NWX-DHHS-OS

Moderator: William Polk
March 3, 2011
1:00 pm CT

Coordinator: Welcome and thank you for standing by. At this time all participants will be in a listen only mode until the question and answer session. To ask a question at that time please press star 1.

Today's conference is being recorded. If you have any objections you may disconnect at this time.

I would now like to turn the call over to (Susan Lumsden). You may begin.

(Susan Lumsden): Thank you very much. Good afternoon everybody, this - welcome to the second call that we're having for the funding opportunity announcement for the Exchange Establishment Grants.

The first call and the recordings are available on our Website. And that is on the http://cciio.cms.gov/ . This call is going to be focused on the Table B, Appendix B. And these are all the milestones that are relevant to the core areas of the Exchange.

And we're very fortunate to have our policy team who will be going over each of those core areas. We got quite a few compliments on this appendix and the detail that it provided for you all.

So this call today, you'll hear a lot of voices today because it will be the subject matter expert for each of the core areas. So just beware. You'll be hearing quite a few voices on the call today.

So we're going to be going over each of those core areas. And then we'll take questions at the end. And our colleagues from CMS are also on the line. Rick Friedman and his team who will be going over some of the key things at the end that you should be thinking about as you're doing your application.

Throughout these presentations please be thinking of the program integration with other agencies that are in your state, particularly Medicaid. As you know the Exchange is responsible for the eligibility.

But as they move over to Medicaid, we know the interoperability of those systems is going to be extremely important to assure no wrong door for the clients.

So before we get started I'm going to run through a couple of the frequently asked questions that we've received, three in particular. And then I'm going to turn it over to Donna Laverdiere to - who has - who will be heading up the policy discussion.

So the first of three questions that we received was around the eligibility screen. How does the state know it meets the Level 2 eligibility screen for having the necessary legal authority to establish and operate an Exchange?

The answer to that - and this is also going to be on our Website over the next couple of days so you can look, and the transcript will also be posted.

So the answer is whether a state has the necessary legal authority to establish an Exchange is the question of state law. To demonstrate the state has legal authority to establish and operate an Exchange that complies with federal regulation the state must submit one of the following items.

One, a current copy of the current law or current regulation that clearly indicates the state has the necessary legal authority to establish an Exchange or that clearly establishes the Exchange.

Or two, other legislation related to help reform implementation or another general authority that the state determines provide the necessary legal authority to establish the Exchange and a written legal opinion and the correspondent or formal legal opinion from the legal counsel of the office of the applicant.

Please note that the proposed or pending legislation will not be sufficient to establish that a state has that necessary legal authority.

The next question that we received was again around eligibility. And is HHS willing to accept a state's definition of quasi-governmental entity as this definition may vary from state to state?

For the purposes of determining whether an applicant is a quasi-governmental agency, HHS will look to whether the entity has been created or established by the state through legislation or other law and has state oversight, i.e. the governing body is established, appointed and overseen by the state.

In addition, the grantee must comply with all grant regulations that apply to state grantees. Quite a few had questions around this because a lot of you are looking to establish your legislation and looking at your governing bodies.

So some of you are looking at non-profits, and that's fine. Just know that non-profits aren't eligible to apply directly for grant funding. So they would need to be sub-contracted with by the state or quasi-governmental organization.

Okay. And the third question that we got is around Level 1. The question is, bless you, the question is the FOA is confusing as to whether the applicant must address all establishment core areas in Level 1. From the program narrative, our instructions were confusing.

We want to just request funding to focus on one core area. Is that possible in Level 1? Yes. In addition, is IT a required core area for Level 1? And also is providing assistance to individual and small business a requirement for Level 1?

As you look at the program narrative, it does indicate that you need to address IT and you need to address how you're going to provide assistance to individuals.

So Level 1 applicants may apply for funding for one or more of the Exchange establishment core areas. Level 1 applicants may also choose to apply for funding for all of the Exchange establishment core areas.

That being said, a few clarifications --we do ask all applicants to explain the progress in all the core areas under past performance. We understand Level 2 applicants are further ahead. That's the separate eligibility criteria.

Secondly, in the proposal to meet the program requirement section in the program narrative. The applicant should one, focus and describe in detail the core areas that they wish to apply for.

And secondly, briefly address how they plan to meet the other core areas by 2014. This can be an overall summary. It does not need to go into detail on the core areas that you're not applying for.

Again, just look at your overall approach and strategy for those other core areas. Third, explain the role or dependents of IT and the core areas that you're going to be working on or that you're applying for funding.

If IT for some reason doesn't apply, again include how you plan on addressing the IT portion of the Exchange overall. And then yes, providing assistance to individuals and small businesses is required. That is what the Exchange is all about.

So you should, as in IT, explain how you plan to address this area over time overall. And with that said, I'm going to turn it over to Donna to start going through the - each core area. And she will explain what page we are on so you can reference as we go.

Donna Laverdiere: Thanks (Susan). We're going to take the next portion of the call to kind of walk you through Appendix B in the FOA. It starts on Page 54 of the FOA and goes through Page 70.

We're going to do our best to just provide you with a high-level overview of the table. We know there is lots of information in here. And we just want to give you an opportunity to focus on what's in the table and to come up with

some questions that you can ask us at the end after we've gone through all of the material.

And just want to let you know that this table is a work in progress. And, you know, as our thinking is evolving and as we're drafting the regulation, you know, we're going to have to make some changes to this table.

And we'll be issuing hopefully an updated Appendix after we release the notice of proposed rulemaking which is targeted for June.

So as I said, we'll try to move quickly through the content, and then we'll take your questions at the end. And with that, I'll turn it over to Katherine Bryant to talk about the first core area which is background research.

(Katherine Bryant): Thank you Donna. We're starting on Page 55 of the FOA. Background research is an activity that most states are currently undertaking with their planning grants, you know, to determine where they're going to move forward with their Exchange and how. It's (going to lay) your foundation.

So in 2011 the recommended milestone that we have for background research is to conduct analysis of state insurance market. And develop recommendations for Exchange structure based on this analysis.

Analysis should - must include number of uninsured in the state, size of the current individual and small group markets and the number of carriers in each market and market shares for the ten largest carriers.

The second core area that I'll be discussing is stakeholder consultation. I'm going to go through high-level stakeholder consultation and then (Lisa Marie Gomez) is going to discuss tribal consultation.

Stakeholder consultation is also an activity that grantees are currently carrying out with their planning grants. So in 2011 we recommend establishing a stakeholder advisory committee with the support of the governor and state legislature to solicit input on Exchange design and function by stakeholder groups.

And to complete stakeholder meetings that cover all regions of the state. In 2012 a recommended milestone is to provide to HHS publicly available minutes from completed open stakeholder meetings.

In 2013 we recommend complete stakeholder meetings and provide publicly available minutes related to the open enrollment process and outreach materials.

And in 2014 we recommend post evidence of regular consultation with required stakeholders and other groups. And hold regular public meetings to solicit public input on the Exchange Website, (Lisa Marie).

