STATE OF OHIO
DEPARTMENT OF INSURANCE (ODI)
INFORMATION TECHNOLOGY/HEALTH CARE POLICY

in collaboration with

STATE OF OHIO
DEPARTMENT OF JOBS AND FAMILY SERVICES
OFFICE OF OHIO HEALTH PLANS

REQUEST FOR QUOTATION (RFQ)
IT GAP ANALYSIS *for an* OHIO HEALTH INSURANCE EXCHANGE
June 28, 2011

Purpose

The Ohio Department of Insurance (ODI), Offices of Information Technology and Security (OITS) and Health Care Policy (HCP), in collaboration with the Ohio Department of Jobs and Family Services (ODJFS), Office of Ohio Health Plans (OHP), is seeking quotations from state term schedule vendors with professional IT services offerings for an ***IT Gap Analysis identifying current technological capabilities compared to the functional requirement of running an Ohio Health Insurance Exchange compliant with the Patient Protection and Affordable Care Act (PPACA) enacted March 23, 2010 (P.L. 111-148) which will inform future resource and financial needs for options available to Ohio***.

This request is to cover one 6-week period commencing on July 25, 2011 and ending on September 2, 2011. At the end of the period, ODI will utilize the analysis in evaluating Level 1 Health Exchange Establishment federal grant application opportunities.

The successful vendor will perform this work governed by the terms and conditions of their current and valid state term schedule, and as such, will submit pricing for this work at or below their maximum state term schedule pricing. No exception to the pricing, terms and conditions of the vendor's state term schedule will be permitted and the ***total cost for all work outlined in this RFQ shall not exceed $200,000.00***.

The vendor will submit their lowest-cost proposal which meets all or the majority of the State's requirements outlined in the Scope of Work section of this RFQ. If the vendor is not able to meet all the requirements outlined in the Scope of Work section, the vendor is asked to itemize the remaining items over and above the $200,000.00 threshold.

Background

In March of 2010, the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010 were signed into law. The two laws are collectively referred to as the Affordable Care Act (ACA). The Affordable Care Act includes a variety of provisions regarding insurance coverage, health care choices, and health care accessibility.

Section 1311 of the Affordable Care Act provides that each State may elect to establish an American Health Benefit Exchange ("Exchange"). If a state elects not to establish an Exchange or does not take steps necessary to implement an Exchange in compliance with federal law, the Secretary of HHS will establish and operate an Exchange within such a state. If Ohio elects to build an Exchange, it would need to be up and running by January, 2014 and would:

- Certify (meaning that certain standards are met) qualified health plans for purchase by Ohioans
- Provide for the establishment of a Small Business Health Options Program ("SHOP" Exchange) designed to assist qualified employers in facilitating the enrollment of their employees in qualified health plans

- Administer premium tax credits & cost-sharing reductions to individuals and families
- Respond to consumer requests for assistance
- Provide an easy-to-use website and written materials so consumers can assess eligibility and enroll in health insurance coverage
- Coordinate eligibility & enrollment in Medicaid & Children's Health Insurance Program (CHIP)

Governor John R. Kasich voiced his opposition to the Affordable Care Act (ACA) when Congress was debating it. He favors repealing it and replacing it with policies that more directly reduce costs without increased federal government interference, and, in the interim, seeks to minimize the ACA's negative effect on Ohio's health care policies.

ODI, in collaboration with ODJFS, is responsible for coordinating the IT Gap Analysis that will identify Ohio's current technological capabilities compared to the functional requirements of running an Ohio Health Exchange compliant with the ACA. As part of this IT GAP analysis ODI seeks to identify options that will allow the state to mitigate ACA policies that are not in the best interest of Ohioans.

Description

Ohio must identify gaps between its current technological infrastructure and the requirements for an Ohio Exchange along with the necessary remediation. As Ohio identifies missing components of the necessary technical structure for an Ohio Exchange, it will need to make decisions about acquiring those components should Ohio pursue an Ohio Exchange.

The federal government has identified some rigorous standards for the Exchange and Ohio must understand its options to develop, expand or purchase products that conform to those standards developed by the Centers for Medicare and Medicaid Services (CMS) and the United States Department of Health and Human Services (HHS), Center for Consumer Information and Insurance Oversight (CCIIO) office. These standards and protocols are outlined (and periodically updated) in the *Guidance for Exchange and Medicaid Information Technology (IT) Systems, Version 2.0* which can be downloaded at:

http://edocket.access.gpo.gov/2010/pdf/2010-27971.pdf. (these standards are also included as an attachment to this RFQ)

Technical requirements for an Ohio Exchange include:

- Seamless coordination between Medicaid/Children's Health Insurance Program (CHIP) and the Ohio Exchange, and between the Ohio Exchange and private companies offering health plans for purchase through the Ohio Exchange, employers offering their employees enrollment in the SHOP Exchange, and navigators (entities funded from operations funds of the Exchange that will assist consumers in their Exchange enrollment options).
- Ability for individuals to explore their health coverage options and quickly and accurately enroll into coverage using an on-line portal which includes screening and eligibility determination.
- Routing (using information and data exchanges) and enrollment in the Exchange, Medicaid or CHIP in real time.
- A timely and responsive Enrollment Management/Resolution process for people who experience eligibility discrepancies between the information they provide and the information obtained through authoritative sources.
- A Premium Billing and Collection process.
- Avoiding duplication of costs, processes, data and effort on the part of either the State or the beneficiary by evaluating individuals for eligibility in the Exchange, Medicaid and CHIP using a coordinated set of rules.

- Verification from federal agencies such as the Internal Revenue Service (for the purpose of verifying premium tax credits).
- Generating data in support of performance management, public transparency, policy analysis, and program evaluation for IT systems.
- Compliance with all relevant Health Insurance Portability and Accountability Act (HIPAA) standards and all applicable federal and State of Ohio laws, including protection of personal health information for IT projects.
- Usability features or functions that accommodate the needs of persons with disabilities, including those who use assistive technology.
- Reasonable steps to provide meaningful access by persons with limited English proficiency.
- Providing high-level integration of process flow and information flow with such business partners as navigator, health plans, small businesses, brokers, employers, and others.
- Applying a modular, flexible approach to systems development, including the use of open interfaces and exposed application programming interfaces, and separation of business rules from core programming, available in both human and machine-readable formats
- Leveraging the concept of a shared pool of configurable, secure computing resources (e.g. cloud computing).
- Ensuring systems are highly available and respond in a timely manner to customer requests.

Scope of Work

The gap analysis shall provide the below four major summary components:

DELIVERABLE #1: A comparison of the current State of Ohio infrastructure to the new requirements mandated for implementation by January 1, 2014 under the ACA for each section below;

DELIVERABLE #2: Potential solution(s) for eliminating gaps or duplicative efforts between the current infrastructure and ACA requirements if Ohio pursues an Ohio Exchange;

DELIVERABLE #3: Potential solution(s) for interfacing Ohio's systems, including the Medicaid and CHIP eligibility system (CRISe), with the federal Exchange if Ohio does not pursue an Ohio Exchange;

DELIVERABLE #4: For each of the potential solutions identified in Deliverable #2 and Deliverable #3, detailed information regarding the following items:

- Total State Resource Cost Estimates
- Total Contractual (Vendor) Cost Estimates
- Total estimated Cost
- Financing Options for the technology infrastructure
- Capacity readiness to meet ACA timeline
- Risks (Complexity, Control, Known vs. Unknown, Time, Costs, Performance, Strategic Alignment, Consumer Acceptance, Remaining Useful Technology Life, etc.)

In addition to the above four major summary components (deliverables), the gap analysis shall specifically examine and incorporate into the deliverables the following:

1.) Business requirements for the Exchange system:

- Medicaid/CHIP changes to eligibility under ACA.

- Provision of subsidized Exchange products and testing for the eligibility of these subsidies.

- Non-subsidized Exchange products including business requirements for selecting and enrolling in health insurance plans.

- Small Business Health Option Program (SHOP) requirements including selecting and enrolling in a health insurance plan, and billing and collection of premiums.

- Expanding ODI's Application Programming Interface (API) which currently pulls in all Ohio product filing from SERFF (System for Electronic Rate and Form Filing) to support a front end to Ohio's Exchange.

2.) Interface requirements for the Exchange system need to be explored, particularly as they require the system to find the consumer's personal data and pull it from another system into the eligibility component of the Exchange. The analysis shall identify the most effective and efficient means of meeting these interface requirements and focus on:

- Required federal interfaces; Internal Revenue Service (IRS), Social Security Administration (SSA), and Homeland Security;

- Other federal interfaces including Public Assistance Reporting Information System (PARIS), Electronic Verification of Vital Events (EVVE);

- Other interfaces including Vital Records, Base Wage, Unemployment Insurance, New Hire File;

- Expansion of ODI's Application Programming Interface (API) which currently pulls in all Ohio product filing from SERFF (System for Electronic Rate and Form Filing) to meet Exchange requirements;

- Business requirements for the system to communicate through the various interfaces mentioned above;

- Opportunities to leverage investments to work toward a single eligibility system.

3.) The challenges and solutions related to making real time decisions, particularly as they relate to collection of documentation required to make a determination of eligibility.

4.) The business requirements for providing commercial product information for a market organizer (aggregator) model.

5.) Business requirements for customer support functionality, including navigation and issue resolution through the process.

6.) Identification of necessary steps to ensure that security and privacy requirements are met as required by all relevant HIPAA, federal and State of Ohio laws; and identify recommended changes to State of Ohio policies or rules regarding the collection, storage or use of private citizen data that may be needed to implement an Exchange.

7.) Projections of the scalability of the current infrastructure to meet significantly expanded population growth under ACA.

8.) **Evaluation of current system performance and steps to ensure sufficient performance to meet the requirements of the Exchange.**

9.) **Analysis of reporting requirements under ACA, current reporting capabilities and solutions for meeting reporting requirements.**

10.) **Consideration of the current infrastructure and the ACA requirements for an Exchange.**

11.) **Analysis of the risks associated with this effort and among potential options. These options should include, but are not limited to:**

- Expansion of current infrastructure to create an Exchange
- Development of a new system to manage the various components of the Exchange
- Developing an interface between Ohio's eligibility infrastructure and a federally operated Exchange.

12.) **Potential costs for potential solutions and options.**

13.) **Resources required for the implementation of potential solutions for clear guidance on the State's allocation.**

14.) **Timeline for development and implementation of potential solutions and options.**

In addition to the above four major summary components and fourteen analysis areas, the gap analysis shall be presented to technical and non-technical staff of the ODI, ODJFS, and other officials as identified by ODI and ODJFS in one two-hour session at a mutually-convenient time for all parties prior to the conclusion of the contract.

Candidate Qualifications

The successful vendor and vendor's assigned IT professionals and subject matter experts will be able to work under the direction and leadership of ODI's Chief Information Officer to perform the gap analysis. ODI's Chief Information Officer, in conjunction with a representative of ODJFS for activities related to the CRISe system and a representative of the State Office of Information Technology for activities related to statewide enterprise infrastructure, will work with the vendor's team throughout the contract duration and serve as the state's official resource and point-of-contact.

The successful vendor must provide IT professionals with extensive hands-on experience and knowledge in performing complicated IT Gap Analysis work for states and/or large organizations with multiple, outdated systems.

Additionally, the successful vendor's IT professionals will have deep experience in federal and state health and human services, Medicaid, and commercial health plan operations. Experience with Medicaid eligibility systems, commercial eligibility and analysis related to the ACA Exchange requirements is preferred.

The successful vendor must commit a dedicated lead IT professional on this project that has proven in-depth knowledge with the ACA Exchange technical requirements. The vendor's lead IT professional will have the overall responsibility for the vendor's team and the project.

Vendor Requirements

Any vendor that submits a proposal will:

- Be responsible for the screening of all assigned IT professionals who work on this project to ensure they meet the qualifications noted above.
- Be asked to provide a copy of a recent criminal background check for each assigned IT professional working on this project or provide a standard business letter, signed by the individual legally authorized to bind the company, which includes a statement of the understanding that the person's background check is clear of any items, before he/she begins working on this project.
- Be able to respond to ODI requests by email and /or phone within a 24 hour period.
- Be responsible for all assigned IT professionals to demonstrate experience and skill with learning unfamiliar processes, translating knowledge into new contexts, interpreting/comparing/contrasting facts ordering/grouping/inferring causes, predicting consequences, using methods/concepts/theories in new situations, solving problems, classifying and organizing data, deconstructing components, generalizing from facts, combining and relating knowledge from several areas, drawing conclusions, comparing and discriminating between idea, making choices based on reasoned argument, verifying the value of evidence.
- Be responsible for all assigned IT professionals to demonstrate verbal and written communication skills and the ability to present information effectively, tailor presentation to a wide variety of audiences (including executive management), present complex concepts and recommendation clearly for management decision-making purposes.
- Be responsible for all assigned IT professionals to demonstrate the ability to comprehend, interpret and apply policies: ability to coordinate and facilitate a team for effective results; ability to continually adjust in a dynamic environment and to work as a member of a team.

