New! Interoperability Implementation Timeline!

YOUR ESSENTIAL

INTEROPERABILITY TOOLKIT

An ACF/HHS Resource Guide

This newly released compendium of interoperability documents is designed to help state human services agencies connect with their health counterparts and maximize Affordable Care Act benefits. It includes:

- *An overview of recent changes allowing states more flexibility to support interoperability*
- *A tri-agency letter with followup guidance on exceptions to A-87 cost-allocation requirements*
- *Additional materials to help you enhance operational efficiency, lower costs and improve client outcomes*

CHECK OUT ALL THE POLICY, FUNDING AND TECHNOLOGY CONTENTS … AND WATCH FOR FUTURE UPDATES!

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ADMINISTRATION FOR CHILDREN AND FAMILIES

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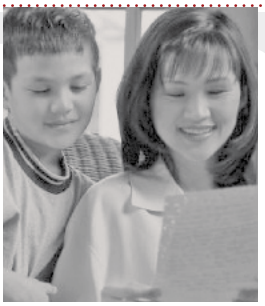
"Interoperability is picking up steam all across the government, and I'm proud that the Administration for Children and Families is in the vanguard."

George Sheldon, Acting Assistant Secretary, ACF

Read George Sheldon's introductory letter to the updated Interoperability Toolkit at http://www.acf.hhs.gov/interop/ToolkitMsg.html.

Please direct questions to David Jenkins at ACF.Toolkit@acf.hhs.gov.



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Advance Planning Document Process

HHS published the final rule on revisions for federal prior approval governing state systems development for Medicaid, Child Welfare and Child Support Enforcement, as well as the cost allocation of system development costs for the Temporary Assistance for Needy Families block grant. The primary goal of the final rule is to encourage state IT innovation by simplifying and streamlining procedural requirements for low-risk projects, while at the same time increasing independent oversight of higher-risk projects.

Enhanced Medicaid Funding for Eligibility Determination

CMS has developed requirements for the enhanced funding for eligibility systems. Two of the documents in the Interoperability Toolkit relate to this enhanced funding:

- **Enhanced Funding Requirements: Seven Conditions and Standards**

  CMS outlined requirements for states to receive enhanced (90/10) funding for eligibility systems. The seventh condition requires states to ensure interoperability between exchanges and public health agencies, human services programs and community organizations.

- **Enhanced Funding Requirements: Expedited Advance Planning Document Checklist**

  CMS has developed an Expedited Enhanced Funding APD checklist.

Technology

National Human Services Interoperability Architecture

ACF has contracted with Johns Hopkins University School of Public Health and Applied Physics Laboratory to develop a National Human Services Interoperability Architecture.

Human Services Domain – National Information Exchange Model (NIEM)

ACF will be the Domain Steward for a new Human Services NIEM domain. An enclosed summary describes efforts to start up this new domain.

Please direct questions to David Jenkins at ACF.Toolkit@acf.hhs.gov.



ACF INTEROPERABILITY OVERVIEW

The Department of Health and Human Services (HHS) has taken dramatic and decisive action over the past year to create opportunities to improve information sharing, system integration and program coordination among Center for Medicare and Medicaid Services (CMS), Administration for Children and Families (ACF) and Food and Nutrition Services (FNS), with the goal of expanding access and improving outcomes.

Much discussion has occurred in the past several years about WHY interoperability is important for government and for the population served. Interoperability is important because:

- Linking health and human services can improve client outcomes by treating the whole person with improved care coordination, increase timely access to critical information for decision making, prevent illness, reduce exacerbating conditions, decrease hospital reentries and help build individuals' self-sufficiency.
- Health programs can benefit from closer linkages with human services by having access to more timely and accurate verification information for eligibility determination and enrollment purposes. States will have access to a larger pool of eligible clients that are not yet enrolled in Medicaid but are likely to be involved already with some human service programs. A larger enrolled population will also spread the financial risk of the health insurance exchange.
- Stronger system linkages will increase the use of shared services, streamline business and information systems, and minimize duplicative costs for building, maintaining and updating redundant systems. Transparency across programs will also improve the ability of systems to reduce fraud, waste and abuse.

The WHY is certainly important, but this document addresses the question of WHY NOW? The benefits that are possible because of the Affordable Care Act (ACA) provide a unique opportunity to accomplish two goals: improving client outcomes and enhancing operational efficiency. The Affordable Care Act is creating significant opportunities for interoperability, but these opportunities are time limited and states must act quickly to link human services and Medicaid eligibility systems.

This overview provides a timeline and brief overview of the aspects of the Affordable Care Act legislation and other policies that support coordinated efforts to build health insurance exchange eligibility programs that also benefit human services. (The detailed legislation and policy documents are included in the ACF Interoperability Toolkit). This is NOT an overview of the Affordable Care Act – it is a focused view on the aspects of the Affordable Care Act and other federal efforts that create an opportunity for states to implement eligibility systems for human services as part of their overall exchanges and Medicaid eligibility efforts.

The Time Is NOW

TIMEFRAMES FOR IMPLEMENTING THE HEALTH insurance exchanges required under the current law are aggressive. By January 2014, states must have health insurance exchanges built and operating in their states or adopt a federal solution. The planning for these insurance exchanges is occurring now in states that are considering implementation and will likely be completed by the end of 2012. Even though states are intensively working on implementing their insurance exchanges, additional planning related to human services will have an

POLICY INDEX

"Linking human services with the Affordable Care Act provides a unique opportunity to improve client outcomes and enhance operational efficiency."

Please direct questions to David Jenkins at ACF.Toolkit@acf.hhs.gov.

ACF INTEROPERABILITY OVERVIEW *Continued*

enormous payoff in having integrated or interoperable eligibility determination. If human service program needs are incorporated into the planning and requirements documents now so that their conceptual and technical requirements are reflected in the overall plan, this will allow states to utilize the exchange-developed eligibility systems for their human service programs.

While there is potential to make significant progress, time is limited. In order for states to take advantage of the 90% FFP for the design, development and implementation of their eligibility systems, the expenses must be incurred before the end of 2015 (see description of the tri-agency letter on cost allocation below).

The chart on the following page displays the timeframe for each of the major initiatives that the states must implement to have interoperable eligibility systems that include human service programmatic areas in addition to Medicaid.

Some of the points that are important to note are:

- All sources of additional or enhanced funds for design, development and implementation of eligibility systems end on December 31, 2015.
- States must have approval or conditional approval by January 1, 2013 that their exchanges will be operational prior to January 1, 2014.
- States can still apply for Establishment Grants. CMS has awarded a second round of Establishment Grants at the end of 2011, and has indicated that grants may be awarded through 2014.
- States can implement exchanges on January 1, 2015 and still utilize Exchange Grant funds (subject to the Funding Opportunity Announcement eligibility criteria).
- States can improve exchanges that are implemented on January 1, 2014 and continue to use Exchange Grant funds.
- Enhanced FFP for Medicaid eligibility systems (90/10) is available for approved activities and procurements where expenses are incurred prior to December 31, 2015.
- Enhanced FFP for Medicaid maintenance and operations of 75% is only available for the activities that received 90/10 support.
- The exceptions to OMB Circular A-87 that allow states to utilize components of Medicaid eligibility systems for human services without cost allocating the expense expire on December 31, 2015.

Background

THIS SECTION PROVIDES BACKGROUND information on the opportunities that are currently available and when taken as a whole make the case for why states should act NOW to take advantage of some of the new opportunities. The following are summarized and the ACF Interoperability Toolkit contains links to each of the Affordable Care Act components:

» Patient Protection and Affordable Care Act, including section 1561

» Health Insurance Exchanges, Planning Grants and Establishment Grants

Please direct questions to David Jenkins at ACF.Toolkit@acf.hhs.gov.



ACF INTEROPERABILITY OVERVIEW *Continued*

» Enhanced FFP (aka 90/10 funding)

» Exceptions to OMB Circular A-87 on cost allocation

PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010 (ACA)

IN EARLY 2010, PRESIDENT OBAMA signed the Affordable Care Act. This legislation has three primary goals: 1) expanding health insurance coverage, 2) reducing health care spending and 3) increasing the regulation of private health insurers. Most provisions will take effect over a four-year period beginning in 2010.

Major provisions for expanding health insurance coverage include:

- Expand Medicaid eligibility to include all individuals and families with incomes up to 133% of the federal poverty level (effective 2014)
- Simplified enrollment into CHIP and Medicaid
- Low-income persons and families above the Medicaid income level and up to 400% of the federal poverty level will receive subsidies on a sliding scale if they choose to purchase insurance through an "exchange" (effective 2014)

HEALTH INSURANCE EXCHANGES

HEALTH INSURANCE EXCHANGES ARE TO BEGIN operation in each state by 2014. These are envisioned as a marketplace where individuals and small businesses can compare insurance policies and premiums and purchase health insurance (with a government subsidy, if eligible).

The intention is to have these exchanges serve as the single point of entry for covering the uninsured. These exchanges will include features such as online eligibility verification and mechanisms for allowing employers to offer subsidies if they connect their employees and/or retirees to exchanges. The major objective is to design exchanges so that they help purchasers find the highest-value insurance plan personalized to their specific health condition(s) and the doctor/hospital networks they prefer.

Section 1561 of the Affordable Care Act required that HHS, with the Health Information Technology (HIT) Policy Committee and the HIT Standards Committee, develop standards and protocols to facilitate interoperable systems, and secure electronic enrollment of individuals in federal and state health and human service programs. These recommendations were approved in September 2010 by HHS Secretary Kathleen Sebelius and a link is included in the ACF Interoperability Toolkit.

In late November 2011, CMS released frequently asked questions (FAQs) and further identified significant opportunities for flexibility for states that have been laid out in guidance and a recently distributed press release that provided updates on state progress, outlined areas of flexibility for implementation of the Affordable Care Act for states, and provided links to a frequently asked questions document: (http://www.cms.gov/apps/media/press/release.asp?Counter=4187&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=false&cboOrder=date). The FAQ document is available at: http://cciio.cms.gov/resources/files/Files2/11282011/exchange_q_and_a.pdf.pdf.

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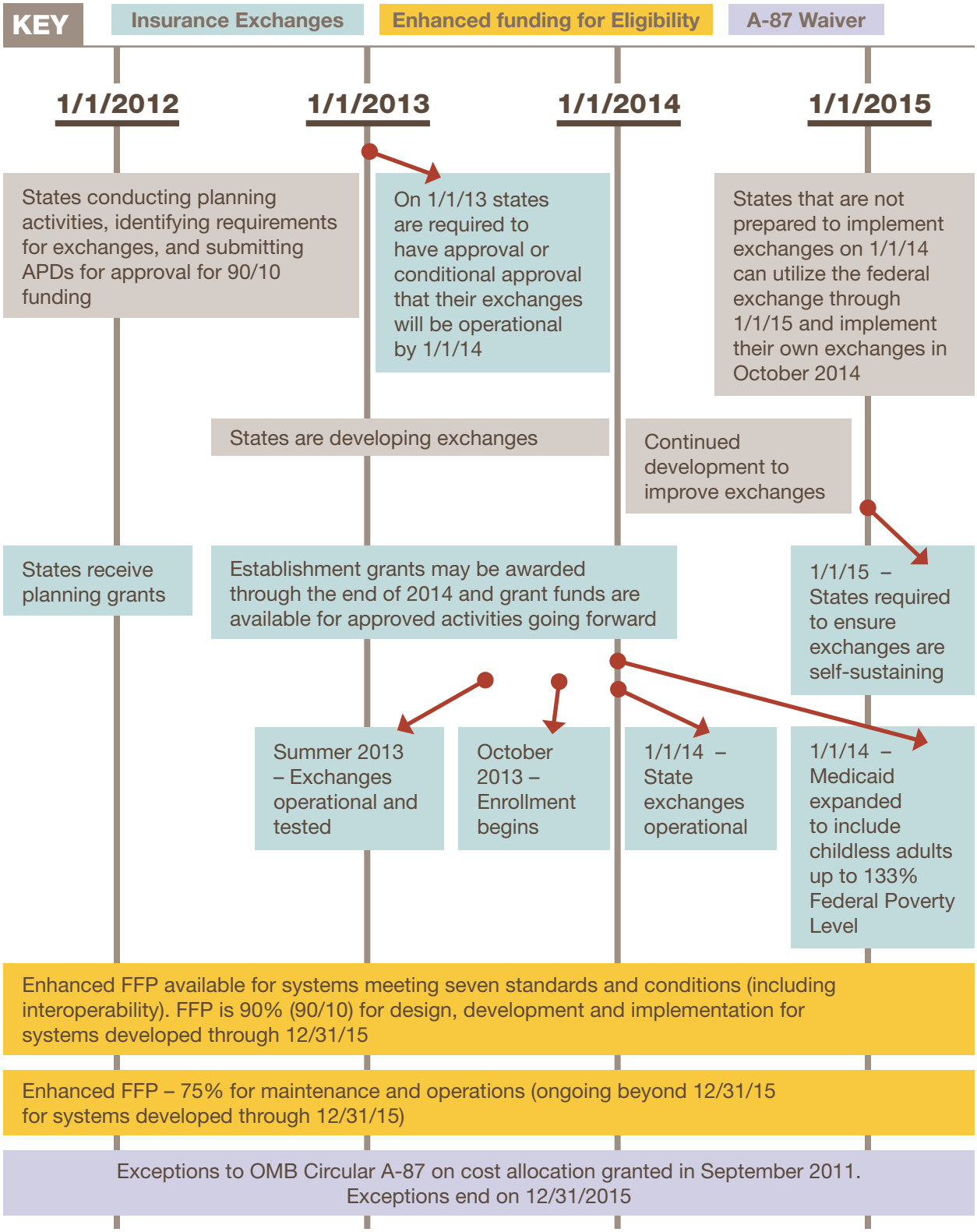
ACF INTEROPERABILITY OVERVIEW *Continued*

Implementation Timeline: Key Dates for States



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ACF INTEROPERABILITY OVERVIEW *Continued*

In February 2012, CMS announced an additional round of Establishment Grants to 10 states. To date, 49 states and the District of Columbia have received Planning Grants. Further, CMS indicates that 33 states and the District of Columbia are making significant progress in creating affordable insurance exchanges and a number of states are continuing to pursue Establishment Grants. CMS also noted in a recent release the multiple opportunities that states have to apply for funding, including a six-month extension for states to apply for Level One Establishment Grants.

