Hello,

The first Oregon Health Insurance Exchange Board meeting will be held on September 30, 2011 from 8:00am - noon at The Market Square Building, 1515 SW 5th Avenue, 9th Floor, Portland, OR 97201.

Please check our website http://www.oregon.gov/OHA/health-insurance-exchange.shtml next week for a webstream link, agenda and other business materials.

If you have any questions about the meeting, please contact Katie Mikesell at 503-269-0269.

Applicant: The Oregon Health Authority (OHA) was created by the 2009 Oregon legislature to bring most health-related programs in the state into a single agency to maximize its purchasing power. It works to lower and contain costs, improve quality and increase access to health care in order to improve the lifelong health of Oregonians. OHA touches over 850,000 Oregonians' lives, through the Public Employees Benefits Board, Oregon Educators Benefits Board, Medicaid, Healthy Kids (CHIP), Family Health Insurance Assistance Program (premium assistance program) and both the Oregon and Federal Medical Insurance Pools (high risk pools). Once the newly authorized Oregon Health Insurance Exchange Corporation is formally established, the grant will transfer from OHA to the Exchange. The Exchange will be a public corporation governed by an Executive Director and nine-member Board of Directors.

Populations Served: While the state has made great strides in offering coverage under the Oregon Health Plan and the Healthy Kids program, an Exchange will further improve all Oregonians' access to quality and affordable health care. The Exchange will provide access to the estimated 560,000 Medicaid eligibles, 360,000 individuals in the commercial market, and 98,000 small business employees (1-100 employees).

Projects, Deliverables: Grant funding will support the final design and initial implementation of the Exchange's business and operations plan. Oregon will do the following to implement Exchange authorizing legislation by: hire an Executive Director and key staff; build a financial management plan and structures; finalize fraud, waste, and abuse plan; appoint a Board of Directors to provide oversight and management; finalize interagency agreements with relevant agencies; develop transition plans for state programs/their enrollees; consult with stakeholders; determine whether additional risk mediation activities are required; finalize protocols and payment rules for producers and Navigators; develop marketing and communications strategies, begin evaluation activities; and create a detailed business plan in preparation for the February 2012 Legislative Session. Once the business plan is approved, implementation activities will occur through and beyond the end of the grant period.

The Health Insurance Exchange builds on Oregon's past and current health reform efforts. Oregon has been developing an Exchange for several years and is an Early Innovator IT grantee. This grant will support the state's continued progress toward Exchange implementation.

I. INTRODUCTION

Oregon is well situated to implement a health benefits exchange. The state has spent the past half-decade planning and implementing health reform initiatives aimed at improving the access, quality and affordability of health care for all Oregonians. This work has included recommendations for health insurance market reforms--including the development of a health insurance exchange--and other proposals consistent with the requirements of the Patient Protection and Affordable Care Act of 2010.

As part of this comprehensive plan to transform health care in Oregon, legislation was enacted in 2009 to create the Oregon Health Authority (OHA) and its nine-member citizen policy-making and oversight body, the Oregon Health Policy Board. The legislation tasked the OHA and the Oregon Department of Consumer and Business Services with developing a plan for a health insurance exchange. This legislation and the subsequent exchange-related work of the OHA and Policy Board set the stage for Oregon's successful application for an Exchange Planning Grant.

In the summer of 2010, Oregon conducted key background research related to the establishment of a state Exchange. Specifically, the state estimated the number of individual and small employer group Exchange enrollees and the value of tax credits that will come into the state pursuant to the ACA. In September 2010 the state held a series of public forums and conducted a statewide consumer survey to solicit input from Oregonians. This research and outreach helped form the basis of Senate Bill 99 (SB 99)[1], the Exchange authorizing legislation introduced in January 2011. Also in 2011, the state has been working with national experts on the development of a detailed operational plan and implementation timeline.

Most recently, SB 99 was passed by the Legislature and signed by the Governor. Oregon's legislation is one of the first in the nation to pass with strong bipartisan support in both chambers; 24 of 30 Senators and 48 of 60 Representatives voted in favor of the bill.[2] The legislation establishes an independent public corporation to operate the Oregon Health Insurance Exchange, a single statewide exchange that serves both individuals and small businesses. The Exchange will be run by a nine-member Board of Directors to be appointed by the Governor and confirmed by the Senate. Oregon's goal is to create an Exchange that is compliant with the ACA and furthers the state's health reform goals of improved access, quality and affordability.

Current Health Reform Efforts in Oregon

Over the past several months, Oregon has advanced its health reform efforts. Earlier this year the state convened a Health System Transformation Team, a group of 45 people from all areas of health and health care who, along with a bi-partisan group of lawmakers, was charged with developing a plan to improve the health delivery system for Oregon Health Plan and Medicaid clients. The plan focuses on coordinated mental, physical, behavioral, and oral health to free up dollars trapped in an inefficient system, increase focus on prevention, and improve care. The plan (HB 3650) then went to the legislature for consideration, where it was passed in June.

With the passage of HB 3650, the state is working to change the health care delivery system, beginning with people eligible for Medicare and Medicaid. The bill allows for the creation of

[1] http://www.leg.state.or.us/11reg/measpdf/sb0001.dir/sb0099.en.pdf

[2] Oregon's House of Representatives is evenly split 30-30 between Republicans and Democrats. The Oregon Senate has a two vote Democratic majority.

Coordinated Care Organizations (CCOs) that will be accountable for achieving better health outcomes and cost savings, primarily through vastly improved coordination of care among the various levels of service available to keep a patient healthy. Cost savings from using CCOs will offset daunting social services budget cuts that would otherwise occur in Oregon.

How Oregon's Proposal Supports the State's Grant Goals and Objectives

The overall goals for Oregon's Exchange development and implementation work are:

- Establish an ACA compliant Exchange; and
- Establish an Exchange that supports the state's overall health reform goals.

Oregon's objective for the Level 1 Exchange Establishment Grant is to conclude its operational planning and begin implementing a statewide Exchange. Oregon's funding proposal supports the project goals and objective by allowing Oregon to hire staff and design and build policy and systems infrastructure. It will also support consultant costs for technical assistance on business operations, as well as contracts for other services. Among other activities, the Establishment Grant will support continued outreach and education through statewide public forums, consumer and other stakeholder advisory committee meetings, and Board meetings.

The $8.96 million requested will provide the resources Oregon needs to meet the federally required milestones and timeframes delineated in the Establishment Grant announcement, and are reflected in the attached work plan. In developing the staff plan for the Level 1 grant, Oregon will engage subject matter experts as early as possible so that these staff can work closely with the IT team on the development of the Exchange IT solution.

An interim Executive Director will be hired in July 2011. The Governor is seeking nominations for the Board of Directors, with appointments to be made by the end of the summer. Senate confirmations will be held in September and the Board will start meeting by October.

By the end of the grant period (August 2012) Oregon will have accomplished the following:

- Establishment of the Exchange Board of Directors and management team;
- Adoption of articles of Exchange governance artifacts, such as by-laws or other documents;
- Executed agreements with DCBS Insurance Division relating to risk mitigation and other services, the OHA Division of Medical Assistance Programs (state Medicaid Agency) relating to roles and responsibilities regarding eligibility determination, plan enrollment and strategies for implementing a "no wrong door" policy;
- Establishment of policies and systems for human resources management, and Exchange financial management processes;
- Significant progress toward completion of the business operating functions of the Exchange, including but not limited to working toward certification of qualified health plans and establishment of the Exchange website and premium calculator and eligibility and enrollment systems;
- Submission of a successful Level 2 Establishment Grant; and
- Finalization of a full evaluation plan and collection of initial data.

Oregon has to date enjoyed a productive working relationship with its federal partners on the development of its Exchange. The state looks forward to continuing to work closely with CCIIO to build an Exchange that is ACA-compliant and meets the requirements for continued funding.

A Note on Organization: The narrative is organized by the Core Areas from the grant announcement. Each section focuses on a Core Area, with information on Oregon's past progress and planned activities presented for that Core Area.

The Board of Directors to be appointed in the coming months will approve or amend the staffing plan and other proposals included in this application. Recognizing that some details may change, the work of the Exchange will occur no matter how the organizational chart is arranged. Recognizing that the Board will explore and refine operational and program plans, this proposal highlights the work that will be conducted in each core area during the grant year. Oregon will work with its CCIIO Project Officer and other CMS staff to gain approval of and input on any changes recommended by the Board.

II. CORE AREAS: Past Progress and Proposal to Meet Program Requirements

BACKGROUND RESEARCH

Past Progress

Oregon has analyzed estimates of the number of Medicaid enrollees and individual and small group commercial participants in the Exchange, as well as the number and demographics of Oregonians who will likely remain uninsured.[3] In addition, Oregon conducted high level estimates of the operational costs associated with administering an exchange and assessed the operational cost impacts of running an exchange under a "dual" market[4] (in which individuals and small groups can purchase through the Exchange or in the outside market) and in a "sole" market[5] (in which all individual and small group consumers get insurance through the Exchange). Legislation authorizing the Exchange assumes a dual market.

The Oregon Department of Consumer and Business Services (DCBS) published its fifth annual *Health Insurance in Oregon* report in January 2011.[6] This report provides an overview of how commercial health insurance is regulated in Oregon and the financial performance of the state's insurers. Insurers are compared by market segment and information is provided on how many Oregonians are enrolled in commercial/state regulated insurance and federal health insurance programs, and how many are uninsured.

Oregon signed a contract with Wakely Consulting Group in January 2011. The following contract deliverables will be finalized in the third and fourth quarters of the Planning Grant: a Resources and Needs Assessment, Finance Recommendations (five year administrative budget

[3] http://www.oregon.gov/OHA/OHPB/meetings/2010/100810-est-cov-exp-fed.pdf
Dr. Jonathan Gruber of the Massachusetts Institute of Technology produced the enrollment estimates Oregon used for its analysis. Dr. Gruber estimated individual enrollment in the Exchange and his work provided a starting point for determining employer enrollment. Based on Dr. Gruber's modelling, the Institute for Health Policy Solutions projected likely enrollment by employees of small employer groups.
[4] http://www.oregon.gov/OHA/OHPB/meetings/2010/101214-hiex-sm.pdf
[5] http://www.oregon.gov/OHA/OHPB/meetings/2010/101116-exchange.pdf
[6] http://insurance.orgon.gov/health_report/3458-health_report-2011.pdf

projects and sustainability plan), and a detailed Business and Operations Plan.[7] The business plan recommendations from Wakely Consulting will help the Exchange craft a business plan for Board approval in the fall. The Board-approved business plan will be submitted for approval by the 2012 Legislature. Wakely Consulting Group is also assisting with the development of short- and long-term Exchange staffing projections.

Oregon also has a contract with the Institute for Health Policy Solutions (IHPS) to provide assistance in Exchange development, including on the small employer (SHOP) portion of the exchange and streamlining and coordinating program eligibility and enrollment functions across programs. Previously, IHPS provided support to the Oregon Exchange team through a contract with the Office for Oregon Health Policy and Research. This contract was focused on providing assistance to the state in its development of health reform, including exchange development.

Proposal to Meet Program Requirements

The establishment of a state Exchange is part of Oregon's larger effort to change the way health care is provided and paid for in the state. As part of its reform efforts, Oregon is currently developing the concept of Coordinated Care Organizations (CCO): community-based non-profit organizations that will provide and coordinate physical health care, behavioral health care and dental care in a way that reduces duplicated treatments and ensures that consumers have access to the resources needed to remain healthy and manage their medical conditions. Exchange staff participates on the group developing the CCO model and will continue to be engaged in this work. This will allow the Exchange to determine how CCOs can be accessed through the Exchange and to work with OHA to develop waiver requests or conduct other activities aimed at integrating the state's health reform activities with Exchange implementation and operations.

