent to reuse as much of their Exchange architecture, requirements, and design assets as possible.

As stated in the Level One grant application, 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.

The Wakely team has developed an initial release strategy to enable Vermont to meet the critical milestones required for setting up an Exchange. The plan is comprised of two primary releases slated for October 1, 2013 and October 1, 2014. Release One would serve as a preliminary release of functionality to secure conditional approval of the Exchange, including MAGI (Modified Adjusted Gross Income). Release Two, will enhance and strengthen the core functionality established in Release One. The State plans to follow the proposed schedule shown in Figure 1 for the Application Components Release. This figure illustrates the planned breakdown of Vermont's end-to-end solution allocated across each of the proposed releases. The values in each Release represent the percentage of functionality of each component included in the release. For components with functionality released to production in both releases, an additional Release Two budget estimate of 20% is included for associated rework of the Release One version.

| Application Component Name | Release 1 | Release 2 |
|---|---|---|
| Business Process Management | 100 | 0 |
| Financial Transaction Processing | 80 | 40 |
| Information Management | 40 | 80 |
| Knowledge Management | 20 | 100 |
| Broker / Navigator Relationship Management | 80 | 40 |
| Customer Service & Account Management | 80 | 40 |
| Marketing and Outreach | 90 | 30 |
| Master Person Registry | 70 | 50 |
| Insurance Plan Management | 60 | 60 |
| Premium & Tax Credit Processing | 60 | 60 |
| Risk Management | 80 | 40 |
| Appeals Management | 20 | 100 |
| Comparison Shopping | 60 | 60 |
| Eligibility Assessment | 60 | 60 |
| Enrollment Processing | 60 | 60 |

*Figure 1: Application Component Name*

**Financial Management**

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 conducted a preliminary analysis of the various financial management functions necessary for the successful operation of an Exchange. Potential systems and responsible parties were identified to perform each function. This report may be found here. Vermont also developed process flows to begin to identify detailed points of contact with key stakeholders. Vermont used Level One funds to contract with Wakely Consulting Group to assess the functionality of state-based accounting and financial management systems to support these functions. Wakely found that some functions could be fulfilled through some remediation of existing systems, primarily VISION (Vermont Integrated Solution for Information and Organizational Needs) and PeopleSoft (PeopleSoft will completely replace current payroll/benefits system in 2013), while others would need an Exchange-specific solution.[5] Wakely's subcontractor, KPMG, and another contractor, Gartner, are currently working with the State to leverage the results of the system assessment to define an appropriate delivery plan for Exchange-related financial functions. Important areas of analysis include: (1) confirming additional Exchange functions that can be leveraged by the state's existing PeopleSoft System; (2) identifying likely areas of integration, including AP/Purchasing, Payroll, Human Resources, systems of internal control (for the prevention of Fraud, Waste, and Abuse); and (3) identifying shared analytics, quality rating and performance measurement capabilities to identify opportunities for improving access, quality, outcomes and cost of services.

Wakely also developed a financial model for Vermont's Exchange, which projects revenue and expenses over the next five years and estimates resources the Exchange will need to fund ongoing operations post 2014. The model allows for flexibility so that as the design of the Exchange becomes more detailed, the model is easily adapted to reflect these details. Because the Exchange will not be able to use cooperative agreement funds to fund ongoing operations, a critical Level One task was to develop a plan to ensure sufficient resources to support ongoing operations. This preliminary financial self-sustainability plan is contained with the Budget Narrative section of this document.

**Program Integrity**

Due to the high visibility of the Exchange and Vermont's reform efforts overall, it is imperative that detailed policies and procedures be established 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 the Exchange. 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 begins to design, build, and implement 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 final Blueprint and implementation plan will be completed in August 2012. Vermont's Exchange meets all State statute requirements regarding fiscal and administrative oversight.

**Health Insurance Market Reforms**

Vermont has reviewed all rulemaking provided to date regarding health insurance market reforms. The Exchange 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.

Essential Health Benefits: Vermont contracted with Wakely Consulting to work with the State to conduct an actuarial cost analysis of any mandated benefits beyond the Essential Health Benefits (EHB) that Vermont

[5] http://hcr.vermont.gov/sites/hcr/files/HIX_docs/4_Financial%20Financial%20System%20Assessment%20-%20Preliminary%20Report.pdf

policymakers wish to include in the standard benefit plan design. To date, Vermont has narrowed the options for the EHB benchmark plan to the two largest small group plans and the state employee plan. The benchmark will likely need to be supplemented with additional benefits, such as habilitative services, prescription drugs, pediatric vision and pediatric oral services. Wakely also provided the pricing differences associated with the benchmark plan options as part of this analysis. This report was presented to the Exchange Advisory Committee and the Green Mountain Care Board in April 2012. Revised recommendations were presented in June 2012 and are posted online. This analysis is currently unable to be completed because the state needs federal guidance on the benefits noted above before finalizing price impact comparisons.

Plan Design / Actuarial Value: Vermont may require standardized benefit designs for QHPs sold at each of the metal levels. The State is currently in the process of developing these plan designs within the context of understanding potential member disruption. An analysis of the current market has already been completed, as have stakeholder engagement meetings with the insurers and the public. Once these plan designs have been developed, they may need to be modified once the federal actuarial value (AV) model is released. The Exchange may decide to explore adding state-specific information or high-level adjustments (e.g. demographics) to the federal model to be more representative of the experience in Vermont.

Rate and Form Filing Reviews: DFR has started its work of enhancing the review of rate and form filings by enforcing the additional requirements dictated by the ACA as well as Vermont's Act 48 of 2011. 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.

The Department also works with insurers on an ongoing basis to ensure they are in compliance with all filing requirements. The Department has built its own data collection tools to streamline information submissions between carriers and to verify claims data used to compile rates. On July 1, 2011, Vermont was declared by HHS to have an effective rate review program. Given the passage of Act 171, the GMCB is the decision-maker on every rate filing regardless of the level of the filing. Additionally, the GMCB allows public comment on any filing, not just those greater than 5%. In order to have an effective rate review program, the following factors must be considered in the review of major medical rate filings in the small and individual group markets: medical cost trend changes by major service categories, changes in utilization by major service categories, cost-sharing changes by major service categories, changes in benefits, changes in enrollee risk profile, impact of over- or under-estimate of medical trend in previous years on the current rate, reserve needs, administrative costs related to programs that improve health care quality, other administrative costs, applicable taxes and licensing or regulatory fees, medical loss ratio, and the issuer's capital and surplus.

Cost-Containment: Using Level One funding, Bailit and Burns and Associates provided technical assistance to the GMCB in developing clinical and financial models intended to reduce anticipated medical expenditures. The consultants provided the GMCB with models to test a range of payment reform options intended to maximize provider participation and reduce cost across Vermont. Current focus has been on the following payment models:

- Population-based payments to integrated health care delivery systems;
- Global physician/hospital budgets; and
- Bundled payments for specific diagnoses and procedures.

The three basic payment models provide clear steps toward development of a mixed model of payment that would balance incentives for reduced utilization, high quality care, improved access to care, and positive patient experience, while supporting adherence to an overall state health care budget. It is anticipated that these payment reform models and cost containment strategies will be integrated into the Exchange.

**Providing Assistance to Individuals and Small Businesses, Coverage Appeals, and Complaints**

An important priority of the Exchange is providing effective consumer assistance to individuals and small businesses. Vermont recognizes that providing a high level of service to consumers will be particularly important as there will be no available market outside the Exchange. To that end, Vermont has developed goals for the consumer experience within the Exchange for both individuals and small businesses. These goals include being consumer-friendly, understanding and addressing the specific needs of populations, and allowing for easy and quick problem resolution.

Vermont staff and legislators have met regularly to discuss how to implement the Exchange to maximize its usefulness to individual consumers and small businesses. In addition, staff and executive leadership continues to meet with other stakeholders, including associations, insurers, unions, consumer advocates and nonprofits, chambers of commerce, and others in small groups or individually to determine how the Exchange might impact existing coverage and programs.

The Exchange has identified four functions that it feels are critical to providing the level of support required by the ACA:

1. Creating a Call Center with a toll-free hotline to assist all Vermonters seeking health insurance;
2. Developing a broad network of Navigators;
3. Working closely with agents and brokers; and
4. Building on the capacity of the existing Office of the Health Care Ombudsman (HCO).

The first two functions are described in more detail under the Business Functions section of this Narrative. However, building expertise within the Office of the Health Care Ombudsman (HCO) will need to be conducted separately from general operational planning. The HCO is an existing health insurance consumer assistance program that helps state residents resolve problems, answer questions, file complaints and appeals, and enroll in state health care programs. Vermont plans to use the HCO, an outside entity, to provide these services for the Exchange and therefore needs to evaluate what modifications to existing HCO functions and capacity are needed to meet consumer needs in the Exchange environment.

The HCO deals with all types of health insurance inquiries: commercial insurance, state Medicaid programs, Medicare, TriCare, etc. The Office received Vermont's Consumer Assistance Program grant under the ACA for fiscal year 2011. The HCO has a proven track record as a strong independent voice for consumers in the state. Over the years it has demonstrated considerable expertise in consumer education and problem resolution. In addition, it already coordinates with many other consumer and advocacy organizations, some of whom are likely to become Navigators. Vermont used Level One funding to develop an implementation plan and educational materials for the HCO. The Exchange has also been analyzing HCO-collected data on consumer problems to help inform ongoing preparation under this core area of Exchange development. It is expected that the HCO will work closely with the Call Center and Navigators.

**Business Operations/Exchange Functions**

Using Planning grant funds, Vermont contracted with Bailit to assess at a high-level the business functions of the Exchange. Bailit recommended responsible parties for each function and identified certain operations the Exchange should focus on during the next phase of development. This report helped structure early strategic decision-making on roles and responsibilities across agencies. Through Level One funding, several contractors assisted Vermont in developing a comprehensive workplan for developing a broad range of Exchange functions to be implemented during the next phase of grant funding. The work conducted under these grants laid the groundwork for Vermont to move from development toward operationalizing these functions. Progress made in each of the business operations areas is provided below.