ENHANCED FFP FOR ELIGIBILITY DETERMINATION

ON APRIL 19, 2011, CMS issued the final rule for federal funding for Medicaid eligibility determination activities related to design, development and implementation or enhancement (42 CFR Part 433). A link to the rule and the advance planning document (ADP) and checklist is included in the ACF Interoperability Toolkit. This rule, and the enhanced funding it will provide for automated eligibility-determination systems, is widely referred to as "90/10." In order to be eligible for these enhanced funds, expenses must be incurred before December 31, 2015. Systems that are developed utilizing the 90/10 funding are eligible for an enhanced FFP of 75% for ongoing maintenance and operations for systems that were implemented utilizing the 90/10 funding.

As published in the federal register (pages 21950 – 21975), the rule articulates the "enhanced Federal financial participation (FFP) that is available for design, development and installation or enhancement of eligibility determination systems." Included in this rule, in Section IV Provisions of the Final Regulations, Part B Standards and Conditions for Receiving Enhanced Funding, are several "delineating standards and conditions that must be met by States in order for the Medicaid technology investments to be eligible for the enhanced match."

One of these standards and conditions for states to obtain the enhanced funding makes mention of interoperability with human services and reads as follows:

> *"Ensure seamless coordination and integration with the Exchange (whether run by the State or Federal government), and allow interoperability with health information exchanges, public health agencies, human services programs, and community organizations providing outreach and enrollment assistance services."*

TIME LIMITED EXCEPTION TO OMB CIRCULAR A-87: COST ALLOCATION

IN AUGUST 2011 AND January 2012, leaders of CMS, FNS and ACF released joint letters explaining the recently granted time-limited exception to OMB Circular A-87, and outlined important considerations to make use of the exception, a list of allowable shared services to which the exception generally applies, and instructions to states on the APD submission process related to the exception. These exceptions will permit states to integrate human service eligibility processes into their health insurance exchange and Medicaid/CHIP systems without cost-allocating the common development costs benefiting multiple programs.

States can now develop technology components for eligibility and enrollment for Medicaid utilizing 90/10 funding, and that can also be utilized in other human service programs without allocating the costs. (Note: costs for components that are not necessary to the Medicaid eligibility system still have to be cost allocated). This exception to A-87 removes what many states had identified as a major barrier to implementing linkages between health and human service eligibility determination systems.

Please direct questions to David Jenkins at ACF.Toolkit@acf.hhs.gov.

ACF INTEROPERABILITY OVERVIEW *Continued*

The following is a list of allowable shared services to which the exception generally applies, to the extent that these business processes are core components of the health program eligibility system:

- Client Portals
- User Interfaces
- Master Client Index
- Business Rules Engine and Operating Systems
- Interfaces to: Federal and State verification sources; Community Assisters/Outreach Organizations; Exchange Infrastructure
- Enterprise Service Bus
- Data Warehouse
- Workflow Management Tools
- Notices
- Customer Services Technical Support
- Automated Account Creation and Case Notes
- Identity Management
- Document Imaging and Digitization of Case Records
- Privacy and Security Controls
- Business Intelligence
- Analytic Tools, including Decision Support and Program Integrity
- Telecommunications
- Information Security and Privacy Controls
- Infrastructure and Data Center Hosting

Note: This is not a comprehensive list of the design and development shared services that may be allowed. The tri-agency letter included in the ACF Interoperability Toolkit refers questions to relevant federal agency representatives.

Tools to Support Interoperability

ACF IS FUNDING THE DEVELOPMENT of a National Human Services Interoperability Architecture (NHSIA) and has taken the initiative to become the Domain Steward for the National Information Exchange Model (NIEM). These technology tools can provide critical support and assistance to states seeking to enhance their information sharing and business process capabilities and at the local level to impact client experiences and outcomes.

- NIEM enables information sharing by enabling information exchange between organizations in emergency situations as well as day-to-day operations. NIEM does not offer standard language for entire systems and does not concern itself with exchanges of large quantities of data for statistical or informational purposes only. NIEM is about meaningful exchanges of information, primarily at the state and local levels. It makes most sense to think of NIEM in terms of the on-the-ground business practices, such as sharing information between child welfare systems and education to better protect children and help families, or helping to smooth the transition between prison and community supports for inmates upon

Please direct questions to David Jenkins at ACF.Toolkit@acf.hhs.gov.

ACF INTEROPERABILITY OVERVIEW *Continued*

release. State, local and federal agencies, community-based organizations, associations and vendors all need to be involved to make NIEM successful.

- NHSIA is an architectural framework that can support common eligibility and information sharing across programs, agencies and departments; improved efficiency and effectiveness in delivery of human services; prevention of fraud; and better outcomes for children and families. When complete, it will consist of business, information, security and technology models to guide programs and states in the accurate reporting and delivery of services. The NHSIA Project is leveraging past developments of various federal and state programs, including Medicaid Information Technology Architecture (MITA), National Information Exchange Model (NIEM), Global Reference Architecture (GRA), service-oriented architecture (SOA) and cloud computing projects. NHSIA is consistent with MITA and extends MITA for human service programs.

On the Horizon: A Confidentiality Toolkit

THE NEXT COMPONENT TO BE ADDED TO THE ACF Interoperability Toolkit will relate to recommendations on confidentiality and privacy. Confidentiality and privacy are keystones of our society and our culture. With the advent of electronic and computer technologies, the ability to share and access information has become easier and, at the same time, the ability to protect information that needs to remain confidential and private has been greatly aided and enabled. Therefore, it is a delicate balancing of interests both to promote information sharing AND protect confidentiality and privacy to achieve the ultimate three goals of: (1) IMPROVING services and the outcomes of the services, (2) INCREASING efficiency and (3) REDUCING duplication of efforts/redundant activities and services. The purpose of the federal Confidentiality Toolkit will be to reach that delicate balance of important interests and maximize the ability to achieve these three goals. It will analyze and explain all federal laws that have a substantial impact on the implementation of human services and health services in states and local jurisdictions.

States and local jurisdictions can use the federal Confidentiality Toolkit as a model to analyze and explain their state's confidentiality and privacy laws and to determine how to share necessary information and, at the same time, protect people's rights to confidentiality and privacy. For example, in talking with persons from different jurisdictions, systems and roles, a common lament is that information cannot be shared because "HIPAA prohibits it." With the toolkit, a caseworker, manager or director can learn how to facilitate the sharing of important personal health information with a human service system so that the health and human service systems can work together and be more effective for the client and efficient with resources. Specifically, it will help people in the field decide WHAT information they need, WHY they need the requested information, HOW they can legally obtain the information, WHO else needs the information and HOW to keep the information secure.

Other Work in Interoperability and Integration

ADDITIONAL WORK ON PROMOTING interoperability and integration of health and human services has taken place. This section highlights two recent and promising articles. Both of these efforts, as well as the ACF Interoperability initiative, have been undertaken to assure that states utilize the current federal fund-

Please direct questions to David Jenkins at ACF.Toolkit@acf.hhs.gov.



ACF INTEROPERABILITY OVERVIEW *Continued*

ing opportunities to develop efficient systems that provide improved services and outcomes, as well as to improve efficiency of government administration:

National Workgroup on Integration (NWI). In September 2011, APHSA established NWI, held NWI's first convening and released a report entitled "Bridging the Divide: Leveraging New Opportunities to Integrate Health and Human Services" (http://www.aphsa.org/Home/Doc/NWI-report.pdf). The report describes the background of the Affordable Care Act and the opportunities available, and provides state examples. It also describes the future activities of the APHSA National Workgroup on Integration.

Coalition for Access and Opportunity. In October 2011, the Coalition for Access and Opportunity developed a report entitled "How Human Services Programs and Their Clients Can Benefit from National Health Reform Legislation," written by Stan Dorn of the Urban Institute. You can access this report at http://www.urban.org/UploadedPDF/412446-National-Health-Reform-Legislation.pdf.

Please direct questions to David Jenkins at ACF.Toolkit@acf.hhs.gov.

focus

By George Sheldon

George Sheldon is the acting assistant secretary of the Administration for Children and Families in the U.S. Department of Health and Human Services.

Health Reform and Human Service Interoperability:
The Times, They Are A-Changing

We've made substantial progress in the delivery of social services over the last several years. But the fragile economy that has strapped state and federal budgets is forcing us to do even more with less. Fortunately, other new developments support these efforts. Namely, new ways of communicating and storing and sharing data emerge daily, allowing us to streamline existing service delivery systems. And the Affordable Health Care Act—in addition to ushering in significant improvements in Americans' access to medical treatment—also requires states to design enrollment systems for their new health care exchanges that are consumer-friendly and integrated with human service programs.

We cannot underestimate the impact of health care reform on our operations. No matter how a state exercises its flexibility in organizing and administering Medicaid and CHIP, many of the 30 million people who are eligible for these programs or the new health insurance exchanges are also likely to be eligible for human service programs. An effort to standardize data elements and resolve cross-agency policy conflicts and confidentiality issues across health and human service programs will allow us to enroll more clients, realize programmatic and technological efficiencies and, most importantly, connect people who need help with agencies and nonprofits that can help them.

All of these pressures have combined to spur a revolution that marches under the banner of "interoperability." Its cause is a much more smoothly functioning, more technologically savvy future for health and human service delivery. Interoperability is picking up steam all across the government, and I'm proud that the Administration for Children and Families is in the vanguard.

Borrowed from the world of technology, interoperability is a relatively new word as applied to human services—although it's not an entirely original concept. The 20th century term for it was "service integration." These days, it is that and more.

Essentially, interoperability recognizes that human problems are not a series of discrete conditions, each occupying its own silo and addressed by a specific government remedy. Real people's problems don't fit neatly in compartments; they spill over programmatic lines and established bureaucratic procedures. Real life is complex and nuanced—a reality that government agencies don't reflect.

Interoperability addresses this problem by placing clients at the center of the services we provide, limiting technical and bureaucratic barriers between programs that make it harder for people to get the services they need. When interoperability works, everyone wins. Clients experience the system as easier to navigate. Agencies and their nonprofit partners reduce duplicative efforts, efficiently collect and use comparable data, and ultimately carry out their missions more effectively.

Fortunately, we have much of what it takes to make our systems more interoperable. We have state-of-the-art technology and experts who know how to unleash its potential, and we have a federal administration that is committed to the effort. And finally, the Affordable Care Act is acting as a powerful engine, driving local, state and federal officials and nonprofit leaders, from both health and human service agencies, to develop interoperable systems.

The Administration for Children and Families has a number of interoperability initiatives underway.

- We are creating a national human service architecture that will serve as the technical framework of interoperability.
- We are also developing a National Information Exchange Model that serves as a clearinghouse for commonly used terminology and establishes a process to identify and share essential information.
- And finally, we have launched a variety of in-house initiatives. Every program within the Administration for Children and Families has implemented an interoperability plan and teams composed of program staff are serving as point people for creative ideas.

Clearly, no revolution was ever won in a day, and many issues remain to be resolved, such as cost allocation and confidentiality. The momentum created by the Affordable Care Act is a great start, but, achieving interoperability will require novel strategies and approaches—including, but not limited to, technological solutions—and sufficient time to implement them. It will also require a strong and continuing federal–state–nonprofit partnership.

The philosophical underpinning of interoperability is that the client must always be at the center of whatever we do. That is why we must win this revolution. That is why the human service culture must not be one that fears innovation. The reward will be better outcomes for the children, families and individuals that we are privileged to serve.

For more information on ACF's interoperability efforts, visit *http://www.acf.hhs.gov/interop/toolkit.pdf/*.

Reprinted courtesy of the American Public Human Services Association (APHSA), 2011

POLICY INDEX

"When interoperability works, everyone wins."

Please direct questions to David Jenkins at ACF.Toolkit@acf.hhs.gov.

EXECUTIVE ORDER 13563: IMPROVING REGULATION AND REGULATORY REVIEW

Federal Register
Vol. 76, No. 14
Friday, January 21, 2011

Presidential Documents

Title 3—

The President

Executive Order 13563 of January 18, 2011

Improving Regulation and Regulatory Review

By the authority vested in me as President by the Constitution and the laws of the United States of America, and in order to improve regulation and regulatory review, it is hereby ordered as follows:

Section 1. *General Principles of Regulation.* (a) Our regulatory system must protect public health, welfare, safety, and our environment while promoting economic growth, innovation, competitiveness, and job creation. It must be based on the best available science. It must allow for public participation and an open exchange of ideas. It must promote predictability and reduce uncertainty. It must identify and use the best, most innovative, and least burdensome tools for achieving regulatory ends. It must take into account benefits and costs, both quantitative and qualitative. It must ensure that regulations are accessible, consistent, written in plain language, and easy to understand. It must measure, and seek to improve, the actual results of regulatory requirements.