During the grant year, research and analytical staff will analyze various policy issues significant to the successful establishment and operation of the Exchange. Senior Policy Analysts supported by the grant will: (1) evaluate existing state mandates on health insurance carriers and federally required essential benefits; (2) investigate potential waivers of the ACA that Oregon may pursue to support an effective Exchange; (3) work with OHA staff on the development of CCOs; and (4) provide ongoing analytical and research support to the Exchange Board of Directors. Please see the staffing plan described in the budget narrative and organizational chart for more information.

DCBS will continue to publish its annual report, which provides valuable information on Oregon's insurance markets. Information from this report, with estimates of likely Exchange enrollment, will allow Oregon to consider: how to evaluate carrier network coverage and plan performance; the development of potential quality measures; and how to evaluate consumer experience with Oregon carriers. The Exchange will work with DCBS on risk adjustment mechanisms. Areas of responsibility will be outlined in the Interagency Agreement currently being developed. During the grant period Oregon will also investigate the need for waivers of specific Affordable Care Act provisions that could allow the state increased flexibility, such as enrolling groups of over 100 before 2017, or allowing CCO enrollment through the Exchange.

Oregon will also contract for evaluation activities. Collection of baseline data and process measures will begin during the grant year. Please refer to pages 29-35 for more detailed

[7] Copies of the final Wakely reports will be included as appendices in future Planning Grant Quarterly Reports.

information on the Exchange's Evaluation Plan and corresponding research related to the Core Areas.

STAKEHOLDER CONSULTATION

Past Progress

Community Meetings. In September 2010, OHA held six statewide community meetings to gather public input on creation of an Exchange. 850 people participated from across the state. The meetings, at which 850 people participated statewide, led to the creation of an emergent themes document that informed the Exchange work of the Oregon Health Policy Board and ultimately helped guide the development of Exchange legislation. Also in fall 2010, the OHA utilized a web-based public input survey get feedback from Oregonians about their vision for health care reform in the state and to obtain input on the Policy Board's vision and general direction, including the establishment of a Health Insurance Exchange. One thousand nine hundred fifty (1,950) people completed surveys during the public comment period.

Consumer Advisory Work Group. During the planning grant year, stakeholders have had the opportunity to give feedback on the direction and structure of the Exchange at quarterly Consumer Advisory Work Group meetings. These meetings will continue through summer 2011. In addition, OHA staff has participated in a variety of meetings with consumers, advocates and other stakeholders. The meetings have ranged from the general (a group of health care "allies" discussing various elements of the exchange) to specific (the Exchange Development Director participated in a panel exploring how minorities in Oregon will help shape the Exchange).

State Agency Coordination and Input. The Exchange holds monthly Steering Committee meetings. Steering Committee members represent the Oregon Health Authority (Division of Medical Assistance Programs; Office of Information Services; Office of Client and Community Services; Office of Healthy Kids; Office for Oregon Health Policy and Research; Office of Private Health Partnerships), the Department of Human Services (Division of Children, Adults and Families; Division of Seniors and People with Disabilities) and the Department of Consumer and Business Services, Insurance Division. The Steering Committee provides oversight of Exchange activities, gives input to the content of the quarterly reports and grant applications, and reviews draft consultant reports/data. Oregon envisions that once the Board is formally appointed, the Steering Committee will become an interagency technical assistance work group.

Tribal Feedback Process. Senate Bill 770 (2001)[8] established a requirement that state agencies develop a working relationship with Oregon Tribes. The Department of Human Services-Oregon Health Authority (DHS-OHA) has a dedicated Tribal Relations Liaison. SB 770 stipulates state agencies develop a process for including Tribes in state planning processes. The DHS-OHA Tribal Relations Liaison meets with the Tribes quarterly to assess needs, changes in planning, new opportunities and funding related to: alcohol and drug abuse prevention and treatment; child welfare; elder care; health care; mental health; public health; and additional human service issues as determined by the Tribes. The Exchange's Development Director initially met with the Tribes in May 2011, and will continue to attend meetings on an ongoing basis.

[8] www.leg.state.or.us/01reg/pdf/ESB770.pdf

Proposal to Meet Requirements

Consumer Advisory Committee. The Exchange authorizing legislation (SB 99) requires ongoing stakeholder involvement for the Exchange. This fall the Exchange Board will establish an Individual and Employer Consumer Advisory Committee, which will provide input from a variety of stakeholders regarding the ongoing operation of the Exchange and any related issues. The Exchange Board will determine the membership, with members representing: individuals and employers that purchase health plans through the exchange; individuals who enroll in state medical assistance through the exchange; and organizations that help individuals to enroll in health plans through the exchange, including insurance producers and advocates for hard-to-reach populations. Membership will include racial and ethnic minorities and be representative of the state's geographic diversity.

Additional Stakeholder Groups. Additional work groups that the Exchange may establish once the Board is formally appointed include a group providing input on the development of the Navigator program, a group providing input into standards for qualified health plans and a group providing input for the role of brokers in the Exchange. The Exchange plans on conducting four to five community forums in late fall to gather public input into the development of the Business Operations Plan. Input will also be solicited via the Exchange web page. Oregon also plans on developing an e-newsletter for distribution to key stakeholders. Each newsletter will contain a key question about which the Exchange would like public feedback, ensuring the greatest degree of transparency possible with stakeholders.

Consumers on Board of Directors. SB 99 requires that at least two Board members be consumers, one an individual consumer purchasing a qualified health plan through the Exchange; the other a small employer purchasing a qualified health plan through the Exchange. Until health plans are available through the Exchange, consumer members will be drawn from individuals and small employers who will be eligible to purchase health plans through the Exchange.

Oregon anticipates that the advisory committee and ad hoc workgroups will each meet quarterly during the grant year. In addition, the Exchange plans to conduct four public forums across the state to inform the public of the Exchange, its mission, services and coverage options. Oregon will also continue to consult with Native American Indian tribes regarding Exchange operations. Staff will participate in quarterly meetings with Tribal representatives.

Level 1 Grant funds will support the staffing of the Exchange Board, its committees and other stakeholder engagement efforts, as well as associated travel and meetings expenses. Communications staff will coordinate community forums and develop the e-newsletter.

LEGISLATION AND REGULATORY ACTIONS

Past Progress

In December 2010 OHPB released its legislative report outlining recommendations for the development of Oregon's Exchange and recommending next steps. In February 2011, Exchange authorizing legislation (Senate Bill 99) was introduced. As of June 6, 2011, Senate Bill 99 has been passed by the Legislature with strong bipartisan support and is awaiting the Governor's signature. The Governor signed the bill into law during June 2011.

Proposal to Meet Program Requirements

With the passage of SB 99, Oregon has effectively met the program requirements for this core area. However, SB 99 requires legislative review and approval of the Exchange Business Operations Plan in February 2012 (the next legislative session). The Exchange is well positioned to provide within that timeframe a detailed business plan to the Legislature. The preliminary business plan is on track to be completed and ready for Board review well in advance of the February legislative session. As discussed above, the Board will hold a series of public forums across the state to educate the public about the Exchange and solicit input on the draft business plan. The feedback received during the public forums will be presented to the Board for consideration, and refinements to the draft plan will be made as needed. Prior to, and during the February 2012 session, the Board and Exchange staff will work closely with legislators.

Once Exchange legislation passes, the Exchange may need to draft and adopt Administrative Rules to implement federal requirements for Exchange operations. Areas where there may be a need for development of Administrative Rules include, but are not limited to:

- the process for certifying, decertifying and recertifying Qualified Health Plans;
- clarification regarding the open enrollment process; and
- A process for consumer complaints and appeals adjudication.

During the grant year, staff will identify areas requiring the adoption of administrative rules and develop such rules for Board consideration and approval. There will also be an ongoing need to track and analyze federal guidance related to the implementation of the ACA and Exchanges.

GOVERNANCE

Past Progress

SB 99 ensures accountability and transparency of the Oregon Exchange by establishing a nine-member Board of Directors appointed by the Governor and confirmed by the Senate and guaranteeing strong public participation. The law requires the Board to be comprised of two voting ex-officio members (the directors of the Oregon Health Authority and the Department of Consumer and Business Services), up to two members who are representatives of the health and insurance industries, and at least two Exchange enrollees in small group and individual plans.

Meetings of the Board are required to be open to the public. Members must submit formal notification of conflicts of interest and may be removed by the Governor for malfeasance or corrupt behavior. To minimize the potential for conflicts of interest, insurance agent/producer and provider industry representation is limited to a maximum of two seats on the Board.

Proposal to Meet Program Requirements

With the statutory framework in place for Exchange governance, Oregon's focus now shifts to the establishment of the governing body. As outlined in the work plan, the major activities under the grant will be: appoint a Board of Directors; hire an executive director and other key positions to staff the Board of Directors; and develop necessary articles of incorporation and bylaws consistent with state and federal requirements. These activities are described in detail below.

Appoint a Board of Directors. Oregon anticipates having a fully operational nine member Board by September-October 2011. Upon the conclusion of the 2011 Legislative Session (no later than June 30, 2011), work will begin to develop an announcement to fill the positions. The legislation establishing the Exchange stipulates that the President of the Senate, the Senate Minority Leader, the Speaker of the House of Representatives and the House Minority Leader will select one member from their respective chambers to provide oversight of the corporation during its implementation. Specifically, this legislative body may recommend individuals for nomination to the Board, as well as review the formal business plan.

We anticipate that staffing the Exchange Board will require significant staff time and resources, particularly over the first six to twelve months it is in existence. There will be a need for intense work with the Board members to get them rapidly up to speed on the Affordable Care Act and the activities in support of Exchange development and operations. A significant number of the Exchange staff will be directly engaged in working with the Board and supporting the board's ability to approve and implement its business plan.

Hire an Executive Director. Exchange authorizing legislation allows the Governor to appoint an interim executive director of the Exchange, who may serve up to 120 days. During this time, a national search will ensue to find a permanent executive director. On June 24, the Governor appointed Howard "Rocky" King as interim executive director.[9] Prior to his appointment, Mr. King was the interim Director of Health Care Purchasing for OHA. He has also served as the Senior Policy Advisor for Health Reform for the Director of the Department of Consumer and Business Services, the administrator of the Senior Health Insurance Benefit Assistance program and the Oregon Medical Insurance Pool and the Family Health Insurance Assistance Program.

By-Laws and Related Documentation. An ad hoc committee will be assembled to work on the proposed bylaws, during which time chief legal and policy staff for the Exchange will be hired. The Exchange Board may amend the proposed bylaws, and give final approval in October 2011. The Exchange exists as a corporation upon passage of SB 99; legal staff has determined that no Articles of Incorporation are needed at this time. However the Board and Executive Director will formally register with the Secretary of State as an organization established by "act of State".

During the first six months of the grant period, funds will be used to operationalize an Exchange governance structure.

Legislative Oversight. Senate Bill 99 included several ways of ensuring Legislative oversight and transparency of Exchange implementation. A committee of four legislators will:

- Recommend individuals for nomination to the board;
- Review the development of the Exchange's formal business plan; and
- Advise the corporation and the OHA on any Exchange implementation issues.

During the development of the Exchange IT solution, the Legislative Fiscal Office will be regularly updated on the implementation of an information technology system for the Exchange. In addition, before the 2012 legislative session, the Exchange will twice report to legislative committees on its business plan development. By February 2012, the Exchange will submit its formal business plan to the Legislature for approval.

[9] The press release is available at:
http://us2.campaign-archive1.com/?u=41b11f32beefba0380ee8ecb5&id=4c133e0c8c&e=8dde76ac8f

PROGRAM INTEGRATION

Past Progress

Leadership of the OHA Division of Medical Assistance Programs (DMAP), the state Medicaid agency, and DHS Division of Children, Adults and Families (CAF), Office of Self Sufficiency Programs, and DCBS Insurance Division serve on the Exchange Steering Committee. Leadership from these divisions also attends regular meetings with the OHA Director of Health Care Purchasing to discuss key cross over issues related to the Exchange.

