



Exchange IT Assessment

Phase 1 Workshop

November 10, 2010

Deloitte.

Workshop Agenda and Objectives

Workshop Agenda

Introductions & Workshop Objectives

HIX Operating Model

PPACA Requirements & Associated Technology Components

Technology Operating Model & Components Review

- Technology Operating Model
 - Component 1: Portal
 - Component 2: Business Rules Engine
 - Component 3: Document Management
 - Component 4: Document Generation
 - Component 5: Data Exchange
 - Component 6: Reporting
 - Component 7: CRM
 - Component 8: Workflow Engine
 - Component 9: Calculators
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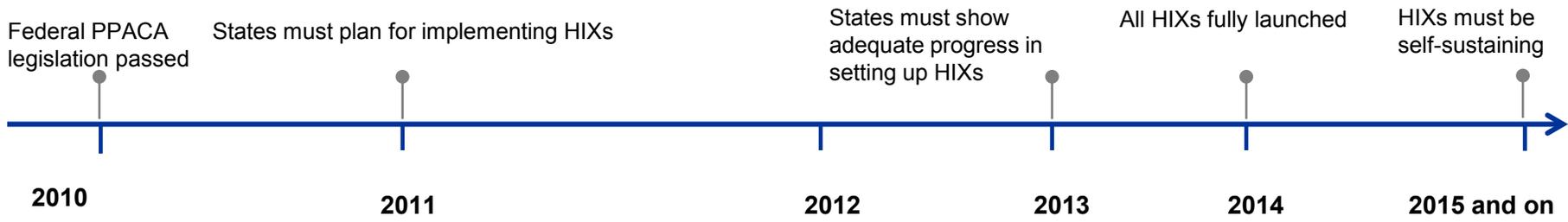
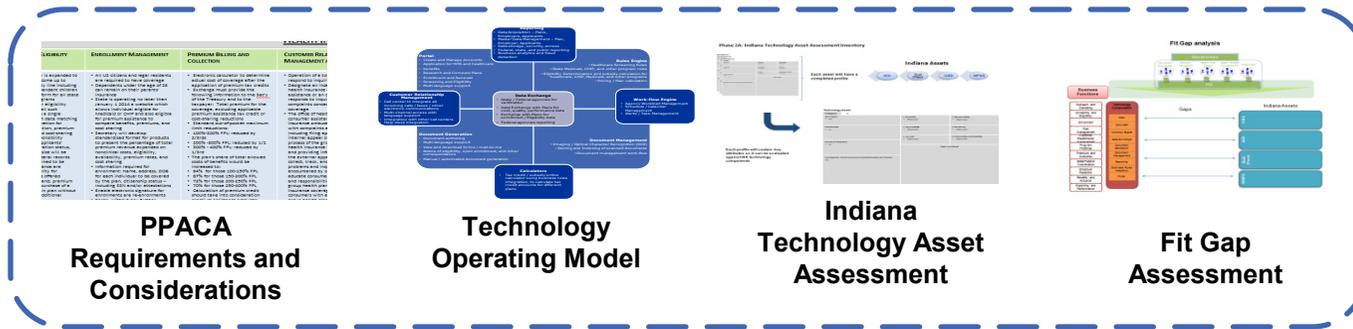
Looking Ahead to Phase 2

Wrap Up

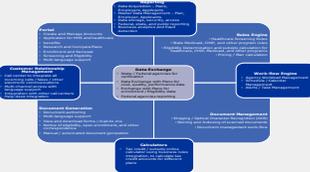
Workshop Objectives

- Establish a common understanding of the Exchange Operating Model and the business functions required by the legislation
- Present and discuss the reference Exchange Technology Operating Model
- Discuss the nine core technology components and the features the component must support to meet the functional requirements
- Finalize the existing core applications to be assessed as part of the next phase

Exchange IT Assessment Project



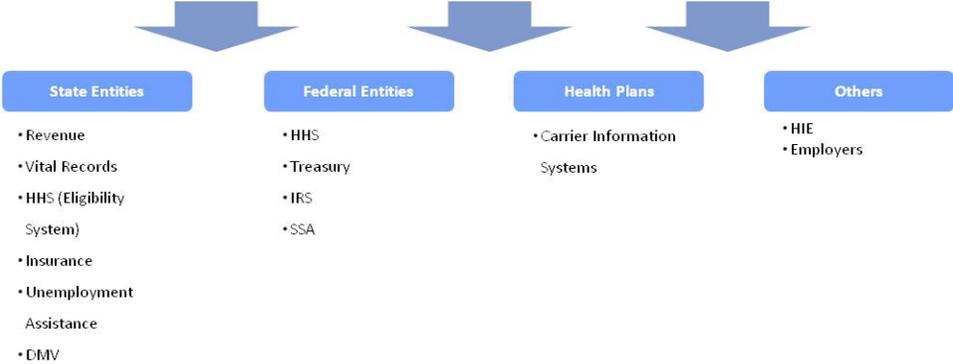
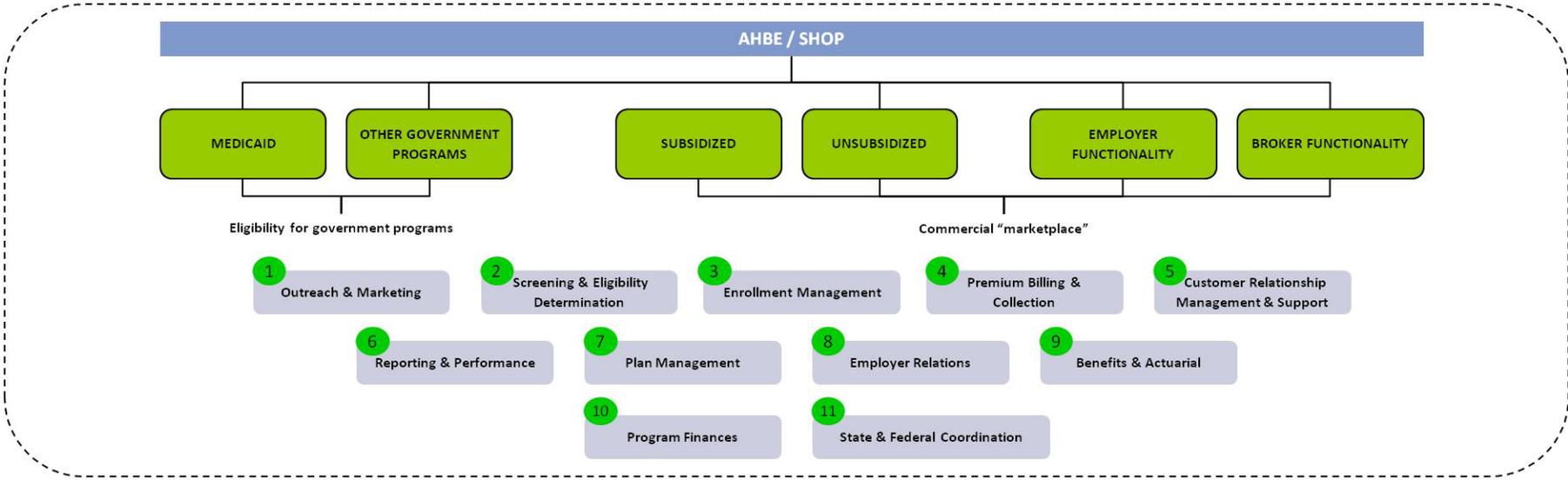
Project Deliverables

	Deliverable	Description	Value to Indiana
Phase 1	<p>PPACA Requirements and Considerations</p> 	<ul style="list-style-type: none"> Decomposes PPACA legislation and identify Exchange requirements Identify of additional functional considerations Group requirements into business functions Identify technology components by business function 	Analyzes the PPACA legislation specific to the Exchange to define the business functions required to support HIX implementation and operations
	<p>Technology Operating Model</p> 	<ul style="list-style-type: none"> Illustrates technology required to support HIX business functions Details definition and break down of each technology component 	Establishes the reference HIX technology operating model that is used to perform the fit-gap analysis against existing technology assets
Phase 2A	<p>Indiana Technology Asset Inventory</p> 	<ul style="list-style-type: none"> Identifies relevant Indiana assets Develops individual asset profile including assessment of functionality, scalability, maintainability and other attributes 	Provides Indiana with an understanding of the existing Indiana technology assets that could be leveraged to support the implementation of an HIX
Phase 2B	<p>Fit Gap Assessment</p> 	<ul style="list-style-type: none"> Compares existing Indiana technologies to HIX reference technology components Identifies gaps between the current assets and the reference technology model components 	Establishes the gaps and provides Indiana with a starting point for addressing and prioritizing the gaps from a technology perspective for implementing an HIX

HIX Operating Model

HIX Operating Model

HEALTH INSURANCE EXCHANGE OPERATING MODEL



PPACA Requirements & Associated Technology Components

Outreach and Marketing

PPACA LEGISLATIVE REQUIREMENTS	ADDITIONAL CONSIDERATIONS
<ul style="list-style-type: none"> • States may allow agents and brokers to enroll individuals in any plan on an Exchange in the State, and to assist applications for premium tax credits and/or cost sharing reductions • States may establish rate schedules for broker commissions paid by health plans • Exchanges shall establish grants (out of operational funds) to support health care Exchange "navigators" • Navigators: Individuals and organizations who will help employers, employees, consumers and self-employed individuals understand and enroll in plans via the Exchange • Navigators should be qualified and licensed and may include trade, industry and professional associations, community and consumer-focused non-profits, chambers of commerce, licensed insurance agencies and brokers, etc. • Navigators may not be health plans or receive any considerations from health plans • Consult and coordinate with external stakeholder groups 	<ul style="list-style-type: none"> • Establish broker management and oversight process: hiring and access, process to monitor broker enrollment patterns, performance, customer satisfaction • Provide access to both Individual Exchange and SHOP for Brokers and Navigators • Establish and manage rate schedules in collaboration with plans and brokers • Develop additional functionality and screens for brokers to manage their clients and activities • Establish process to evaluate effectiveness of navigator grant funds in reaching targeted populations

Screening and Eligibility Determination

PPACA LEGISLATIVE REQUIREMENTS	ADDITIONAL CONSIDERATIONS
<ul style="list-style-type: none"> • Medicaid eligibility is expanded to individuals with income up to 133% of the poverty line including adults without dependent children • Single application form for all State health subsidy programs • Secure interface for eligibility determination for all such programs based on a single application through data matching • Eligibility determination for Exchange participation, premium tax credits, reduced cost-sharing and individual responsibility exemptions; and applicants' citizenship/ immigration status, income and family size will be verified against Federal records • Individuals determined to be ineligible for assistance are screened for eligibility for enrollment in plans offered through Exchange as well as premium assistance for the purchase of a plan and, enrolled in plan without having to submit additional application • Inform individuals of eligibility requirements for the Medicaid program, the CHIP program, or any applicable State or local public program and if screening of an application by the Exchange determines individual is eligible for any program, enroll individual • Ensure that individuals applying for Medicaid or CHIP but found ineligible are screened for eligibility in Exchange plans • Exchange may contract eligibility determination to the State Medicaid agency for all subsidy programs • A qualified employer is a small employer that elects to make all full-time employees eligible for one or more qualified health plans offered in the small group market 	<ul style="list-style-type: none"> • Determine whether to implement upfront screening process and functionality • Define common requirements for eligibility across all State programs and certified plans • Determine hierarchy and flow of website navigation to redirect individuals towards enrollment once deemed eligible • Define tailored set of business rules for eligibility determination process for small business employees • Develop process and supporting technology to manage eligibility rule changes or updates in individual data