***Certification, Recertification, and Decertification of Qualified Health Plans:*** There are just two main carriers in the Vermont non-group and small group markets. Ensuring adequate participation from carriers will be key since only two carriers (MVP Healthcare and Blue Cross Blue Shield of Vermont) compromise the vast majority of Vermont's non-group and small group markets. CMS just released information on June 22, 2012, that it has approved a co-op in Vermont. Because this was a confidential process, the state has yet to review the co-op design in the state licensure process.

Per Act 48, the DFR leads the premium rate review process, with the Green Mountain Care Board as the oversight body. The Exchange will build on existing DFR activities related to plan management when

developing its certification process and procedures. When certifying QHPs, the Exchange must minimally consider affordability, promotion of high-quality care, promotion of wellness programs, and participation in Vermont's health care reform efforts. Vermont has drafted a potential QHP certification process as identified in Figure 2 below.

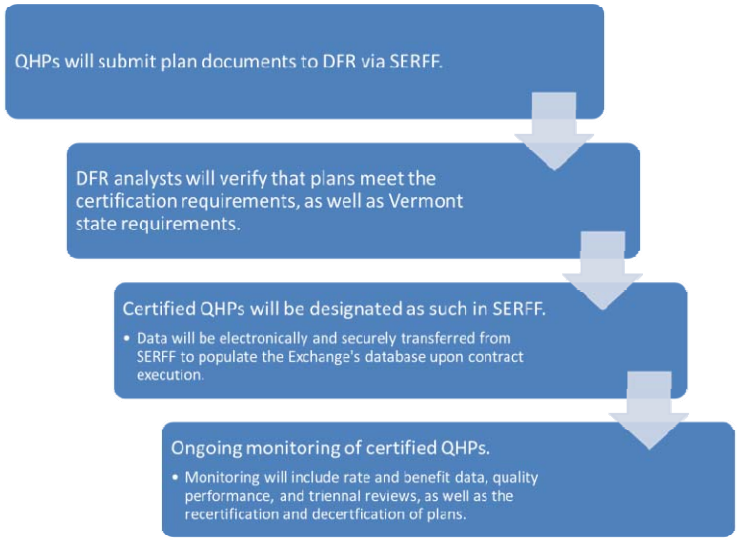


*Figure 2: Proposed QHP certification process*

Using Level One Establishment funding, and working with Wakely Consulting Group, Vermont has reviewed ACA's criteria for the certification of QHPs and has started to develop a crosswalk between federal minimum standards and related state requirements. Wakely will be assisting the state throughout the summer of 2012 to:

- Identify any changes required in state regulations to conform to minimum federal requirements;
- Develop state-specific standards for QHP Certification;
- Develop a certification timeline; and
- Develop draft contracts and other artifacts necessary to perform the plan management function.

The Exchange has also initiated outreach to consumers and carriers to solicit input and feedback on the QHP certification process. The Exchange will continue to take into account the needs of consumers and their advocates in developing the Exchange certification approach.

***Call Center:*** Using Level One establishment funds, Vermont engaged Wakely Consulting and their subcontractor KPMG to perform an assessment of the existing outsourced Medicaid call center vendor and its capacity to comply with the consumer assistance requirements of the ACA. This process involved comprehensive interviews with the current call center vendor operations team, the state's Office of Healthcare Ombudsman, members of the eligibility determination call center team, and personnel responsible for managing premium billing and collections for the Catamount Health program. The assessment included a review of the current call center vendor contract and an inventory of call center support functions. The analysis took into account the current call center services provided by state agencies related to eligibility determination and premium billing functions since these will be critical functions in the 2014 environment. Categories and observation areas of call center services that were evaluated focused on general call center administration, staff, processes, technology, metrics and measurements, and financial considerations. The format of the assessment followed a process of observations, potential impacts, and a recommendation to comport to industry best practice and compliance with ACA guidance.[6]

The existing landscape was assessed against the federal guidance and ACA requirements related to call center/Exchange functions in order to recommend areas within the existing outsourced call center contract

[6] http://hcr.vermont.gov/sites/hcr/files/HIX_docs/5_Call%20Center%20Assessment%20Narrative.pdf

that would need to be enhanced or integrated with the new Exchange technology to ensure compliance with Exchange requirements.[7] Recommendations included:

- Establish a single point of contact for all support services and consolidate technology, resources, and facilities;
- Utilize skill-based routing and establish clear roles for Tier I and Tier II support organizations.
- Establish formal contract governance over call center services;
- Standardize execution of change, issue, and knowledge management across all support organizations;
- Develop a formal quality assurance review program for management of all policies and procedures used within all support organizations, and establish metrics for evaluating quality within the service delivery model;
- Consider a standard approach to measuring and reporting on customer satisfaction across all support groups; and
- Establish formal performance targets for all support organizations.

***Exchange Website:*** The Exchange website will play a critical role in the function of the Exchange and many of its components. The primary function of the website will be to enroll eligible Vermonters in health coverage. The secondary functions of the website will be to provide information for all Vermonters pertaining to health coverage and the health reform laws in a clear and transparent way. Currently, the Exchange uses state web services to host Exchange-related information and reports as part of the greater DVHA website. The Exchange intends to continue the use of this website to communicate information on Exchange activities and health care reform to Vermont residents until a new, Exchange-specific website is developed. Vermont's contract with GMMB includes the development and testing of an Exchange name and brand, which will be incorporated into the overall web-strategy of the Exchange. As part of the work, GMMB has conducted a benchmark survey to assess Exchange awareness and how consumers would like to access information.

Working closely with the IT team and contractors, the Exchange developed high-level business requirements for the web functions of comparison of QHPs, application and selection of QHPs, premium tax credit and cost-sharing reduction calculator, and consumer assistance. Vermont is actively exploring UX2014 and other options for reuse and collaboration. The technical implementation of the Exchange is described within the Exchange IT Systems section of this Narrative.

***Premium Tax Credit and Cost-sharing Reduction Calculator:*** Tools for the calculation of advance premium tax credits will be provided through the Exchange website. Vermont has begun to plan for the type of business processes and interfaces that will be needed to support this function. Detailed requirements for this tool will be developed as part of the greater IT build.

***Quality Rating System:*** Designing a rating system involves making choices about the metrics to include in the rating, how to secure the data for the metrics, how to combine the data into a single rating, how to benchmark, and how to report the information. These decisions will depend in part on federal requirements for a rating system (not yet released) and the scope of current quality and wellness activities in Vermont. The Exchange has decided to leverage existing channels of data collection and reporting to the extent feasible in implementing the public reporting and rating requirements of the ACA. Vermont used Level One Establishment funds to contract with the University of Massachusetts Medical School (UMMS) to develop a quality rating program for the Exchange.

UMMS worked with stakeholders to understand the scope and depth of Vermont activities in the arenas of quality and wellness. The UMMS team interviewed stakeholders to determine their involvement and experience with quality measurement and public reporting; rating providers; quality improvement activities; metrics currently collected; and incentive and wellness programs. These interviews were completed in June 2012 and UMMS is currently working on synthesizing the findings. The findings will inform how and what type of data the Exchange decides to report to the public.

[7] http://hcr.vermont.gov/sites/hcr/files/HIX_docs/6_State%20of%20Vermont%20%20Interim%20Report.pdf

The Exchange will provide incentives to health plans for superior performance on their quality improvement projects. UMMS will be making recommendations to Vermont about best practices for incentive and rewards systems, as well as how the scope and type of current quality improvement projects being conducted by entities within the state impact these recommendations.

***Navigator Program:*** Using Level One funding, Vermont contracted with GMMB to assist with the design of Vermont's Navigator program and to help identify possible Navigators. GMMB conducted research with a diverse group of residents and stakeholders to identify their needs and preferences. Findings were drawn from the following research methods: a state-wide benchmark survey conducted among 1,004 adults age 18 and older and stakeholder interviews with 15 representatives from several sectors, including community organizations, health care associations, brokers, providers, small businesses, insurance carriers, and consumer advocacy organizations.

This research provided a number of insights on the design of the Navigator program. These research findings yielded the following recommendations for the Navigator program:

- The program must ensure a base level of training and/or certification of Navigators to ensure they are knowledgeable about all aspects of the Exchange and relevant aspects of the ACA and Vermont Act 48;
- Navigators should have some experience with target populations and the health care system in Vermont;
- Stakeholders in Vermont identified "people skills," such as patience, empathy, and listening skills as important characteristics;
- The small business community needs access to individuals who are trained to specifically meet their needs, including knowledge of tax credits and the impact on their business; and
- Navigators must be 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.

GMMB, working with Wakely Consulting, will continue to assess other important design features of the Navigator program as part of their Level One work. The design issues that will be evaluated and addressed during the summer of 2012 include: the ability of the Navigator to fulfill the role adequately based on current operational resources and capacity; development of specific milestones and performance measures to evaluate selected Navigators once operational; initial and longer-term funding requirements.

***Eligibility Determinations for Exchange participation, advance payment of premium tax credits, and cost-sharing reductions:*** A single Exchange portal will be used to determine eligibility for premium tax credits, cost-sharing reductions, and CHIP and MAGI-related Medicaid programs. This portal will include real-time determinations and a single-session enrollment process. In order to maximize seamlessness and efficiency among affected programs, Vermont will implement a single eligibility system, which must be ready for open enrollment in October 2013. This system will be based on an external rules engine, which Vermont will enhance over time to support SNAP, TANF, Fuel Assistance, Child Care, General Assistance, and non-MAGI Medicaid. As outlined in its approved IAPD, Vermont intends to have the eligibility process completely automated through the new Vermont Integrated Eligibility Workflow System (VIEWS) with staff intervention only occurring in the application process if there are additional items that need to be verified or if a case needs further work to determine eligibility. A cross-functional workgroup of Vermont staff have started to draft the supporting business rules for the creation of this system.