(Lisa Marie Gomez): Okay. In regards to tribal consultation, beginning in 2011 states that have one or more federally recognized tribes located within its borders are to provide documentation demonstrating that it has established a process of consultation with such tribes regarding this start up and ongoing operation of the Exchanges.

Implemented that process and provide assurance that it will continue to conduct and document tribal consultation for Exchange matters. The tribal consultation process will continue each year through 2014.

Further guidance will be provided on this and other - and (in specific) issues. States are encouraged to review and adapt to procedures for state Medicaid consultation.

(Katherine Bryant): Great and now to Donna to discuss legislative and regulatory actions. Thanks.

Donna Laverdiere: The Affordable Care Act requires that each state that elects to establish an Exchange adopt and have in effect the federal standards for Exchanges. And states may or may not need to pass enabling legislation or issue regulations to implement these standards.

But each state that operates an Exchange must make sure that they have the legal authority to do so and to do so in adherence with federal standards. And this goes back to the FAQ that (Susan) was discussing earlier on the call.

So under this core area, we recommend that if you do need to pass enabling legislation that you begin drafting your legislation or your implementing regulations in 2011 so that you can establish legal authority for the Exchange; that you introduce that legislation in 2011 if you can and hold public hearings in 2011. And then in 2012, by the second quarter, we recommend that you have the necessary legal authority to establish and operate an Exchange.

And we highlight that for the second quarter of 2012 because, as you know, for a Level 2 establishment grant you need to have the necessary legal authority to establish an Exchange. And the last date to apply for a Level 2 establishment grant is June 30 of 2012...

Woman: Twenty-ninth.

Donna Laverdiere: Oh, June 29, 2012. Sorry, moving on to governance core area. States have flexibility in the governance structure they choose for their Exchanges. An Exchange can be run by a state agency, including a quasi-governmental entity or a non-profit that is established by the state.

In addition, a state can choose to partner with other states to establish a regional Exchange. Or it can establish a subsidiary Exchange within the state.

So in 2011 we have a mandatory milestone that you develop a governance model by working with stakeholders in your state to answer key questions about the governance structure of the Exchange, including a State versus a regional Exchange.

How will the state establish an Exchange? Will it be a state agency, a quasi-governmental entity or a non-profit? And how will it structure its governing body?

And we also recommend that in 2011 you start determining the standards you're going to have in place for your governing body, including public accountability, transparency and preventing conflicts of interest.

And then in 2012, like I said under legislative and regulatory action, you need to have established your governance structure for the Exchange in the second quarter because that is, again, an eligibility criterion for a Level 2 establishment grant.

And we also recommend that you appoint your governing board and your management team. And that you develop a formal operating charter or by-laws that are consistent with state and federal requirements, including public accountability, transparency and conflicts of interest.

Okay and now we're going to turn it over to (Kirk Grothe) and (Mark Oh) to talk about Exchange IT systems.

(Kirk Grothe): Hi, good afternoon. (Mark Oh), the Deputy Director, is going to go year by year for 2011, 2012, '13 and '14, what the expectations are on the milestones.

I just want to highlight a couple of things for you. You know, achieving these milestones aren't just simply checking off a box. From our standpoint, they're critical to allow us, as they are completed in the allocated time, to serve as a gauge for making sure that all the IT systems development work is on track.

At the end of the day we want to help you have a fully functional IT Exchange. We have a recommendation that we hope that you adopt and manage the implementation of your IT Exchange using an agile and iterative development process.

That's going to allow you to quickly adapt to requirement changes, both on the business and systems side to ensure that those changes are propagated properly into the systems development, to your test plan and the eventual implementation of your system.

As the evolution from inception to design and deployment takes place, we understand that it's going to be dynamic in nature. And we are asking you to develop a dynamic construct and approach to allow that dynamic nature of this rather rapid timeframe that we have to meet all the requirements that you have to allow your project teams to be successful.

With that, (Mark)'s going to go over the specific milestones for the next couple of years.

(Mark Oh): Thanks (Kirk). Starting with 2011, one of the most important first steps for a successful IT implementation is understanding the capability of your current system.

This includes identifying your strengths and your weaknesses. And as part of the first quarter of 2011 activity, we recommend all the states to complete an IT gap analysis.

And as part of this process, we recommend you assess what components of your current system can be re-purposed and what components cannot be. And start making preparations to address the potential deficiencies.

You should also identify the items that will need to be upgraded. And then you should look at identifying the proposed Exchange IT systems that's going to align the IT system with identified program goals and objectives.

In the second quarter of 2011 we recommend states to complete documenting the preliminary business requirements associated with building the IT system.

During this quarter you should also look at establishing your enterprise architecture framework that includes the business, information and technical reference architectures.

This process will include tailoring the system development life cycle approach so that it fits your need. As well as building on the current system, it will serve as a roadmap for your overall systems development and implementation aspects of it.

During the third quarter, states should look at completing their assessment of both known and possible system security risks so that you can make proper preparations to address those risks.

Additionally, during this quarter you should also look at completing the preliminary designs, system requirements and document your Release plan.

In the fourth quarter, states should look at targeting the finalized requirements. This is at both the systems and business level, as well as your detailed systems design, your enterprise architecture components, with a special emphasis on integration and interoperability.

By this point you should already be developing your systems or be fully prepared to execute your development strategy.

Going into 2012, in the first quarter, as you are in your full swing of your development cycle you should evaluate and capture changes to the business system requirements. And to remain agile to the dynamic environment of systems and development life cycle that (Kirk) spoke of.

This process and evaluation also captures and implements changes on an ongoing basis. And this will go across multiple quarters in 2012.

The second quarter you should (target) to baseline your Exchange IT systems as much as possible while staying flexible to agile updates.

Key activity for this process is going to be ensuring your preliminary baseline systems are properly aligned to the business goals and objectives.

The third quarter, as development activities are being wrapped up and unit testing and functional testing are in progress, a baseline system takes place. This also includes the testing of a software, hardware and special emphasis once again on the system interfaces.

In the fourth quarter of 2012, as development is being completed and all system components go through a comprehensive system testing, it is important to note that testing should be completed with the approved test data and actual interfaces to make sure the interfaces that are built will go through proper operations.

Another key activity during this time is to make sure to test both infrastructure and the system security for system performance aspect of it, as well as making sure the proper security has been established from your overall system readiness perspective.

Going into 2013, especially during the first part of 2013, states need to participate in end to end integration testing with all of the other critical partners. This includes federal agencies, qualified health plans, CMS and so forth, to make sure that all aspects of the system functionality perform as expected and matches the results of your business goals and objectives.

This is going to be a very comprehensive and thorough testing of all of the critical functionalities within the Exchange IT system.

During the third quarter, the final operational readiness review will be conducted. This review will be completed with states and all of the critical partners where we'll be reviewing the testing results as well assessing the overall system readiness and acceptance.

