

State Health Reform Assistance Network

Charting the Road to Coverage

ISSUE BRIEF

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Managing State-Level ACA Implementation Through Interagency Collaboration

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Managing State-Level ACA Implementation Through Interagency Collaboration

EXECUTIVE SUMMARY

This issue brief is designed to offer the collective wisdom and practical insights of state officials and technical experts related to the leadership and interagency coordination needed to implement the Affordable Care Act (ACA). It relies on the expertise developed through the State Health Reform Assistance Network (*State Network* or SN), an initiative of the Robert Wood Johnson Foundation (RWJF), which provides technical assistance to ten states to help them implement the coverage provisions of the ACA.

The issue brief begins by defining collaboration and outlining several reasons it is particularly imperative now. It discusses the role of leadership and a clear vision for reform. It outlines specific strategies being used by states, from low-tech solutions such as regular meetings and clear delineation of roles and responsibilities, to higher-tech tools including document-sharing and project management software. The brief then explores the potential of work planning and formal memorandums of understanding (MOUs). Issues raised by the need to procure and develop new information technology (IT) systems and the imperative to consult with outside stakeholders are addressed. It also explores the unique challenges related to the new entities being developed, Health Benefit Exchanges (Exchanges), which may or may not be a formal part of state government.

Following are some of the tips, tools and current practices described in the brief:

Tips, Tools and Current Practices Related to Governance of Interagency Collaboration

- A clear vision and goals from the Governor and the legislature are critical for setting the course for state-driven health reform.
- Interagency coordinating councils of cabinet-level officials have been used successfully in some states. Clear leadership is needed to ensure that the goals of the cabinet-level meetings are well-defined. Coordinating councils can set the direction for reform and make major decisions, but these groups, by themselves, are not sufficient to accomplish the goal of seamless integration.
- Regular meetings and communication between senior-level policy and operational staff from key state agencies are critical; states should make sure these meetings include the *right people* and have the *right agendas*.
- Offices of Health Reform and other staff specifically charged with health reform implementation assure that key staff remains focused on the changes required by the ACA. They also prevent health reform from getting lost in the other tasks state staff must maintain throughout the change process.
- Select the right people to lead reform and make their roles and responsibilities clear from the outset. Health reform leaders should be innovative thinkers with a track record of successful collaboration on projects, strong communication skills and they should have the respect of other state staff.
- Evaluate staff based on their participation in collaboration efforts.

Tips, Tools and Current Practices for Project Management and Work Planning

- States should put a high value on project management. When possible, staff with specific expertise in planning a project and moving it to completion should be utilized. Staff time should be dedicated to this function.
- Project management is different than project leadership. Both are important.
- Work plans can be effective tools for tracking progress, fostering accountability and ensuring that project goals and deadlines are met.
- States should give thought to the level of detail needed for work plans and how work plans can roll up into useable high-level priority lists and dashboards for communicating with senior-level staff and other stakeholders. The tools needed by project leaders and detailed implementers may be different.
- The project management tools and software used by states will vary based on their previous experience with sophisticated project management tools and the time they are able to devote to learning and using those tools.
- The following tools are available to states:
 - A guide to commonly-used project management software (Tables 2 and 3)
 - Exchange Timeline (Appendix A)
 - State Milestones for ACA Implementation (Appendix B)

- Exchange Work Plan Template (Appendix C)
- Division of Insurance Work Plan Template (Appendix D)
- Division of Insurance Self Audit Timeline (Appendix E)
- Medicaid Work Plan Template (Appendix F)
- Memorandum of Understanding Checklist (Appendix G)

Tips, Tools and Current Practices for Effective IT Implementation

- Regular and structured communication between policy staff and IT staff is critical for the development of a strong IT system.
- Policy and IT staff tend to have very different knowledge bases, so it is important to take the time to enable both sides to understand one another.
- Build flexibility into your IT procurement.
- Collaboration between Medicaid and the Exchange is critical as new systems are developed.
- For states with separate IT offices or agencies, it is critical to have staff dedicated to understanding and facilitating ACA-related reforms.

Tips, Tools and Current Practices for Effective Stakeholder Engagement

- The majority of *State Network* states that have been successful in engaging stakeholders have instituted a formal stakeholder process connected to ACA implementation with work groups and advisory committees.
- Organizing work groups by topic rather than by constituency may prove more productive. In this way, the various interests can work out differences with each other. When you form a work group of only consumer advocates or carriers, for example, you run the risk of exacerbating adversarial relationships rather than facilitating discussion across constituencies.
- Understand the difference between engaging stakeholders for consultation and participation in decision-making and simply informing them of decisions being made by the state. Stakeholders will not be fooled by a process that claims to be participatory but is actually a process for the state to report its own decisions.
- Some stakeholders may be trusted allies in the reform process and can be used as ambassadors in critical moments to build support or spread the word about specific reforms. Identify these allies and positive roles they can play. To the extent possible, seek to have all stakeholders become allies.
- Recognize that many stakeholder groups are diverse. If you cannot garner support from a state association, you may be able to get support from a regional group or other subgroup.
- For states in which the executive and legislative branches have an adversarial relationship, state officials may be able to use trusted stakeholder groups to bring needed legislative reforms forward.
- A good stakeholder process needs to be well-managed. Without someone mapping stakeholder roles, setting the agenda, bringing content to the meeting, and facilitating input, a stakeholder process will founder. Adequate staff resources must be dedicated to stakeholder engagement.

Tips, Tools, and Current Practices for Coordinating with Exchanges

- The model set by Massachusetts—having general authorizing legislation that charges the Exchange board with making many of the detailed technical decisions—is a model for all states to strongly consider. Exchanges must be able to make complex decisions in a timely way and this may be best accomplished by technical experts in a less politicized environment than most state legislatures.
- While most Exchanges are being established as independent entities (as either a nonprofit or a separate public entity), they still will need to coordinate with state agencies on a range of issues.
- Formal memorandums of understanding (MOUs) are a helpful tool for clarifying respective roles with divisions of insurance, human services agencies, high risk pools, state finance offices and others.
- Exchange staff should consider asking for federal funding to pay for staff in other state agencies that are tasked with Exchange-related responsibilities.

INTRODUCTION

This issue brief is designed to offer the collective wisdom and practical insights of state officials and technical experts related to the leadership and interagency coordination needed to implement the Affordable Care Act (ACA). It relies on the expertise developed through the State Health Reform Assistance Network (*State Network* or SN), an initiative of the Robert Wood Johnson Foundation (RWJF), which provides technical assistance to ten states to help them implement the coverage provisions of the ACA.

The *State Network* has brought together technical experts with in-depth policy knowledge in the areas of Medicaid, insurance regulation, Exchanges, and communications strategy. While this technical expertise is proving valuable for the participating states, the program has also found that some of the most difficult issues facing state leaders are the less technical challenges of leadership and interagency collaboration. It is those issues this issue brief is designed to address.

Specific challenges related to leadership and interagency coordination include how to:

- Develop a shared vision and common understanding across state government, including between agencies with very different cultures;
- Make critical decisions given those differing perspectives (and constituencies);
- Encourage agencies to share information and develop integrated work processes;
- Foster trust;
- Ensure that various agencies are on track with implementation; and
- Cope with the challenges raised by change and shifting power dynamics.

To begin to address the challenges of managing an enormous endeavor such as implementing the ACA, the *State Network* has collected tips and lessons learned from participating states. The issue brief begins by defining collaboration and outlining several reasons why it is particularly imperative now. It discusses the role of leadership and a clear vision for reform. It outlines specific strategies being used by states, from low-tech solutions such as regular meetings and clear delineation of roles and responsibilities, to higher-tech tools including document-sharing and project management software. It explores the potential of work planning and formal memorandums of understanding (MOUs). It addresses the issues raised by the need to procure and develop new information technology (IT) systems and the imperative to consult with outside stakeholders. It also explores the unique challenges related to the new entities being developed, Health Benefit Exchanges (Exchanges), which may or may not be a formal part of state government.

METHODS

Much of the information in this issue brief is drawn from interviews and ongoing conversations with the ten *State Network* states: Alabama, Colorado, Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island and Virginia. It reflects the lessons learned from these states, the technical assistance experts¹ and the *State Network* management team.² In addition, we have relied on both government and academic sources to provide a research background for the analysis. While there is some literature on interagency coordination and system change, very little is directly connected to the challenges posed by implementation of health reform. Thus, in the spirit of sharing real-time learning, this issue brief attempts to impart what we know so far related to managing health reform implementation.

WHAT IS COLLABORATION AND WHY IS IT NEEDED?

For the purposes of this report, *collaboration will be defined and used broadly to include a variety of arrangements that promote greater cooperation and joint decision-making between agencies*. To give more specificity to the types of mechanisms that can be used to promote broad collaboration as defined above, a recent Congressional Research Service report outlined six options:

- Collaboration: voluntary participation among members of relatively equal status;
- Coordination: an arrangement with a lead agency directing the work of multiple agencies;
- Merger: joining two or more agencies into a single department with unified leadership;

¹ The *State Network* contracts and coordinates with seven technical assistance providers (TAPs) that work directly with state agencies and officials on ACA implementation. During the first year of the *State Network* the TAPs have been: the Center for Health Care Strategies; Georgetown University Health Policy Institute; GMMB; Manatt Health Solutions; the National Academy for State Health Policy; the State Health Access Data Assistance Center; and the Wakely Consulting Group.

² The *State Network* management team includes staff from Princeton University and AcademyHealth.

- **Integration:** a long-term arrangement that brings together parts of agencies to accomplish a particular task;
- **Networks:** integration across levels of government, often state and local; and
- **Partnerships:** when the private sector is brought into close alliance with government to advise or share decision-making (Kaiser, May 31, 2011).

Current Challenges to Collaboration

There has been a growing understanding, both in the literature and among government leaders, of the need for greater collaboration between government agencies in the area of health and health care due to the growing complexity of the market and government's role in it, the urgent need to restrain rising costs, and the budget pressures (and related need for efficiency) being faced by all levels of government. The need for interagency collaboration between state health agencies has become more acutely apparent since the passage of the ACA.

Following are just a few examples that illustrate the importance of interagency collaboration under ACA:

- The ACA envisions a seamless consumer experience for those receiving coverage from Medicaid and the Exchange. An integrated information technology (IT) approach is needed to determine eligibility and enroll consumers.
- Data show that many consumers will cycle frequently between Medicaid and the Exchange (Sommers & Rosenbaum, 2012), which will require Medicaid and the Exchange to jointly consider how to ensure that people will receive continuous care in spite of possible changes in coverage status.
- The Exchanges are charged with monitoring the quality and performance of health plans as well as plan certification, but in many cases, these tasks are already being carried out by state insurance or Medicaid agencies. States will need to develop a coordinated strategy to take advantage of administrative simplification, and proper resource allocation across agencies while preventing contradictory or burdensome reporting requirements.
- Failure to coordinate insurance regulations across markets inside and outside the exchange creates a risk of adverse selection, undermining those markets.

To date, the health policy landscape in many states has been characterized less by interagency collaboration and more by distinct agencies working in isolation with their own constituencies. In most cases, each agency ultimately answers to the Governor, but it is rare that consistent vision and policy goals are enforced across multiple state agencies. For example, in a recent issue brief for State Coverage Initiatives, staff at Bailit Health Purchasing interviewed state officials charged with purchasing insurance for state employees. They found that very few states have consistent goals (related to quality and value) across state employee health benefit plans and other state-purchased insurance, most notably Medicaid (Joshua Slen, 2010). In addition to silos within the administration of Medicaid itself (e.g., separate mental health and substance abuse administration), the ACA requires coordination across even bigger silos. Medicaid and insurance agencies – which traditionally have never taken into account the way their programs and regulated entities interact – will now require more coordinated oversight.

PRACTICAL STRATEGIES TO PROMOTE INTERAGENCY COLLABORATION

A Clear and Coherent Vision for Health Reform

The single-most valuable tool for promoting effective interagency collaboration is a clear and consistent vision articulated from top government officials. While it is tempting to dive immediately into the details of understanding and implementing the ACA, it is important for state leaders to pause and consider their own state's goals and vision. The ACA offers an enormous amount of flexibility to states, and offers multiple tools for accomplishing various objectives. In a paper for State Coverage Initiatives titled "State Implementation of National Health Reform: Harnessing Federal Resources to Meet State Policy Goals" (Dorn, 2010), the author outlines a range of goals states could embrace as they implement health reform:

- Maximizing residents' health coverage and access to care;
- Helping health care and coverage function more like a traditional, healthy market through improved competition and transparency;
- Holding insurers accountable for providing high-quality coverage at reasonable cost to the consumer;
- Reforming the health care delivery system to slow cost growth while improving quality; and
- Limiting state general fund spending on health care.

Several of these goals can be pursued in tandem or states can select variations based on their unique health care markets and political environments. Regardless of the goals that are selected, a clear vision can be an important organizing principle for state staff across agencies.

The reality is that many state officials do not have the luxury of receiving a clear vision from state leaders. Those leaders may be ambivalent about whether the state should implement the ACA, which might be seen as an unwelcome federal requirement rather than an opportunity to embrace state-driven goals. Or, there can be disagreement among state leaders; for example, the Governor does not share the same view as one or both of the houses of the state legislature. Likewise, some Governors could be unwilling to state their views publicly, for fear of generating political opposition. All of these scenarios present implementation challenges, especially since the federal government is offering significant flexibility to states in how they implement the law.

Indeed, the ACA highlights one of the real challenges of federalism. Because the extensive political stakeholder process to find consensus and build a compromise solution took place at the federal level, there is an inherent risk that states will not take sufficient ownership of health reform to develop a true state-driven vision. States that have previously considered state-level health reform have an advantage in that there is already institutional knowledge and shared understanding of the issues and challenges. For states that have not had a robust discussion on many of the issues raised by ACA, cutting through the thicket of options and decision points can be a real challenge.

Even when a clear vision has been identified, it can get lost in the minutia of implementation. For example, in a recent meeting related to the small group market exchange (Small Business Health Options Program, or SHOP), *State Network* leaders challenged states to pause and consider what *value* they hoped to add to the market through the SHOP exchange. Why would employers, employees, or carriers choose to participate? It was important to take the first—and critical—step of asking *why* they were undertaking this task in the first place before they got completely mired in the complex details of *how* implementation should take place. This example also illustrates how the question of goals and objectives may need to be revisited in relation to specific programs or policy choices. It may not always be immediately clear how to maximize state goals in each given situation.

Governance and Coordination of Interagency Collaboration

Once a vision has been established, the next critical step is to decide how reform implementation will be managed and by whom. Clearly, it requires collaboration across multiple state agencies. Several of the *State Network* states issued formal Executive Orders that identified who had the responsibility for health reform implementation. In some states, Governors selected an interagency coordinating council (typically consisting of a handful of cabinet-level officials). A few identified a lead agency while most did not. These Executive Orders sometimes set up a formal process for gathering public input.

Table 1
New Coordinating and Governing Structures Enacted in *State Network* States Following the Passage of the ACA

State Network State	Executive Order	Description
Alabama	Yes	Governor Robert Bentley created the Health Insurance Exchange Study Commission by Executive Order on June 2, 2011 which included the Commissioners of Medicaid and Insurance and the Director of Finance. The Study Commission is an advisory group to the Governor that made recommendations to the governor and legislature in late 2011. Governor Bentley also appointed an Executive Director in June 2011 to coordinate Alabama's efforts to establish and implement a state-based Exchange in accordance with the provisions of the ACA.
Colorado	Yes	Former Governor Bill Ritter issued an Executive Order to designate a Director of Health Reform Implementation and an Interagency Health Reform Implementing Board to develop a strategic plan for implementation of the ACA. When Governor John Hickenlooper was elected in 2011, he established an internal health care team and worked with the legislature to establish a non-profit Health Benefits Exchange with its own governing board. A legislative oversight committee was also established to oversee Executive Director selection, certain financial decisions, and the initial work plan of the board.
Maryland	Yes	Governor Martin O'Malley signed an Executive Order on March 24, 2010 creating the MD Health Care Reform Coordinating Council consisting of the Executive Director of the Office of Health Care Reform; and the Secretaries of Health and Mental Hygiene; Budget and Management; Human Resources; and Labor, Licensing and Regulation. The legislature then established a quasi-governmental Health Benefits Exchange with its own governing board.

Michigan	No	Michigan has established a Health Reform Steering Committee that includes the Department of Community Health; the Department of Technology, Management and Budget; the Department of Licensing and Regulatory Affairs; the Office of Financial and Insurance Regulation; the Department of Human Services; and others that meet regularly to discuss and coordinate on health care related issues, including health reform. This mechanism helps keep agencies informed and involved in multiple aspects of the reforms to be implemented in Michigan.
Minnesota	Yes	Governor Mark Dayton signed an Executive Order on October 31, 2011 creating the MN Health Care Reform Task Force (charged with broadly studying health reform) and directing the Minnesota Department of Commerce to design and develop a Minnesota Health Insurance Exchange.
New Mexico	No	Governor Susana Martinez established an Office of Health Reform that is located in the Human Services Department and is charged with coordinating health reform efforts across agencies.
New York	Yes	New York's reform efforts are coordinated by an inter-agency team directed by the Governor's office including staff from Department of Health, the Department of Financial Services (Insurance Division), and staff charged with initial planning for the Exchange. Governor Andrew Cuomo also established an exchange for New York within the state's health department through Executive Order .
Oregon	No	Prior to passage of the ACA and as a part of the state's own health reform efforts, Oregon integrated several health-related agencies and functions into one agency: the Oregon Health Authority . The legislature then established a quasi-governmental Health Benefits Exchange with its own governing board.
Rhode Island	Yes	Governor Lincoln Chafee signed an Executive Order creating the Rhode Island Healthcare Reform Commission on January 11, 2011. The Executive Committee of the Commission includes the Lt. Governor, Secretary of the Executive Office of Health and Human Services, Health Insurance Commissioner, Director of Administration, and the Governor's Policy Director. The full commission, comprised over 200 stakeholders, is charged with the coordination and management of all healthcare reform efforts, and maximizing stakeholder engagement. Governor Chafee also established the Rhode Island Health Benefits Exchange through Executive Order .
Virginia	No	Virginia utilizes the Virginia Health Reform Initiative (VHRI) , which was established by the Governor. VHRI has an Advisory Council of 24 members and is chaired by Secretary of Health and Human Resources. The group originally met from August 2010 to September 2011 and generated recommendations related to exchange development, Medicaid reform, insurance reform, purchasing, technology, capacity and delivery/payment reform. The group reconvened in May 2012 with a series of meetings to discuss ongoing policy issues around exchange development.

High-level interagency coordinating councils have become a starting point for cross-agency collaboration in many states. These entities have been valuable for establishing a commitment to interagency coordination, defining state goals and vision, determining the roles of each agency in health reform, and making key policy decisions. Of course, if the group has no defined leader and the agency heads are unable or unwilling to work through difficult issues related to vision and responsibilities related to reform, these councils can prove ineffective. While cabinet-level meetings serve an important role for vision and decision-making, some states found that – as the work became more detailed, technical and voluminous – additional, more detailed discussions of the policy issues that were arising on a daily basis in various agencies were needed. Regardless of the success of cabinet-level coordinating councils, experience across the *State Network* participants indicates that states also need a commitment to collaborate at the staff level. New York, for example, established a regular ACA implementation meeting coordinated by the Governor's office and attended (weekly) by two or three senior-level staff³ from the Department of Health (which includes Medicaid), the Department of Financial Services, and the Exchange planning staff. Other individuals are brought into the meetings when their specific jurisdictional area is affected. Alabama and Rhode Island

³ For the purpose of this report, senior-level staff refers to individuals with decision making authority and direct lines of communication with the Governor's Office, and/or agency or departmental leadership.

have continued their meetings among agency heads, but they also meet regularly with senior-level staff. The staff meetings discuss more detailed issues, including those related to workflow and division of labor, and they identify major decisions and agenda items to bring to the cabinet-level meetings. In both states, the cabinet-level or agency officials play a key role in connecting to public advisory groups, as well.

These examples have yielded some key lessons for those establishing regular meetings to promote interagency coordination:

- *Get the right people in the room.* Including too many people in regular interagency coordination meetings will prevent real, substantive discussion and debate from taking place. The most successful state collaboration meetings have two or three decision-makers from each relevant agency that can meet regularly and develop a sense of trust and shared vision. Ten to twelve total people is a reasonable target.
- *Set the right agenda.* Typically, a senior-level policy person is responsible for setting the agenda for the interagency collaboration meetings in *State Network* states. This could be someone from the Governor's office or senior-level staff charged with health reform coordination or Exchange implementation. While midlevel and administrative staff can help collect input from the group, a senior-level person should be charged with planning and approving the agenda.

Another strategy implemented by several *State Network* states is creating an Office of Health Reform. This strategy was used in the *State Network* states of Maryland, New Mexico, and Virginia. If resources are available, establishing such an office enables the state to hire new staff with the exclusive responsibility of overseeing and managing health reform implementation, which can be preferable to just adding more responsibilities to already busy staff. An Office of Health Reform can be a way for a Governor to ensure his or her policy goals are pursued and monitored across agencies.

As you can see in Table 1, governance of interagency collaboration can be formal (as in Maryland which utilizes an Office of Health Care Reform) or informal (as with a standing meeting with interagency staff). Whether governance is established through a formal or informal mechanism, there are several characteristics of successful governance of interagency coordination.

Tips, Tools and Current Practices Related To Governance of Interagency Collaboration

- A clear vision and goals from the Governor and the legislature are critical for setting the course for state-driven health reform.
- Interagency coordinating councils of cabinet-level officials have been used successfully in some states. Clear leadership is needed to ensure that the goals of the cabinet-level meetings are well-defined. Coordinating councils can set the direction for reform and make major decisions, but these groups, by themselves, are not sufficient to accomplish the goal of seamless integration.
- Regular meetings and communication between senior-level policy and operational staff from key state agencies are critical; states should make sure these meetings include the right people and have the right agendas.