***Seamless eligibility and enrollment process with Medicaid and other State health subsidy programs:*** Vermont has decided to implement an integrated eligibility system for all health care programs, both public and private, using VIEWS. This allows for the eligibility and enrollment process to be seamless from the consumer's point of view, and will allow for the maximum uptake of any insurance product whether the user is determined eligible for Medicaid/CHIP, premium tax credits, cost-sharing reductions, or no financial assistance, and whether the user is enrolling in Medicaid, the Basic Health Program (should Vermont decide to create one), or a QHP, including potentially stand-alone dental plans. There will be a single integrated process from the point of application to a determination of eligibility and, for families or individuals who

need to choose a plan, plan selection and enrollment. The consumer experience should be the same regardless of the program or programs for which the individual/family applies or is determined eligible. Vermont intends to incorporate non-MAGI Medicaid and other programs after the system is operational for the Exchange in 2014.

***Enrollment Process:*** Vermont has assessed CMS' enrollment guidance by reviewing CMS blueprints, Notice of Proposed Rulemakings, and other resources. The Exchange must enroll individuals in QHPs, present participating employers with consolidated bills, collect premiums from employers, and offer individuals the choice of paying premiums directly to the QHPs. Ideally, individuals and employers will be able to access real-time eligibility decisions and health plan enrollment through the Exchange web portal. Enrollment options by phone, by mail, or in person must also be available. Vermont contracted with Wakely Consulting to evaluate existing enrollment and premium payment processes in publicly-funded programs, such as Catamount Health, to help the state develop the most consumer-friendly enrollment processes for the non-group and small group market. Wakely will use this research to develop efficient and seamless enrollment and reconciliation procedures within the Exchange for individuals, employers, and employees, including the ACA requirement that there be no gap in coverage when an individual is changing plans. Wakely will also provide Vermont recommendations on billing and payment procedures for individuals and employers. This project will be used to inform the development of business requirements for the IT system build and to assist in developing enrollment processes that could support both the Exchange and Medicaid.

***Application and Notices:*** 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 the VIEWS/Exchange IT systems development, healthcare applications will be de-coupled and updated to comport with all necessary changes under ACA and Vermont's unique Medicaid expansion populations. Vermont is hoping to adopt the healthcare application that CMS is currently developing. Based on that product, Vermont will decide what supplemental or additional forms are needed to support the application process. Over time, as the system is more fully operational and stable, Vermont will assess the full integration of all state and federal benefit programs. 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.

***Individual Responsibility Determinations****:* The Exchange must be able to determine whether an individual is exempt from the individual mandate obligations due to membership in an exempted group: income less than 100% FPL, lack of affordable coverage, religious reasons, or hardship. The Vermont Exchange will manage individual responsibility exemption applications. The determination of these exemptions will be performed in cooperation with federal data sources and systems. This process will be automated to the greatest extent possible. The submittal of individual responsibility applications, notification of determination, and the workflow management of this function are included in the scope of the Exchange IT build. Vermont has begun to outline the key administrative processes that support this function.[8]

***Adjudication of appeals of eligibility determinations:*** Vermont contracted with PHPG to review existing appeals processes and recommend changes to those processes or new processes if necessary for individual and employer appeals. Pursuant to federal guidance, individuals may contest eligibility determinations for premium subsidies and Exchange participation. PHPG conducted a landscape scan of existing appeals infrastructure within the state and reviewed existing processes for appealing eligibility determinations in other state programs. Level One funding was used to evaluate what resources would be necessary to handle Exchange-related appeals. Vermont has also identified specific goals of the Exchange appeals and complaints function, including:

- Provide as many web-based tools as possible to support this process;
- Allow follow-up through electronic means if possible;
- Automatically generate notices upon receipt of a complaint or appeal; and

[8] http://hcr.vermont.gov/sites/hcr/files/HIX_docs/7_Determinations%20individual%20mandate%20exemptions%20%5BCompatibility%20Mode%5D.pdf

- Establish report tracking functions to monitor number of complaints and appeals by division and type.

***Notification and Appeals of Employer Liability**:* Vermont has begun to assess how it will handle employer appeals and notifications. Small employer surveys and interviews have been conducted to inform this process. Small businesses will need to have a way to appeal decisions that they are not "eligible employers" who can buy insurance on the Exchange, and also decisions that their insurance plan does not meet Minimum Essential Coverage requirements. While Vermont awaits further federal guidance on this requirement, the Exchange planning process has nonetheless assumed that employer appeals will flow through the IT system in the same way as individual enrollee appeals. The IT planning and build process has included the system requirements for the employer appeals process.

***Information Reporting to the IRS and Enrollees:*** Section 1401 (f)(3) of the ACA requires the Exchange to provide certain information to any enrollee and to report this information to the Internal Revenue Service (IRS). This information is vital for the IRS's overall administration of the premium assistance tax credit and for enrollees' ability to claim or reconcile the credit on their tax filing at the end of the tax year. Vermont has begun evaluating the means of capturing the data required for this process and through its IT planning process has begun drafting specifications for building the capacity to communicate the required information to both the IRS and the enrollee.

***Outreach and Education:*** Communicating the benefits and availability of the Exchange will require a combination of marketing and strategic communications outreach, as well as a series of integrated tactics. Vermont contracted with GMMB to develop an outreach and education plan that outlines a diverse set of activities—some geared to specific audiences such as low-income individuals, small business owners, and Navigators—all working together as a unified campaign. The findings from quantitative and upcoming qualitative research will inform this messaging, as well as the specific activities to reach, inform, and motivate target audiences to use the Exchange.

GMMB is assisting the State to develop a comprehensive outreach, education, and engagement campaign to inform both individuals and employers throughout Vermont about the Exchange. The campaign must be designed to meet the needs of individuals with disabilities, individuals with limited English-speaking proficiency, and other potential barriers to enrollment as required by the ACA. To assist the State in developing a comprehensive outreach and education campaign, GMMB's scope of work includes the following:

- Survey 1,000 Vermonters ages 18 – 64 to determine awareness of the Exchange and to test ideas that will drive the creative materials and strategies;
- Conduct a brand assessment of public and private brands to ensure that the Exchange brand is clear and distinct thus demonstrating that it is an unbiased clearinghouse of plans;
- Conduct eight focus groups;
- Develop a unified outreach, education and engagement plan that allows for a diverse set of activities and focuses on measureable results. Components of the campaign will make use of community and corporate partnerships, the Medicaid and Exchange Joint Advisory Committee and other health care stakeholders, Navigators, policy-makers, and government agencies;
- Develop tools such as FAQs and a list of core educational topics to ensure consistent language between the Navigators and call center; and
- Develop a stakeholder training program that provides widespread training for state staff and vendors, as well as providers, advocacy organizations, small businesses, chambers of commerce, and other interested organizations. Training sessions may employ various delivery systems, such as the Vermont Interactive Television studios around the state, regional in-person trainings, and telephone/webinar trainings.

***Risk Adjustment and Traditional Reinsurance:*** Vermont is in the process of making design decisions around risk adjustment and reinsurance. Preliminary thinking is that Vermont is inclined to defer to federal management of the risk adjustment program. Because of market dynamics, specifically adverse selection and rate shock, the state is still considering options with respect to reinsurance administration and design. A

final determination will be made in the fall of 2012 for these programs, and Vermont will develop an implementation plan that will address the necessary steps based on either state or HHS administration of each program.

***Small Business-Specific Exchange Functions:*** Vermont began planning for small business participation in the Exchange in late 2011 when it issued an RFP for assistance in developing the design for its small business Exchange. Utilizing Level One Establishment grant funding, Wakely Consulting was hired to perform this work, and the two parties agreed that Wakely would develop an operational guide[9] to include the following eight core components: (1) administrative requirements by six key functions (online shopping and initial application process for both employers and employees, eligibility and verification, enrollment, premium billing and collections, broker election, management and compensation, and appeals); (2) current and recommended roles for broker community and compensation models; (3) overview of business association market; (4) employee choice model dynamics and adverse selection implications; (5) rating and premium contribution strategies; (6) tax considerations; (7) transition plan strategies to ease disruption; and (8) call center functionality to support the needs of employers, employees, and brokers.

Wakely subcontracted with RKM Research and Communications to conduct in-depth interviews with 50 small businesses currently offering health insurance to evaluate their observations of the current small group market and to determine their preferences for plan choice models in the exchange. The interview process, conducted in May of 2012, also asked respondents to evaluate their current use of brokers and future contemplated use if commissions were separate from base premiums. GMMB was hired with Level One funding to conduct detailed interviews with 15 stakeholder groups (including community organizations, businesses, providers, brokers, insurance carriers, and consumer advocacy organizations) in order to identify recurring themes arising around navigators, the enrollment process, outreach strategies, and educational communications. This work will inform components of the Exchange development for both the individual and small business users.

Vermont also engaged Wakely to provide a number of other employer-related actuarial studies and/or work plans using Level One funding. These included: the market impact of employers dropping coverage, market impact of employer decisions to self-insure, survey of HDHPs in the market today, and a glide path for rate impacts on specific groups.

### b. Proposal to Meet Program Requirements

Based on the activities completed to date, Vermont is on schedule to establish a fully functional Exchange by October 1, 2013, along with meeting HHS' requirements and milestones for Establishment Level Two grant funding. To accomplish the activities necessary to ensure that the Exchange can meet certification requirements, the following activities are proposed under each Core Area laid out by HHS.

**Background Research**

Vermont has completed the background research necessary to move forward with Exchange implementation; moreover, staff will continue to work with external researchers and to refine enrollment estimates and assess policy decisions. This will include microsimulation modeling on enrollment post January 1, 2014. Having a better estimate of overall enrollment and the rate of growth will ensure the Exchange is prepared for demand and will help eliminate waste. During the Level Two Establishment Grant period, the Exchange will also continue to work on a legal analysis of ERISA implications.