(b) This order is supplemental to and reaffirms the principles, structures, and definitions governing contemporary regulatory review that were established in Executive Order 12866 of September 30, 1993. As stated in that Executive Order and to the extent permitted by law, each agency must, among other things: (1) propose or adopt a regulation only upon a reasoned determination that its benefits justify its costs (recognizing that some benefits and costs are difficult to quantify); (2) tailor its regulations to impose the least burden on society, consistent with obtaining regulatory objectives, taking into account, among other things, and to the extent practicable, the costs of cumulative regulations; (3) select, in choosing among alternative regulatory approaches, those approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; distributive impacts; and equity); (4) to the extent feasible, specify performance objectives, rather than specifying the behavior or manner of compliance that regulated entities must adopt; and (5) identify and assess available alternatives to direct regulation, including providing economic incentives to encourage the desired behavior, such as user fees or marketable permits, or providing information upon which choices can be made by the public.

(c) In applying these principles, each agency is directed to use the best available techniques to quantify anticipated present and future benefits and costs as accurately as possible. Where appropriate and permitted by law, each agency may consider (and discuss qualitatively) values that are difficult or impossible to quantify, including equity, human dignity, fairness, and distributive impacts.

Sec. 2. *Public Participation.* (a) Regulations shall be adopted through a process that involves public participation. To that end, regulations shall be based, to the extent feasible and consistent with law, on the open exchange of information and perspectives among State, local, and tribal officials, experts in relevant disciplines, affected stakeholders in the private sector, and the public as a whole.

(b) To promote that open exchange, each agency, consistent with Executive Order 12866 and other applicable legal requirements, shall endeavor to provide the public with an opportunity to participate in the regulatory process. To the extent feasible and permitted by law, each agency shall afford the public a meaningful opportunity to comment through the Internet on any proposed regulation, with a comment period that should generally

"Regulations shall be based... on the open exchange of information."

Please direct questions to David Jenkins at ACF.Toolkit@acf.hhs.gov.

EXECUTIVE ORDER 13563 *Continued*

be at least 60 days. To the extent feasible and permitted by law, each agency shall also provide, for both proposed and final rules, timely online access to the rulemaking docket on regulations.gov, including relevant scientific and technical findings, in an open format that can be easily searched and downloaded. For proposed rules, such access shall include, to the extent feasible and permitted by law, an opportunity for public comment on all pertinent parts of the rulemaking docket, including relevant scientific and technical findings.

(c) Before issuing a notice of proposed rulemaking, each agency, where feasible and appropriate, shall seek the views of those who are likely to be affected, including those who are likely to benefit from and those who are potentially subject to such rulemaking.

Sec. 3. *Integration and Innovation.* Some sectors and industries face a significant number of regulatory requirements, some of which may be redundant, inconsistent, or overlapping. Greater coordination across agencies could reduce these requirements, thus reducing costs and simplifying and harmonizing rules. In developing regulatory actions and identifying appropriate approaches, each agency shall attempt to promote such coordination, simplification, and harmonization. Each agency shall also seek to identify, as appropriate, means to achieve regulatory goals that are designed to promote innovation.

Sec. 4. *Flexible Approaches.* Where relevant, feasible, and consistent with regulatory objectives, and to the extent permitted by law, each agency shall identify and consider regulatory approaches that reduce burdens and maintain flexibility and freedom of choice for the public. These approaches include warnings, appropriate default rules, and disclosure requirements as well as provision of information to the public in a form that is clear and intelligible.

Sec. 5. *Science.* Consistent with the President's Memorandum for the Heads of Executive Departments and Agencies, "Scientific Integrity" (March 9, 2009), and its implementing guidance, each agency shall ensure the objectivity of any scientific and technological information and processes used to support the agency's regulatory actions.

Sec. 6. *Retrospective Analyses of Existing Rules.* (a) To facilitate the periodic review of existing significant regulations, agencies shall consider how best to promote retrospective analysis of rules that may be outmoded, ineffective, insufficient, or excessively burdensome, and to modify, streamline, expand, or repeal them in accordance with what has been learned. Such retrospective analyses, including supporting data, should be released online whenever possible.

(b) Within 120 days of the date of this order, each agency shall develop and submit to the Office of Information and Regulatory Affairs a preliminary plan, consistent with law and its resources and regulatory priorities, under which the agency will periodically review its existing significant regulations to determine whether any such regulations should be modified, streamlined, expanded, or repealed so as to make the agency's regulatory program more effective or less burdensome in achieving the regulatory objectives.

Sec. 7. *General Provisions.* (a) For purposes of this order, "agency" shall have the meaning set forth in section 3(b) of Executive Order 12866.

(b) Nothing in this order shall be construed to impair or otherwise affect:

(i) authority granted by law to a department or agency, or the head thereof; or

(ii) functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(c) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

EXECUTIVE ORDER 13563 *Continued*

(d) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

THE WHITE HOUSE,
January 18, 2011.

[FR Doc. 2011–1385
Filed 1–20–11; 8:45 am]
Billing code 3195–W1–P

WHITE HOUSE MEMORANDUM ON FLEXIBILITY

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release February 28, 2011

February 28, 2011

MEMORANDUM FOR THE HEADS OF EXECUTIVE DEPARTMENTS AND AGENCIES

SUBJECT: Administrative Flexibility, Lower Costs, and Better Results for State, Local, and Tribal Governments

Over the last 2 years, my Administration has worked with State, local, and tribal governments through the Recovery Act and other means to create jobs, build infrastructure, and protect critical programs and services in the face of declining revenues. But through smarter government we can do even more to improve outcomes and lower costs for the American taxpayer.

Federal program requirements over the past several decades have sometimes been onerous, and they have not always contributed to better outcomes. With input from our State, local, and tribal partners, we can, consistent with law, reduce unnecessary regulatory and administrative burdens and redirect resources to services that are essential to achieving better outcomes at lower cost. This is especially urgent at a time when State, local, and tribal governments face large budget shortfalls and American taxpayers deserve to know that their funds are being spent wisely.

On January 18, 2011, I signed Executive Order 13563, which, among other things, calls for careful analysis of regulations by executive departments and agencies (agencies), including consideration of costs and benefits. Executive Order 13563 also requires retrospective analysis of existing significant rules and greater coordination across agencies to simplify and harmonize redundant, inconsistent, or overlapping requirements, thus reducing costs.

"Executive Order 13563... requires... greater coordination across agencies to simplify and harmonize redundant, inconsistent, or overlapping requirements."

Please direct questions to David Jenkins at ACF.Toolkit@acf.hhs.gov.



WHITE HOUSE MEMORANDUM *Continued*

Executive Order 13563 applies to regulations involving and affecting State, local, and tribal governments. In particular, my Administration has heard from these governments that the array of rules and requirements imposed by various Federal programs and agencies may at times undermine their efforts to modernize and integrate program delivery. While appropriate data collection requirements are important to program accountability, some of these requirements are unduly burdensome, may not properly align compliance requirements with outcomes, are not synchronized across programs, and fail to give governments and taxpayers meaningful information about what works and what needs to be improved or be stopped. I believe that working together, State, local, and tribal governments and Federal agencies can distinguish between rules and requirements that support important goals -- such as promoting public health and welfare; protecting the rights of individuals, organizations, and private businesses; and assuring that programs produce intended outcomes -- from rules and requirements that are excessively burdensome or may not serve their intended purpose.

Through this memorandum, I am instructing agencies to work closely with State, local, and tribal governments to identify administrative, regulatory, and legislative barriers in Federally funded programs that currently prevent States, localities, and tribes, from efficiently using tax dollars to achieve the best results for their constituents.

Section 1. Coordination and Collaboration. To facilitate coordination across Federal agencies and State, local, and tribal governments, I direct the Director of the Office of Management and Budget (OMB) to lead a process, in consultation with State, local, and tribal governments, and agencies, to: (1) provide input to multiple agencies on State-specific, regional, or multistate strategies for eliminating unnecessary administrative, regulatory, and legislative burdens; (2) enable State, local, and tribal governments to request increased flexibility, as appropriate, from multiple agencies simultaneously and receive expeditious and judicious consideration of those requests; (3) establish consistent criteria, where appropriate, for evaluating the potential benefits, costs, and programmatic effects of relaxing, simplifying, or eliminating administrative, regulatory, and legislative requirements; and (4) facilitate consensus among

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WHITE HOUSE MEMORANDUM *Continued*

State, local, and tribal governments and agencies on matters that require coordinated action.

The Director of the OMB shall also take the following actions:

- Review and where appropriate revise guidance concerning cost principles, burden minimizations, and audits for State, local, and tribal governments in order to eliminate, to the extent permitted by law, unnecessary, unduly burdensome, duplicative, or low-priority recordkeeping requirements and effectively tie such requirements to achievement of outcomes.

- With agencies that administer overlapping programs, collaborate with State, local, and tribal governments to standardize, streamline, and reduce reporting and planning requirements in accordance with the Paperwork Reduction Act. The OMB should play a lead role, with appropriate agencies, in helping to develop efficient, low-cost mechanisms for collecting and reporting data that can support multiple programs and agencies.

- Facilitate cost-efficient modernization of State, local, and tribal information systems, drawing upon the collaboration of the Chief Information Officer in the OMB and the Chief Technology Officer in the Office of Science and Technology Policy.

- Provide written guidance to agencies on implementation of this memorandum within 60 days of the date of this memorandum.

Sec. 2. Streamlining Agency Requirements. Within 180 days of the date of this memorandum, agencies shall take the following actions to identify regulatory and administrative requirements that can be streamlined, reduced, or eliminated, and to specify where and how increased flexibility could be provided to produce the same or better program outcomes at lower cost.

- Work with State, local, and tribal governments to identify the best opportunities to realize efficiency, promote program integrity, and improve program outcomes, including opportunities, consistent with law, that reduce or streamline duplicative paperwork, reporting, and regulatory

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burdens and those that more effectively use Federal resources across multiple programs or States. Agencies should invite State, local, and tribal governments to identify not only administrative impediments, but also significant statutory barriers, to efficiency and effectiveness in program implementation.

- Establish preliminary plans to (1) consolidate or streamline processes that State, local, and tribal governments must use to obtain increased flexibility to promote the same or better outcomes at lower cost; (2) establish transparent criteria or principles for granting such increased flexibility, including those that are generally available and those that may be granted conditionally; and (3) ensure continued achievement of program results while allowing for such increased flexibility.

- Identify areas where cross-agency collaboration would further reduce administrative and regulatory barriers and improve outcomes. This should include identifying requirements for State planning documents that are prerequisites for awards from individual Federal programs that could be consolidated into one plan serving a number of agencies and programs.

- Report the results of these actions to the Director of the OMB.

Sec. 3. General Provisions. (a) This memorandum shall be implemented consistent with applicable law and subject to the availability of any necessary appropriations.

(b) Nothing in this memorandum shall be construed to impair or otherwise affect the functions of the Director of the OMB relating to budgetary, administrative, or legislative proposals.

(c) This memorandum is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

BARACK OBAMA

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COST ALLOCATION GUIDANCE

United States Department of Agriculture

August 10, 2011

Dear State Exchange Grantees, Medicaid and CHIP Directors, and Health and Human Services Directors:

As part of the Administration's commitment to promote flexibility for States and to ensure effective and efficient use of State and Federal resources, we are providing a time-limited, specific exception to the cost allocation requirements set forth in OMB Circular A-87 (Section C.3) to allow, at the option of the State, Federally funded human services programs to benefit from investments in State eligibility systems being made by State-operated Exchanges, Medicaid and the Children's Health Insurance Program (CHIP). This exception, discussed below, allows States the opportunity to thoughtfully consider the benefits of integrating the eligibility determination functions across health and human services programs and the timing of any such integration.

Integrated systems can realize efficiencies for States and better customer service for families. At the same time, States have a short timeframe to accomplish the eligibility system changes needed to implement Affordable Care Act health insurance changes that take effect in 2014. We encourage States to consider the benefits of interoperable systems, and how system development might be staged to ensure that the Affordable Care Act timeframes are met. Ultimately, decisions about whether to integrate the eligibility functions across programs and the schedule for such integration is a State decision. We are committed to providing coordinated Federal support and technical assistance throughout the process.

Background

As you know, the Affordable Care Act is projected to expand health insurance coverage to tens of millions of individuals starting January 1, 2014, through new Affordable Insurance Exchanges (Exchanges) and expansions in Medicaid. In addition, the Affordable Care Act substantially changes the way Medicaid programs cover individuals, creating a new national income standard and methodology which will work in coordination with CHIP, and premium tax credits and reduced cost-sharing through the Exchanges.

To accommodate these demands, many States are making long-needed investments in eligibility systems, to provide a high-quality customer experience to all individuals seeking health coverage, to accurately and quickly make a decision about a person's eligibility, and to get the individual enrolled into coverage.

"This exception... allows States... to thoughtfully consider the benefits of integrating the eligibility determination functions across health and human services programs."