Enrollment Management

PPACA LEGISLATIVE REQUIREMENTS	ADDITIONAL CONSIDERATIONS
<ul style="list-style-type: none"> • All US citizens and legal residents are required to have coverage • Dependents under the age of 26 can remain on their parents' insurance • State is operating no later than January 1, 2014 a website which allows individual eligible for Medicaid or CHIP and also eligible for premium assistance to compare benefits, premiums, and cost sharing • Secretary will develop standardized format for products to present the percentage of total premium revenue expended on nonclinical costs, eligibility, availability, premium rates, and cost sharing • Information required for enrollment: Name, address, DOB for each individual to be covered by the plan, citizenship status – Including SSN and/or attestations • Enable electronic signature for enrollments and re-enrollments • Enroll through such website, individuals who are identified as being eligible for State plan, waiver, or child health assistance without any further determination by the State • Individuals determined to be ineligible for assistance are screened for eligibility for enrollment in plans offered through Exchange as well as premium assistance for the purchase of a plan and, enrolled in plan without having to submit additional application • Coordinate, for individuals who are enrolled in the State plan or under a waiver and who are also enrolled in a qualified health plan offered through such an Exchange • Start Initial open enrollment period by July 1, 2012 • If applicant information related to enrollment, premium tax credits and cost-sharing reductions is positively verified, HHS Sec'y will notify the Treasury Sec'y of the amount of any advance payment to be made • State must develop procedures to assure children found ineligible for Medicaid are enrolled in certified qualified health plans 	<ul style="list-style-type: none"> • Determine process for enrollments across multiple channels such as website, in person, phone, mail: handoffs, tracking and system of record • Define transition process for individuals enrolled in discontinued State programs or plans • Standardize required eligibility and enrollment data elements to enable streamlined process across programs and plans • Simplify enrollment requirements across all programs • Define enrollment process and data integration between plan websites and Exchange

Premium Billing and Collection

PPACA LEGISLATIVE REQUIREMENTS	ADDITIONAL CONSIDERATIONS
<ul style="list-style-type: none"> • Electronic calculator to determine actual cost of coverage after the application of premium tax credits • Exchange must provide the following information to the Sec'y of the Treasury and to the taxpayer: Total premium for the coverage, excluding applicable premium assistance tax credit or cost-sharing reductions • Standard out-of-pocket maximum limit reductions: <ul style="list-style-type: none"> • 100%-200% FPL: reduced by 2/3rds • 200% -300% FPL: reduced by 1/2 • 300% - 400% FPL: reduced by 1/3rd • The plan's share of total allowed costs of benefits would be increased to: <ul style="list-style-type: none"> • 94% for those 100-150% FPL • 87% for those 150-200% FPL • 73% for those 200-250% FPL • 70% for those 250-400% FPL • Calculation of premium credit should take into consideration premium assistance amounts, coverage months, minimum essential coverage, unaffordable coverage under an employer-sponsored plan, free choice vouchers, applicable 2nd lowest cost silver plan, adjusted monthly premium for such plan, applicable %, and advance payment of credits • The Secretary of HHS will notify the Exchange and the Secretary of Treasury, and the Secretary of Treasury will make the necessary payments to the insurer, who must reduce the individual's premiums and cost-sharing • States may provide subsidies in addition to the Federal subsidies • If Sec'y notifies Exchange that enrollee eligible for premium credit or cost-sharing reduction due to lack of minimum essential coverage through an employer (or unaffordable coverage), the Exchange must notify employer (and employer may be liable for tax) • In the case of an eligible small employer, there shall be a small employer health insurance credit for any taxable year • The aggregate cost of applicable employer-sponsored coverage should be included in W2 	<ul style="list-style-type: none"> • Identify processes and supporting technology for Federal Secretary / Exchange / Treasury Secretary / Plan / Individual payment integration and management • Define management process for dually enrolled and payer of last resort payment • Make available summary financial information for each taxpayer across Plan, Federal and State payments

Customer Relationship Management and Support

PPACA LEGISLATIVE REQUIREMENTS	ADDITIONAL CONSIDERATIONS
<ul style="list-style-type: none"> • Operation of a toll-free hotline to respond to inquiries for assistance • Designate an independent office of health insurance consumer assistance or an ombudsman that responds to inquiries and complaints concerning insurance coverage • The office of health insurance consumer assistance or health insurance ombudsman must help with complaints and appeals filing, including filing appeals with the internal appeal or grievance process of the group health plan or health insurance issuer involved, and providing information about the external appeal process; collect, track, and quantify problems and inquiries encountered by consumers; educate consumers on their rights and responsibilities with respect to group health plans and health insurance coverage; assist consumers with enrollment in a group health plan or health insurance coverage by providing information, referral, and assistance; and resolve problems with obtaining premium tax credits • Establish a program under which to award grants to "Navigators" 	<ul style="list-style-type: none"> • Provide in person customer service processes • Define appeals process for broad group of stakeholders listed in the reform • Determine touch points and coordination between Consumer Assistance Office and Exchange • Define required transparent plan information provided by the State to facilitate plan selection by individual • Determine which customer service functions will be managed across each channel • Develop documents management policies and processes

Reporting and Performance

PPACA LEGISLATIVE REQUIREMENTS	ADDITIONAL CONSIDERATIONS
<ul style="list-style-type: none"> • Publish average costs of licensing, regulatory fees and other payments required by the Exchange, as well as administrative costs, moneys lost to waste, and fraud and abuse • Implement data-driven fraud detection protocols • Maintain accurate accounting of all activities, receipts and expenditures; and an annual report must be submitted • Report on quality measures and performance of health plans • Conduct enrollee satisfaction surveys for every plan with more than 500 employees • Within five years of operations, the Comptroller General will conduct an ongoing study of activities and enrollees. The study will review operations and administration, including complaint data and ability to meet goals. It will include observations, operational or policy improvement recommendations, the number of doctors not accepting new patients and provider network adequacy, cost and affordability of insurance • Qualified health plans must make the same quality reports related to pediatric care that are required of the State Medicaid-CHIP agency 	<ul style="list-style-type: none"> • Define processes, time frames and data elements for review of health plan performance (enrollment and financial) • Determine how to use claims-paid data and data analytics to understand enrollment and cost dynamics • Define procurement processes which can be kept transparent and shared on the website • Identify data storage and analytical tools and processes to ensure plan performance • Identify overlap between PPACA quality reports and CHIPRA as well as HIT required quality reports

Plan Management

PPACA LEGISLATIVE REQUIREMENTS	ADDITIONAL CONSIDERATIONS
<ul style="list-style-type: none"> Review , approve or deny certification based on coverage transparency, the accurate and timely disclosure of claims policies and procedures; periodic financial disclosures; enrollment and disenrollment data; denied claims; rating practices; cost-sharing and payments with respect to out-of-network (OON) coverage; enrollee and participant rights Require health plans seeking certification to submit to the Exchange, the Secretary, the State Insurance Commissioner, and to the Public the following: Claims payment policies and practices, periodic financial disclosures, data on enrollment and disenrollment, data on the number of denied claims, data on rating practices, information on cost-sharing and payments with respect to out-of-network coverage, information on enrollee and participant rights Plan seeking certification must allow individuals to learn the amount of cost-sharing under the plan that the individual is responsible for Review and approve/deny requests for premium rate increases, and take into account excess premium growth outside the Exchange Provide for timely acknowledgment, response and status reporting that supports a transparent claims and denial management process HHS Sec'y will notify plan issuers of enrollees who are eligible for cost-sharing reductions, and issuers will reduce cost-sharing under the plan Exchanges must provide access to at least four levels of coverage Catastrophic plan only for individuals under 30 A licensed health insurance insurer must charge the same premium whether the plan is offered via the Exchange, offered directly or through an agent Director of the Office of Personnel Management shall contract to offer at least 2 multi-State plans through the Exchange 	<ul style="list-style-type: none"> Determine detailed procedures for certification, recertification and decertification of health plans as qualified health plans Define detailed requirements for each product category Develop survey or tool to rate plan product based on user experience

Employer Relations

PPACA LEGISLATIVE REQUIREMENTS	ADDITIONAL CONSIDERATIONS
<ul style="list-style-type: none"> • A qualified employer may provide support for coverage of employees under a qualified health plan by selecting any level of coverage to be made available to employees through an Exchange • A small employer may continue to participate if it ceases to be a small employer because of an increase in the number of employees • Beginning in 2017, each State may allow issuers in the State's large group market to offer qualified health plans through an Exchange • Transfer to the Secretary of the Treasury, the name and taxpayer identification number of each individual who was an employee but who was determined to be eligible for the premium tax credit because the employer did not provide minimum essential coverage; or the employer provided minimum essential coverage which was determined to either be unaffordable or not provide the required minimum actuarial value • Transfer to the Secretary of the Treasury, the name and taxpayer identification number of each individual who notifies the Exchange that they have changed employers or have ceased coverage • Provide to each employer the name of each employee who ceases coverage under a plan • "Offering employer" is one who offers minimum essential coverage to its employees consisting of coverage through an eligible employer-sponsored plan; and who pays any portion of the costs • An offering employer shall provide free choice vouchers to each qualified employee. The free choice voucher amount shall be equal to the monthly portion of the cost of the eligible employer-sponsored plan which would have been paid by the employer if the employee were covered under the plan with respect to which the employer pays the largest portion of the cost of the plan. Such amount shall be equal to the amount the employer would pay for an employee with self-only coverage unless such employee elects family coverage 	<ul style="list-style-type: none"> • Develop employer website functionality to allow for management of employee enrollees • Develop SHOP specific functionality • Define free choice voucher processes and tracking mechanisms • Define employer penalties and associated billing processes • Identify how out of State employers and associated enrollees will be managed

Benefits and Actuarial

PPACA LEGISLATIVE REQUIREMENTS	ADDITIONAL CONSIDERATIONS
<ul style="list-style-type: none"> Levels of coverage are defined as Bronze: 60% of the full actuarial value the plan Silver: 70% of the full actuarial value the plan Gold: 80% of the full actuarial value the plan Platinum: 90% of the full actuarial value the plan Health insurance issuers are to consider all enrollees in all health plans offered by the issuer in the individual market (except grandfathered plans) to be members of a single risk pool; Also all enrollees in all health plans offered by the issuer in the small group market (except grandfathered plans) to be members of a single risk pool The Secretary shall establish and administer a program of risk corridors for calendar years 2014, 2015 and 2016 Each State shall assess a charge on health plans and health insurance issuers (with respect to health insurance coverage) if the actuarial risk of the enrollees of such plans or coverage for a year is less than the average actuarial risk of all enrollees in all plans or coverage in such State for such year that are not self-insured group health plans Reward quality through market based incentives 	<ul style="list-style-type: none"> Define a capitation model with specific stop loss reinsurance and aggregate risk sharing features Use of predictive modeling to minimize practice of “risk selection” by insurers Define Exchange risk adjustment processes