Exchange staff serves on a multi-disciplinary work group that meets regularly to work through eligibility and enrollment issues in preparation for 2014. Exchange staff members are also intimately involved in the cross-department team that recently selected an IT vendor, and are currently advising on the development of the IT infrastructure of the Exchange.

In preparation for executing the required Interagency Agreements, conversations are underway between Exchange staff and leadership of both DMAP and the Insurance Division to clarify roles and responsibilities with regard to the operation of the Exchange.

Current Eligibility Determination Process

To provide context for the work in which Oregon is engaged to modernize and automate eligibility determination for the Exchange and Medicaid, the following describes the current human services eligibility process.

DMAP currently contracts with CAF Office of Self-Sufficiency Programs to make Medicaid and Children's Health Insurance Program (CHIP) eligibility determinations for non-disabled, non-senior applicants. The vast majority of Medicaid/CHIP non-senior, non-disabled Medicaid applications are submitted on paper, and are either delivered in person to CAF self-sufficiency field offices or mailed to those offices. CAF self-sufficiency offices are responsible for enrollment of clients in a broad range of programs (Medicaid, CHIP, Supplemental Nutrition Assistance Program [SNAP], Temporary Assistance for Needy Families [TANF], etc.). While some offices are specialized, most eligibility workers are responsible for determining eligibility for all programs. An important exception is the Oregon Health Plan (OHP) Statewide Processing Center, which processes medical program applications only.

DMAP also administers application assisters programs: the Application Assistance Program, Outreach and Enrollment Grant Program and Volunteer Organization, and the Children's Health Insurance Program Reauthorization Act (CHIPRA) Application Assister. These providers work with families to assist them in starting the application process for their children. Application assisters help families navigate the eligibility process by connecting the families and the eligibility workers for the initial application contact. Providers stamp the completed paper application with their date stamp and provider number.

The State has "medical only" applications and joint program applications which are used for self-sufficiency program eligibility decisions. Clients are asked to submit documentation of income (in the case of job income, they are asked to submit a recent pay stub), private major medical insurance card, alien status documentation and other eligibility related paperwork. At redetermination clients are mailed paper forms. They are asked to identify any changes in their circumstances and, if necessary, provide new income documents for verification.

Eligibility workers physically type the data from Medicaid and CHIP applications into the state's eligibility computer system. The eligibility worker reviews third-party documentation (such as Employment Department records of unemployment benefits and wage records), state child support records (to verify the existence and amount of child support), and federal Social Security Administration (SSA) records to verify citizenship and SSA-related income such as Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI) and survivor's benefits. Workers may also call employers to verify employment and income information. Eligibility workers are only supposed to request additional documentation from applicants if scans of such databases cannot verify the necessary information.

Recently, the State adopted a new policy regarding verification of a client's income statements: the worker first reviews the client's stated income amount and compares the amount against all available information, including previously stated income amounts, previously verified income amounts and sources of available third-party information. If the client does not provide a copy of income payment document and the stated income amount is reasonable, the worker considers the income amount verified. The exception is self-employed clients, who are required to provide documentation of at least one income amount/expense. For both self-employed and non-self-employed clients, if the client is unable to provide any documentation, the worker will accept the client's statement if it is deemed reasonable. Workers then rely on state rules and publications, as well as their training, to determine whether an applicant household is eligible for Medicaid or CHIP. Workers use the definitions of households and income for Medicaid purposes given by federal law and, in cases where federal law is flexible, state law and policy. After the determination has been made, the applicant will be mailed an approval notice the day after the approval is entered onto the eligibility system.

Oregon currently has two versions of online applications. One is a medical only "fillable pdf" with electronic signature that is submitted via the web to an imaging system. The other is a multiple program on-line application that is submitted to a central server, assigned to the appropriate branch and available to eligibility workers on-line. For both, the applicant's information is not directly downloaded into the state's eligibility system and databases, but has to be keyed in by a eligibility worker. Once eligibility has been entered by the worker, the eligibility information is automatically updated real time and batched to the state's electronic Medicaid Management Information System (MMIS). Managed care enrollment may be entered by the eligibility worker, but the functionality is limited. Many times the eligibility worker has to request DMAP staff maintain managed care enrollment, exemptions and exceptions.

Proposal to Meet Program Requirements

OHA and DHS recognize that current processes need to change significantly to support proposed Exchange operational requirements and comply with the ACA provisions governing Medicaid eligibility. OHA and DHS know States must, to the extent practicable, establish eligibility using data matching arrangements.[10] Applicants must be able to apply online or by phone. Definitions of households and income will change for Modified Adjusted Gross Income populations.

By 2014 it is anticipated that Oregon will have developed a new, integrated eligibility system that will be able to determine eligibility for exchange tax credits as well as for Medicaid and

[10] Section 1413(c)(c)(3) of the Affordable Care Act of 2010.

other state programs. Oregon envisions that this system will determine eligibility in real-time for most applicants. OHA and DHS are finalizing the procurement of an automated eligibility system. OHA and DHS leadership are in the process of determining the extent to which Medicaid eligibility can be a purely online, real-time process, and the circumstances under which delays can be expected and/or applicants will still need to engage with eligibility workers, who will need to be trained in the new MAGI rules and will also need to know that for some categories, MAGI will not apply. Under a "no wrong door" policy, it may make sense for one agency to do eligibility determination for all subsidized medical programs in order to minimize the chance of applicants slipping through the cracks or getting bounced from one eligibility determination unit to another. These discussions will continue throughout the Level 1 grant period and key decision points for the Exchange Board will be identified.

Oregon has contacted officials in other States that have implemented online automated eligibility systems to learn from their experience, and is seeking federal guidance on issues relating to the simplification and 'automatability' of the eligibility process.

DHS managers from other human services programs are involved in planning discussions. OHA, DHS and the Exchange are committed to working together to establish an eligibility system that is as simple, streamlined and aligned as possible for all programs. The SNAP program director has identified barriers to determining SNAP eligibility in an online, real-time fashion; SNAP has also given OHA data showing that a large percentage of Medicaid new eligibles are likely to already be SNAP recipients. OHA Director Dr. Bruce Goldberg and DHS Director Erinn Kelley-Siel wrote to both US HHS Centers for Medicare and Medicaid Services (CMS) and US Department of Agriculture Food and Nutrition Services (FNS) to highlight opportunities for alignment and simplification. Oregon has requested FNS to consider modifying its rules to allow automated, real-time SNAP eligibility determinations, and has asked CMS to consider automatic enrollment of SNAP clients below 138% of Federal Poverty Level (FPL) into Medicaid in 2014.

The DHS Division of Seniors and People with Disabilities (SPD) is working with OHA and Exchange personnel to determine how seniors and people with disabilities who access the Exchange /Medicaid portals will be informed of their rights and options. SPD, OHA and Exchange personnel working together to ensure that the portals have "off-ramps" for non-MAGI populations and that such off-ramp signs do not pose a dangerous distraction to MAGI drivers.

Oregon has accomplished this level of coordination by: joint SPD and Exchange meetings; having staff from all relevant offices involved in the selection of an automated eligibility and enrollment system; and through the ongoing coordination efforts of key staff.

In the Level 1 grant period Oregon will continue to plan and implement an integrated, automated eligibility system that meets the requirements of all programs, and to plan for workforce training to reflect post-2014 realities. More broadly, the Exchange team will continue to work with OHA and DHS leadership and other staff to implement a modern, automated eligibility and enrollment system that works for Medicaid eligibles and the tax credit population. Inter-agency efforts will be memorialized in Interagency Agreements prepared for Board approval in the fall of 2011.

In addition, IHPS is helping Oregon establish an Exchange that maximizes coordination between Medicaid, CHIP and commercial programs, including but not limited to exploring how Exchange eligible parents of Medicaid or CHIP eligible children will be able to coordinate health plans, provider networks or other relevant program elements to maximize access and health.

INFORMATION TECHNOLOGY

Past Progress

Oregon's DHS and OHA are working together to use information technology to substantially improve eligibility and enrollment for Medicaid and social services programs. This modernization strategy sets the stage for Oregon to create an innovative and comprehensive technology solution that will allow consumers to use a single web-based interface to determine their eligibility for tax credits within the Exchange or for Medicaid, learn about their coverage options and enroll in health coverage.

As described in Oregon's Innovator IT Grant application, the State is building a rules-based framework that supports automation of benefit eligibility determination, interfaces with existing benefit systems and creates insurance exchange functionality.

The decision to develop an integrated, modern IT infrastructure for Medicaid and the Exchange based on technology standards and a configurable commercial framework is consistent with the joint DHS and OHA enterprise technology plan.[11] Adopted in 2009, the plan enables the coordinated, consistent delivery of health and human services in Oregon, creating a roadmap to migrate from silos of custom-developed and proprietary commercial applications to a framework-based technology infrastructure that supports increased organizational flexibility and responsiveness to changing customer needs. Oregon believes that this migration is necessary to achieve the objectives and goals of health care reform.

Oregon has investigated multiple technology solutions for streamlining and modernizing the information technology environment to improve medical eligibility determinations and have determined that a configurable framework built using a service-oriented architectural approach best supports the goals and objectives set forth in the ACA and the programs administered by DHS and OHA.

In August 2010, a vendor fair was used to identify a selection of vendors with products meeting eligibility solution needs: intake through citizen portals, workflow automation through worker portals, and benefits determination through policy and rules automation. Vendors provided information about their solutions' readiness to support health reform.

In preparation for the IT Innovator grant application submitted in December 2010, Oregon prepared an IT needs assessment. This needs assessment has been updated and amended for this application, and is found starting on page 22 of the narrative.

In the first quarter of 2011, Oregon expanded its IT preparation by documenting the detailed eligibility, enrollment and other Exchange functional and technical requirements that are essential to obtaining a technical solution. A software vendor was selected in May 2011 and the state began its process to procure a System Integrator vendor to help customize the software to meet Oregon's needs.

The State has undergone two successful federal reviews. The first CMS gate review was conducted in March 2011. The Oregon HIX IT Project presented its Architecture Review plan, including an in-depth summary of the project progress to that point. The plan includes the IT

[11] The Oregon Health Authority and Department of Human Services technology plan is available at http://oregon.gov/OHA/technology/cio_messages/2009/dhs-tch-pln-09-15.pdf.

Project Status, performance measures and detailed acquisition, risk management, project initiation, change management and communication plans. Following submission, CMS requested clarifying information regarding specifics relating to the technology. Oregon provided this information and successfully met the requirements for the gate review.

The second CMS gate review was held in May 2011Oregon provided a Project Baseline Review regarding the status of the HIX IT Project, including a detailed project management plans that encompass all areas of the operational process, as well as high-level program area requirements. Oregon successfully passed this gate review.

Proposal to Meet Program Requirements

As described in Oregon's Exchange IT Innovator grant application and the gate review materials the state has submitted to CMS over the first half of 2011, the state is building a streamlined and seamless electronic eligibility and enrollment system that will allow Oregonians to access insurance coverage without regard to their income eligibility for Medicaid or premium tax credits. The work conducted under the Exchange IT Innovator Grant is facilitating the implementation of the Exchange within the following domains:

Business Rules Management System. Development of business rules to manage all of the workflow and business processes that support the Exchange, including federal subsidy eligibility determination and Medicaid eligibility determination.

Internal Portal. Establishment of web-based screens and workflow so that the Exchange can manage the Exchange. The internal portal uses the business rules management system to establish internal business processes including, but not limited to, ongoing case management functions such as monitoring for eligibility changes, management of open enrollment and detecting fraud.

External Portal. Establishment of a single Exchange presentation to consumers, employers and insurance carriers offering health plans in the Exchange. The portal uses the business rules engine to enable comparison and selection of health plans by consumers and also uses the back office integration tools to prepare and submit payments and premiums to insurance plans.