**Stakeholder Consultation**

Vermont views stakeholder interaction and feedback as critical to building an Exchange that serves the needs of all consumers, as well as creating an environment that supports productive business relationships with insurance carriers, providers, and brokers. Maintaining stakeholder engagement throughout the Exchange's development and implementation will be critical to the success of the Exchange and subsequent outreach and education activities. The Exchange will continue to meet with a variety of stakeholders such as

[9] http://hcr.vermont.gov/sites/hcr/files/HIX_docs/8_VT%20Operational%20Guide%20Sm%20Bus%20Exchange%20062012%20Presentation%20FINAL.pdf

insurance carriers, providers, consumer advocates, employers, brokers, veterans, and others. Exchange staff will also hold specific meetings on key programmatic functions for the stakeholders impacted as the Exchange moves into its implementation phase. The Exchange will coordinate all outreach and education efforts with important stakeholders to ensure Vermonters have access to information and support within their communities. Because there will be no outside market for small employers, the Exchange will meet regularly with Chambers of Commerce and other groups that interact closely with small employers to prepare for this transition.

In addition to external stakeholder engagement, 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.

**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. With Level Two Establishment funds, Exchange staff will maintain contact with HHS to respond to proposed regulations and bring attention to any specific issues that are important to the operation of the Exchange.

**Governance**

Level Two funding will allow the Exchange Deputy Commissioner, as well as managers in other departments critical to Exchange development and operations, to recruit and hire additional staff, as well as contract with experts and consultants, as identified in the staffing study completed by Wakely as part of the Level One work. Exchange staff will be responsible for establishing the policies and procedures for key functions with advice and counsel from other state agencies when applicable. Exchange staff will continue to support the Joint Exchange/Medicaid Advisory Committee meetings, and will raise important administrative and policy issues for discussion and advice.

**Program Integration**

Exchange staff will continue to use internal working groups and the Medicaid and Exchange Advisory Committee 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, streamlined coverage for Exchange and Medicaid-eligible pregnant women, and stakeholder engagement on selected Medicaid implementation policy issues.

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, including departments responsible for eligibility determination, certification of QHPs, quality reforms, and system testing. The Exchange will also test information sharing with appropriate state agencies prior to go-live.

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, such as the development of the reinsurance and risk adjustment programs, and with the Green Mountain Care Board in their decisions on the essential health benefits benchmark plan and QHP plan designs. Funds are included in this request for work on these important policy considerations, as well as to contract with a management consultant to review current organization structures and identify how agencies may need to change to improve effectiveness of Exchange functions.

**Exchange IT Systems**

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.

As stated in Vermont's Planning Review with CMS (Centers for Medicare and Medicaid Services), Vermont has also had initial conversations with Rhode Island and is looking for similar relationships with other states about potential operational reusability which includes shared data center, call center, and premium management operations. The State will pursue procurement activities to acquire the services of a systems integrator to execute the necessary DDI activities to build and configure or to repurpose a commercial or transfer solution for external sources to meet the needs of the Exchange solution.

Through the Exchange IT systems and core exchange components, the technical architecture of the Health Benefit Exchange will link existing systems with newly developed Exchange functions to deliver a flexible and real-time transaction processing model. Recognizing that legacy systems and business processes may not easily interoperate with the proposed solution, these systems will be integrated with the Health Benefit Exchange via an enterprise service bus that acts as a messaging broker between the State's existing system and the Health Benefit Exchange solution.

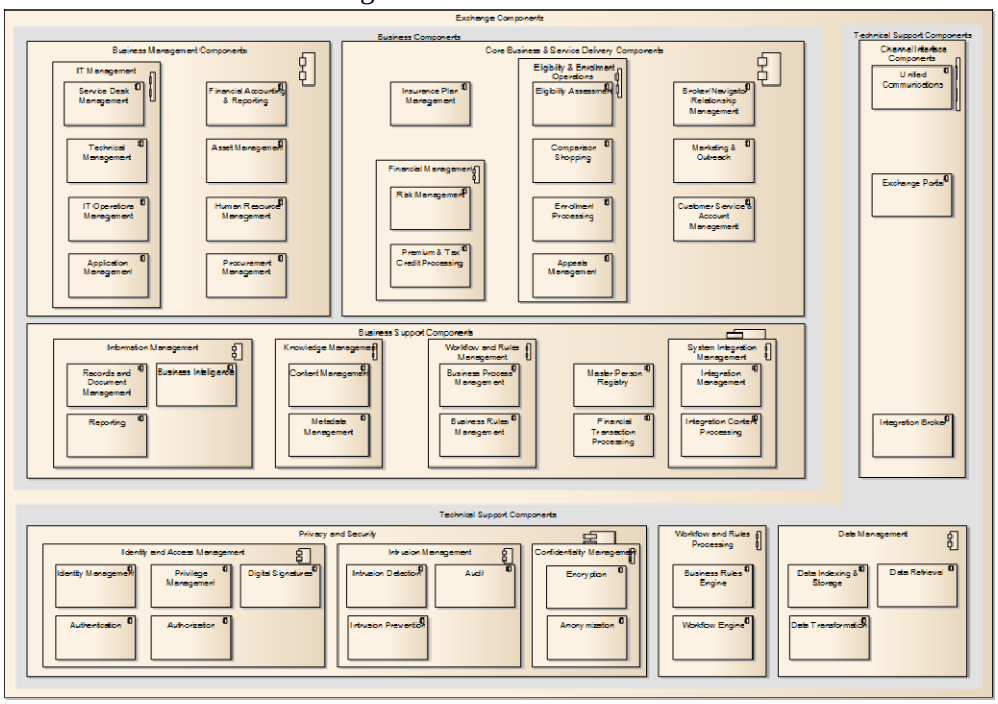


*Figure 3: ERA Component Model*

Technical Architecture

As stated in the IAPD V4.0, Vermont has been increasingly involved with Oregon and is considering Oracle as its core infrastructure platform. This relationship has provided a wealth of information and is one that Vermont will continue to leverage. The Oracle suite of SOA core components has been procured as the integrated platform for shared services to support Vermont's MES (Medicaid Enterprise Service, formerly known as MMIS), Health and Non-Health Program Eligibility, and Exchange systems.
The Wakely team is providing assistance in the development of a Vermont Health Benefit Exchange (HIX) architecture that seeks alignment with Exchange Reference Architecture guidance. Figure 3 depicts the to-be architecture and its major components.

Vermont has engaged Gartner Consulting to conduct an assessment of Oregon's approach and Oracle SOA solution to determine alignment with Vermont's current Oracle suite and identify a DDI plan for realizing the Medicaid and Exchange vision for the Vermont Health Services Enterprise.[10]

The Vermont Health Benefit Exchange will consist of a multi-tier architecture and will utilize the following layers and design patterns:

- User Interface Layer: Browser-based application to display information to consumers;
- Enterprise Integration Layer: Identity resolution for members; conducts transactions with existing legacy state systems and interaction with federal services for verification and transactions. Alignment with open standards and NIEM (National Information Exchange Model) will be enforced;
- Business Rules Layer: Separate set of technology-neutral business rules that will be maintained as a set of policies that can be imported and exported with other states and systems;
- Additionally, maintaining a separate business rules layer enables the use of external state innovator systems either at the rule level or the actual system;
- Information Management Layer: A separate layer will be used to define the types of data that will be measured and reported to ensure quality, integrity, value, and usefulness of the insurance exchange functions. This layer will encapsulate the reporting and evaluation measures that the project will utilize for core operations and project tracking;
- Security Layer: Separate authentication, authorization, access control, and audit rules and engines for evaluation will be constructed. For audit, measurement and management tools will be in place in order to verify adherence to security policies; and
- Data Layer: Consistent and exchange-wide data schema will be used to model both the data and relational data storage and mapping to the integration service transactions

Applicable Standards

The standards described below will be incorporated into ongoing program requirements, particularly those utilized to select and implement the core Exchange functions. The State's approach to meeting applicable standards is outlined below; all IT systems and components that the State procures or leverages will meet these requirements:

- Medicaid Seven Standards and Conditions: Vermont will continue to work with CMS to be fully aligned with its prescribed Seven Standards and Conditions for IT systems to implement flexible, modular, reusable, reconfigurable IT systems.
- 1561 Recommendations: The State of Vermont intends to utilize the NIEM (National Information Exchange Model) standard for interactions with federal verification sources and with State systems. As the NIEM is established for the health domain, State of Vermont will enforce and implement these standards as part of its web services deployment on the Enterprise Service Bus.
- Accessibility: Vermont's user interface will be Sections 508 and 405 compliant, and will adhere to the W3C (World Wide Web Consortium) Accessibility Guidelines.
- FIPS (Federal Information Processing Standards): State of Vermont will follow the relevant application federal guidelines to enable:

[10] "CMS Planning Review, Vermont Health Benefit Exchange May 2012"

- Leveraging State of Vermont's IT governance to review and align security controls between state policies and insurance exchange operations;
- Repeatable processes and guidelines for selecting and implementing security controls;
- Incorporation of security controls and requirements into the ESB ( Enterprise Service Bus);
- System security according to FIPS 199; and
- Systematic and periodic assessment and measurement standards adherence.

Implementation Strategy

Vermont has adopted an Exchange IT Systems implementation strategy that favors early innovator solution reuse and COTS configuration implementation methods to increase productivity and lower DDI costs. Figure 4 indicates the associated productivity assumptions of each implementation method as applied to exchange components based on the size and complexity of the component as measured in function points. The days per function point are IT DDI days. Lower function point values represent more expedited implementation options.