Shortly following this period is when Exchange IT systems from various states will be deployed to support the open enrollment. And then finally in 2014 and throughout 2014, we need to continue to evaluate the Exchange IT systems and make appropriate enhancements so that the business operations can be continuously supported as well as maintaining overall Exchange IT system.

With that, we'll wrap up the Exchange IT systems milestones and go to (Anna) for program integration.

(Anna Wolke): Thank you (Mark). So I'm going to discuss the core area of program integration. Section 1413 of the Affordable Care Act requires the Exchange of a high degree of coordination with Medicaid, CHIP and the Basic Health Programs in order to ensure a seamless eligibility and enrollment process across all programs.

The Exchange and the agencies administering CHIP, Medicaid and the Basic Health Program will need to partner closely throughout system design, development and testing as well as throughout implementation in order to provide a streamline 21st Century shopping experience for consumers.

We encourage states to consider full integration of the Exchange eligibility and enrollment functions with those of Medicaid, CHIP and the Basic Health Programs if applicable, in order to leverage functional similarities and help achieve seamless interoperability among coverage programs.

The Exchange will also need to work closely with the State Department of Insurance in its role of overseeing the regulations and licensure of health insurance issuers, including those that offer qualified health plans through the Exchange.

So as you'll notice, several of the milestones included in this core area of program integration relate to the building and testing of information technology systems to support Exchange functions.

And these IT related milestones are also repeated throughout Appendix B. So while these activities are associated with different milestones, we believe that there will be major opportunities for the consolidation of design, development and testing efforts, including consolidation of architecture.

So as we discuss these milestones we encourage states to appreciate the importance of promoting close coordination in the consolidation of development efforts across these core areas.

So now I'll just go through the milestones that are in your appendix. And just to keep in mind, all of these milestones, or actually all for 2011 are required for the state work plan.

So by the end of second quarter 2011, we require that the Exchange perform detailed business process documentation to reflect the current state business processes. And include future state process changes to support the proposed Exchange operational requirements.

Also by the close of second quarter 2011 we require that the Exchange initiate communication with the state HIT coordinators, State Department of Insurance and the state Medicaid and CHIP agencies and other state human service agencies as appropriate. And hold regular collaborative meetings to develop work plans for ongoing collaboration.

By the end of second quarter 2011 we also ask that you execute an agreement with the State Department of Insurance, which would include determination of the roles and responsibilities of the Exchange and the State Department of Insurance as they related to qualified health plans offered inside and outside the Exchange.

And a strategy for limiting adverse selection between the Exchange and the outside market, possibly including legislative changes to level the playing field.

By the end of second quarter 2011, we also require that the Exchange execute an agreement with any state agency administering Medicaid, CHIP and the Basic Health Program and other specific health and human service programs as appropriate.

This would include a determination of the roles and responsibilities related to eligibility determination, verification and enrollment, identification of challenges in the program integration process, strategies for mitigating those issues and timelines for completion, strategies for compliance with a no wrong door policy, standard operating procedures for interactions between the Exchange, Medicaid, CHIP and the Basic Health Programs and cost allocation among the Exchange grants, Medicaid financial, federal financial participation and other funding streams as appropriate.

Moving on to 2012, throughout 2012 we recommend that collaboration occur among the Exchange, Medicaid, CHIP and the Basic Health Program. On the business and systems approaches to identifying work with all possible doors into the system in order to ensure common processing of eligibility regardless of where the individual enters.

And in 2013, throughout 2013 we recommend that states collaborate on testing of systems for the Exchange, Medicaid, CHIP and the Basic Health Program. And coordinate the beginning of open enrollment with Medicaid, CHIP and the Basic Health Program.

So with that, I'll pass it on to (Jen Snow) to talk about financial management.

(Jen Snow): Thanks. So our focus in this section on financial management as well as the next one, which (Gabe) will be talking about in regards to oversight and program integrity.

Our intention is to be good custodians of federal funds and to ensure consumer protection. And there's a lot of sections to still go over today like quality ratings and enrollment. So I'll be sure to be brief.

Like many of the sections, the general theme is to follow a year by year pattern. So in 2011 it's sort of a year of consideration. 2012 is the year to start developing plans. 2013 is when you start to test those plans. And 2014 is when the plan becomes a reality.

So for example in 2011, you know, the milestone is to adhere to HHS financial monitoring activities carried out for the planning grant and under the establishment cooperative agreement.

Also to begin defining a financial management structure and the scope of activities required. And to establish a financial management structure and commit to hiring experienced support financial management activities of the Exchange.

Moving on to 2012, you know, there's three steps. The first is developing a plan to ensure sufficient resources and determine if legislation is necessary to assess user fees.

To assess adequacy of reporting systems and to conduct a third party objective review of internal control systems.

Finally moving on to 2013, as we get closer to that magic year of 2014 and we've got to demonstrate the capability to manage the finances of the Exchanges.

And in 2014, you know, finally posting information related to the Exchange financial management and to submit the required annual reporting back to HHS.

Now on the heels of all this financial management comes the oversight and program integrity pieces which (Gabe) will talk about.

(Gabe McGlamery): Okay. Section 1313(a)(5) of the Affordable Care Act requires the Secretary to prevent against fraud and abuse in the Exchange. This means that we have to work closely with the states and Exchanges to make sure fraud waste and abuse protections are in place.

And to make sure that states have the necessary flexibility to properly develop those protections.

Exchanges are encouraged to utilize systems that are existing in the state and to modify them as appropriate. Given the indirect relationship HHS has with issuers, providers and other downstream entities and the need to strike a balance with state flexibility,we propose milestones to assist the Exchange in

developing and implementing fraud and abuse procedures. Part of the procedures the Exchange will develop should include requiring qualified health plan issuers to develop, implement and execute their own fraud and abuse prevention and protection procedures.

Before the end of 2011 we recommend that the states develop, implement and execute operating procedures to detect, correct and prevent and promptly report to HHS incidences of fraud, waste, and abuse related to the expenditure of Exchange planning and Exchange establishment grants.

We also recommend that states continue their planning process and hire staff for oversight and program integrity functions.

Before the close of 2012, we recommend that states outline operating procedures that will govern how the states will detect, correct, prevent and report HHS incidence of fraud, waste, and abuse in the Exchange, and all activities administered by the Exchange.

The procedures should include compliance plans for qualified health plan issuers, oversight and enforcement of qualified health plan issuers, procedures and requirements. Reporting to HHS or the appropriate government entity, prohibition of affiliations with individuals de-barred by federal agencies or excluded from participation in Medicare and Medicaid, and prohibitions on marketing fraud.

Throughout 2013, we recommend that states finalize and establish the plan outlined in 2012 as a standard operating procedure to detect, deter and protect against fraud, waste and abuse before the close of 2013.

We also recommend that states develop procedures reporting to HHS on efforts to prevent fraud waste and abuse. Throughout 2014 we recommend that the state Exchange must comply with HHS requirements related to recording, auditing and preventing fraud waste and abuse, now on to Donna.

Donna Laverdiere: Yes, sorry about that. I just want to orient you to where we are in the FOA. We're now on Page 61 of the milestones table on providing assistance to individuals with small businesses, coverage appeals and complaints.