Back Office Integration. Configuring the enterprise services bus and other tools to integrate with program management systems such as health plan information systems and the Medicaid Management Information System (MMIS). Ultimately, the back office integration takes output from the eligibility rules configured in the business rules management system and prepares it in a format that can be delivered to MMIS or commercial insurance plans for benefit enrollment or to other State and Federal Systems for verification.

Reporting. Implementing the transactional, decision support and compliance reporting functions from information gathered from the back office data stores. It includes both operational "canned" reports for business management and the establishment of a data warehouse for more sophisticated program management and decision support needs.

Oregon is on track to complete its requirements documentation, development of a baseline system, and testing of all system components. The work under the Exchange IT grant will continue for the remainder of the IT Innovator grant period, through February 2013. Oregon is finishing the Architecture/Concept phase of the work and beginning to develop the Exchange

business rules. For more information on the development of Oregon's Exchange IT system, see Oregon's Exchange IT application and gate review materials.

Work to be conducted under the Establishment Grant. In addition to the work conducted under the IT grant, during the Level I Establishment Grant period Oregon will be conducting additional technology-related work required to establish the Exchange, including determining the requirements for the organization's financial systems and internal IT needs. We propose to utilize the assistance of contracted consultants to help Oregon:

- Validate the Exchange IT project's costs and timeline;
- Determine the organization's ongoing IT needs, assess the associated costs, and develop a procurement strategy;
- Develop Exchange Master Data Management strategy and plan; and
- Assist in the planning for ongoing IT operations.

The recommended steps will be approved by the Exchange Board and appropriate resources secured through Oregon's Level II grant application.

To validate the IT project costs and timeline, the contractors will create a cost model based on the emerging Exchange architecture, the CMS reference architecture, and the vendor exercise. The contractor will then use constructive cost modeling and function point analysis techniques to generate a much more robust estimate of the cost of designing, implementing and operating the Exchange solution. It could also extend the cost model to cover the business costs of Exchange implementation and ongoing operation. In addition, the contractor could be used to build a change governance capability and to design and pilot the implementation of project portfolio management and architecture governance capabilities.

A contractor-developed proposal for an Exchange master data management strategy and plan will address: data architecture, data governance, data reporting and data quality. In addition, a contractor can provide support to the Exchange's Chief Technology Officer in order to guide planning for ongoing operations of IT elements of the Exchange business.

FINANCIAL MANAGEMENT

Past Progress

As part of the Exchange Planning Grant, Oregon contracted with national experts to develop a financial implementation model. The model provides detailed expenditures for the Level 1 grant period, and estimates both revenue and expenditures for 2012-2015. The model is interactive and designed to incorporate Oregon-specific data on market size, premium rates, contract size and enrollment ramp-up to project Exchange expenses and revenues. The model allows Exchange staff to easily adjust certain key assumptions and analyze the impact on revenues and expenditures, and to determine the level of carrier assessment and user fees required to meet the operating and financial management goals of the Exchange.

Financial management requirements are addressed in the Exchange's authorizing legislation. Senate Bill 99:

- Establishes a Health Insurance Exchange Fund in the state treasury. Fee revenues will be deposited into the continuously appropriated fund for the operation of the Exchange;

- Authorizes the Exchange Board to impose administrative and user fees to fund operation of the Exchange; and
- Requires the Secretary of State to conduct annual financial audits of the Exchange and the Health Insurance Exchange Fund and to report its findings to the Governor, legislative leadership, the Oregon Health Authority, the Oregon Health Policy Board, the Department of Consumer and Business Services and the appropriate federal authorities.

Financial management strategies are currently being discussed in the Exchange Early Innovator Information Technology Grant. The IT solution must be able to meet the financial and accounting reporting requirements of the Exchange. For example, the Exchange IT system under development will include functionality to assist with financial management by having the ability to capture, store, and generate reports on financial data.

Proposal to Meet Program Requirements

In planning for the establishment of the Exchange, the state has identified the need for a robust financial accounting and management reporting system. With potential total enrollment in excess of 300,000 members across the individual and small group markets, the number of financial transactions the Exchange will be processing will require a highly automated, sophisticated, and scalable accounting system. It also requires the ability to produce timely and accurate financial and management reports at a level of detail that will be expected from all stakeholders including residents, the legislature, health insurance carriers, and other market partners and affiliations of the Exchange, as well as our federal partners.

In the immediate term, the Exchange needs to hire finance personnel such as the Chief Financial Officer and key budget and accounting staff. These staff will develop the necessary underlying accounting and reporting structure, such as a trial balance and chart of accounts, as well as help determine an appropriate accounting and financial management technology solution. Based on consultant work during the planning phase, we do not believe that the state has an accounting and financial management reporting system that can be modified to address the complexities associated with the Exchange. Therefore this task will be one of the first areas of focus under the Level I Establishment Grant. As an interim step, we plan to purchase a modest off-the-shelf accounting package that will allow the Exchange to perform basic accounting and reporting and begin to develop the necessary financial controls and protocols. At the same time Exchange finance staff will begin researching and evaluating a longer-term accounting and financial management solution.

During the he grant period the Board will make key decisions regarding specific Exchange business functions (i.e. call center, Navigator program, eligibility determination, etc.) that should be conducted by the Exchange, and which functions may be outsourced. Interagency agreements and contracts will reflect financial compensation and reporting requirements. In addition the Interagency Agreements with OHA and DCBS will incorporate risk management strategies.

OVERSIGHT AND PROGRAM INTEGRITY

State Health Insurance exchanges are required to comply with a number of ACA-specified provisions regarding financial and program integrity. Exchanges are subject to audits by the Secretary of HHS as well as state-level audits and operational reviews. With this in mind, the

Oregon Exchange has been developed with multiple layers of oversight: the Legislature, Exchange Board, advisory committees, Oregon's Secretary of State, and the Secretary of HHS, CCIIO and other relevant federal partners. Oregon legislative leadership will provide advice and oversight to the Exchange throughout implementation, with the Exchange presenting a business plan to the Legislature in February 2012 for approval and continuing to provide quarterly and annual reports on the Exchange's progress towards implementation.

The Exchange will also be responsible for a broad range of obligations and responsibilities, and will interact with a number of market partners and affiliations such as carriers, brokers and navigators, state agencies and consumers. In addition, as a new entity responsible for implementing a complex law affecting nearly all Oregonians, the Exchange will need to display a high degree of transparency, competency, and program integrity. As a result, the Oregon Exchange will be designing and implementing a system of internal control and program integrity measures that reflect the best practices of the public and private market segments.

Past Progress

In Project Quarter 3 of the Planning Grant, Oregon established a working relationship between Exchange staff and the Oregon Secretary of State's Audit Division to provide guidance and recommendations during the Establishment Grant period around financial management, internal controls, and the development of audit protocols. The Exchange's enabling legislation specifies that the Secretary of State conduct annual financial audits and biennial performance audits, in addition to ongoing quarterly and annual reporting to the Legislature. Exchange staff has also begun working with the OHA Fraud, Waste, and Abuse (FWA) program to outline the steps that will be needed to create a plan for the Exchange.

Proposal to Meet Program Requirements

The Chief Financial Officer, key staff and contracted consultants will determine the financial management and reporting needs of the Exchange, and then evaluate the financial management software options available to the organization and how they meet both the business demands and integration requirements with the rest of the IT systems.

During the Level 1 Establishment Grant period staff will catalogue the various types of reports required by state and federal statute, identify what data elements will be needed to produce the reports and ensure those elements are incorporated into the IT systems, and develop an appropriate process to distribute the reports and other informational products.

Supported by Establishment Grant funds, the Exchange will work with the Secretary of State Audit Division to research and evaluate internal control and program integrity measures currently in effect in various state government programs, but will also look to the private market for best practices systems and processes. Exchange activities that will the early focus to ensure a strong system of internal controls include:

- Segregation of duties;
- Authorization of transactions;
- Physical safeguards of property and equipment;
- Supervision of operations;
- Records retention; and

- Information processing (accounts payable, bank reconciliations, and receipt of funds).

During the grant year, the Exchange will work cooperatively with the Audit Division to develop the processes and protocols to be used during the annual financial audits and biennial performance audits, as well as the specific roles and responsibilities of each entity. Designing systems that easily generate the types of reports or data needed by the auditors will make the ongoing audit function more efficient and effective for both parties.

The Exchange staff will work with OHA and DHS to develop goals and protocols for the Exchange's FWA program that are modelled on programs in place at OHA and DHS. Once the plan is developed, Exchange staff and OHA Exchange IT Early Innovator grant staff will ensure that the system is configured to capture and report the data necessary to operate a FWA program.

Protocols and standards for privacy, information security, and system backups will be developed in consultation with the OHA Office of Information Systems (including the staff of the Early Innovator grant). The Exchange will work with state agency partners to develop an effective disaster recovery plan.

The Exchange staff will develop rules critical to the implementation of the Exchange during the Level 1 grant year, including determining the required rule structure for a public corporation.

HEALTH INSURANCE MARKET REFORM

Past Progress

Oregon has a long history of insurance reform efforts, including some of the country's most transparent insurance rate review processes. In 2010, the Department of Consumer & Business Services' Insurance Division worked with staff from the OHA, DHS and Department of Justice to identify sections of the Insurance Code that needed to be updated to align with the Affordable Care Act. That work culminated in Senate Bill 89 (harmonizing the Insurance Code with federal law), Senate Bill 91 (which establishes requirements for bronze and silver health benefit plans, and limits the sale of catastrophic plans to the Exchange), and Senate Bill 99 (which establishes the Exchange as a public corporation in Oregon). In addition to these bills, the legislature passed Senate Bill 94, a health insurance administrative simplification bill developed out of Oregon's health care reform efforts. The passage of these bills sets Oregon apart as one of the few states to have legislative authority to implement the health insurance reforms as set forth in the ACA.

Proposal to Meet Program Requirements

During this year Oregon will finalize an Interagency Agreement or Memorandum of Understanding between the Exchange and the Department of Consumer & Business Services to clarify the roles and responsibilities of each agency in regards to rate review, licensure and certification of carriers and health benefit plans, development of plan grading criteria, risk adjustment and reinsurance, and consumer protection and education activities.

PROVIDING ASSISTANCE TO INDIVIDUALS AND SMALL BUSINESS, COVERAGE APPEALS AND COMPLAINTS

Past Progress

Oregon has identified some existing programs that can serve as a model in developing our assistance and engagement activities. Oregon Health Connect, a consumer assistance program, is currently housed in the Insurance Division and funded by a federal grant. Oregon's children's health care coverage initiative (Healthy Kids) has successful outreach efforts including two Navigator-type enrollment programs. The OHA Office for Private Health Partnerships has a long-standing education and outreach programs in addition to an insurance agent (producer) referral program. These programs collect a variety of data that can be used to shape the initiatives the Exchange will implement.

Oregon also has identified a variety of stakeholder groups and associations who have direct ties to the populations the Exchange will serve and will engage them in the development and implementation of education and outreach materials.

The state has also identified current agencies with robust appeal and consumer complaint programs, including the DCBS Insurance Division, OHA Family Health Insurance Assistance Program, Oregon Medical Insurance Pool, Oregon Health Plan and ombudsman programs.

Proposal to Meet Program Requirements

SB 99 establishes a statutory committee (Individual and Employer Consumer Advisory Committee) to collect stakeholder input on issues relating to Exchange operations. The Board may also establish other advisory and technical committees and directly solicit input from insurance producers who serve small businesses.

Federal grant funding for the Oregon Health Connect (OHC) consumer assistance program is ending later this year. Per federal guidance, the program will be supported by Exchange funding and Exchange and Insurance Division will develop an appropriate transition plan for OHC staff and functions to integrate the program more fully into the Exchange.

Exchange funding will also support risk mitigation activities and market analyses conducted by DCBS. Exchange staff will work with DCBS to implement the requirements of SB 91, which establishes the requirements for bronze and silver level health plans.