NASHP MILESTONES FOR DEVELOPING A COORDINATED APPROACH TO IMPLEMENTING THE ACA

During 2010, the National Academy for State Health Policy (NASHP) convened a group of leading state health policymakers to identify priorities for successful health reform implementation. Alan Weil, NASHP Executive Director, published "State Policymakers' Priorities for Successful Implementation of Health Reform" in May 2010 to describe the ten priorities; NASHP then added an eleventh overarching priority: "Developing a Coordinated Approach to Implementing the ACA." These eleven priorities are used to organize and measure states' progress toward implementing reform, as indicators of progress, each with milestones that need to occur along the way. For the coordinated approach indicator, the milestones⁴ selected are:

- Designate a lead person or entity to coordinate the state's implementation of the ACA;
- Form or designate a coordinating body with representation from key state agencies relevant to the implementation of the ACA;
- Develop one master, cross-agency implementation work plan and timeline;
- Identify state staffing and other resources necessary for carrying out implementation work plan;
- Conduct a fiscal analysis of the components of implementation;
- Conduct an analysis of existing IT systems and identify areas in need of modernization;
- Identify and review which state laws and regulations must be modified to implement the provisions of the ACA;
- Enact state laws to make required changes;
- Promulgate rules and regulations to make required changes consistent with state and federal law;
- Establish criteria and/or a process for deciding which ACA-funded federal grant opportunities to pursue; and
- Establish a system for monitoring implementation and reporting to stakeholders. (National Academy for State Health Policy, 2012)

⁴The indicators and milestones are part of the National Academy for State Health Policy (NASHP) StateRefor(u)m initiative which is funded by the Robert Wood Johnson Foundation. StateReFor(u)m is an online network for health reform implementation where users share documents and offer ideas on state-level implementation of national health care reform. In the spring of 2010, NASHP brought together the Executive Committee of the Academy, a group of leading state health policymakers, and sought their perspective on the keys to successful health reform implementation. Those discussions produced a core list of ten priorities for health reform implementation, subsequently with an 11th component, and those eleven priorities were translated into indicators of progress towards health reform implementation. With input from a number of additional state officials, NASHP developed specific milestones that need to occur to achieve completion of the indicator. For more information on StateRefor(u)m indicators and milestones visit <http://www.statereform.org>.

- Offices of Health Reform and other staff specifically charged with health reform implementation assure that key staff remains focused on the changes required by the ACA. They also prevent health reform from getting lost in the other tasks state staff must maintain throughout the change process.

While many systems can be put in place to ensure strong management of health reform implementation, it is also important to identify innovative thinkers with a track record of successful collaboration on projects and strong communication skills, and to establish clear roles and responsibilities. The literature on health reform adds another valuable tip related to interagency collaboration: successful collaboration is aided when staff is evaluated based on their participation in collaboration efforts (Daley, 2008). This valuable lesson can be applied across health reform implementation. As staff take on more health reform related tasks, especially in the face of state budget shortfalls, competing demands within the state, and limited bandwidth of existing staff, management should be clear about how staff should prioritize their responsibilities and reward staff that help the state meet its health reform goals.

Technology and Tools for Interagency Coordination

During the start-up phase of the *State Network*, staff held conversations with state officials to learn about their concerns and anticipated needs. Many state officials expressed a worry that “things would fall through the cracks,” or that “they couldn’t get their arms around” the enormous task they faced in implementing the ACA. How would they keep track of everything that needed to be done, monitor that deadlines were being met, and ensure that tasks were accomplished in the right order?

In order to meet this need, the *State Network* worked with its team of technical assistance providers to develop a series of tools to assist with work planning, project management, and interagency coordination. The following tools were developed and will be described below:

- A guide to commonly-used project management software (Tables 2 and 3)
- Exchange Timeline (Appendix A)
- State Milestones for ACA Implementation (Appendix B)
- Exchange Work Plan Template (Appendix C)
- Division of Insurance Work Plan Template (Appendix D)
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- Memorandum of Understanding Checklist (Appendix G)

The templates and other tools can serve as a starting point for discussion and can be adapted by states to reflect their own environment. We know that work planning and management tools are only effective when they are tailored to the responsibilities and resources of the team and tasks and embraced and consistently used by those charged with managing health reform and implementing it on a day-to-day basis.

Project Management Staff and Software

As a state considers management of health reform implementation, two key questions are who will manage the reform process and how will they undertake that task.⁵ First, states that have hired dedicated project managers have benefited greatly. These project managers are not the ultimate decision makers but have access to decision makers, engender respect of peers and staff, and possess enough substantive knowledge to manage issues and not just processes. These individuals facilitate progress and ensure that policy decisions are being effectively implemented. The skills needed to keep projects running on track are often undervalued, but they can mean the difference between success and failure.

Second, states will need to decide which software tool best suits their project management needs, ranging from fairly low-tech excel spreadsheets to fairly complex software designed specifically for project management. While all the “bells and whistles” of project management software can seem exciting, it is important to match the complexity of your project management tools with the skills and comfort level of those who will be regularly using them. A few states have been using project management software for years; in those cases, enhancing existing software to manage ACA implementation could be very effective. For states and managers without that experience, significant time and money could be invested in a tool that is rarely or poorly used. In addition, the software choice should be directed by the tasks a state hopes to accomplish. A guide to the commonly used project management tools can be found in Tables 2 and 3.

⁵ We recognize that there is a whole field of project management with research and skills that could greatly benefit state implementers of health reform. Summary of the knowledge held by experts in project management is far beyond the scope of this issue brief, but we encourage state officials to investigate this field, learn from those within and outside the health care field, and consider hiring some staff with specific project management experience.

Table 2:

Project Management Tools Evaluation*

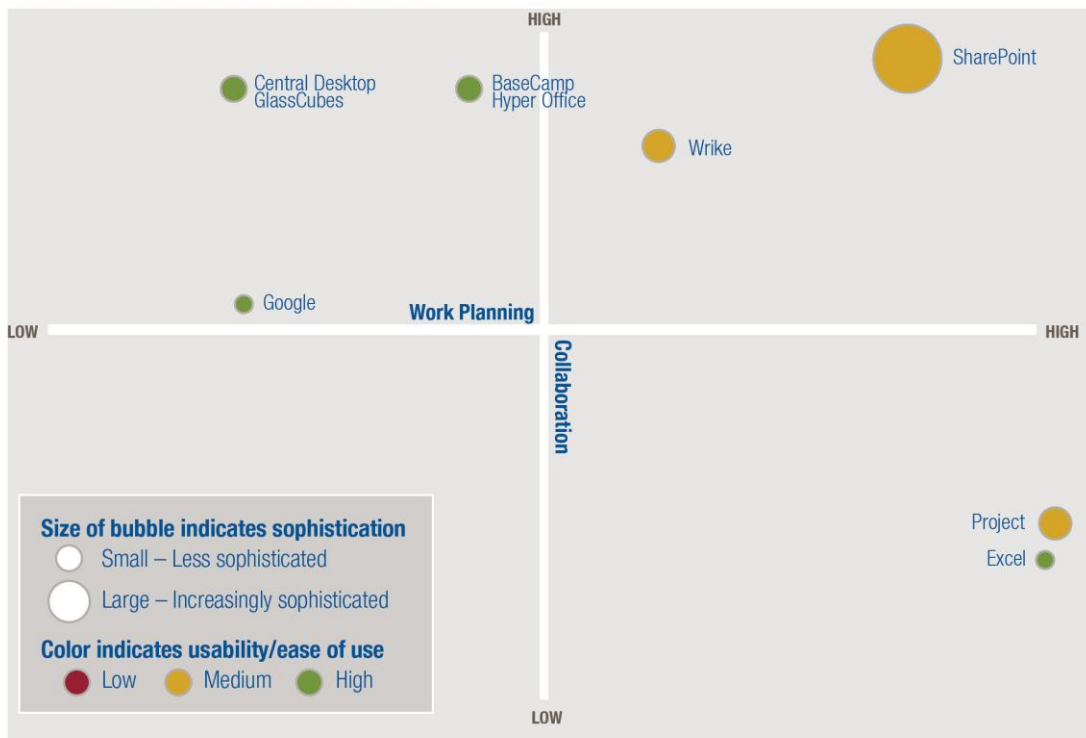
Tools	Work Planning	Collaboration	Usability	Off the Shelf	Adaptability	Sophistication	Monthly Pricing	Storage Space	Users
Microsoft Excel	●	●	●	●	●	●	License based	NA	NA
Microsoft Project	●	●	●	●	●	●	License based	NA	NA
Microsoft SharePoint	●	●	●	●	●	●	License based	Configurable	NA
Central Desktop	●	●	●	●	●	●	\$99	50 GB	20
Glasscubes	●	●	●	●	●	●	\$125	20 GB	20
Hyper Office	●	●	●	●	●	●	\$79.99	2.5 GB	10
BaseCamp	●	●	●	●	●	●	\$99	30 GB	Unlimited
Google	●	●	●	●	●	●	\$5 per user	25 GB per user	Unlimited
Wrike	●	●	●	●	●	●	\$99	15 GB	15

● Low Functionality ● Medium Functionality ● High Functionality *Note: Tools were reviewed using publicly available information and product trials, when available

Prepared by: Manatt Health Solutions. Produced for State Network Kick-Off Meeting, Chicago IL, July 13-15, 2011.

Table 3:

Project Management Tools Evaluation



Prepared by: Manatt Health Solutions. Produced for State Network Kick-Off Meeting, Chicago IL, July 13-15, 2011.

Finally, a state will want to think about the multiple audiences who will be using the work plans, dashboards (that provide an at-a-glance review of project status) and other tracking tools that are developed. Senior-level staff may only need to track a handful of indicators while on-the-ground staff may need to keep track of multiple detailed tasks and projects. States will

need to consider whether a single tool can be developed that serves multiple purposes. Or will separate tracking documents be needed for various audiences? [Appendix A](#) provides one example of a high-level document that was initially developed for one state’s Exchange board. It is a one-page timeline that lays out the major tasks of the Exchange.

State Milestones for ACA Implementation

At the beginning of 2012, states articulated that they would value a high-level document that would list key milestones that must be met in order for states to be ready for certification of the Exchanges in 2013 and implementation in 2014. Manatt Health Solutions, consulting with *State Network* states and technical assistance providers, developed a document titled, “State Milestones for ACA Implementation,” that lists milestones for Exchanges, Medicaid, and private insurance market reforms. This document can be found in [Appendix B](#).

Exchange Work Plan Template

Manatt Health Solutions developed a template work plan for states in the *State Network* related to the Exchange, which can be found in [Appendix C](#). They used an Excel spreadsheet model to allow for versatility across states, as all states have access to and familiarity with the application. The work plan was designed to allow states to track tasks, key decision points, person responsible, start and end dates, and deliverables. Some states have added an additional column that allows them to track the status of a work item using green, yellow, red shading, which provides a quick visual guide to the progress of implementation. Tasks marked green are on track, those in yellow are in danger of falling behind, and those in red are not expected to meet deadline. Project managers can focus on yellow and red tasks to help staff overcome or work around existing barriers.

The template lists the major tasks that need to be undertaken by the Exchange, driven largely by the federal guidance in this area. The task headings include:

- Background Research
- Stakeholder Consultation
- Legislative and Regulatory Action
- Governance
- Program Integration
- Exchange IT Systems
- Financial Management
- Oversight and Program Integrity
- Health Insurance Market Reforms
- Providing Assistance to Individuals and Small Businesses, Coverage Appeals, and Complaints
- Certification, Recertification, and Decertification of QHPs
- Call Center

The work plan was created at a medium level of detail targeted for managers charged with overall Exchange implementation, which means that more detail is likely needed for staff charged with day-to-day implementation of specific parts of the ACA while less detail may be desired for agency or senior leadership such as cabinet secretaries that are charged with setting priorities and monitoring progress. For leadership, work plans could be rolled up into dashboards that monitor progress on several high-priority deliverables. Staff responsible for on-the-ground implementation will likely add more detail as work progresses.

Division of Insurance Work Plan Template

Technical assistance providers from Georgetown University Health Policy Institute developed a work plan template and self-audit tool for state divisions of insurance, which can be found in [Appendices D and E](#). The self-audit tool is a chronological, step-by-step checklist that gives state officials a guide as they analyze their insurance laws, rules and regulations for compliance with ACA. This is an important first step for states as they determine which changes will be needed and what they will do to make those changes (e.g., legislative packages, regulatory changes, bulletins, etc.).

The work plan template is a matrix designed to ensure that “nothing falls through the cracks” and includes certain plan management functions. It helps states identify tasks that have been completed, what is on-going, and what needs to begin. States can use the columns provided to color-code priorities, assign start and end dates, identify lead personnel, and define deliverables. This tool is organized by activity (activity number does not represent priority).

The task list headings in this template include:

- ACA Standards and Authority Required for Implementation
- ACA Standards Oversight and Plan Compliance

- Rate Review Policy Decisions and Oversight
- Data Submission to HHS
- Insurance Market Policy Decisions
- Licensing Framework
- Determine Rules/Policies/Oversight Inside/Outside Exchange
- Outreach and Education Plan
- Internal Staff Processes

Medicaid Work Plan Template

The *State Network* worked with Manatt Health Solutions to develop a work plan template for state Medicaid programs, which can be found in [Appendix F](#). The task list headings in this template are:

- Eligibility and Enrollment
 - Maintenance of Effort
 - Medicaid Expansion
 - PAPD/IAPD
 - FMAP Calculation
 - Modified Adjusted Gross Income and Elimination of the Asset Test
 - Premium Assistance for Employer Sponsored Insurance
 - Foster Children
 - Enrollment Simplification and Coordination with the Exchange
 - Presumptive Eligibility Determinations by Hospitals
 - Hospice Care
 - Family Planning Program
 - Protections for Recipients of HCBS Against Spousal Impoverishment
 - Business Requirements, Operational Implementation and System Enhancements
 - Coverage Transitions Analysis
 - CHIP Transition
 - Special Rules for American Indians
 - PARIS Data Matching
- Benefit Package Design
- Basic Health Program
- Health Plan Administration
 - Certification
 - Quality Assessment and Monitoring
 - Contracting and Oversight
 - Risk Adjustment
 - Reinsurance

Memorandum of Understanding Checklist

Effective implementation of the ACA will require that state agencies not only collaborate on an informal basis, but that they develop formal agreements on who will manage which aspects of the new system once health reform is implemented. For example, Medicaid and the Exchange will need to develop a seamless eligibility determination and enrollment process for consumers. Medicaid programs have traditionally approved the eligibility of all applicants to that program. Will that continue to be the case going forward? If so, how will communication flow between Medicaid and the Exchange to ensure a simple, real-time consumer experience? Alternatively, states could allow the Exchange to check the eligibility of the majority of new Medicaid recipients, with only complex cases going through the Medicaid agency. On the insurance side, states will need to determine how licensing (typically a function of insurance agencies) and certification of qualified health plans (a responsibility of Exchanges) will interact and how, together, the two agencies will protect against adverse selection inside or outside the Exchange. However states configure these responsibilities, they will need to develop clear protocols and written agreements to document responsibilities, work flow, and data sharing between the two entities. This dynamic plays out across a range of issues, including health plan certification and decertification, management of call centers and consumer complaints, and development and maintenance of an IT infrastructure to name a few.

In anticipation of the need for formal memorandums of understanding (MOUs) across a range of topics, the *State Network* worked with Georgetown University Health Policy Institute and Manatt Health Solutions to develop a checklist designed as a tool that a state agency (and quasi-state agency) can use to identify and document functions it currently performs and to determine if, when exchanges are set up, the state agency should continue to perform those and similar functions or have another state agency assume those functions. This tool can also be used to help determine where there is overlap among agencies and to ensure that none of the essential functions that an exchange must perform are overlooked. This checklist can be found in [Appendix G](#).

Tips, Tools and Current Practices for Project Management and Work Planning

- States should put a high value on project management. When possible, staff with specific expertise in planning a project and moving it to completion should be utilized. Staff time should be dedicated to this function.
- Project management is different than project leadership. Both are important.
- Work plans can be effective tools for tracking progress, fostering accountability and ensuring that project goals and deadlines are met.
- States should give thought to the level of detail needed for work plans and how work plans can roll up into useable high-level priority lists and dashboards for communicating with senior-level staff and other stakeholders. The tools needed by project leaders and detailed implementers may be different.
- The project management tools and software used by states will vary based on their previous experience with sophisticated project management tools and the time they are able to devote to learning and using those tools. Simple Excel spreadsheets and document sharing technology may be right for some states, while others will be able to make good use of project management tools with more specialized functionality to generate Gantt charts and automatically track contingencies.

Additional Factors that Impact Interagency Collaboration: Information Technology, Stakeholder Engagement and Exchanges

As the *State Network* works with states to promote effective management of health reform and smooth interagency coordination, it has become clear that a few specific implementation issues are particularly important to understand and manage, namely: IT systems; stakeholder engagement; and the unique issues related to Exchange governance. Each of these areas merits in-depth study and discussion that is beyond the scope of this issue brief. What follows is a short discussion of the major issues that have arisen related to each of the topics and a few early lessons.

Information Technology and ACA Implementation

When the ACA initially passed, state officials immediately recognized that building the technology to support implementation would be one of ACA's biggest challenges. State officials would need to begin work in this area immediately if they were to meet the ACA deadlines. Previous experience with Medicaid IT procurements indicated that writing the specifications, issuing the requests for proposals (RFPs), selecting a vendor and then working with that vendor to develop a workable system could take many years. In addition, states would be attempting to procure systems that would have functionality that did not currently exist to connect to a federal data hub that was not yet built. It would be an enormous task.

While policymakers in many states debated the merits of exchanges and health reform in general, many state officials quickly began an assessment of the capability of their current systems. Many of the legacy Medicaid systems that were being assessed (both for determining eligibility and processing claims data) were old and outdated and barely able to manage the current demands, much less the new functionality that would be required. The decision to procure new IT was also spurred by the availability of federal funds for Exchange IT through the end of 2014 and a 90/10 match on all IT spending for new and updated systems for Medicaid ([Department of Health and Human Services, 2010](#)).

As the work of assessment and procurement of new IT systems has gotten underway in the *State Network* states, we have made several observations:

- Even when there is political disagreement related to ACA implementation, state officials have needed to make decisions related to IT. This dilemma has played out most publicly in the Early Innovator states, several of which

have decided to return federal funds rather than proceed with IT development.⁶ Most other states have quietly attempted to meet IT-driven timelines in the absence of a clear state-wide vision for reform. A number of states have taken advantage of 90 percent federal match rates by upgrading antiquated systems, and positioning their systems to meet coordinated system requirements under the ACA. A few states have been completely stymied by overt political opposition and lack of access to federal exchange resources.

- The slow and administratively burdensome state procurement process can be one of the greatest challenges in moving forward on implementation work. States can benefit from creating structures to facilitate expedited procurement processes. Maryland, in the establishment of its Exchange, stipulated that the entity could use such processes to keep the implementation process moving forward and be nimble in procuring essential contractors to meet deadlines.
- State officials that have not received clear guidance from their leaders have a vision articulated by the federal government: to the greatest extent possible, eligibility determinations must be done in real time and be seamless between Medicaid and the Exchange ([Medicaid Program, Eligibility Changes under the Affordable Care Act of 2010](#)).
- In some cases, the demands of the IT process and the deadlines it imposes can have a positive impact on policymakers, forcing them to make critical decisions that otherwise might have been delayed or avoided. Information technology forces everyone to think concretely about what the ACA will really mean in their state.
- Many states have a separate agency or division that is charged with IT implementation. Having yet another agency involved has the potential to deepen the challenges related to interagency coordination. If IT offices are understaffed, state agencies can be forced to compete for the scarce time of IT staff.
- The need for updated IT at both the Exchange and Medicaid creates another potential pitfall for states. Some states have elected to pursue one consolidated IT system for both entities, while others are planning to implement two separate but interoperable systems.

Tips, Tools and Current Practices for Effective IT Implementation

- Regular and structured communication between policy staff and IT staff is critical for the development of a strong IT system. For example:
 - Rhode Island had seven half-day facilitated meetings between policy and IT staff as they developed their [IT RFP](#).
 - Both Oregon and New York (two Early Innovator states that already have IT consultants working in their states) report weekly meetings between IT staff and vendors and key policy staff to work through the technical requirements of various systems.
- Policy and IT staff tend to have very different knowledge bases, so it is important to take the time to enable both sides to understand one another.
- Build flexibility into your IT procurement.
 - For example, Minnesota issued an RFP ([Minnesota Department of Commerce](#)) that called for bids in 8 functional areas.⁷ The selected contractors would need to show that they could develop modules with high functionality that would also be interoperable with the other modules. The products being developed would need to be flexible enough to respond to policy decisions as they are made.
 - Use a modular, flexible approach to system architecture planning, procurement and development, including the separation of the technical infrastructure and the business rules so that emerging and changing rules can be adapted without major systems modifications.
- Collaboration between Medicaid and the Exchange is critical as new systems are developed. States have taken various approaches to building their systems. For example, Rhode Island is building an integrated eligibility system that will serve both the Exchange and Medicaid, but enrollment will be done by two different systems, one for Medicaid and one for the Exchange. Maryland and Minnesota are procuring a joint Exchange/Medicaid IT system for a single streamlined MAGI Eligibility process. In those states, Medicaid and the Exchange will

⁶ State initially selected to receive Early Innovator funding were: Kansas, Maryland, a multi-state consortia of New England states led by the University of Massachusetts Medical School, New York, Oklahoma, Oregon, and Wisconsin. These funds were designed to help several states quickly develop IT solutions that could then be used in other states. Since the initial announcement, Kansas, Oklahoma and Wisconsin have elected to return their Early Innovator grants.

⁷ The eight functional areas are: Individual Eligibility and Exemption; Individual Enrollment; Small Employer Eligibility and Enrollment; Health Benefit Plan and Navigator/Broker Certification and Display; Provider Display; Fund Aggregation and Payment; Account Administration; and Mobile Application or Accessibility.

share one system for MAGI eligibility and enrollment, but may phase in non-MAGI eligibility categories over time.⁸ Other states (Colorado, for example) are procuring separate systems for Medicaid and the Exchange. In that case, close communication and cooperation between Medicaid, State Technology Offices, and the Exchange is critical to ensure an ultimate consumer experience that is seamless. This collaboration can be hindered by the fact that Medicaid is a more mature program with many established policies and ongoing resource demands. Exchanges will need to be more nimble as they adhere to a simpler eligibility determination process, but they may lack the experience that can be found in most Medicaid agencies.

- For states with separate IT offices or agencies, it is critical to have staff dedicated to understanding and facilitating ACA-related reforms.