COST ALLOCATION GUIDANCE *Continued*

We have provided previous guidance to States about how these systems should be developed and deployed to meet the goals of the Affordable Care Act, which calls for coordinated eligibility determination mechanisms. In accordance with this previous guidance, State eligibility systems, in order for the improvements to be eligible for Federal assistance, must be able to determine eligibility for Medicaid, CHIP, and premium tax credits and cost sharing benefits through the Exchange in a streamlined and integrated fashion. Medicaid, CHIP, and the Exchange will each contribute funding to a shared eligibility service or system that will apply a coordinated set of eligibility rules and use a common verification system to determine placement in one of the coverage programs available. As a reminder, this Federal guidance can be found in the "Guidance for Exchange and Medicaid Information Technology (IT) Systems, Version 2.0" (located at http://www.cms.gov/Medicaid-Information-Technology-MIT/Downloads/exchangemedicaiditguidance.pdf and http://www.cms.gov/Medicaid-Information-Technology-MIT/).

Exceptions to Certain Cost Allocation Requirements

Because other Federally funded human services programs can benefit from the changes being made to create a modern infrastructure to determine eligibility for Exchanges, tax credits, Medicaid and CHIP, we sought and received an exception to OMB Circular A-87 to allow States to reuse these assets for other programs and purposes without having to allocate those development costs to these other programs.

The exception allows human services programs (including, but not limited to, Temporary Assistance for Needy Families (TANF), Child Care and Development Fund (CCDF), and the Supplemental Nutrition Assistance Program (SNAP)) to utilize systems designed specifically for determining a person's eligibility for certain health coverage programs (Medicaid, CHIP, and premium tax credits and cost sharing benefits through the Exchange) without sharing in the common system development costs, so long as those costs would have been incurred anyway to develop systems for the Exchanges, Medicaid, and CHIP. Incremental costs for additional requirements needed for the inclusion of those programs, whether they are added to those projects at initial or later stages, must be charged entirely to the benefitting program.

This exception is effective immediately, applies only to development costs for eligibility determination systems, and terminates on December 31, 2015. Maintenance and operational costs for these systems shall continue to be cost allocated as currently required under OMB Circular A-87. Additional guidance and technical assistance related to the exception will be provided in the upcoming months.

CMS will track and compare development across States benchmarking costs and system capacity, to ensure that States are accurately capturing which costs and components are attributable to the underlying system for the Exchanges, Medicaid, and CHIP, and which are attributable to the addition of human services programs. We will provide more guidance at a later time.

As you know, the Affordable Care Act's coverage expansions are effective January 1, 2014, and the systems that support eligibility determinations need to be operational and fully tested no later

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COST ALLOCATION GUIDANCE *Continued*

than the summer of 2013. Toward that end, any system requirement that would delay meeting that deadline will not be permitted. Because of these tight timeframes, we encourage States pursuing an integrated eligibility system strategy consider mechanisms for phasing their IT development such that the functionality needed to determine eligibility for human services programs, such as TANF or SNAP, can be added after the health components are up and running. The exception to OMB Circular A-87 cost allocation principles remains in place through December 31, 2015, to allow such phased projects.

The U.S. Departments of Health and Human Services (HHS) and Agriculture (USDA) are committed to a strong partnership with States and our Federal partners as we work together to implement the Affordable Care Act.

Sincerely,

Cindy Mann
Deputy Administrator
and Director for Center for Medicaid, CHIP
and Survey & Certification,
Centers for Medicare & Medicaid Services,
Department of Health & Human Services

Kevin Concannon
Undersecretary for Food, Nutrition
and Consumer Services,
U.S. Department of Agriculture

George Sheldon
Acting Assistant Secretary
for Administration for Children and Families,
Department of Health & Human Services

Steve Larsen
Deputy Administrator and Director for
Center for Consumer Information and
Insurance Oversight,
Centers for Medicare & Medicaid Services,
Department of Health & Human Services

Please direct questions to David Jenkins at ACF.Toolkit@acf.hhs.gov.

ADDITIONAL GUIDANCE ON OMB CIRCULAR A-87: COST ALLOCATION

United States Department of Agriculture

January 23, 2012

Dear State Exchange Grantees, Medicaid and CHIP Directors, and Health and Human Services Directors:

On August 10, 2011, we announced a time-limited, specific exception to the cost allocation requirements set forth in OMB Circular A-87 (Section C.3) that requires benefitting programs to pay their share of the costs associated with building State-based information technology systems. The exception allows Federally-funded human services programs to benefit from investments in the design and development of State eligibility-determination systems for State-operated Exchanges, Medicaid and the Children's Health Insurance Program (CHIP). This letter provides additional guidance on how States may take advantage of this exception to leverage these investments to serve multiple programs and needs. The U.S. Departments of Health and Human Services (HHS) and Agriculture (USDA) are committed to a strong partnership with States and our Federal partners as we work together to implement the Affordable Care Act.

Timeline

January 1, 2014 marks the expansion of health insurance coverage through new Affordable Insurance Exchanges (Exchanges) and Medicaid. We encourage States to consider the benefits of interoperable systems and how system development can be staged to ensure that the Affordable Care Act timeframes are met. Many States will make long-needed investments in Medicaid, CHIP and Exchange eligibility systems, and these systems need to be operational and fully tested no later than the summer of 2013. While we encourage States to take into account the needs and requirements of human services programs in developing these systems, any human services system requirement that would delay meeting the deadline will not be permitted.

States pursuing an integrated eligibility system strategy should consider mechanisms for phasing their IT development, such that the additional functionality needed to determine eligibility for human services programs can be added after the health components are operational. It is not required that a State implement a shared eligibility system through a phased approach, but it is an allowable approach and may enable States to implement the health components of an enterprise system in accordance with the Affordable Care Act requirements.

Such phased projects would be allowed under the exception to OMB Circular A-87 cost allocation principles, which remains in place through December 31, 2015. States would need to incur costs for goods and services furnished no later than December 31, 2015 to make use of this exception. This would mean that if an amount has been obligated by December 31, 2015, but the good or service has not yet been furnished by that date, then such expenditure must be cost allocated as currently required under OMB Circular A-87.

"HHS and USDA are committed to a strong partnership with States and our Federal partners as we work together to implement the Affordable Care Act."

ADDITIONAL GUIDANCE ON OMB CIRCULAR A-87: COST ALLOCATION *Continued*

Additional Considerations to Using the Exception

1. Maintenance and operational costs for these systems shall continue to be cost allocated as currently required under OMB Circular A-87.

2. Further, any service, expansion of service, or increase in capacity beyond that required for the health programs, must be cost allocated to the benefitting program, consistent with the current practice under OMB Circular A-87. For example, the automation needed to track a court's determination of "reasonable efforts" to maintain a family is a function needed for title IV-E foster care and does not benefit Medicaid, CHIP, or the Exchange. An example of an "increase in capacity" that would require a State to allocate to the other benefiting Federal human services programs would be the need for additional infrastructure, equipment and/or data storage capacity.

3. To the extent that human services programs can make use of core eligibility determination business processes and technical services that will be used in the integrated eligibility systems, their ability to link to the system more easily and cost-efficiently in the future without requiring extensive changes to the common components is a cost-effective approach to systems engineering.

4. Regardless of the approach, should a State elect to implement a multi-program enterprise system, the project team must engage all programs that may be included in the eventual enterprise system in a cross-program collaborative planning and design process. The cross program collaboration should start as soon as possible and continue throughout the development life cycle of the planned enterprise system.

Allowable Shared Services under the Exception

A number of business processes and technical services that the Medicaid, CHIP, and Exchange programs may need to build or enhance to determine program eligibility and enroll clients into health care coverage have the potential for being useful to other Federally-funded human services programs. Taking steps now to explore the feasibility of developing shared eligibility services across all health and human service programs will reduce the number of duplicative and costly "siloed" systems performing the same function for different programs.

Under the exception to OMB Circular A-87 cost allocation principles, to the extent these business services are core components of the health program eligibility system, design and development costs would not be required to be cost allocated to the other Federally-funded human services programs for certain business process and technical services, such as the following:

- ✓ Client Portals
- ✓ User Interfaces
- ✓ Master Client Index
- ✓ Business Rules Engine and Operating Systems
- ✓ Interfaces to: Federal and State verification sources; Community Assisters/ Outreach Organizations; Exchange Infrastructure
- ✓ Enterprise Service Bus

Please direct questions to David Jenkins at ACF.Toolkit@acf.hhs.gov.

ADDITIONAL GUIDANCE ON OMB CIRCULAR A-87: COST ALLOCATION *Continued*

- ✓ Data Warehouse
- ✓ Workflow Management Tools
- ✓ Notices
- ✓ Customer Services Technical Support
- ✓ Automated Account Creation and Case Notes
- ✓ Identity Management
- ✓ Document Imaging and Digitization of Case Records
- ✓ Privacy and Security Controls
- ✓ Business Intelligence
- ✓ Analytic Tools, including Decision Support and Program Integrity
- ✓ Telecommunications
- ✓ Information Security and Privacy Controls
- ✓ Infrastructure and Data Center Hosting

Because each State's system solution may vary, States interested in taking advantage of the opportunities permissible under the exception should discuss their cost allocation approach with their representatives from the Centers for Medicare & Medicaid Services (CMS), the Administration for Children and Families (ACF), and Food and Nutrition Service (FNS) who are working together to ensure a close level of coordination. The list above is not exhaustive, and there may be other services that are allowable under the exception. As noted above, any expansion of these services or increase in capacity beyond that required for health programs must be cost allocated to the benefitting program, consistent with current practice under OMB Circular A-87. CMS and the Human Services Federal partners would be pleased to discuss specific variations from those listed above, provided they are consistent with Federal guidance.

Advance Planning Document (APD) Process

On October 28, 2010, the regulations governing the APD process were changed at 45 CFR 95 Subpart F. The purpose of the revised APD process is to simplify and streamline the submission and review process for those system-related documents. Considering the 2014 Affordable Care Act deadline, CMS developed an expedited APD checklist for use with Medicaid and CHIP that aligns with Exchange review initiatives. The expedited APD checklist can be found here: http://www.medicaid.gov/AffordableCareAct/Provisions/Information-Technology-Systems-and-Data.html. Both ACF and FNS have agreed to accept the CMS checklist for enterprise projects that support multi-agency or cross-agency initiatives. Consistent with current practice, States should continue to submit APDs to all program offices from which they are requesting funding, and if necessary, to ACF's Office on Administration that acts as the clearinghouse for all HHS-related APDs that include two or more HHS entitlement programs and coordinates review with FNS. If the State only requests funding for eligibility systems that provide functionality for the Medicaid and CHIP programs without the intent of building an integrated system in the future, the APD should be submitted directly to CMS for review and approval.

CMS issued the expedited APD checklist template prior to OMB's approval of the exception to OMB Circular A-87 cost allocation principles. The template does not include a specific section for a State to explain and document its efforts to include the common eligibility systems needs of human services programs under this exception. Therefore, we request the following information with submission of the expedited APD checklist:

Please direct questions to David Jenkins at ACF.Toolkit@acf.hhs.gov.

ADDITIONAL GUIDANCE ON OMB CIRCULAR A-87: COST ALLOCATION *Continued*

- A State must provide a detailed narrative to indicate which human services programs will eventually be included in the proposed solution.
- For a State pursuing a phased-in IT approach, the narrative should explain how the State will identify, capture, and implement the foundational needs of human services programs as they first implement Medicaid, CHIP, and Exchange requirements for the enterprise system project.
- The narrative should also identify the human services agencies and staff working on the design and implementation of the ACA-related system.

We recognize the State might not need or use funding from ACF or FNS during the first phase of the IT project. Nevertheless, the State must demonstrate in the CMS expedited APD checklist and accompanying narrative that the State staff responsible for the Federal human service programs that will eventually benefit from the new application are meaningfully involved in the design and development process of the common components of the enterprise system. This level of coordination will alert USDA and ACF, as appropriate, of the need to monitor progress of the system through the review of the State's APD updates and the CMS Gate Review process and will allow those other human services programs to transition to an active review responsibility as the State focuses on the unique needs of those programs in later phases of the project.

Funding requests should follow the guidance of the CMS-issued expedited APD checklist, which summarizes the Federal requirements for planning and implementation activities. States requesting funding for integrated eligibility systems should submit their APD to CMS and the human services program offices that will eventually benefit from the system. The Federal human service agencies in ACF and USDA have committed to a timely review of these submissions.

Please refer questions to the Federal analyst responsible for your program area.

Sincerely,

/s/

Cindy Mann
Deputy Administrator and Director for
Center for Medicaid and CHIP Services,
Centers for Medicare & Medicaid Services,
Department of Health & Human Services

/s/

Kevin Concannon
Under Secretary for Food, Nutrition
and Consumer Services,
U.S. Department of Agriculture

/s/

George Sheldon
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PATIENT PROTECTION AND AFFORDABLE CARE ACT SECTION 1561 RECOMMENDATIONS

Toward A More Efficient, Consumer-Mediated And Transparent Health And Human Services Enrollment Process

On March 23, 2010, President Obama signed the Affordable Care Act, which extends health care coverage to an estimated 32 million uninsured individuals and makes coverage more affordable for many others. Section 1561 requires HHS, in consultation with the Health Information Technology (HIT) Policy Committee and the HIT Standards Committee (the Committees), to develop interoperable and secure standards and protocols that facilitate electronic enrollment of individuals in Federal and State health and human services programs.