Working with stakeholders, the Exchange will develop the initial framework for the Navigator program based on forthcoming federal guidance, and will also outline a plan for integrating insurance producers in outreach and enrollment efforts. Based on federal guidance, the Exchange will also develop rules for insurance producers seeking to provide assistance to consumers through the Exchange. Staff and contractors engaged in these activities will also provide content assistance to the Exchange IT project, informing the development of Navigator and Producer portals.

Oregon has identified several research and evaluation activities that will be conducted during the Level 1 grant year that will inform the development of a strategic plan for outreach, education, marketing and communication campaigns, with specific emphasis on hard-to-reach populations and small businesses. Those activities are outlined in the Evaluation Section below.

The Exchange will work with the programs identified in the Past Progress section around appeals and complaints to start to develop a framework for the Exchange, but actual development and implementation of those programs will take place in the Level Two grant years.

EXCHANGE BUSINESS OPERATIONS

Past Progress

Several bodies of work were used to create Oregon's Work Plan with respect to business operations and Exchange functions. Oregon first began serious consideration of an exchange in 2007. Over the course of the next year, the Oregon Health Fund Board's Exchange Workgroup held a series of public meetings to develop recommendations to present to the legislature in 2009, which in turn led to legislation that required OHA to present a business plan for an exchange by the end of 2010.

A technical advisory committee made up of insurance carriers, insurance producers, small business owners, and advocates helped develop the policy framework and questions that became the body of the business plan. It was vetted at various points of its development in Oregon Health Policy Board (OHPB) public meetings. The OHPB and OHA travelled across the state in September 2010 to get public input on the Exchange which was also incorporated into the business plan. This business plan was used as the framework for Oregon's enabling legislation in 2011 which went through extensive public legislative hearings.

The business plan and Senate Bill 99 were used to help establish the goals and milestones for the Work Plan, in addition to the federal guidance provided as part of this funding opportunity. Oregon also called upon its experience in starting and operating its premium assistance program (the Family Health Insurance Assistance Program or FHIAP, which is a mini-exchange) in developing reasonable and practical milestones and objectives.

Wakely Consulting also wrote an Exchange concept paper for Oregon, as well as a resource and gap analysis for the state. These reports were also used in the development of the Work Plan.

Proposal to Meet Program Requirements

Oregon has developed an organizational chart that maps out each of the functions outlined below to a specific department or division(s) within the Exchange, and has assigned an adequate level of staffing to perform those functions both for this Level 1 grant year and, at a less refined level, for the ongoing business needs of the Exchange. We believe it is crucial in this critical first year of implementation to have permanent, high-level staff in place to make key operational decisions. In many cases for this Level 1 grant, we haven't received enough detailed federal guidance to fully anticipate the amount of resources that will be needed to meet the required milestones, but we believe our staffing requests will allow us the flexibility to meet all the forthcoming demands and requirements. We also believe there are cases where we've identified necessary staff or contract work, but it doesn't neatly fit into just one of these business operations. For example, actuarial analysis will need to happen in several operational areas (such as benefit analysis and plan certification).

Oregon is also working with Wakely Consulting to develop a detailed business plan for approval by the Oregon Legislature in February 2012. This will also shape and refine the Work Plan and

the staff work that will done during the rest of the Level 1 grant year and influence the development of the Level Two grant application.

Certification, recertification, and decertification of qualified health plans. The Exchange will engage a Plan Management manager and certification analyst to begin development of draft standards and processes to be used in certifying qualified health plans, based on federal guidance. We will work with stakeholders and other interested parties to gather input on these standards. Staff will also work closely with the IT grant staff to ensure that we leverage the capabilities of the new data and technology system to automate and streamline as much of the process as possible.

Call Center. The Exchange will work with the Insurance Division in planning the transition of the Oregon Health Connects responsibilities and staff to the Exchange, as well as a plan to staff for calls prior to implementation. Staff will work with consultants and other similar state programs to determine if the Exchange should build a call center in-house or should contract for those services and if contracting, determining the requirements and criteria to be used in developing an Request for Proposal.

Exchange website. As an Early Innovator IT grant state, Oregon has selected a software solution and has already begun to develop requirements for its entire IT system including the website and web portal. The Exchange staff is working with the Oregon Health Authority and Department of Human Resources Self-Sufficiency Modernization project to create a seamless eligibility and shopping experience for people applying for coverage. Work on the high-level processes and detailed work flows will intensify during the Level 1 grant year. The web portal (when completed) will allow members to manage their Exchange and Medicaid accounts including: applying for benefits (including SNAP and TANF), making premium payments, estimating their tax credits and cost-sharing reductions, comparing insurance plans, and enrolling in plans. We have identified two web communications positions to work with IT grant staff to design this portal, and in the interim design and deploy a website for the Exchange that provides easy-to-use, timely information about the Exchange and its implementation activities.

Premium tax credit and cost-sharing reduction calculator. The Exchange will use federal guidance and/or prototype systems to integrate into the systems we are developing (see above).

Quality rating system. Oregon has spent considerable time and energy in developing quality standards that could be used throughout the state's health care system (not just the Exchange) as part of its overall health system transformation work. Once the federal guidance is released on the Quality Rating System, the Exchange will evaluate whether or not to contract with state and/or national quality organizations to do the analysis, and will work with appropriate stakeholders to incorporate relevant Oregon-specific measures to the rating system. The Evaluation Analyst will be hired during the grant year, and will help oversee these efforts.

Navigator program. Oregon will use its successful Healthy Kids and FHIAP programs as models, along with specific federal requirements and guidance, to develop the framework and milestones for its Navigator program. The Exchange will work with other state agencies, stakeholders and advocacy groups to determine what organizations may be candidates for the Navigator program, and analyze existing data to identify geographic or demographic segments that may need special attention when developing the program. We will look into seeing if there are sources of potential members that are appropriate to share with Navigators and/or brokers, and if there are, developing the protocols to use. The IT software solution chosen by Oregon has

a strong and robust Navigator/broker management model which not only allows the Exchange to track, measure and evaluate the programs, but provides a portal for Navigators/brokers to manage their clients. During this grant year, the Outreach Coordinator will oversee these efforts until a Navigator Program Coordinator is hired in the Level Two grant period.

Eligibility determinations for Exchange participation, advance payment of premium tax credits, cost-sharing reductions, and Medicaid. Oregon has already established an internal steering committee that is made up of representatives of the other state subsidy or assistance programs and the Oregon Insurance Division. Staff will be hired to help develop the policy and operational framework for these processes. Oregon's Self-Sufficiency Modernization initiative to streamline eligibility processes is already working in concert with the Exchange in developing the common IT systems to do Exchange and Medicaid determinations, tax credits and cost-sharing reductions. The Early Innovator IT grant will continue to accelerate the work on all these areas during the Level 1 grant year.

Seamless eligibility and enrollment process for Medicaid and other state health subsidy programs. The work of the Early Innovator IT grant and the Self-Sufficiency Modernization initiative focuses on the development of simple, streamlined, seamless eligibility and enrollment processes all applicable assistance programs. The Chief Technology Officer and policy staff will supervise these implementation activities during the grant year and will be responsible for coordinating operational policies with the appropriate OHA and DHS programs.

Enrollment process. Staff focused on enrollment and billing will help develop the policy and operational framework for these processes, as well as the requirements and system work flows for the enrollment process, and will modify that work as applicable federal guidance is received.

Applications and notices. Work on this business function won't begin until more development of the system is completed and additional guidance and instructions from the federal government is provided. It is slated begin after the end of this Level 1 grant year.

Individual responsibility determinations. Oregon has begun to develop requirements and system work flows for the individual responsibility determination process, and will modify that work as applicable federal guidance is received.

Administration of premium tax credits and cost-sharing reductions. Oregon has begun to develop requirements and system work flows for the premium tax credit and cost-sharing reduction process, and will modify that work as applicable federal guidance is received. Senior policy analysts will oversee this work, in consultation with the COO and CFO.

Adjudication of appeals of eligibility determinations. Work on this business function won't begin until the end of this Level 1 grant year after more development of the eligibility system is completed and additional federal is provided, but it will build upon the appeals processes used in comparable state programs.

Notification and appeals of employer liability. The work on this business function is really dependent on the issuance of guidance and instructions from the federal government. Once that is received, more detailed systems work will begin though high-level development has already started. Senior policy analysts will develop this work, in consultation with the COO and the SHOP Exchange Manager.

Information reporting to IRS and enrollees. The work on this business function is needs further guidance and instructions from the federal government before detailed systems can begin

though high-level development has already started. Senior policy analysts will develop this work, in consultation with the COO.

Outreach and education. Oregon understands the need for careful, thoughtful strategic planning around the outreach and education efforts, as well as other communications. Past survey and focus group work has determined that many people don't understand health insurance or their benefits, and don't know how to be an informed consumer of health care. We believe we need to first educate Oregonians about health care and health reform in general, so they will have a context for the Exchange-specific branding and marketing efforts that will begin closer to implementation. Several key communications and staff and contractors will develop these strategic plans and educational and marketing materials, and deploy them to appropriate audiences. We will also conduct specific market research (focus groups and surveys) to help inform the development of these communications, outreach and education plans.

Risk adjustment and transitional reinsurance. The work on this business function is needs further guidance and instructions from the federal government before detailed systems can begin though high-level development has already started. The Exchange will fund risk adjustment and reinsurance personnel to analyze the federal guidance and work as a liaison with the Oregon Insurance Division since these types of programs impact the entire marketplace.

SHOP Exchange-specific functions. Oregon commissioned a report on SHOP functions from the Institute of Health Policy Solutions earlier this year that we will use as a starting point while awaiting federal guidance and requirements. The Exchange will also hire an SHOP Exchange Manager to develop processes and policies specifically for the SHOP, and to coordinate with other areas of the Exchange to ensure that the needs of small businesses and their employees are met. IHPS will also provide assistance to Oregon as it develops SHOP processes and procedures, including but not limited to helping the state develop a streamlined process for employee enrollment that maximizes employee choice while reducing administrative burden for employers.

III. IT NEEDS ASSESSMENT

TECHNICAL ARCHITECTURE

Current/legacy software and hardware

DHS/OHA Current State

Over the past 30 years, the current DHS/OHA legacy systems were developed on different platforms including mainframe, client/server, distributed and Web-based architectures. In recent years Oregon has matured its development efforts with the use of a system development lifecycle (SDLC), resulting in solutions that more closely align with business needs and the 2009-2015 DHS/OHA enterprise technology plan.[12] In approving the 2009-2015 enterprise technology plan, the DHS/OHA Information Technology Governance Council adopted a vision of rational, service-based architecture for state IT systems including eligibility determination systems. Oregon has already begun seeking opportunities to implement this vision.

[12]The DHS/OHA Enterprise Technology Plan is available at http://tinyurl.com/23aetyw.

Oregon's most flexible and modern applications are based on Web Services Architecture using SOAP and WSDL and are aligned with service-oriented architecture approaches.

Limitations. Because of Oregon's many disparate systems, only a limited amount of client information is accessible and reusable across multiple programs. Inconsistent data are stored in application silos with duplicated functionality where security and access varies. In addition, Oregon has developed hundreds of custom interfaces between these silos to support integrated business processes, making systems extremely complex, inflexible and expensive to maintain. The grant funds will allow Oregon to begin the move to a system that no longer requires custom "fixes" that bridge between legacy systems. Starting with a system for commercial insurance (tax credit) and Medicaid eligibility and enrollment, we will build a system that will eventually expand to other social service programs, allowing the state to move past its current reliance on inflexible systems in separate silos.

Software and Hardware. The vast majority of current systems are hosted in the Oregon State Data Center. Many of the current OHA systems are based on IBM mainframe, AIX midrange servers and distributed servers running within the Microsoft Windows Server or Linux operating system environments. The client server systems were developed using legacy tools such as Sybase PowerBuilder and databases. Web-enabled systems primarily use Websphere, .Net, Java. or ColdFusion. Oregon uses DB2, Microsoft SQL Server and Oracle relational databases for data storage and management and uses integrated development tools like Rational Application Developer (RAD) and Eclipse and tools such as JIRA and Subversion for issue tracking and application source code management (SCM).