Program Finances

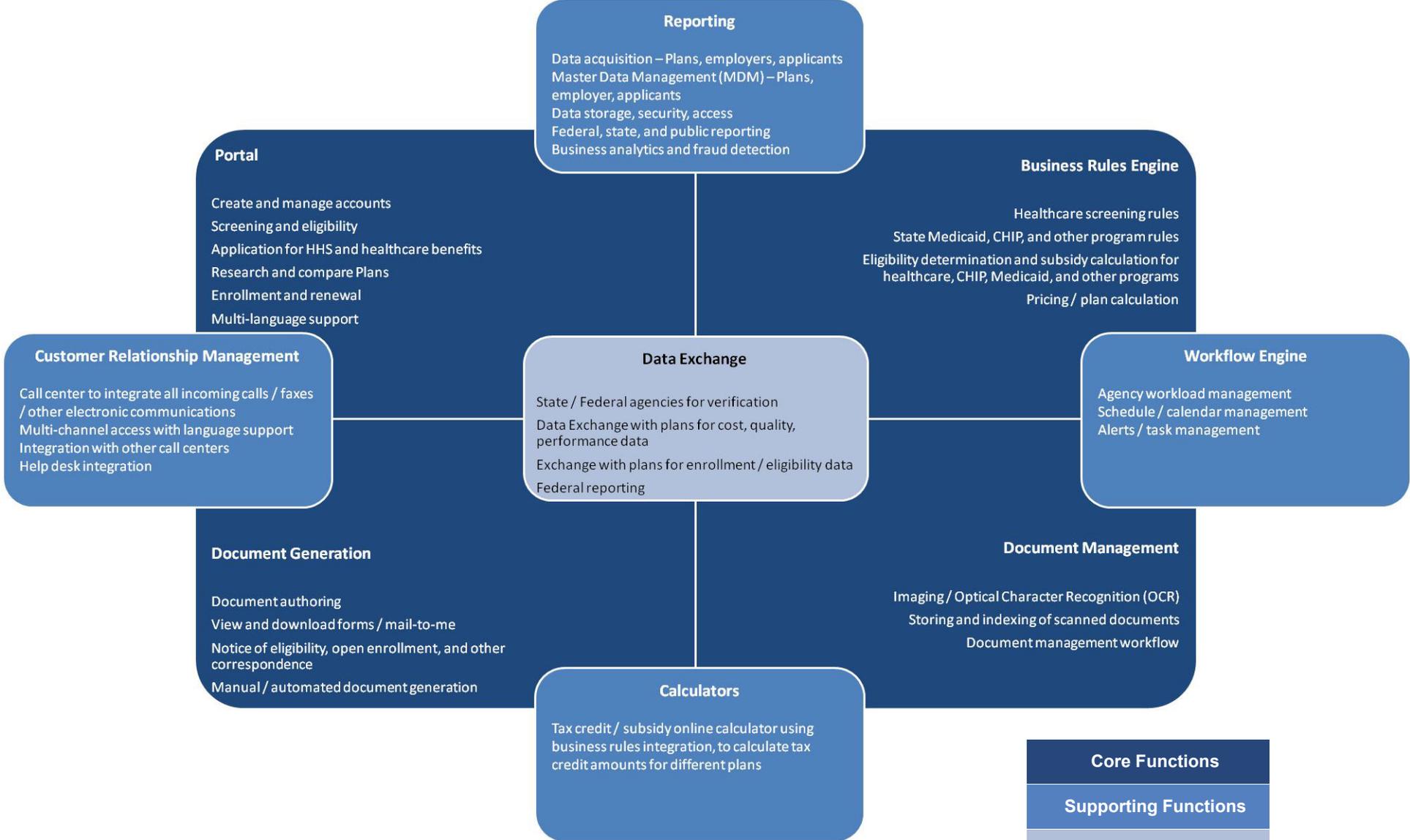
PPACA LEGISLATIVE REQUIREMENTS	ADDITIONAL CONSIDERATIONS
<ul style="list-style-type: none">• States must ensure the Exchange is self-sustaining by January 1, 2015• Exchange may charge assessments or user fees to participating health plans, or to otherwise generate funding• Administrative and operational funds cannot be used to fund retreats, promotional giveaways, etc.• Pay for new spending, in part, through spending and coverage cuts in Medicare Advantage• Grants to be made available to States for planning and activities related to establishing an Exchange. Grants may be renewed	<ul style="list-style-type: none">• Define targeted optimal revenue sources mix• Define percent administrative fee on the policies sold to become financially sustainable• Identify approach to funding initial start up and administrative cost

State and Federal Coordination

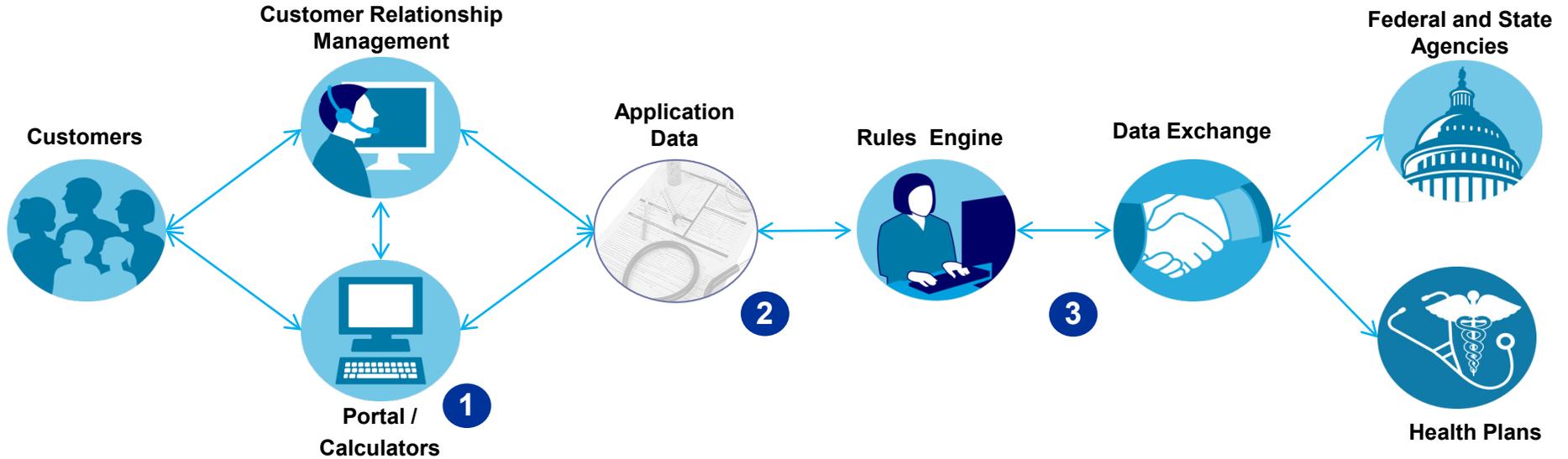
PPACA LEGISLATIVE REQUIREMENTS	ADDITIONAL CONSIDERATIONS
<ul style="list-style-type: none"> • Transfer applicant-provided information to HHS Sec'y for verification • Data matching program will be primary mechanism for establishing, verifying and updating eligibility • Verification and determination amongst Federal agencies will be completed online, and Sec'y will notify Exchange of results; Sec'y may delegate some verification responsibility to the Exchange • Exchange must provide to the Sec'y of the Treasury and to the taxpayer relating to any Exchange plan, any information provided to the Exchange, including change in circumstances necessary to determine eligibility, and the amount of the premium assistance tax credit; name, address and TIN of the primary insured, and the name and TIN of each individual covered under the policy; total premium, excluding applicable premium assistance tax credit or cost-sharing reductions; level of coverage provided, and the period of coverage; aggregate amount of any advance payment; information needed to determine if taxpayer received excess advance payment • If applicant-provided information related to enrollment, premium tax credits and cost-sharing reductions is positively verified, HHS Sec'y will notify the Treasury Sec'y of the amount of any advance payment to be made; also, if applicant-provided information relating to exemption from individual responsibility requirement is verified, HHS Sec'y will issue a certification of exemption • Exchange must also transfer to the Sec'y of Treasury the name and TIN of: Those issued an exemption from the individual mandate; each individual who has an employer but was determined eligible for the premium tax credit; each individual who notifies the Exchange that they have changed employers; each individual who ceases coverage during the year • State may authorize Exchange to contract with an eligible entity to carry out Exchange responsibilities 	<ul style="list-style-type: none"> • Define how plan data across State and Federal entities will be integrated to support State goals • Identify how State and Federal business rules will be maintained and synched • Define overall data security and privacy