The Committees submitted to the National Coordinator for Health Information Technology the following approved, initial recommendations, which seek to encourage adoption of modern electronic systems and processes that allow a consumer to seamlessly obtain and maintain the full range of available health coverage and other human services benefits. The core of these recommendations is the belief that the consumer will be best served by a health and human services eligibility and enrollment process that:

- Features a transparent, understandable and easy to use online process that enables consumers to make informed decisions about applying for and managing benefits;
- Accommodates the range of user capabilities, languages and access considerations;
- Offers seamless integration between private and public insurance options;
- Connects consumers not only with health coverage, but also other human services such as the Supplemental Nutrition Assistance Program (SNAP) and the Temporary Assistance for Needy Families (TANF) program;
- Provides strong privacy and security protections.

See Appendix A for additional information on consumer usability.

Recommendations[1]

Core Data

Recommendation 1.1: We recommend that Federal agencies and States administering health and human services programs use the National Information Exchange Model (NIEM) guidelines to develop, disseminate and support standards and processes that enable the consistent, efficient and transparent exchange of data elements between programs and States.

Further work will be done to refine these standards using the NIEM guidelines and in coordination with Standards Development Organizations (SDOs). As required by the National Technology Transfer and Advancement

[1]The standards and protocols in these recommendations should be applicable to health insurance Exchanges. Under the Affordable Care Act, States will administer health insurance Exchanges unless they choose not to do so. The Federal government will operate an Exchange for residents of any State that chooses not to operate an Exchange. These standards are intended to apply to both Federal and State operated Exchanges. For simplicity, the Recommendations and Appendices use the term "State" to describe the responsibility of the Government entity operating the Exchange. Similarly, in a State that delegates authority for determining eligibility for Medicaid, CHIP or the Exchange to counties or other local government entities, we intend that the same standards apply. Finally, for the purposes of income verification the Exchanges may handle tax return information provided by the IRS. The safeguards and data security measures that apply to this data under federal tax law are outside the scope of this report.

"Section 1561 requires HHS... to develop interoperable secure standards... that facilitate electronic enrollment of individuals in Federal and State health and human services programs."

SECTION 1561 RECOMMENDATIONS *Continued*

Act and Office of Management and Budget Circular A-119, the Committees used a voluntary, consensus-based process to develop these initial recommendations.

See Appendix B for information on standards for core data elements commonly exchanged across health and human service programs (e.g., Medicaid, Children's Health Insurance Program (CHIP), SNAP, TANF).

Verification Interfaces

Recommendation 2.1: We recommend that Federal agencies required by Section 1411 of the Affordable Care Act to share data with States for verification of a consumer's initial eligibility, renewal and change in circumstances for Affordable Care Act health insurance coverage options (including Medicaid and CHIP) use a set of standardized Web services that could also support the eligibility determination process in other health and human services programs such as SNAP and TANF.

Recommendation 2.2: We recommend development of a Federal reference software model, implementing standards for obtaining verification of a consumer's initial eligibility, renewal and change in circumstances information from Federal agencies and States to ensure a consistent, cost-effective and streamlined approach across programs and State delivery systems.

The initial build of this toolset should include interfaces to the Federal agencies referenced in Recommendation 2.1. In order to ensure comprehensive and timely verification, additional interfaces to Federal, State or other widely-available data sources and tools should be added, including the National Directory of New Hires, the Electronic Verification of Vital Events Record (EVVE) system, State Income and Eligibility Verification (IEVS) systems, Public Assistance Reporting Information System (PARIS) and the U.S. Postal Service Address Standardization API.

See Appendix C for additional information about the Federal reference software model.

Business Rules

Recommendation 3.1: Federal agencies and States should express business rules using a consistent, technology-neutral standard format, congruent with the core data elements identified through the NIEM process. Upon identification of a consistent standard, Federal agencies and States should clearly and unambiguously express their business rules (outside of the transactional systems).

See Appendix D for additional discussion of technology options.

Recommendation 3.2: To allow for the open and collaborative exchange of information and innovation, we recommend the Federal government maintain a repository of business rules needed to administer Affordable Care Act health insurance coverage options (including Medicaid and CHIP), which may include an open source forum for documenting and displaying eligibility, entitlement and enrollment business rules to developers who build systems and the public in standards-based and human-readable formats.

To allow for seamless integration of all health and human services programs, business rules for other health and human services programs such as SNAP and TANF should be added to the repository over time.

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SECTION 1561 RECOMMENDATIONS *Continued*

Transmission of Enrollment Information

Recommendation 4.1: We recommend using existing Health Insurance Portability and Accountability Act (HIPAA) adopted transaction standards (e.g., ASC X12N 834, ASC X12N 270, ASC X12N 271) to facilitate transfer of consumer eligibility, enrollment, and disenrollment information between Affordable Care Act health insurance coverage options (including Medicaid and CHIP), public/private health plans and other health and human service programs such as SNAP and TANF.

This recommendation supplements the existing requirement that electronic transactions constituting "covered transactions" under HIPAA comply with adopted HIPAA transaction standards.

Recommendation 4.2: We recommend further investigation of existing standards to acknowledge a health plan's receipt of an HIPAA ASC X12N 834 transaction and, if necessary, development of new standards.

See Appendix E for additional information on existing HIPAA standards.

Privacy & Security

All entities involved in health information exchange – including individual and institutional providers and third party service providers such as Health Information Organizations (HIOs) and other intermediaries – should follow the full complement of fair information practices (FIPs) when handling personally identifiable health information. Formulation of FIPs comes from the Office of the National Coordinator's *Nationwide Privacy and Security Framework for Electronic Exchange of Individually Identifiable Health Information*.

Recommendation 5.1: We recommend that consumers have: 1) timely, electronic access to their eligibility and enrollment data in a format they can use and reuse; 2) knowledge of how their eligibility and enrollment information will be used, including sharing across programs to facilitate additional enrollments, and to the extent practicable, control over such uses; and 3) the ability to request corrections and/or updates of such data.

This recommendation builds upon the Health Information Technology for Economic and Clinical Health (HITECH) Act, which gave consumers the right to obtain an electronic copy of their protected health information from HIPAA covered entities that use or maintain an electronic health record, including health plans and clearinghouses. Additional investigation into format and content of such disclosures is needed.

See Appendix F for additional steps Federal agencies and States may need to take to facilitate a consumer-mediated approach to data sharing and examples of administrative tasks which may require Federal agencies or States administering health plans to reuse data.

Recommendation 5.2: We recommend that the consumer's ability to designate third party access be as specific as feasible regarding authorization to data (e.g., read-only, write-only, read/write, or read/write/edit), access to data types, access to functions, role permissions and ability to further designate third parties. If third party access is allowed, access should be:

- Subject to the granting of separate authentication and/or login processes for third parties;
- Tracked in immutable audit logs designating each specific third party access and major activities;
- Time-limited and easily revocable.[2]

[2]This recommendation does not address access by an individual's personal representative as provided in the HIPAA Standards for Privacy of Individually Identifiable Health Information.

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SECTION 1561 RECOMMENDATIONS *Continued*

See Appendix F for information on existing standards that States may use to implement this recommendation.

Recommendation 5.3: We recommend that States administering health and human services programs implement strong security safeguards to ensure the privacy and security of personally identifiable information. Specifically, we recommend the following safeguards:

- Data in motion should be encrypted. Valid encryption processes for data in motion are those which comply, as appropriate, with NIST SP 800-52, 800-77, or 800-113, or others which are Federal Information Processing Standards (FIPS) 140-2 validated.
- Automated eligibility systems should have the capability to:
  - *Record actions related to the PII provided for determining eligibility.* The date, time, client identification, and user identification must be recorded when electronic eligibility information is created, modified, deleted, or printed; and an indication of which action(s) occurred must also be recorded.
  - *Generate audit log.* Enable a user to generate an audit log for a specific time period and to sort entries in the audit log.

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ADVANCE PLANNING DOCUMENT PROCESS

"HHS has published the final rule on revisions to 45 CFR Part 95, which provides the requirements for federal prior approval of state Information Technology projects and procurements utilizing federal financial participation. These regulations govern the state systems development for titles XIX (Medicaid), IV-B/E (Child Welfare) and IV-D (Child Support) of the Social Security Act, as well as the cost allocation of system development costs for the Temporary Assistance for Needy Families (TANF) block grant. The primary goal of the final rule is to encourage state IT innovation by simplifying and streamlining procedural requirements for low-risk projects, while at the same time increasing independent oversight of higher-risk ones. This should enable states to move more quickly from developing new approaches to actually putting them into effect, ensuring at the same time that the federal government effectively protects public resources. The final rule also provides a major shift away from imposing federal procurement criteria to deferring to state procurement laws, policies and procedures."

The Federal Register notice is available at http://edocket.access.gpo.gov/2010/pdf/2010-26727.pdf

FUNDING INDEX

"The primary goal of the final rule is to encourage state IT innovation."

Please direct questions to David Jenkins at ACF.Toolkit@acf.hhs.gov.



Centers for Medicare & Medicaid Services/HHS

ENHANCED FUNDING REQUIREMENTS: SEVEN CONDITIONS AND STANDARDS

MEDICAID IT SUPPLEMENT (MITS-11-01-V1.0)

Introduction

BACKGROUND

Under sections 1903(a)(3)(A)(i) and 1903(a)(3)(B) of the Social Security Act, the Centers for Medicare & Medicaid Services (CMS) has issued new standards and conditions that must be met by the states in order for Medicaid technology investments (including traditional claims processing systems, as well as eligibility systems) to be eligible for the enhanced match funding. The final regulation establishing these standards and conditions was made public on April 14, 2011 at http://www.regulations.gov/#!searchResults;rpp=10;po=70;s=CMS-2010-0251.

Our purpose in moving to this standards and conditions-based approach to approving federal funding is intended to foster better collaboration with states, reduce unnecessary paperwork, and focus attention on the key elements of success for modern systems development and deployment.

In this document, we provide more detail about the seven conditions and standards and the kinds of information, activities and documentation the federal government will examine over the course of a systems development lifecycle to allow for initial and ongoing approval of enhanced funding. More importantly, these dimensions of development and artifacts are essential to help states ensure they are making efficient investments and will ultimately improve the likelihood of successful system implementation and operation. This document, and the principles contained in our April 2011 final regulation, build on the work CMS, states and private industry have done over the last six years under the Medicaid Information Technology Architecture (MITA) initiative.

MITA is intended to foster integrated business and information technology (IT) transformation across the Medicaid enterprise to improve the administration and operation of the Medicaid program. (The Medicaid enterprise is comprised of the states, the federal government, and stakeholders who are directly and indirectly part of the administration and health care delivery ecosystem.) The MITA initiative provides a common framework for all Medicaid stakeholders to focus on opportunities to build common services by decoupling legacy systems and processes, and liberating data previously stored and contained in inaccessible silos. The MITA framework facilitates a more modern and agile approach to traditional systems development lifecycle approaches that have had great difficulty in keeping up with the rate of change demanded by the changing business landscape of health care delivery and administration. By providing a common Framework for the Medicaid Enterprise to plan, architect, engineer, and implement new and changing business requirements, the effort to modernize Medicaid IT systems and processes becomes more stable, uniform, and lowers the risk of poor implementation. Over time, this effort will drive the states' systems toward a widespread network of shared, common technology and processes that support improved state administration of the Medicaid program. Our initial emphasis is on streamlining the eligibility and enrollment process, improving user experiences, increasing administrative efficiencies, and supporting with greater effectiveness the ability to manage care and produce improved health outcomes for Medicaid beneficiaries.

"Our purpose is...to foster better collaboration with the states, reduce unnecessary paperwork, and focus attention on the key elements of success."



ENHANCED FUNDING REQUIREMENTS: SEVEN CONDITIONS AND STANDARDS *Continued*

The MITA initiative began in 2005 with the concept of moving the design and development of Medicaid information systems away from the siloed, sub-system components that comprise a typical Medicaid Management Information Systems (MMIS) and moving to a service oriented architecture (SOA) framework of designing Medicaid information systems along the core principle that business processes inform and drive the implementation of business services. The MITA initiative produced an architecture framework—business, technical, and information—along with a business maturity model for process improvement, that guides the planning of technology and infrastructure build-out to meet the changing business needs of Medicaid programs. MITA enables all state Medicaid enterprises to meet common objectives within the MITA framework while still supporting local needs unique to the particular state. All MITA framework documents are available to the public at http://www.cms.gov/MedicaidInfoTechArch/.

CMS is also issuing Guidance for Exchange and Medicaid Information Technology (IT) Systems (IT Guidance) relevant to Medicaid agencies as it articulates expectations and supports development and design for Medicaid and Exchange operations. Medicaid and Exchange IT Guidance focuses on those business functions and supporting IT solutions needed for successful implementation of expanded coverage through premium tax credits and reduced cost sharing, and enrollment in Medicaid and Children's Health Insurance Program (CHIP).

CMS recognizes that there is not a "one size fits all" technology solution to every business challenge. Each technology investment must be viewed in light of existing, interrelated assets and their maturity. There are trade-offs concerning schedules, costs, risks, business goals, and other factors that should be considered when making technology investments; however, CMS must ensure that enhanced Federal Financial Participation (FFP) funding is approved only when Medicaid infrastructure and information systems projects meet statutory and regulatory requirements to support efficient and effective operation of the program.

PURPOSE AND SCOPE

THE PURPOSE OF THIS DOCUMENT is to assist states as they design, develop, implement and operate technology and systems projects in support of the Medicaid program. This document provides additional insight and context to states to allow them to meet the conditions and standards for enhanced federal match for Medicaid technology investments. Future editions of this guidance will be developed with additional input from and consultation with states.