Custom Development Efforts and COTS Implementations. Over the last several years, Oregon developed custom solutions or implemented proprietary commercial products to meet critical business needs. Over time, the custom development and product development processes have matured, making it an optimal time to begin migration to a configurable and commercial framework. This is a natural evolution in terms of people, process and technology change. Oregon's current technology environment will not be sufficient to develop the seamless consumer experience required as part of the Affordable Care Act.

Target system software and hardware

In 2009 the Oregon DHS and OHA adopted the 2009-2015 technology plan to enable the coordinated, consistent delivery of health and human services in Oregon. This plan created a roadmap to migrate from silos of custom-developed and proprietary commercial applications to a framework-based technology infrastructure that supports increased organizational flexibility and responsiveness to changing customer needs. Oregon believes that this migration is necessary to achieve the objectives and goals of health care reform.

Consistent with Oregon's enterprise technology plan, the State is implementing a modern IT infrastructure based on technology standards and a configurable commercial framework. See the Oregon technology plan for more information.[13]

Commercial Framework. Based on market research, Oregon has concluded that the procurement of a commercial framework of business rules management, internal portal, external portal, back office integration tools and a shared reporting infrastructure based on a service-

[13] http://tinyurl.com/23aetyw

oriented architecture is a key strategic investment for achieving the State's technology vision. As part of the package, the commercial solutions are configured to meet federal rules. In 2010, Oregon asked vendors to respond to a series of questions specific to their investment, partnering, and preparation for the impacts of H.R. 3200, America's Affordable Health Choices Act of 2009 (an early version of health reform) and H.R. 4872, Healthcare and Education Affordability Reconciliation Act of 2010. Their responses demonstrated the vendors' awareness and intention to align with health reform including the Affordable Care Act.

The commercial framework approach offers many benefits both for implementing and operating the Exchange. These include:

- Holistic view of consumer both from a data and process perspective
- Health and Human Services best practices and alignment
- Comprehensive view of clients for workers
- Cost reductions and economies of scale created by multiple clients
- Technology best practices and standards
- Integrated eligibility solution
- Rules engine
- Robust messaging
- Data warehousing and reporting
- Workflow and process automation
- Configurability with minimal customization

Oregon also plans to use the commercial framework across all program areas including an eligibility automation project that supports Medicaid, Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance to Needy Families (TANF) and Employment Related Day Care (ERDC). This project is now in a procurement phase. This approach, which is consistent with Oregon's technology plan, will enable the State to create a seamless environment for clients and consumers.

Future Hardware and Software. Oregon DHS and OHA are considering hosting the commercial framework in the Oregon State Data Center. The future state platform will be built on robust, proven hardware and software platforms that can reside in Oregon's Tier III certified State Data Center. In June a contract was finalized with Oracle. The final decision on platform was based on the solution that best meets the business needs of the Exchange and best aligns with the DHS/OHA technology plan. The selected commercial solution framework is three-tier architecture and has SOA, web 2.0 and XML capabilities. The underlying operating system is UNIX.

Policy-Rules Engine. Market research and strategic alignment demonstrates the value of central management of policies and rules across programs in a shared environment. The policy-rules engine is a foundational component of the framework solution Oregon is implementing. The policy-rules engine allows natural language definition and audit and versioning capabilities that reduce the complexity of managing rules while reducing errors in their implementation. Oregon will use the policy-rules engine and other integrated framework components to help consumers compare health insurance products, provide consolidated billing and premium payment for employers and help small businesses manage health insurance administration in a seamless way.

The underlying infrastructure of the framework and the configuration will be made available to other states to accelerate nationwide implementation of insurance exchanges. Oregon is participating in multi-state advisory meetings during the development of the Exchange and will be partnering with other states in an advisory capacity as we design, develop and implement the state's fully configured framework. The state is committed to serving in a consulting role for states that decide to use the Oregon framework and configurations to meet their health insurance exchange objectives.

In addition to providing a marketplace for individual consumers seeking Medicaid and commercial insurance, groups and insurance plans, the longer-term plan for the framework is that it will also automate the intake, assessment and determination of eligibility across the other major benefits programs: ERDC, SNAP and TANF. The eligibility component of the framework supports the essential criteria of the Health Insurance Exchange and represents modules that will be both comprehensive and reusable by other states. As part of Oregon's technology plan, the framework will use open standards-based interfaces to other state systems to ensure that enrollment, tax credits administration and cost-sharing assistance administration are seamless for consumers, clients and insurance plans. The framework and interfaces to other systems will be deployed to ensure that as consumer and client eligibility changes, they will continue to receive the best possible mix of benefits and value.

Past Progress (Under Cooperative Agreement to Support Innovative Exchange IT Systems)

The Oregon Health Insurance Exchange IT Project is presently in the initiation stage of project planning. This phase has lead to the creation of the project management office, acquisition of software, high level reviews and risk assessments, as well as the identification of contractors for specific services.

The Project Management Office (PMO) has been established with the appointment of PMO staff. The management staff joins an existing team of analysts dedicated to the HIX IT system. This team has begun fulfilling the designed staffing plan.

Oregon has made the selection to use the Oracle framework for the Exchange. The contract negotiations are underway. A solicitation for a system integrator vendor is in development. The system integrator will assist with the integration of the Oracle framework with the policy rules engine. This is a key position for our state as we couple the Exchange with components of self sufficiency program eligibility.

Oregon recently selected L.R. Kimball as the security contractor. The contract has been executed and the vendor started work on the project in early June. Maximus has been chosen as the Quality Assurance vendor. Contract negotiations are underway.

APPLICABLE STANDARDS

Affordable Care Act Section 1561 Recommendations

National Information Exchange Model (NIEM). As part of Oregon's Information Security policy, the State has incorporated the Information Exchange Package Documentation (IEPD) lifecycle of NIEM into our design and development processes. This strategy will allow us to

integrate data across domains within the framework to facilitate enrollment of individuals using common data among multiple systems.

Data management implications. NIEM requires the State to publish a data dictionary for data elements that are exchanged and adopt the schemas and namespaces that are provided under the NIEM framework. The State recognizes the importance of a published data dictionary and it is part of the overall data management direction.

- The State will create governance for data management, evaluate compliance with NIEM and share schemas with other states. Creating data governance is part of the planning process that is already under way.
- The State already has achieved a moderate level of NIEM maturity as we have data dictionaries and have developed an overall data management strategy. The State understands that the scope of NIEM applies to specific definitions of data exchange supported by the capabilities of an Import/Export tool. Oregon will employ such a tool that facilitates implementation of the NIEM framework.
- The State already has the capability to participate in XML exchanges.
- The State agrees that the NIEM framework will help reduce its maintenance footprint as it creates re-usable data exchange tools, components and schemas.

Adaptation to the recommendations of Section 1561 of the Affordable Care Act.

Core Data. The State is planning to use an enterprise data dictionary for core data and follow NIEM guidelines. This includes a core set of eleven data elements collected from clients during the application process for social service programs such as Medicaid. These data elements are name, date of birth, Social Security number, gender, address, citizenship, immigration status, possible incarceration history, race/ethnicity, household composition and income.

Verification Interfaces. The State is working to procure a commercial solution framework that supports standardized web services for integrated eligibility. The framework will be able to interface with federal, state or other widely available data sources and tools including U.S. Postal Service address standardization Application Programming Interface (API) etc. for information verification.

Business Rules. The State is working to procure a commercial solution framework that includes a rules engine that allows business rules for all programs including SNAP and TANF to be expressed in a consistent, technology-neutral format. These rules will be stored and managed outside of the transactional systems.

Transmission of Enrollment Information. The State is working to procure a commercial solution framework for integrated eligibility that will use HIPAA transaction standards.

Use of x12n HIPAA 834 enrollment and 270/271 eligibility transactions. DHS/OHA has implemented version 4010 of the x12n HIPAA 834 enrollment and 270/271 eligibility transactions. Oregon is in the process of implementing version 5010 by the federally mandated January 1, 2012 compliance date.

Federal Information Processing Standards (FIPS). The State of Oregon will assess and test a minimum of 184 controls addressing FIPS 200 requirements that will be applied to the

information assets and Health Insurance Exchange system. For example, a control and associated requirement is the "intrusion and incident response" control, in requirement Section 3 of FIPS.

HIPAA

The State of Oregon will assess and test a minimum of 111 controls that address administrative, physical and technical HIPAA Privacy Rule and Security Rule requirements that will be applied to the information assets and exchange system. For example, one control would be "collecting and use the minimum data necessary" in requirement 164.514(d).

Oregon's policy is to adhere to HIPAA guidelines and rules and will continue to employ this policy when implementing new Exchange interfaces. The State will also provide guidance on compliance with HIPAA to potential contractors and vendors during the procurement process.

Accessibility for Individuals with Disabilities

As can be verified by looking at the tasks in the attached work plan, the State is committed to providing accessibility to information technology for persons with disabilities as spelled out in section 508 of the Rehabilitation Act.

- The State does not refuse persons with disabilities participation in services, programs or activities simply because that person has a disability.
- The State does provide programs and services in as integrated setting as possible, unless separate or different measures are necessary to ensure equal opportunity.
- The State operates its programs so that, when viewed in their entirety, they are readily accessible to and usable by individuals with disabilities.
- The States tries to ensure effective communication with individuals with disabilities.
- Where necessary to ensure that communications with individuals with hearing, vision, or speech impairments are as effective as communications with others, the State tries to provide appropriate auxiliary aids.

Security

Collection Limitation. Oregon's information security policies guide the collection of data to meet program needs. The foundation of Oregon's policy follows best practice regarding information protection which limits the collection, use and exposure of information assets. The exchange system will be built following Oregon's policy and information security best practices.

Data Integrity & Quality. Oregon understands the importance of data quality and integrity in safeguarding consumer information. Oregon has mature data resource management and information security functions that promote good data stewardship and data management best practices. Oregon has experience with advanced data practices, including those related to data collection, extraction, transformation, loading, matching and analytics. The approach of implementing a modern configurable framework with advanced data management functionality will allow Oregon to perform sound data and analytic methods to drive decision making for the Exchange.

Openness & Transparency. Oregon has an established Information Security Office (ISO) that administers security policy. A core charter element of the ISO is that the protection of information assets and the consumer's expectation of privacy are addressed through communications and Awareness and Education materials. The Health Insurance Exchange project will develop and disseminate these materials.

Purpose Specification. The Affordable Care Act specifies that data taken from the exchange will be used for the purpose of detecting and monitoring trends in health and disparities at the state and federal level.

Use Limitation. The Health Insurance Exchange will disseminate data collected as needed by state and federal partners. The exchange will ensure that the data reported will not adversely affect any individual as required by the Affordable Care Act.

Security Safeguards and Controls. The Health Insurance Exchange will have protocols in place regarding the security of the data collection. Oregon will enter into agreements through memorandums of understanding (MOU) which provides a common understanding regarding the intent for which the data will be used.

Individual Participation and Control. Oregon exchange users will have the ability to dictate which services they will be considered for. Due to the wide array of programs accessible through the exchange, Oregon recognizes the importance of allowing users the ability to dictate how their information is used within other human service programs. Additionally, OHA will develop or adopt regulations, rules and policies to allow an individual access to their own information. This approach allows individuals to take personal responsibility of their information, its accuracy and timely updates.

Accountability and Oversight. The State of Oregon ISO is responsible for the management of information security compliance within OHA. The management includes documenting which OHA resources are responsible for specific compliance requirements and working with these resources to conduct information security assessments.

Taxpayer Privacy and Safeguard Standards.