This core area encompasses various different activities that can be carried out by the Exchange. A key principle of the Exchange is providing high quality customer service and assistance to individuals in small businesses.

Consumers are going to be contacting the Exchange with a variety of needs. And the Exchange needs to be equipped to meet them. In addition to providing customer service in the areas of Exchange eligibility and enrollment, the Exchange should also be able to provide information to consumers on filing grievances and appeals.

So just to kind of give you a quick overview of what we have for milestones in this core area -- in 2011 you should be coordinating with any existing organizations in your state who perform these functions.

And a mandatory milestone that we have is analyzing the data collected by consumer assistance programs, if you have a consumer assistance program in your state. The data that they're going to be collecting will be useful when you're going through your certification of qualified health plans. So we want to make sure that you're connecting those dots.

In 2012 a mandatory milestone, if you choose to operate these functions within the Exchange, you should establish protocols for appeals of coverage determinations, including review standards and timelines, the provision of help to consumers, and draft a scope of work for these activities. And also continue analyzing the data that I just mentioned.

In 2013 we recommend that you establish a process for reviewing consumer complaint information because that will also be an important set of data for when you're certifying qualified health plans. You'll want to know what complaints you've been receiving.

And we also think that you should probably establish a process for referrals to the consumer assistance program if that's being carried out by another entity in the state.

And finally in 2014 we recommend that you have an ongoing process to ensure that any consumer complaints or coverage appeal requests are referred directly to the state program that is designated to process these calls.

And now I'm going to turn it over to Carrie Skura to talk about the certification of qualified health plans.

Carrie Skura: Thanks Donna. This area covers the Exchange's procedures for certifying a health plan as a qualified health plan, allowing that plan to be offered through the Exchange. And overseeing the plan as it participates in the Exchange.

This milestone begins with the third quarter of 2011. At this time the Exchange will need to set out the criteria in which you'll base certification decisions. And you will need to establish a process by which health plans can apply to participate in the Exchange.

The Affordable Care Act requires the secretary to establish some basic standards for all qualified health plans. A few of these areas include network adequacy and marketing practices.

So the criteria for certifying health plans would be based in part on a minimum standard set forth and rule making.

By the fourth quarter you will want to have developed a clear certification policy, including a timeline for health plans to submit applications. And for you to evaluate those applications and select qualified health plans.

While your staff develops the certification criteria and the certification policy, it will be essential for you to collaborate with the Department of Insurance, especially if the Exchange is housed in a separate agency.

The Exchange and the Department of Insurance will have to decide the rules for each agency in certification, as well as the continuous oversight of the qualified health plans.

This certification policy and criteria will most likely include the drafting of regulations as well. To assess this process during this time, you will want to continue your engagement with stakeholders, including consumer groups, issuers, providers and your state's residents.

You will also want a variety of mediums to ensure that all willing stakeholders can participate. 2012 will begin with a continuation of the tasks from 2011, including refining the certification process, developing specific standards for certification of a qualified health plan.

During the first quarter, you will need to focus on the IT aspects of the certification process. This would entail strategy and timeline for resources, including systems that would handle all aspects of the issuer's application.

A major component of this will be the ability to receive benefit and rate. During the second quarter of 2012 your staff should be focused on the continued development of a certification application for the issuers, as well as other supporting documentation.

This may include initial notices or solicitation, an FAQ document and certification agreements. These documents will need to set the QHP issuer's responsibilities as it participates in the Exchange including, for example, paying the user fee.

Let's see, by the end of the second quarter these documents should be near completion, if not ready for their release. By the third quarter of 2012 you'll want to release the initial solicitation for issuers to apply for certification of their health plans.

Depending on how the certification timeline is structured, this application may or may not require issuers to provide rate and benefit information. You may choose to solicit that information in a second stage application.

In the same quarter that you release the solicitation, it is highly advisable that you hold a conference for bidders and make your staff available to respond to questions from issuers about the application.

Continuing into the fourth quarter of 2012, you should begin training issuers on their responsibilities for offering qualified health plans and the additional requirements that they may be held to within the state.

Meanwhile you should continue to be developing your own capacity to carry out the plan certification and oversight function.

By the first quarter of 2013 you should launch your plan management system and bid evaluation system to allow the upload of the issuer's applications for their health plans and other required information.

This is a required milestone because it is critical to the Exchange's ability to receive applications from issuers and engage in the certification process.

Once the plan management system has been launched, the Exchange can then collect submissions in response to the solicitation. At this point the Exchange can begin evaluating proposals.

If you so choose, you could have the issuers submit the app - the plan rate and benefit information in the second stage application the following quarter.

During the second quarter of 2013 the Exchange's certification of the health plans should be in full swing. And will need to be wrapped up by the end of the quarter.

This would include a full review and evaluation of the applications, as well as any negotiations the Exchange might engage in with issuers.

Also during the second quarter of 2013, agreements should be executed with the issuer using the agreements you would have prepared back in the second quarter of 2012.

Upon completion of certification of the plans and execution of the agreements, the public will need to be notified of the selection with an official announcement from the Exchange.

In the third quarter of 2013, prior to open enrollment, the Exchange should conduct plan readiness review activities. This would include testing the enrollment and fee for the plans, reviewing the plan's enrolling materials, testing the financial reconciliation processes and working with plans to go over cross-functional implementation processes.

In 2014 and beyond your certification activities will focus on oversight with your qualified health plan issuers. This involves ensuring that issuers continue to comply with the terms of your agreement and the certification requirements that you used to certify them as a QHP.

These may include network adequacy requirements or quality data submission requirements.

I am now going to turn the call over to (Lauren) who will speak about the call center.

(Lauren Block): Thank you. As you can see for the call center, there's only one required milestone listed. But I'll just go over a couple of other things that we'd like to see you accomplish in the development of the toll free hotline to respond to request for assistance from consumers.

We'd first suggest that during 2011 you explore partnering with other groups such as the state consumer assistance program or the health ombudsman program or others with whom you might consider jointly contracting to operate the call center.

By the second quarter of 2013 you should try - you should complete the procurement for customer service if the new contract is in fact being established, which would include identifying the vendor and issuing an award.

Also in the second quarter you should develop customer service representative protocols, as well as protocols for accommodating the hearing impaired and those with other disabilities, foreign language and translation services.

Also during that quarter, we encourage you to train customer service representatives on eligibility verification and enrollment process.

We then get to the required milestone, which is that by the end of the third quarter you must launch your customer service functionality and publicize the 1-800 number to include prominently posting information on the Exchange Website relating to contacting customer service for assistance.

And you should aim to have your call center ready before open enrollment. So we encourage you to do so sooner. We also recommend that you establish a process for referrals to consumer assistance programs if they're available in an entity outside of the - where the call center is located.

I'm now going to talk about the Exchange Website and calculator for which we have several required milestones. The function entails maintaining a Website, including standard, comparative information on plans and providing an electronic calculator.