Stakeholder Engagement

At the same time state officials are trying to coordinate work across multiple agencies, they also must develop a strong plan for engaging outside stakeholders, many of whom will be critical to the success of health reform. For example, the Exchange will have no products to sell if insurers do not agree to participate. Brokers could steer clients away from the Exchange if they see it as a threat to their livelihood. Connecting with vulnerable and hard-to-reach populations will be difficult without the help of trusted community groups. Quality improvements and delivery system reforms can only be accomplished in partnership with health care providers. And advocates could derail efforts if they feel the health system does not meet the needs of consumers. The health system is incredibly complicated and the input of diverse perspectives is valuable to the decision-making process.

The stakeholder strategy is impacted by several themes that have already arisen throughout this brief: 1) Developing a strong internal vision and strategy is essential to having a clear and coherent strategy with stakeholders – it is difficult to implement a clear external strategy when there is no clear internal strategy; 2) Just as the ACA demands greater coordination between agencies, it also requires better coordination of the input from a range of stakeholders. While each agency may have been able to work separately in the past with its own constituencies, it is increasingly important for successful ACA implementation to bring these constituents together to promote system-wide reform. A good stakeholder strategy can mean the difference between constructive engagement and ultimately partnership with key outside groups versus a stakeholder engagement process that is divisive with the potential to derail reforms.

Tips, Tools and Current Practices for Effective Stakeholder Engagement

- The majority of *State Network* states that have been successful in engaging stakeholders have instituted a formal stakeholder process connected to ACA implementation with work groups and advisory committees. For example, an Exchange may set up a formal board or a steering committee that utilizes a wider range of stakeholders in work groups on specific topics. States can also set up health reform task forces whose mandates go beyond Exchange implementation (for example, the [Minnesota Health Reform Task Force](#) and the [Rhode Island Healthcare Reform Commission](#)).
- Organizing work groups by topic rather than by constituency may prove more productive. In this way, the various interests can work out differences with each other. When you form a work group of only consumer advocates or carriers, for example, you run the risk of exacerbating adversarial relationships rather than facilitating discussion across constituencies.
- Understand the difference between engaging stakeholders for consultation and participation in decision-making and simply informing them of decisions being made by the state. Stakeholders will not be fooled by a process that claims to be participatory but is actually a process for the state to report its own decisions.
- Some stakeholders may be trusted allies in the reform process and can be used as ambassadors in critical moments to build support or spread the word about specific reforms. Identify these allies and positive roles they can play. To the extent possible, seek to have all stakeholders become allies.

⁸ Maryland and Rhode Island are also including eligibility for other social service programs into their IT build.

- Recognize that many stakeholder groups are diverse. You may have support among only some carriers, some business leaders and some brokers, for example, and while a state association may take one position on reform, a regional group may take a different position.
- For states in which the executive and legislative branches have an adversarial relationship, state officials may be able to use trusted stakeholder groups to bring needed legislative reforms forward.
- A good stakeholder process needs to be well-managed. Without someone mapping stakeholder roles, setting the agenda, bringing content to the meeting, and facilitating input, a stakeholder process will founder. Adequate staff resources must be dedicated to stakeholder engagement.

Coordination Issues Raised by Exchanges

If coordination between existing health-related agencies is not complicated enough, the development of a new Exchange entity may raise a host of additional issues. In some states, Exchange staff is still operating under the auspices of an existing agency. As more states establish formal governance structures for their Exchanges, more entities officially reside outside of state government and have an independent governing board. Depending on how closely the goals of the Governor, legislature and Exchange board are aligned, this arrangement can introduce a range of additional turf battles and implementation challenges. On the other hand, a few states (mostly those in which the three entities are more closely aligned) have used the new resources and staff connected to the Exchange as a valuable locus for organizing state-wide reform efforts.

Issues connected to the Exchange vary almost as widely as the states and personalities that are implementing them; nevertheless, following are a few current practices and insights for states attempting to navigate the governance issues raised by Exchanges.

Tips, Tools, and Current Practices for Coordinating with Exchanges

- The model set by Massachusetts – having general authorizing legislation that charges the Exchange board with making many of the detailed technical decisions – is a model for all states to strongly consider. Exchanges must be able to make complex decisions in a timely way and this may be best accomplished by technical experts in a less politicized environment than most state legislatures.
- While most Exchanges are being established as independent entities (as either a nonprofit or a separate public entity), they still will need to coordinate with state agencies on a range of issues. They may contract with state agencies for certain services or they may develop programs in which Exchange staff must work in partnership with state staff. In order to promote effective coordination, the Governor may want to request formal agreement from the Exchange on how this coordination should take place. Since the Governor must sign off on Exchange funding requests, he or she could use that opportunity to ask for a more formal agreement related to coordination.

HOW MARYLAND HAS USED PUBLIC PARTICIPATION TO INFORM EXCHANGE IMPLEMENTATION

Maryland has set up a quasi-governmental Exchange governed by an independent 9-member board. As directed by the Maryland General Assembly, the board established four advisory committees to assist the development of a framework for operating the Exchange. Each advisory committee, comprising about 15-20 Maryland stakeholder representatives each, met several times between June and December of 2011. The public was encouraged to attend any meeting of the board or its advisory committees. The committee members were selected by the Exchange board through an application process that allowed the board to ensure that each committee had a range of expertise. Each committee was supported by Exchange staff and a team of consultants with whom the state contracted to conduct studies on the broad topics under consideration. The studies reviewed the Maryland landscape and identified key decision points for the work groups. The Maryland Health Benefit Exchange used the following committees* and studies in 2011:

- Operating Model and Insurance Rules Advisory Committee
 - [Operating Model Study](#)
 - [Market Rules and Risk Selection Study](#)
- SHOP (the small business exchange) Advisory Committee
 - [SHOP Study](#)
- Navigator and Enrollment Advisory Committee
 - [Navigator Study](#)
 - [Public Relations and Advertising Study](#)
- Finance and Sustainability Advisory Committee
 - [Finance and Sustainability Study](#)
 (Pearce, Executive Director, Maryland Health Benefit Exchange, October 18, 2011)

Each advisory committee made specific recommendations related to their topic area. The Maryland Exchange Director took the recommendations from each of the work groups and folded them into presentations⁹ that identified the key decision points for the Board. In this way, the board was able to quickly focus on the important issues and questions. The Exchange board recommendations, informed by the consultant studies and advisory committee reports, were integrated into a 59-page [report](#) to the legislature. Most of the recommendations to the legislature then were incorporated into the O'Malley Administration's legislative package for 2012.

The Maryland Health Benefit Exchange will continue to use advisory committees to support planning and implementation. For example, in 2012, the Exchange will establish new advisory committees to provide input on the design of the navigator programs, implementation of continuity of care provisions, and certification requirements for qualified health plans.

* Advisory Committees worked collaboratively with consultants for each study and the public. Each committee submitted reports of their efforts to the Maryland Health Benefit Exchange Board to help guide the Board as it made recommendations to the General Assembly. Committee reports can be found here: <http://dhhm.maryland.gov/exchange/SitePages/nov15materials.aspx>

⁹ The presentations were titled: [Discussion on Operating Model, Market Rules, Navigator and Advertising](#); [Discussion on SHOP, Dental, Financing, and Continuity](#); [Discussion on Fraud/Waste/Abuse Fraud/Waste/Abuse, Multi-State Contracting, and Revisited Topics](#). They were developed by Exchange Director Rebecca Pearce and can be accessed (as of March 21, 2012) here: <http://dhhm.maryland.gov/healthreform/exchange/SitePages/meetings.aspx>.

- Another tool for coordination between Exchanges and state agencies will be formal memorandums of understanding (MOUs). MOUs are a helpful tool for clarifying respective roles with divisions of insurance, human services agencies, high risk pools, state finance offices and others.¹⁰ (See [Appendix E](#) for a list of possible issues that may require coordination between Exchanges and state agencies.)
- In many cases, existing state agencies have expertise that will be needed by the Exchange, but those agencies do not have sufficient staff time and resources to meaningfully participate in reform efforts. The Exchange can ask for federal funding to pay for staff in state agencies as long as that staff is tasked with exchange-related responsibilities. Exchanges can build good will with state agencies by offering additional funding or staff, and it gives them leverage when asking state agencies to work on ACA-related tasks.
- Exchange staff will likely have a significant impact on the pace and tone of health reform activities in the state. While existing agencies have an established staff and culture (with a long memory of how things have always been done), Exchanges are new entities that are mostly small and nimble, without an established culture. Exchange staff is being asked to make many decisions quickly. Friction is possible between Exchange staff concerned about getting stymied by too much bureaucratic process and staff from other agencies who want to be consulted. This is a tension state officials will need to manage.

CONCLUSION

Implementing the ACA requires a new level of vision, leadership, management skills and coordination from state health policymakers. In most states, these skills must be employed in an uncertain or contentious political environment and in spite of significant budget and staffing shortages. It is a daunting task. As a result, some potential lessons from leading states will be unrealistic for state officials facing different environments. At the same time, ACA presents an historic moment in which all states are faced with similar challenges and opportunities related to the realization of health reform. It appears that many of the tips, tools and current practices outlined in this issue brief can be transferable and will enable the type of cross-state learning that will be required to make ACA implementation a success in as many states as possible.

ABOUT THE STATE NETWORK PROGRAM

State Health Reform Assistance Network, a program of the Robert Wood Johnson Foundation, provides in-depth technical support to states to maximize coverage gains as they implement key provisions of the Affordable Care Act. The program is managed by the Woodrow Wilson School of Public and International Affairs at Princeton University. For more information, visit www.statenetwork.org

ABOUT ACADEMYHEALTH

AcademyHealth is a leading national organization serving the fields of health services and policy research and the professionals who produce and use this important work. Together with its members, it offers programs and services that support the development and use of rigorous, relevant and timely evidence to: increase the quality, accessibility and value of health care; reduce disparities; and improve health. A trusted broker of information, AcademyHealth brings stakeholders together to address the current and future needs of an evolving health system, inform health policy, and translate evidence into action. For more information, visit www.academyhealth.org

ABOUT STATE COVERAGE INITIATIVES

A national program of the Robert Wood Johnson Foundation administered by AcademyHealth, State Coverage Initiatives (SCI) provides timely, experience- and evidence-based information and assistance to state leaders in order to help them move health care reform forward at the state level. SCI is collaborating intensively with the *State Network* program office at Princeton University to support the technical assistance to participating states. For more information, visit www.statecoverage.org

ABOUT THE ROBERT WOOD JOHNSON FOUNDATION

The Robert Wood Johnson Foundation focuses on the pressing health and health care issues facing our country. As the nation's largest philanthropy devoted exclusively to health and health care, the Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, measureable and timely change. For nearly 40 years the Foundation has brought experience, commitment, and a rigorous, balanced approach to the problems that affect the health and health care of those it serves. When it comes to helping Americans lead healthier lives and get the care they need, the Foundation expects to make a difference in your lifetime. For more information, visit www.rwjf.org.

ABOUT GEORGETOWN UNIVERSITY HEALTH POLICY INSTITUTE

Georgetown University's Health Policy Institute is a multi-disciplinary group of faculty and staff dedicated to conducting research on key issues in health policy and health services research. Institute members are engaged in a wide diversity of projects, focusing on issues relating to health care financing, the uninsured, federal health insurance reforms, quality of care and outcomes research, mental health services research, and the impact of changes in the health care market on providers and patients. For more information, visit <http://ihcrp.georgetown.edu/>

ABOUT MANATT HEALTH SOLUTIONS

Manatt Health Solutions (MHS) is an interdisciplinary policy and business advisory division of Manatt, Phelps & Phillips, LLP, one of the nation's premier law and consulting firms. MHS helps clients develop and implement strategies to address their greatest challenges, improve performance and position themselves for long-term sustainability and growth. For more information, visit www.manatt.com

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¹⁰ The U.S. Department of Health and Human Services Office of Consumer Information and Insurance Oversight's Cooperative Agreement to Support State Establishment of State Operated Health Insurance Exchanges (both Level I and Level II) requires program integration between the exchange and other programs specifically Medicaid and states' Divisions of Insurance. The Cooperative Agreement can be accessed here http://ccio.cms.gov/resources/fundingopportunities/foa_exchange_establishment.pdf.

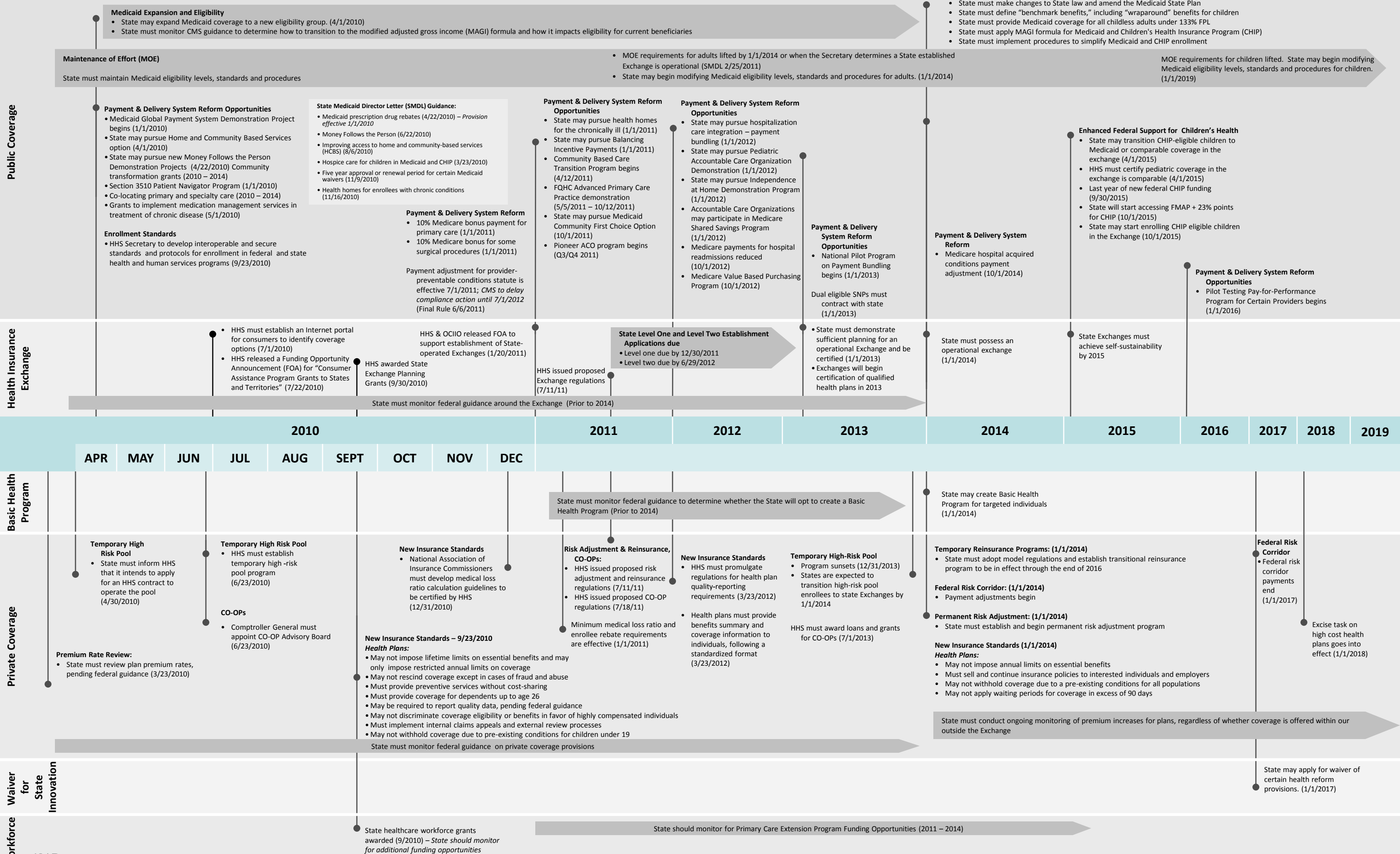
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Appendix A: Implementing Federal Health Care Reform Coverage Provisions: A State Implementation Timeline

Prepared by **Manatt Health Solutions**

Draft – July 27, 2011



Appendix B: State Milestones for ACA Implementation

Prepared by *Manatt Health Solutions*

PURPOSE

This document identifies critical Affordable Care Act (ACA) implementation milestones for states to have achieved by the end of 2012. Organized under the major areas of Health Insurance Exchange, Private Insurance Market Reforms and Medicaid Expansion, these milestones are key checkpoints for states to stay on track in meeting 2014 implementation deadlines. These milestones have implications for policy development, business operations and IT system architecture and as such are useful as a high level framework for state Exchange development and implementation efforts. At the same time, for states relying on the Federally Facilitated Exchange, the milestones highlight core Exchange functions, some of which states may want to assume. This document may be used to inform and educate various audiences, including public officials and health care stakeholders, regarding the priorities for state health care reform through the end of the year.

MILESTONES	COMMENTS
EXCHANGE	
Goals: Operationalize a state based Exchange that meets requirements for federal approval in January 2013	
Exchange Set-Up	
Secure Exchange establishment authority	Required to secure Establishment grant Level 2 funding and Exchange approval
Establish Exchange Board/governing structure: <ul style="list-style-type: none"> Appoint members and obtain conflicts disclosures Develop Exchange Charter, bylaws, committee structure, policies, meeting schedule 	Required to provide governance materials as part of Exchange approval
Hire core Exchange staff: Executive Director, Policy Director, Finance Director, Operations Director, IT Director	
Develop Exchange staffing plan 2013-2015	
Submit final Exchange Establishment funding request, including sustainability plan	
Define and memorialize in MOUs relationship of Exchange to Insurance Department, Medicaid Agency, and other state agencies	<ul style="list-style-type: none"> MOUs may be provided as evidence of collaboration as part of Exchange approval Required for Establishment grant Level 2 application
Identify necessary state-federal interfaces, define and memorialize MOUs with federal agencies	
Identify level of reliance on federally managed services	<ul style="list-style-type: none"> Advance premium tax credit determinations Individual mandate exemptions Employer sponsored insurance verification
Engage with stakeholders on a regular basis	<ul style="list-style-type: none"> Required as condition of receipt of Establishment funds
Eligibility	
Determine preferred option for Joint Application for Qualified Health Plans (QHPs) and Insurance Affordability Programs (IAPs): <ul style="list-style-type: none"> Use HHS Secretary model application; Modify HHS Secretary model application and seek Secretary 	Pending Secretary’s model application

MILESTONES	COMMENTS
approval for use; or, <ul style="list-style-type: none"> Develop state specific application and seek Secretary approval for use. 	
Determine whether state will offer a Basic Health Program	Pending federal guidance
Determine whether state Exchange will: (i) provide tax credit eligibility determination functionality or rely on federally managed service; (ii) make Medicaid/CHIP determinations or assess Medicaid/CHIP eligibility and rely on Medicaid Agency for eligibility determinations.	Determine roles of HHS, state Exchange, and Medicaid, CHIP and Insurance Agencies and incorporate into MOUs
Define reasonable compatibility standard, change reporting requirements and verification requirements, state data sources	System design implications
Define eligibility business process model and functional requirements	<ul style="list-style-type: none"> Required to provide business process models as part of Exchange approval Define roles and responsibilities between Exchange and Medicaid
Define consumer eligibility notice requirements for QHPs and IAPs	Required to provide description of notices as part of Exchange approval
Enrollment	
Define enrollment business process model and functional requirements	Required to provide policies and procedures as part of Exchange approval
Define consumer enrollment notice requirements	Required to describe relevant notices as part of Exchange approval
Plan Management	
Define QHP certification requirements: <ul style="list-style-type: none"> Network adequacy Marketing Accreditation Transparency 	<ul style="list-style-type: none"> Required to certify plans as Exchange function and provide policies and procedures as part of Exchange approval Develop QHP “best interest” test <i>These decisions will have an impact on and should be closely coordinated with private market reform decisions</i>
Hire procurement staff	
Define plan management business process model and functional requirements	<ul style="list-style-type: none"> Required to oversee and monitor plans, analyze rates, and review benefit packages as Exchange function and provide policies and procedures as part of Exchange approval
Develop and implement multi-year issuer engagement plan	Required to engage with issuers as Exchange function and provide description and approach as part of Exchange approval <ul style="list-style-type: none"> Outreach and education Helpline, TA, training
Develop QHP procurement strategy addressing key policy issues: <ul style="list-style-type: none"> Mandated carrier participation Service areas Standardized benefits Limited product offerings Limited network products 	<i>These decisions will have an impact on and should be closely coordinated with private market reform decisions. In states pursuing a BHP and states with significant Medicaid managed care penetration, considerations should be given to coordinating procurement strategies across programs</i>
Develop quality rating plan including process for carrier data	Required as part of Exchange approval

MILESTONES	COMMENTS
collection and analysis	
Issue QHP application/RFP	
Draft model QHP contract	
Consumer Assistance	
Define Navigator criteria and selection process and issue Navigator application or RFP	Required to establish a Navigator program and provide description of eligible entities, implementation plan, and funding strategy as part of Exchange approval
Define consumer assistance business process model and functional requirements <ul style="list-style-type: none"> • Call center • Web • Mail • Walk-in 	Required to establish consumer assistance mechanisms and provide description of approach and implementation plans as part of Exchange approval
Develop eligibility appeal process	Required to provide as Exchange function and describe process and capacity as part of Exchange approval
Financial Management	
Define and document Exchange fraud, waste and abuse prevention procedures	Required to provide policies and procedures as part of Exchange approval
Determine whether Exchange will provide individual premium billing functionality	System design implications
Define financial management business process model and functional requirements	Required to describe financial management plan and financial systems IT plan as part of Exchange approval
Refine and update Exchange sustainability plan	Required to provide description of sustainability approach as part of Exchange approval
Determine: (i) whether state will run a risk adjustment program or have HHS do it; and, (ii) what role state will play in collecting data and administering either a federal or state risk adjustment model	Required to provide decision and policies and procedures as part of Exchange approval
Determine whether state will establish or contract with a not-for-profit reinsurance entity	Required to provide decision and policies and procedures as part of Exchange approval
SHOP-Specific Functions	
Define eligibility business process model and functional requirements for employee/employers	Required to describe process as part of Exchange approval
Define enrollment business process model and functional requirements for SHOP <ul style="list-style-type: none"> • Rolling enrollment • Special enrollment periods 	Required to describe process as part of Exchange approval
Define role of SHOP in premium billing	Required to describe role as part of Exchange approval
Define plan management business process model and functional requirements for SHOP (variations from individual Exchange include: SHOP certification requirements and ensuring uniformity in timing of rate changes)	Required to describe process as part of Exchange approval
System Design and Vendor Procurement	
Complete initial system design work for all Exchange core business functions:	<ul style="list-style-type: none"> • Eligibility <ul style="list-style-type: none"> ○ Individual mandate exemptions