Privacy and Security. The State of Oregon uses governance and compliance tools to manage information privacy and security requirements controls and issues. For the Health Insurance Exchange project we will rely on guidance from the following documents: OMB Circular A-130; Appendix III (CMS data use agreement security requirements); FIPS 200 (grant and CMS data use agreement security requirements); NIST 800-53 (grant and CMS data use agreement security requirements); HIPAA Privacy Rule and Security Rule; ACA 1561 Recommendations (Privacy and Security); and ARRA HITECH. The requirements and controls include, but are not limited to: awareness and education (A&E); access control; human resource (State and vendor); systems (application and hosting); physical and environmental security; asset management; incident management; business continuity; and disaster recovery. The Health Insurance Exchange system and associated information assets will meet the privacy and security requirements cited above.

The protection of information assets and the consumer's expectation of privacy are addressed through communications and A&E materials. These are reviewed and enhanced as necessary to help users and system support staff (including contractors and vendors) understand their responsibilities in protecting the information assets. Information privacy and security

requirements are essential components in all agreements, including contracts that involve the exchange of information assets and system access.

The foundation of information protection is to limit the collection, use and exposure of information assets. The exchange system will be built upon this foundation.

Security is managed through program management; the security plan includes the following elements: an overview of system security requirements; a description of the corresponding planned or existing security controls; a formal risk assessment; analysis of impacts of changes; and specification of required security controls. This process ensures that existing security and control procedures are not compromised, support programmers and administrators are given access only to those parts of the system necessary for their work, and that formal agreement and approval for any change is obtained.

Federal Information Processing Standards (FIPS)

The State of Oregon will assess and test a minimum of 184 controls addressing FIPS 200 requirements that will be applied to the information assets and Health Insurance Exchange system. An example of a control and associated requirement would be the "intrusion and incident response" control, in requirement Section 3 of FIPS.

SUMMARY

Following the state's history of innovation in health policy and based on its commitment to health information technology and experience modernizing the eligibility and enrollment for its Medicaid and social services programs, Oregon has begun building an innovative IT solution supporting a Health Insurance Exchange. Oregon's legislative leadership in health reform has established a governance structure that provides the guidance and support to create an innovative, practical and reusable technical solution for creation of an Exchange. A wide range of stakeholders, including the State's health policy leadership, Exchange advisory groups, federal partners, states interested in Oregon's technical solution and many others help support this work. The technical architecture and IT standards are well developed, in part because of the Medicaid modernization work that took place prior to the Exchange development, and that continues alongside this project. Consumers' needs are also being taken into account to ensure that the result provides a seamless experience for health insurance coverage, no matter a person's income or circumstance. Oregon is happy to be building on its past as a health policy innovator to create an IT solution that can be a model for other states and propel our own Health Insurance Exchange forward.

IV. EVALUATION PLAN

EVALUATIVE RESEARCH METHODOLOGIES

Oregon will conduct three evaluative research projects during the Level 1 grant period, supporting the development of a robust multiple-year evaluation plan for the Level 2 application.

A high level summary of the Exchange's evaluation plan for Level 1 follows the description of proposed research activities.

1. Focus Groups

Core Area: 11 (Exchange Business Operations: Call Center; Exchange Website & Calculator; Navigator; Eligibility; Enrollment Process; Outreach and Education; SHOP)

A series of focus groups will be conducted to establish a baseline of consumers' understanding about health insurance choices and their expectations for learning about health insurance, applying for coverage, and enrollment. During the last quarter of 2011, a series of statewide focus groups will be conducted that include segments for individuals (uninsured and insured), Medicaid eligible (enrolled and not enrolled), small business employers (who do and do not offer insurance) and their employees (enrolled and not enrolled). Research objectives include:

- Understanding peoples' decisions to apply/enroll or not;
- Assessing how people currently research and apply for coverage/eligibility/enrollment and what experiences have been positive or negative; explore understanding, past experience with and usefulness of a premium calculator;
- Identifying expectations of employers for the administrative requirements and cost; assessing expectations of consumers for cost and choice offerings;
- Discovering which websites people use frequently—both non-health related and health related (health plan, medical, etc.), and what are considered appealing features, usability and outcomes;
- Identifying which social networks people use and how they use them to find out about news, products and services;
- Evaluating where people turn for assistance during the enrollment process or while covered and what experiences have been positive or negative;
- Finding out the current understanding of an Exchange (once explained), expectations for an Exchange: attitudes, values and beliefs;
- Testing potential messages about the Exchange, its purpose and offerings; and
- Determining what people want for coverage and number of choices.

2. Small Employer Survey

Core Areas: 1 (Background Research); 9 (Health Insurance Market Reform); 10 (Assistance to Individuals and Small Business); 11 (SHOP)

A phone survey or online survey will be conducted to establish a baseline of the status of insurance coverage for small employers with 1-50 employees, both those that currently offer health benefits and those that do not. By the final quarter of 2012, an estimated 500 Oregon small businesses will be surveyed with objectives to include:

- Assessing how many employers currently offer coverage, type of coverage, employees eligible, employer contribution, and level of benefits – by industry and area of state;

- Documenting premiums paid and most recent premium increase;
- Identifying the barriers encountered for employers that do not offer coverage;
- Evaluating attitudes towards an Exchange;
- Finding out which features of the Exchange are most appealing;
- Discovering employers' administrative capabilities for health benefits; and
- Learning employers' expectations for quality measures and outcomes.

This study will be repeated at the close of the first year of Exchange implementation to assess the impact of the Exchange on small business insurance.

3. Steering Committee/Exchange Board Participation Assessment

Core Areas: 2 (Stakeholder Consultation); 4 (Governance)

The Steering Committee has been an important part of stakeholder involvement in launching the Exchange. The Exchange Board, once convened, will provide an important forum for stakeholders. To evaluate this component of stakeholder involvement, an assessment using a brief online survey will be conducted to determine the committee/Board members' perceptions of their contributions to the Exchange. The objectives will include: 1) gauging the perceived level of involvement by committee/Board members, 2) assessing the degree of impact perceived by member involvement, and 3) gathering other input about process strengths and weaknesses of member participation in Exchange development. The first assessment of the Steering Committee and Board will be completed in the fourth quarter of 2011. The second assessment of the Board will occur in the third or fourth quarter 2012. In addition, five short phone interviews of members of each group will be conducted in conjunction with both survey time frames.

LEVEL 1 EVALUATION PLAN SUMMARY

The Level 1 Evaluation Plan includes an evaluation of progress meeting the milestones described for each Core Area, and the identification of interventions where targets are not met. A draft Level 2 Evaluation Plan with key indicators and associated measures for each milestone is being developed and will be refined during the Level 1 grant period, based on the outcomes from the evaluative research described above. The Level 2 Evaluation Plan is being developed with Portland State University and Office for Oregon Health Policy and Research.

The following overview of the draft Evaluation Plan mirrors the 2011-12 Exchange work plan submitted in this application. It describes the milestones, key indicators, and measures associated with key indicators that highlight the completion of principal activities. Indicators will be developed during the Level 1 grant period for the Core Areas where federal guidance is pending or planning is not yet completed, such as Core Area 11 (Business Operations).

For many of the key indicators and required federal milestones, measures have been developed to identify whether the specific activities (i.e. reports, legislation, definitions, meetings, system requirements, documentation, etc.) have been completed on time. If not, Exchange staff will determine what has been a barrier to completion, revise the timeline, assess the impact on other

parts of the work plan, and determine whether interventions are required. These evaluation findings will be reported quarterly to the Exchange Executive Director and the Exchange Board.

1. Background Research

The objective is to determine resource needs and funding in order to conduct Exchange operational planning. The 2011-12 work plan outlines five Oregon-specific milestones and 23 key indicators. The majority of milestones and key indicators in this core area have already been met.

Report of findings: A principal measure will be completion of a Report of Findings in determining if the health plans' premium rates are consistent with federal guidance. A principal measure will be that the annual report on premium rates has been completed on time throughout the pre-implementation and implementation periods, as the new plan rates are established.

2. Stakeholder Consultation

The objectives for this Core Area are to: ensure that Oregon's Exchange is attractive to and works for individual and business consumers; and to get input and support of key state agencies and divisions in the development of Oregon’s Exchange. The 2011-2012 work plan identifies four Oregon-specific milestones and 15 key indicators. Stakeholders from the community, public agencies, and consumers will be regularly consulted during this grant period and tribal governments will be consulted as intended by the federal milestones both in the planning and implementation phases. Consultation with the Consumer Advisory Workgroup, Steering Committee and the Tribes has already begun and continued meetings are included as key indicators. Steering Committee and Exchange Board evaluative research (participation assessment) will be conducted as part of the Level 1 Establishment Grant.

Report of findings: The measures show the necessary meetings are being held and staff will determine how feedback is incorporated. A federal milestone is that tribal consultations are occurring and documented, as measured by agenda items and meeting minutes.

3. Legislative/Regulatory Action

The objectives are to ensure the Exchange has the required statutory and regulatory responsibilities and authority to conduct federally required functions and activities, and to ensure that any relevant statutory or regulatory changes not included in the Exchange authorizing legislation are enacted. The 2011-2012 work plan identifies three Oregon-specific milestones and 15 key indicators. Enabling legislation was signed into law during June 2011. Key measures will document that a Board of Directors has been established, executive functions are established, and a formal plan of operations is completed by June 30, 2012.

Report of findings: A key measure will be completion of a findings report regarding additional requirements that need to be included in state statute. This report will be presented to the Board.

4. Governance

The objective is to determine the structure and oversight of the Exchange. The 2011-2012 work plan identifies one Oregon-specific milestone and ten key indicators. Implementing the

Exchange as a public corporation has several measures to assure that the governing body is appointed and confirmed, executive staff is hired and the business operations plan is completed on schedule. As part of this grant application, a Level 1 organizational chart has been included. A formal business plan will be created by the Board, with stakeholder input, and will be approved by the Legislature in February 2012.

Report of findings: A key measure will be a completed business plan submitted to the Legislature for approval before February 2012. Establishing a viable governance structure is a critical federal milestone during the Level 1 grant period. This includes formal appointment of a Board, hiring of an Executive Director and key staff, and development and adoption of By-Laws.

5. Program Integration

The objectives are: to achieve interoperability between the Exchange and other state programs to ensure seamless eligibility verification and enrollment processes; and to identify eligibility determination issues. The 2011-2012 work plan identifies nine key indicators associated with these objectives. Program integration of eligibility determination is one of the key indicators: documentation is currently underway regarding detailed business processes and changes to support Exchange operational requirements. Ongoing documentation will occur throughout Level 1, supporting compliance with federal milestones. As federal guidance is provided and as the IT design commences, the business processes may require revision in order to achieve program integration. Final IT solution testing will be completed by the fourth quarter of 2012 and could require changes to business processes in order to improve program integration.

Report of findings: Per federal milestones, formal inter-agency agreements between the Exchange, OHA Division of Medical Assistance Programs (Medicaid agency), Department of Consumer and Business Services (the state Insurance Division) will be executed by the end of 2011. The Medicaid agreement will memorialize roles, responsibilities and protocols with regard to eligibility determination, enrollment and compliance with “no wrong door” strategies. The agreement with the State Department of Insurance will clarify roles and responsibilities with the Exchange and outline strategies to mitigate adverse selection.

6. Information Technology Systems

Oregon's evaluation plan for its Exchange IT grant application is based on two main objectives: to develop and implement an Exchange technical solution that implements the core functions of an innovative ACA-compliant Exchange using a configurable technology framework and shared information technology environment while following federal guidance, leveraging prior work conducted by the state (Self-Sufficiency Management project) to meet federal requirements for a technical solution that can be easily transferred to and utilized by other states; and to establish a web-based, easy to access technical solution that uses a single portal for health insurance coverage and that seamlessly connects with a similarly streamlined, web-based eligibility and enrollment process for other state-administered social services programs. The 2011-2012 work plan identifies three Oregon-specific milestones, eleven federal milestones and 18 key indicators.