Conditions and Standards

MODULARITY STANDARD

THIS CONDITION REQUIRES THE USE of a modular, flexible approach to systems development, including the use of open interfaces and exposed application programming interfaces (API); the separation of business rules from core programming; and the availability of business rules in both human and machine-readable formats. The commitment to formal system development methodology and open, reusable system architecture is extremely important in order to ensure that states can more easily change and maintain systems, as well as integrate and interoperate with a clinical and administrative ecosystem designed to deliver person-centric services and benefits.

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ENHANCED FUNDING REQUIREMENTS: SEVEN CONDITIONS AND STANDARDS *Continued*

Modularity is breaking down systems requirements into component parts. Extremely complex systems can be developed as part of a service-oriented architecture (SOA). Modularity also helps address the challenges of customization. Baseline web services and capabilities can be developed for and used by anyone, with exceptions for specific business processes handled by a separate module that interoperates with the baseline modules. With modularity, changes can be made independently to the baseline capabilities without affecting how the extension works. By doing so, the design ensures that future iterations of software can be deployed without breaking custom functionality.

A critical element of compliance with this condition is providing CMS with an understanding of where services and code will be tightly coupled, and where the state will pursue a more aggressive decoupling strategy.

Use of Systems Development Lifecycle methodologies. States should use a system development lifecycle (SDLC) methodology for improved efficiency and quality of products and services. The system development lifecycle methodology should have distinct, well-defined phases for inception through closeout; include planning that describes schedules, target dates, and budgets; should exhibit controls over the life of the project via written documentation, formal reviews, and signoff/acceptance by the system owner(s); and should have well-documented, repeatable processes with clear input and output criteria (e.g., artifacts). States should assess deliverables against CMS guidelines such as MITA and Medicaid and Exchange IT Guidance.

CMS is implementing a streamlined systems development life cycle process for Exchange Grants that accommodates CMS feedback and direction to the states. All grantees have received guidance on this process. We will also distribute information on our combined Exchange/ Medicaid governance processes to states through a variety of different mechanisms, including informational bulletins and by posting materials on our CMS website. States will be required to participate in this process for eligibility and enrollment systems needed to implement expansions under the Affordable Care Act. States may refer to this SDLC process as a model they can employ internally for other Medicaid IT projects. Otherwise, the system development methodology framework selected by the state should suit the specific kinds of project, based on varying technical, organizational, project, and team factors. Some mature methodologies for consideration include the traditional "waterfall" model; Rapid Application Development (RAD); Spiral Approach; Unified Process or Rational Unified Process (RUP), which reinforces the usage of Unified Modeling Language (UML); and Agile Development.

The objective of any SDLC process is to provide structure and discipline, and states are to build secure IT solutions based on SOA principles. The application of and adherence to SOA principles should facilitate the delivery of flexible, agile, and interoperable MMISs. States should employ an open, reusable system architecture that separates the presentation layer, business logic (i.e., service layer), and data layer for greater flexibility, security, performance, and quality of design, implementation, maintenance, and enhancement in the software life cycle. The system architecture should utilize a user interface (UI) framework that deploys presentation components to allow for communication with disparate populations using different media formats such as web, email, mobile, and short message service (i.e., text messaging).

Identification and description of open interfaces. States should emphasize the flexibility of open interfaces and exposed APIs as components for the service layer. States should identify all interfaces in their

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ENHANCED FUNDING REQUIREMENTS: SEVEN CONDITIONS AND STANDARDS *Continued*

development plan and discuss how those interfaces will be maintained. States must develop and maintain an exposed API to any data services hub available for the reporting of data, verifications, and exchange of data among states. Service interfaces should be documented in an Interface Control Document (ICD). This ICD, for which CMS can provide a template, should contain details of hardware, operating systems, software, memory, service packs, product keys, and versions.

Use of business rules engines. States should ensure the use of business rules engines to separate business rules from core programming, and should provide information about the change control process that will manage development and implementation of business rules. States should be able to accommodate changes to business rules on a regularized schedule and on an emergency basis.

States should identify and document the business rules engines used, the manner in which the business rules engine(s) is implemented in the state's architecture, the type of business rules engine (e.g., forward-chaining, backward-chaining, deterministic/domain specific, event processing, inference-based, etc.); the licensing and support model associated with the business rules engine(s); and the approximate number of rules the business rules engine(s) executes for a given business process.

Submission of business rules to a HHS-designated repository. States should be prepared to submit all their business rules in human-readable form to an HHS repository, which will be made available to other states and to the public. In their APD, states must specify when they expect to make those business rules available. CMS will provide additional detail and specifications about how to submit those rules. If the states want to protect distribution of any specific business rules (e.g., those that protect against fraud), states may specify their desire to protect those rules.

MITA CONDITION

THIS CONDITION REQUIRES STATES TO ALIGN to and advance increasingly in MITA maturity for business, architecture, and data. CMS expects the states to complete and continue to make measurable progress in implementing their MITA roadmaps. Already the MITA investments by federal, state, and private partners have allowed us to make important incremental improvements to share data and reuse business models, applications, and components. CMS strives, however, to build on and accelerate the modernization of the Medicaid enterprise that has thus far been achieved.

MITA Self Assessments. CMS will be reviewing and producing MITA 3.0 in 2011. This next version of MITA will take into account the changes required by the Affordable Care Act and the availability of new technologies such as cloud computing and build out maturity levels 4 and 5. Once completed, CMS expects all states to update their self assessments within 12 months. If a state has not yet completed a self assessment, it may wait until version 3.0 is published (expected in 2011).

MITA Roadmaps. States will provide to CMS a MITA Maturity Model Roadmap that addresses goals and objectives, as well as key activities and milestones, covering a 5-year outlook for their proposed MMIS solution, as part of the APD process. This document will be updated on an annual basis. States should demonstrate how they plan to improve in MITA maturity over the 5-year period and their anticipated timing for full MITA maturity. States should ensure that they have a sequencing plan that considers cost, benefit, schedule, and risk.

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ENHANCED FUNDING REQUIREMENTS: SEVEN CONDITIONS AND STANDARDS *Continued*

Concept of Operations (COO) and Business Process Models (BPM). States should develop a concept of operations and business work flows for the different business functions of the \state to advance the alignment of the state's capability maturity with the MITA Maturity Model (MMM). These COO and business work flows should align to any provided by CMS in support of Medicaid and Exchange business operations and requirements. States should work to streamline and standardize these operational approaches and business work flows to minimize customization demands on technology solutions and optimize business outcomes. CMS will provide more direction in future guidance about the form and format for the COO and BPMs.

INDUSTRY STANDARDS CONDITION

STATES MUST ENSURE ALIGNMENT WITH, and incorporation of, industry standards: the Health Insurance Portability and Accountability Act of 1996 (HIPAA) security, privacy and transaction standards; accessibility standards established under section 508 of the Rehabilitation Act, or standards that provide greater accessibility for individuals with disabilities, and compliance with federal civil rights laws; standards adopted by the Secretary under section 1104 of the Affordable Care Act; and standards and protocols adopted by the Secretary under section 1561 of the Affordable Care Act.

CMS must ensure that Medicaid infrastructure and information system investments are made with the assurance that timely and reliable adoption of industry standards and productive use of those standards are part of the investments. Industry standards promote reuse, data exchange, and reduction of administrative burden on patients, providers, and applicants.

Identification of industry standards. CMS will communicate applicable standards to states. Standards would be updated periodically to ensure conformance with changes in the industry. States will be required to update systems and practices to adhere to evolving industry standards in order to remain eligible for enhanced FFP funding.

The state must identify all industry standards relevant to the scope and purpose of their project and produce development and testing plans to ensure full compliance. States must also have risk and mitigation strategies in place to address potential failures to comply.

Incorporation of industry standards in requirements, development, and testing phases. States must implement practices and procedures for the system development phases such as requirements analysis, system testing, and user acceptance testing (UAT). States' plans must ensure that all systems comply fully and on-time with all industry standards adopted by the Secretary of HHS.

To comply with to the Rehabilitation Act's section 508(c) for accessibility of user interfaces for disabled persons, states must produce a Section 508 Product Assessment Package as part of their SDLC. The state should perform regularly scheduled (i.e., automatic) scans and manual testing for Section 508(c) compliance for all types of user interface screens (static, dynamic, Web, client-server, mobile, etc.) to meet the standards for full compliance. Software is available that assist with Section 508(c) compliance testing.

LEVERAGE CONDITION

STATE SOLUTIONS SHOULD PROMOTE SHARING, leverage, and reuse of Medicaid technologies and systems within and among states.

Please direct questions to David Jenkins at ACF.Toolkit@acf.hhs.gov.

ENHANCED FUNDING REQUIREMENTS: SEVEN CONDITIONS AND STANDARDS *Continued*

States can benefit substantially from the experience and investments of other states through the reuse of components and technologies already developed, consistent with a service-oriented architecture, from publicly available or commercially sold components and products, and from the use of cloud technologies to share infrastructure and applications. CMS commits to work assertively with the states to identify promising state systems that can be leveraged and used by other states. Further, CMS would strongly encourage the states to move to regional or multi-state solutions when cost effective, and will seek to support and facilitate such solutions. In addition, CMS will expedite APD approvals for states that are participating in shared development activities with other states, and that are developing components and solutions expressly intended for successful reuse by other states.

CMS will also review carefully any proposed investments in sub-state systems when the federal government is asked to share in the costs of updating or maintaining multiple systems performing essentially the same functions within the same state.

Multi-state efforts. States should identify any components and solutions that are being developed with the participation of or contribution by other states.

Availability for reuse. States should identify any components and solutions that have high applicability for other reuse by other states, how other states will participate in advising and reviewing these artifacts, and the development and testing path for these solutions and components will promote reuse. As the capability becomes available, states should supply key artifacts to a common, national cloud-based repository accessible by all states and CMS. Further definition of these artifacts (SLDC deliverables, business requirements and process flows, and conceptual and logical data models) and how to provide them to the national repository will follow in subsequent guidance.

Identification of open source, cloud-based and commercial products. States should pursue a service-based and cloud-first strategy for system development. States will identify and discuss how they will identify, evaluate, and incorporate commercially or publicly available off-the-shelf or open source solutions, and discuss considerations and plans for cloud computing. States should identify any ground-up development activity within their development approaches and explain why this ground-up activity has been selected.

Customization. States will identify the degree and amount of customization needed for any transfer solutions, and how such customization will be minimized.

Transition and retirement plans. States should identify existing duplicative system services within the state and seek to eliminate duplicative system services if the work is cost effective such as lower total cost of ownership over the long term.

BUSINESS RESULTS CONDITION

SYSTEMS SHOULD SUPPORT ACCURATE AND TIMELY processing of claims (including claims of eligibility), adjudications, and effective communications with providers, beneficiaries, and the public.

Ultimately, the test of an effective and efficient system is whether it supports and enables an effective and efficient business process, producing and communicating the intended operational results with a high degree

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ENHANCED FUNDING REQUIREMENTS: SEVEN CONDITIONS AND STANDARDS *Continued*

of reliability and accuracy. It would be inappropriate to provide enhanced federal funding for systems that are unable to support desired business outcomes.

Degree of automation. The state should be highly automated in systematic processing of claims (including claims of eligibility) and steps to accept, process, and maintain all adjudicated claims/transactions.

Customer service. States should document how they will produce a 21st-century customer and partner experience for all individuals (applicants, beneficiaries, plans, and providers). This 21st-century customer experience should include the ability to submit and manage interactions with Medicaid through the web and to self-manage and monitor accounts and history electronically. It should also outline how customer preferences for communications by email, text, mobile devices, or phones will be accommodated. States should also commit to testing and evaluation plans to ensure providers, applicants, and others interacting with and using their systems will have the opportunity to provide feedback and assessment of accessibility, ease of use, and appropriateness of decisions.

Performance standards and testing. CMS intends to provide additional guidance concerning performance standards—both functional and non-functional, and with respect to service level agreements (SLA) and key performance indicators (KPI). We expect to consult with states and stakeholders as we develop and refine these measures and associated targets. As this list of measures will be focused on very core elements/indicators of success, states should also consider adding state-specific measures to this list.

For the implementation of IT system enhancements, states will execute tests against test cases intended to verify and validate the system's adherence to its functional and non-functional requirements.

For operational IT systems, states will periodically evaluate system performance against established SLAs. When SLAs are not met, states will create and execute a Plan of Action with Milestones (POAM). CMS reserves the right to inspect a state's performance assessment outcomes and POAMs. States will periodically evaluate operational business processes against established KPIs. When KPIs are not met, states will create and execute a POAM. CMS reserves the right to inspect a state's performance assessment outcomes and POAMs.

REPORTING CONDITION

SOLUTIONS SHOULD PRODUCE TRANSACTION DATA, reports, and performance information that would contribute to program evaluation, continuous improvement in business operations, and transparency and accountability.

Systems should be able to produce and to expose electronically the accurate data that are necessary for oversight, administration, evaluation, integrity, and transparency. These reports should be automatically generated through open interfaces to designated federal repositories or data hubs, with appropriate audit trails. MITA 3.0 will provide additional detail about reporting requirements and needs that arise from the Affordable Care Act. Additional details about data definitions, specifications, timing, and routing of information will be supplied later this year.