During 2011, you should begin developing the requirements for systems and program operations. And that would include the online comparison of qualified health plans through the Web such as to include functionality for

how to collect and present customized plan information. Functionality of the tax credit and cost-sharing reduction calculator, managing requests for assistance, establishing requirements for an online application that would come from enrollees, I'm sorry, from applications and selection of qualified health plans.

And providing links to other state health subsidy programs and other health and human service programs as appropriate. So that would be identifying which those may be.

During 2012, during the first quarter you should begin the systems development for the items mentioned - that I mentioned for 2011. And by the end of the fourth quarter we expect that you'll complete your systems development as well as the final user testing for an informational Website.

During 2013, during the first quarter you should launch your informational Website. And then we currently have listed that by the end of the first quarter you should collect and verify data for the plan comparison tool.

However, in the section on certification of qualified health plans, this is covered. So you can report on those tasks under certification of qualified health plan core area instead of in this section.

But we do maintain the requirement that you launch the comparison Website with live data and include pricing information, but without the enrollment functionality during, well you need to launch it during Q3.

Also by the end of the third quarter we require that you have tested the comparison site with consumers and stakeholders. And that will allow time to make any changes necessary. So we encourage you to do the testing early on.

I'm now going to turn it over to (Rebecca) who is going to talk about quality rating.

(Rebecca Zimmermann): Thank you. Exchanges are requiredto implement the secretary's quality rating system. After each qualified health plan is assigned a quality rating, the Exchange would display the rating information as part of the plan to their process.

In 2011, before the quality rating system and data specifications are fully developed, the Exchange should anticipate qualified health plan data reporting requirements as the Exchange develops the draft agreements for the qualified health plans.

And throughout 2012 the Exchange should be integrated in the quality rating functionality and the system business requirements for the Website, a process that should also include testing and validation.

By the third quarter of 2012 the Exchange should have integrated a quality rating functionality in their system. And by 2013, once the Exchanges have selected the qualified health plans, you should gauge in the data collection and evaluation activities in order to inform the quality rating.

Prior to open enrollment, the Exchange will post the quality system information on the Exchange Website to give enrollees time to make an informed choice of plan.

And with that, I'm going to go back to (Lauren) for the navigator program.

(Lauren Block): Thank you. Section 1311(i) of the Affordable Care Act requires each Exchange to establish a navigator program under which it will award grant funds from the operational funds of the Exchange.

These grants are intended to provide support to entities that will assist consumers in comparing their plan options and enrolling in qualified health plans.

In 2011 and 2012 we encourage you to develop your own high-level milestones and timeframes for establishment of the program. It would include determining how you will fund the navigator program before 2014 since navigators are going to be critical to helping people during the initial open enrollment period, which will occur prior to 2014.

In 2012 we encourage you to determine the targeted organizations in the state who would likely qualify as navigators. And this could entail holding meetings or advertising, other sorts of outreach.

You should also be working on your request for a proposal by this time, depending on the grant cycle within your state. By the end of the second quarter of 2013 we require that each Exchange must have awarded grants for navigators and begin training.

I do apologize; we had indicated in the FOA that it would include contracts. They're not contracts. These are just grants for navigators. So you can ignore the word contract there.

And then finally during the quarter before open enrollment begins the navigators should begin operating. I'm now going to turn it over to (Ben) to discuss eligibility determination.

(Ben Walker): Hi. Section 1411, 1412 and 1413 of the Affordable Care Act describe the eligibility determination process for enrollment in qualified health plan, advance premium tax credits, reductions in enrollee out of pocket costs and Medicaid, CHIP and the Basic Health Programs.

The Exchange will implement these processes by accepting applications, conducting verifications with support from HHS and other federal agencies, and determining individual eligibility.

A number of the milestones in this core area include references to coordination with Medicaid and CHIP agencies, which are also included in the core area on program integration, which (Anna) discussed earlier.

The particular reasons that we receive those milestones in this section are because first, we think that it's critical that the Exchange leverage the expertise that exists in Medicaid and CHIP agencies regarding eligibility determination.

Second, we think that Exchanges need to consider carefully opportunities for infrastructure and process integration with Medicaid and CHIP.

And third, a high degree of operational coordination is going to be required to address common issues between Medicaid, CHIP and the Exchange. Particularly given the high degree of overlap in populations across the three programs.

As such, we note at this point and time a state Exchange planner should be working closely with their respective Medicaid and CHIP agencies and should

have created or be in the process of creating institutional structures to support future work, all the way through implementation.

Eligibility determination is also another of many areas of Exchange operations in which there are significant systems requirements. Accordingly, this section included the systems milestones that (Kirk), (Mark) and (Anna) described earlier and others referenced, including developing requirements for systems in 2011, developing the systems themselves in 2012 and conducting end to end testing in 2013.

And just one particular note in this section is that again, going back to our emphasis on coordination with Medicaid and CHIP agencies. We know that when you're thinking about the systems life cycle, and in particular testing, that should include attention both from the Exchange perspective, as well as from the perspective of the Medicaid and CHIP programs.

Now we'll go back to (Lauren) who will talk about milestones related to the enrollment process.

(Lauren Block): Thank you. The Exchange will need to facilitate plan selection for an individual who is eligible to enroll in a qualified health plan. And that will include receiving individual qualified health plan selections, completing enrollment transactions with qualified health plans according to approved standards, and maintaining records of enrollment.

During the first quarter of 2011 the Exchange should be begin developing requirements for systems and program operations, including submitting enrollment transactions to qualified health plan issuers, receiving acknowledgments of enrollment transactions and submitting relevant data to HHS.

During 2012 and by the first quarter, Exchanges should begin systems development, which should be completed by the end of the fourth quarter.

I'm now going to talk about applications and notices. The Exchange must implement all requirements for applications and notices consistent with federal requirements, including facilitating the use of a single streamlined application for Exchange eligibility, as well as applicable state health subsidy programs.

Notices will include key information that the Exchange must communicate with applicants, enrollees and employers. For example the Exchange will have to notify individuals upon determination of eligibility for enrollment in a qualified health plan through the Exchange.

During 2011 the Exchange should review federal requirements for applications and notices, begin customizing federal applications and notices as allowable and begin developing requirements for any Exchange created applications and notices.

By the third quarter of 2013 and before the initial open enrollment period begins, the Exchange should finalize all applications and notices, including stakeholder review, testing and translation.

The Exchange must then begin using the applications and notices once the open enrollment period begins.

I'm now going to turn it over to (Anna) to talk about exemptions from individual responsibility requirements and payment.

(Anna Wolke): So Section 1311 of the Affordable Care Act requires the Exchange to grant certifications of exemptions from the individual responsibility requirement and payment.

The requirement and payment are both enforced by the Internal Revenue Service in accordance with Section 1411 of the Affordable Care Act. The Exchange must have in place a process to receive and adjudicate requests from individuals for exemptions from the requirement and payment. And be able to transmit information to HHS and Treasury on the outcome of such exemption requests.