MILESTONES	COMMENTS
<ul style="list-style-type: none"> Complete initial technical design Begin system configuration and development 	<ul style="list-style-type: none"> Medicaid MAGI IAP income verification Re-determination Appeals Enrollment Plan Management Customer Service Financial Management
Determine Early Innovator/Enroll UX/other state system components appropriate for reuse	
Develop procurement strategy based on Exchange operational model	
Develop and issue RFPs for system vendors consistent with procurement strategy	
PRIVATE INSURANCE	
Goals: Implement ACA-mandated insurance market reforms. Make decisions with regard to discretionary reforms in the individual and small group insurance markets. Define essential health benefits package.	
Review reference plans and develop state Essential Health Benefit	<ul style="list-style-type: none"> Required to define and select QHPs Required to define Medicaid benchmark benefit <p><i>These decisions will have an impact on and should be closely coordinated with Medicaid, QHP strategy and procurement decisions</i></p>
Refine and expand insurance market and Exchange impact research and modeling	<p>Specific analysis may include:</p> <ul style="list-style-type: none"> Size of individual and small group market Take-up rates and anticipated premiums Market risk profiles (risk characteristics) Distribution of rate impacts
Identify nature and timing of statutory and regulatory modifications needed to effectuate insurance market changes	
Identify areas of state flexibility, assess options, and make policy decisions	<ul style="list-style-type: none"> Small group rules: <ul style="list-style-type: none"> Counting of employees Groups of 1 <p><i>These decisions will have an impact on and should be closely coordinated with QHP strategy and procurement decisions</i></p>
Determine whether to merge individual and small group markets	<p><i>These decisions will have an impact on and should be closely coordinated with QHP strategy and procurement decisions</i></p>
Individual Market	
Develop transition strategy for PCIP and other public programs	<p>Required to provide PCIP transition plan as part of Exchange approval</p>
Develop strategy to implement guaranteed issue and rate bands	<ul style="list-style-type: none"> Rating Areas 3:1 Rate Band or state Specific Standard
Develop strategy to minimize adverse selection	<ul style="list-style-type: none"> Level playing field issues Level of alignment for rules inside and outside the Exchange Insurer participation standards
Small Group Market	
Define level of employee choice	<ul style="list-style-type: none"> Implement employer-selected level of

MILESTONES	COMMENTS
	coverage <ul style="list-style-type: none"> Consider whether to use a “pick a plan” model and/or to allow broader forms of employee choice on all benefit levels
Determine whether state will define small group as 50 or 100 for SHOP participation in 2014	<ul style="list-style-type: none"> Consider level playing field issues Required to provide decision as part of Exchange approval
Identify self insurance market dynamics and decide on whether to impose ban or other limits	

MEDICAID	
Goals: Prepare for implementation of Medicaid expansion and modernized eligibility systems.	
Eligibility	
Identify areas of state flexibility, assess options, and make policy decisions	<ul style="list-style-type: none"> 12 months continuous eligibility Extension of Medicaid eligibility to month end CHIP waiting periods Point-in-time v. annual income Reasonable compatibility
Crosswalk state laws and regulations with existing statute to identify statutory and regulatory modifications and timing needed to effectuate eligibility policy changes: <ul style="list-style-type: none"> MAGI standards and coverage levels Eligibility requirements 	
Secure statutory and regulatory authority necessary to implement changes to eligibility standards and procedures	
Develop transition strategy for populations > 133% FPL	<ul style="list-style-type: none"> Interdependencies on statute, regulation and systems Implications for state programs
Develop transition strategy for populations < 133% FPL	May include other 1115 waiver populations, e.g. HIV, mental health
Develop reasonable compatibility standard	
Develop draft consumer notices	
Define business processes and requirements for MAGI and non-MAGI eligibility determinations	To the extent that the state has a separate CHIP program, CHIP will also have to coordinate with Medicaid in implementing MAGI determinations
Develop state plan/waiver amendments	
Enrollment	
Define enrollment business process model and functional requirements	<ul style="list-style-type: none"> Coordination between Exchange and Medicaid Protocol for Medicaid managed care vs. fee for service enrollment
Define Medicaid plan management business process model and functional requirements	<ul style="list-style-type: none"> Coordination between Exchange and Medicaid Communication of information to state

MILESTONES	COMMENTS
	Medicaid Agency and plans
Benefits	
Evaluate Medicaid standard benefit package and EHB and define Medicaid benchmark benefits for new adult group	<ul style="list-style-type: none"> • Interdependency on EHB • Analysis of coverage and fiscal implications and considerations
Identify MCO plan contracting changes	
Develop state plan/waiver amendments	
Program Financing and Funding Opportunities	
Complete FMAP methodology analysis, select methodology and communicate to CMS; define newly eligibles	Required to provide selection to CMS by 12/31/12 under Medicaid NPRM
Develop and submit Advance Planning Documents (APDs)	
Operational	
Define and memorialize in MOUs relationship of Medicaid Agency to Exchange, Insurance Department, other state agencies	MOUs may be provided as evidence of collaboration as part of Exchange approval
Identify necessary state-federal interfaces, define and memorialize MOUs with federal agencies	
Develop Medicaid plan procurement strategy	Evaluate in context of QHP plan procurement strategy
System Design and Vendor Procurement	
Determine approach to Medicaid eligibility system modification, upgrade, or replacement to meet ACA requirements	Evaluate whether state will pursue an integrated Exchange/Medicaid eligibility solution
Develop procurement strategy based on Medicaid eligibility system approach	
Develop and issue RFPs for system vendors consistent with procurement strategy	

Appendix C: Workplan for States

Prepared by: Mannat Health Solutions

Exchange Model Work Plan - 8.8.11

Activity/Sub-Tasks	Decisions/Considerations	Responsibility	Start Date	Completion Date	Deliverables	Source	ACA Section	2010 Q1	2010 Q2	2010 Q3	2010 Q4	2011 Q1	2011 Q2	2011 Q3	2011 Q4	2012 Q1	2012 Q2	2012 Q3	2012 Q4	2013 Q1	2013 Q2	2013 Q3	2013 Q4	2014 Q1	2014 Q2	2014 Q3	2014 Q4	
Background Research																												
Identify key areas of analysis	-Major payer sources -Enrollment projections -Cost of coverage		Sep-10	Dec-10			§§ 1311, 1312, 1313, 1321, 1322, 1323, 1324																					
Develop insurance market analysis research plan			Dec-10	Feb-11	Research plan																							
Complete insurance market analysis and develop recommendations on Exchange structure	- Potential market impacts of future OPM plans and a possible health co-operative - Combined or separate small group and individual markets? - Combined or separate risk pools inside and outside of the Exchange?		Feb-11	Dec-11	Findings and Recommendations	CCIIO Exchange FOA Milestone																						
Stakeholder Consultation																												
Identify key stakeholders	Determine whether Tribes are present in that State that need to be consulted		Jan-11	Feb-11	Group roster		§§ 1311, 1312, 1313, 1321, 1322, 1323, 1324																					
Establish stakeholder consultation group			Feb-11	Jun-11	Group roster	CCIIO Exchange FOA Milestone																						
Schedule stakeholder group meetings			Jun-11	Dec-14	Meeting schedule	CCIIO Exchange FOA Milestone																						
Convene stakeholder groups			Jun-11	Dec-14	Meeting agendas and materials	CCIIO Exchange FOA Milestone																						
Publish stakeholder meeting information/summaries available on public website			Jun-11	Dec-14	Meeting summaries	CCIIO Exchange FOA Milestone																						
Provide stakeholder meeting summaries to HHS			Jun-11	Dec-14	Meeting summaries	CCIIO Exchange FOA Milestone																						
Integrate stakeholder feedback into exchange planning and implementation			Jun-11	Dec-14		CCIIO Exchange FOA Milestone																						
Post stakeholder meeting schedule and summaries on Exchange website			Jun-11	Dec-14		CCIIO Exchange FOA Milestone																						
Legislative and Regulatory Action																												
Review current state authorities regarding Exchange				Jan-11	Legal analysis		§§ 1311, 1312, 1313, 1321, 1322, 1323, 1324																					
Identify legislative timelines				Jan-11	Calendar for Legislative Strategy																							
Secure enactment of necessary legal authority for Governance and Exchange structure establishment				Jun-12	Legislation, Executive Order	CCIIO Exchange FOA Milestone																						
Governance																												
Define Exchange governance model options and facilitate stakeholder discussions and decision-making regarding preferred model				Mar-11	Governance options and recommendations	CCIIO Exchange FOA Milestone																						
Determine governance structure	- State agency, quasi-governmental agency, or non-profit - Structure of governing body - Review of other state governance models			Feb-12		CCIIO Exchange FOA Milestone																						
Determine standards for the Exchange governing body	- Public accountability - Transparency - Prevention of conflicts of interest			Dec-11	Governance structure operating standards	CCIIO Exchange FOA Milestone																						
Establish governance structure				Jun-12	Legislation, Executive Order	CCIIO Exchange FOA Milestone																						
Appoint a governing board (if applicable) and a management team to oversee Exchange operations				Jun-12	Management team job descriptions Governing board roster (if applicable)	CCIIO Exchange FOA Milestone																						

Activity/Sub-Tasks	Decisions/Considerations	Responsibility	Start Date	Completion Date	Deliverables	Source	ACA Section	2010 Q1	2010 Q2	2010 Q3	2010 Q4	2011 Q1	2011 Q2	2011 Q3	2011 Q4	2012 Q1	2012 Q2	2012 Q3	2012 Q4	2013 Q1	2013 Q2	2013 Q3	2013 Q4	2014 Q1	2014 Q2	2014 Q3	2014 Q4	
Develop a formal operating charter or bylaws consistent with State and Federal requirements including public accountability, transparency, and conflicts of interest				Jun-12	Charter or bylaws	CCIIO Exchange FOA Milestone																						
<i>Program Integration</i>																												
Identify relevant state programs and assess programs for integration and alignment opportunities	Programmatic and administrative integration and alignment																											
Perform business process documentation to reflect current state business processes and to include future state process changes to support proposed exchange operational requirements				Jun-11	Medicaid eligibility business process and IT landscape scan, gap analysis, and recommendations	CCIIO Exchange FOA Milestone																						
Initiate communication with State HIT Coordinator, Department of Insurance, State Medicaid Agency, and State Human Services Agency as appropriate; hold regular meetings to develop workplans for collaboration				Dec-14	Inter-agency workgroup meeting schedule, agendas, and meeting summaries	CCIIO Exchange FOA Milestone																						
Execute agreement with State Department of Insurance and State Medicaid agencies				Dec-11	Memorandum of understanding (MOU)	CCIIO Exchange FOA Milestone																						
Collaborate on procurement and development of Exchange and Medicaid IT systems needed to facilitate "no wrong door" for eligibility determinations				Dec-12		CCIIO Exchange FOA Milestone																						
Collaborate on testing of Exchange and other applicable State health subsidy programs (OASHSPs) systems				Dec-13		CCIIO Exchange FOA Milestone																						
Coordinate launch of Exchange open enrollment period with eligibility determinations for Medicaid and OASHSPs				Dec-13		CCIIO Exchange FOA Milestone																						
<i>Exchange IT Systems</i>																												
Conduct a gap analysis of its existing systems and the end goal for systems development by 2014				Mar-11	Gap analysis	CCIIO Exchange FOA Milestone																						
Complete the review of product feasibility, viability, and alignment with Exchange program goals and objectives				Mar-11	Feasibility analysis	CCIIO Exchange FOA Milestone																						
Complete preliminary business requirements and develop an IT architectural and integration framework				Jun-11	Preliminary business requirements	CCIIO Exchange FOA Milestone																						
Complete Systems Development Life Cycle (SDLC) implementation plan				Jun-11	SDLC Plan	CCIIO Exchange FOA Milestone																						
Complete security risk assessment and release plan				Sep-11	Risk assessment and release plan	CCIIO Exchange FOA Milestone																						
Complete preliminary detailed design and system requirements documentation (e.g. technical, design, etc.)				Sep-11		CCIIO Exchange FOA Milestone																						
Finalize IT and integration architecture. Complete final business requirements and interim detailed design and system requirements documentations (e.g. technical, design, etc.)				Dec-11	IT architecture	CCIIO Exchange FOA Milestone																						
Complete final requirements documentation (including System Design, Interface Control, Data Management, & Database Design)				Mar-12	Final requirements documentation	CCIIO Exchange FOA Milestone																						
Complete preliminary and interim development of baseline system and review and ensure compliance with business and design requirements				Jun-12		CCIIO Exchange FOA Milestone																						
Complete final development of baseline system including software, hardware, interfaces, code reviews, and unit-level testing				Sep-12		CCIIO Exchange FOA Milestone																						
Complete testing of all system components including data, interfaces, performance, security, and infrastructure				Dec-12		CCIIO Exchange FOA Milestone																						
Complete final user testing including testing of all interfaces				Sep-13		CCIIO Exchange FOA Milestone																						
Complete pre-operational readiness review to validate readiness of all system components. Complete end-to-end testing and security control validations.				Sep-13		CCIIO Exchange FOA Milestone																						
Prepare and deploy all system components to production environment. Obtain security accreditation.				Sep-13		CCIIO Exchange FOA Milestone																						
Support business operations and maintenance of all systems components.			Jan-14	Dec-14		CCIIO Exchange FOA Milestone																						
<i>Financial Management</i>																												
Adhere to HHS financial monitoring activities carried out under the Exchange grants				Dec-14		CCIIO Exchange FOA Milestone																						

Activity/Sub-Tasks	Decisions/Considerations	Responsibility	Start Date	Completion Date	Deliverables	Source	ACA Section	2010 Q1	2010 Q2	2010 Q3	2010 Q4	2011 Q1	2011 Q2	2011 Q3	2011 Q4	2012 Q1	2012 Q2	2012 Q3	2012 Q4	2013 Q1	2013 Q2	2013 Q3	2013 Q4	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Establish financial management structure and commit to hiring experienced accountants to support financial management activities of the Exchange				Dec-11		CCIIO Exchange FOA Milestone																					
Develop a plan to ensure sufficient resources to support ongoing operations and determine if legislation is necessary to assess user fees				Dec-12	Financial operations plan	CCIIO Exchange FOA Milestone																					
Assess adequacy of accounting and financial reporting systems				Dec-12		CCIIO Exchange FOA Milestone																					
Conduct a third party objective review of all systems of internal control				Dec-12	External audit	CCIIO Exchange FOA Milestone																					
Establish procedures for external audit by a qualified auditing entity to perform an independent external financial audit of the Exchange				Dec-12		CCIIO Exchange FOA Milestone																					
Demonstrate capability to manage the finances of the Exchange soundly, including the ability to publish all expenses receivables, and expenditures consistent with federal requirements				Dec-13		CCIIO Exchange FOA Milestone																					
Post information related to Exchange financial management on its website and identify other means to make financial activities associated with Exchange management transparent				Dec-14		CCIIO Exchange FOA Milestone																					
Submit required annual accounting report to HHS				Dec-14	Accounting reports	CCIIO Exchange FOA Milestone																					
Oversight and Program Integrity																											
							§§ 1311, 1312, 1313, 1321, 1322, 1323, 1324																				
Assess existing fraud, waste and abuse detection policies and systems			Apr-11	Sep-11	Recommendations on financial controls																						
Ensure prevention of fraud, waste and abuse related to expenditure of Exchange Planning and Establishment Grant				Dec-11	Fraud, waste and abuse prevention strategy	CCIIO Exchange FOA Milestone																					
Hire staff for oversight and program integrity functions				Dec-11	Job descriptions	CCIIO Exchange FOA Milestone																					
Establish procedures for external audit by a qualified auditing entity to perform an independent external financial audit of the Exchange				Dec-12		CCIIO Exchange FOA Milestone																					
Research and evaluate best practices in fraud detection procedures			Jan-12	Dec-12	Memorandum of understanding (MOU)																						
Establish fraud detection procedures				Dec-13		CCIIO Exchange FOA Milestone																					
Develop procedures for reporting to HHS on fraud, waste and abuse				Dec-13		CCIIO Exchange FOA Milestone																					
Comply with HHS reporting requirements related to auditing and prevention of fraud, waste, and abuse				Dec-14		CCIIO Exchange FOA Milestone																					
Health Insurance Market Reforms																											
							§§ 1311, 1312, 1313, 1321, 1322, 1323, 1324																				
Track and monitor federal and state legislation, regulations and implementation of health insurance market reforms.			Mar-11	Dec-14																							
<See Private Insurance Work Plan; Incorporate CCIIO Milestones when Available>																											
Providing Assistance to Individuals and Small Businesses, Coverage Appeals, and Complaints																											
							§§ 1311, 1312, 1313, 1321, 1322, 1323, 1324																				
Review and coordinate with existing consumer assistance infrastructure				Mar-11		CCIIO Exchange FOA Milestone																					
Analyze data collected by consumer assistance program				Dec-14	Data report and analysis	CCIIO Exchange FOA Milestone																					
Issue reports to HHS on quarterly basis				Dec-14	Quarterly reports	CCIIO Exchange FOA Milestone																					
Share reports to strengthen qualified health plan accountability and functioning of Exchange on an ongoing basis				Dec-14		CCIIO Exchange FOA Milestone																					
Refine data collection and reporting capacity to: - Support qualified health plan criteria - Use complaint data to strengthen qualified health plan accountability - Establish a process for Exchange to review consumer complaint information by plan				Dec-14		CCIIO Exchange FOA Milestone																					
Identify areas for alignment and integration with existing state infrastructure and Medicaid				Apr-11	Memorandum	CCIIO Exchange FOA Milestone																					
If State chooses to operate functions within the Exchange, establish protocols for appeals of coverage determinations, including review standards and timelines, and provision of help to consumers during the appeals process				Dec-12		CCIIO Exchange FOA Milestone																					

Activity/Sub-Tasks	Decisions/Considerations	Responsibility	Start Date	Completion Date	Deliverables	Source	ACA Section	2010 Q1	2010 Q2	2010 Q3	2010 Q4	2011 Q1	2011 Q2	2011 Q3	2011 Q4	2012 Q1	2012 Q2	2012 Q3	2012 Q4	2013 Q1	2013 Q2	2013 Q3	2013 Q4	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Draft scope of work for building capacity to handle coverage appeals functions				Dec-12	Scope of work	CCIIO Exchange FOA Milestone																					
Report on plans for use of CAP data to strengthen QHP accountability and functioning of Exchanges				Dec-12		CCIIO Exchange FOA Milestone																					
Establish a process for reviewing consumer complaint information collected by the State Consumer Assistance Program when certifying QHPs				Dec-13		CCIIO Exchange FOA Milestone																					
Establish process for referrals to consumer assistance programs if available in another entity				Dec-13	Referral process procedures	CCIIO Exchange FOA Milestone																					
Ensure that any consumer complaint or coverage appeal requests are referred directly to the State program that is designated to process these calls				Dec-14		CCIIO Exchange FOA Milestone																					
Certification, Recertification, and Decertification of QHPs																											
							§§ 1311, 1312, 1313, 1321, 1322, 1323, 1324																				
Review current policy, procedures and administration of state insurance programs			Apr-11	Jun-11	Landscape scan																						
Review QHP certification, recertification, decertification requirements of ACA			Apr-11	Jun-11																							
Identify areas for alignment and integration with existing state infrastructure including insurance and Medicaid programs			Jul-11	Sep-11																							
Collaborate with stakeholders in development of QHP standards and criteria and solicitation of proposals			Sep-11	Dec-11																							
Develop initial Qualified Health Plan (QHP) criteria consistent with federal guidance and state goals				Sep-11	QHP certification criteria	CCIIO Exchange FOA Milestone																					
Develop clear certification policy including timeline for application submission, evaluation, and selection of QHPs				Dec-11		CCIIO Exchange FOA Milestone																					
Engage stakeholders in development of solicitation for proposals				Dec-11		CCIIO Exchange FOA Milestone																					
Develop a strategy and timeline for the integration of staff and IT systems needed to receive applications, evaluate data from insurers, and notify insurers of the result of the solicitations for applications for QHPs				Mar-12		CCIIO Exchange FOA Milestone																					
Make significant progress on the development of an RFP for certification of QHPs				Jun-12		CCIIO Exchange FOA Milestone																					
Draft applicable certification documents (notices/solicitations, applications, agreements, etc.) that will be used in connection with the certification of QHPs. Such documents must address Exchange policies related to the minimum qualifications of a QHP.				Jun-12		CCIIO Exchange FOA Milestone																					
Collect submissions from the solicitation and begin evaluating proposals				Mar-13		CCIIO Exchange FOA Milestone																					
Solicit premium quotes from health plan issuers who responded to the solicitation				Mar-13		CCIIO Exchange FOA Milestone																					
Launch plan management and bid evaluation system to allow upload of QHP bids and other required information				Mar-13		CCIIO Exchange FOA Milestone																					
Complete the certification of QHP, complete and negotiations, and execute contracts to health plan issuers who applied for QHP issuer status				Jun-13		CCIIO Exchange FOA Milestone																					
Issue an announcement on the selection of QHPs to the public				Jun-13		CCIIO Exchange FOA Milestone																					
Before open enrollment or Q3 2013: Conduct plan readiness reviews/activities (e.g., test enrollment interfaces with plans, review member materials, rest financial reconciliation, cross functional implementation sessions with plans, etc.)				Jun-13		CCIIO Exchange FOA Milestone																					
Begin collecting user fees if the Exchange is utilizing this mechanism				Mar-14		CCIIO Exchange FOA Milestone																					
Demonstrate capability for Exchange and/or State Insurance Agency to monitor the practices and conduct, as well as pricing and benefits, of health insurers offering products in the Exchange with regard to products inside and outside the Exchange				Mar-14		CCIIO Exchange FOA Milestone																					
Call Center																											
							§§ 1311, 1312, 1313, 1321, 1322, 1323, 1324																				
Conduct assessment of existing call center capacity in the state	Areas for integration, consolidation			Sep-11	Landscape scan																						
Collaborate with the State Consumer Assistance Program or Health Ombudsman program if applicable, to determine if call center functionalities can be shared				Dec-11		CCIIO Exchange FOA Milestone																					
Complete call center procurement process and select a vendor to operate the call center				Jun-13		CCIIO Exchange FOA Milestone																					