INTEROPERABILITY CONDITION

SYSTEMS MUST ENSURE SEAMLESS COORDINATION and integration with the Exchange (whether run by the state or federal government), and allow interoperability with health information exchanges, public health

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ENHANCED FUNDING REQUIREMENTS: SEVEN CONDITIONS AND STANDARDS *Continued*

agencies, human services programs, and community organizations providing outreach and enrollment assistance services.

CMS expects that a key outcome of the government's technology investments will be a much higher degree of interaction and interoperability in order to maximize value and minimize burden and costs on providers, beneficiaries, and other stakeholders. CMS is emphasizing in this standard and condition an expectation that Medicaid agencies work in concert with Exchanges (whether state or federally administered) to share business services and technology investments in order to produce seamless and efficient customer experiences. Systems must also be built with the appropriate architecture and using standardized messaging and communication protocols in order to preserve the ability to efficiently, effectively, and appropriately exchange data with other participants in the health and human services enterprise.

As stated in MITA Framework 2.0, each state is "responsible for knowing and understanding its environment (data, applications and infrastructure) in order to map its data to information-sharing requirements. The data-sharing architecture also addresses the conceptual and logical mechanisms used for data sharing (i.e., data hubs, repositories, and registries). The data-sharing architecture will also address data semantics, data harmonization strategies, shared-data ownership, security and privacy implications of shared data, and the quality of shared data.

Interactions with the Exchange. States should ensure that open interfaces are established and maintained with any federal data services hub and that requests to the hub are prepared and available for submission immediately after successful completion of the application for eligibility. States must ensure and test communications between Exchange and Medicaid systems so that determinations and referrals can be effectively transmitted from the Exchange. States should describe how shared services will support both the Exchange and Medicaid.

Interactions with other entities. States should consult with and discuss how the proposed systems development path will support interoperability with health information exchanges, public health agencies, and human services programs to promote effective customer service and better clinical management and health services to beneficiaries. States should also consult with and discuss how eligibility systems will allow community service organizations to assist applicants seeking health care coverage to complete forms and to submit those forms electronically.

Next Steps

CMS will continue to refine, update, and expand this guidance in the future, based on initial and continuing feedback from states, beneficiaries, providers, and industry; and with experience over time. We intend to actively solicit feedback and well as to invite it. Our experience with states that are early in implementing new eligibility systems in support of Exchanges, Medicaid, and CHIP, as well as states that are beginning or in early stages of development of new claims systems, will be instrumental in helping us to further refine and shape this guidance.

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ENHANCED FUNDING REQUIREMENTS: SEVEN CONDITIONS AND STANDARDS *Continued*

Acronyms

API	Application Programming Interface
BPM	Business Process Model
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
COO	Concept of Operations
FFP	Federal Financial Participation
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
IT	Information Technology
KPI	Key Performance Indicator
MITA	Medicaid Information Technology Architecture
MMIS	Medicaid Management Information System
MMM	MITA Maturity Model
POAM	Plan of Action and Milestones
RAD	Rapid Application Development
RUP	Rational Unified Process
SDLC	System Development Life Cycle
SLA	Service Level Agreement
SOA	Service-Oriented Architecture
UAT	User Acceptance Testing
UI	User Interface
UML	Uniform Modeling Language

FUNDING INDEX

Cost Allocation Guidance

Additional Guidance on the OMB Circular A-87: Cost Allocation

Patient Protection and Affordable Care Act Section 1561 Recommendations

Advance Planning Document Process

Enhanced Funding Requirements: Seven Conditions and Standards

Enhanced Funding Requirements: Expedited Advance Planning Document Checklist

Please direct questions to David Jenkins at ACF.Toolkit@acf.hhs.gov.

Centers for Medicare & Medicaid Services/HHS

ENHANCED FUNDING REQUIREMENTS: EXPEDITED ADVANCE PLANNING DOCUMENT CHECKLIST

MEDICAID IT SUPPLEMENT (MITS-11-02-V1.0)

Expedited Checklist: Medicaid Eligibility & Enrollment and Information System(s) – Advance Planning Document (E&E – APD)

PURPOSE: This Expedited Eligibility and Enrollment (E&E) – APD checklist is for states to complete and submit to CMS for review and prior approval in order to receive enhanced federal funding for Medicaid Information Technology (IT) system(s) projects related to eligibility and enrollment functions. This template may be used by any state that is submitting or has submitted an Early Innovator or Establishment grant application.

Specifically, this checklist:

1. Guides states in obtaining prior approval to secure ninety percent (90%) federal financial participation (FFP) for the design, development, implementation (DDI), and/or enhancements of a system(s); and seventy-five percent (75%) FFP for maintenance and operations [42 CFR §433 Subpart C].
2. Contains Seven Standards & Conditions that the state's APD must meet.
3. Contains federal requirements for both PLANNING and IMPLEMENTATION activities of an APD [45 CFR § 95 Subpart F (Revised October 28, 2010)].
4. Streamlines the process for states by requiring fewer documents, as well as potentially shortening the review timeframe for CMS, and if applicable, other Agencies, of system projects related to the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act). Although federal regulations allow up to sixty (60) days for APD approvals, CMS' goal is to provide an approval within thirty (30) business days upon receipt.

INSTRUCTIONS: The checklist has three columns. Column #1 lists the APD requirements at 45 CFR § 95.605. Column #2 lists the APD required elements divided into sub-columns listing specific requirements whether the state is engaging in the planning and/or implementation APD activities. Column #3 is used to capture the declaration and collaboration activities. CMS will allow the "reuse" of documentation if specific information that is required by this E&E–APD checklist, along with sufficient detailed information to encompass Medicaid functionalities, is provided in a final and approved CCIIO Planning, Early Innovator, and/or Establishment grant application(s), as well as states' final documents/artifacts that are reviewed, approved by CCIIO's Exchange Life Cycle Gate Review Process. Where appropriate, please reference the corresponding page number(s) in the CCIIO grant application(s), the sub-section in the APD that fully addresses the Medicaid E&E-APD requirements, and include as an attachment(s).

APD Submission to: Mr. Richard H. Friedman, Director

Division of State Systems
Centers for Medicaid, CHIP and Survey & Certification
Centers for Medicare & Medicaid Services
Mail Stop: S2-22-16
7500 Security Boulevard
Baltimore, Maryland 21244-1820

Send electronically to "MedicaidE&E_APD@cms.hhs.gov." Questions should be directed to Kirti Patel at kirti.patel@cms.hhs.gov.

"This template may be used by any state that is submitting... an Early Innovator or Establishment grant application."

EXPEDITED APD CHECKLIST *Continued*

Oversight Of Other Federal Partner Agencies

OVERSIGHT OF OTHER FEDERAL PARTNER AGENCIES: In order for CMS to determine the role of other federal partners (i.e., USDA FNS, and HHS ACF) in the APD review process, please characterize the vision as most closely resembling one of the following:

a) ☐ Yes ☐ No Our system development will support the full range of Medicaid and Exchange eligibility and enrollment.

b) ☐ Yes ☐ No Our systems development will support Medicaid-only eligibility and enrollment (individuals whose eligibility is based on factors other than modified adjusted gross income).

c) ☐ Yes ☐ No This systems development is part of a broader enterprise architecture plan. Other health and human services partner programs are included in the planning process, and we anticipate that their requirements will be included to the greatest extent possible in the architecture. Their individual program requirements will be addressed in later phases.

d) ☐ Yes ☐ No We are modifying an existing integrated eligibility system (traditionally understood as involving a range of state operated health and human services programs) and anticipate maintaining existing partnerships and linkages. These partner programs are active participants in the planning of this project.

e) ☐ Yes ☐ No We are unable to determine at this time which programs may be included in the project. We are starting work on the requirements of the Affordable Care Act with regard to Medicaid, while continuing to investigate the appropriate role of other programs. An update of this APD will be provided to the appropriate federal agencies as soon as possible, including the process for inclusion of all program stakeholders, as appropriate.

Regarding the State's Children's Health Insurance Program (CHIP), please specify:

☐ The State CHIP component is part of the systems development approach specified above.
☐ Other, please specify _____

State/Territory Name:_____ **Date of Submission to CMS:** _____
(mm/dd/yyyy)

APD Type:

☐ Planning APD
☐ Implementation APD
☐ Both (Planning and Implementation)
☐ APD Update (Planning_____ or, Implementation_____)

APD Contact: _____
(Name, Title, Department, address, phone, email)

EXPEDITED APD CHECKLIST *Continued*

Section 1: STATEMENT OF NEED AND OBJECTIVES
Section 2: REQUIREMENTS AND ALTERNATIVES ANALYSIS
Section 3: PROJECT MANAGEMENT PLAN

Section	Content		Minimum Requirements, Declaration, and Collaboration Activities
	Planning APD Activities	Implementation APD Activities	
1. Statement of Need and Objectives This section describes the purpose and objectives of the project to be accomplished.	1.1 Statement of purpose including vision, needs, objectives and anticipated benefits. 1.2 Describe the state approach in working and collaborating with the State Exchange entity/component.	1.1 Statement of purpose, including vision 'the roadmap', needs, objectives and anticipated benefits. 1.2 Describe the business need for system(s) development and/or modifications. 1.3 Indicate which system(s) the state is seeking to modify, if any: [please name and describe these systems]. 1.4 Describe the state approach in working and collaborating with the State Exchange entity/component.	If specific information required in this section was provided in an approved and final CCIIO documentation, please indicate which one by checking the box below, provide the page number(s) of its location, specify which APD sub-section(s) it addresses (i.e., 1.1, 1.2), and include as an attachment(s): ☐ Planning Grant App Page (s) ____, APD Section(s) _____ ☐ Innovator Grant App Page(s) ____, APD Section(s) _____ ☐ Establishment Grant App Page(s) ____, APD Section(s) _____ ☐ Gate Review Documents/Artifacts _____, Page(s) _____
2. Requirements and Alternatives Analysis	N/A	2.1 This section provides a summary of the requirements analysis, feasibility study, and alternatives analysis. 2.2 Cost/Benefit analysis.	If specific information required in this section was provided in an approved and final CCIIO documentation, please indicate which one by checking the box below, provide the page number(s) of its location, specify which APD sub-section(s) it addresses (i.e. 2.1, 2.2), and include as an attachment(s): ☐ Planning Grant App Page(s) ____, APD Section(s) _____ ☐ Innovator Grant App Page(s) ____, APD Section(s) _____ ☐ Establishment Grant App Page(s) ____, APD Section(s) _____ ☐ Gate Review Documents/Artifacts_____, Page(s)_____
3. Project Management Plan The Project Management Plan summarizes the project activities, deliverables, and products; project organization, State and contract resource needs; and anticipated system life.	3.1 A detailed description of the nature and scope of the activities to be undertaken and the methods to be used to accomplish the project. 3.2 The project organization including personnel resources (in house and/or contractor) and responsibilities statement. 3.3 Project schedule including major milestones, deliverables and key dates. 3.4 If applicable, procurement and solicitation activities.	3.1 A detailed description of the nature and scope of the activities to be undertaken and the methods to be used to accomplish the project. 3.2 The project organization including personnel resources (in house and/or contractor) and responsibilities statement. 3.3 Project schedule including major milestones, deliverables and key dates. 3.4 If applicable, procurement and solicitation activities.	If specific information required in this section was provided in an approved and final CCIIO documentation, please indicate which one by checking the box below, provide the page number(s) of its location, specify which APD sub-section(s) it addresses (i.e. 3.1, 3.2), and include as an attachment(s): ☐ Planning Grant App Page(s) ____, APD Section(s) _____ ☐ Innovator Grant App Page(s) ____, APD Section(s) _____ ☐ Establishment Grant App Page(s) ____, APD Section(s) _____ ☐ Gate Review Documents/Artifacts_____, Page(s) _____ Status of State MITA Self-Assessment: ☐ Completed (see attachment) ☐ Will be conducted and it will be supplied upon completion ☐ State wishes to obtain copies of other States' MITA Self-Assessments ☐ State authorizes CMS to share MITA Self-Assessment with other States. Additional information regarding MITA concepts, principles, and tools for key planning and/or implementation steps can be found at http://www.cms.hhs.gov/MedicaidInfoTechArch/. If the APD involves other Federal partners, please seek guidance from the appropriate agency.