So I'm going to go over the six milestones that are - and each of these are required to be included in the state work plan. So for 2011, by the end of first quarter 2011 we require the Exchange begun developing requirements for systems and program operations to include accepting requests for exemptions, reviewing and adjudicating requests and exchanging relevant information with HHS.

And by 2012 at the end of first - I'm sorry, in 2012, at the end of first quarter, we require that the Exchange begin systems development to support the exemption adjudication process.

By the end of 4th quarter we require that the Exchange complete systems development. And then begin preparing for final user testing.

And in 2013, by the end of first quarter, we require that the Exchange begin final user testing, including testing all interfaces. By the end of third quarter or prior to the beginning of open enrollment we require that the Exchange complete user testing including full end to end integration testing with other components.

And during enrollment, which may be as early as mid 2013, the Exchange would of course begin processing exemptions from - that they - I'm sorry, exemption requests that they receive from individuals and reporting to HHS on the outcome of those exemption requests.

So, now passing it off to (Ben Walker) to discuss premium tax credit and cost-sharing reduction administration.

(Ben Walker): Thank you (Anna). This section incorporates a number of activities that are required of the Exchange in order to facilitate the administration of advance premium tax credits and reductions in enrollee out-of-pocket costs.

These activities include notifying HHS to begin, end or change an individual's advance premium tax credits or reductions in enrollee out-of-pocket costs. And also providing similar information to the qualified health plan selected by an individual.

These also include the requirements specified in Section 1311(d)(I-J) and 1411(e)(4)(B)(iii) of the Affordable Care Act regarding reporting to the Department of the Treasury and to employers to facilitate the employer responsibility requirements in the Affordable Care Act.

This area is another of many in which there are significant systems requirements. And so the milestones in this section incorporate the standard systems milestones that we have discussed previously.

That is developing requirements in 2011, developing systems in 2012 and conducting end to end testing in time for open enrollment in 2013.

In this section I would note in particular that given the involvement of HHS and qualified health plan issuers as the recipients of data, in this area the testing within the 2013 should include these entities as well.

And now back to (Anna) to talk about the adjudication of appeals of eligibility determinations.

(Anna Wolke): Thank you (Ben). Section 1321 of the Affordable Care Act provides HHS with the authority to issue regulations setting standards for meeting requirements as the secretary determines appropriate.

So pursuant to this authority, we propose that the Exchange must establish an appeals process in which an individual may appeal any eligibility determination made by the Exchange.

So as such, the Exchange will be required to establish this process to adjudicate appeals. So we've include four milestones related to the development of this appeals process; also similar to many of the milestones regarding IT systems infrastructure that have been repeated throughout Appendix B.

By the end of second quarter 2012, we recommend that the Exchange begin developing business processes and an operational plan for appeals functions. By the end of fourth quarter 2012, the Exchange must establish resources to handle appeals of eligibility determinations, including training on eligibility requirements.

For 2013, by the end of third quarter or prior to the beginning of open enrollment we recommend that the Exchange test the appeals process. And then of course during 2014, during open enrollment, which will be as early as

mid-2013, we require that the Exchange begin receiving and adjudicating requests for appeals.

And, oh, I will then move on to notification and appeals of employer liability for the employer responsibility payment. Section 1411(f)(2) of the Affordable Care Act requires that HHS establish a process by which an employer can appeal the determination that it may be liable for a tax imposed because the Exchange has made a determination either that it does not provide minimum essential coverage. Or it does not provide affordable minimum essential coverage.

Requiring the Exchange to establish a process to adjudicate such appeals similar to the processes I just outlined for the individual eligibility appeals processes.

Each of these requirements or these milestones are identical to the ones I just outlined. So I won't walk through those again.

So next we're going to pass it off to (Melissa Cummings-Niedzwiecki) at the Internal Revenue Service who is going to walk through information reporting to IRS and enrollees.

(Melissa Cummings-Niedzwiecki): Thank you (Anna). Section 1401 (f)(3) of the Affordable Care Act requires each state Exchange to provide certain information to any individual enrolled through an Exchange. That same information will be reported to the Internal Revenue Service.

This information is vital both for the IRS in terms of overall tax administration of the premium assistance tax credit and it’s important that the

enrollee get this information so they can claim or reconcile the credit at the end of the year.

In order to provide guidance to states, we have provided the following example milestones, all of which are considered required for your state work plan.

And it's fairly straightforward. But in 2011, we would expect that you would begin the requirements to facilitate the information reporting in the first quarter. So that would include capturing the required data and building the capacity to generate information to the enrollees and also to the IRS.

In 2012 we would expect that you would start actually developing your system in the first quarter. And be ready for testing in the third quarter.

In 2013 we would expect that in the first quarter you would actually start testing. And that you would complete user testing by the end of the third quarter.

And then in 2014 we would expect that your systems would be ready to generate the reports both to the enrollees and to the IRS. So with that, I'll turn it over to (Lauren Block).

(Lauren Block): Thank you. I'm going to briefly talk about outreach and education. Each state will need to have in place an education and outreach program and inform consumers about the Exchange and the new coverage options available to them.

Each Exchange may determine a unique strategy, depending on the population within their state. In 2011 we suggest you perform market analysis and environmental scanning.

During 2012 we think you should start developing a toolkit for outreach, develop performance metrics, design a media strategy and other information dissemination tools, submit final outreach and education plan to HHS and focus tests.

Then in 2013 you will launch your outreach and education strategy and continue to refine messaging based on the response and feedback from consumers.

I'll now turn it over to (Ben) for free choice vouchers.

(Ben Walker): Thank you. Section 10108 of the Affordable Care Act requires that an employer provide a free choice voucher to an employee to enroll in a qualified health plan in certain situations.

Section 36B of the Internal Revenue Code also specifies that an individual who has a free choice voucher is ineligible for premium tax credits and reductions in enrollee out-of-pocket costs.

Consequently the Exchange has to know whether an individual qualifies for a free choice voucher in order to determine whether he or she is eligible for tax credits or cost-sharingreductions.

While the Affordable Care Act doesn't specify the eligibility process for free choice vouchers, because the Exchange must assess the availability and affordability of employer sponsored insurance.

As well as whether an individual has a free choice voucher in order to determine whether the individual is eligible for advance premium tax credits and reductions in enrollee out-of-pocket costs.

We believe that the eligibility process for free choice vouchers should be aligned and integrated with the eligibility process for advance premium tax credits and reductions in enrollee out-of-pocket costs, as opposed to having stand alone process.

Consequently, the milestones in this section generally mirror the systems related milestones included in other core areas, particularly eligibility determination. Again, because we really see these as integrated and linked processes.

We do note that the free choice voucher process will require a high degree of coordination between the Exchange, employers and employees. And as such will require a testing strategy that accommodates all of these parties.

Now (Seth Schneer) is going to talk about milestones specific to the Small Business Health Options program or SHOP Exchange.

(Seth Schneer): Thank you (Ben). Section 1311(b) provides for the establishment of SHOP Exchanges. SHOP Exchanges assist qualified employers in facilitating the enrollment of their employees in qualified health plans offered in the small group markets.