Technology Operating Model & Components Review

Technology Operating Model

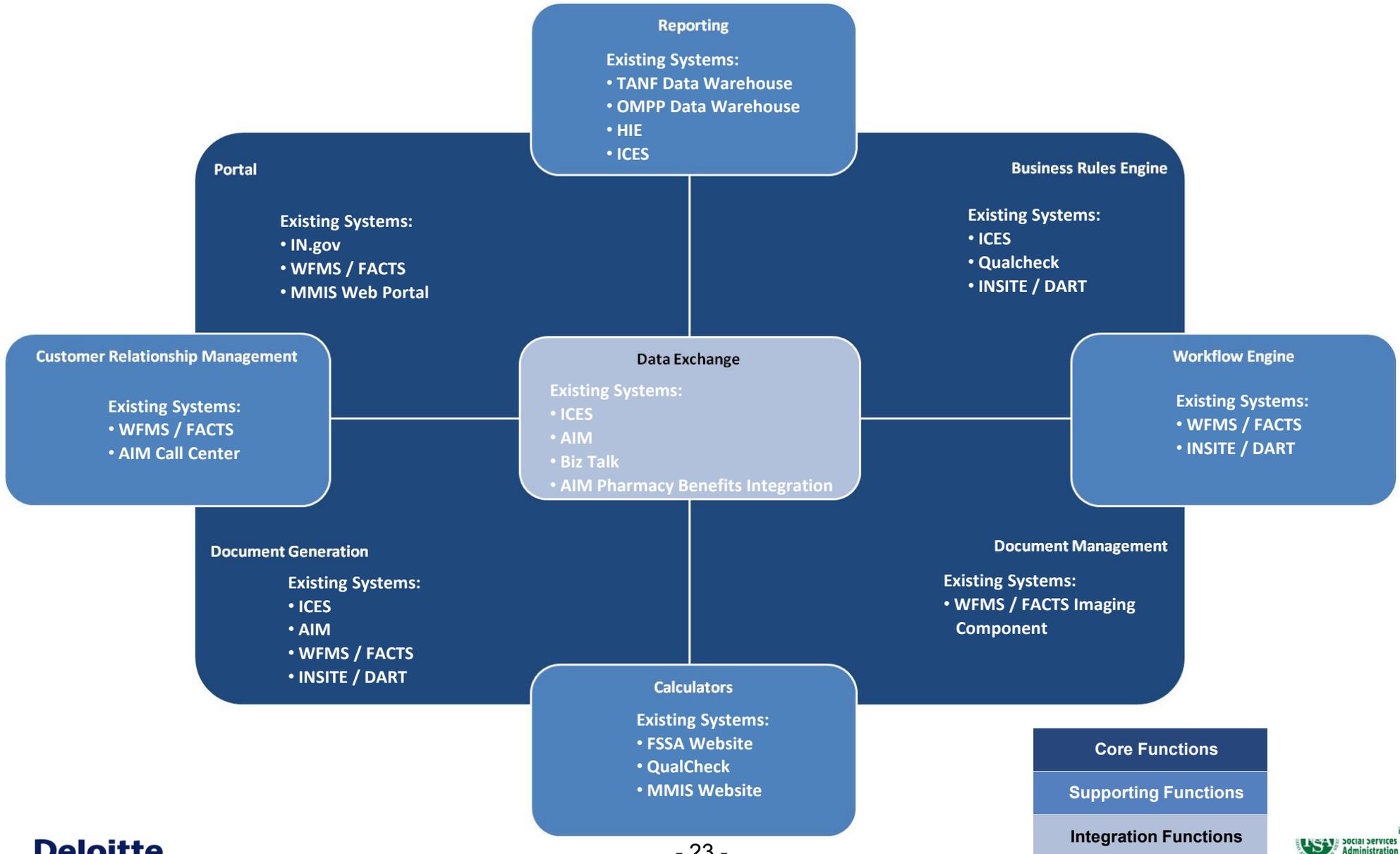


Technology Operating Model: Business Process View



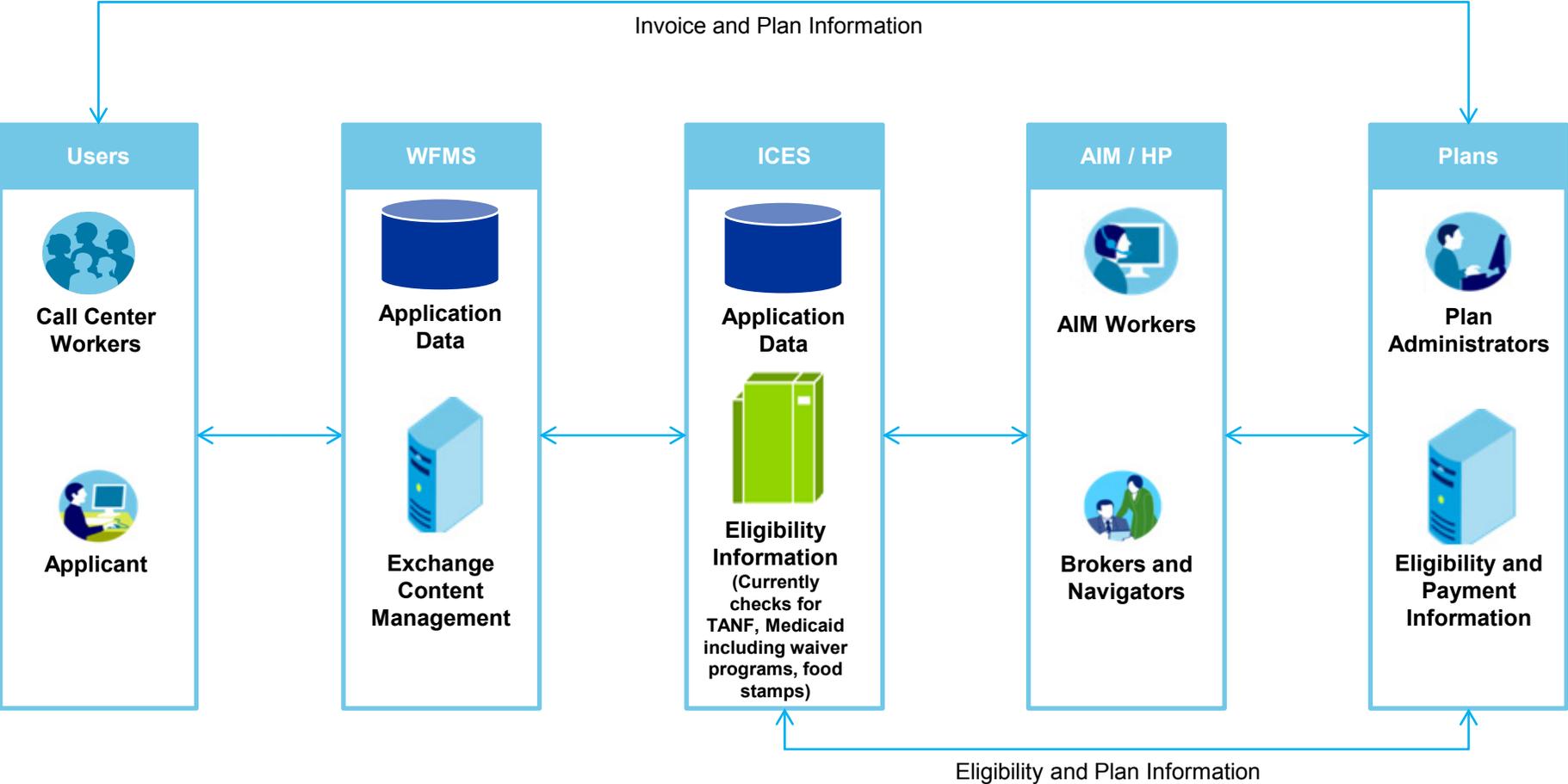
Step	Action	Supporting Technology Components
1.	Uninsured individual logs in and creates account	<ul style="list-style-type: none"> Portal
2.	Individual provides screening and eligibility data	<ul style="list-style-type: none"> Portal
3.	Exchange provides plan and premium eligibility information (subsidized and unsubsidized)	<ul style="list-style-type: none"> Business Rules Engine Data Exchange
4.	Individual is routed to plan (or program) selection page	<ul style="list-style-type: none"> Workflow Engine
5.	Individual determines plan costs by using online calculator	<ul style="list-style-type: none"> Calculator
6.	Individual selects plan and enrolls	<ul style="list-style-type: none"> Portal Business Rules Engine
7.	Plan receives enrollment information	<ul style="list-style-type: none"> Data Exchange
8.	Enrollment documentation is sent to the individual	<ul style="list-style-type: none"> Document Generation Document Management
9.	Individual receives documentation and seeks clarifications via phone	<ul style="list-style-type: none"> CRM
10.	Plan reports enrollment as part of periodic report to Exchange	<ul style="list-style-type: none"> Reporting

Technology Operating Model: Indiana Assets

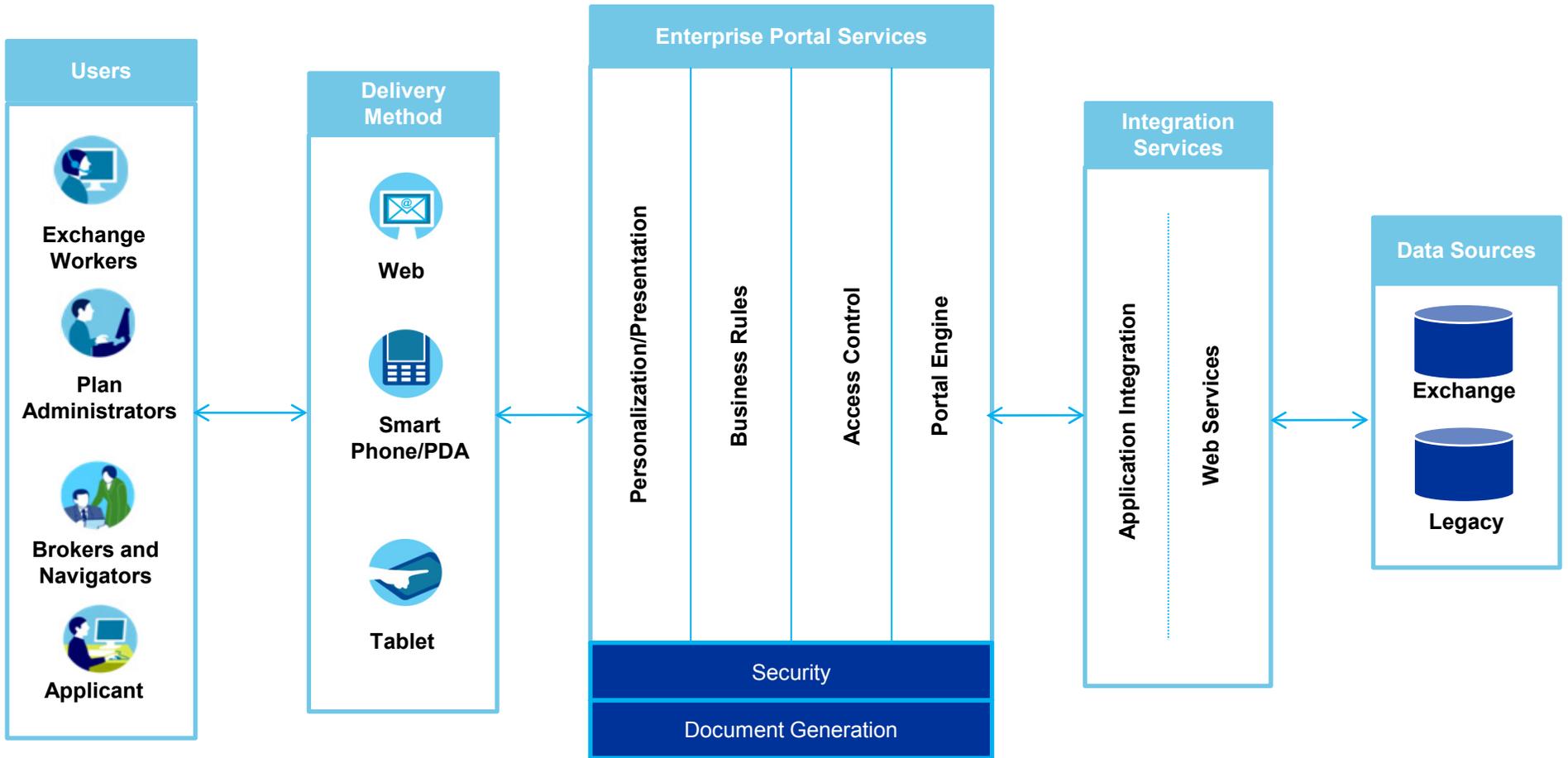


Indiana Current System Layout

Typical Medicaid Eligibility Flow for Indiana (Managed Care Plans)



FUNCTIONALITY	REFERENCE TECHNOLOGY ARCHITECTURE
<ul style="list-style-type: none"> • Outreach <ul style="list-style-type: none"> • Navigator and broker outreach • Applicant outreach – information about insurance plans, rates, quality, etc. • Multi-language support (applicable to other portal functions) • On-line help (applicable to other portal functions) • Intuitive navigation (applicable to other portal functions) • ADA compliance (applicable to other portal functions) • Screening and Eligibility <ul style="list-style-type: none"> • Multi-view support for applicants / brokers / navigators / employers / issuers • Create and manage accounts: “My Accounts” • Security / access rights / HIPAA compliance • Eligibility determination / screening for Medicaid, CHIP, Health subsidy, and other applicable programs data entry and results • Enrollment <ul style="list-style-type: none"> • Multi-view support for applicants / brokers / navigators / employers / issuers • Display of information related to plan – service quality, cost, performance • Change and renew plans annually / benefit change • Plan management <ul style="list-style-type: none"> • Maintain plan data • Health plan cost, quality, performance, and comparison • Enrollment / disenrollment integration • Manage plan certification • Employer Relations <ul style="list-style-type: none"> • Registration, manage benefit level, plan selection, manage employees, manage exemptions, managing free choice vouchers • Program Finances <ul style="list-style-type: none"> • Taxpayer / public view of exchange finances 	<ul style="list-style-type: none"> • Presentation Layer <ul style="list-style-type: none"> • Controls the presentation of information to stakeholders • Presents different views based on the user profile – applicant / employee, broker / navigator, employer, plan, and Exchange worker • Business Rules Layer <ul style="list-style-type: none"> • Governs the navigation of the application • Performs business rules for data profiling, error correction, and data completeness • Governs security and access level • Database Layer <ul style="list-style-type: none"> • Stores the application, plan, and eligibility / subsidy data • External Interface Layer <ul style="list-style-type: none"> • Interface with State systems for eligibility determination • Interface with Federal / State agencies for data verification
	<h3>ADDITIONAL TECHNOLOGY CONSIDERATIONS</h3>
<h3>EXISTING INDIANA ASSETS</h3> <ul style="list-style-type: none"> • IN.gov • WFMS / FACTS • MMIS Web Portal 	<ul style="list-style-type: none"> • 24/7 availability • Performance: There could be over 1.7 million people using exchange (945,000 Medicaid recipients and 837,000 currently uninsured, in addition to 878,000 on Medicare, 205,000 with individual coverage and many who are currently covered by employer coverage – source KFF www.Statefacts.org) • Automation: A simplified process to apply for services that can be automated and integrated with other State and Federal data sources to determine eligibility and automated renewal process • No wrong door: single application form across integrated web sites • Leverage Federal capabilities: HHS will assist States through the operation of and anticipated improvements to the Federal informational Web portal (www.healthcare.gov), the release of a model template for State Exchange Web portals, the development of a model single, streamlined application form