Proposal Content

The successful vendor's proposal for this project must include the following sections and information:

Cover Letter (4%) – a standard business letter, signed by an individual legally authorized to bind the company, which includes a statement of the understanding of the proposal and that its entire contents are governed by the terms, conditions and pricing of the vendor's current and valid state term schedule.

Executive Summary (10%) – a brief, executive-level narrative of the vendor's proposal to ODI. This should also include the Tax Id, Information on MBE or EDGE participation, and State Term Schedule information.

Overview (4%) – a brief description of the vendor's proposal which must include a profile of your company's relevant experience and expertise; as well as the vendor's legal name, address, telephone number, home office location, date established ownership, leadership, number of employees and any other relevant background information.

Resumes (15%) - submit resumes for each proposed assigned IT professional who will be working on this project.

Qualifications (20%) – for each assigned IT professional who will be working on this project, show how they meet or do not meet the candidate qualifications. Persons who the vendor assigns to work on this project must meet most of the qualifications in order to be considered.

Vendor Requirements (4%) – provide an agreement to each vendor requirement.

References (20%) – document the assigned IT professional's experience in same/similar projects by providing a minimum of three (3) references for these same/similar projects. Same or similar projects are defined as the same/similar based on size and scope.

Proposal Cost Summary (10%) – provide itemized costs broken down by the four major summary component areas and the fourteen specific examination/analysis areas noted in the Scope of Work section of this RFP.

Project Schedule (9%) – provide proposed timeline for delivery. This will be scored based upon vendor's ability to provide deliverables in the shortest possible timeframe.

Other Information (4%) – add any supporting information and/or services that will be provided and any associated costs (if there are any).

Project Schedule

RFQ Issued	Tuesday, June 28, 2011
Proposal Due Date	Friday, July 8, 2011; 12:00 noon EST
Vendor Interviews	Tuesday, July 12, 2011
Vendor Selection	Wednesday, July 13, 2011
Internal Processing (Release & Permit/PO)	Wednesday, July 13, 2011 – Monday, July 25, 2011
Final Purchase Order	Monday, July 25, 2011
Work Begins	Monday, July 25, 2011, once a valid purchase order is issued

Proposal Evaluation

ODI, in collaboration with ODJFS, will evaluate the proposals submitted in response to this RFQ based on the vendor's information, value and cost.

Basis for Selection

The vendor that provides the best value to the State will be selected. Best value will be determined by the following rating system:

Cover Letter – 4% of evaluation (4 total possible points)
Executive Summary – 10% of evaluation (10 total possible points)
Overview – 4% of evaluation (4 total possible points)
Resumes – 15% of evaluation (15 total possible points)
Qualifications – 20% of evaluation (20 total possible points)
Vendor Requirements – 4% of evaluation (4 total possible points)
References – 20% of evaluation (20 total possible points)
Proposal Cost Summary – 10% of evaluation (10 points)
Project Schedule - 9% of evaluation (9 points)
Other Information – 4% of evaluation (4 total possible points)

Total Possible Points = 100

Note: A short list of vendors may be asked to provide representative(s) assigned to this project for interview(s) on Tuesday, July 12th, 2011 leading to final vendor selection on Wednesday, July 13th, 2011.

Rejection of Proposals

ODI may reject any proposal that does not supply the requested information, is excessive in cost, or otherwise not in its interest to consider or accept. Additionally, ODI may cancel this RFQ, reject all proposals and seek to do the work by other means.

Reimbursable Expenses

None

Bill to Address

The vendor must submit invoices to the billing address on the purchase order. The vendor's federal tax identification number and ODI purchase order number must appear on the invoice. The provisions of the Ohio Revised Code Section 126.30 will apply to any transaction between the parties.

Inquiries

Questions regarding this RFQ must be directed to Mugsy.Reynolds@insurance.ohio.gov. Inquiry responses, without attribution to the inquirer, will be distributed via email. ODI will make every effort to respond to any questions as expeditiously as possible.

Proposal Submission

Your proposal must be submitted via email to Mugsy.Reynolds@insurance.ohio.gov by 12:00 noon EST on Friday, July 8th, 2011.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 433

[CMS–2346–P]

RIN 0938–AQ53

Medicaid; Federal Funding for Medicaid Eligibility Determination and Enrollment Activities

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would revise Medicaid regulations for Mechanized Claims Processing and Information Retrieval Systems. Specifically, we are proposing to amend the definition of Mechanized Claims Processing and Information Retrieval Systems to include systems used for eligibility determination, enrollment, and eligibility reporting activities. We propose to modify our regulations so that the enhanced Federal financial participation (FFP) is available for design, development and installation or enhancement of eligibility determination systems until December 31, 2015, with enhanced FFP for maintenance and operations available for such systems beyond that date in certain circumstances. We also propose that all Medicaid Management Information Systems (MMISs) meet certain defined standards and conditions in terms of timeliness, accuracy, efficiency, and integrity and that they achieve high positive levels of consumer experience, acceptance and satisfaction in order to receive enhanced FFP.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. January 7, 2011.

ADDRESSES: In commenting, please refer to file code CMS–2346–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the "Submit a comment" instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2346–P, P.O. Box 8016, Baltimore, MD 21244–8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2346–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses: a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

FOR FURTHER INFORMATION CONTACT: Richard Friedman, (410) 786–4451.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.regulations.gov.* Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

I. Background

A. The Current State of the Medicaid Management Information System (MMIS)

A Medicaid management information system (MMIS) is a mechanized system of claims processing and information retrieval used in State Medicaid programs under title XIX of the Social Security Act (the Act). The system is used to process Medicaid claims from providers and to retrieve and produce utilization data and management information about medical care and services furnished to Medicaid recipients. The system also is potentially eligible to receive enhanced administrative funding from the Federal government under section 1903(a)(3) of the Act. Specifically, section 1903(a)(3)(A)(i) of the Act provides that Federal financial participation (FFP) is available at 90 percent of expenditures for the design, development, or installation of mechanized claims processing and information retrieval systems as the "Secretary determines is likely to provide more efficient, economical and effective administration of the plan and to be compatible with the claims processing and information retrieval systems utilized in the administration of title XVIII [that is, Medicare]." In addition, section 1903(a)(3)(B) provides for the availability of FFP at 75 percent of expenditures attributable to operating the "systems * * * of the type described in [section 1903(a)(3)] subparagraph (A)(i)," which are approved by the Secretary and meet certain other requirements (including requirements relating to explanations of benefits). For purposes of this proposed rule, we refer to 90 percent and 75 percent FFP as "enhanced" FFP since it is greater than the 50 percent FFP available for most Medicaid administrative expenses. Finally, section 1903(r) of the Act places conditions on a State's ability to receive Federal funding for automated data systems in the administration of the State plan.

In order to receive an enhanced match, the Secretary must find that the mechanized claims and information retrieval system is adequate to provide

efficient, economical, and effective administration of the State plan. The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111–148, as amended by the Health Care and Education Recovery Act of 2010; Pub. L. 111–152, together referred to as the Affordable Care Act) also made additional changes to the requirements within section 1903(r) of the Act relating to the reporting of data to the Secretary; these requirements will be discussed in separate rulemaking.

Our Federal regulations concerning mechanized claims processing and information retrieval systems are at 42 CFR part 433, subpart C. A State that chooses to develop, enhance, or replace its required system or subsystems must first submit for approval an Advanced Planning Document (APD). The general HHS requirements for approval of APDs are found at 45 CFR part 95, subpart F.

B. Availability of Enhanced FFP for Automated Eligibility Systems

Historically, Medicaid eligibility for many applicants and recipients was determined by an agency other than the State Medicaid agency; under section 1902(a)(10)(A)(i) of the Act, States were required to provide Medicaid to recipients under the Aid to Families with Dependent Children (AFDC) program, as well as recipients of the Supplemental Security Income (SSI) program. In these cases, eligibility determinations were derived from the cash welfare-assistance determination. As a result, States that maintained a Medicaid eligibility determination system usually integrated these systems into the public welfare systems. In 1989, we published a final rule on October 13, 1989 (54 FR 41966, effective November 13, 1989) excluding eligibility determination systems from the enhanced funding that was available under section 1903(a)(3) of the Act, reasoning that the close interrelationship between these cash assistance programs and Medicaid eligibility rendered such enhanced assistance redundant and unnecessary (54 FR 41966 through 41974). As a result, we revised the definition of mechanized claims processing and information retrieval systems to exclude eligibility determination systems.

We also indicated in the final rule that to receive any FFP for Medicaid purposes for an eligibility determination system after November 13, 1989, a State must submit an APD for funding in accordance with the requirements of 45 CFR part 95, subpart F. If we approved the APD, the State agency would receive 50 percent FFP for administrative costs under section 1903(a)(7) of the Act for the system's design, development, and installation, and operation.

C. Changes in Medicaid Eligibility Policies

Since promulgation of the 1989 regulation, a series of statutory changes have dramatically affected eligibility for Medicaid and how Medicaid eligibility is determined. Among other things, new eligibility coverage groups were created and expanded, and in 1996, Medicaid eligibility was "de-linked" from the receipt of cash assistance when the AFDC program was replaced by the Temporary Assistance to Needy Families (Pub. L. 104–193, enacted on July 1, 1997) (TANF) program.

With the passage of the Balanced Budget Act of 1997 (Pub. L. 105–33) (BBA), States were required to coordinate eligibility for and enrollment in Medicaid, with the new Children's Health Insurance Program (CHIP) to ensure enrollment of children in the appropriate program. With passage of the "Express Lane Eligibility" provisions in section 203 of the Children's Health Insurance Reauthorization Program Reauthorization Act of 2009 (Pub. L. 111–3) (CHIPRA), States were provided with the option, and are encouraged, to coordinate and expedite eligibility for children in Medicaid and CHIP by using findings regarding income and other eligibility criteria made by other agencies, such as the Supplemental Nutrition Assistance Program, as the basis for Medicaid and CHIP eligibility adjudications.

With the passage of the Affordable Care Act, we expect that changes to eligibility policies and business processes would need to be adopted. States would need to apply new rules to adjudicate eligibility for the program; enroll millions of newly eligible individuals through multiple channels; renew eligibility for existing enrollees; operate seamlessly with newly authorized Health Insurance Exchanges whether run by the State or HHS if the State chooses not to operate a State Exchange (hereafter referred to as "Exchanges"); participate in a system to verify information from applicants electronically; incorporate a streamlined application used to apply for multiple sources of coverage and health insurance assistance; and produce notices and communications to applicants and beneficiaries concerning the process, outcomes, and their rights to dispute or appeal. We further anticipate, following consultation with States and other stakeholders, additional standard Federal requirements for more timely and detailed reporting of eligibility and enrollment status statistics, including breakdowns by eligibility group, demographic characteristics, enrollment in managed care plans, and participation in waiver programs.

System transformations would be needed in most States to accomplish these changes. These systems transformations should be undertaken in full partnership with Exchanges in order to meet coverage goals, minimize duplication, ensure effective reuse of infrastructure and applications, produce seamless enrollment for consumers, and ensure accuracy of program placements. Extensive coordination and collaboration would be required between Exchanges and Medicaid, including on oversight and evaluation of the interoperability of the Exchange and Medicaid systems.

II. Provisions of the Proposed Regulations

A. Medicaid Eligibility Determinations

Because of the changes made by the Affordable Care Act with respect to Medicaid eligibility, as well as changes in Medicaid eligibility and business processes that have occurred since our 1989 final rule, we propose to consider Medicaid eligibility determinations to be "claims" of eligibility that can be considered part of the MMIS systems that are potentially eligible for the enhanced 90 and 75 percent FFP under section 1903(a)(3) of the Act. This proposed policy would apply only upon the effective date of the subsequent final rule. Additionally, we note that enhanced FFP does not eliminate the responsibility of States to ensure compliance with cost allocation principles outlined in OMB Circular A–87.

Further, as explained below, enhanced FFP at the 90 percent rate for design, development, installation or enhancement would be available for State expenditures only through calendar year (CY) 2015, even if work on approved APDs continues after 2015. Enhanced FFP at the 75 percent rate to maintain and operate systems that previously qualified for 90 percent FFP would be available after 2015 if those systems continue to meet the requirements specified in this rule. Additionally, enhanced funding at 75 percent to maintain and operate systems meeting the standards and conditions is available prior to December 31, 2015, (but after the effective date of any final rule), in recognition of the fact that some States may have already invested in improvements that will allow systems to qualify without the need for additional enhanced development,

design, installation or enhancement funding. For any State receiving enhanced FFP at 90 percent or 75 percent prior to December 31, 2015, systems must continue to meet the requirements specified in this rule in order to continue receiving 75 percent enhanced funding after December 31, 2015.