Activity/Sub-Tasks	Decisions/Considerations	Responsibility	Start Date	Completion Date	Deliverables	Source	ACA Section	2010 Q1	2010 Q2	2010 Q3	2010 Q4	2011 Q1	2011 Q2	2011 Q3	2011 Q4	2012 Q1	2012 Q2	2012 Q3	2012 Q4	2013 Q1	2013 Q2	2013 Q3	2013 Q4	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Develop a call center customer service representative protocols and scripts to respond to likely requests from health care consumers to the state				Jun-13		CCIIO Exchange FOA Milestone																					
Develop protocols for accommodating the hearing impaired and those with other disabilities, as well as foreign language and translation services				Jun-13		CCIIO Exchange FOA Milestone																					
Train call center representatives on eligibility verification and enrollment process, and other application areas, so they can facilitate enrollment of individuals over the phone				Jun-13		CCIIO Exchange FOA Milestone																					
Launch the call center functionality and publicize the 1-800-number; post information the Exchange website related to contacting the call center for assistance				Sep-13		CCIIO Exchange FOA Milestone																					
Exchange Website and Premium Tax Credit and Cost-sharing Reduction Calculator																											
Develop systems and program operations requirements: - Requirements related to online comparison of QHPs - Requirements related to online application and selection of QHPs - Premium tax credit and cost-sharing reduction calculator functionality - Requests for assistance - Linkages to other State health subsidy programs, and other health and human service programs as appropriate				Jun-11	Website requirements	CCIIO Exchange FOA Milestone																					
Begin systems development				Mar-12		CCIIO Exchange FOA Milestone																					
Submit content for informational website to HHS for comment				Dec-12	Website content plan	CCIIO Exchange FOA Milestone																					
Launch information website				Mar-13	Website	CCIIO Exchange FOA Milestone																					
Collect and verify plan data for comparison tool				Mar-13		CCIIO Exchange FOA Milestone																					
Develop testing plan				Jul-13	Testing plan																						
Test comparison tool with consumers and stakeholders				Oct-13		CCIIO Exchange FOA Milestone																					
Before open enrollment, launch comparison tool with pricing information but without online enrollment function				Oct-13		CCIIO Exchange FOA Milestone																					
Launch fully functioning comparison tool with pricing information and online enrollment functionality on the first day of open enrollment				Jun-13		CCIIO Exchange FOA Milestone																					
Quality Rating System																											
Incorporate plan quality rating functionality in business process model development for exchange IT systems			Jun-11	Dec-11	Plan Management BPM																						
Utilize HHS federal quality rating system to develop draft contract for QHPs				Dec-11		CCIIO Exchange FOA Milestone																					
Include quality rating functionality in system business requirements for the Exchange website				Dec-12		CCIIO Exchange FOA Milestone																					
Complete system development of quality rating functionality				Dec-12		CCIIO Exchange FOA Milestone																					
Complete testing and validation of quality rating functionality				Dec-12		CCIIO Exchange FOA Milestone																					
Before open enrollment, post quality rating system information on the Exchange website				Dec-13		CCIIO Exchange FOA Milestone																					
Update quality rating information on the Exchange website and for call center representatives				Dec-14		CCIIO Exchange FOA Milestone																					
Navigator Program																											
Convene stakeholders including consumer advocates, providers, current public insurance application assisters and producers to obtain input on Navigator			Oct-11	Dec-11																							
Develop vision and goals for Navigator Program				Dec-11		CCIIO Exchange FOA Milestone																					
Establish criteria for Navigator Program, including scope of work; required skill sets and experience; targeted populations; geographic reach; certification; and oversight				Dec-11		CCIIO Exchange FOA Milestone																					
Develop high level milestones and timeframes for establishment				Dec-11		CCIIO Exchange FOA Milestone																					
Determine targeted organizations in the State that may qualify as Navigators				Dec-12		CCIIO Exchange FOA Milestone																					

Activity/Sub-Tasks	Decisions/Considerations	Responsibility	Start Date	Completion Date	Deliverables	Source	ACA Section	2010 Q1	2010 Q2	2010 Q3	2010 Q4	2011 Q1	2011 Q2	2011 Q3	2011 Q4	2012 Q1	2012 Q2	2012 Q3	2012 Q4	2013 Q1	2013 Q2	2013 Q3	2013 Q4	2014 Q1	2014 Q2	2014 Q3	2014 Q4		
Develop training curriculum and certification process for Navigators				Jun-13		CCIIO Exchange FOA Milestone																							
Determine Navigator grantee organizations and award grants (funded by the Exchange's operational funds)				Jun-13		CCIIO Exchange FOA Milestone																							
Train and certify Navigators				Jun-13		CCIIO Exchange FOA Milestone																							
Begin operations of Navigators (one quarter preceding open enrollment)				Dec-13		CCIIO Exchange FOA Milestone																							
Eligibility Determination of Exchange Participation, Advance Payment of Premium Tax Credits, Cost-sharing Reductions, and Medicaid																													
Agency coordination with Medicaid/CHIP and state agencies to establish infrastructure to support future work				Dec-14		CCIIO Exchange FOA Milestone	§§ 1311, 1312, 1313, 1321, 1322, 1323, 1324																						
Begin coordination with insurance department on exchange planning efforts				Dec-14		CCIIO Exchange FOA Milestone																							
Begin developing requirements, including Exchange and state subsidy program requirements for: integrating enrollment and eligibility transactions; coordinating appeals; coordinating applications and notices; and managing transactions				Jun-11		CCIIO Exchange FOA Milestone																							
Begin and complete system development and prepare for user testing				Dec-12		CCIIO Exchange FOA Milestone																							
Before open enrollment or Q3 2013: Conduct user testing, including full end-to-end integration testing with all other components				Jun-13		CCIIO Exchange FOA Milestone																							
Begin conducting eligibility determinations for state subsidy programs, coordinating business functions, and receiving referrals from state programs for eligibility determinations				Jun-13		CCIIO Exchange FOA Milestone																							
Seamless Eligibility and Enrollment Process with Medicaid and applicable State Health Subsidy Programs																													
Enrollment Process																													
Begin developing requirements for systems and program operations, including: providing customized plan information to individuals based on eligibility and QHP data; submitting enrollment transactions to QHP issuers; receiving acknowledgements of enrollment transactions from QHP issuers; and submitting relevant data to HHS				Jun-11		CCIIO Exchange FOA Milestone	§§ 1311, 1312, 1313, 1321, 1322, 1323, 1324																						
Begin and complete system development and prepare for user testing				Dec-12		CCIIO Exchange FOA Milestone																							
Before open enrollment or Q3 2013: Conduct user testing, including full end-to-end integration testing with all other components				Jun-13		CCIIO Exchange FOA Milestone																							
Begin enrollment into QHPs				Dec-14		CCIIO Exchange FOA Milestone																							
Applications and Notices																													
Review Federal requirements for applications and notices; begin customizing Federal applications and notices as available; begin developing requirements for Exchange-created applications and notices				Dec-11	Gap analysis	CCIIO Exchange FOA Milestone	§§ 1311, 1312, 1313, 1321, 1322, 1323, 1324																						
Engage stakeholders in developing application and notice content that is accessible to consumers of varying education levels and languages.			Jan-12	Dec-12	Recommendations																								
Before open enrollment or Q3 2013: Finalize applications and notices including stakeholder review, testing, translation of content, etc.				Jun-13		CCIIO Exchange FOA Milestone																							
Begin utilizing applications and notices to support eligibility and enrollment process				Dec-14		CCIIO Exchange FOA Milestone																							
Individual Responsibility Determinations																													
Begin developing requirements for systems and program operations, including: accepting requests for exemptions; reviewing and adjudicating requests; and exchanging relevant information with HHS				Jun-11		CCIIO Exchange FOA Milestone	§§ 1311, 1312, 1313, 1321, 1322, 1323, 1324																						
Begin and complete system development and prepare for user testing				Dec-12		CCIIO Exchange FOA Milestone																							

Activity/Sub-Tasks	Decisions/Considerations	Responsibility	Start Date	Completion Date	Deliverables	Source	ACA Section	2010 Q1	2010 Q2	2010 Q3	2010 Q4	2011 Q1	2011 Q2	2011 Q3	2011 Q4	2012 Q1	2012 Q2	2012 Q3	2012 Q4	2013 Q1	2013 Q2	2013 Q3	2013 Q4	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Before open enrollment or Q3 2013: Conduct user testing, including full end-to-end integration testing with all other components				Jun-13		CCIIO Exchange FOA Milestone																					
Begin processing exemptions from individual responsibility requirements and payment and reporting to HHS on outcome determinations				Dec-14		CCIIO Exchange FOA Milestone																					
Administration of Advance Premium Tax Credits and Cost-sharing Reductions																											
Begin developing requirements for systems and program operations, including providing relevant information to QHP issuers and HHS to start, stop, or change the level of premium tax credits and cost sharing reductions				Jun-11		CCIIO Exchange FOA Milestone																					
Begin and complete system development and prepare for user testing				Dec-12		CCIIO Exchange FOA Milestone																					
Before open enrollment or Q3 2013: Conduct user testing, including full end-to-end integration testing with all other components				Jun-13		CCIIO Exchange FOA Milestone																					
Begin submitting tax credit and cost-sharing reduction information to QHP issuers and HHS				Dec-14		CCIIO Exchange FOA Milestone																					
Adjudication of Appeals of Eligibility Determination																											
Begin developing processes and operational plan for appeals function				Sep-12		CCIIO Exchange FOA Milestone																					
Establish resources to handle appeals of eligibility determinations, including training on eligibility requirements				Dec-12		CCIIO Exchange FOA Milestone																					
Before open enrollment or Q3 2013: Initiate communication with HHS on processes for referring appeals to the Federal appeals process				Jun-13		CCIIO Exchange FOA Milestone																					
Begin receiving and adjudicating requests				Dec-14		CCIIO Exchange FOA Milestone																					
Notification and Appeals of Employer Liability																											
Begin developing requirements for systems and program operations, including coordination of employer appeals with appeals of individual eligibility and submission of relevant data to HHS				Jun-11	Business process model	CCIIO Exchange FOA Milestone																					
Begin and complete system development and prepare for user testing				Dec-12		CCIIO Exchange FOA Milestone																					
Before open enrollment or Q3 2013: Conduct user testing, including full end-to-end integration testing with all other components				Jun-13		CCIIO Exchange FOA Milestone																					
Begin notifying employers in coordination with eligibility determinations				Dec-14		CCIIO Exchange FOA Milestone																					
Information Reporting to IRS and Enrollees																											
Begin developing requirements for systems and program operations, including capturing data used in enrollment process, submitting relevant data to HHS for later use in information reporting, and capacity to generate information reports to enrollees				Jun-11	Business process model	CCIIO Exchange FOA Milestone																					
Begin and complete system development and prepare for user testing				Dec-12		CCIIO Exchange FOA Milestone																					
Before open enrollment or Q3 2013: Conduct user testing, including full end-to-end integration testing with all other components				Sep-12		CCIIO Exchange FOA Milestone																					
Confirm that systems are prepared to generate information reports to enrollees				Jun-14		CCIIO Exchange FOA Milestone																					
Outreach and Education																											
Identify consumer outreach needs and determine geographic and demographic-based target areas and vulnerable populations for outreach efforts				Mar-11		CCIIO Exchange FOA Milestone																					
Develop outreach and education plan to include key milestones and contracting strategy				Jun-11		CCIIO Exchange FOA Milestone																					
Distribute outreach and education plan to stakeholders and HHS for input and refinement				Sep-11		CCIIO Exchange FOA Milestone																					

Activity/Sub-Tasks	Decisions/Considerations	Responsibility	Start Date	Completion Date	Deliverables	Source	ACA Section	2010 Q1	2010 Q2	2010 Q3	2010 Q4	2011 Q1	2011 Q2	2011 Q3	2011 Q4	2012 Q1	2012 Q2	2012 Q3	2012 Q4	2013 Q1	2013 Q2	2013 Q3	2013 Q4	2014 Q1	2014 Q2	2014 Q3	2014 Q4	
Develop a toolkit for outreach to include educational materials and information				Dec-12		CCIIO Exchange FOA Milestone																						
Develop performance metrics and evaluation plan				Dec-12		CCIIO Exchange FOA Milestone																						
Design a media strategy and other information dissemination tools				Dec-12		CCIIO Exchange FOA Milestone																						
Submit final outreach and education plan to HHS (including performance metrics and evaluation plan)				Dec-12		CCIIO Exchange FOA Milestone																						
Focus test materials with key stakeholders and consumers and make refinements based on input				Dec-12		CCIIO Exchange FOA Milestone																						
Launch outreach and education strategy				Dec-13		CCIIO Exchange FOA Milestone																						
Refine messaging as necessary				Dec-13		CCIIO Exchange FOA Milestone																						
Risk Adjustment and Transitional Reinsurance																												
<See Private Insurance Work Plan; Incorporate CCIIO Milestones when Available>																												
SHOP Exchange-specific Functions																												
§§ 1311, 1312, 1313, 1321, 1322, 1323, 1324																												
Research the design and approach of the SHOP Exchange and whether it will be merged with the individual market Exchange				Jun-11	SHOP report	CCIIO Exchange FOA Milestone																						
Begin developing requirements for systems and program operations				Jun-11	SHOP report	CCIIO Exchange FOA Milestone																						
Begin and complete system development and prepare for user testing				Dec-12		CCIIO Exchange FOA Milestone																						
Before open enrollment or Q3 2013: Conduct user testing, including full end-to-end integration testing with all other components				Sep-12		CCIIO Exchange FOA Milestone																						
Begin enrolling employees of small employers into QHPs				Dec-14		CCIIO Exchange FOA Milestone																						
Basic Health Program																												
§ 1331																												
Review ACA requirements																												
Review additional CMS guidance																												
Identify target populations																												
Conduct financial analysis																												
Develop benefit package																												
<Incorporate additional tasks when guidance becomes available>																												
Exchange Federal Funding Requirements																												
Prepare and submit quarterly reports to CCIIO			Nov-10	Jan-15	CCIIO Quarterly Reports																							
Prepare Exchange Level 1 Establishment grant application			Jan-11	Dec-11	Level 1 Grant Application																							
Prepare Exchange Level 2 Establishment grant application			Jan-11	Jun-12	Level 2 Grant Application																							
<Further refine timing depending on state application cycle>																												
Develop Exchange Plan and operational readiness assessment			Jan-13	Jan-14	Exchange Plan and Operational Readiness Assessment																							

Medicaid/CHIP Model Work Plan - 8.8.11																											
Activity/Sub-Tasks	Decisions/Considerations	Responsibility	Start Date	Completion Date	Deliverables	Source	ACA Section	2010 Q1	2010 Q2	2010 Q3	2010 Q4	2011 Q1	2011 Q2	2011 Q3	2011 Q4	2012 Q1	2012 Q2	2012 Q3	2012 Q4	2013 Q1	2013 Q2	2013 Q3	2013 Q4	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Medicaid Expansion																											
Analyze ACA requirements					Summary of federal requirements		§2001																				
Review and analyze additional CMS guidance					Updated summary of federal requirements																						
Review current State program eligibility levels and conditions					State landscape scan																						
Identify populations that must be or may be impacted by Medicaid expansion																											
Assess impacts (policy, fiscal, administrative/operational)					Impact analysis																						
Develop benchmark benefit package	Coordination with current Medicaid and Exchange benefit packages				Benchmark benefit package design																						
Identify necessary policy changes (state law, regulations, administrative guidance)																											
Secure necessary policy changes																											
Identify necessary operational changes																											
Secure necessary operational changes																											
Identify necessary systems changes to shift to MAGI																											
Secure necessary systems changes	Coordination with the Exchange																										
Develop State Plan Amendment				Sep-13	State Plan Amendment																						
Submit State Plan Amendment to CMS				Oct-13																							
Secure State Plan Amendment approval from CMS				Dec-13																							
Develop PAPD/IAPD to cost allocate with Exchange																											
Submit PAPD/IAPD																											
Secure PAPD/IAPD approval from CMS																											
Conduct outreach to stakeholders	Constituencies include: Patients, providers, plans			Nov-13																							
Implement provision				Jan-14																							
Modified Adjusted Gross Income																											
Analyze ACA requirements					Summary of federal requirements		§2002																				
Review and analyze additional CMS guidance					Updated summary of federal requirements																						
Catalogue current State program eligibility categories					State landscape scan																						
Identify which populations are impacted by MAGI					State landscape scan																						
Review current State program income eligibility methodologies					State landscape scan																						
Assess differences between current income counting methodologies and MAGI					Crosswalk of income counting methodologies between current and future state																						
Identify necessary policy changes (state law, regulations, administrative guidance) to bring current income eligibility methodologies into compliance with MAGI																											
Secure necessary policy changes																											
Identify necessary operational changes to shift to MAGI																											
Secure necessary operational changes	- Coordination with the Exchange - Changes in beneficiary materials - Training for eligibility staff																										
Identify necessary systems changes to shift to MAGI																											
Secure necessary systems changes	Coordination with the Exchange																										
Develop State Plan Amendment				Sep-13	State Plan Amendment																						
Submit State Plan Amendment to CMS				Oct-13																							
Secure State Plan Amendment approval from CMS				Dec-13																							
Conduct outreach to stakeholders	Constituencies include: Patients, providers, plans			Nov-13																							
Implement provision				Jan-14																							
Elimination of the Asset Test																											
Analyze ACA requirements							§2002																				
Review and analyze additional CMS guidance																											
Review current State program eligibility conditions and whether asset test is required																											
If asset test required, determine whether population is impacted by elimination																											

Activity/Sub-Tasks	Decisions/Considerations	Responsibility	Start Date	Completion Date	Deliverables	Source	ACA Section	2010 Q1	2010 Q2	2010 Q3	2010 Q4	2011 Q1	2011 Q2	2011 Q3	2011 Q4	2012 Q1	2012 Q2	2012 Q3	2012 Q4	2013 Q1	2013 Q2	2013 Q3	2013 Q4	2014 Q1	2014 Q2	2014 Q3	2014 Q4	
Identify necessary policy changes (state law, regulations, administrative guidance) to eliminate asset test for applicable populations																												
Secure necessary policy changes																												
Identify necessary operational changes to eliminate asset test for applicable populations	Application changes																											
Secure necessary operational changes																												
Identify necessary systems changes to eliminate asset test for applicable populations																												
Secure necessary systems changes																												
Develop State Plan Amendment				Sep-13	State Plan Amendment																							
Submit State Plan Amendment to CMS				Oct-13																								
Secure State Plan Amendment from CMS				Dec-13																								
Conduct outreach to stakeholders	Constituencies include: Patients, providers, plans			Nov-13																								
Implement provision				Jan-14																								
Foster Children																												
Review ACA requirements							\$2004																					
Review additional CMS guidance																												
Determine whether State will provide presumptive eligibility																												
Identify necessary policy changes (state law, regulations, administrative guidance) to provide Medicaid to former foster children up to age 26																												
Secure necessary policy changes																												
Identify necessary operational changes to provide Medicaid to former foster children up to age 26																												
Secure necessary operational changes																												
Identify necessary systems changes to provide Medicaid to former foster children up to age 26																												
Secure necessary systems changes																												
Develop State Plan Amendment																												
Submit State Plan Amendment to CMS																												
Secure State Plan Amendment from CMS																												
Conduct outreach to stakeholders	Constituencies include: Patients, providers, plans			Nov-13																								
Implement provision				Jan-14																								
Hospice Care																												
Analyze ACA requirements				Mar-10			\$2302																					
Review and analyze additional CMS guidance	SMD Letter 9/9/10			Sep-10																								
Identify necessary policy changes (state law, regulations, administrative guidance) to provide benefit																												
Secure necessary policy changes																												
Identify necessary operational changes																												
Secure necessary operational changes																												
Identify necessary systems changes																												
Secure necessary systems changes																												
Complete revised State Plan Pre-Print																												
Submit revised State Plan Pre-Print																												
Secure State Plan Amendment approval from CMS																												
Conduct outreach to stakeholders	Constituencies include: Patients, providers, plans			Nov-13																								
Implement provision				Jan-14																								
Enhancements for Medicaid Payments for Primary Care																												
Analyze ACA requirements							HCERA §1202																					
Review and analyze additional CMS guidance																												
Identify providers / services impacted																												
Identify necessary policy changes (state law, regulations, administrative guidance) to provide payment enhancement																												
Secure necessary policy changes																												
Identify necessary operational changes to provide payment enhancement																												
Secure necessary operational changes																												