The Affordable Care Act allows states to merge their individual market in small business Exchanges. Thus making - thus much of the functionality of a SHOP Exchange can be shared with the individual market Exchange.

It's recommended that you consider many of the other milestones in terms of both their individual Exchange and SHOP Exchange functionality.

For example, background research including an assessment of markets should include an assessment of the small group market. Website design, what portions could be shared between Exchanges on both the front end and back end?

Stakeholder consultation should include outreach to small businesses. QHP - the QHP certification process can be - might be shared between both Exchanges.

Outreach and education may have overlaps. However, you do need to account for the difference in the audiences. And this list is not exhaustive. Clearly there are many other integration points that you should look for.

An Exchange catering to a small business market will have some different administrative needs and cater to a different market. The reason why we have specific SHOP milestones is to show that you need to be planning for these things as well.

Again these milestones are meant to be completed in parallel with those of the individual Exchange (hence their) similarity. They can be found in Appendix B.

(Susan Lumsden): Thank you very much (Seth). Thank you everybody. I'd like to come back around, this is (Susan Lumsden) again, I'd like to come back around to where we started. And that’s to you've seen - heard a lot of themes here, particularly around program integration.

So I'd like to turn it over to Rick Friedman who will kind of bring it all back around in terms of the necessity of really no wrong door and what we're really after in providing affordable, accessible and adequate health insurance, Rick.

Rick Friedman: Thanks (Susan). This is Rick Friedman over at CMS on the Medicaid side. I thought this phone call was quite informative, with everybody going through the different pieces of Appendix B.

I think in particular, (Anna) and (Ben) really brought everybody's attention to the critical role of the Medicaid agencies in all of this. You know, it's been estimated that at least half the people who will be newly enrolled as the result of the Affordable Care Act will be people enrolled into the Medicaid programs across the country.

And the Exchanges have the legal responsibility to determine eligibility for Medicaid, as well as for the other plans, the qualified health plans.

So it's absolutely critical that when you and the state begin to think about applying for a grant that you link up with your Medicaid counterparts. We're doing that at CMS in which we put together teams that represent expertise on the Exchange side and on the Medicaid side.

Such that when a state would submit an application to us on the Medicaid side for an advance planning document for example to get funding for building out the Medicaid piece relative to the Exchange, or pieces. We want to make sure that the Exchange experts at CMS are fully aware of that.

And conversely, when you submit an establishment grant or earlier when early innovator grants were submitted, teams comprised of people from both Medicaid and CMS and the Exchange looked at those grants.

We want to make sure that we have a 360-degree understanding of what's happening in the state. And it's absolutely critical that there be a seamlessness in terms of these builds. So that it appears that way certainly to the consumer, but also in terms of ourselves as we're working on this, whether you're at the federal level, the state level or the county level.

It's critical that you have a multidisciplinary team from Day 1, Hour 1. One other point that I think we brought home before, but there are requirements that things that benefit Medicaid are charged to Medicaid.

So that if within the Exchange for example, there's a part of a Medicaid eligibility determination system that's being built, those costs need to go back to the Medicaid program.

And we've created a faster expedited approach so that we will, working hand and glove with our Exchange partners in CMS, as we go through something called the Exchange life cycle. In which we're actually looking at the development of the IT infrastructure, we'll be doing that with them at the same time.

And so many of the issues that we would typically have for relative to advance planning document, we're actually going to be getting as you're building the system as it goes along. So we're committed to try to do this as expeditiously as possible.

I think it's worth emphasizing however that if you're sitting in a room listening to this call, and you don't have a Medicaid partner with you, a counterpart. I think it really would behoove you and use to make sure that on the next call or in the next activity that we're both engaged in that they are at the table as well, together with the folks that are engaged in developing the Exchange.

(Susan Lumsden): Thank you Rick very much. And Operator, (Danielle) I think we're ready for questions.

Coordinator: Thank you. We will now begin the question and answer session. To ask a question please press star 1. You may withdraw your question by pressing star 2.

Once again, to ask a question please press star 1, one moment please. You have a question from (Gloria McDonald).

(Gloria McDonald): Yes good afternoon, (Gloria McDonald) from the State of Nevada. I just have a request. You talked about updating your core area matrix that we just went through, which was very helpful.

It would be good because I didn't start doing it at the beginning of the conversation if you could add the ACA section numbers into your little boxes. That would be very helpful as a reference tool.

(Susan Lumsden): Outstanding, yes, good idea.

Woman: Also (Gloria), just to mention that in Appendix A you'll see a lot of references to that throughout. And that could be another point. But when we do the revision, we can do that.

(Gloria McDonald): Okay thank you.

Coordinator: Next question comes from (Julia Lurch).

(Julia Lurch): Yes this is (Julia Lurch) from North Carolina. We had a couple of questions. The first one is it appears that there are a lot of activities or milestones that are required for 2011.

And just in general, for states that aren't expecting to have a governance structure in place until, you know, I guess third quarter as the earliest. What is your expectation for what we should be doing in the meantime? I'm not sure if I'm articulating that well, but.

(Susan Lumsden): No, you are. But if you'll notice a lot of things have to do with program integration and IT systems. So you can, even though you might not have a governance structure, you can still be starting to talk between Medicaid and insurance and other programs in your state.

Start, you know, it takes a while to start developing those business processes jointly, the MOUs, looking at your IT gap analysis. So if you'll go through those 2011 milestones, there is quite a lot that you can begin to do.

(Julia Lurch): The next question was on the navigators. You know, we see in the law that the navigators can't be funded through the federal establishment grants. Do you have any thoughts on how states might fund those starting in 2013 when they're not going to have any plans to charge assessments to you yet?

(Susan Lumsden): Right, we are working on that right now. And we're trying to see if there might be some flexibility through other programs. But we do acknowledge

that this is an issue in the statute. And we are trying to see what might be feasible.

(Julia Lurch): Okay. And the last question I had was the notice of proposed rulemaking that's due out in June, will that cover all of these different things including the certification of health plan and the rating systems? All the things that you mentioned that guidance will be coming out on.

Woman: Yes, so the certification of qualified health plans will be included. And I'm just going to turn to (Rebecca) for a second to talk about quality.

(Rebecca): Yes, we do anticipate putting out some ideas about the quality rating system to be comment on in the June NPRM.

Woman: But just to be clear, the NPRM is still, you know, in its infancy in terms of the execution of it. And so I think it's a moving target as to what exactly will be included. And that's all we can say at this point, not because we don't want too, just because we don't know.

(Julia Lurch): Yes and we have one more question.

(Jean Holliday): This is (Jean Holliday) here. I was wondering, we know that several states got those innovator grants that were announced what, a couple of weeks ago.

So the idea I guess is that they will hopefully innovate some things that other states can then (stack) upon or whatever. Are we supposed to be, as a state that's not an innovator state, sort of monitoring that or marrying ourselves to another state who is an innovator state? Or exactly how do you all envision that process working?