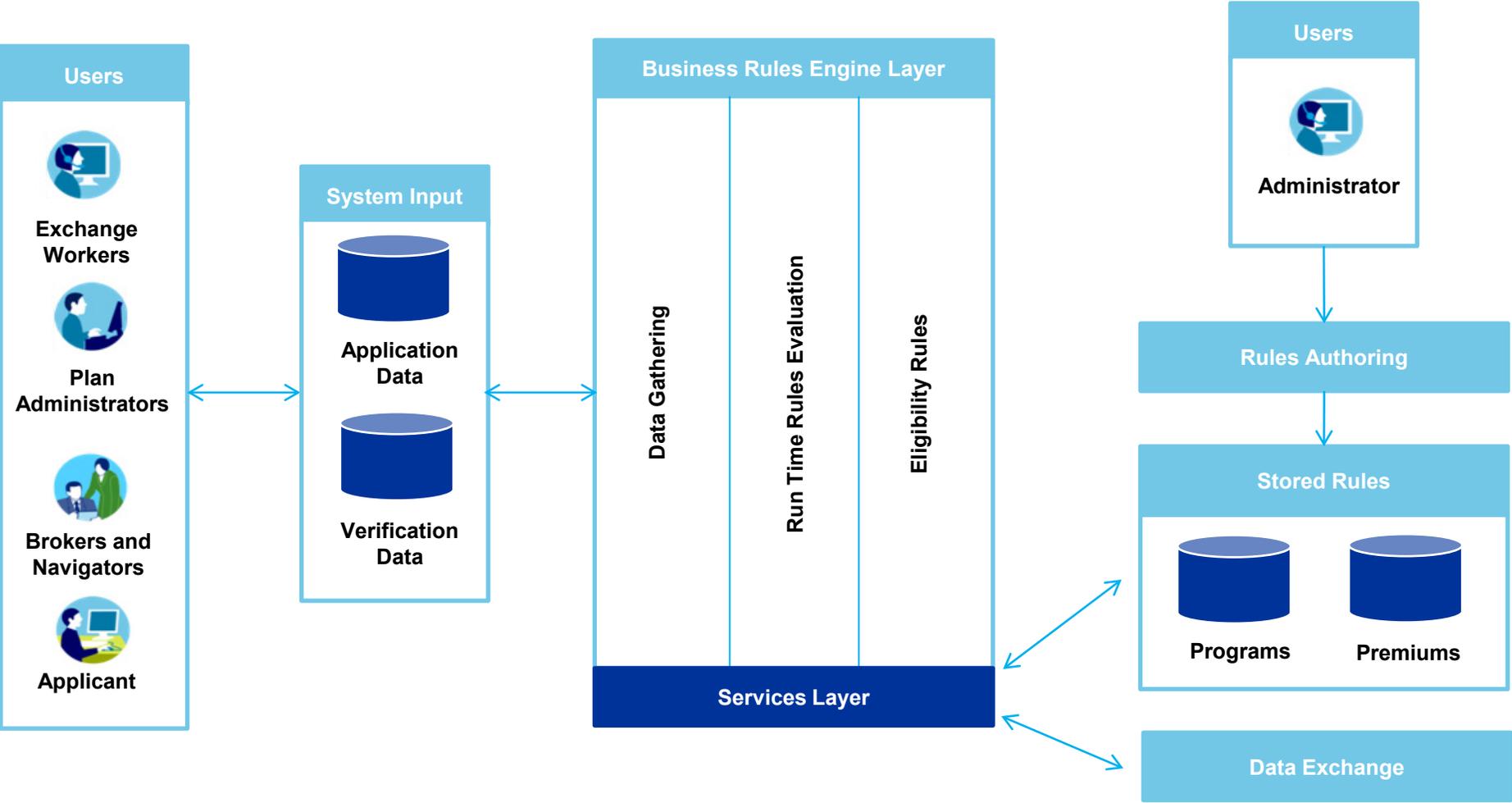


Business Rules Engine

Business Rules Engine

FUNCTIONALITY	REFERENCE TECHNOLOGY ARCHITECTURE
<ul style="list-style-type: none"> • Screening and Eligibility Determination <ul style="list-style-type: none"> • Business rules integration/eligibility determination (using SOA) • Premium eligibility determination and calculation • Enrollment Management <ul style="list-style-type: none"> • Plan search and sort functionality • Data routing 	<ul style="list-style-type: none"> • Data gathering: Process to obtain data from data entry system • Run time rules evaluation: Evaluation of rules based on initial data gathering and requesting additional data and verification • Rules storage and authoring: Development and administration of rules requires special security consideration • Exchange integration: Integrating the rules engine with the exchange will depend on the scale of responsibilities assigned to the Exchange by the State. If the data entry is performed in the exchange and eligibility determination is performed in the eligibility system, rules engine integration will be required • Services integration: Integration services with various components – State and Federal agencies for data profiling and verification, integration with exchange for applicant data, and integration with plans for plan data
EXISTING INDIANA ASSETS	ADDITIONAL TECHNOLOGY CONSIDERATIONS
<ul style="list-style-type: none"> • QualCheck • ICES • INSITE / DART 	<ul style="list-style-type: none"> • Medicaid rules are overly complex due to the varying level of services covered under each program. With the integration of subsidized care, the complexity will grow unless the State and Federal rules governing programs collaborate towards simplifications • Integrating services and eligibility for programs that are currently not administered by the same agency will require complex coordination and rules integration with external programs

Business Rules Engine

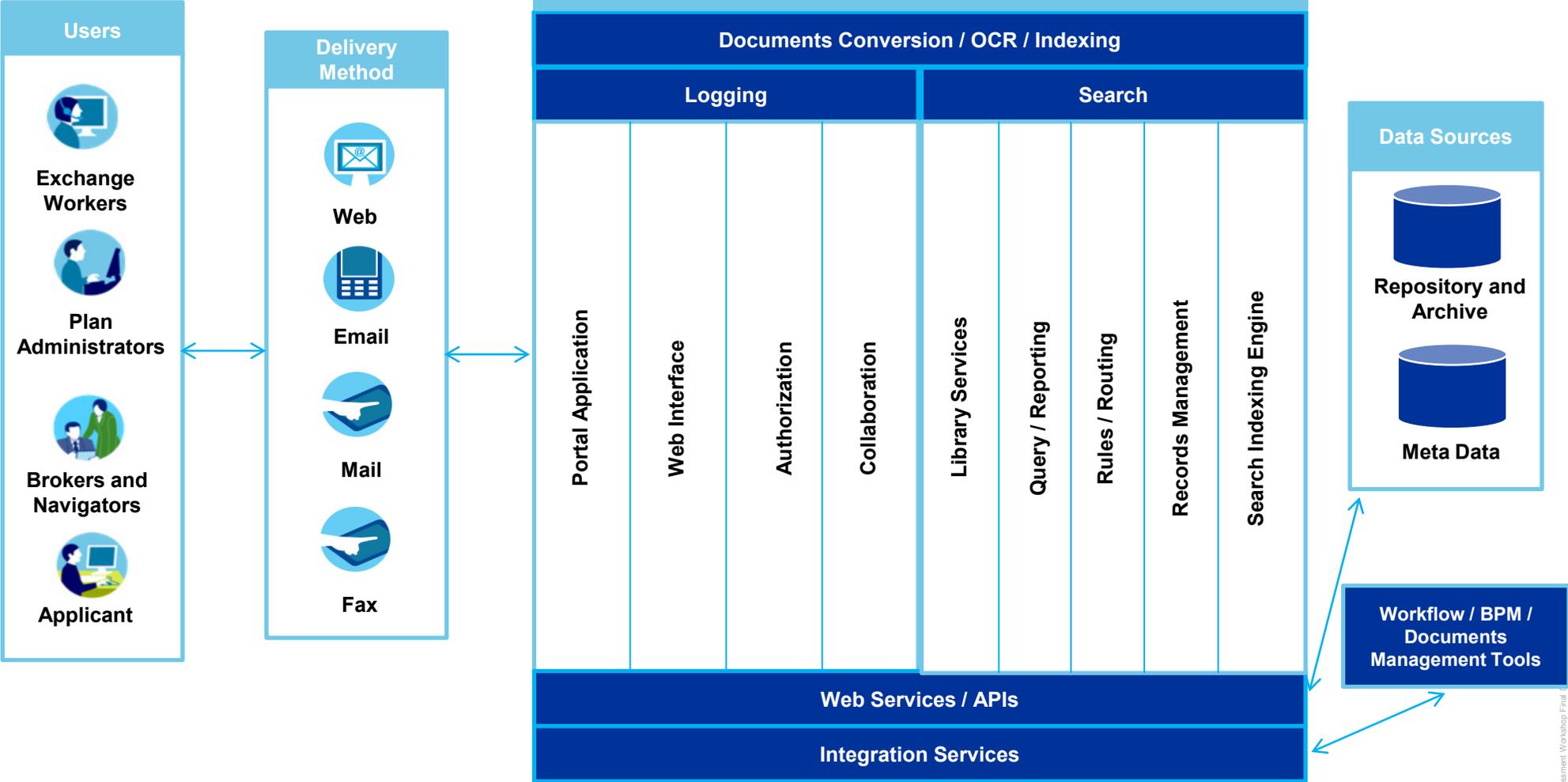


Document Management



FUNCTIONALITY	REFERENCE TECHNOLOGY ARCHITECTURE
<ul style="list-style-type: none"> • Screening and Eligibility <ul style="list-style-type: none"> • Imaging and OCR for paper applications/verifications • Indexing and retrieval of scanned documents • Customer Relationship Management and Support <ul style="list-style-type: none"> • Imaging and OCR for incoming documents • Broker licensing and plan certification processing 	<ul style="list-style-type: none"> • Document Capture <ul style="list-style-type: none"> • Document scanning • Optical Character Recognition (OCR) • Document indexing • Workflow and Integration <ul style="list-style-type: none"> • Governs the security and access to images • Document workflow to trigger next steps • Web services and integration with other systems (eligibility, plan, and other applicable systems) • Storage Layer <ul style="list-style-type: none"> • Metadata repository • Document repository and archive • External Interface Layer <ul style="list-style-type: none"> • Interface with eligibility system • Interface with plans
EXISTING INDIANA ASSETS	ADDITIONAL TECHNOLOGY CONSIDERATIONS
<ul style="list-style-type: none"> • WFMS / FACTS Imaging Component 	<ul style="list-style-type: none"> • Projected volume increase in stored data volume • Leverage of HIE data management and storage best practices • Data conversion scope – Data conversion scope – Need of storing and imaging past eligibility data