**Options considered in the development of Exchange implementation strategy**

| Implementation Method | Description | Productivity Assumption |
|---|---|---|
| **Reuse** | Software component is implemented using a component from a current system which requires no customization and relatively simple configuration | 1 day/FP |
| **Configure – Simple** | Software component is implemented using a COTS or early innovator solution that requires no customization and relatively simple configuration | 1 day/FP |
| **Configure - Complex** | Software component is implemented using a COTS or early innovator solution that requires no customization but reasonably complex configuration (e.g.: configuration of complex business rules and workflows) | 2 days/FP |
| **Hybrid** | Software component is implemented using a COTS or early innovator solution that requires a combination of customization and configuration | 3 days/FP |
| **Build** | Software component is custom coded. | 5 days/FP |

*Figure 4: IT effort estimating assumptions by implementation method*

The SDLC (System Development Lifecycle) approach as illustrated in Figure 5 for constructing the Vermont's Exchange will be a modified iterative development approach. It balances traditional milestones in some project phases with iterative approaches for the core phases of design, development and internal testing.

Exchange IT System Development Lifecycle Methodology

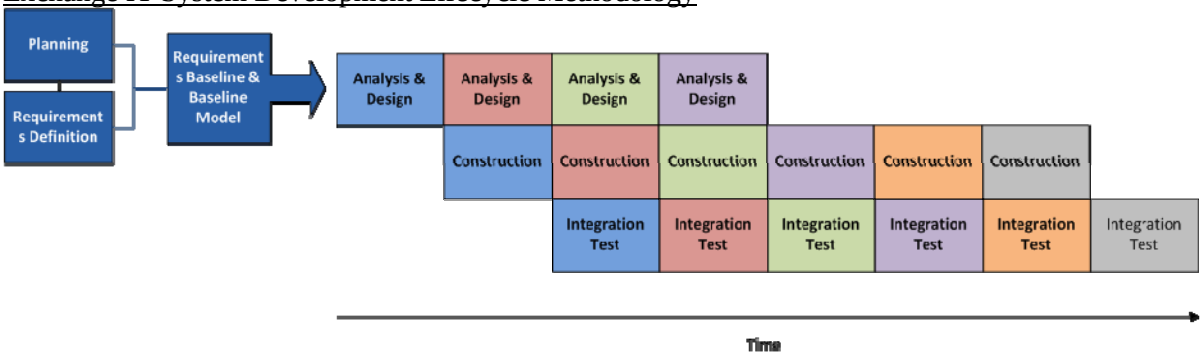


*Figure 5: System Development Lifecycle (SDLC)*

Planning and requirements definition are similar to what is expected of a traditional waterfall methodology approach. This is necessary to facilitate defining the overall needs of the entire Exchange and to allow for

procurement of configurable solutions appropriate to the requirements. Once these phases are complete, Vermont's SDLC transitions to an iterative methodology for the design and construction/ development phases. In these phases, instead of managing very large project phases, the same disciplines and tasks are used, but are managed in smaller work bundles or pieces called "iterations."

Iterations are bounded by time; time is the determining factor in the amount of functionality that can be reasonably produced during each iteration. Breaking the project down into smaller pieces provides for agility in the face of evolving federal and state guidance and makes it easier to shift work among iterations. Additionally, since the overall requirements for the Exchange have been defined up front, there is no rigid requirement that a particular Exchange business function be developed before another, allowing multiple teams to work in parallel during the Development phase. The result of each iteration is a working system that grows in functionality as time progresses. Stakeholders will see concrete, measurable results at the end of each cycle, preventing extensive (and expensive) redesign during the Acceptance Test phase of the project.

Exchange IT System Integration

Vermont has developed an integration approach that will result in an integrated Exchange platform that will leverage data from the existing legacy systems. The exchange integration architecture illustrated in Figure 6 reflects the physical systems with which the Exchange/IES (Integrated Eligibility System) solution will need to be integrated as it is implemented.

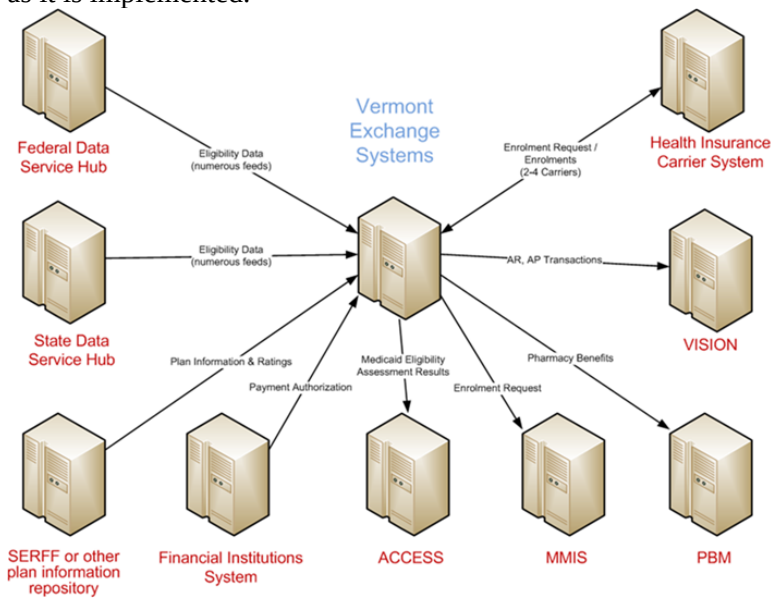


*Figure 6: Integration architecture of legacy or proposed physical systems with Exchange solution*

## Financial Management

Vermont has identified two critical areas where additional work is needed: 1) financial management, and 2) premium billing/collections and reporting. The level of effort and cost required to remediate the existing systems to support the billing/collection needs of the Exchange will most likely exceed the benefits of enhancing the existing system. The Exchange plans to leverage this funding opportunity to develop the requirements and design elements for the premium billing processes. The transaction history of the new billing system will journalize into VISION to meet the state-level financial reporting requirements. In seeking longer-term economies of scale, the Exchange may assess whether it could work with other state programs for a possible longer-term business solution in which the Exchange can perform premium billing functions for these programs. This may provide overall lower administrative cost to the state and allow the Exchange to generate alternative sources of revenue. Although current financial staff can provide some of the functions necessary for the Exchange, Vermont will need to add staff in the areas of accounting and budgeting, financial statement preparation, and management reporting to adequately support the complex functions of the Exchange. These staff, working in conjunction with consultants, as necessary, will begin to develop the underlying accounting and reporting structures, such as a trial balance and chart of accounts, as

well as assist the technology team with the development of the appropriate reporting and billing technology solutions.

The Exchange expects to demonstrate its capability to manage finances soundly, including the ability to publish all receivables and expenditures consistent with federal requirements. Critical financial management information will be posted to the Exchange website to ensure transparency to stakeholders. The Exchange will submit accounting reports to HHS as requested. In order for Vermont to ensure that VISION is prepared to support the reporting needs of the Exchange come 2013, Vermont will also be using Level Two funds to develop a detailed list of financial/transactional reports and the associated business requirements.

Vermont will continue to refine its financial model and sustainability plan as the Exchange moves closer to full operability. Ongoing analysis of enrollment projections, implementation costs, and operational costs require that the model be continually updated as budget assumptions change. The Exchange will continue to coordinate with federal agencies on future guidance and integration points related to financial reporting and data.

**Program Integrity**

The Exchange will build from the work accomplished with Level One funding to implement its own system of internal controls and protections based on the plan developed by Wakely Consulting. During this next phase the Exchange will evaluate best practices in the private market, as well as the framework established by the Committee of Sponsoring Organizations (COSO). This analysis will include recommendations on procurement standards, vendor oversight, reporting needs, and the reconciliation of major accounts. Vermont will work to implement these controls prior to 2013.

The Exchange will also establish procedures for an annual independent audit. State Health Benefit Exchanges are required to comply with a number of ACA-specified provisions regarding financial oversight and program integrity. The Exchange will be subject to regular audits by the Secretary of HHS and State auditors, as well as subject to other ad-hoc operational reviews. Specifically, Level Two funds will support Exchange staff as they complete the following tasks: (1) Develop accounting policies and procedures, reporting needs, and reconciliation of major accounts for the Exchange; (2) Refine requirements for IT system build; (3) Establish document retention policies; (4) Develop procedures to retain accounting information related to ACA and State law; and (5) Perform ongoing assessment of internal controls to eliminate fraud/abuse.

**Health Insurance Market Reforms**

Level Two funds will be used to fund additional analyses related to the development of more detailed recommendations on and implementation of certain market reforms.

Essential Health Benefits: Vermont requests additional funding to continue its analysis of essential health benefits, specifically to analyze differences in the supplemental benefit options as well as understand the further cost impact of additional benefits. Vermont proposes to hire a contractor with actuarial expertise to work with the State to conduct the comparison and cost impact. The Exchange expects to utilize this contractor throughout 2012 and 2013 as plan options are refined and finalized.

Plan Design / Actuarial Value: The Exchange proposes to hire a contractor with actuarial expertise to work with the State to conduct a review of the federal model and determine if any adjustments are needed to have the model accurately represent the Vermont population and experience. Funding is not being requested for Vermont to develop its own baseline data to be used in the federal model. This project will include an analysis of the Federal model and suggest adjustment factors, if needed.

Rate and Form Filing Review: DFR will continue to refine its rate and filing review process as Exchange implementation moves forward. The rate 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. Depending on the ultimate recommendation of the EHB analysis, actuaries and policy analysts will also need to establish standards to ensure that the review of plans contains a meaningful scope of benefits 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. DCF and GMCB are working closely to ensure that carriers provide the information necessary to support the evaluative measures described above.

Payment Reform: Vermont's medical costs are over 17% of the Gross State Product and premium costs are increasingly unaffordable to Vermonters. Level Two funding will enable Vermont to continue its cost containment efforts, providing necessary data enhancements, and financial and clinical modeling necessary for this work. These efforts will help ensure that as many Vermonters as possible are able to purchase insurance through the Exchange.

**Providing Assistance to Individuals and Small Businesses, Coverage Appeals, and Complaints**

During this grant period, the Exchange will supplement the existing consumer assistance infrastructure to establish a more integrated and efficient way to meet the needs of consumers. The Exchange intends to augment the current contracts with the Health Care Ombudsman's Office for consumer assistance.