(Terence Kane): Hi, this is (Terence Kane). You'll notice that in the FOA we've asked, and as part of your application and carrying out the program requirements, to review all the products that are produced from the early innovators.

And we ask you to give it a fair look. And if for whatever reason those different component parts produced from the early innovator will not fit your IT systems development, we ask you to explain the reasons for that.

(Jean Holliday): Okay thank you.

(Susan Lumsden): And you also asked how we saw that working. We are going to offer a lot of opportunities for those that are IT innovator grantees to share. Certainly we're going to tag on to any of the consortium meetings.

We'll have a portal that they'll be able to put their products on. We've already developed profiles of those IT innovators that we have to have them review them first. Make sure they're correct. And then we will send those out to you all so you can begin to see what might match with what your needs are.

(Jean Holliday): Okay thank you very much.

(Susan Lumsden): Okay and we need to hear, (sounds) we need to hear from you all what would work for you in terms of sharing, in person, on a portal, conference calls. Let us know what method would work best for you.

(Jean Holliday): Okay thank you very much.

Coordinator: Next question comes from (Jim Young).

(Jim Young): I'm sorry, hi. You went over a lot of information on Appendix B. And a lot of it was really good. And it appears that you had written down. Is it possible to get a copy of those written scripts as you went through Appendix B?

(Susan Lumsden): They'll be a transcript of this call.

(Jim Young): Appreciate it, thank you.

Coordinator: Next question comes from (Angela Sherwin).

(Angela Sherwin): Yes hi. My name is (Angela Sherwin) and I'm calling from Rhode Island. I'm noticing, and in 2011, as we're planning our IT systems, one of the key pieces of information that we need for eligibility related IT, for free choice voucher IT and for premium subsidy determination infor - IT is access to employer sponsored insurance.

And the affordability of employer sponsored insurance. So I'm wondering if in our timelines we should be planning on building some sort of state-based database for ESI? Or if there are plans for a federal database for ESI that are in the works? Or how we should factor that into this timeline?

(Ben Walker): Hi (Angela). It's (Ben Walker).

(Angela Sherwin): Hi (Ben).

(Ben Walker): How are you? It, you know, I think that we've done a lot of work here on the federal level to talk with particular state Medicaid and CHIP programs about their experience in working with and acquiring information about access to employer sponsored insurance.

We're aware that there are a number of approaches that have been tried over the years. And some of them have succeeded and others there have been some challenges with.

And so we're really still in an active information gathering mode on that. We're really intrigued and interested to hear from all the folks working on Exchange planning across the country about the approaches that you all think would work best for you.

So I, we definitely don't have a conclusion on that right now. But it's an area in which we'd really like to hear your input.

(Angela Sherwin): Thanks.

Coordinator: Once again, to ask a question press star 1.

(Susan Lumsden): And while we're waiting for other questions, as we noticed, many, many of you are putting forth legislation as we speak. And we know these are moving quickly. If you would like us to look at your legislation to see how it complies with the ACA, we'd be happy to do that just as in terms of technical assistance.

Shelly Bain who many of you know is the one taking the lead for that. And her email, you can either email me and I'll send it to her directly. But remember her email, it's shelley, S-H-E-L-L-E-Y dot bain, B-A-I-N@hhs.gov.

And she's been giving some good TA to states about things that they may want to include, or things that she's seen.

Coordinator: You have a question from (John Steck). Your line is open.

(John Steck): Will the notice of proposed rulemaking that's due in June, will that include the specifications for the federal interfaces? This question is from Washington State.

(Susan Lumsden): Thank you. (Ben) then maybe (Kirk) you'll want to chime in.

(Ben Walker): Yes, I would just start by saying that right now the work we're doing for the June notice of proposed rulemaking we are going to be talking very extensively about the eligibility process with, you know, obviously verification is a big piece of that.

And so we are going to be talking about the relationships that are needed there. And so we do anticipate, you know, anticipate covering that. And also, soliciting comments as part of that, about different approaches that we could use for some of the various verification information that's needed.

(Kirk) or (Mark), anything to add on that?

Man: No, we believe the business interface information should be ready about the time the proposed rule is going to be out. Technical interfaces, we work with each state on those.

(Susan Lumsden): And Rick Friedman, anything to add there?

Rick Friedman: I think they covered it pretty well. Relative to any change to your Medicaid system, you should just work with your Seattle regional office in this case. And they would coordinate with their friends in (SISL).

(John Steck): Thank you.

Coordinator: Next question comes from (Pam King).

(Jeremiah Samples): This is (Jeremiah Samples), West Virginia. And you may have referenced this in the discussion, but is there any thought to state developed risk adjustment tools and the potential for all payer claims database funding coming from these implementation grants? And if not, how might those types of tools be developed?

(Katherine Bryant): Hi (Jeremiah), this is (Katherine). Would you mind emailing me your question and I'll connect with our risk adjustment people?

(Jeremiah Samples): Sure.

(Katherine Bryant): Okay thank you. Your luck, they weren't here.

(Susan Lumsden): Also for everybody, if you do have other questions that you think of after this call, if you could please email them by next Friday to (Katherine Bryant). Obviously you can do it after that.

But as many questions as we can get to her by next Friday, then we can try to get as many answers posted before the next call.

(Katherine Bryant): And my contact information is in the back of the funding opportunity announcement.

Coordinator: Question from (Nasarani).

(Susan Lumsden): And what state are you from?

(Nasarani): Hi, it's Michigan.

(Susan Lumsden): Great, go ahead.

(Nasarani): Well my question is while you're working with the Medicaid and CHIP agencies, I just wanted to know what your guideline around having the Exchange determine Medicaid eligibility online, real-time. What's the guideline around that?

(Ben Walker): Yes that's an excellent question. Definitely something that we know a lot of states are thinking about. And an area in which, you know, I think the IT guidance that we released early in the year made clear that we do have, you know, very, very high goals for the eligibility experience. That we're going to provide to folks, both through the Medicaid program as well as through the Exchange.

And so we certainly encourage people to be thinking about things like real time eligibility determination and verification. And here on the federal level we're working as we develop our rules to try to identify ways that we can support that.

And I'd ask if (Kirk), (Mark) or (Rick) have anything else on that note?

(Kirk): We're going to be looking from the policy side (Ben) to give some final guidance around that. And then we'll be working on the specifications to work around that.

What we can tell today is that we would ask states to consider as they're looking at their alternatives and preliminary designs to note that our threshold

is going to be more of a real time request and specification than it would be some less than real time processes.

Rick Friedman: But, and this is Rick. Just the performance metrics are really still under development. But they're consistent with the direction that both (Kirk) and (Ben) were talking about.

(Nasarani): All right, thank you.

Coordinator: And there are no further questions.

(Susan Lumsden): Wonderful. Again, if people have further questions please email (Katherine Bryant) with any other questions. And we will try to post those before the next call. Thank you everybody. Have a great rest of your day.

Man: Thank you.

Woman: And operator can we do post-conference?

Coordinator: Thank you, one moment.

END