Activity/Sub-Tasks		Decisions/Considerations	Responsibility	Start Date	Completion Date	Deliverables	Source	ACA Section	2010 Q1	2010 Q2	2010 Q3	2010 Q4	2011 Q1	2011 Q2	2011 Q3	2011 Q4	2012 Q1	2012 Q2	2012 Q3	2012 Q4	2013 Q1	2013 Q2	2013 Q3	2013 Q4	2014 Q1	2014 Q2	2014 Q3	2014 Q4	
Identify necessary systems changes to track and provide payment enhancement	- Identification of primary care providers and services required to receive enhancement																												
Secure necessary systems changes																													
Develop State Plan Amendment					Sep-12																								
Submit State Plan Amendment to CMS					Oct-12																								
Secure State Plan Amendment approval from CMS					Dec-12																								
Conduct outreach to stakeholders	Constituencies include: Patients, providers, plans				Nov-12																								
Implement provision					Jan-13																								
CHIP Transition (Should federal CHIP funding not be re-authorized)								\$2101, 10203																					
Analyze ACA requirements																													
Review and analyze additional CMS guidance																													
Project spending for CHIP and identify when allotments will be exhausted					Oct-15																								
Plan for transition of children into Medicaid and/or Exchange coverage					Nov-15																								
Reduced Medicaid DSH Payments								HCERA §1203																					
Analyze ACA requirements																													
Review and analyze additional CMS guidance																													
Determine how state will implement DSH reductions on hospital basis					Jan-13																								
Notify DSH hospitals																													
Identify necessary policy changes (state law, regulations, administrative guidance) to reduce DSH payments																													
Secure necessary policy changes																													
Identify necessary operational changes to reduce DSH payments																													
Secure necessary operational changes																													
Identify necessary systems changes to reduce DSH payments																													
Secure necessary systems changes																													
Implement DSH reductions					Oct-13																								
Payment Adjustment for Health Care-Acquired Conditions								§2702																					
Analyze ACA requirements																													
Review and analyze additional CMS guidance	Final Rule 76 Fed Reg 32816				Jun-11																								
Crosswalk federal health care-acquired conditions with any existing state requirements					Jun-11																								
Identify necessary policy changes (state law, regulations, administrative guidance) to come into compliance					Jul-11																								
Secure necessary policy changes																													
Identify necessary operational changes to come into compliance																													
Secure necessary operational changes																													
Identify necessary systems changes to come into compliance																													
Secure necessary systems changes																													
Develop State Plan Amendment using CMS template					Jan-12																								
Submit State Plan Amendment to CMS					Apr-12																								
Secure State Plan Amendment approval from CMS					Jul-12																								
Health Homes For Enrollees With Chronic Conditions								§2703																					
Analyze ACA requirements																													
Review and analyze additional CMS guidance	SMD Letter 11/16/10				Nov-10																								
Conduct analyses to develop proposal	- Identify population criteria - Identify provider infrastructure - Define services and how health IT will be linked - Identify monitoring approach - Identify quality measures and evaluation approach - Determine payment methodology																												
Conduct financial analysis to identify state's optimal 8 quarter timeframe for enhanced FFP																													

Activity/Sub-Tasks		Decisions/Considerations	Responsibility	Start Date	Completion Date	Deliverables	Source	ACA Section	2010 Q1	2010 Q2	2010 Q3	2010 Q4	2011 Q1	2011 Q2	2011 Q3	2011 Q4	2012 Q1	2012 Q2	2012 Q3	2012 Q4	2013 Q1	2013 Q2	2013 Q3	2013 Q4	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Draft proposal using State Plan Pre-Print and web-based application																												
Implement		Effective 1/1/11																										
Pediatric Accountable Care Organization Demonstration Project								\$2706																				
Analyze ACA requirements																												
Review and analyze additional CMS guidance																												
Conduct policy, operational and financial analyses to determine whether State would like to exercise this option		Effective 1/1/12																										
Demonstration Project to Evaluate Integrated Care Around a								\$2704																				
Analyze ACA requirements																												
Review and analyze additional CMS guidance																												
Conduct policy, operational and financial analyses to determine whether State would like to exercise this option		Effective 1/1/12																										
Home- and Community-Based Services State Plan Option								\$2402																				
Analyze ACA requirements																												
Review and analyze additional CMS guidance																												
Conduct policy, operational and financial analyses to determine whether State would like to exercise this option		Effective 4/1/10																										
Balancing Incentive Payments Program								\$10202(a)																				
Review ACA requirements																												
Review additional CMS guidance																												
Conduct policy, operational and financial analyses to determine whether State would like to exercise this option		Effective 10/1/11																										
Medicaid Money Follows the Person (MFP) Rebalancing								\$2403																				
If current grantee, submit a written request to the CMS Grants Office in the summer of 2011 for continued participation in the MFP grant program		SMD Letter 6/22/10			Jun-11																							
If not current grantee, review grants.gov to determine application opportunities					Through 2015																							
Medicaid Community First Choice Option								\$2401																				
Review ACA requirements																												
Review additional CMS guidance																												
Conduct policy, operational and financial analyses to determine whether State would like to exercise this option		Effective 10/1/11																										
Develop State Plan Amendment using CMS template																												
Submit State Plan Amendment to CMS																												
Secure State Plan Amendment approval from CMS																												
Medicaid Prescription Drug Rebates								\$2501																				
Analyze ACA requirements																												
Review and analyze additional CMS guidance		SMD Letters 4/22/10 and 9/28/10																										
Assess current state practices in providing Medicaid prescription drugs						State Landscape Scan																						
Determine whether State will modify practices to provide prescription drugs through MCOs		Fiscal impacts																										
Identify necessary policy changes (state law, regulations, administrative guidance) to come into compliance																												
Secure necessary policy changes																												
Identify necessary operational changes to come into compliance		Plan contract changes																										
Secure necessary operational changes																												
Identify necessary systems changes to come into compliance																												
Secure necessary systems changes																												
Develop communication strategy with plans						Communications Plan																						
Develop State Plan or Waiver Amendment, as appropriate																												
Submit State Plan or Waiver Amendment to CMS																												
Secure State Plan or Waiver Amendment approval from CMS																												

Private Insurance Model Work Plan - 8.8.11

Activity/Sub-Tasks	Decisions/ Considerations	Responsibility	Start Date	Completion Date	Deliverables	Source	ACA Section	2010 Q1	2010 Q2	2010 Q3	2010 Q4	2011 Q1	2011 Q2	2011 Q3	2011 Q4	2012 Q1	2012 Q2	2012 Q3	2012 Q4	2013 Q1	2013 Q2	2013 Q3	2013 Q4	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Temporary High Risk Pool																											
Notify HHS of intent to establish PCIP or to rely on federal model				Apr-10	Letter of intent		§1101																				
Establish high risk pool				Jun-10																							
Operate high risk pool			Jul-10	Dec-13																							
Consistently monitor federal guidance/policy revisions and incorporate changes, as needed			Jul-10	Jan-14																							
Develop communication strategy to alert eligible/potential enrollees about the program			Jul-10	Dec-13	Communications plan																						
Develop communication strategy for enrollees related to transition to Exchange			Jan-13	Mar-13	Communications plan																						
Notify enrollees of Exchange options			Jun-13	Jun-13	Notices																						
Transition coverage				Jan-14																							
Transitional Reinsurance																											
Analyze ACA requirements					Summary of federal requirements		§1341																				
Review and analyze additional federal guidance					Updated summary of federal requirements																						
Assess current state reinsurance programs, if applicable					State landscape scan																						
Determine whether to establish or contract with one or more applicable reinsurance entities to carry out the program, or to enter into an agreement with one or more other states to provide for a reinsurance entity to carry out such program in all such states.	Will reinsurance be part of Exchange? How will State handle cross-state insurance issuers?			Jan-13																							
Establish a reinsurance entity (or entities) to collect reinsurance contributions from all health plans that participate in the Individual and Small Group market.				Dec-13																							
<Incorporate additional tasks pending federal guidance>																											
Risk Adjustment																											
Analyze ACA requirements					Summary of federal requirements		§1343																				
Review and analyze additional federal guidance					Updated summary of federal requirements																						
Assess current state risk adjustment programs, if applicable					State landscape scan																						
Identify potential data sources for development of risk scores																											
Engage with HHS in consultative process																											
Establish risk adjustment program	Will risk adjustment program be part of the Exchange?																										
<Incorporate additional tasks pending federal guidance>																											
Risk Corridor																											
Analyze ACA requirements					Summary of federal requirements		§1342																				
Review and analyze additional federal guidance					Updated summary of federal requirements																						
Decide on whether state will seek authority to implement state-based program rather than rely on federal program																											
Identify interdependencies with MLR																											
<Incorporate additional tasks pending federal guidance>																											
Premium Rate Review																											
Analyze ACA requirements					Summary of federal requirements		§§1003, 10101(i)																				
Review and analyze additional federal guidance	HHS Final Rule April 2011				Updated summary of federal requirements																						
Assess if state law grants the Insurance Commissioner the necessary powers to review rates/approve/deny rates	Adjust state law, as required				State landscape scan and gap analysis																						
Monitor federal funding announcements	Round 1 grant awards made in August 2010; Round 2 grant awards FOA issued February 2011. Voluntary Letter of Intent to Apply: July 1, 2011 Phase I: Application Due Date: August 15, 2011 Phase II: Application Due Dates: August 15, 2012; August 15, 2013																										
Develop grant application for Cycle I grant			Jun-10	Jul-10																							

Activity/Sub-Tasks	Decisions/ Considerations	Responsibility	Start Date	Completion Date	Deliverables	Source	ACA Section	2010	2010	2010	2010	2011	2011	2011	2011	2012	2012	2012	2012	2013	2013	2013	2013	2014	2014	2014	2014
								Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Submit Cycle I application			Jul-10	Jul-10																							
Adhere to grant requirements			Aug-10	Sep-11																							
<STATE SPECIFIC GRANT-FUNDED ACTIVITIES>		State may insert activities funded under grant																									
Develop grant application(s) for Cycle II grant			Feb-11	Aug-13																							
Submit Cycle II application				Aug-2011; Aug-2012; Aug-2013																							
Adhere to grant requirements																											
<STATE SPECIFIC GRANT-FUNDED ACTIVITIES>		State may insert activities funded under grant																									
Conduct ongoing monitoring of plan premium rates				Jan-14																							
Medical Loss Ratios							§§1001, 10101																				
Review of existing state MLR requirements across markets/products																											
Review federal MLR requirements and impact on individual market (if any) including any pending or future state MLR waivers																											
Review federal supplemental guidance and NAIC model law																											
Establish a system to ensure health insurance plans' compliance with minimum medical loss ratios and associated rebates to consumers	Commercial market rebates in January 2011 based on 2010 plan year			Jan-11																							
Lifetime and Annual Limit Prohibitions							§§ 1001[PHSA § 2711], 10101[a], 1251, HCER A § 2301																				
Analyze ACA requirements related to lifetime limits			Mar-10	Apr-10	Summary of federal requirements																						
Review and analyze additional federal guidance	June 28, 2010 Interim Final Regulations		Jun-10	Jul-10	Updated summary of federal requirements																						
Assess current state requirements against federal requirements			Mar-10	Jul-10	State landscape scan and gap analysis																						
Identify necessary policy changes (state law, regulations, administrative guidance) to come into compliance																											
Review NAIC Model Act (if applicable) and determine whether language will be adapted																											
Secure necessary policy changes					Modified state policies																						
Identify necessary operational changes to come into compliance																											
Secure necessary operational changes																											
Identify necessary systems changes to come into compliance																											
Secure necessary systems changes																											
Develop guidance to plans					Insurance Department guidance																						
Notify plans				Aug-10; Dec-10	Meetings, issuances																						
Enforce lifetime limits prohibition	e.g., monitoring, plan reporting			Sep-10																							
Enforce annual limit prohibition				Jan-14																							
Rescission Prohibition							§§ 1001 [PHSA § 2712], 1251, HCER A § 2301																				
Analyze ACA requirements			Mar-10	Apr-10	Summary of federal requirements																						
Review and analyze additional federal guidance	June 28, 2010 Interim Final Regulations		Jun-10	Jul-10	Updated summary of federal requirements																						
Assess current state requirements against federal requirements			Mar-10	Jul-10	State landscape scan and gap analysis																						
Identify necessary policy changes (state law, regulations, administrative guidance) to come into compliance			Apr-10	Jul-10																							
Review NAIC Model Act (if applicable) and determine whether language will be adapted			Apr-10	Jul-10																							
Secure necessary policy changes			Jul-10	Sep-10	Modified state policies																						
Identify necessary operational changes to come into compliance			Apr-10	Jul-10																							
Secure necessary operational changes			Jul-10	Sep-10																							
Identify necessary systems changes to come into compliance			Apr-10	Jul-10																							

Activity/Sub-Tasks	Decisions/ Considerations	Responsibility	Start Date	Completion Date	Deliverables	Source	ACA Section	2010	2010	2010	2010	2011	2011	2011	2011	2012	2012	2012	2012	2013	2013	2013	2013	2014	2014	2014	2014
								Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Secure necessary systems changes			Jul-10	Sep-10																							
Develop guidance to plans			Jun-10	Aug-10	Insurance Department guidance																						
Notify plans			Aug-10	Aug-10	Meetings, issuances																						
Enforce recission prohibition			Sep-10	Sep-10																							
Preventive Health Services																											
Analyze ACA requirements			Mar-10	Apr-10	Summary of federal requirements		§§ 1001 [PHSA § 2713]																				
Review and analyze additional federal guidance	July 19, 2010 Interim Final Regulations		Jul-10	Jul-10	Updated summary of federal requirements																						
Assess current state requirements against federal requirements			Mar-10	Jul-10	State landscape scan and gap analysis																						
Identify necessary policy changes (state law, regulations, administrative guidance) to come into compliance			Apr-10	Jul-10																							
Review NAIC Model Act (if applicable) and determine whether language will be adapted			Apr-10	Jul-10																							
Secure necessary policy changes			Jul-10	Sep-10	Modified state policies																						
Identify necessary operational changes to come into compliance			Apr-10	Jul-10																							
Secure necessary operational changes			Jul-10	Sep-10																							
Identify necessary systems changes to come into compliance			Apr-10	Jul-10																							
Secure necessary systems changes			Jul-10	Sep-10																							
Develop guidance to plans			Jun-10	Aug-10	Insurance Department guidance																						
Notify plans			Aug-10	Aug-10	Meetings, issuances																						
Enforce provision			Sep-10	Sep-10																							
Dependent Coverage Extension																											
Analyze ACA requirements			Mar-10	Apr-10	Summary of federal requirements		§§ 1001 (PHSA § 2714), 1251, HCER A § 2301																				
Review and analyze additional federal guidance	May 13, 2010 Interim Final Regulations		May-10	Jun-10	Updated summary of federal requirements																						
Assess current state requirements against federal requirements			Mar-10	Jul-10	State landscape scan and gap analysis																						
Identify necessary policy changes (state law, regulations, administrative guidance) to come into compliance			Apr-10	Jul-10																							
Review NAIC Model Act (if applicable) and determine whether language will be adapted			Apr-10	Jul-10																							
Secure necessary policy changes			Jul-10	Sep-10	Modified state policies																						
Identify necessary operational changes to come into compliance			Apr-10	Jul-10																							
Secure necessary operational changes			Jul-10	Sep-10																							
Identify necessary systems changes to come into compliance			Apr-10	Jul-10																							
Secure necessary systems changes			Jul-10	Sep-10																							
Develop guidance to plans			Jun-10	Aug-10	Insurance Department guidance																						
Notify plans			Aug-10	Aug-10	Meetings, issuances																						
Enforce provision			Sep-10	Sep-10																							
Prohibition on Discrimination in Favor of Highly Compensated Individuals																											
Analyze ACA requirements			Mar-10	Apr-10	Summary of federal requirements		§ 1001 [PHSA § 2716], 10101[d]																				
Review and analyze additional federal guidance			May-10	Jun-10	Updated summary of federal requirements																						
Assess current state requirements against federal requirements			Mar-10	Jul-10	State landscape scan and gap analysis																						
Identify necessary policy changes (state law, regulations, administrative guidance) to come into compliance			Apr-10	Jul-10																							
Review NAIC Model Act (if applicable) and determine whether language will be adapted			Apr-10	Jul-10																							
Secure necessary policy changes			Jul-10	Sep-10	Modified state policies																						
Identify necessary operational changes to come into compliance			Apr-10	Jul-10																							
Secure necessary operational changes			Jul-10	Sep-10																							

Activity/Sub-Tasks		Decisions/ Considerations	Responsibility	Start Date	Completion Date	Deliverables	Source	ACA Section	2010 Q1	2010 Q2	2010 Q3	2010 Q4	2011 Q1	2011 Q2	2011 Q3	2011 Q4	2012 Q1	2012 Q2	2012 Q3	2012 Q4	2013 Q1	2013 Q2	2013 Q3	2013 Q4	2014 Q1	2014 Q2	2014 Q3	2014 Q4
	Identify necessary systems changes to come into compliance			Apr-10	Jul-10																							
	Secure necessary systems changes			Jul-10	Sep-10																							
	Develop guidance to plans			Jun-10	Aug-10	Insurance Department guidance																						
	Notify plans			Aug-10	Aug-10	Meetings, issuances																						
	Enforce provision			Sep-10	Sep-10																							
Guaranteed Issue								§ 1201 [PHSA §§ 2702, 2703]																				
	Analyze ACA requirements			Mar-10	Apr-10	Summary of federal requirements																						
	Review and analyze additional federal guidance					Updated summary of federal requirements																						
	Assess current state requirements against federal requirements			Mar-10	Jul-10	State landscape scan and gap analysis																						
	Identify necessary policy changes (state law, regulations, administrative guidance) to come into compliance				Jun-12																							
	Review NAIC Model Act (if applicable) and determine whether language will be adapted				Jun-12																							
	Secure necessary policy changes				Sep-13	Modified state policies																						
	Identify necessary operational changes to come into compliance																											
	Secure necessary operational changes																											
	Identify necessary systems changes to come into compliance				Jun-12																							
	Secure necessary systems changes				Sep-13																							
	Develop guidance to plans			Sep-13	Nov-13	Insurance Department guidance																						
	Notify plans			Dec-13	Dec-13	Meetings, issuances																						
	Enforce provision			Jan-14	Jan-14																							
Waiting Periods								§ 1201 [PHSA § 2708], § 1251, HCER A § 2301																				
	Analyze ACA requirements			Mar-10	Apr-10	Summary of federal requirements																						
	Review and analyze additional federal guidance					Updated summary of federal requirements																						
	Assess current state requirements against federal requirements			Mar-10	Jul-10	State landscape scan and gap analysis																						
	Identify necessary policy changes (state law, regulations, administrative guidance) to come into compliance				Jun-12																							
	Review NAIC Model Act (if applicable) and determine whether language will be adapted				Jun-12																							
	Secure necessary policy changes				Sep-13	Modified state policies																						
	Identify necessary operational changes to come into compliance																											
	Secure necessary operational changes																											
	Identify necessary systems changes to come into compliance				Jun-12																							
	Secure necessary systems changes				Sep-13																							
	Develop guidance to plans			Sep-13	Nov-13	Insurance Department guidance																						
	Notify plans			Dec-13	Dec-13	Meetings, issuances																						
	Enforce provision			Jan-14	Jan-14																							
Coverage of Emergency Services								§ 2719A																				
	Analyze ACA requirements			Mar-10	Apr-10	Summary of federal requirements																						
	Review and analyze additional federal guidance			May-10	Jun-10	Updated summary of federal requirements																						
	Assess current state requirements against federal requirements			Mar-10	Jul-10	State landscape scan and gap analysis																						
	Identify necessary policy changes (state law, regulations, administrative guidance) to come into compliance			Apr-10	Jul-10																							
	Review NAIC Model Act (if applicable) and determine whether language will be adapted			Apr-10	Jul-10																							
	Secure necessary policy changes			Jul-10	Sep-10	Modified state policies																						
	Identify necessary operational changes to come into compliance			Apr-10	Jul-10																							
	Secure necessary operational changes			Jul-10	Sep-10																							

Activity/Sub-Tasks		Decisions/ Considerations	Responsibility	Start Date	Completion Date	Deliverables	Source	ACA Section	2010 Q1	2010 Q2	2010 Q3	2010 Q4	2011 Q1	2011 Q2	2011 Q3	2011 Q4	2012 Q1	2012 Q2	2012 Q3	2012 Q4	2013 Q1	2013 Q2	2013 Q3	2013 Q4	2014 Q1	2014 Q2	2014 Q3	2014 Q4	
	Identify necessary systems changes to come into compliance			Apr-10	Jul-10																								
	Secure necessary systems changes			Jul-10	Sep-10																								
	Develop guidance to plans			Jun-10	Aug-10	Insurance Department guidance																							
	Notify plans			Aug-10	Aug-10	Meetings, issuances																							
	Enforce provision			Sep-10	Sep-10																								
Access to Pediatric Care								§ 2719A																					
	Analyze ACA requirements			Mar-10	Apr-10	Summary of federal requirements																							
	Review and analyze additional federal guidance			May-10	Jun-10	Updated summary of federal requirements																							
	Assess current state requirements against federal requirements			Mar-10	Jul-10	State landscape scan and gap analysis																							
	Identify necessary policy changes (state law, regulations, administrative guidance) to come into compliance			Apr-10	Jul-10																								
	Review NAIC Model Act (if applicable) and determine whether language will be adapted			Apr-10	Jul-10																								
	Secure necessary policy changes			Jul-10	Sep-10	Modified state policies																							
	Identify necessary operational changes to come into compliance			Apr-10	Jul-10																								
	Secure necessary operational changes			Jul-10	Sep-10																								
	Identify necessary systems changes to come into compliance			Apr-10	Jul-10																								
	Secure necessary systems changes			Jul-10	Sep-10																								
	Develop guidance to plans			Jun-10	Aug-10	Insurance Department guidance																							
	Notify plans			Aug-10	Aug-10	Meetings, issuances																							
	Enforce provision			Sep-10	Sep-10																								
Patient Access to Obstetrical and Gynecological Care								§ 2719A																					
	Analyze ACA requirements			Mar-10	Apr-10	Summary of federal requirements																							
	Review and analyze additional federal guidance			May-10	Jun-10	Updated summary of federal requirements																							
	Assess current state requirements against federal requirements			Mar-10	Jul-10	State landscape scan and gap analysis																							
	Identify necessary policy changes (state law, regulations, administrative guidance) to come into compliance			Apr-10	Jul-10																								
	Review NAIC Model Act (if applicable) and determine whether language will be adapted			Apr-10	Jul-10																								
	Secure necessary policy changes			Jul-10	Sep-10	Modified state policies																							
	Identify necessary operational changes to come into compliance			Apr-10	Jul-10																								
	Secure necessary operational changes			Jul-10	Sep-10																								
	Identify necessary systems changes to come into compliance			Apr-10	Jul-10																								
	Secure necessary systems changes			Jul-10	Sep-10																								
	Develop guidance to plans			Jun-10	Aug-10	Insurance Department guidance																							
	Notify plans			Aug-10	Aug-10	Meetings, issuances																							
	Enforce provision			Sep-10	Sep-10																								
Standardized Format for Benefits and Coverage Summaries								§ 2715, § 1251, HCER A § 2301																					
	Analyze ACA requirements					Summary of federal requirements																							
	Review and analyze additional federal guidance					Updated summary of federal requirements																							
	Assess current state requirements against federal requirements					State landscape scan and gap analysis																							
	Identify necessary policy changes (state law, regulations, administrative guidance) to come into compliance																												
	Review NAIC Model Act (if applicable) and determine whether language will be adapted																												
	Secure necessary policy changes					Modified state policies																							
	Identify necessary operational changes to come into compliance																												
	Secure necessary operational changes																												
	Identify necessary systems changes to come into compliance																												
	Secure necessary systems changes																												