EXPEDITED APD CHECKLIST *Continued*

Section 4: PROPOSED PROJECT BUDGET AND COST DISTRIBUTION
Section 5: STATEMENT OF SECURITY/INTERFACE AND DISASTER RECOVERY REQUIREMENTS
Section 6: ASSURANCES

Section	Content		Minimum Requirements, Declaration, and Collaboration Activities
	Planning APD Activities	**Implementation APD Activities**	
4. Proposed Project Budget and Cost Distribution This section describes the resource needs for planning and/or implementation for which FFP is requested.	4.1 Resource needs by categories, cost elements and amounts, including: State and/or contractor staff costs, facility/equipment, travel, outreach and training, etc. (In-house staff costs and other costs by outside contractors. These costs should be distinguished from each other). 4.2 Estimated total budget with costs broken down by categories (state/federal, and by applicable FFP rates). 4.3 Cost Allocation Plan and/or Methodology	4.1 Resource needs by categories, cost elements and amounts, including: State and/or contractor staff costs, facility/equipment, travel, outreach and training, etc. (In-house staff costs and other costs by outside contractors. These costs should be distinguished from each other). 4.2 Estimated total budget with costs broken down by categories (State/Federal, and by applicable FFP rates). 4.3 Cost Allocation Plan and/or Methodology 4.4 An estimate of prospective cost distribution to the various State and Federal funding sources and proposed procedures for distributing costs. This cost distribution should be broken down into calendar quarters.	If specific information required in this section was provided in an approved and final CCIIO documentation, please indicate which one by checking the box below, provide the page number(s) of its location, specify which APD sub-section(s) it addresses (i.e. 4.1, 4.2), and include as an attachment(s): ☐ Planning Grant App Page(s) ____, APD Section(s) _____ ☐ Innovator Grant App Page(s) ____, APD Section(s) _____ ☐ Establishment Grant App Page(s) ____, APD Section(s) _____ ☐ Gate Review Documents/Artifacts_____. Page(s) _____
5. Statement of Security/ Interface and Disaster Recovery Requirements	N/A	Evidence of declaration by checking the boxes in the next column that the state will meet these requirements.	☐ The State Agency will implement and/or maintain an existing comprehensive ADP security and interface program for ADP systems and installations involved in the administration of the Medicaid program. ☐ The State Agency will have disaster recovery plans and procedures available.
6. Assurances This section includes procurement activities, monitoring and reporting activities, including access to records, licensing, ownership of software, and the safeguarding of information contained within the system. These assurances are required for automated data processing equipment. If the APD involves other federal partners, please certify your compliance with assurances associated with all Federal stakeholders.	✓ Procurement Standards (Competition / Sole Source) ✓ Access to Records ✓ Software & Ownership Rights/Federal Licenses/Information Safeguarding/HIPAA Compliance/Progress Reports Indicate by checking "yes" or "no" whether or not you will comply with the Code of Federal Regulations (CFR).	✓ Procurement Standards (Competition / Sole Source) ✓ Access to Records ✓ Software & Ownership Rights/Federal Licenses/Information Safeguarding/HIPAA Compliance/Progress Reports ✓ Independent Verification &Validation (IV&V) – optional where considered a high-risk project. Indicate by checking "yes" or "no" whether or not you will comply with the Code of Federal Regulations (CFR).	Procurement Standards (Competition / Sole Source): SMM Section 11267 ☐ Yes ☐ No 45 CFR Part 95 Subpart F §95.615 ☐ Yes ☐ No 45 CFR Part 95 §92.36 ☐ Yes ☐ No Access to Records: 42 CFR Part 433.112(b)(5) – (9) ☐ Yes ☐ No 45 CFR Part 95 Subpart F §95.615 ☐ Yes ☐ No SMM Section 11267 ☐ Yes ☐ No Software & Ownership Rights, Federal Licenses, Information Safeguarding, HIPAA Compliance, and Progress Reports: 45 CFR Part 95 Subpart F §95.617 ☐ Yes ☐ No 42 CFR Part 431.300 ☐ Yes ☐ No 42 CFR Part 164 ☐ Yes ☐ No IV&V: 45 CFR Part 95.626 ☐ Yes ☐ No If no, provide a detailed explanation in your APD under the appropriate section.

EXPEDITED APD CHECKLIST *Continued*

Section 7: ADDRESSED OR NOT ADDRESSED

Section	Content		Minimum Requirements, Declaration, and Collaboration Activities
	Planning APD Activities	Implementation APD Activities	
7. Addressed or Not Addressed This section ensures that the state will come into compliance with the standards and conditions pursuant to 42 CFR §433 Subpart C.	For planning activities only, addressed or not addressed is required by checking the boxes in the next column.	For implementation activities, addressed or not addressed is required by checking the boxes in the next column and by providing where in the APD section(s) the supporting information for each of the seven standards and conditions. For example – **APD section(s) : 1, 2, and 3** (where sections 1, 2, and 3 of the APD provided the information that addressed the requirements regarding the S&C #1)	1. ☐ Yes ☐ No **Modularity Condition.** Use of a modular, flexible approach to systems development, including the use of open interfaces and exposed application programming interfaces; the separation of business rules from core programming; and the availability of business rules in both human and machine readable formats. **APD section(s): _____** 2. ☐ Yes ☐ No **MITA Condition.** Align to and advance increasingly in MITA maturity for business, architecture, and data. **APD section(s): _____** 3. ☐ Yes ☐ No **Industry Standards Condition.** Ensure alignment with, and incorporation of, industry standards: the Health Insurance Portability and Accountability Act of 1996 security, privacy and transaction standards; accessibility standards established under section 508 of the Rehabilitation Act, or standards that provide greater accessibility for individuals with disabilities, and compliance with Federal civil rights laws; standards adopted by the Secretary under section 1104 of the Affordable Care Act; and standards and protocols adopted by the Secretary under section 1561 of the Affordable Care Act. **APD section(s): _____** 4. ☐ Yes ☐ No **Leverage Condition.** Promote sharing, leverage, and reuse of Medicaid technologies and systems within and among States. **APD section(s): _____** 5. ☐ Yes ☐ No **Business Results Condition.** Support accurate and timely processing of claims (including claims of eligibility), adjudications, and effective communications with providers, beneficiaries, and the public. **APD section(s): _____** 6. ☐ Yes ☐ No **Reporting Condition.** Produce transaction data, reports, and performance information that would contribute to program evaluation, continuous improvement in business operations, and transparency and accountability. **APD section(s): _____** 7. ☐ Yes ☐ No **Interoperability Condition.** Ensure seamless coordination and integration with the Exchange (whether run by the state or federal government), and allow interoperability with health information exchanges, public health agencies, human services programs, and community organizations providing outreach and enrollment assistance services. **APD section(s): _____**

EXPEDITED APD CHECKLIST *Continued*

Section 8: STATE CERTIFICATION

8. State Certification	The Department *(name)* for the State of *(name)* by signing below, agrees that the APD requirements, indicated above in column 3, are included in the indicated approved and awarded CCIIO grant application and approve use of this information to fulfill the regulatory requirements required by submitting this APD. The Department *(name)* for the State of *(name)* by signing below, agrees that the APD requirements, indicated above in column 3, are included in the indicated approved and awarded CCIIO grant application and approve use of this information to fulfill the regulatory requirements required by submitting this APD. (Signature) Name _____ Title_____ State Department Name_____

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-NEW. The time required to complete this information collection is estimated to average (5 hours) or (300 minutes) per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

NATIONAL HUMAN SERVICES INTEROPERABILITY ARCHITECTURE

The National Human Services Interoperability Architecture (NHSIA) is being developed for the Administration for Children and Families (ACF) by Johns Hopkins University (JHU) as a framework to support: common eligibility and information sharing across programs, agencies, and departments; improved efficiency and effectiveness in delivery of human services; prevention of fraud; and better outcomes for children and families. It will consist of business, information, security, and technology models to guide programs and states in the accurate reporting and delivery of services. The NHSIA Project is leveraging past developments of various Federal and state programs, including Medicaid Information Technology Architecture (MITA), National Information Exchange Model (NIEM), Global Reference Architecture (GRA), Service Oriented Architecture (SOA), and cloud computing.

Currently, systems supporting ACF programs are often "siloed", meaning they are vertically integrated to support delivery of a narrow range of services, and are not interfaced or well-integrated with other processes and systems that deliver related services to the same community. Siloed systems may provide excellent service within their scope. However, from the perspective of the whole environment, they may be characterized by redundant data entry, inability to exchange information, susceptibility to duplicate and fraudulent payments, and unnecessarily complicated and expensive operations. The desired state is to have an environment characterized by interoperability. Interoperable systems share information and processes to efficiently deliver integrated services to the user community. Interoperability can be achieved via the design and implementation of an overall architecture that defines the principles, standards, services, security practices, and interfaces to be followed by the component elements within the total system.

NHSIA is intended to serve multiple audiences at all levels of government and private organizations, including Federal departments and agencies; state, local, and tribal governments; private companies; and non-profit organizations. The individuals most impacted on a day-to-day basis by the implementation of the architecture will be case-workers and the client community, but the benefits of NHSIA will be apparent to states, program managers, technology and security staffs and other departments and agencies that work with ACF and their common client base. They will all benefit from the guidance it provides to transforming business processes and supporting information technology (IT).

The development of a national architecture will enable information exchange and sharing IT services across currently siloed federal, state, local and private human service information systems. The ultimate intended outcome is to have a national architecture to guide federal, state, and local governments and private institutions and vendors in improving sharing information and IT services across human service programs and systems.

Architecture Framework and Viewpoints

An **architecture** is a description of the components, structure, and unifying characteristics of a system or system of systems. An enterprise architecture is a rigorous, comprehensive description of an enterprise, including mission and goals; organizational structures, functions, and processes; and information technology including software, hardware, networks, and external interfaces. NHSIA can be considered a multi-enterprise architecture.

An **architectural framework** is a structure for describing an architecture. A framework must be carefully chosen to suit the objectives of each specific architecture to be developed. Numerous generic frameworks

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National Human Services Interoperability Architecture

Human Services Domain – National Information Exchange Model (NIEM)

"NHSIA is intended to serve multiple audiences at all levels of government and private organizations."

Please direct questions to David Jenkins at ACF.Toolkit@acf.hhs.gov.

NHSIA *Continued*

have been defined by governments, private consultants, and systems integrators. These generic frameworks are intended to be tailored to specific applications. The NHSIA approach adapted the frameworks defined by the Federal Enterprise Architecture (FEA) and the DoD Architectural Framework (DoDAF)[1] and is illustrated in Figure 1.

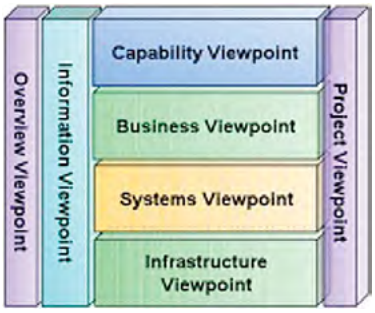

FIGURE 1: Architecture Viewpoints

The architecture is described in terms of multiple viewpoints. Each viewpoint serves the needs of a specific user, such as an executive manager making investment decisions, an operational user of the systems, or a systems developer designing data structures, services and applications.

The proposed framework is very comprehensive. It is envisioned that NHSIA needs a high level description for each of these viewpoints. It is not possible (or necessary) to go to great depth in all of these areas within the resources available to the NHSIA project. But a level-of-detail sufficient to support portfolio management and pilot programs will be provided.

Each of these viewpoints will contain a number of products, referred to as artifacts. Artifacts may be documents, narratives, lists, charts, graphics, diagrams, matrices, spreadsheets, schematics, or any other form of documentation that can clearly and concisely convey some aspect of the architecture.

Next Steps

In order for states to embrace NHSIA, it is important that their input be incorporated in its development. To that end, ACF, JHU, and Stewards of Change (SOC) will engage states to refine the architecture; bringing their lessons learned and best practice to the effort.

After review of publicly available information, a number of states have been identified as early adopters in terms of implementing enterprise architecture and interoperability of heath and human services, and some are even preparing to move forward on large systems that could benefit from NHSIA. ACF, JHU, and SOC will begin outreach to states by targeting the early adopter states for initial presentations and feedback on the architecture. As the architecture is further developed, it will be shared with all interested states with the end goal of providing an architecture that is used broadly for human services in every state.

[1]DoD Architecture Framework, version 2.0, Volume 1: Introduction, Overview and Concepts, Manager's Guide, 28 May 2009.

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National Human Services Interoperability Architecture

Human Services Domain – National Information Exchange Model (NIEM)

HUMAN SERVICES DOMAIN – NATIONAL INFORMATION EXCHANGE MODEL (NIEM)

The National Information Exchange Model (NIEM) is a Federal, State, Local and Tribal interagency initiative providing a foundation for seamless information exchange through the use of standardized Extensible markup Language (XML). NIEM is a framework to[1]:

- Bring stakeholders and Communities of Interest together to identify information sharing requirements in day-to-day operational and emergency situations;
- Develop standards, a common lexicon and an on-line repository of information exchange package documents to support information sharing;
- Provide technical tools to support development, discovery, dissemination and re-use of exchange documents; and
- Provide training, technical assistance and implementation support services for enterprise-wide information exchange.

NIEM was launched in 2005 through a partnership agreement between the U.S. Department of Homeland Security and the U.S. Department of Justice. In 2011, the U.S. Department of Health and Human Services became a full partner in NIEM alongside DOJ and DHS.

As a component of this partnership, HHS now has domain stewardship responsibility for two NIEM Domains: the Office of the National Coordinator (ONC) is Domain Steward for the Health Domain; and the Administration for Children and Families (ACF) is Domain Steward for the Human Services Domain. At present, ACF is "standing up" the Human Services Domain. Standing up a domain includes creating a governance structure and charter, convening a Community of Interest, setting the strategic direction and scope, and rolling out a training and communications plan.

NIEM enables information sharing, focusing on information exchanged between organizations, in emergency situations as well as day-to-day operations. NIEM does not offer standard language for entire systems and does not concern itself with exchanges of large quantities of data for statistical or informational purposes only. NIEM is about meaningful exchanges of information, primarily at the state and local level. It makes most sense to think of NIEM in terms of the on-the-ground business practices, such as sharing information between child welfare systems and education to better protect children and help families, or helping to smooth the transition between prison and community supports for former inmates upon release. State, local, and federal agencies, community-based organizations, associations, and vendors all need to be involved to make NIEM successful.

To learn more about NIEM, there are publications and tutorials available at the NIEM website, www.niem.gov.

[1]NIEM Website: http://www.niem.gov/whatIsNiem.php

"NIEM is about meaningful exchanges of information, primarily at the state and local level."

Please direct questions to David Jenkins at ACF.Toolkit@acf.hhs.gov.