Document Management

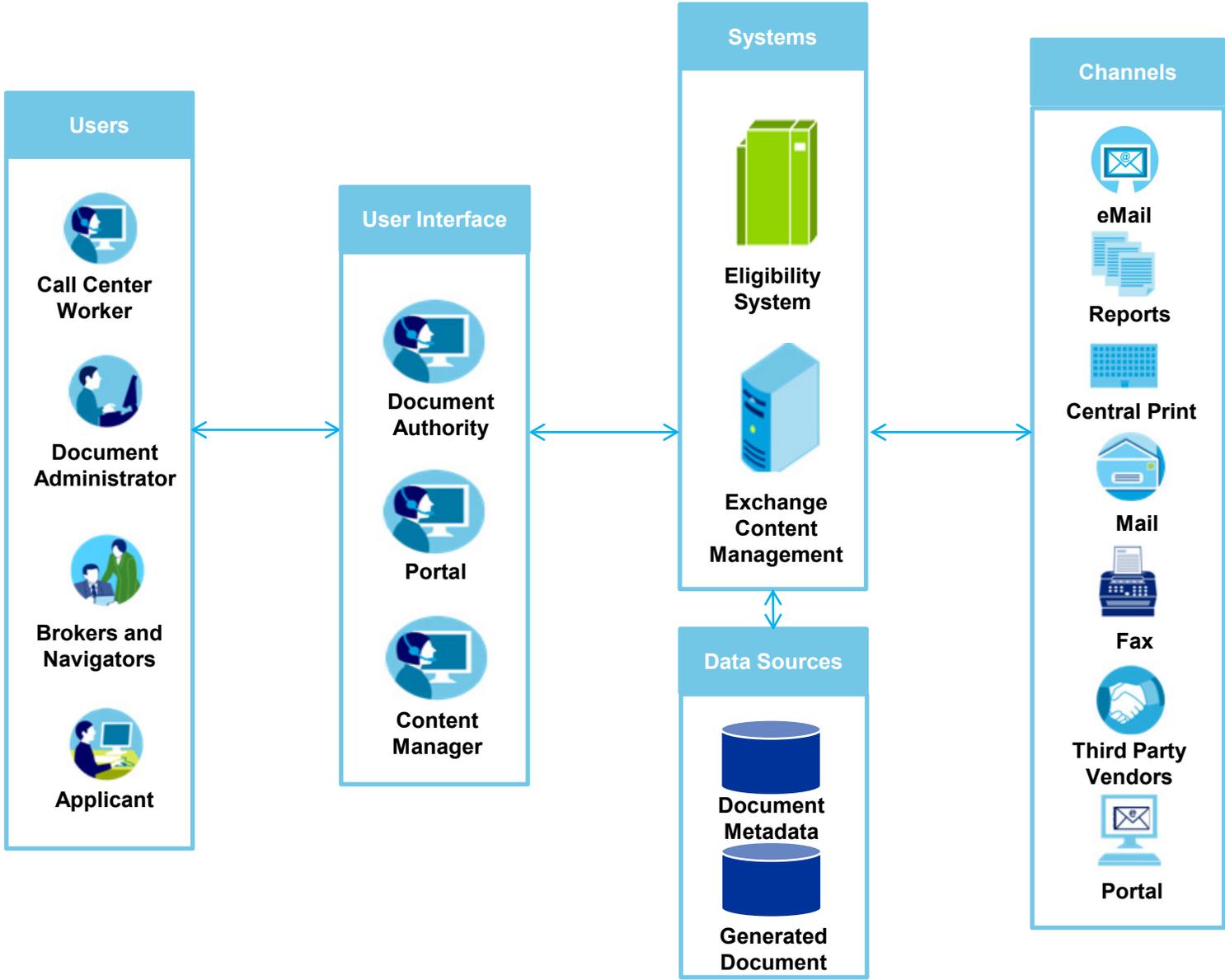


Document Generation

Document
Generation

FUNCTIONALITY	REFERENCE TECHNOLOGY ARCHITECTURE
<ul style="list-style-type: none"> • Outreach and Marketing <ul style="list-style-type: none"> • View and download application form/plan comparison sheet/plan material • Mail-it to me feature • Multi-language support • Screening and Eligibility <ul style="list-style-type: none"> • Notice of eligibility, other periodic correspondence as needed • Enrollment Management <ul style="list-style-type: none"> • It is our assumption that all plan related mailing will be done by individual plans providers once applicant selects a plan • Customer Relationship Management and Support <ul style="list-style-type: none"> • Manual document generation based on client interaction 	<ul style="list-style-type: none"> • Presentation Layer / User Interface <ul style="list-style-type: none"> • Document authoring by document specialists • Aids in Viewing / Modifying / Printing documents • Document generation workflow for authoring and generation • Business Rules Layer (System) <ul style="list-style-type: none"> • Governs the security and access to documents • Performs data gathering based on document template • Performs integration of document template and data • Database Layer (System) <ul style="list-style-type: none"> • Stores the generated documents • External Interface Layer (Publication) <ul style="list-style-type: none"> • Interface with printer / print vendor for printing and mailing • Address validation and address verification
EXISTING INDIANA ASSETS	ADDITIONAL TECHNOLOGY CONSIDERATIONS
<ul style="list-style-type: none"> • ICES • AIM • WFMS / FACTS • INSITE / DART 	<ul style="list-style-type: none"> • Real time or quasi real time document generation requirements • Print and mailing volume may be very large and overwhelm current State systems • Tradeoffs (costs, consistency, quality) associated with centralization level of document creation/generation

Document Generation



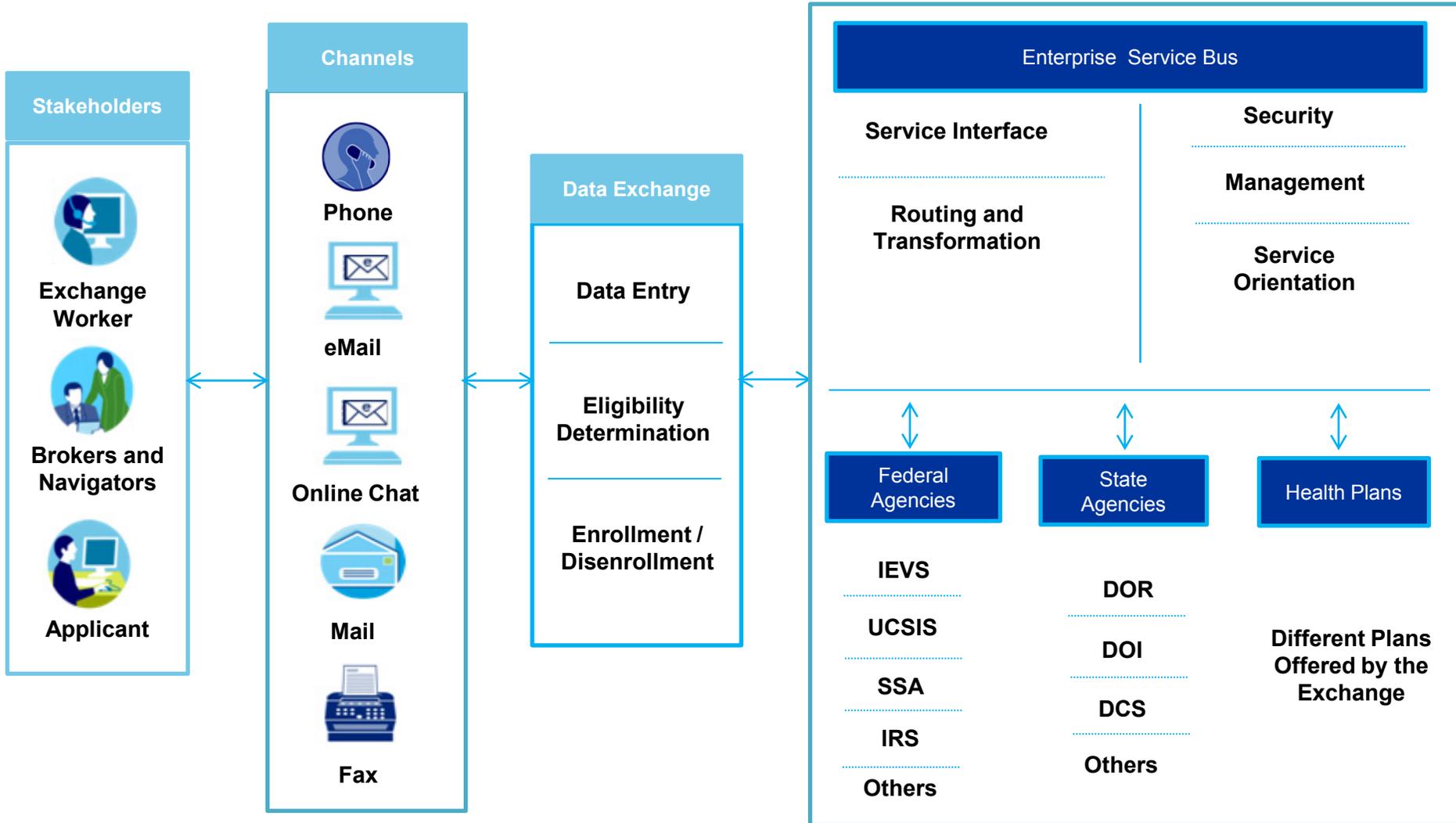
Data Exchange

Data Exchange

FUNCTIONALITIES	REFERENCE TECHNOLOGY ARCHITECTURE
<ul style="list-style-type: none"> • Screening and Eligibility determination <ul style="list-style-type: none"> • Data exchange with State/Federal agencies for verification (using SOA/ESB) • Premium Billing and Collection <ul style="list-style-type: none"> • Data exchange(using ESB) with plans for transferring subsidy information • Enrollment Management <ul style="list-style-type: none"> • Data Exchange(using ESB) with plans for transferring enrollments/subsidy eligibility information • Data Exchange with plans for managing enrollment • State/Federal Coordination <ul style="list-style-type: none"> • Data Exchange(using ESB) Federal: IRS, HHS, SSA, Other Federal verifications • Data Exchange(using ESB) State: Eligibility determination, other applicable programs, State verification • Data Exchange(using ESB) Plans: Health Plans 	<ul style="list-style-type: none"> • Enterprise Service Bus <ul style="list-style-type: none"> • Service interface • Routing and transformation • EDI engine • Business to business translator services • Security • Management • Service orientation • Integration <ul style="list-style-type: none"> • Federal / State / Health Plans
EXISTING INDIANA ASSETS	ADDITIONAL TECHNOLOGY CONSIDERATIONS
<ul style="list-style-type: none"> • ICES • AIM • BizTalk • AIM Pharmacy Benefits 	<ul style="list-style-type: none"> • Large number of target systems and organizations • Time to process requirements • Data security and privacy considerations during Data Exchange • Potentially different technologies used by different Data Exchange partners • Compliance with applicable standards: FIPS, HIPAA 5010, Section 1561, HL7, ICD10.