Activity/Sub-Tasks	Decisions/ Considerations	Responsibility	Start Date	Completion Date	Deliverables	Source	ACA Section	2010 Q1	2010 Q2	2010 Q3	2010 Q4	2011 Q1	2011 Q2	2011 Q3	2011 Q4	2012 Q1	2012 Q2	2012 Q3	2012 Q4	2013 Q1	2013 Q2	2013 Q3	2013 Q4	2014 Q1	2014 Q2	2014 Q3	2014 Q4
Develop guidance to plans					Insurance Department guidance																						
Notify plans					Meetings, issuances																						
Enforce provision																											
<i>Community Rating</i>																											
Analyze ACA requirements					Summary of federal requirements		§2701																				
Review and analyze additional federal guidance					Updated summary of federal requirements																						
Assess current state requirements against federal requirements					State landscape scan and gap analysis																						
Identify necessary policy changes (state law, regulations, administrative guidance) to come into compliance																											
Review NAIC Model Act (if applicable) and determine whether language will be adapted																											
Secure necessary policy changes					Modified state policies																						
Identify necessary operational changes to come into compliance																											
Secure necessary operational changes																											
Identify necessary systems changes to come into compliance																											
Secure necessary systems changes																											
Develop guidance to plans					Insurance Department guidance																						
Notify plans					Meetings, issuances																						
Enforce provision																											

Appendix D: Insurance Work Plan Template

Prepared by: Georgetown University Health Policy Institute, *Mila Kofman, J.D.*, *Katie Dunton, J.D., M.P.A*

Insurance Work Plan Template						
Decisions and Considerations		Start Date	End Date	Deliverables	Lead	Notes
Activity 1: ACA Standards and Authority Required for Implementation						
	Identify and review which state laws must be modified to comply with federal law (see attached ACA self-audit tool: “ACA Provisions within Traditional Authority of Insurance Department” 2010 through 2014 and beyond provisions)					
	Identify provisions that <u>must</u> be changed legislatively (if not changed, high risk of federal direct enforcement and a finding that the state has not enacted necessary market reforms)					
	2010					
	2011					
	2012					
	2013					
	2014					
	Identify provisions that <u>should</u> be changed legislatively (if not changed, likely to be able to use existing state authority to enforce but there is risk of a challenge to state enforcement by a carrier or other stakeholder)					
	Draft “must-have” legislation to bring state into compliance with federal law					
	Draft “should-have” legislation to bring state into compliance with federal law					
	CCIIO review of legislative language					
	Enact statutory changes					
	Identify provisions that could be changed through regulation					
	2010					
	2011					

Insurance Work Plan Template						
Decisions and Considerations		Start Date	End Date	Deliverables	Lead	Notes
	2012					
	2013					
	2014					
	Draft/update and issue regulations to bring state into compliance with federal law (or via bulletins)					
Activity 2: ACA Standards Oversight and Plan Compliance						
	Identify and analyze current regulatory enforcement and oversight authority including limitations on existing authority, form and rate reviews, market conduct exams, consumer services/complaint investigations, etc.					
	Determine whether policy form and/or marketing material review is necessary for implementation and enforcement					
	Update forms checklists as necessary					
	Update consumer complaint database, investigations process as necessary					
	Identify alternative compliance authority and develop a strategy if changes to state laws are not enacted					
	Review state implementation/enforcement of 9/23/10 changes on private health insurance policies in individual and group, grandfathered and nongrandfathered policies					
	Review state external and internal review laws for ACA consistency based on final federal regulations					
	Obtain feedback from CCIO on state-based enforcement					
	Develop a state-specific plan for enhanced regulatory rate oversight authority					
	Compare current state benefit mandates with federal laws, regulations, and the essential health benefit packages and identify differences (for rate review)					
	Identify/analyze benchmark plans – largest plan by enrollment of 3 largest small group, state employee health benefit plans, FEHBP, HMO					
	Transition period to coordinate state mandates					

Insurance Work Plan Template						
Decisions and Considerations		Start Date	End Date	Deliverables	Lead	Notes
with selected benchmark (2014-2015)						
Develop strategy for insurers' preparedness for full implementation of 2010 and future ACA standards						
Activity 3: Rate Review Policy Decisions and Oversight (authority, AG role, hearings, transparency, etc.)						
Review state's rate review authority (all markets) for consistency with federal HHS rate oversight regulations (individual, small group, and association markets – in and out of state)						
Review state laws for transparency, confidentiality, and proprietary restrictions on rate filings to ensure consistency with federal regulations						
Determine if state-specific threshold is needed						
Notify and work with HHS on state-specific threshold						
Work with CCIIO to determine state-specific options for rate review if necessary						
Develop a state-specific plan based in federal determination and state goals						
Determine if statutory authority needs to be expanded						
Obtain necessary statutory authority						
Determine if guidance to carriers through regulations/bulletins is necessary						
Promulgate regulations/bulletins						
Begin implementation of enhanced state approach (2011 and 2012 filings)						
Ensure initial and on-going compliance and consistency with federal regulations (public input, public information on rate filings, information when necessary to CCIIO, etc.)						
Review federal MLR requirements and impact on individual market (if any) including any pending or future state MLR waivers						
Obtain necessary statutory authority for MLR						

Insurance Work Plan Template						
Decisions and Considerations		Start Date	End Date	Deliverables	Lead	Notes
	Implement statutory changes if necessary through regulations/bulletins					
	Review federal MLR supplemental NAIC data filings for individual, small group, and large group markets					
	Decide if Division of Insurance will enforce MLR requirements					
	If applicable, establish a system to ensure health insurance plans' medical loss ratios and associated rebates to consumers					
	Establish a process of coordination with rate review process if necessary					
	Develop a plan to adjust risk for qualified plans in the individual and small group markets inside and outside the Exchange consistent with federal laws and regulations					
	Implement necessary risk adjustment mechanism, risk corridors, and temporary reinsurance (if allowed by CCIO)					
	Collect and report risk adjustment data					
	Decide what if any activities are necessary for working with the NAIC on risk adjustment mechanism, reinsurance, etc.					
Activity 4: Data Submission to HHS						
	Identify and ensure all necessary data submissions to HHS (e.g., grants, carrier data submissions, etc.) (Can SERFF systems be used?)					
Activity 5: Insurance Market Policy Decisions						
	Establish an internal process for discussing policy questions – including where state law is stronger					
	Discuss and make recommendations regarding transition/phase-in individual and small group rating laws – internally deferred.					
	Identify stakeholder process to discuss possible transition plan					

Insurance Work Plan Template						
Decisions and Considerations		Start Date	End Date	Deliverables	Lead	Notes
	Analyze current consumer protection standards (Activity 1) - decide whether to change state consumer protection standards that are stronger/weaker than ACA					
	Identify market issues, e.g. MEWAs, association plans, captive health insurers and decide how to transition to 2014					
	Decide what additional data is necessary to make policy decisions (e.g., federal grants to study merging markets and impact on premiums)					
	Consider whether to study the impact of ACA (including AV minimums and federal subsidies) to identify state-based opportunities					
	Review whether new licensing mechanisms are necessary for risk-bearing entities (ACO, Medicaid Managed Care with commercial populations, CO-OPs)					
	Review CO-OP law and policy related to federal standards					
	Decide whether to keep separate or merge the individual and small group markets 2014					
	Consider and decide issues around health care choice compacts, regional exchanges, etc.					
	Decide whether to extend the state's small group market to groups of 51-100 between 2014 and 2016					
	Identify stakeholder process for policy decisions input when appropriate					
Activity 6: Licensing Framework						
	If new licensing is necessary, identify and establish a process(es) for risk-bearing arrangements (ACO, Medicaid Managed Care with commercial populations after 2014, CO-OPs)					
	Develop an implementation plan for roll out, work with stakeholders, work with sister state agencies, etc.					
	Examine existing oversight and make decisions whether existing tools must be modified to encompass newly licensed arrangements					

Insurance Work Plan Template						
Decisions and Considerations		Start Date	End Date	Deliverables	Lead	Notes
	Add to financial and/or market conduct examination schedules if applicable					
	Legal analysis re: enrollment/Exchange as producer					
Activity 7: Determine Rules/Policies/Oversight Inside/Outside Exchange (See Exchange Functions Checklist)						
	Identify exchange-related questions, issues, policy decisions					
	Decide Insurance's primary, secondary, and no responsibility areas with exchange functions					
	Determine if statutory changes or regulatory guidance is necessary					
	Promulgate necessary regulations, bulletins, etc.					
	Update agency agreements as necessary					
	Make decisions about statutory changes (which agency takes the lead)					
	Determine if systems changes are necessary, e.g. call center at Insurance					
	Decide whether insurance regulators will continue to have authority over all health insurance products, including policies sold through exchanges					
	Decide whether insurance regulators will have any level of authority over entities involved with Exchange (carriers, producers, navigators, CO-OPs)					
	Functions areas to address/consider:					
	Standards and oversight for qualified health plans					
	Standards and oversight for navigators (training, licensing/registration, etc.)					
	Analyze producer licensing to determine navigator preemption issues					
	Rate review for Exchange products					
	Form review for Exchange products					
	Standards for appeals process for Exchange products					

Insurance Work Plan Template						
Decisions and Considerations		Start Date	End Date	Deliverables	Lead	Notes
	Other jurisdiction issues over Exchange products					
	OPM multi-state plans regulations and changes to review/oversight					
	Review federal regulations and make necessary state adjustments					
	Identify and review which state laws and regulations must be modified					
	Enact state laws to make required changes					
	Promulgate regulations to make required changes					
	Analyze possible sources of adverse selection in the Exchange					
	Develop and adopt strategies designed to mitigate that risk					
	Analyze possible sources of adverse selection between the Exchange and outside market					
	Develop and adopt strategies designed to mitigate that risk					
Activity 8: Outreach and Education Plan						
	Examine current outreach activities and identify stakeholder/areas for enhanced activities					
	Create outreach and education strategy					
	Assess initial outreach and enhance/change as necessary					
Activity 9: Internal Staff Processes						
	Create internal implementation team					
	Identify on-going activities, responsibilities, loop-back with Commissioner					
	Analyze resources and determine if resource realignment or other reorg is necessary					
	Succession planning for future retirements, staff changes, etc.					
	Identify appropriate staff for Exchange activities including participation in workgroups					

Insurance Work Plan Template						
Decisions and Considerations		Start Date	End Date	Deliverables	Lead	Notes
	Develop and implement internal communications to update implementation team, discuss technical issues, and discuss policy questions					
[Activity 10: Written agreements with Exchange]						
	{Insert tasks from agreements as needed}					

Appendix E: ACA Provisions Within Traditional Authority of Insurance Department

Prepared by: Georgetown University Health Policy Institute, *Mila Kofman, J.D., Katie Dunton, J.D., M.P.A*

Effective 2010						
Section		Applicability				State Action
		Group	Group Grandfather *	Individual	Individual Grandfather *	
PHSA §2704	No pre-ex for children under 19	✓	✓	✓		
PHSA §2711	No lifetime limits	✓	✓	✓	✓	
PHSA §2711 + Guidance	Limited annual limits	✓	✓	✓		
PHSA §2712 + Regs	Rescissions prohibited except in cases of fraud or intentional misrepresentation	✓	✓	✓	✓	
PHSA §2713 + Regs	Preventive care ¹ , no cost-sharing	✓		✓		
PHSA §2714 + Regs	Dependent coverage up to age 26 (exception for dependents with job-based coverage before 2014)	✓	✓	✓	✓	
PHSA §2715A	Additional information relating to transparency in coverage to be submitted by carriers and made available to the public (further guidance to be issued)	✓		✓		
PHSA §2716	Prohibition on discrimination based on salary	✓				
PHSA §2719 + Regs	Enhanced external appeals and internal review of coverage determinations and claims	✓		✓		
PHSA §2719A + Regs	Enhanced access to primary care, pediatricians, ER, OBGYN	✓		✓		
42 USC 18011 (PPACA §1251) + Regs	*“Grandfathered plan” defined in Sec. 1251. Guidance and clarification has been issued.					

¹ HRSA women’s preventive care required to be covered for plan or policy years starting on or after Aug. 1, 2012 (final rule released Aug. 11, 2011).

Regulations and guidance are available at: <http://www.healthcare.gov/center/regulations/index.html>

Effective 2011						
Section		Applicability				State Action
		Group	Group Grandfather*	Individual	Individual Grandfather*	
PHSA §2718 + Regs	MLR at 85% for <u>large group</u>	✓	✓	n/a	n/a	
PHSA §2718 + Regs	MLR at 80% for <u>small group</u> and individual	✓	✓	✓	✓	
PHSA §2719 + Regs	Internal appeals	✓		✓		
PHSA §2719 + Regs	External review process	✓		✓		
PHSA §2794 + Regs ²	Rate review – “unreasonable” rate increase (grants available)	✓		✓		

² Limited to individual and small group markets.

Effective 2012						
Section		Applicability				State Action
		Group	Group Grandfather*	Individual	Individual Grandfather*	
PHSA §2715	Uniform explanation of coverage documents and standardized definitions	✓	✓ ⁴	✓	✓	
PHSA §2718	MLR refunds: state can enforce - review supplemental annual statement ³	✓	✓	✓	✓	

³ Compare with rate filings for potential errors.

⁴ Reg issued Aug. 22, 2011 - §2715 is applicable to both grandfathered and nongrandfathered plans.

Effective 2013						
Section		Applicability				State Action
		Group	Group Grandfather*	Individual	Individual Grandfather*	
42 USC §18021 (PPACA)	CO-OPs – deadline for federal \$\$, licensed by state - Enabling legislation/transitional	✓	n/a	✓	n/a	

§1322) + Regs	rules depending on state law					
42 USC §18021 (PPACA §1302) + Regs	Essential benefits – deadline for establishment by HHS ⁵	✓ ⁶		✓		

⁵ Compare to existing state law.

⁶ Large group when included in exchange.

Effective 2014 and Beyond						
Section		Applicability				State Action
		Group	Group Grandfather	Individual	Individual Grandfather	
PHSA §2719 + Regs	External review – NAIC Model	✓		✓		
PHSA §2701	Community rating with limits on rate factors (states can have tighter limits) <ul style="list-style-type: none"> • Age 3:1 • Tobacco 1.5:1 • Geographic rating area (established by State) • Prohibit: gender, health, group size (small group market), industry • Allowed: geography and family composition 	✓		✓		
PHSA §2702	Guaranteed availability of coverage	✓	+	✓	+	⁺ HIPAA requirements apply
PHSA §2703	Reaffirms HIPAA guaranteed renewability of coverage	✓	+	✓	+	
PHSA §2704	No pre-ex for all	✓	✓	✓		
PHSA §2705	Prohibition on discrimination based on health status (expands on HIPAA protections by adding wellness program provisions and extends nondiscrimination protections to individual market)	✓	+	✓		

Effective 2014 and Beyond						
Section		Applicability				State Action
		Group	Group Grandfather	Individual	Individual Grandfather	
PHSA §2706	Nondiscrimination in health care – participation by credentialed providers	✓		✓		
PHSA §2707	Small group and individual plans must include essential benefits package (includes large group markets within Exchange)	✓		✓		
PHSA §2708	Prohibition on excessive waiting periods	✓	✓			
PHSA §2709	Coverage for approved clinical trials	✓		✓		
42 USC §18061 (PPACA §1341) + Regs	Transitional reinsurance program for (plan years beginning 2014 through 2016)	✓ ⁷		✓ ⁷		
42 USC §18062 (PPACA §1342) + Regs	Establishment of risk corridors	✓ QHPs		✓ QHPs		
42 USC §18063 (PPACA §1343) + Regs	Risk Adjustment	✓ ⁸		✓ ⁸		
42 USC §18012 (PPACA §1252) + Regs	Rating reforms must apply uniformly to all health insurance issuers in each market	✓		✓		
42 USC §18022 (PPACA §1302) + Regs	Plans required to offer Essential Health Benefits ⁹	✓		✓		
42 USC §18024 (PPACA	Small group market size – State may define as 1-50 employees until 2016, then 1-100					

Effective 2014 and Beyond						
Section		Applicability				State Action
		Group	Group Grandfather	Individual	Individual Grandfather	
§1304) + Regs						
42 USC §18024 (PPACA §1304) + Regs	Individual and small group markets may be merged, but may not include grandfathered pools	✓		✓		
42 USC §18024 (PPACA §1304) + Regs	Carriers must combine all non-grandfathered plans into single risk pool within a market	✓		✓		
42 USC §18051 (PPACA §1331) + Regs	Basic Health Programs ¹⁰ for low-income individuals not eligible for Medicaid			✓		

⁷ All issuers & TPAs contribute funding, individual market plans (in and out of Exchange) are eligible for payments.

⁸ Transfers funds from lowest risk plans to highest risk plans.

⁹ Issuers offering individual or small group coverage must provide essential benefits. This requirement does not extend to the large group market or to self-funded plans (see section 2707). State must assume cost for additional benefits beyond Essential Health Benefits [Sec. 1311(d)(3)(B)].

¹⁰ Authorizing this product to be offered and licensing issue.

For information about CRITICAL EXCHANGE FUNCTIONS UNDER ACA see “Exchange Functions” Chart

ACA Provisions with Potential Market Impact	
Section	Provision
2011	
PHSA §2793	Establish health insurance ombudsman (grant available) ¹¹
42 USC §18001 (PPACA §1101)	Temporary high risk pool
42 USC §18002 (PPACA §1102) + Regs	Retiree reinsurance
42 USC §18003 (PPACA §1103) + Regs	Web portal – insurance regulator provides information to CCIO
2012	
PHSA §2715 + Regs	Uniform explanation of coverage & and coverage facts label; standardized definitions (March 2012)
PHSA §2717	Health insurance issuers required to report to Federal government and State commissioner ensuring quality of care
2013	
	HHS certification of Exchange
2014	
42 USC §18054 (PPACA §1334)	Multi-State Plans – regulations to clarify state role yet to be issued
42 USC §18023 (PPACA §1303)	State may opt out of abortion coverage for QHPs or terminate opt out
42 USC §18053 (PPACA §1333)	Health care choice compact

¹¹ In addition to ombudsman programs, Exchange Proposed Reg proposes to require exchange to do consumer education (§155.205) in addition to the navigator requirement (§155.210).

Pre-ACA Compliance		
Section		State Action
42USC §300gg-5; 29 USC §1185a	Mental Health Parity Act of 1996/Mental Health Parity and Addiction Equity Act of 2008	
42 USC §300gg-51	Newborns' and Mothers' Health Protection Act	
42 USC §300gg-52	Women's Health and Cancer Rights Act	
42 USC §300gg-53	<i>Genetic</i> Information Nondiscrimination Act	
29 USC §1185c	Michelle's Law	

Appendix F: Medicaid Work Plan

Prepared by: Manatt Health Solutions

Activity/Sub-Tasks	Decisions/ Considerations	Deliverables	Interdependencies	Lead Area(s)	Start Date	Completion Date	Status	Notes
ACA Coordination								
Develop workplan								
Review and continually re-assess work plan goals, timelines, deliverables, milestones, and responsible parties with overall project								
Establish workstream teams and schedule regular meetings/calls								
Implement and conduct regular workstream calls								
Implement and conduct regular Medicaid project management calls								
Implement status progress reporting tool and process								
Other PM processes?								
Perform business process documentation to reflect current state business processes and to include future state process changes to support proposed exchange operational requirements								
Initiate communication with State HIT Coordinator, Department of Insurance, and State Human Services Agency as appropriate; participate in regular meetings to ensure coordination of work								

Activity/Sub-Tasks	Decisions/ Considerations	Deliverables	Interdependencies	Lead Area(s)	Start Date	Completion Date	Status	Notes
Execute agreement with Exchange								
Collaborate with Exchange on procurement and development of Exchange and Medicaid IT systems needed to facilitate "no wrong door" for eligibility determinations								
Collaborate on testing of Exchange and other applicable State health subsidy programs (OASHSPs) systems								
Coordinate launch of Exchange open enrollment period with eligibility determinations for Medicaid and OASHSPs								
I. Eligibility and Enrollment								
<i>Maintenance of Effort (MOE) §§2001, 2101</i>								
Analyze ACA requirements								
Review and analyze additional CMS guidance								
Assess impact of MOE requirements on MN (policy, fiscal, administrative/operational)								
Ensure compliance with MOE requirements								
Determine whether to pursue waiver from MOE requirements								
Draft waiver proposal (as needed)								
Negotiate with CMS and secure waiver approval (as needed)								

Activity/Sub-Tasks	Decisions/ Considerations	Deliverables	Interdependencies	Lead Area(s)	Start Date	Completion Date	Status	Notes
Implement waiver (as needed)								
<i>Medicaid Expansion §2001</i>								
Analyze ACA requirements								
Review and analyze additional CMS guidance								
Review current State program eligibility levels and conditions								
Identify populations that must be or may be impacted by Medicaid expansion								
Assess impacts (policy, fiscal, administrative/operational)								
Gather stakeholder and Legislature feedback as appropriate								
Identify necessary policy changes (state law, regulations, administrative guidance)								
Draft legislative proposals								
Estimate program costs/savings								
Draft bill language								
Secure necessary policy changes								
Identify necessary operational changes								
Secure necessary operational changes								

Activity/Sub-Tasks	Decisions/ Considerations	Deliverables	Interdependencies	Lead Area(s)	Start Date	Completion Date	Status	Notes
Identify necessary systems changes to shift to MAGI								
Secure necessary systems changes								
Develop State Plan Amendment								
Submit State Plan Amendment to CMS								
Negotiate effective income limits with CMS								
Secure State Plan Amendment approval from CMS								
Develop PAPD/IAPD to cost allocate with Exchange								
Submit PAPD/IAPD								
Secure PAPD/IAPD approval from CMS								
Implement provision - Conduct outreach to stakeholders - Train staff - Draft bulletins								
<i>FMAP Calculation §2001</i>								
Analyze ACA requirements								
Review and analyze additional CMS guidance								
Prepare comments to CMS guidance, if applicable								
Evaluate final methodologies - Participate in CMS Feasibility Study								