The Exchange will also use Level Two funding to develop a consumer friendly appeals process and the processes needed to support small business complaints. Other activities the state will perform to support Exchange implementation, include:

- Establishing metrics to measure effectiveness of the Exchange in meeting the needs of consumers;
- Creating a process for reviewing consumer complaint information collected by state consumer assistance programs when certifying QHPs;
- Engaging consultants, business organizations, and brokers to make recommendations on the design of small business-oriented Exchange functions, including the type of assistance services that would be most beneficial to small employers; and
- Development of a tool to track complaints and monitor trends. This tool will provide extensive reporting and data extract functions. The tool will be able to track multiple data points, including reason code, disposition, and action taken.

**Business Operations/Exchange Functions**

As Vermont moves closer to full implementation of its Exchange, significant funding of business operational development is proposed. The Exchange will build on preliminary design planning during the Level One grant period to establish the operational systems necessary for the Exchange. State staff, working with contractors when needed, will continue establishing the operations of QHP certification, the call center, Navigator training, marketing and outreach, web design, and performance management. All of these activities are described in more detail below. A firm grasp of how these functions will operate will help the Exchange accelerate the IT planning and development process.

***Certification, Recertification, and Decertification of Qualified Health Plans:*** DFR intends to use the SERFF system to support the plan management and certification functions of the Exchange. SERFF will be

able to capture health plan information, including premium costs, actuarial value, covered benefits, cost sharing, and accreditation status. Once certified, QHP data will be securely transferred into the Exchange database using a Web Services application. Ongoing analysis of rates, benefits, and quality measures will be required to assess each plan's continuing compliance. Using Level Two funding, the Exchange will collaborate with DFR to identify the relevant measures SERFF will be required to report. DFR will develop procedures and make any necessary system enhancements to capture and present this data with transparent and timely reporting. These procedures will include conducting plan readiness and review activities such as testing enrollment interfaces with carriers, reviewing member materials, testing financial reconciliation, and holding cross functional implementation sessions with carriers. The Exchange and DFR intend to hire dedicated staff to oversee and support the certification process and ongoing plan management functions.

***Call Center:*** In order to proceed to the implementation steps of deciding on and then amending the existing call center contract, developing call center protocols and scripts, and preparing for integration with new Exchange technology and ultimately supporting open enrollment in 2013, a number of policy and technology questions need to be addressed. The Exchange intends to use Level Two grant funds to support the following activities:

- Define the Exchange services that will be built/delivered by the Exchange and how the existing call center will use or integrate with those services (Website, Eligibility, Enrollment, Shopping, Appeals, Certificate of Exemption, self-service functions);
- Finalize details on where transitions between the call center and existing entities will occur (specifically related to eligibility determination and employer support);
- Establish back-end IT infrastructure that connects the customer service vendor with the Exchange solution;
- Decide whether the small business servicing needs a separate call center or if they can be combined;
- Develop materials and train call center representatives on eligibility verification, enrollment processes, and other Exchange processes and solution modules; and
- Ensure processes are in place so that the call center can coordinate and refer callers to other public programs if needed.

***Exchange Website:*** The development of the Exchange website will rely on information available from federal guidance and recommendations, as well as other more general research pertaining to usability and functionality of a website. The website will be designed by a contractor lifting from existing designs, such as UX2014, to the extent possible while addressing the unique digital literacy needs of Vermonters. The website will function as a tool for Vermonters to access coverage and make informed decisions. Web functionality will be built to support plan comparisons, cost-sharing calculator, tax credit calculator, and employer cost calculator.

Level Two funds will be used to hire a contractor to develop the graphic design and interior content pages to be used by the system integrator in building the site. This contractor will also ensure that the website design meets standards for user accessibility, is Section 508 compliant, and also follows the Americans with Disability Act requirements. In addition, the content for the website will use best practices for plain talk, so that Vermonters can understand and actively use the website. Website content will be tested with focus groups and shared with the appropriate stakeholders.

***Premium Tax Credit and Cost-Sharing Reduction Calculator:*** During this grant period, business rules will be developed that will allow for resolution of most discrepancies through automation, including explanations of discrepancies for the consumer, opportunities to correct information or explain discrepancies, and hierarchies to deal with conflicts based on source of information and extent and impact of conflicts on eligibility. Development of this tool will be included as part of the greater Exchange IT build.

***Quality Rating System:*** UMMS is currently working with Vermont staff to develop a set of recommendations for what quality data the Exchange would like to collect and report on. The ultimate rating criteria will be decided by Exchange leadership after the appropriate stakeholder consultation. Information on quality rating will be continually reviewed for additional data that could potentially be used by the Exchange to measure quality.

The Exchange will be including quality rating functionality in the business requirements for its IT infrastructure and website design. The following tasks will be specifically supported by this grant:

- Select type of quality and cost metrics to rate QHPs;
- Determine availability of data to support metrics;
- Integrate with Exchange website build; and
- Develop implementation plan for updating ratings and on-going data maintenance.

***Navigator Program:*** Vermont will use Level Two grant funding to continue to implement its Navigator program. Vermont has conducted stakeholder meetings to inform the development of the Navigator certification criteria, identification of potential navigators, and decisions on compensation models.

Vermont will continue to work with a contractor to further define and implement the plan GMMB completed under the Level One funding period, through the following activities:

- Establish policies and procedures for Navigators;
- Issue the Request for Proposal and execute contracts with Navigators;
- Establish a Navigator program management structure;
- Implement the Navigator training program; and
- Develop a plan to continue to educate and support Navigators to ensure they can be efficient and effective in their role.

Vermont will continue to explore the sustainability of the Navigator program to assess its longer-term impact on Exchange financing and return on investment.

***Eligibility Determinations for Exchange Participation, Advance Payment of Premium Tax Credits, and Cost-Sharing Reductions:*** Using Level Two funds, Exchange operations and IT staff will work to continue to develop processes including use cases and business rules that will govern the eligibility for premium tax credits and cost-sharing reductions. The Exchange will work with Medicaid's eligibility team to facilitate the building of joint business rules. This work will include the development of processes to verify applicants' citizenship and income with the federal hub, and to provide assistance to individuals who are not immediately determined eligible for financial assistance. Level Two funding will also be used to ensure that ongoing operations—such as eligibility transactions, appeals, applications and notices, and transitions (including data conversions)—are developed to support Vermont's integrated eligibility approach.

***Seamless Eligibility and Enrollment Process with Medicaid and Other State Health Subsidy Programs:*** Level Two funds will be used to ensure that the appropriate eligibility and enrollment systems are developed, and the necessary integration points identified, to support a seamless experience for the consumer. Vermont will build capacities for Exchange function to include MAGI verification, eligibility determination for tax subsidies, eligibility for waiver of the mandate, exemption from the requirement to enroll in an employer plan, electronic communication with insurance plans and employers, and small business enrollment functions. The State intends for consumers to be able to have the entirety of their needs met through one shopping and application experience. Vermont plans to use Level Two funding in conjunction with the IAPD to bring in a systems integrator to assist with making this vision a reality.

Vermont currently has state eligibility workers serve as application assisters for consumers who apply to Medicaid and the various Medicaid expansion programs in Vermont. However, additional staff will be needed in several phases of this project, primarily during the transition from 'old' federal and state program rules and processes to the new ACA and Exchange rules. Eligibility staff will need to be trained and in place prior to open enrollment in October 2013 to handle the increased volume in applications and detailed

eligibility questions due to the Exchange. The State anticipates extensive training and some program specialization may be necessary to ensure that questions, concerns, and unique circumstances of all applicants can be addressed by this workforce. Weekly and ad-hoc meetings have been held to begin work on mapping the eligibility and enrollment workflows and use cases that will be needed to adequately support both the Exchange and Medicaid.

***Enrollment Process:*** Vermont will work to ensure that the technical and programmatic components of enrollment are fully developed prior to the initial enrollment period in 2013. The Exchange is also coordinating with Medicaid on enrollment of eligible individuals in Medicaid through the same system to avoid any duplication of process. Staff is aware of the fast-paced schedule that is required for implementation, and is carefully considering how to mitigate any risks that could affect the plan management and enrollment release schedule.

***Application and Notices****:* Vermont intends to use Level Two funding to continue DVHA's commitment to clear and effective member communication. The Exchange hopes to transition to a less paper-facilitated solution for member communication through the development of electronic modes of beneficiary notification. However, hard copy applications and notices will be available for consumers who prefer that format. Vermont is exploring technology to enable the digitization of information submitted on paper forms so that the data can be electronically processed in the new Exchange Integrated eligibility systems. The Exchange, in collaboration with other programs, plans to review existing notices for readability and format. All forms and notices will satisfy the ACA accessibility requirements. The Exchange will work with the Medicaid Integration contractor on best way to synthesize messaging. Existing State staff will test content and ensure forms meet accessibility requirements.

***Individual Responsibility Determinations:*** The Exchange will continue to define detailed business requirements for this process as further guidance is released from HHS and as IT systems design occurs. The Exchange will use validated data and responses from federal and other data sources to determine and communicate exemptions. The IT build will include processes for resolution of data discrepancies, be automated to the extent possible, and perform the appropriate notifications of exemptions to federal agencies and applicants. The resulting system will accept, manage, and communicate adjudication of appeals of individual responsibility exemption determinations. Level Two funds will assist the Exchange in determining resources needed to successfully administer these determinations, including development of an estimated appeal volume and the amount of state resources that could be leveraged for this process.

***Administration of Premium Tax Credits and Cost-Sharing:*** Building from Level One work, the Exchange will finalize decisions related to the financial management of tax credits and develop detailed reporting requirements to CMS/IRS. Because this functionality is closely integrated with IT systems, Exchange staff will need to provide oversight of Exchange System Integrator Vendor design and development activities.