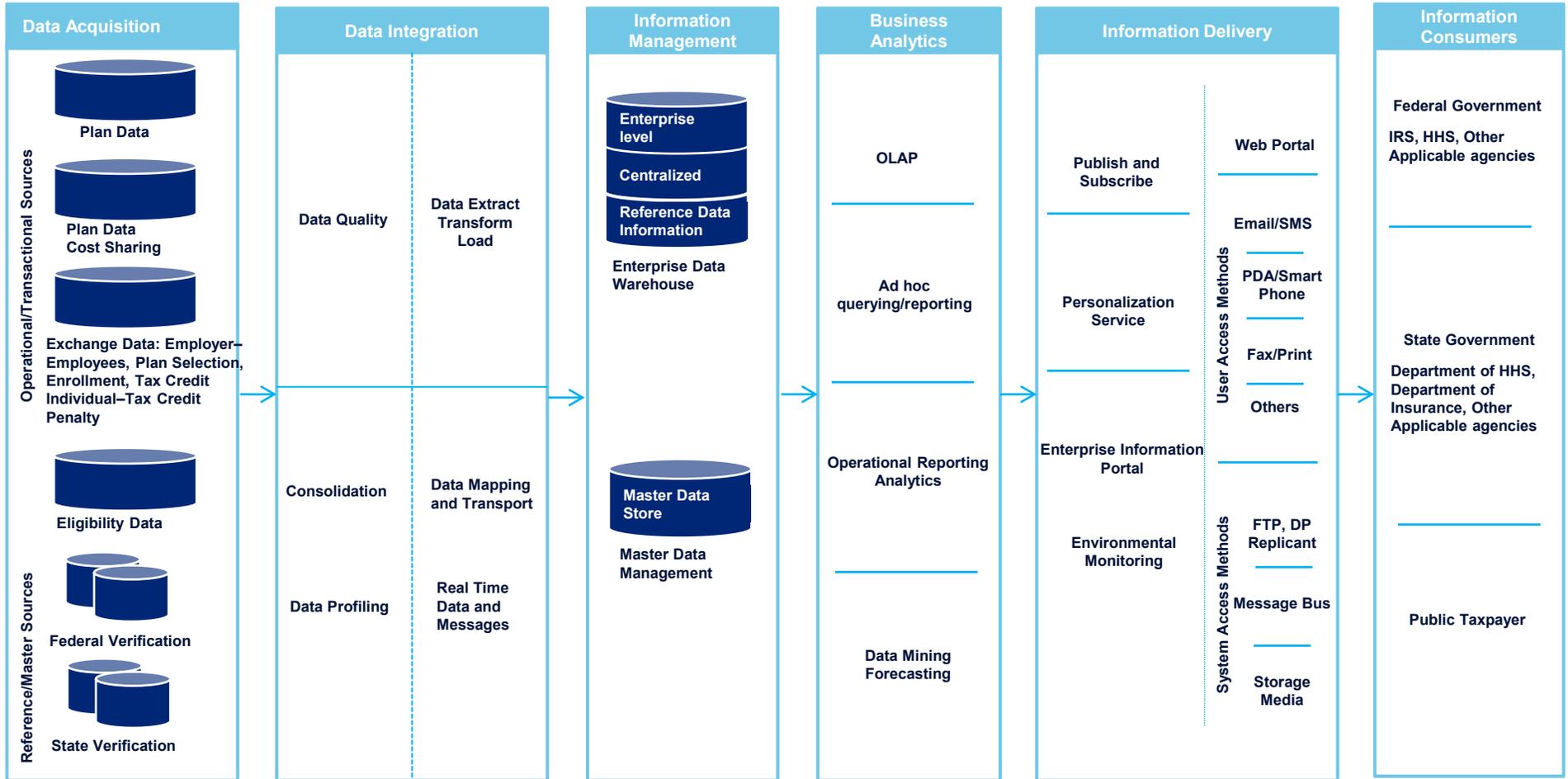
Data Exchange

Data Exchange



FUNCTIONALITY	REFERENCE TECHNOLOGY ARCHITECTURE
<ul style="list-style-type: none"> • Premium Billing and Collection <ul style="list-style-type: none"> • Data management: Security/access rights/IRS and SSA compliance, audit trails for data viewing • Financial data storage: Data storage of all plan costs, subsidies, cost sharing, tax credit data • Plan data reporting of cost sharing of Federal payments • Employer data reporting for Federal tax credit • Individual data reporting for W2 • Reporting and Performance <ul style="list-style-type: none"> • Data acquisition: Plan data – quality, performance, certification, premium, cost sharing, geographic locations served. Employer data – enrollment, tax credit, penalty. Individual data – tax credit, penalty • Master data management: Plan data management, employer data management, individual data management (data ownership, data profiling, data matching, error detection) • Information management: data storage, data security, data access, data transformation tools, reporting authoring tools • Information delivery: Federal reporting – Treasury (tax credit and penalty data), HHS (Cost sharing, plan cost, plan quality, plan performance, fraud, expenses, etc.), portal reporting – reporting of plan data (quality, performance, premium cost sharing), other State mandated reporting • Business analytics: Fraud detection – data driven fraud analytics, performance management – data driven performance and cost / quality analytics • Employer Relations <ul style="list-style-type: none"> • Tax credit, penalty reporting • Benefits and Actuarial <ul style="list-style-type: none"> • Business analytics: Predictive analytics to identify plan expenditure and calculate risk/reinsurance needs • Financial tools: Actuarial tool integration: Integration with tools to calculate/manage actuarial information. financial tools: fraud detection, tracking and reporting • Program Finances <ul style="list-style-type: none"> • Public /Taxpayer reporting of expenses, fraud, premium cost sharing, and subsidy information 	<ul style="list-style-type: none"> • Data Acquisition <ul style="list-style-type: none"> • Plan, employer, and applicant data • Data standardization • Data Integration <ul style="list-style-type: none"> • Data quality • Data profiling • Extract, transformation, and load • Real-time data and messages • Information Management <ul style="list-style-type: none"> • Enterprise data warehouse • Master data management • Business Analytics <ul style="list-style-type: none"> • Online Analytics Processing (OLAP) • Ad-hoc querying and reporting • Operational reporting analytics • Data mining and forecasting • Information Delivery <ul style="list-style-type: none"> • Enterprise information portal (personalization, publish and subscribe, environment) • User access methods (web, PDA/smart phone, email, print, other) • System access methods (FTP, Storage, Message) • Information Consumers <ul style="list-style-type: none"> • State, Federal, and public views • Access control and authorization
EXISTING INDIANA ASSETS	ADDITIONAL TECHNOLOGY CONSIDERATIONS
<ul style="list-style-type: none"> • TANF Data Warehouse • OMPP Data Warehouse • ICES 	<ul style="list-style-type: none"> • Projected number of reports for each user type • Online Vs. Offline reporting scope • Identify early on business analytics needs that will help reduce cost, improve services

Reporting



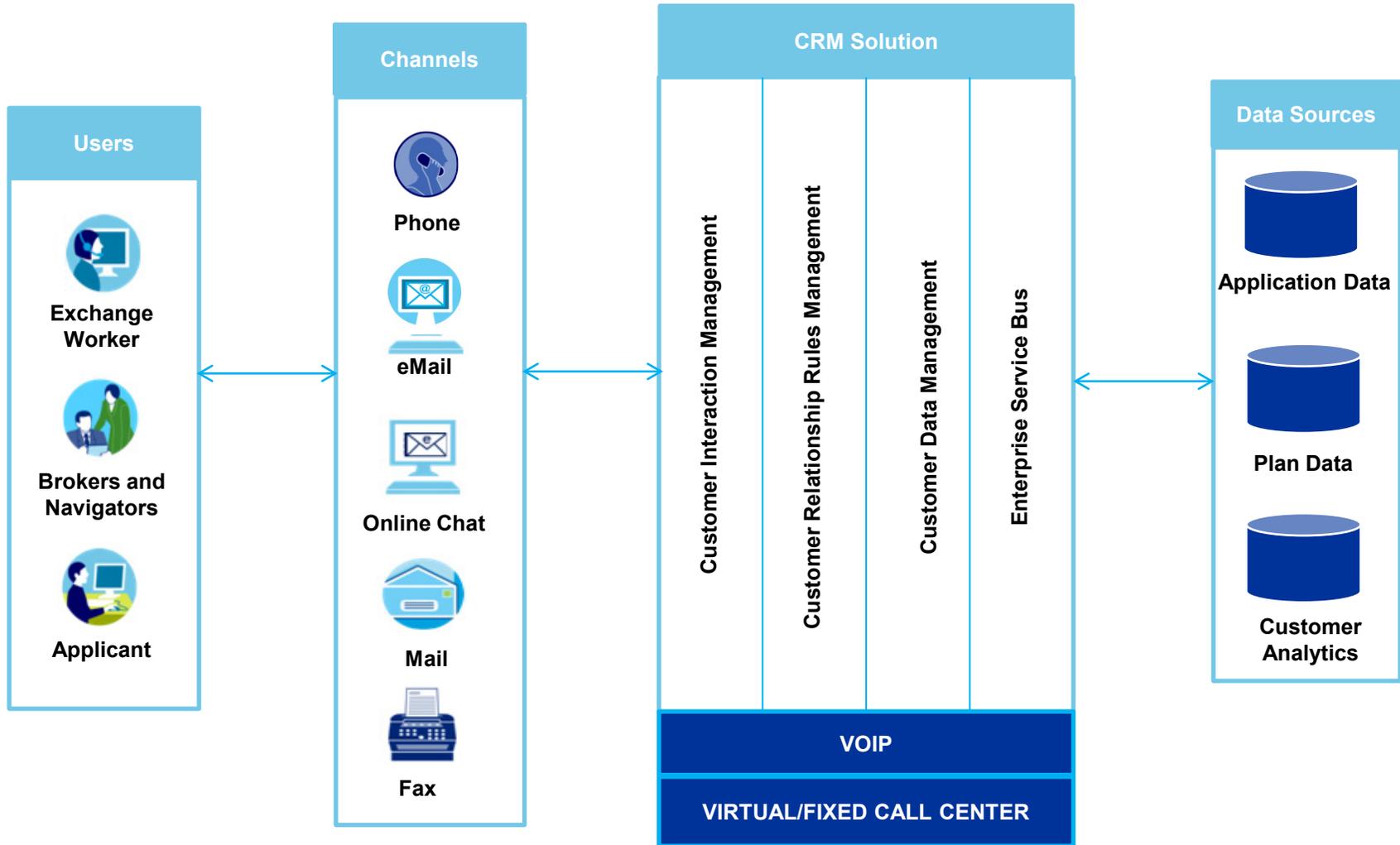
Customer Relationship Management (CRM)



FUNCTIONALITY	REFERENCE TECHNOLOGY ARCHITECTURE
<ul style="list-style-type: none"> • Customer Relationship Management and Support <ul style="list-style-type: none"> • Fixed / virtual call center to integrate all incoming calls / faxes / other electronic communications such as email, online chat, and call-me feature • Multi-channel access with language support • Integration with other call centers operated by States for other applicable programs • Interactive voice response / voice response unit support • Account management support for plans, brokers, navigators, employers, applicants (password reset, etc.) • Help-desk integration for technical support 	<ul style="list-style-type: none"> • Customer Interaction Management <ul style="list-style-type: none"> • Multi-channel interaction such as email, fax, call, chat, regular mail • Escalation procedures and infrastructure • Standard customer interaction data gathering • Customer Relationship Rules Management <ul style="list-style-type: none"> • Interaction based on pre-configured rules such as transferring calls / chats to different worker based on security level, channel selected, type of interaction (inquiry, application for services, etc.) • Customer Data Management <ul style="list-style-type: none"> • Security on what data can be modified • Access control on what data can be stored from customer interaction • Integration Services <ul style="list-style-type: none"> • Interface with applicant and plan data • Integration with customer analytics and reporting to identify better ways to serve customer • Integration with portal and documents management
EXISTING INDIANA ASSETS	ADDITIONAL TECHNOLOGY CONSIDERATIONS
<ul style="list-style-type: none"> • WFMS / FACTS • AIM Call Center 	<ul style="list-style-type: none"> • Hours of operations • Off peak and peak volume operation • Technology impact of customer relationship management services delegation to plans

Customer Relationship Management (CRM)

Customer Relationship Management (CRM)