We are limiting the timeframe for which enhanced 90 percent FFP is available for design, development, installation or enhancement of automated eligibility systems because we view the changes made by the Affordable Care Act for the new eligibility rules in Medicaid as requiring immediate, substantial commitment to, and investment in, technologies. That is, we expect that changes to State systems would be completed with the start of the new Affordable Care Act provisions and support the operation of Exchanges on January 1, 2014. However, we realize that States may need to make additional changes to State systems to provide for additional functionality in support of Medicaid eligibility rule modifications. Thus, we are providing for an additional 2 years of 90 percent enhanced FFP so that States' systems would have additional time to ensure the peak performance of their systems.

At the same time, once appropriate systems are deployed to support the eligibility changes in the Affordable Care Act, we anticipate significant efficiencies in both application maintenance and business operations. Thus, we believe that after CY 2015, 2 years after the Affordable Care Act changes have gone into effect, additional investments in the design, development, and installation of such systems would no longer continue to result in "more" efficient, effective or economical administration of the State plan, as required by section 1903(a)(3)(A)(i) of the Act.

Additional investments in State eligibility systems are unlikely to yield similar rates of improvement and a regular administrative match (that is 50 percent FFP for design, development, installation or enhancement) should be sufficient for efficient and effective administration of State Medicaid programs. We also note that ending enhanced funding in 2015 follows closely with the end of Federal grants for development of health insurance exchanges. States would need to incur costs for goods and services furnished no later than December 31, 2015 to receive 90 percent FFP for the design, development, installation or enhancement of an eligibility determination system.

Further, we are proposing to limit the availability of 75 percent enhanced funding for maintenance and operations to those eligibility determination systems that have complied with the standards and conditions in this rule by December 31, 2015. As discussed above, the eligibility changes of the Affordable Care Act will require that States modify their eligibility systems in time to comply with all such eligibility changes, and we believe that to meet the requirements of section 1903(a)(3)(A)(i) of the Act, all such modifications must be in place by December 31, 2015. If eligibility systems cannot meet our standards and conditions by such deadline, then we believe such systems will not be operating in a more efficient, economical or effective manner, because of their inability to timely meet the requirements of the Affordable Care Act for seamless coordination with the Exchange and implementation of simplified Medicaid eligibility rules and expanded coverage. Therefore we believe their subsequent operation would not meet the statutory requirements that they result in a more efficient, economical and effective operation of the State plan.

B. Standards and Conditions for Receiving Enhanced Funding

Under sections 1903(a)(3)(A)(i) and 1903(a)(3)(B) of the Act, we are proposing standards and conditions that must be met by States in order for their Medicaid technology investments (including traditional claims processing systems, as well as eligibility systems) to be eligible for the enhanced match. These authorities provide that the enhanced FFP of 90 percent is not available unless the Secretary determines that a system is "likely to provide more efficient, economical, and effective administration of the plan" as described in section 1903(a)(3)(A)(i) of the Act. Similarly, section 1903(a)(3)(B) of the Act specifies that enhanced FFP of 75 percent is not available for maintenance or operations unless the system is "of the type described in subparagraph (A)(i)" and is approved by the Secretary).

Over the last 5 years CMS developed and implemented the Medicaid Information Technology Architecture (MITA). MITA is intended to foster integrated business and IT transformation across the Medicaid enterprise to improve the administration of the Medicaid program. (The Medicaid enterprise is comprised of the Federal government, the States, and any trading partners who exchange Medicaid transactions with either the States or the Federal government).

We believe the MITA initiative has accelerated the pace of modernization and over time, this effort will drive States' systems toward a widespread network of technology and processes that support improved State administration of the Medicaid program, with a focus on streamlining and simplifying the enrollment process, and improving health outcomes and administrative procedures for Medicaid beneficiaries.

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 MMIS and moving to a Service Oriented Architecture (SOA) method of designing Medicaid information systems using discretely identified and described business services to drive system requirements. The MITA initiative uses an architecture framework—business, technical, and information—along with a business maturity model and process and planning guidelines, to provide a framework for the planned use of technology and infrastructure to meet the changing business needs of Medicaid programs. MITA enables all State Medicaid enterprises to meet common objectives within the Framework, while still supporting local needs unique to one particular State.

All MITA framework documents are available to the public at *http://www.cms.gov/MedicaidInfoTechArch/*. The MITA Framework describes the maturity model, policies, and procedures.

We know that there is not a "one size fits all" technology solution to every business challenge and recognize that each technology investment must be viewed in light of existing, interrelated assets and their maturity. We also recognize that there are trade-offs concerning schedules, costs, risks, business goals, and other factors that should be considered when making technology investments. However, we wish to ensure that enhanced FFP is approved only when infrastructure and application projects maximize the extent to which they utilize current technology development and deployment practices and produce reliable business outputs and outcomes.

We are proposing to define MITA at § 433.111(c) in this rule and we propose to build on the work of MITA by codifying that enhanced FFP (either at the 90 percent rate for design, development, installation or enhancement; or at the 75 percent rate for maintenance and operations) is only available when certain standards and

conditions are met. Specifically, we articulate a set of standards and conditions that States must commit to in order to receive enhanced FFP:

• *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.* We believe that this commitment 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- and citizen-centric services and benefits.

• *Align to and advance increasingly in MITA maturity for business, architecture, and data.* We expect to see States continuing to make measurable progress in implementing their MITA roadmaps. Already the MITA investment by Federal, State, and private partners have allowed us to make important incremental improvements to share data and reuse business models, applications and components. However, it is critical to build on and accelerate the modernization we have collectively begun under MITA, so that States achieve the final vision of MITA and have a comprehensive framework with which to meet the technical and business demands required by an environment that will increasingly rely on health information technology and the electronic exchange of healthcare information to improve health outcomes and lower program costs.

• 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.

We must ensure that Medicaid technology investments are made both to ensure the timely and reliable adoption of industry standards and to make most productive use of those standards as they become available. Use of industry standards promotes reuse, data exchange, and reduces administrative burden on patients, providers, and applicants. We would communicate applicable standards to States. Standards would be updated periodically to ensure conformance with the standards in the industry. States would be required to update systems and practices to adhere to evolving industry standards in order to remain eligible for enhanced FFP. Use of standards to promote accessibility for individuals with disabilities ensures that Medicaid technology investments would be equally effective in providing access to benefits and services for all users, and would comply with Federal civil rights laws prohibiting discrimination against individuals with disabilities, such as section 504 of the Rehabilitation Act and Title II of the Americans with Disabilities Act.

• *Promote sharing, leverage, and reuse of Medicaid technologies and systems within and among States.* We would examine APDs to ensure that States make appropriate use and reuse of components and technologies available off the shelf or with minimal customization to maximize return on investment and minimize project risk. We intend to work with States to identify promising State systems that can be leveraged and used by other States. We anticipate that we would be able to expedite review of APDs incorporating such successful models. Further, we would strongly encourage States to move to regional or multi-State solutions as often as possible, and we would help facilitate collaboration and communication among States. We would also scrutinize carefully any proposed investments in sub-State systems when we are asked to share in the costs of updating or maintaining multiple systems performing essentially the same functions within the same State.

• *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 effectively communicating intended operational results with a high degree of reliability and accuracy. We do not believe that it would be appropriate for us to provide enhanced Federal funding for systems that are unable to support desired business outcomes.

• *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 electronically and accurately produce and expose data necessary for oversight, administration, evaluation, integrity, and transparency. This includes program data on claims, expenditures, and enrolled individuals; participation in waivers and plans; performance data, such as processing times, accuracy, and appeal results; and traditional systems standards such as availability and down time.

We would develop a range of data and performance metrics on which States would be required to report on a regular basis, as a condition of receiving ongoing enhanced FFP for maintenance and operation.

• 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.

We expect that a key outcome of our technology investments is a much higher degree of interaction and interoperability in order to maximize value and minimize burden and costs on providers and beneficiaries. Additionally, we expect that technology investments must comply with standards to ensure security and accessibility consistent with current Federal law and investments must comply with the requirements under existing Federal civil rights protections for all individuals in developing the system architecture.

We seek comments on these standards and conditions. In particular, we seek comments on the following:

• What types of Federal leadership, technical assistance, and sub-regulatory guidance would be helpful to support States as they come into compliance with these standards and conditions.

• Whether this list of standards and conditions is sufficiently robust and complete to guide decisions on technology investments of the scope and size of MMIS.

Further, to ensure that States have an opportunity to come into compliance with these requirements, we are proposing that States currently receiving enhanced FFP for MMIS have a period of transition to come into compliance with the standards and conditions above. Under our proposed schedule, the following transition periods would apply:

• *For new MMIS development (new APDs requesting 90 percent FFP for design, development, installation, and enhancement):* No transition period. We believe all APD requests submitted after

the effective date of the final rule must comply with all of our final standards and conditions.

• *For MMIS development already underway (approved APDs providing 90 percent enhanced FFP):* 12-month transition period (beginning with the effective date of the final regulation) in which to submit an updated Implementation APD (IAPD) detailing how systems would be modified to meet the required conditions and standards. This transition period would allow systems that are currently being developed to come into compliance with our standard and conditions, while ensuring that new systems receiving Federal funding are eventually designed in a manner that results in the most efficient use of technology.

• *For maintenance and operations of MMIS currently receiving 75 percent FFP:* 36-month transition period (beginning with the effective date of the final regulation) in which to submit an IAPD with plans to upgrade or modify systems to meet the required conditions and standards.

• *Eligibility systems (currently receiving 50 percent for development and maintenance and operations):* Because eligibility systems are not currently receiving enhanced funding, we propose no transition period for new requests for enhanced funding for eligibility systems. Any APDs requesting enhanced funding for eligibility systems funding following the effective date of this regulation would have to meet the standards and conditions above. States with eligibility systems currently under development (approved APDs providing 50 percent FFP) can update their APDs to reflect how they would comply with these standards and conditions in order to begin receiving 90 percent FFP. Similarly, eligibility systems currently receiving 50 percent FFP for State expenditures would need to comply with our final standards and conditions to receive a 75-percent FFP.

We request comments on this proposed transition schedule and whether the transition periods should be reduced or extended. We also request comments on how, during the transition period and beyond, we can provide strong Federal leadership by fostering collaboration among States, identifying and disseminating best practices, creating Federal models or components (*e.g.,* the Office of Consumer Information and Insurance Oversight's (OCIIO) Cooperative Agreement providing funding to create efficiencies in the design, development, and implementation of the Exchange IT systems), and assisting individual States.

Lastly, we are proposing that these standards and conditions be enforced through both front-end and back-end review processes. Front-end review would entail APD review and prior approval processes where States apply for enhanced match before entering into IT investment projects. Back-end reviews would entail certifications of the systems capabilities, as well as ongoing performance monitoring.

C. Reviews and Performance Monitoring of MMISs

Previously, regulations at § 433.119 indicated that we would review at least once every 3 years each system operation initially approved under § 433.114 and, based on the results of the review, reapprove it for FFP at 75 percent of expenditures if certain standards and conditions were met. The 3-year system performance reviews (SPRs) served as an evaluation instrument in determining the extent to which an MMIS performance is sustained after the initial certification. As part of SPRs, we determined if the system program logic was accurately and timely processing claims and payment information according to standards determined in Federal regulation. Subsequent recertification of a State's MMIS was based upon the results of the SPR. Prior to 1998, SPRs were performed annually.

We stopped performing such periodic reviews after enactment of section 4753 of the BBA (*See* section 11100 of the State Medicaid Manual). SPRs currently are performed only as part of focused reviews. The BBA also eliminated references to development and application of performance standards used to conduct periodic standards-based reviews of previously certified MMISs. As such, many of the provisions in 42 CFR part 433, subpart C should have been revised to comply with the repealed requirements; for example, much of the language included in § 433.119 through § 433.121 references the SPRs and the reduction of FFP in the event that States did not have systems that remained capable of processing claims and payments and/or were not performing well in completing these activities.

While the BBA eliminated the mandate that we perform SPRs, we do not believe it removed our discretion to perform reviews under our general authority to ensure that MMISs continue to operate in a manner that complies with Federal law, regulations, and guidance. The Secretary has authority to perform periodic reviews of MMIS systems (including eligibility determination systems receiving an enhanced FFP) to ensure that systems receiving enhanced FFP continue to meet the requirements of section 1903(a)(3) of the Act and that they continue to provide efficient, economical, and effective administration of the plan. Section 1903(a)(3)(B) of the Act allows for 75 percent FFP for the sums expended that are "attributable to the operation of systems * * * of the type described in subparagraph (A)(i)." The type of system described in "subparagraph (A)(i)" is one that, on an ongoing basis, results in "more efficient, economical and effective administration of the plan." In addition, the Secretary has authority under section 1903(r) of the Act to ensure continuing compliance with the requirements of that section.