Activity/Sub-Tasks	Decisions/ Considerations	Deliverables	Interdependencies	Lead Area(s)	Start Date	Completion Date	Status	Notes
Select methodology								
Implement methodology								
<i>Modified Adjusted Gross Income §2002 and Elimination of the Asset Test §2002</i>								
Analyze ACA requirements								
Review and analyze additional CMS guidance - Participate in CMS Feasibility Study								
Develop comments on proposed regulations								
Catalogue current State program eligibility categories								
Identify which populations are impacted by MAGI								
Gather stakeholder and Legislature feedback as appropriate								
Develop white paper on effects of applying MAGI methodology to the over age 65, blind, and disabled populations residing in the community								
Review and document current MN law, policies, procedures, modalities, and systems responsible for evaluation Medicaid income methodology								
Crosswalk As-Is and To-Be and identify changes/gaps								
Identify necessary policy changes (state law, regulations, administrative guidance) to bring current income eligibility methodologies into compliance with MAGI								

Activity/Sub-Tasks	Decisions/ Considerations	Deliverables	Interdependencies	Lead Area(s)	Start Date	Completion Date	Status	Notes
Draft legislative proposals								
Estimate program costs/savings								
Draft bill language								
Secure necessary policy changes								
Identify functional and performance requirements and process workflow options in the To-Be environment for Medicaid								
Develop use cases								
Conduct scenario testing								
Refine functional and performance requirements and process workflows in the To-Be environment for Medicaid								
Define business process models								
Identify necessary operational changes to shift to MAGI								
Secure necessary operational changes								
Identify necessary systems changes to shift to MAGI								
Secure necessary systems changes								
Develop State Plan Amendment								
Submit State Plan Amendment to CMS								

Activity/Sub-Tasks	Decisions/ Considerations	Deliverables	Interdependencies	Lead Area(s)	Start Date	Completion Date	Status	Notes
Negotiate effective income limits with CMS								
Secure State Plan Amendment approval from CMS								
Develop PAPD/IAPD								
Submit PAPD/IAPD								
Secure PAPD/IAPD approval from CMS								
Implement provision - Conduct outreach to stakeholders - Train staff - Draft bulletins								
<i>Foster Children §2004</i>								
Review ACA requirements								
Review additional CMS guidance								
Determine whether State will provide presumptive eligibility								
Identify necessary policy changes (state law, regulations, administrative guidance) to provide Medicaid to former foster children up to age 26								
Draft legislative proposals								
Estimate program costs/savings								
Draft bill language								
Secure necessary policy changes								

Activity/Sub-Tasks	Decisions/ Considerations	Deliverables	Interdependencies	Lead Area(s)	Start Date	Completion Date	Status	Notes
Identify necessary operational changes to provide Medicaid to former foster children up to age 26								
Secure necessary operational changes								
Identify necessary systems changes to provide Medicaid to former foster children up to age 26								
Secure necessary systems changes								
Develop State Plan Amendment								
Submit State Plan Amendment to CMS								
Secure State Plan Amendment approval from CMS								
Implement provision - Conduct outreach to stakeholders - Train staff - Draft bulletins								
<i>Hospice Care §2302</i>								
Analyze ACA requirements								
Review and analyze additional CMS guidance								
Identify necessary policy changes (state law, regulations, administrative guidance) to provide benefit								
Draft legislative proposals								
Estimate program costs/savings								

Activity/Sub-Tasks	Decisions/ Considerations	Deliverables	Interdependencies	Lead Area(s)	Start Date	Completion Date	Status	Notes
Draft bill language								
Secure necessary policy changes								
Identify necessary operational changes								
Secure necessary operational changes								
Identify necessary systems changes								
Secure necessary systems changes								
Complete revised State Plan Pre-Print								
Submit revised State Plan Pre-Print								
Secure State Plan Amendment approval from CMS								
Conduct outreach to stakeholders								
Implement provision - Conduct outreach to stakeholders - Train staff - Draft bulletins								
<i>Family Planning Program §2303</i>								
Analyze ACA requirements								
Review additional CMS guidance								
Model and analyze need for standalone MN Family Planning Program								

Activity/Sub-Tasks	Decisions/ Considerations	Deliverables	Interdependencies	Lead Area(s)	Start Date	Completion Date	Status	Notes
Identify necessary policy changes (state law, regulations, administrative guidance)								
Draft legislative proposals								
Estimate program costs/savings								
Draft bill language								
Secure necessary policy changes								
Identify necessary operational changes								
Develop transition/phase down plan								
Secure necessary operational changes								
Identify necessary systems changes								
Secure necessary systems changes								
Develop State Plan Amendment								
Submit State Plan Amendment to CMS								
Secure State Plan Amendment approval from CMS								
Negotiate FPP phase down with CMS								
Implement provision - Conduct outreach to stakeholders - Train staff - Draft bulletins								

Activity/Sub-Tasks	Decisions/ Considerations	Deliverables	Interdependencies	Lead Area(s)	Start Date	Completion Date	Status	Notes
<i>Eligibility and Enrollment Business Requirements</i>								
Review and document current MN law, policies, procedures, modalities, and systems responsible for Medicaid: <ul style="list-style-type: none"> - Application - Verification - Change Reporting - Recertification - Notices - Appeals 								
Analyze proposed implementing regulations								
Crosswalk As-Is and To-Be and identify gaps								
Gather stakeholder and Legislature feedback as appropriate								
Develop comments on proposed regulations								
Identify functional and performance requirements and process workflow options in the To-Be environment for Medicaid: <ul style="list-style-type: none"> - Application - Verification - Change Reporting - Recertification - Notices - Appeals 								
Develop use cases								

Activity/Sub-Tasks	Decisions/ Considerations	Deliverables	Interdependencies	Lead Area(s)	Start Date	Completion Date	Status	Notes
Conduct scenario testing for: <ul style="list-style-type: none"> - Application - Verification - Change Reporting - Recertification - Notices - Appeals 								
Refine functional and performance requirements and decide on process workflows in the To-Be environment for Medicaid: <ul style="list-style-type: none"> - Application - Change Reporting - Recertification - Notices - Appeals 								
Analyze final implementing regulations								
Refine functional and performance requirements and process workflows in the To-Be environment for Medicaid: <ul style="list-style-type: none"> - Application - Verification - Change Reporting - Recertification - Notices - Appeals 								

Activity/Sub-Tasks	Decisions/ Considerations	Deliverables	Interdependencies	Lead Area(s)	Start Date	Completion Date	Status	Notes
Define business process models for: - Application - Verification - Change Reporting - Recertification - Notices - Appeals								
<i>Eligibility and Enrollment Operational Implementation</i>								
Determine current MN state agency Medicaid eligibility and enrollment workload distribution: document current eligibility functions and populations, which transition to Exchange, which stay with MN Medicaid, and resource implications								
Assess and determine role of counties post-transition								
Gather stakeholder and Legislature feedback as appropriate								
Develop a proposed transition plan and identify potential risks of transition (e.g. Medicaid cost allocation issues)								
Develop workplan and timeline to transition operations to Exchange as necessary								
Identify necessary policy changes (state law, regulations, administrative guidance)								
Draft legislative proposals								
Estimate program costs/savings								
Draft bill language								

Activity/Sub-Tasks	Decisions/ Considerations	Deliverables	Interdependencies	Lead Area(s)	Start Date	Completion Date	Status	Notes
Secure necessary policy changes								
Identify necessary operational changes								
Secure necessary operational changes								
Identify necessary systems changes								
Secure necessary systems changes								
Develop State Plan Amendment								
Submit State Plan Amendment to CMS								
Secure State Plan Amendment approval from CMS								
Develop manuals and train staff								
<i>Eligibility and Enrollment System Enhancements</i>								
Requirements analysis for implementation of: electronic interface between Exchange and MMIS and MAXIS; electronic interface between Exchange and federal hub; online application updates and integration with Exchange								
System design for implementation of: electronic interface between Exchange and MMIS and MAXIS; electronic interface between Exchange and federal hub; online application updates and integration with Exchange								

Activity/Sub-Tasks	Decisions/ Considerations	Deliverables	Interdependencies	Lead Area(s)	Start Date	Completion Date	Status	Notes
System programming for implementation of: electronic interface between Exchange and MMIS and MAXIS; electronic interface between Exchange and federal hub; online application updates and integration with Exchange								
System testing for implementation of: electronic interface between Exchange and MMIS and MAXIS; electronic interface between Exchange and federal hub; online application updates and integration with Exchange								
Requirements analysis for implementation of: enhanced eligibility determination system; MMIS changes; MAXIS changes; electronic interface between Exchange and VerifyMN (i.e., state databases)								
System design for implementation of: enhanced eligibility determination system; MMIS changes; MAXIS changes; electronic interface between Exchange and VerifyMN (i.e., state databases)								
System programming for implementation of: enhanced eligibility determination system; MMIS changes; MAXIS changes; electronic interface between Exchange and VerifyMN (i.e., state databases)								
System testing for implementation of: enhanced eligibility determination system; MMIS changes; MAXIS changes; electronic interface between Exchange and VerifyMN (i.e., state databases)								

Activity/Sub-Tasks	Decisions/ Considerations	Deliverables	Interdependencies	Lead Area(s)	Start Date	Completion Date	Status	Notes
<i>Coverage Transitions Analysis</i>								
Review Minnesota specialty programs and develop white paper on MA specialty programs								
Conduct and validate legal analysis (cost sharing, benefits and eligibility levels) to identify source of law for MN populations and enrolled populations as basis for transitions analysis.								
Develop white paper on separating eligibility groups for over age 65 and blind and disabled (under age 65)								
Develop white paper on medically needy								
Crosswalk existing coverage programs and populations to available coverage options under the ACA								
Evaluate options and develop recommendations on program and population transitions								
Gather stakeholder and Legislature feedback as appropriate								
Determine MN Medicaid population transitions to Medicaid benchmark, QHP, and BHP (possibly) and high level implementation plan/timeline								
Identify necessary policy changes (state law, regulations, administrative guidance) to transition populations								
Draft legislative proposals								
Estimate program costs/savings								

Activity/Sub-Tasks	Decisions/ Considerations	Deliverables	Interdependencies	Lead Area(s)	Start Date	Completion Date	Status	Notes
Draft bill language								
Secure necessary policy changes								
Identify necessary operational changes to transition populations								
Secure necessary operational changes								
Identify necessary systems changes to transition populations								
Secure necessary systems changes								
Develop State Plan Amendment								
Submit State Plan Amendment to CMS								
Secure State Plan Amendment approval from CMS								
Implement provision - Conduct outreach to stakeholders - Train staff - Draft bulletins								
<i>CHIP Transition §§2101, 10203</i>								
Analyze ACA requirements								
Review and analyze additional CMS guidance								
Project spending for CHIP and identify when allotments will be exhausted								

Activity/Sub-Tasks	Decisions/ Considerations	Deliverables	Interdependencies	Lead Area(s)	Start Date	Completion Date	Status	Notes
Assess transition options for children and state fiscal impact								
Gather stakeholder and Legislature feedback as appropriate								
Develop transition plan for children into Medicaid and/or Exchange coverage								
Identify necessary policy changes (state law, regulations, administrative guidance)								
Draft legislative proposals								
Estimate program costs/savings								
Draft bill language								
Secure necessary policy changes								
Identify necessary operational changes								
Secure necessary operational changes								
Identify necessary systems changes to administer new benefit package								
Secure necessary systems changes								
Develop State Plan Amendment and potential CHIP close-out plan								
Submit State Plan Amendment and potential CHIP close-out plan to CMS								

Activity/Sub-Tasks	Decisions/ Considerations	Deliverables	Interdependencies	Lead Area(s)	Start Date	Completion Date	Status	Notes
Secure State Plan Amendment and potential CHIP close-out plan approval from CMS								
Implement provision - Conduct outreach to stakeholders - Train staff - Draft bulletins								
II. Benefit Package Design								
<i>Benefit Package Design §2001</i>								
Review and analyze additional CMS guidance								
Review current State benefit packages								
Develop and assess benchmark benefit package - Estimate utilization - Conduct financial modeling to assess state fiscal impact - Assess impacts to consumers - Assess logistics of administration								
Gather stakeholder and Legislature feedback as appropriate								
Review assessments and make decision								
Identify necessary policy changes (state law, regulations, administrative guidance)								
Draft legislative proposals								
Estimate program costs/savings								

Activity/Sub-Tasks	Decisions/ Considerations	Deliverables	Interdependencies	Lead Area(s)	Start Date	Completion Date	Status	Notes
Draft bill language								
Secure necessary policy changes								
Identify necessary operational changes								
Secure necessary operational changes								
Identify necessary systems changes to administer new benefit package								
Secure necessary systems changes								
Develop State Plan Amendment								
Submit State Plan Amendment to CMS								
Secure State Plan Amendment approval from CMS								
Implement provision - Conduct outreach to stakeholders - Train staff - Draft bulletins								
III. Basic Health Plan								
<i>Basic Health Program §1331</i>								
Review ACA requirements								

Activity/Sub-Tasks	Decisions/ Considerations	Deliverables	Interdependencies	Lead Area(s)	Start Date	Completion Date	Status	Notes
Conduct financial feasibility assessment: <ul style="list-style-type: none"> - Determine size and demographics of eligibles likely to enroll - Estimate value of second lowest cost silver plan - Calculate value of premium tax credit and cost sharing reduction - Calculate cost of purchasing BHP - Calculate difference between BHP-related revenue and cost 								
Develop white paper on need for MinnesotaCare								
Assess logistics of administration of BHP								
Assess delivery model options								
Assess impact on Exchange scale and sustainability								
Review additional CMS guidance and adjust assessment as necessary								
Gather stakeholder and Legislature feedback as appropriate								
Review assessments and make decision								
(if State opts for BHP) Develop benefit package								
(if State opts for BHP) Identify necessary policy changes (state law, regulations, administrative guidance) to provide benefit								
(if State opts for BHP) Draft legislative proposals								

Activity/Sub-Tasks	Decisions/ Considerations	Deliverables	Interdependencies	Lead Area(s)	Start Date	Completion Date	Status	Notes
(if State opts for BHP) Develop transition/phase down plan								
(if State opts for BHP) Draft bill language								
(if State opts for BHP) Secure necessary policy changes								
(if State opts for BHP) Identify necessary operational changes								
(if State opts for BHP) Secure necessary operational changes								
(if State opts for BHP) Identify necessary systems changes								
(if State opts for BHP) Secure necessary systems changes								
(if State opts for BHP) Negotiate MinnesotaCare phase down with CMS								
(if State opts for BHP) Prepare and submit adoption of BHP with CMS								
(if State opts for BHP) Contract with plans								
(if State opts for BHP) Implement provision - Conduct outreach to consumers - Train staff - Draft bulletins								
<Incorporate additional tasks when guidance becomes available>								

Activity/Sub-Tasks	Decisions/ Considerations	Deliverables	Interdependencies	Lead Area(s)	Start Date	Completion Date	Status	Notes
IV. Health Plan Administration								
<i>Plan Certification § 1311</i>								
Review current certification policy, procedures and administration in Medicaid program								
Review BHP/QHP certification, recertification, decertification requirements of ACA and additional CMS guidance								
Identify areas for alignment and integration with existing Medicaid infrastructure and/or joint development and deployment of a new Medicaid/Exchange certification process and standards								
<i>Plan Quality Assessment and Monitoring §1311</i>								
Review current plan quality assessment policy, procedures and administration of Medicaid program								
Review BHP/QHP plan quality assessment and monitoring requirements in ACA and additional CMS guidance								
Identify areas for alignment and integration with existing Medicaid infrastructure and/or joint development and deployment of a new Medicaid/Exchange plan quality assessment and monitoring process								
<i>Plan Contracting and Oversight §1311</i>								
Review current plan contracting and oversight policy, procedures and administration in Medicaid program								

Activity/Sub-Tasks	Decisions/ Considerations	Deliverables	Interdependencies	Lead Area(s)	Start Date	Completion Date	Status	Notes
Review BHP/QHP plan contracting and oversight requirements of ACA and additional CMS guidance								
Identify areas for alignment and integration with existing Medicaid infrastructure								
<i>Risk Adjustment §§ 1321, 1343</i>								
Review current plan risk adjustment policy, procedures and administration in Medicaid program								
Review Exchange risk adjustment requirements of ACA and additional CMS guidance								
Identify areas for alignment and integration with existing Medicaid infrastructure and/or joint development and deployment of a new Medicaid/Exchange methodology								
<i>Reinsurance §§ 1321, 1341</i>								
Review current plan reinsurance policy, procedures and administration in Medicaid program								
Review Exchange reinsurance requirements of ACA and additional CMS guidance								
Identify areas for alignment and integration with existing Medicaid infrastructure								

Appendix G: Memorandum of Understanding

Prepared by: Georgetown University Health Policy Institute, *Mila Kofman, J.D.*, *Katie Dunton, J.D., M.P.A.* and *Manatt Health Solutions*

11 Core Elements Outlined by HHS for certification for State-based exchange				
	Insurance regulators	Medicaid	Other	Exchange entity
Background research				
Stakeholder consultation				
Legislative and regulatory action				
Governance				
Program integration				
Exchange IT systems				
Financial Management				
Oversight and program integrity				
Health insurance market reforms				
Provide assistance to individuals, small business, coverage appeals, complaints				
Business operations of exchange				

For more information, see Exchange Establishment Funding Opportunity Announcement (January 20, 2011)

Exchange Functions (Includes minimum required and other functions)				
	Insurance regulators	Medicaid	Other	New exchange entity
Certification of QHPs				
• Establish procedures for certification				
• Contracting with QHPs				
• Monitor ongoing compliance				
• Rate increase justification (may be part of rate review)				
• Form review – can be used to check that essential elements are included				
• Collect information from QHPs to meet transparency requirements (claims payment policies & practices, financial, enrollment data, claims denials, rating practices, cost-sharing, enrollee rights)				
• Recertification process				
• Decertification process				
• Mandated benefits above essential benefits				
• Determine actuarial value of plans (bronze, silver, gold, platinum, or catastrophic)				
Licensing and Oversight				
• Enforcement and oversight over private health insurance products				
• Licensing and oversight for insurance risk-bearing entities				
• Licensing and oversight of CO-OPs				
• Medicaid managed care plans (if insure commercial population where applicable)				
• Enforcement for products sold within and outside exchange				
• Market oversight to minimize adverse selection (e.g., market surveillance, market conduct exams, etc.)				
• Form review				
• Rate review				
• Oversight of multi-State plans (OPM) sold through exchange (depending on regulations)				
• Compliance with pre-2014 insurance market reforms (9/23/10 provisions, MLR, etc.)				
• Compliance with post-2014 insurance market reforms (guaranteed issue, no pre-ex, community rating limits)				
Consumer Assistance Tools				
• Call center (operate toll-free call center for consumers requesting assistance)				
• Sec. 2715 materials (4-page coverage summary, standard terminology)				
• Exchange website				
• Exchange calculator – facilitates comparison of available QHPs after applicable premium tax credit and cost-sharing reduction				
• Quality rating system – includes enrollee satisfaction initiatives				
• Outreach and education				
• Navigator Program (see below)				
• External review pre-2014				

Exchange Functions (Includes minimum required and other functions)				
	Insurance regulators	Medicaid	Other	New exchange entity
<ul style="list-style-type: none"> External review post-2014 				
Navigator Program				
<ul style="list-style-type: none"> Establish program (Exchange Navigators & Medicaid “application assisters”) 				
<ul style="list-style-type: none"> Prescribe licensing, certification or other standards 				
<ul style="list-style-type: none"> Oversight of navigators 				
<ul style="list-style-type: none"> Admin functions by navigators for Medicaid 				
Eligibility determinations and Enrollment				
<ul style="list-style-type: none"> Eligibility determinations for QHPs 				
<ul style="list-style-type: none"> Eligibility determinations for affordability programs (Medicaid, CHIP, BHP, premium tax credits, cost-sharing reductions) 				
<ul style="list-style-type: none"> Notice of eligibility determinations 				
<ul style="list-style-type: none"> Redetermination of eligibility (periodically & annually) 				
<ul style="list-style-type: none"> Medicaid screening (basic & full) 				
<ul style="list-style-type: none"> Calculation of advance payments of premium tax credit 				
<ul style="list-style-type: none"> Adjudication of appeals of eligibility determinations 				
<ul style="list-style-type: none"> Seamless eligibility and enrollment process with Medicaid and other State health subsidy programs 				
<ul style="list-style-type: none"> Enrollment process 				
<ul style="list-style-type: none"> Applications for enrollment and notices provided to enrollees 				
<ul style="list-style-type: none"> Establish secure electronic interface for data exchange with Medicaid, CHIP and BHP 				
Responsibilities of Individuals and Employers				
<ul style="list-style-type: none"> Individual responsibility determinations 				
<ul style="list-style-type: none"> Notification and appeals of employer liability 				
Administering Tax Credits and Subsidies				
<ul style="list-style-type: none"> Administration of premium tax credits and cost-sharing reductions 				
<ul style="list-style-type: none"> Administration of subsidy – reflect how subsidy gets paid. 				
<ul style="list-style-type: none"> Information reporting to IRS and enrollees 				
3 Rs				
<ul style="list-style-type: none"> Risk adjustment 				
<ul style="list-style-type: none"> Reinsurance 				
<ul style="list-style-type: none"> risk corridors 				
Functions related to oversight and financial integrity requirements				
<ul style="list-style-type: none"> Compliance with GAAP 				
<ul style="list-style-type: none"> Ensure program integrity related to fed & state funds 				
<ul style="list-style-type: none"> Prevent fraud, waste, and abuse 				

✓ **Should indicate current authority and similar functions**

For more information, see Proposed Rules CMS-9989-P, July 11, 2011; CMS-9974-P, Aug. 11, 2011; CMS-2349-P, Aug. 11, 2011

SHOP Exchange Functions (§155.705, Proposed rule issued July 11, 2011)				
	Insurance Regulators	Medicaid	Other	New Exchange Entity
Enrollment and eligibility functions				
Employer choice reqs and SHOP options				
Premium aggregation (single monthly bill for all QHPs)				
QHP certification				
Rates and changes (no rate variation during plan year)				
QHP availability in merged (qualified employee may enroll in any QHP meeting small group reqs.) and unmerged markets (qual employee may only enroll in QHPs in small group market)				
Expansion into large group market (insurers in large group may offer health plans inside SHOP in 2017)				

For more information, see §155.705, proposed rule (July 11, 2011)