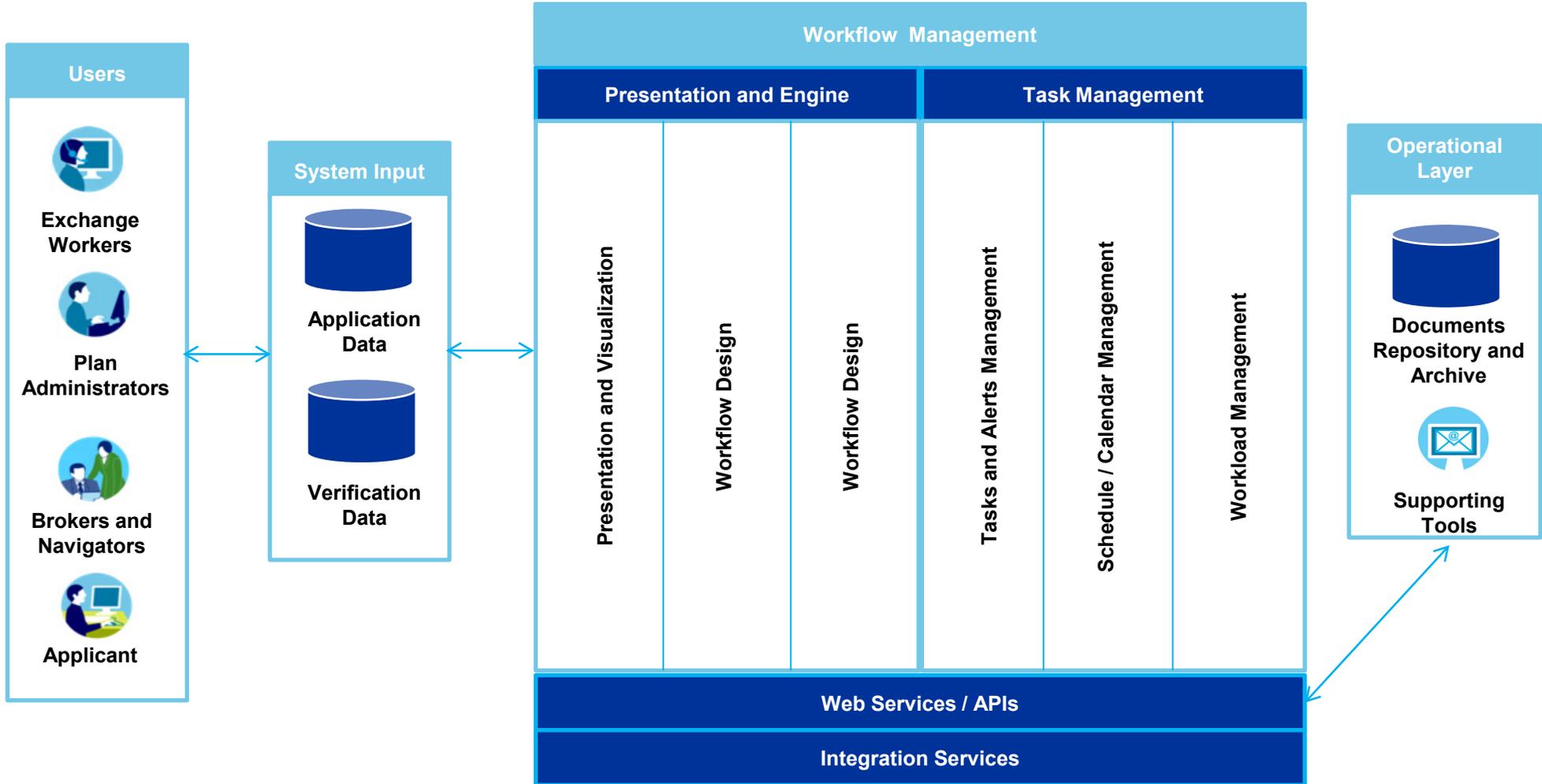


Workflow Engine



FUNCTIONALITY	REFERENCE TECHNOLOGY ARCHITECTURE
<ul style="list-style-type: none"> • Screening and Eligibility Determination <ul style="list-style-type: none"> • Agency workload management • Schedule / calendar management • Alerts / task management • Enrollment Management <ul style="list-style-type: none"> • Agency workload management • Schedule/calendar management • Alerts/task management 	<ul style="list-style-type: none"> • Presentation Layer <ul style="list-style-type: none"> • Presentation and virtualization • Workflow design • Workflow Management Engine • Task Management Layer <ul style="list-style-type: none"> • Tasks and alerts management • Schedule / calendar management • Workload management • Operational layer <ul style="list-style-type: none"> • Supporting tools • Documents repository and archive
EXISTING INDIANA ASSETS	ADDITIONAL TECHNOLOGY CONSIDERATIONS
<ul style="list-style-type: none"> • WFMS / FACTS • INSITE / DART 	<ul style="list-style-type: none"> • Cross website workflow support and customer experience boundary limits • Scalability to support projected users and load • Integrating workflow in processes used by multiple systems such as eligibility, enrollment, plan systems

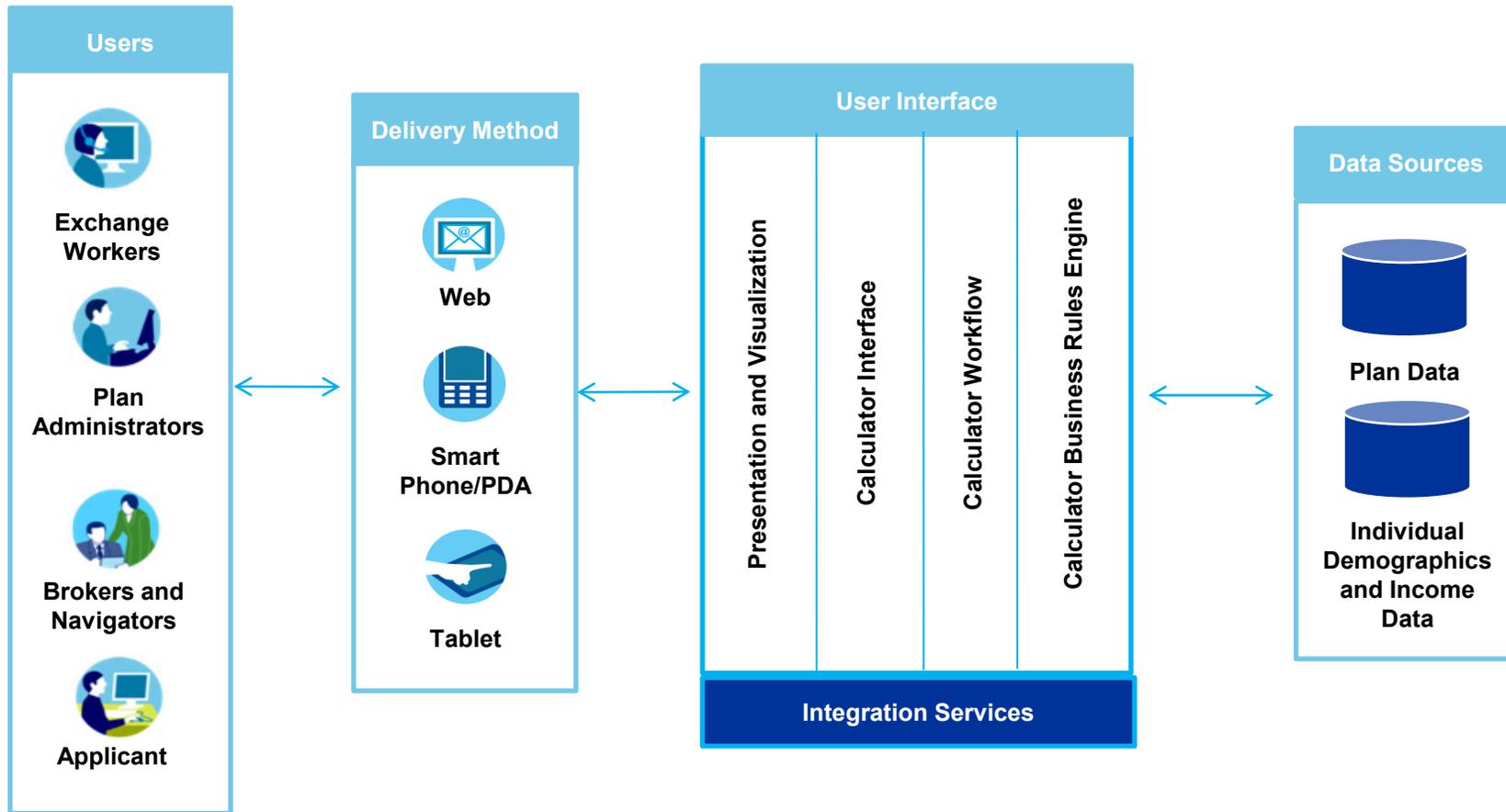
Workflow Engine



Calculators

Calculators

FUNCTIONALITY	REFERENCE TECHNOLOGY ARCHITECTURE
<ul style="list-style-type: none"> • Employer Support: <ul style="list-style-type: none"> • Tax Credit: Online calculator using business rules integration, to calculate tax credit / subsidy amounts for different plans • Premium Billing and Collection <ul style="list-style-type: none"> • Tax Credit: Online calculator using business rules integration, to calculate tax credit / subsidy amounts for different plans 	<ul style="list-style-type: none"> • Presentation and virtualization • Calculator interface • Calculator workflow • Calculator rules engine • Data storage: individual and plan data
EXISTING INDIANA ASSETS	ADDITIONAL TECHNOLOGY CONSIDERATIONS
<ul style="list-style-type: none"> • FSSA Website • QualCheck • MMIS Website 	<ul style="list-style-type: none"> • Near real time performance • Integration of calculator and eligibility functionality to align calculated results • Automated data feed



Technology Components: Minimal Vs. Comprehensive View

Component	Minimal Model	Comprehensive Model
Portal	<ul style="list-style-type: none"> Eligibility determination, enrollment for State programs Broad plan choices Passing of enrollments to plans' websites via links 	<ul style="list-style-type: none"> Enrollment into subsidized and unsubsidized plans State negotiated plans/benefits and limited plan options Publication of meeting minutes, progress reports and communications Online broker licensing, plan certification processes GIS Integration (plans may be regional / local)
Business Rules Engine	<ul style="list-style-type: none"> Passing of data to eligibility systems Passing of data to plans for enrollments No premium claim data management or associated billing rules 	<ul style="list-style-type: none"> Implementation of strong rules/search functionality (e.g. by price, quality, benefit need) Assumes full responsibility for collecting and reporting subsidized premium Maintenance of broad set of enrollment rules Integration with eligibility rules engine
Document Management	<ul style="list-style-type: none"> No electronic document integration to the eligibility system Documentation received is simply forwarded to relevant agency, plans or systems 	<ul style="list-style-type: none"> Documentation stored and managed by the Exchange All paper documentation stored electronically
Document Generation	<ul style="list-style-type: none"> Limited documents generation capabilities Some forms available online to be printed Notices sent by eligibility system, MMIS, plans Outreach documentation is responsibility of navigators 	<ul style="list-style-type: none"> Forms created, available and printed by the Exchange Outreach documentation created and centralized by Exchange Language support
Data Exchange	<ul style="list-style-type: none"> Passes on application data only Acceptance of required reporting data elements from plans 	<ul style="list-style-type: none"> Integration with plans for enrollment, quality, cost data: Plan intakes enrollment data via 100% automated transaction Full responsibility for collecting and reporting subsidized premium by the Exchange Integration with State, Federal, plans for data profiling
CRM	<ul style="list-style-type: none"> Facilitation to Exchange workers to provide information upon request Delegates most customer inquiries and support services to plans 	<ul style="list-style-type: none"> Multi-channel support for purchase and enrollment for all segments Creation and operation of Sales/Telemarketing function Maintenance of customer interaction history and records Integration with Eligibility and MMIS systems
Reporting	<ul style="list-style-type: none"> Required PPACA reports available offline Periodic upload of required plan data 	<ul style="list-style-type: none"> Quality and cost comparison with historical outcomes: elaborate customer satisfaction and surveying tools Master data management Business analytics and forecasting Separation of report view for each user type: taxpayer, State, Federal, plans
Workflow Engine	<ul style="list-style-type: none"> Limited workflow integration Focus limited to information, little applications/functionality 	<ul style="list-style-type: none"> End to end customer experience Workflow integration with MMIS, eligibility and plan systems
Calculators	<ul style="list-style-type: none"> Stand alone calculator functionality 	<ul style="list-style-type: none"> Default display of user provided data through automated data feed Screen integrated with application and enrollment process workflow

Looking Ahead to Phase 2

Phase 2A: Indiana Technology Asset Assessment

Assessment scope will focus on the following assets:

- WFMS / FACTS
- ICES
- HIE
- AIM
- SERFF and SIRCON
- IN.gov



Develop an asset profile that will contain key attributes so it can be evaluated against HIX technology components



To develop the asset profiles we are:

- Reviewing documentation and background information on assets
- Conducting interviews with stakeholders during week of 11/15

For illustration purposes only



Phase 2B: Gap Analysis

Indiana Asset	HIX Technology Component	Gap(s)	Overall Assessment
AIM/WFMS/ICES/HIE	Web Portal	• • •	High
AIM/WFMS/ICES/HIE	Business Rules Engine	• • •	Medium
AIM/WFMS/ICES/HIE	Data exchange	• • •	Low
AIM/WFMS/ICES/HIE	Reporting tool	• • •	High
AIM/WFMS/ICES/HIE	Customer Relationship Management	• • •	High

For illustration purposes only

	High = Strong alignment to HIX Technology Component. Requires configuration but no major development or procurement to meet requirements.
	Medium = Moderate alignment to HIX Technology Component. Requires development modifications to system and/or additional system procurement to meet requirements.
	Low = Little to no alignment to HIX Technology Component. Requires procurement /development of new system(s) to meet requirements.

Wrap Up