Given our proposed modifications to part 433 of our regulations, as well as the new enhanced FFP for certain eligibility determination systems, we believe it is prudent for us to clearly state the expectation that ongoing successful performance is a necessary condition for receipt of the 75 percent FFP for operations and maintenance. We plan to establish standards and conditions that would ensure that all MMIS systems receiving enhanced FFP are complying with regulatory and statutory requirements. Through sub-regulatory guidance, we would explain further how we would measure whether the requirements are being met, such as through a core set of standards and conditions that focuses on the dimensions for systems that communicate to beneficiaries. We would also explain how States can meet any such performance measures.

For example, we would measure how a system meets requirements for providing notices to beneficiaries, claims and applications intake and acceptance, efficient timely and accurate processing of claims, applications and renewals, proper determinations, and experience with appeals, interoperability with Exchanges, as well as traditional systems standards such as availability and down time. We expect to see such data automatically generated by the systems in which we invest, with standards and conditions established in consultation with stakeholders and based on industry experience.

Additionally, we propose to evaluate systems based upon their interoperability with other Federal and State health programs. Thus, in operating their systems, States would need to ensure that they consult documents articulating the

Department's strategy on interoperability, such as the Guidance for Exchange and Medicaid Information Technology Systems.

We would expect that any failures or deficiencies would be the basis for investigation and opportunity for corrective action before making a determination that enhanced FFP would be discontinued.

Therefore, we propose to modify §§ 433.119 through 433.121 to eliminate any reference to SPRs but, more importantly, to reflect this requirement for performance monitoring and review. We are requesting comments on this proposal, as well as on the types of standards and conditions that should be employed initially and over time.

Additionally, States should consider that we propose to evaluate systems and consider interoperability with other Federal and State health programs. Thus, States should consider other documents that articulate the Department's strategy such as the Guidance for Exchange and Medicaid Information Technology Systems and continue to consider such guidance in meeting the requirements of this proposed rule.

D. Partial Systems Improvements or Modernizations

Throughout this proposed rule, we have used the word "system" or "technology" to refer to what might well be a system of systems maintained in States in support of MMIS functions. We recognize that a modernization agenda in such a State might well move in phases. However, States submitting partial system updates would need to submit and have an approved roadmap for achieving full compliance with the standards and conditions in this regulation. We would track progress against approved roadmap when determining if system updates meet the standards and conditions for the enhanced match. We also recognize that some enhancements currently eligible for enhanced funding are intended to satisfy a specific requirement or to address a compliance issue, for example, ICD–10 or implementation of the National Correct Coding Initiative. We invite comments on alternative approaches to best address these cases in applying our standards and conditions or performance monitoring.

E. Other Technical Changes to Federal Regulations at 42 CFR Part 433 Subpart C—Mechanized Claims Processing and Information Retrieval Systems

Since the enactment of the BBA, other provisions of our regulations have since been superseded. For example, regulations at § 433.113 (referencing the need to have mechanized claims processing and information retrieval systems by a certain deadline, or face reduced Federal Medicaid funds as a consequence) and § 433.130 (referencing waiver provisions for qualifying States with a certain 1976 population and expenditures) no longer apply. As we are revising our regulations to provide for the enhanced FFP for systems that perform eligibility and enrollment activities, we propose to also revise other provisions in part 433, subpart C to conform to the proposals set out in this rule. Thus, we are proposing to delete §§ 433.113 and 433.130 in their entirety, and references to the provisions in these sections that we are deleting.

Specifically, we propose to add a new definition to § 433.111 at (c) to include MITA. MITA is both an initiative and a framework. It is a national framework to support improved systems development and health care management for the Medicaid enterprise. It is an initiative to establish national guidelines for technologies and processes that enable improved program administration for the Medicaid enterprise. The MITA initiative includes an architecture framework, models, processes, and planning guidelines for enabling State Medicaid enterprises to meet common objectives with the framework while supporting unique local needs.

Further, we propose to amend § 433.111(b)(3) to eliminate the requirement that "Eligibility determination systems are not part of mechanized claims processing and information retrieval systems or enhancements to those systems." This, in effect, would mean that, once the subsequent final rule is effective, mechanized claims processing and information retrieval systems would include eligibility determination systems, including the allocated Medicaid portion of integrated eligibility determination systems. We note that eligibility determination systems would be eligible for the 90 and 75 percent FFP only after the effective date of our final rule.

We also propose to eliminate the provision at § 433.112(c), which currently states that "eligibility determination systems are not part of mechanized claims processing and information retrieval systems and are not eligible for 75 percent FFP under this Subpart. These systems are also not eligible for 90 percent FFP for any APD approved after November 13, 1989."

We propose to add language to § 433.112 to indicate that 90 percent and 75 percent FFP would be available for the design, development, installation or enhancement, and maintenance and operation (respectively) of mechanized claims processing systems, including those that perform eligibility determination and enrollment activities, as well as the Medicaid portion of integrated eligibility determination systems, if such systems meet our standards and conditions. (The 90 percent FFP for eligibility determination systems would be available only for a time-limited period, and the 75 percent FFP for eligibility determinations would be available only for those systems that come into compliance with the standards and conditions before the end of that time-limited period.)

By amending § 433.112, 90 percent and 75 percent FFP for a State's reasonable administrative expenditures for the design, development, installation or enhancement, and maintenance and operations to mechanized claims processing and information retrieval systems, (MMISs), including those that perform eligibility determination and enrollment activities, as well as the Medicaid portion of eligibility determination systems, would be available only if the APD is approved by us before the State's expenditure of funds and if the system meets the standards and conditions. For those systems that are currently approved for 90 percent FFP, we would provide a transition period of 12 months for States to submit an IAPD to modify and upgrade systems meet the standards and conditions established by this rule. For those systems that are already approved and currently receiving 75 percent FFP for maintenance and operations, the States would be required to submit an IAPD to modify and upgrade systems to meet the standards and conditions within 36 months. Both transition periods would begin with the effective date of the subsequent final rule. New systems seeking 90 percent FFP would need to demonstrate that they would meet all standards and conditions established by this rule. Eligibility determination systems currently operating would need to come into compliance with the standards and conditions in order to begin receiving 75 percent FFP for State expenditures. We believe this would provide States with a reasonable period of transition while still ensuring that State systems move expeditiously towards improvement and advanced technology.

States would be required to supply information and demonstrate consideration of the following items to CMS for review and approval and as part of the APD before we would grant approval of enhanced funding. We

would scrutinize all proposed investments and would decline to approve enhanced funding (resulting in 50 percent FFP) for proposals that do not demonstrate careful consideration and application of these standards and conditions. States would ensure that MMIS systems, including those that perform eligibility determinations and enrollment activities (as well as the Medicaid portion of eligibility determination systems) would be required to meet the following requirements:

(1) Use 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, available in both human and machine readable formats.

(2) Align to and advance increasingly in MITA maturity for business, architecture, and data.

(3) Ensure alignment with, and incorporation of, industry standards: The Health Insurance Portability and Accountability Act of 1996 privacy, security, 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.

(4) Promote sharing, leverage, and reuse of Medicaid technologies and systems within and among States.

(5) Support accurate and timely processing of claims (including claims of eligibility), adjudications, and effective communications with providers, beneficiaries, and the public.

(6) Produce transaction data, reports, and performance information that would contribute to program evaluation, continuous improvement in business operations, and transparency and accountability.

(7) Ensure seamless coordination and integration with the Exchange, and allow interoperability with health information exchanges, public health agencies, human services programs, and community organizations providing outreach and enrollment assistance services.

States can also choose to continue as they currently operate and receive 50 percent matching. However, this would not change the need for States to meet the substantive requirements of Federal legislation.

Further, we are proposing to codify at § 433.112(c) that we would provide 90 percent FFP for the design, development, installation or enhancement of an eligibility determination system only before December 31, 2015, even if work on an approved APD continues after 2015.

We believe that changes to State systems would be completed with the start of the new Affordable Care Act and support the operation of Exchanges on January 1, 2014. However, we realize that States may need to make additional changes to State systems to provide for additional functionality in support of the Exchanges, and/or Medicaid and CHIP eligibility expansions. Thus, we are providing for an additional 2 years of 90 percent enhanced FFP so that States' systems are provided with additional time to ensure the performance and efficiency of their systems.

States would need to incur costs for goods and services furnished no later than December 31, 2015 to receive 90 percent FFP for the design, development, installation or enhancement of an eligibility determination system.

Lastly, we propose to revise § 433.119 to account for performance monitoring and reviews and to make related conforming changes to part 433.

III. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

The changes specified in this proposed rule do not impose any new reporting, recordkeeping or disclosure requirements. States already submit to us for review and approval APDs for funding for automated data processing in accordance with Federal regulations at 45 CFR part 95, subpart F. The burden associated with the aforementioned information collection requirements is currently approved under OCN 0938–1088 and expires May 31, 2013. We are, however, requesting comments on our analysis; that is, that the specific requirements imposed by this rule do not mandate any additional information collection requirements on States.

IV. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

V. Regulatory Impact Analysis

A. Overall Impact

The estimated costs of the Federal-share for Medicaid administration have been reflected in the Mid-Session Review of the FY 2011 President's Budget.

We have examined the proposed impacts of this rule as required by Executive Order 12866, the Regulatory Flexibility Act (RFA), section 1102(b) of the Act regarding rural hospital impacts, the Unfunded Mandates Reform Act, Executive Order 13132 on Federalism, and the Congressional Review Act.

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for rules with economically significant effects ($100 million or more in any 1 year). This proposed rule is anticipated to have an annual effect on the economy of $100 million or more, making it an economically significant rule under the Executive Order and a major rule under the Congressional Review Act. Accordingly, we have prepared a RIA that to the best of our ability presents the costs and benefits of the proposed rule.

States could continue to receive the traditional 50 percent FFP for reasonable administrative expenditures for designing, developing, installing, or enhancing the Medicaid portion of their integrated eligibility determination

systems. Similarly, States could continue to receive 50 percent FFP for expenditures associated with the maintenance and operation of such systems.

This proposed rule addresses the impact related to enhanced FFP for mechanized claims processing and information retrieval systems, including those that perform eligibility determination and enrollment activities, as well as the Medicaid portion of integrated eligibility determination systems that the Secretary determines are likely to provide more efficient, economical, and effective administration of the State plan.

In projecting the impact to the Federal government and State Medicaid agencies, we considered how the proposed standards and conditions on MMIS and the availability of enhanced match for State eligibility systems through CY 2015 would impact State investments over the 10-year period of 2011 through 2020. As discussed further below, we considered the expected costs to the Federal government of providing the enhanced match rate, changes in state investments due to the application of standards and conditions on MMIS (including eligibility systems), and possible savings as a result of the use of more modern, reusable, and efficient technologies.

B. Potential Savings

We considered a number of ways in which application of the standards and conditions, including increased use of MITA, could result in savings; however, as no States have yet reached MITA maturity, it is difficult to predict the savings that may accrue over any certain timeframe. These areas include the following:

(1) *Modular technology solutions:* As States, or groups of States, would begin to develop "modular" technology solutions, these solutions could be used by others through a "plug and play" approach, in which pieces of a new MMIS would not need to be reinvented from scratch every time, but rather, could be incorporated into the MMIS framework.

We assume that savings associated with reusable technology could be achieved in both the development and operation of new systems. We expect that States would dispense with the need to engage in significant requirements analyses and the need to pay for new modules to be built when there are successful models around the country that they can draw down from a "technology bank" maintained by the Federal or State governments.

(2) *Increased use of industry standards and open source technologies:* While HIPAA administrative transaction standards have existed for 5 to 7 years, use of more specific industry standards to build new systems would allow such systems to exchange information seamlessly—a major goal of the Affordable Care Act, and one that is the explicit purpose of the standards work envisioned within section 1561 of the Act. We also believe that more open source technology would encourage the development of software solutions that address the needs of a variety of diverse activities—such as eligibility, member enrollment, and pharmacy analysis of drug claims. Software that is sufficiently flexible to meet different needs and perform different functions could result in cost savings, as States are able to use the systems without making major adaptations to them.

(3) *Maintenance and operations:* As States take up the changes in this proposed rule, the maintenance/operation costs of new systems should decrease. Less maintenance should be required than that necessary to reengineer special, highly customized systems every time there is a new regulatory or legal requirement.

(4) *Reengineering business processes, more Web-based solutions, service-oriented architecture (SOA):* Savings are likely to result from the modular design and operation of systems, combined with use of standardized business processes, as States are be compelled to rethink and streamline processes as a result of greater reliance on technology.

C. Calculation of MMIS Costs

MMIS costs are estimated at approximately $10.0 billion over the 5-year budget window and $23.0 billion over the 10-year budget window. These costs represent only the Federal share.