***Adjudication of Appeals of Eligibility Determinations:*** Using Level One funds, Pacific Health Policy Group produced a recommended approach for processing individual and employer appeals. The Exchange, working very closely with Medicaid staff, will use the PHPG report to operationalize the recommended process, including the development of the systems and infrastructure capacity to administer appeals functions including the tracking of appeals, status, action taken on appeals, internal notification of timely follow-up, and noticing to consumers on appeal status and decisions. The Exchange will also use funding to develop training materials for call center workers, eligibility workers, Navigators, and others on eligibility requirements and appeals. Part of this training will also focus on internal staff, so appeals are forwarded to the federal appeals process when appropriate.

***Notification and Appeals of Employer Liability:*** Level Two grant funds will be used to implement the appeals function and the requirement that employers be notified if one of their employees is determined eligible for advance payment of a premium tax credit. The Exchange will hire the necessary staff to oversee the development and implementation of the appeals process, as well as identify the type and location of staff needed to support this process.

***Information Reporting to the IRS and Enrollees:*** Vermont's efforts to support this function will accelerate under this grant period as further guidance is released. Specifically the Exchange will:

- Identify reporting requirements per ACA and CMS/HHS guidelines;
- Solicit stakeholder input on the type of data the Exchange should report;
- Develop list of mandatory and optional reports;
- Create report templates;
- Develop or acquire the necessary databases to support reporting;
- Identify all interfaces; and
- Create reporting schedule.

***Outreach and Education:*** The Exchange desires funding to support the main components of an extensive outreach campaign. Due to the rural nature of the Vermont population, it is important that the Exchange utilize all means available to promote Exchange enrollment and other health care changes. The Exchange intends to pursue the following activities:

- Grassroots activities and strategic partnerships that provide face-to-face communications with target audiences;
- Compelling TV, print, online, and non-traditional advertising to introduce the Exchange to Vermont residents;
- A proactive earned media strategy to push a positive narrative about the Exchange prior to and after launch;
- A thoughtful and detailed stakeholder outreach initiative working with other government agencies, community groups, and other health care stakeholders;
- A research-informed Navigator outreach effort;
- A fresh and innovative small business outreach strategy; and
- Integrated social media outreach that links and maximizes earned media and online engagement.

The outreach and education plan will also include an evaluative component, so that the State can apply lessons learned and reassess tactics throughout the course of open enrollment and beyond. Level Two funds will be used to launch the outreach and education plan developed by GMMB under the Level One grant.

***Risk Adjustment and Traditional Reinsurance:*** Several important steps will need to be completed using Level Two grant funding in order for Vermont to implement these programs in a way that ensures a stable market. Regardless of whether the State or HHS administers these programs, Vermont needs to continue its planning and preparation in order to meet federal deadlines. The State and issuers will also need to understand the effect of these programs and prepare their data and processes. Because HHS has indicated that they will not be able to run simulations in advance of 2014, in time for pricing products in 2014, the state of Vermont needs to support these activities. The State's approach will be to use the Vermont Health Care Claims and Uniform Reporting and Evaluation System (VHCURES) All Payers Claims Database and/or a distributed approach to both risk adjustment and reinsurance simulations to model the impact of these programs on premium rates. Included in these efforts will be stakeholder engagement meetings. Two rounds of simulation will be performed. The first round will focus on the identification of data issues and working through the process of data collection and validation. The second round will focus on developing estimates for pricing and parameter selection (if state specific reinsurance parameters are filed). Simulations will include analysis of high risk enrollees and coordination with other research including the market reform impact analysis and EHB work.

Rate Review: Risk Adjustment and Reinsurance will have important effects on premium rates. Issuers will need to estimate these effects and file adjusted rates with appropriate support as part of the rate filing process. The State seeks assistance in ensuring that the rate review process includes the appropriate level of structure and flexibility. This process will allow additional information to be considered in premium rate development, but careful competitive concerns and protections will need to be considered.

Reinsurance Design and Administration: Should the Exchange decide to administer its own reinsurance program, Vermont will think through what would need to be accomplished to develop this function. This may entail setting up a reinsurance entity, hiring, contracting for a banking function, and the developing detailed policies and procedures.

***Small Business-Specific Exchange Functions:*** Utilizing in part the Small Business Operational Guide developed with Level One funding as a planning and development blueprint, the Exchange will develop business requirements and IT system requirements to complete the work necessary to stand up the small business-specific functions of the Exchange. Additionally, the Exchange will develop a small business strategy for implementing an employee choice model that best meets the needs of the small business community within the context of the state's bigger plan to provide portability between the individual and small business-specific Exchange functions. The Exchange will conduct regular meetings with small business stakeholders to ensure that their input continues to inform the development of the Exchange and to maximize the viability and effectiveness of the program, particularly given the absence of an outside market. One component of the program will be to leverage and subsidize brokers during the first year of operations to help small business transition to this new purchasing model.

### c. Summary of Exchange IT Gap Analysis

**Current State Assessment**

The Wakely Consulting team conducted an "As-Is" or current state assessment of the State of Vermont's IT systems and the system capabilities to fulfill requirements in the ACA. The team had reviewed existing State systems for the following Exchange functions:

- Financial Accounting and Reporting;
- Financial Management;
- Plan Management;
- Premium and Tax Credit Processing;
- Eligibility Assessment;
- Comparison Shopping;
- Enrollment Processing;
- Appeals Management;
- Broker/Navigator Relationship Management;
- Marketing and Outreach; and
- Customer Service and Account Management.

The Wakely team assessed the following four systems for their reuse potential: ACCESS, Vermont's custom-built human and health services eligibility and enrollment system; CSME (Central Source for Measurements and Evaluation), a custom-built analytics tool; OnBase, a commercial records and document management system; and EVR (Event Replicator), a commercial add-on to ACCESS to enhance access to eligibility and enrollment data.

In parallel with the current state assessment of existing State systems, the State conducted an assessment of existing state IT infrastructure and business processes and cross-walked the functional and technical components with those required to operate the Exchange. The State leveraged an Exchange Reference Architecture framework derived from ACA requirements, subsequent guidance, and the State's vision for the Exchange.

**Gap Analysis Summary**

Vermont's IT systems are built on software technology that ranges from decades-old, transaction-based systems operating on mainframes to 3-tier web-based systems. The Wakely team recommends that most of the current IT systems assessed not be considered for functional reuse to support the Vermont Health Insurance Exchange. The team found that the overall technical quality of each system with the exception of OnBase is low. Only OnBase is a candidate for technical re-use, and the Wakely team recommends further exploration of OnBase's suitability.

The degree of functional and technical capability of each system is summarized in the bubble chart below (Figure 7). Systems in the top right quadrant (high functional and technical capability) are candidates for reuse. Systems in the bottom left quadrant (low functional and technical alignment) are not candidates for reuse by the HIX and may be candidates for retirement in a legacy renewal initiative. Systems in the top left quadrant have strong functional alignment but poor technical alignment; to be reusable, some improvement of the technical platform would be required. Systems in the bottom right quadrant have strong technical

alignment but poor functional alignment. The technical elements of these systems might be reusable as a base from which to build out more aligned functionality.

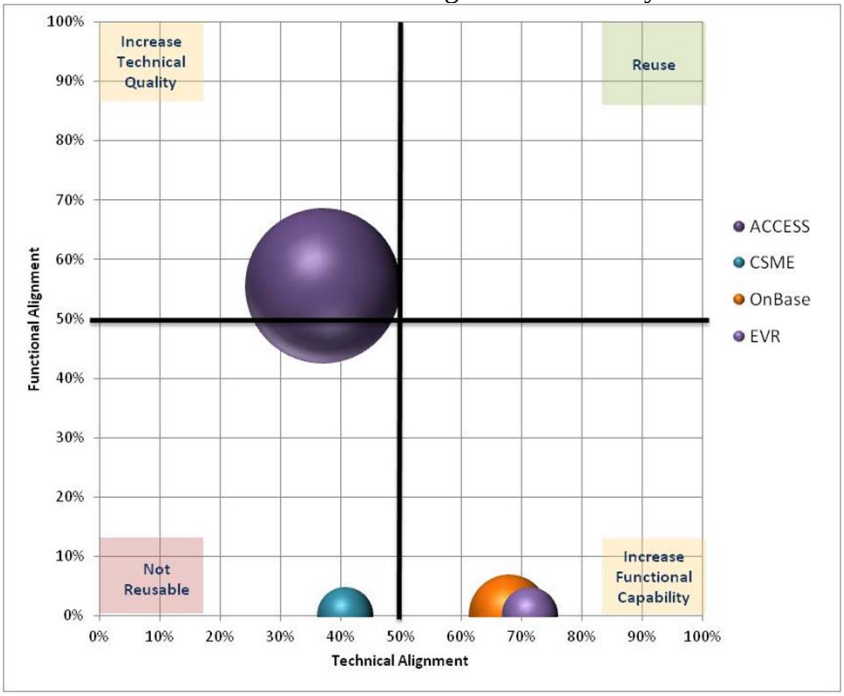


*Figure 7: Functional and Technical Capabilities Summary*

OnBase appears in the lower right quadrant, indicating that it is a good candidate for reuse from a technical perspective in the Vermont Exchange. It can be considered for reuse for the records and document management component of Information Management. The State may need to purchase additional modules to fill the current functional gaps.

ACCESS appears in the upper left quadrant indicating that it provides moderate ERA (Exchange Reference Architecture)/MITA (Medicaid Information Technology Architecture) functionality but is technically unsuitable. ACCESS data should be considered for reuse. EVR system is a commercial add on to ACCESS and it appears in the lower right quadrant indicating that it provides no ERA / MITA business functionality. As it is custom built for the ACCESS legacy solution, it is only useful if ACCESS is retained. The CSME system appears in the bottom left quadrant indicating that it provides no ERA / MITA business functionality and has poor technical functionality. CSME should not be considered for reuse.