To calculate the impact of the regulation on MMIS costs, we assumed that new systems on average would cost $150 million over 3 years for each State ($50 million total cost per year, or $45 million Federal costs at 90 percent FFP per year). We assumed ten States have sophisticated systems that are very close to meeting the proposed regulation standards. As a result, we assumed the remaining 41 States would have approved APDs in place to replace or update their MMIS between FY 2011 and FY 2013 to comply with the new regulation standards and conditions.

We assumed that early adopter States would see increased development, design, and installation costs, whereas late adopter States would see increased development, design, and installation savings as they are able to take advantage of efficiencies gained by the early adopter States. Specifically, for those States that update or build new systems in FY 2011 and FY 2012, we assumed a 10 percent annual cost increase to new MMIS systems for design, development, and installation. For those States that build new systems in FY 2013 and FY 2014, we assumed a 5 percent annual savings to new MMIS systems for design, development, and installation.

While it is difficult to predict State behavior, we believe all States would comply with the standards and conditions proposed in this regulation to receive the 90 percent FFP, and have assumed that for the purpose of these estimates.

For maintenance, we assumed those States that have implemented the new regulation requirements would see a 20 percent annual savings, and for operations, we assumed those States that have implemented the new regulation requirements would see a 5 percent annual savings.

Based on these assumptions, we estimate the net Federal budgetary impact on baseline MMIS costs from FY 2011 through 2015 of implementing the proposed regulation is approximately $1.1 billion, and the net Federal budgetary impact from FY 2011 through 2020 is approximately $557 million in savings.

D. Calculation of Eligibility Systems Costs

For eligibility systems, we applied the same methodology we used to calculate net Federal costs to MMIS under the proposed regulation.

In order to meet the requirements of the Affordable Care Act, States would build new systems or modernize existing systems. Rather, most States will add new functionalities to interface with the Exchanges and implement new adaptability standards and conditions (such as incorporation of new mandated eligibility categories). We assume baseline costs for development, design, and installation at 50 percent FFP for all States are approximately $815 million from FY 2011 through 2015 and $1.1 billion from FY 2011 through 2020. Eligibility systems costs for maintenance and operations at 50 percent for all States are approximately $1.2 billion from FY 2011 through 2015 and $2.7 billion from FY 2011 through 2020. These costs represent only the Federal share.

To calculate the impact of the regulation, we assumed that new systems on average would cost $50 million over 3 years for each State

($16.7 million total cost per year, or $15 million Federal costs at 90 percent FFP per year). We assumed that 25 States would replace their eligibility systems in FY 2011 through CY 2015. We assumed no States would build new systems past FY 2014 (beyond what is assumed in the baseline) due to the timing of the start of major coverage provisions in the Affordable Care Act, the length of time needed to build new systems (approximately 3 years), and the enhanced match ending after CY 2015. For maintenance, we assumed States that have implemented new systems meeting the required standards and conditions would see a 20 percent annual savings, and for operations, we assumed those States that have implemented the new systems would see a 5 percent annual savings. These assumptions are consistent with our approach for savings under MMIS in the proposed regulation.

The net Federal cost impact from FY 2011 through 2015 of implementing the proposed regulation on eligibility systems is approximately $2.2 billion, and the net Federal cost from FY 2011 through 2020 is $2.9 billion. These costs represent only the Federal share.

E. Total Net Cost Impact

Combining the impact of the proposed regulation, the total net Federal cost impact is approximately $3.3 billion for FY 2011 through 2015 and approximately $2.3 billion for FY 2011 through 2020. We see lower costs over the 10-year budget window due to the increased savings to MMIS over time.

Aligned with these Federal net costs, States will see a corresponding decrease in their net State share due to the enhanced Federal match for eligibility systems they will receive through CY 2015 and the benefits accrued to their systems by putting in place the set of standards and conditions articulated in this proposed regulation. Combining the impact of the proposed regulation, the total net State budget impact is approximately $792.5 million in savings for FY 2011 through 2015 and approximately $1.9 billion in savings for FY 2011 through 2020. Similar to the Federal budget impact, we expect to see higher savings achieved by States over the 10-year budget window due to the increased savings to MMIS over time.

The projections in this analysis are subject to considerable uncertainty, as they reflect projected costs based on technology and innovation. While we believe that advancements in technology would likely have an impact on States' systems, it is difficult to predict with certainty how significant the technology advancements may be and how they would affect State systems. For example, we have worked for many years developing the MITA maturity model. We believe that States should adopt the MITA framework as the basis for all MMIS replacements and major system upgrades related to the MMIS, and while we are requiring that States move to a MITA framework in order to receive enhanced funding, to date there are no States that have reached full MITA maturity. Consequently, having no States at full MITA maturity would indicate that it takes time, money and considerable effort for States to make changes to their current technology.

Additional uncertainty exists because we are unsure of the rate of adoption for States to make the changes in this proposed rule. The enhanced FFP is available for approximately 5 years, from CY 2011 through CY 2015, and States could upgrade or replace their systems at any point within the 5-year period. Further, States may simply choose to make moderate changes to existing systems, and even with the 90 and 75 percent enhanced FFP, such moderate changes could be less costly overall for States than replacing their systems.

Additional uncertainty exists about the rate of State adoption since some States may consider the costs needed to move to a more advanced system to be too high to undertake such a project. Similarly, States may decide not to make changes due to implementation of performance requirements and the performance reviews.

We acknowledge that there are uncertainties regarding our assumptions, including State behavior, and the associated cost estimates with respect to states implementing new systems within the timeframe assessed. However, we have offered our estimates with a 25 percent upper and lower range to capture such uncertainty in actual implementation outcomes. Due to a number of uncertainties in our assumptions, we believe a range of estimates better represents the net cost impact of this proposed regulation. Tables 1 and 2 represent a 25 percent range for these aggregate net costs to the Federal and State government, respectively. It is important to point out that we believe that systems transformation is necessary to meet the vision of the Affordable Care Act and consequently, these costs are necessary and would provide for efficient systems that in the end would provide for more efficient and effective administration of the State plan. The separate impacts to MMIS and eligibility systems are summarized below.

TABLE 1—NET FEDERAL COST IMPACT OF PROPOSED REGULATION

[Dollars in millions*]

	FY 2011–2020
MMIS (excluding Eligibility)	(417.4)–(695.7)
Eligibility Systems	2,154.6–3,591.0
Total	1,737.2–2,895.3

* Numbers in parentheses represent savings to the Federal Government.

TABLE 1.1—NET FEDERAL COST IMPACT OF PROPOSED REGULATION BY FISCAL YEAR

[Dollars in millions*]

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2011–2020
MMIS (excluding Eligibility)	231.1	469.4	435.6	54.3	(83.0)	(322.6)	(329.0)	(333.1)	(337.4)	(341.8)	(556.6)
Eligibility Systems	328.9	436.7	634.6	469.3	337.4	127.9	130.5	133.1	135.8	138.5	2,872.8
Total	560.0	906.1	1,070.2	523.6	254.4	(194.7)	(198.5)	(200.0)	(201.6)	(203.3)	2,316.2

* Numbers in parentheses represent savings to the Federal Government.

TABLE 2—NET STATE COST IMPACT OF PROPOSED REGULATION

[Dollars in millions *]

	FY 2011–2020
MMIS (excluding Eligibility)	(170.6)–(284.4)
Eligibility Systems	(1,255.4)–(2,092.3)
Total	(1,426.0)–(2,376.7)

* Numbers in parentheses represent savings to State governments.

TABLE 2.1—NET STATE COST IMPACT OF PROPOSED REGULATION BY FISCAL YEAR

[Dollars in millions *]

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2011–2020
MMIS (excluding Eligibility)	25.7	52.2	48.4	1.3	(24.1)	(61.6)	(65.2)	(66.6)	(68.0)	(69.5)	(227.5)
Eligibility Systems	(285.6)	(276.7)	(258.0)	(139.9)	64.3	(149.5)	(152.5)	(155.5)	(158.6)	(161.8)	(1,673.8)
Total	(259.9)	(224.6)	(209.6)	(138.6)	40.2	(211.1)	(217.7)	(222.1)	(226.6)	(231.3)	(1,901.3)

* Numbers in parentheses represent savings to State Governments.

F. Regulatory Flexibility Analysis

The Regulatory Flexibility Act (RFA) requires agencies to prepare an Initial Regulatory Flexibility Analysis to describe and analyze the impact of proposed rule on small entities unless the Secretary can certify that the regulation would not have a significant impact on a substantial number of small entities. In the healthcare sector, Small Business Administration size standards define a small entity as one with between $7 million and $34 million in annual revenues. For the purposes of the RFA, essentially all non-profit organizations are considered small entities, regardless of size. Individuals and States are not included in the definition of a small entity.

Since this rule would affect States, which are not considered small entities, the Secretary has determined that this proposed rule would not be likely to have a significant economic impact on a substantial number of small entities. Therefore, we have not prepared a regulatory flexibility analysis.

Additionally, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operation of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. We are not preparing an analysis for section 1102(b) of the Act because we have determined that this rule would not have a significant impact on the operations of a substantial amount of small rural hospitals. There is no negative impact on the program or on small businesses.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditures in any one year by State, local, or tribal governments, in the aggregate, or by the private sector of $135 million. This rule does not mandate expenditures by the State governments, local governments, tribal governments, or the private sector. This rule provides that States can receive enhanced FFP if States ensure that the mechanized claims processing and information retrieval systems, (MMISs), including—for a limited time—those that perform eligibility determination and enrollment activities, as well as the Medicaid portion of integrated eligibility determination systems, meet with certain conditions including migrating to the MITA framework and meeting certain performance requirements. This is a voluntary activity; i.e., States can continue to receive the traditional 50 percent FFP match rate for reasonable administrative expenditures for the design, development, or enhancement and maintenance and operations to the Medicaid portion of integrated eligibility determination systems in order to make eligibility determinations for Title XIX. This rule imposes no substantial mandates on States. The State role in determining Medicaid eligibility is dependent upon the population type; specifically, some populations such as the elderly, blind, and disabled are typically determined by the Medicaid State agency whereas other population types may have their Medicaid eligibility determined by cash-assistance programs. Mechanized claims processing and information retrieval systems, including those that perform eligibility determination and enrollment activities and the Medicaid portion of integrated eligibility determination systems, at a minimum, will need to be updated. However, providing 90 percent FFP for design, development, and installation or 75 percent FFP for maintenance and operations of such systems reduces the financial burden on States to 10 percent of the costs compared to the 50 percent financial burden currently in place. Specifically, while this entails certain procedural responsibilities, these activities do not involve substantial State expense; providing 90 percent and 75 percent FFP reduces the total State outlay.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. We wish to note again that this is a voluntary activity and as such this regulation does not mandate any direct costs on State or local governments. Consequently, the requirements of Executive Order 13132 are not applicable.

G. Alternatives Considered

We considered that an alternative to our proposed rule would be that we not provide enhanced match for State systems builds and not provide Federal standards and conditions. In fact, States could continue to receive the traditional 50 percent FFP for reasonable administrative expenditures for designing, developing, installing, or enhancing Medicaid eligibility determination systems. Similarly, States could continue to receive 50 percent FFP for expenditures associated with

the maintenance and operation of such systems.

However, States must continue to meet the requirements of Federal legislation. Since the Affordable Care Act significantly alters Medicaid eligibility and requires coordination with the Exchanges, it is imperative that States have the resources and systems to be able to meet this challenge.

Therefore, we believe that if States were left to develop eligibility systems without Federal standards and conditions and without the benefit of enhanced match, States systems may not comport with our ultimate goal; that is, that design, development, implementation, and operation of IT and systems projects are in support of the Affordable Care Act.

H. Statement of Need

This regulation is important since with the passage of the Affordable Care Act, we expect that changes to eligibility policies and business processes would need to be adopted. System transformations would be needed in most States to apply new rules to adjudicate eligibility for the program; enroll millions of newly eligible individuals through multiple channels; renew eligibility for existing enrollees; operate seamlessly with newly authorized Health Insurance Exchanges ("Exchanges"), or with Federal "Exchanges" if States choose not to operate a State Exchange; participate in a system to verify information from applicants electronically; incorporate a streamlined application used to apply for multiple sources of coverage and financial assistance; and produce notices and communications to applicants and beneficiaries concerning the process, outcomes, and their rights to dispute or appeal.

We wish to ensure that that a key outcome of our technology investments is a much higher degree of interaction and interoperability in order to maximize value and minimize burden and costs on providers and beneficiaries. Thus, we are committed to providing 90 percent FFP for design, development, and installation through CY 2015 or 75 percent FFP for maintenance and operations of such systems. We have provided that States must commit to a set of standards and conditions in order to receive the enhanced FFP. This enhanced FFP reduces the financial burden on States to 10 percent of the costs compared to the 50 percent financial burden currently in place and ensures that States utilize current technology development and deployment practices and produce reliable business outputs and outcomes.

I. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf*), in Table 3, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this rule. This table provides our best estimate of the net costs decrease in Medicaid payments as a result of the changes presented in this rule. Because of the uncertainties identified in establishing the cost estimates, CMS intends to update the estimates with any final rule.

TABLE 3—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED NET COSTS, FROM FY 2011 TO FY 2020

[In $ millions]

Category	TRANSFERS			
	Year dollar	Units discount rate		Period covered
	2010	7%	3%	
Annualized Monetized Transfers	Primary Estimate	$311.31	$266.55	FYs 2011–2020
	Low Estimate	233.48	199.91	
	High Estimate	389.14	333.19	
From	Federal Government to State Governments			
Annualized Monetized Transfers	Primary Estimate	−189.87	−189.82	FYs 2011–2020
	Low Estimate	−142.40	−142.36	
	High Estimate	−237.34	−237.28	
From	State Governments to System Vendors, Integrators			

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects in 42 CFR Part 433

Administrative practice and procedure, Child support Claims, Grant programs—health, Medicaid, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as set forth below:

PART 433—STATE FISCAL ADMINISTRATION

1. The authority citation for part 433 continues to read as follows:

Authority: Section 1102 of the Social Security Act, (42 U.S.C. 1302).

Subpart C—Mechanized Claims Processing and Information Retrieval Systems.

2. Section 433.110 is amended by revising paragraph (a)(2) to read as follows:

§ 433.110 Basis, purpose, and applicability.

(a) * * *

(2) Section 1903(r) of the Act, which imposes certain standards and conditions on mechanized claims processing and information retrieval systems (including eligibility determination systems) in order for these systems to be eligible for Federal funding under section 1903(a) of the Act.

* * * * *

3. Section 433.111 is amended by—

A. Removing paragraph (b)(3).

B. Adding paragraph (c).

The addition reads as follows:

§ 433.111 Definitions.

* * * * *

(c) "Medicaid Information Technology Architecture (MITA)" is defined at § 495.302.

4. Section 433.112 is amended by-–

A. Adding "Subject to paragraph (c) of this section," at the beginning of paragraph (a).

B. Revising paragraphs (b)(2) and (c).

C. Removing the cross-reference to "45 CFR 74.171" and adding "45 CFR 74.27(a)" in its place in paragraph (b)(7).

D. Adding paragraphs (b)(10) through (16).

The revisions and additions read as follows:

§ 433.112 FFP for design, development, installation or enhancement of mechanized claims processing and information retrieval systems.

* * * * *

(b) * * *

(2) The system meets the system requirements and standards and conditions in Part 11 of the State Medicaid Manual, as periodically amended.

* * *

(10) Use 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, available in both human and machine readable formats.

(11) Align to, and advance increasingly, in MITA maturity for business, architecture, and data.

(12) Ensure alignment with, and incorporation of, industry standards: the Health Insurance Portability and Accountability Act of 1996 privacy, security 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.

(13) Promote sharing, leverage, and reuse of Medicaid technologies and systems within and among States.

(14) Support accurate and timely processing and adjudications/eligibility determinations and effective communications with providers, beneficiaries, and the public.

(15) Produce transaction data, reports, and performance information that would contribute to program evaluation, continuous improvement in business operations, and transparency and accountability.

(16) Ensure seamless coordination and integration with the Exchange, and allow interoperability with health information exchanges, public health agencies, human services programs, and community organizations providing outreach and enrollment assistance services.

(c) FFP is available at 90 percent of a State's expenditures for the design, development, installation, or enhancement of an eligibility determination system that meets the requirements of this subpart beginning, and no earlier than, [effective date of the final rule], and only through December 31, 2015.

§ 433.113 [Removed]

5. Section 433.113 is removed.

6. Section 433.114 is amended by—

A. In paragraph (a), removing "(h)" and adding in its place "(i)".

B. Revising paragraph (b).

The revision reads as follows:

§ 433.114 Procedures for obtaining initial approval; notice of decision.

* * * * *

(b) If CMS disapproves the system, the notice will include the following information:

(1) The findings of fact upon which the determination was made.

(2) The procedures for appeal of the determination in the context of a reconsideration of the resulting disallowance to the Departmental Appeals Board.

7. Section 433.116 is amended by—

A. In paragraph (a), removing "Subject to 42 CFR 433.113(c)," and replacing it with "Subject to paragraph (j) of this section,".

B. In paragraph (b), removing "(h)" and adding in its place "(i)".

C. Adding new paragraphs (i) and (j).

The additions read as follows:

§ 433.116 FFP for operation of mechanized claims processing and information retrieval systems.

* * * * *

(i) The standards and conditions of § 433.112(b)(10) through (16) must be met.

(j) Beginning and no earlier than, [add in effective date of final rule], FFP is available at 75 percent of a State's expenditures for the operation of an eligibility determination system that meets the requirements of this subpart. FFP at 75 percent is not available for eligibility determination systems that do not meet the standards and conditions by December 31, 2015.

§ 433.117 [Amended]

8. Section 433.117 is amended by—

A. Amending paragraph (a) by removing the phrase "all conditions" and adding in its place the phrase "all standards and conditions".

B. Amending paragraph (c)(2) by removing the reference "(h)" and adding "(i)" in its place.

9. Section 433.119 is amended by—

A. Revising paragraphs (a) introductory text.

B. Revising paragraph (a)(1).

C. Amending paragraph (a)(2) by removing the reference "(h)" and adding "(i)" in its place.

D. Revising paragraphs (a)(4) and (c).

The revisions read as follows:

§ 433.119 Conditions for reapproval; notice of decision.

(a) CMS periodically reviews each system operation initially approved under § 433.114 and reapproves it for FFP at 75 percent of expenditures if the following standards and conditions are met:

(1) The system meets the requirements of § 433.112(b)(1), (3), (4), (7) through (16).

* * * * *

(4) A State system must meet all of the requirements of this subpart within the appropriate period CMS determines should apply as required by § 433.123(b).

* * * * *

(c) After performing the review under paragraph (a) of this section, CMS will issue to the Medicaid agency a written notice informing the agency whether the system is reapproved or disapproved. If the system is disapproved, the notice will include the following information:

(1) CMS's decision to reduce FFP for system operations from 75 percent to 50 percent of expenditures, beginning with the first day of the first calendar quarter after CMS issues the written notice to the State.

(2) The findings of fact upon which the determination was made.

(3) A statement that State claims in excess of the reduced FFP rate will be disallowed and that any such disallowance will be appealable to the Departmental Appeals Board.

10. Section 433.120 is amended by revising paragraph (b) to read as follows:

§ 433.120 Procedures for reduction of FFP after reapproval review.

* * * * *

(b) CMS will reduce FFP in expenditures for system operations from 75 percent to 50 percent.

11. Section 433.121 is amended by revising paragraph (a) to read as follows:

§ 433.121 Reconsideration of the decision to reduce FFP after reapproval review.

(a) The State Medicaid agency may appeal (to the Departmental Appeals Board under 45 CFR part 16) a disallowance concerning a reduction in

FFP claimed for system operations caused by a disapproval of the State's system.

* * * * *

§ 433.130 [Removed]

12. Section 433.130 is removed.

Authority: (Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program).

Dated: October 14, 2010.

Donald M. Berwick,

Administrator, Centers for Medicare & Medicaid Services.

Approved: October 28, 2010.

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

[FR Doc. 2010–27971 Filed 11–3–10; 11:15 am]

BILLING CODE 4120–01–P

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; and
- 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.

---

[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 t

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 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.

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; and

- Time-limited and easily revocable.[2]

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.

[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.

Appendix A
Consumer-Centric Approach

Adopting a consumer-centric approach to eligibility determinations and enrollment in health and human services programs is essential to the core purpose of the Affordable Care Act and should be a key focus for the successful modernization of new and existing electronic systems. Such an approach accounts for the needs and preferences of the consumer and considers functions, tools and/or applications that facilitate State efforts to support consumers in enrolling for and maintaining health coverage and other human services benefits.

Key components of a consumer-mediated approach include:

- Allowing consumers to apply for or renew benefits online;
- Providing superior customer service, facilitated by real-time transactions and multiple modes of communication between consumers and States;
- Allowing third parties to assist consumers in enrolling for and maintaining benefits; and
- Seamlessly integrating systems that serve the consumer in pursuit of health coverage (e.g., health insurance Exchanges, Medicaid, CHIP, private insurance) and human services programs (e.g. SNAP, TANF).

Definitions

- *Consumer Usability*: The International Standards Organization (ISO) defines usability as "the extent to which a product can be used by specified users to achieve specified goals with effectiveness, efficiency and satisfaction in a specified context of use." Usability is a qualitative attribute that assesses how easy user interfaces are to use. The word "usability" also refers to methods for improving ease of use during the design process.

- *Consumer Mediated*: Adopting approaches where the consumer has the authority to make choices and direct use and reuse (i.e., for themselves, by programs or by other authorized third parties) of their enrollment information to the extent practicable.

Key Assumption
While the primary charge of the Workgroup was the development of protocols and standards for electronic eligibility and enrollment processes and systems, States will likely use a variety of strategies. These methods might include:

- Online or mail in applications;
- Phone service;
- Assistance from third parties such as family members, care givers, community-based organizations, health providers or others;
- In person services, when desired.

To accommodate the needs of various populations and ensure consumers have easy, timely access to the benefits they need, consumers should be able to begin the process through any available channel. Regardless of the method used to apply, the consumer should have access to

the full range of coverage options and services, should receive clear, understandable instructions on future steps, and should be continuously supported through the application process and into enrollment, if eligible.

For example, a consumer may begin the application process online, but find that he or she is unable to complete the application for any number of reasons including technical difficulties or lack of information. If this occurs, the consumer should be able to submit the remaining information and complete the application process through another modality including over the phone or in person, with assistance if desired. Flexible, adaptable processes that support consumers through the process ensure the consumer is able to obtain and retain the needed benefits.

Consumer-Friendly User Interface

Recommendation 2.2 provides for the 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. When planning for the integration of this reference software into new or existing systems, States should consider developing a reference application with a consumer-friendly user interface design. This application may, but not necessarily, be full-featured software. At a minimum, it should adequately represent a consumer-mediated workflow.

An initiative at the Internal Revenue Service (IRS) highlights a consumer-mediated approach that could be applied in the health and human services eligibility process. IRS provides an automated tool that allows individuals applying for student aid to obtain necessary tax return information from IRS electronically, review it, elect whether or not to export the data to the electronic student aid application and seamlessly use the data to complete the student aid application.

Consumer-Friendly Design and Access

Eligibility and enrollment systems should be designed and built to meet the diverse needs of users (e.g., consumers, State personnel, other third party assisters) without barriers or diminished function or quality. Guided by this framework, electronic eligibility and enrollment systems should include usability features or functions that achieve the following:

- Assist the consumer in understanding their rights and meaningfully choosing among available options (e.g., privacy options, application options, coverage options);
- Guide the consumer through screen-and-enroll processing in a reliable, accurate manner that supports efficient data entry (e.g., requiring the minimum amount of data and supporting documentation from the consumer) in as close to real-time as possible;
- Provide and solicit information at an appropriate literacy level that meets the language needs of the consumer;
- Accommodate the needs of persons with disabilities including through the use of assistive technologies;
- Allow for storage of data – including documents and data supplied by the consumer, obtained from other sources, and/or inferred or derived from other data – for reuse in the renewal process;

- Allow the consumer to view, print, save, and export the data in a format that can be used and reused by the consumer;
- Facilitate the consumer to submit documentation where necessary (e.g., to demonstrate a change in circumstances);
- Enable the consumer to use the system from multiple locations and over time without having to re-enter data or re-start the process;
- Provide status updates to inform the consumer of where they are in the enrollment process and what, if any, action may be required to complete the process;
- Provide a process whereby consumers can make inquiries to State personnel, resolve disputes regarding data inputs, verification and eligibility decisions and, where necessary, formally appeal decisions; and
- Facilitate a consumer's ability to obtain assistance from third parties such as family members, care givers, health care providers and community-based organizations in their efforts to complete the application and renewal process.

States should also consider implementing system functions or communication tools to ensure consumers receive clear, timely information on their application and enrollment status and benefits. A critical step to ensuring receipt of routine and/or urgent notices is allowing the consumer to designate a preferred mode of communication (e.g., email, text message, voicemail).

An initiative at the Department of Homeland Security (DHS) highlights the effectiveness of these types of consumer communication tools. DHS recently launched a new website that allows legal immigrants to check the status of their applications online and via text message. In its first month alone, three million people registered to receive text message updates on the status of their applications.

Appendix B
Core Data Analysis

The standard definition and expression of core data elements is necessary to support interoperability and electronic exchange of data between health and human service programs. Recommendation 1.1 provides that Federal agencies and States administering health and human services programs use the National Information Exchange Model (NIEM) guidelines to develop, disseminate and support the standards and processes that enable the consistent, transparent exchange of data elements between programs and States.

This recommendation is not intended to suggest that Federal agencies or States should modify either their core data elements or the way they collect and display those data elements within their own systems. Rather, the NIEM process ensures that common data elements can be sent between programs using a consistent standard such that the receiving program can easily identify and incorporate the data element into their own systems.

Overview of Core Data Analysis

As a first step, a review of the data elements collected from a consumer during the application process by a sample of Medicaid, CHIP, SNAP and TANF programs was conducted. This review revealed a core set of eleven data elements currently collected by all four programs (see Table 1 for a complete list).

Subsequently, a sample of 34 health and human services programs across ten States was used to identify similarities and gaps in data element definition across the programs and to assess the complexity of data harmonization. The following considerations were used to determine complexity:

- Variation of data name and definition across programs;
- Prevalence of similar variations across programs;
- Similarity and range of data values sets across programs; and
- Existing data standards such as those identified in HL7, X12, and NIEM.

Table 1 highlights initial findings regarding the anticipated complexity of harmonization for a given data element.

Table 1 – Core Data Element Complexity Rating

Core Data Element Name	Complexity of Harmonization	Key Findings
Name	Low	Consistent terminology and similarity in foundational data values will enable creation of a harmonized data element definition and mapping to existing standards.
Date of Birth	Low	Consistent data values and semantics will facilitate creation of a harmonized data element definition and mapping to existing standards.
Social Security Number	Low	Consistent terminology and similarity in foundational data values will enable creation of a harmonized data element definition and mapping to existing standards.

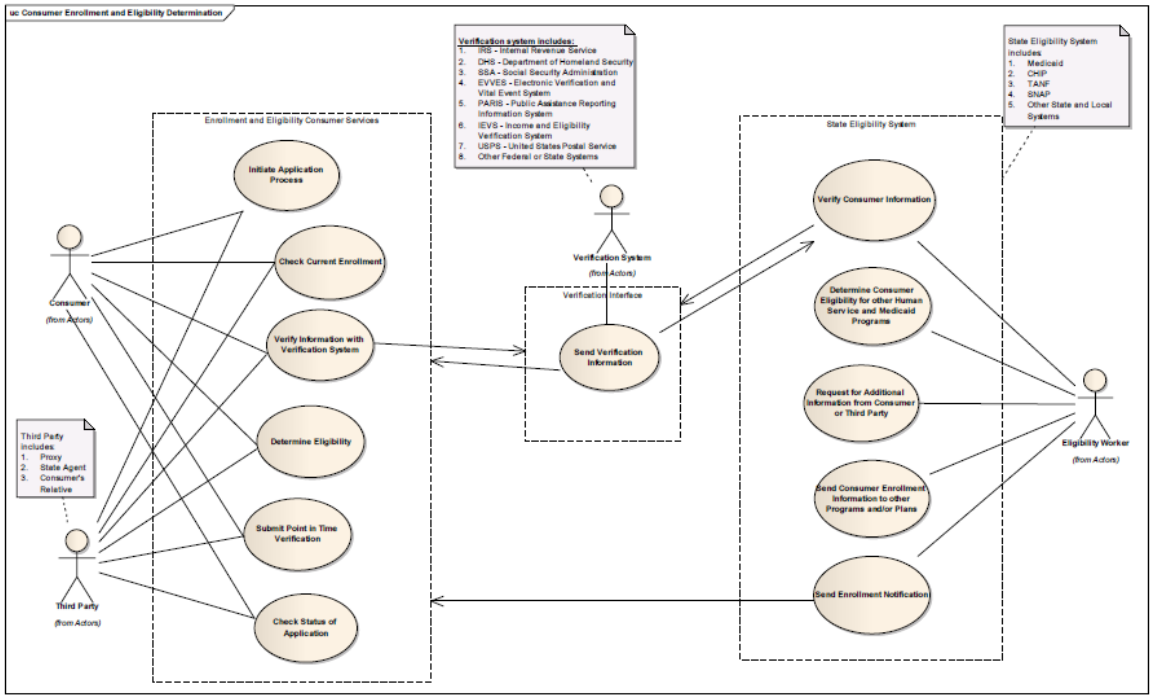
Core Data Element Name	Complexity of Harmonization	Key Findings
Gender	Low	Consistent data values and semantics will facilitate creation of a harmonized data element definition and mapping to existing standards.
Address	Medium	Creation of a harmonized data element definition and mapping to existing standards must consider sub-concepts of address (e.g., mailing address, home address, etc.).
Citizenship	Medium	To harmonize data element definition and accurately map to existing standards, clarification of business rules and interfaces is required.
Immigration Status	Medium	To harmonize data element definition and accurately map to existing standards, clarification of business rules and interfaces is required.
Incarceration	Medium	To harmonize data element definition and accurately map to existing standards, clarification of business rules and interfaces is required.
Race/Ethnicity	High	Wide variability occurring in the nomenclature and definition of race/ethnicity values within standards and between programs.
Household Composition	High	Harmonization to a consistent data definition across programs requires further understanding of underlying program and jurisdiction business rules.
Income	High	*Income* is a derived data concept, determined through calculation of several associated concepts. Harmonizing to a unique definition requires further elaboration of underlying program and jurisdiction business rules.
Primary Care Provider	N/A	Data element was only found in 1 of 34 State program enrollment applications.

An important aspect of the data analysis effort is mapping to existing data standards such as HL7, NIEM, and X12. In addition to providing for the reuse of existing standards, such mapping provides a mechanism to increase interoperability between eligibility and enrollment systems and creates an opportunity to address gaps, duplications, and/or overlaps in information.

Interoperability Specification Development

The Affordable Care Act describes a set of guidelines and requirements that are intended to facilitate consumer enrollment in State health and human services programs. Figure 1 provides high-level use cases focusing on the consumer eligibility and enrollment process. It includes verification of core data elements to determine eligibility, as well as the exchange of data between programs for additional eligibility determinations.

Figure 1 – Consumer Eligibility and Enrollment Use Case Model



Details for each use case are described in Table 2.

Table 2 – Foundational Use Cases Supporting Enrollment and Eligibility Processes in Health and Human Services Programs

Use Case	Description
Initiate Application Process	A consumer or third party applies for a program by entering basic demographic information into the Enrollment and Eligibility Consumer Services.
Check Current Enrollment	The Consumer or Third Party checks for the Consumer's existing coverage. Matching is initially done using a single identifier, followed by a probabilistic formula, or other method to obtain current enrollment information.
Verify Information with Verification System	The Consumer electronically verifies their demographic information in real-time with the Verification System. The information received from the Verification System may be pre-populated in real-time on the Application. The Consumer may verify the following information: • Identify • Residency • Income • Citizenship • Legal Status • Household Size
Determine Eligibility	The Consumer reviews information about their potential eligibility for private insurance, subsidized insurance, Medicaid, CHIP, and other HHS programs.

Use Case	Description
Submit Point in Time Verification	The Consumer or Third Party submits a Point in Time Verification where there is a change in the Consumer's circumstance or the information received from the Verification System is inaccurate or incomplete.
Check Status of Application	The Consumer checks the status of an existing enrollment application.
Send Verification Information	The verification system sends requested verification information to the consumer and Eligibility Worker. The verification information may include: • Identity verification • Residency verification • Income verification • Citizenship verification • Legal Status verification • Household Size verification
Verify Consumer Information	The Eligibility Worker obtains verification information from the Verification System after the Consumer has indicated that the information returned by the Verification System is inaccurate or does not reflect the Consumer's current circumstances. The Eligibility Worker may verify the following Consumer information: • Identity • Residency • Income • Citizenship • Legal Status • Household Size
Determine Consumer Eligibility for other Programs	The Eligibility Worker determines a Consumer's eligibility for other programs. This only happens if the Consumer indicates that the information returned by the Verification Systems is accurate and reflects the Consumer's current circumstances, and the program does not require additional information.
Request for Additional Information from Consumer or Third Party	If the information received from the consumer is incomplete or if the consumer's circumstances have changed the accuracy of information in the eligibility system, the Eligibility Worker may request additional information from the Consumer or Third Party.
Send Consumer Enrollment Information to other Programs and/or Plans	The Eligibility Worker sends the Consumer's enrollment information to other programs and/or plans, as authorized by the Consumer or otherwise permitted by law.
Send Enrollment Notification	The Eligibility System creates an official notice explaining the outcome (Approval or Denial) of the eligibility determination. This notice is mailed to the Consumer and also sent to the Enrollment and Eligibility Consumer Services. The Consumer is given an opportunity to appeal the decision.

Verification of consumer enrollment data against a verification system exemplifies the need to establish a common understanding of data elements prior to information exchange. For example, the "Verify Information with Verification System" use case above may require the exchange of personally identifiable information (e.g., name, date of birth, address, income, etc.) between a program system and multiple verification systems (e.g., SSA, DHS, IRS). The program system passes data elements to the respective verification system(s) to facilitate conclusive identification of a record in the verification system containing information belonging to the consumer applying for benefits. If the program system and the verification system do not use the same definition to define each data element, a discrepancy is created which could affect the consumer's eligibility for benefits if there is no standard method to bridge the gaps between the two definitions.

Table 3 illustrates how different definitions of income may result in different calculated values by the State program and Federal or State verification source.[1]

Table 3 – Sample Income Calculation Scenario for a Human Services Program

	Human Services Program	Verification Source
Definition of Income	Net adjusted monthly income	Gross monthly income
Example Income Calculation	**Scenario**: • One household member • Gross monthly income of $828.00 • Monthly medical costs of $41.91 • Standard credit of $141.00 for households of 1-3 people • Medical Expense Credit is applied when medical expense are greater than $35.00 per month **Calculation**: $828.00 Gross Income - $141.00 Standard Credit - $ 6.91 Medical Expense Credit **=$680.09 Net Adjusted Monthly Income**	**Scenario**: • One household member • Gross monthly income of $828.00 • Monthly medical costs of $41.91 • Verification Source does not apply a Standard Credit • Verification Source does apply a Medical Expense Credit **Calculation**: $828.00 Gross Income - $ .00 Standard Credit - $ .00 Medical Expense Credit **=$828.00 Gross Monthly Income**

Summary of Proposed Enrollment Data Standards

Table 4 presents proposed data standards derived from preliminary data analyses findings, use case identification, application of known business rules, and mapping to existing data standards. The findings outlined below are intended as representative data standards and require further refinement and elaboration based on elaboration of use cases, business rules, and interface descriptions.

[1] Note that this example is limited the calculation of income for a human services programs, as the ACA establishes modified adjusted gross income (MAGI) as the measure of income for the health insurance Exchanges.

Table 4 – Proposed Enrollment Data Standards

Data Element Name	Data Type	Data Definition	Source
Name	niem-xsd: string	A combination of names and/or titles by which a person is known.	Source: NIEM v2.1 Path: nc:PersonName
Date of Birth	niem-xsd:date	The date a person was born	Source: NIEM 2.1 Path: nc:PersonBirthDate Reference: National Center for Vital Health Statistics http://www.ncvhs.hhs.gov/ncvhsr1.htm
Social Security Number	niem-xd: string	A unique reference to a living person; assigned by the United States Social Security Administration.	Source: NIEM v2.1 Path: nc:PersonSSNIdentification Reference: Social Security Administration http://www.socialsecurity.gov/cbsv/docs/CBSVUserGuide042310.pdf
Gender	niem-xsd: string	A gender or sex of a person.	Source: NIEM v2.1 Path: nc:PersonSex/nc:PersonSexCode Reference: National Center for Vital Health Statistics http://www.ncvhs.hhs.gov/ncvhsr1.htm
Address	niem-xsd: string	A postal location to which paper mail can be directed.	Source: NIEM v2.1 Path: nc:Address Reference: United States Postal Service http://ribbs.usps.gov/aec/documents/tech_guides/AEC_AECII_UG.PDF
Citizenship	niem-xsd: string	The legal standing of a person assigned by a country which provides rights, duties, and privileges due to the person's birth or naturalization.	Source: NIEM v2.1 Path: scr:Citizenship Reference: 1. Department of Homeland Security http://www.dhs.gov/files/statistics/stdfdef.shtm#2 2. Social Security Administration http://www.ssa.gov/gix/Bendex%20record.pdf

Data Element Name	Data Type	Data Definition	Source
Legal Status	niem-xsd: string	A role type used to qualify a person's legal status within a country or nation.	Source: HL7 Reference Information Model (RIM_0231). V 02-31 (3/21/2010) Path: RoleCode> AssocativeRoleType> MutualRelationshipRoleType> FormalRelationshipRoleType> CitizenRoleType Reference: Department of Homeland Security http://www.dhs.gov/xlibrary/assets/privacy/privacy_pia_uscis_pcq_vis.pdf
Incarceration[2]	niem-xsd: boolean	A mandatory confined supervision of a person.	Source: NIEM v2.1 Path: j:Incarceration
Race[3]	niem-xsd: string	A classification of a person based on factors such as geographical locations and genetics.	Source: NIEM v2.1 Path: nc:PersonRaceCode Reference: Office of Management and Budget http://www.whitehouse.gov/omb/fedreg_1997standards
Ethnicity[4]	niem-xsd: string	A cultural lineage of a person.	Source: NIEM v2.1 Path: nc:PersonEthnicityCode Reference: Office of Management and Budget http://www.whitehouse.gov/omb/fedreg_1997standards
Household Composition[4]	N/A	N/A	N/A
Income[5]	N/A	N/A	N/A
Primary Care Provider[6]	N/A	N/A	N/A

[2] Incarceration may require further definition and metadata elaboration to account for Federal and State program requirements. Business rules may require programs to collect information such as history of incarceration, duration of previous incarceration, facility name and facility type.