The Wakely team developed a matrix of system ratings against individual functional or technical components. Figure 8 describes the colors that are used in the matrix.

| Color | Description |
|---|---|
| Green | The functions that this system supports for this component average a rating of High |
| Yellow | The functions that this system supports for this component average a rating of Med |
| Red | The functions that this system supports for this component average a rating of Low |
| Grey | The functions that this system supports for this component average a rating of Unknown |
| White | The system was not designed to provide this functionality |

*Figure 8: System Fit Gap Rating Scale*

## Functional Observations

The table below summarizes the ability of each system to meet the functional requirements for each of the functional components of a health insurance exchange. As can be seen in Figure 9, all of the systems assessed are capable of supporting only a small amount of component functionality.

| Functional Component | Current IT Systems | | | |
|---|---|---|---|---|
| | ACCESS | CSME | OnBase | EVR |
| Financial Accounting & Reporting | N/A | N/A | N/A | N/A |
| Asset Management | N/A | N/A | N/A | N/A |
| Human Resource Management | N/A | N/A | N/A | N/A |
| Procurement Management | N/A | N/A | N/A | N/A |
| Policy & Oversight | N/A | N/A | N/A | N/A |
| Plan Management | | | | |
| Financial Management | 23% | | | |
| Eligibility & Enrollment Operations | 22% | | | |
| Care Management | | | | |
| Broker/Navigator Rel'n Mgmt | | | | |
| Marketing & Outreach | | | | |
| Customer Service & Account Management | 22% | | | |

*Figure 9: Functional Component Fit-Gap Rating Technical Observations*

Similar to the functional observations, the Wakely team created a matrix to summarize the ability of each system to meet the technical requirements for each of the technical components for the Vermont HIX. This summary is shown in Figure 10. The same scoring mechanism is used as the one described earlier; however, many of the technical components are considered to be building blocks that provide basic capabilities which other components access. The technical components were rated as either being provided or not provided and therefore have no percentage of functional support for the component.

| Technical Component | Current IT Systems | | | |
|---|---|---|---|---|
| | ACCESS | CSME | OnBase | EVR |
| Information Management | 40% | 25% | 15% | |
| Knowledge Management | | | 75% | |
| Workflow and Rules Management | 15% | | 15% | |
| Master Person Registry | 100% | | | |
| Financial Transaction Processing | 25% | | | |
| System Integration Management | 8% | | | |
| Identity and Access Management | 33% | 17% | 33% | |
| Intrusion Management | | | | |
| Confidentiality Management | | | | |
| Data Indexing & Storage | | | | 67% |
| Data Retrieval | | 50% | | 50% |
| Data Transformation | | 100% | | 100% |
| Unified Communications | | | | |
| HHS Portal | | | | |
| Integration Broker | | | | |

*Figure 10: Technical Component Fit-Gap Rating*

### d. Evaluation Plan

Vermont, working with its contractor Wakely Consulting Group, has developed a draft data and evaluation plan[11] for the Exchange. This plan provides a detailed explanation of key indicators, baseline data, methods for monitoring progress and evaluating the achievement of program goals, plans for timely interventions when targets are not met or unexpected obstacles delay plans, and plans for ongoing evaluation of Exchange functioning once it is operational. The data and evaluation plan proposes a strategy for tracking the performance of the Exchange, as well as the impact of the Exchange on health insurance coverage; health care access, quality and affordability; and health care outcomes. Due to the extensive evaluation measures already established in Vermont, this plan segregates valuable indicators into categories that allow the State to distinguish between pre- and post-market, Exchange-specific, and broader health reform measures. This

[11] http://hcr.vermont.gov/sites/hcr/files/HIX_docs/9_Vermont%20Evaluation%20plan%206.14.pdf

provides State leaders the ability to track the Exchange separately from the greater reform agenda in Vermont.

The proposed plan selects metrics to be evaluated, reviews existing sources that could potentially serve as baseline data points, and documents the source and availability of baseline data for each of the indicators. The plan identifies strategies for obtaining data necessary for evaluating the Exchange moving forward, such as survey deployment, collection of enrollment data, and collaboration with other agencies. A robust measurement and evaluation program will provide the state with data to demonstrate success, identify issues needing mid-course correction, continually improve its programs, and identify unmet public health and programmatic needs that should be addressed. 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 Exchange will solicit substantial stakeholder input on all evaluative measures.

**Documentation Supporting Level Two Eligibility**

As documented in the Progress to Date section of the Narrative and in the Workplan, Vermont has met the Establishment Two eligibility criteria:

1. On May 26, 2011, Act 48 was signed into law, thereby providing the necessary legal authority for the establishment of an Exchange in Vermont. Further commitment by the State was demonstrated by the recent passage of Act 171 requiring individuals and small groups to purchase health insurance through the Exchange.[12]

2. Act 48 authorized the establishment of the Exchange within the Department of Vermont Health Access. Housing the Exchange within a State agency allows Vermont to more easily utilize the expertise of other State agencies, boards, and personnel. Detailed organizational charts documenting how these entities interact to support the functions required of the Exchange are included in Section I of this document. In December 2011, Lindsey Tucker was hired as the Exchange Deputy Commissioner.

3. Vermont developed, and includes with this application, a complete budget through 2014, along with an accompanying narrative.

4. An analysis of financial sustainability for the Exchange, included in Attachment A, demonstrates Vermont's initial plans for self-sustainability by 2015. This analysis will continue to be refined in advance of Act 48's requirement that the Agency of Administration submit a sustainability plan to the Vermont Legislature in January 2013.

5. Vermont already has in place substantial statutory and regulatory requirements that govern the financial and administrative functions of state agencies. The Exchange will be subject to all of these controls, as well the supporting administrative procedures that pertain to hiring, contracting, and being subject to an annual and ad-hoc audits by the State's Attorney General's Office. The Exchange will continue to meet any and all reporting requirements identified by CMS.

   In addition to these controls, the Exchange has established the necessary measures to ensure the appropriate financial management of grant funds. Vermont has set up a restricted receipt account for Exchange grant funding, which protects these funds from state budgetary adjustments and ensures that these funds can only be used for the specific purposes of the grant. Grant funds are administered through comprehensive, accurate, written procedures that have been approved by the Agency of Administration. This approach includes quality assurance to ensure that the financial management system disburses, tracks, and accounts for grant disbursements accurately. Vermont has built an internal network of core staff that meet almost weekly to ensure coordination between projects, project costs, funding streams (between the APDs and Grants), and allocation of funds that address Federal and State needs.

[12] Full text of Act 48 and other material can be found here, http://hcr.vermont.gov/library.

As described in the Project Narrative and Workplan, the Exchange will continue to develop effective controls to protect against fraud, waste, and abuse. This includes the development of internal policies and procedures for a well-executed planning, forecasting, and budgeting process, timely reconciliations of major accounts, vendor oversight, procurement management, effective internal controls, payment process oversight, and operational controls to ensure systems are performing accurately and timely. The Single State Audit for State Fiscal Year 2012 will include the expenditure of Level One grant funds, and future audits will include Level Two expenditures and ongoing Exchange expenditures post-implementation.

6. The Narrative and Workplan describe in detail how the Exchange will create, continue, and expand the capacity for providing assistance to individuals and small businesses in Vermont, including the expansion of the State's current call center to serve all Vermont residents seeking health insurance and the implementation of a Navigator program. Working closely with many different stakeholders and Wakely Consulting Group, the Exchange has outlined how the current call center will need to be remediated to support the Exchange, the remaining operational decisions that need to be addressed, and how this project's implementation will impact the greater IT systems development.[13] The call center will augment State outreach efforts through the Healthcare Ombudsman's Office (Vermont's consumer assistance entity) and many different stakeholder groups the Exchange intends to partner with. Further detail is found in the draft outreach and education plan,[14] a preliminary outline of the how the Exchange intends to address the unique needs of Vermonters.

   Housing the Exchange within the Department of Vermont Health Access is just one indication of Vermont executive leadership's strong commitment to health reform and administrative efficiency. The call center will for most Vermonters be their first interaction with the new, integrated delivery system established by Act 48. The Exchange will engage with and consider other health-related programs that may want to leverage the shared call center that will be operationalized using funds from this Level Two Establishment Grant.

7. Other supporting documents relating to this grant application can be found at:

Lindsey Tucker Resume
http://hcr.vermont.gov/sites/hcr/files/HIX_docs/1_Lindsey%20Tucker%20Resume.pdf
DFR MOU
http://hcr.vermont.gov/sites/hcr/files/HIX_docs/2_DFR%20MOU.pdf
DCF MOU
http://hcr.vermont.gov/sites/hcr/files/HIX_docs/3_DCF%20MOU.pdf
Financial System Assessment – Preliminary Report
http://hcr.vermont.gov/sites/hcr/files/HIX_docs/4_Financial%20Financial%20System%20Assessment%20-%20Preliminary%20Report.pdf
Call Center Assessment Narrative
http://hcr.vermont.gov/sites/hcr/files/HIX_docs/5_Call%20Center%20Assessment%20Narrative.pdf
State of Vermont Interim Report
http://hcr.vermont.gov/sites/hcr/files/HIX_docs/6_State%20of%20Vermont%20%20Interim%20Report.pdf
Determinations individual mandate exemptions
http://hcr.vermont.gov/sites/hcr/files/HIX_docs/7_Determinations%20individual%20mandate%20exemptions%20%5BCompatibility%20Mode%5D.pdf
VT Operational Guide Sm Bus Exchange 062012 Presentation
http://hcr.vermont.gov/sites/hcr/files/HIX_docs/8_VT%20Operational%20Guide%20Sm%20Bus%20Exchange%20062012%20Presentation%20FINAL.pdf
Vermont Evaluation Plan 6.14
http://hcr.vermont.gov/sites/hcr/files/HIX_docs/9_Vermont%20Evaluation%20plan%206.14.pdf
Outreach and Education Plan
http://hcr.vermont.gov/sites/hcr/files/HIX_docs/10_Outreach%20and%20Education%20Plan.pdf

[13] http://hcr.vermont.gov/sites/hcr/files/HIX_docs/5_Call%20Center%20Assessment%20Narrative.pdf
[14] http://hcr.vermont.gov/sites/hcr/files/HIX_docs/6_State%20of%20Vermont%20%20Interim%20Report.pdf