[3] Race and Ethnicity were originally recommended as the single data element. Splitting this data element into two separate data elements will allow for more accurate definition

[4] Proposed Household Composition definition and metadata are not provided, as further elaboration and comparison of applicable business rules are required to express the unambiguous definition of this attribute.

[5] Proposed Income definition and metadata are not provided, as further analysis is required to outline how discrete data elements (e.g., employment income, self-employment income, unearned income, utilities, medical expenses, etc.) are used to calculate income, as well as how States apply business rules to derive income.

Further Elaboration

While we have identified data standardization priorities that will ultimately facilitate consumer enrollment and enable consistent eligibility and enrollment information exchange across health and human services programs, additional work is needed. The use cases, derived from the Affordable Care Act, should be refined to ensure proper workflows that support consumer eligibility determinations and enrollment processes. As information becomes available, the use cases and associated artifacts should address system interactions and process flows in greater depth.

Future iterations in the interoperability specification development process will include a platform independent model that provides a logical data representation of the use cases. It will also include platform specific models with a representative physical data model and service description, specifying data types, data lengths, and other key metadata such as the originating source of data, data owner and system of record for ongoing maintenance and updates.

[6] Proposed Primary Care Provider definition and metadata are not provided, as this data element was only found in one of 34 State program enrollment applications. Further analysis will be done to determine the definition and metadata attributed to this data element by health plans.

Appendix C
Verification Interfaces

Definitions
As used in these Recommendations and Appendices, the following definitions are applicable:

- *Application:* a program, potentially containing a graphical user interface, allows a human to interact so as to provide input or output.
- *Consumer*: human or machine or both.
- *Verification Interface*: the mechanism used to allow an information system to share information for the purposes of verification of a consumer's personal information (e.g. name, date of birth, address, income, etc.) with other information systems. A Web service is an example of an interface.
- *Web Service*: loosely coupled machine-to-machine interactions over a network consisting of sets of (HTTP) request and response messages along with a definition of the structure of the messages, expressed in a NIEM Compliant XML format.

Federal Reference Software
To achieve seamless integration with the Federal verification Web services, States must use the same standards (e.g., WSI based Web services and NIEM compliant XML messages).

We believe the Federal reference software recommended in Recommendation 2.2 should access Federal Web services to aid State programs in the creation and implementation of the verification Web services. This software must integrate Web services interfaces in a way that will minimize program implementation efforts. Given the variety of programming languages and business logic in use, we believe SDKs (Software Development Kits, including software and associated artifacts) should be accompanied by well documented, high-level sample source code and API messages. These SDKs and their sample implementations should be robust enough to allow for reuse by developers. Materials should be made readily available to the public, and collaborative improvement of the materials is strongly encouraged.

A critical first step in ensuring the data can be used in a consumer-mediated online system as called for in the recommendations is providing data for individuals rather than households. To support a consumer-mediated online application process, verification interfaces facilitated by the Federal reference software should be automated and real-time and, where practical and applicable, pre-populate the application when performing new enrollments, eligibility requests, renewals or changes across multiple programs.

Where real-time, automated verification information does not produce the required information, or information consistent with the consumer's current circumstance, States should implement processes to provide for the digital submission (e.g., ability to fax, scan or e-mail) of verification documentation that can be submitted and reused for initial and subsequent eligibility determinations.

Other Best Practices

In addition to verification data from Federal and State systems, new and existing State eligibility and enrollment systems should facilitate automated queries across programs to determine if an consumer is known to other eligibility and/or enrollment systems (e.g., because the consumer is currently or has been previously enrolled) prior to completing the application process. If a consumer is known to another eligibility and/or enrollment system, the system should allow for the retrieval of relevant eligibility data.

Further, streamlined eligibility and enrollment in an interoperable system requires the seamless transmission and receipt of data between programs. Rather than force legacy system changes to accommodate different verification sources and formats (e.g., HL7, XML), States may include Web services or translation tools that reliably and consistently translate or transform data from various sources and formats in their implementation plans.

To allow consumers to direct and manage use and reuse of their information, Federal and State data suppliers (e.g., SSA, IRS, DHS and other Federal and State entities) should examine data use, retention and reuse policies to allow for the reuse of a consumer's eligibility and enrollment information, where practicable. Areas to examine include the appropriate uses of personal information, including the sharing of data across health and human services programs to facilitate additional enrollments, renewals, and transitions between programs. Where allowed and practicable, States should provide for "express lane" determinations across programs (i.e., an eligibility finding for one program is a *de facto* finding for a second program with no additional eligibility verification necessary).

Appendix D
Business Rules

As used in these Recommendations and Appendices, a business rule is anything that captures and implements business, policies and practices and can be used to: 1) enforce policy (e.g., program hierarchy, exception handling), 2) make a decision (e.g., eligibility determination, point in time verification), and/or 3) infer new data from existing data (e.g., persons with the same address live in the same household).[1]

Given this definition, business rules should:

- Adopt a *consumer-mediated approach* by supporting efficient and timely eligibility determination, renewal and enrollment for the programs and in the context preferred by the consumer;
- Support *consistent, technology-neutral expression* of rules along a *continuum of implementation* modalities (e.g., enhancing legacy systems to developing new systems)*;*
- Support the *augmentation* of current State systems;
- Support interfaces between State eligibility systems and other systems that may support consumer enrollment, such as those used by community-based organizations, providers, and portals;
- *Accelerate* States' ability to comply with Affordable Care Act requirements;
- *Support integration* across systems and across programs to support a seamless user experience by addressing program hierarchy and providing capacity for addition of other programs;
- Guide the adoption and utilization of federated *core data*;
- Where necessary and possible, "buffer" the impact of imperfect information and data whether from verification sources (e.g., automated and point-in-time) or others; and,
- Minimize *maintenance* and allow for *scalability*.

Consistent, Technology-Neutral Expression of Business Rules
Recommendation 3.1 applies to business rules used in multiple eligibility and enrollment contexts including:

- Screening a consumer for potential entitlements or benefits (e.g., determining which programs a consumer is eligible for, which are most likely to suit articulated needs, and why); and,
- Making an eligibility finding for a particular program (e.g., finding that a consumer is ineligible for SNAP benefits because the calculated income exceeds the threshold required for eligibility).

A key component of Recommendation 3.1 is that Federal agencies and States express their business rules in a consistent, technology-neutral standard. The clear and unambiguous

[1] Definition taken in part from IBM: http://publib.boulder.ibm.com

expression of business rules, as well as the output of these business rules – the eligibility finding and justification – has enormous value for both developers and consumers. Clear and consistent expression will ease development of technology solutions and facilitate seamless interoperability between programs, as developers will be able to identify and understand the rules that should be coded into new and existing systems. In addition, compliance with Recommendation 3.1 would provide maximum transparency to the consumer by providing a foundation for clear, understandable eligibility determinations.

Recommendation 3.1 also recommends that Federal agencies and States express their rules outside transactional systems. The primary reason for this is to develop a consistent, reusable set of business logic that can be written once and applied broadly. In contrast, business rules which exist only as computer code are harder to understand, enforce, extract and modify. This recommendation provides optimal flexibility during the implementation phase, as Federal agencies and States will be able to choose amongst a number of implementation options for new and existing systems including:

- Hand coding business rules into existing legacy systems;
- Parameterized and consumed by new or existing systems; or
- Creating a comprehensive eligibility determination engine to apply new business rules.

Business Rules Repository

A business rules repository maintained by the Federal government, but including both Federal and State rules, is key to enhancing and encouraging collaboration around the clear expression of business rules. Documenting and displaying eligibility, entitlement and enrollment business rules in a standards-based format will be helpful for developers, while documenting and displaying the same rules in a human readable format will allow for greater transparency to the consumer and will aid consumer advocacy groups in explaining and assisting consumers with the eligibility and enrollment process.

To ensure maximum utility of this resource, we believe three representations of each Federal and State business rule should be included in this repository:

- *Business representation*: A consistent business representation of the rule (e.g., SBVR) such that an eligibility determination can be consistently interpreted and understood by business analysts;
- *Technical representation*: A consistent technical representation of the rule (e.g., RIF) such that common, Federal rules can be maintained and centrally reused; and
- *Consumer-friendly representation*: A consistent consumer-friendly representation of the rule such that consumers with varying literacy skills and language competency can clearly understand the basis for an eligibility determination using the rule.

Additionally, the open source forum referenced in Recommendation 3.2 is intended to be a resource for developers to use to exchange best practices, code and other information to ease development of Federal and State technology solutions implementing business rules. The open source forum is also intended to be a resource for States and others to store their own business rules (to support their own system development and generate consumer-friendly guidance), as well as a resource for States to share their business rules to reduce cost, complexity and time of

development. Ideally, Federal agencies and States should adopt a similar approach for other health and human service programs (e.g., SNAP and TANF) over time.

Federal agencies and States should also consider business rules when contemplating implementation and execution of the Workgroup's other recommendations. Federal agencies developing the Federal reference software in Recommendation 2.2, for example, should seek opportunities to use the business rules repository as a way of creating code that could be reused by States.

Appendix E
Transmission of Enrollment Information

Since 2003, standard HIPAA transactions have been used to enroll consumers into public and private health coverage programs. The core of these recommendations is that it is most practical to leverage existing, widely-used HIPAA transaction standards (e.g., HIPAA 834, 270, 271) to send and respond to eligibility queries, as well as transmit enrollment data between public and private insurance programs. Recommendations 4.1 and 4.2 are intended to support uniform and efficient transmission of enrollment information across a range of health coverage plans, human service programs and service providers.

The intended use of the HIPAA standards recommended in Recommendation 4.1 is described below:

- *Eligibility:* The HIPAA 270/271 transaction set should be used to determine if a consumer has coverage with a particular public or private health insurance program. The HIPAA 270 standard is used to send an eligibility inquiry and the 271 standard is commonly used to respond to that inquiry.

- *Enrollment and Dis-enrollment:* HIPAA 834 transactions should be used to transmit enrollment information necessary to enroll consumers into public and private health coverage options.

As required by Section 1104 of the Affordable Care Act, the National Committee on Vital and Health Statistics (NCVHS) will be recommending that the Secretary designate an entity to draft standard operating rules for eligibility and claims systems. Entities administering health coverage programs should consult these operating rules for additional information.

Appendix F
Privacy and Security

Fair Information Practices

Consistent with laws and regulations requiring States to incorporate Fair Information Practices into new and existing electronic systems, States should implement the following best practices to address FIPs in new and existing State eligibility and enrollment systems:

- *Collection and Use Limitation:* State systems should be designed to collect and use the minimum data necessary for an eligibility and enrollment determination. This should be balanced with the desire to reuse information for multiple eligibility decisions.
- *Data Integrity & Quality:* States should establish a minimum threshold level for data matches, adopting a glidepath toward achieving advanced probabilistic matching.
- *Openness & Transparency:* Clear, transparent policies about authorizing access and use of data should be provided to the consumer in the Privacy Notice.

Consumer Mediated Approach

We believe that the following best practices should be used to facilitate a consumer-mediated approach to data sharing:

- Provide consumer information to the consumer in a human-readable form that allows them to view, print, or save data in a format they can use and reuse;
- Enable data to be exported into commonly-used software formats such as spreadsheets, text files, etc.;
- Develop separate pathways for download requests from the consumer and download requests via automated processes acting on the consumer's behalf; and,
- Limit data use to that specified in the Privacy Notice unless the consumer consents to additional uses.

OAuth is an example of a consumer mediated authorization mechanism between third parties and their data origins. OAuth is a delegated authorization platform that allows a consumer to selectively grant, limit or revoke specific privileges to third parties without revealing their private credentials to those third parties or developers.

Consistent with the Privacy Act, the Privacy Notice provided to the consumer during the application process will govern the consumer's rights to confidentiality and privacy. The Privacy Notice should be provided to the consumer prior to or at the time of collection of personally identified information in a method the consumer can understand. The Privacy Notice should also clearly indicate all entities that will be permitted to use a consumer's eligibility data, as well as the permissible uses of such data.