Report of findings: As Oregon is a recipient of the IT Innovator Grant, the state must demonstrate compliance with the mandated federal milestones through the Gate Review process. Quarterly progress is also noted in the required CCIIO quarterly reports, which note challenges and barriers to implementation, and how these issues are resolved.

The focus groups being suggested as part of Level 1 evaluative research will assist the state in developing an IT solution that is both ACA compliant and meets the needs of Oregonians. It is anticipated that for the Level 2 application the IT evaluation plan will include more detailed customer satisfaction data reported via focus groups, telephone surveys and on-line surveys. Additionally it is anticipated that the IT system itself will be configured to report Oregon specific data points, as well as data points required by CCIIO (pending federal guidance).

7. Financial Management

The objective is to establish a financial management structure and accounting system that adhere to applicable provisions of generally accepted accounting requirements, ensure sound financial management of Exchange fund and build in an audit component. The 2011-12 work plan identifies one major objective based on the federal milestone: establishing an Exchange financial management system, as well as 36 key indicators. Consultants have already completed preliminary financial modeling and analysis, and a final financial report and sustainability plan will be completed by the fourth quarter of the Planning Grant. Legislation authorizing the Exchange has both Secretary of State financial and performance audit functions embedded in it.

Report of findings: Measures for completing the draft and final business operational plan as well as additional financial modeling will be completed during this grant period. Oregon anticipates having draft financial benchmarks for the Level 2 application.

8. Oversight and Program Integrity

The objective is to develop and implement oversight and program integrity activities to detect and prevent fraud, waste, and abuse and comply with related state and federal laws. The 2011-2012 work plan outlines a key objective of developing and implementing oversight and program integrity activities, with an Oregon- specific milestone of selecting an audit firm to assess a system of internal controls and processes. Ten key indicators are associated with this Core Area.

Report of findings: A key measure is that Oregon will have a plan for the prevention of fraud, waste and abuse developed prior to Level 2 application. Key staff will be hired for oversight and program integrity functions. During this grant period an audit firm will be selected to provide an objective third-party review of all systems of internal control; assess adequacy of accounting and financial reporting systems; assess adequacy of accounting and financial reporting systems; and test compliance with laws, regulations, contracts and the grant agreement.

9. Health Insurance Market Reform

The objective is to implement health insurance market reforms of the Affordable Care Act. The 2011-2012 work plan identifies four key indicators. Three of the indicators have already been met: there has been stakeholder consultation on market reform issues during the community forums held in September 2010, a plan to implement reforms has been developed and legislation authorizing the reforms passed during the 2011 Legislative Session.

Report of findings: Legislation has passed which will require health insurance carriers offering plans in the individual and small group markets to provide bronze and silver plan coverage and specifies requirements for catastrophic plans. Writing of Administrative Rules will begin during this grant period and the legislation will become effective January 2, 2014.

10. Assistance to Individuals and Small Businesses, Coverage Appeals and Complaints

The objective is to develop and establish consumer service components and processes to ensure the Exchange is responsive to consumer information needs and concerns. The 2011-2012 work plan identifies eight key indicators, three of which are federal milestones. Meetings with existing public and private organizations that provide consumer assistance will be held to assess available services and capacity regarding eligibility; filing grievances and appeals; and collection of consumer information and data on inquiries, problems and solutions. These meetings will begin during the third and fourth quarters of 2011, and will continue throughout the Level 1 grant period. The Exchange will assess organizational capacity for data collection in order to track services. Based on the analysis, the Exchange will determine whether to out-source functions.

Report of findings: One measure is that a standard data collection tool and process for the Exchange will be developed by March 2012. A protocol for appeal of coverage determination, and a scope of work for building capacity to handle coverage appeals functions will be completed by the final quarter of 2012. Analysis and recommendations to use information for QHP accountability and Exchange functioning will be documented by the final quarter of 2012.

11. Exchange Business Operations

Performance measures for this Core Area will be further developed during the Level 1 grant period. The 2011-2012 work plan identifies business functions in which work is already underway, i.e. call center, Exchange website and calculator, Navigator program, eligibility and enrollment, etc. The focus groups being proposed during the Level 1 grant period will help drive the development of evaluation and performance criteria for the Exchange. Additionally, the small employer survey being proposed will assist with the development and evaluation of SHOP-specific functions. There are still several outstanding business functions for which states are awaiting federal guidance.

	Activities/Tasks	START DATE	END DATE	STATUS	RESPONSIBLE
	Complete / On schedule / Delay / Issues/Stopped — * Federal Requirement				
	ACTIVITIES HIGHLIGHTED IN AQUA ARE REFERENCED IN THE 2011-12 ESTABLISHMENT GRANT NARRATIVE				
	Background Research				
	Objective: Determine resource needs and funding in order to conduct operational planning for the Exchange				
	Milestone: Estimate Exchange Enrollment				
	Estimate range of enrollment take-up for individual/small-group markets	8/1/10	complete		
	Estimate the number of covered lives for "grandfathered"plans: federal estimates will be applied to OR enrollment data	3/1/11	complete		Don Myron: Policy Analyst
	Assess the impact of Medicaid expansions and changes		ongoing		Steve Novick: Policy Analyst
	Milestone: Analyze the size Individual and Group Markets				
	Evaluate existing state mandates on carriers	9/1/11	3/31/12		HIX; DCBS
	Assess impact of new insurance rating rules on premiums		ongoing		DM/ DCBS
	Understand the potential of adverse selection to be experienced by exchange and develop mitigating policies	6/1/10	ongoing		Rocky King; Director Health Care Purchasing
	Consider impact on the exchange of PPACA's risk adjustment requirements	10/1/10	ongoing		RK/DM
	Milestone: Analyze the number of carriers in each market and respective market shares of each				
	Insurance Division does this on an ongoing basis		complete		DCBS
	Milestone: State begins to develop a strategic plan for its Health Benefit Exchange in context of implementing PPACA's other key elements and passing state health care reform enabling legislation				
	Develop goals of an Exchange	4/1/10	complete		OHPB
	Decide whether to organize state-based exchange, join multi-state exchange, or cede functions to HHS	10/1/10	complete		OHPB
	Decide on basic strategy for exchange e.g. more or less aggressive in selective contracting for qualified health plans (QHPs)	6/1/10	complete		OHPB
	Implement state review of health plan premium rates consistent with federal guidance	10/1/10	ongoing		DCBS
	Enact insurance market reforms, including definition of small group market (50 vs. 100): SB 91, effective 1/2/2014		ongoing		DCBS + Legis

Complete | On schedule | Delay | Issues/Stopped

* Federal Requirement

	Activities/Tasks	START DATE	END DATE	STATUS	RESPONSIBLE
	Authorize creation of Health Benefit Exchange	2/1/11	6/1/11		Legis
	Investigate potential waivers of ACA	7/1/11	ongoing		HIX + DCBS
	Research requirements and costs for community providers to be liscensed carriers and potential Exchange role	7/1/11	ongoing		HIX + DCBS
	Work with OHA on development of CCO's	7/1/11	ongoing		OHA + HIX
	Assess incremental costs to the state of its mandated benefits, in light of federal definition of Essential Health Benefits: contingent upon federal guidance	12/1/10	10/1/11		DCBS
	Decide whether to develop a Basic Health Program (for uninsured up to 200% FPL)	12/1/10	complete		OHA
	Milestone: Coordination and Management of Research Studies				
	Impact on rates and market resulting from guaranteed issue	9/1/11	ongoing		HIX + DCBS
	Impact of chrning on Medicaid and the commercial market	9/1/11	ongoing		HIX + DCBS
	Impact of federally required rate changes to small group and individual markets, including the advisability of merging these markets	9/1/11	ongoing		HIX + DCBS
	Impact of small ACA-required small group expansion	9/1/11	ongoing		HIX + DCBS
	Milestone: Implement Level 1 Evaluation Plan				
	Conduct statewide focus groups	9/1/11	2/1/12		HIX + PSU
	Small employer survey	1/1/12	12/31/12		HIX + PSU
	Steering Committee and Board assessment	10/1/11	12/31/12		HIX + PSU
	HIX coordination with PSU + OHPR in level 2 evaluataion plan development	7/1/11	3/31/12		HIX + PSU + OHPR
Stakeholder Consultation					
Objective: Ensure Oregon's Exchange is attractive to and works for individual and business consumers					
Milestone: Establish and Utilize Consumer Advisory workgroup					
	Announce establishment of committee and solicit members	10/1/10	complete		HIX
	Hold meetings	12/1/10	12/1/11		HIX
	Complete Consumer Advisory Workgroup meetings upon appointment and confirmation of Exchange Board		11/1/11		
	Exchange Board will establish an Individual and Employer Consumer Advisory Committee	1/1/12	3/1/12		Exchange Board

	Activities/Tasks	START DATE	END DATE	STATUS	RESPONSIBLE
	Complete Complete On schedule Delay Issues/Stopped * Federal Requirement				
Milestone: Establish, implement and document a process for consultation with federally recognized Indian Tribal governments *					
*	Continue to implement and document Tribal consultations*	5/25/11	ongoing		OHA+HIX
Milestone: Establish exchange planning grant Steering Committee					
	Announce establishment of committee	9/1/10	9/30/10		Nora Leibowitz; Development Director HIX
	Choose members	9/1/10	9/30/10		NL
	Hold monthly meetings	9/30/10	ongoing		NL
	Complete Steering Committee meetings: becomes advisory board	11/1/11	ongoing		HIX
Milestone: Exchange will include stakeholder feedback in the development of its "Plan of Operations"					
	Begin regular meetings with key stakeholders	11/1/11	4/1/12		HIX
	Solicit input from interested stakeholders on draft business operations plan	11/1/11	4/1/12		HIX
	Establish additional work groups as needed (i.e.Navigator work group, carrier work group, broker work group, etc.)	11/1/11	ongoing		Board
	Solicit stakeholder input via e-newsletter	2/1/12	ongoing		HIX staff
	Begin policy development and document key processes (certification of exemption from the mandate; rating of health plans; information to disseminate with decision support tools; navigator etc	1/1/12	4/1/12		HIX
	Create analyses to inform upcoming key decisions	1/1/12	ongoing		HIX
Legislative Regulatory Action					
Objective: Ensure Exchange has required statutory and regulatory responsibilities and authority to conduct federally-required functions and activities*					
Milestone: Pass Exchange authorizing legislation					
*	Draft + introduce enabling legislation*	11/1/10	complete		OHA + Leg. Council
*	Hold public hearings on Exchange enabling legislation*	2/1/11	complete		Legis
*	Pass legislation*	5/1/11	complete		Legis
Objective: Ensure any relevant statutory or regulatory changes not included in the Exchange authorizing legislation are enacted*					
	Milestone: Legislative approval of Exchange Business Plan				
	Pass SB 99	6/30/11	complete		Legis
	Board edits and approves draft Business Plan	9/1/11	10/31/11		Board
	Hold public forums + finalize Business Plan	11/1/11	12/31/11		HIX

	Activities/Tasks	START DATE	END DATE	STATUS	RESPONSIBLE
	Complete Complete On schedule Delay Issues/Stopped * Federal Requirement				
	Educate legislators about the Business Plan	1/1/12	2/29/12		HIX
	Pass legislation approving Exchange Business Plan	2/1/12	2/29/12		Legis
	Identify areas that require Admininistrative Rules	7/1/11	ongoing		HIX
Milestone: State establishes Health Benefit Exchange and continues the planning to go operational					
*	Appoint and approve governing board and begin search for Executive Director (ED)*	7/1/11	ongoing through Feb. 2012		Gov. Office/Legis
	Develop and adopt By-Laws	7/1/11	10/1/11		HIX, ED Board
*	ED begins hiring key personnel*	7/1/11	ongoing through 2012		HIX + ED
	Locate physical space for exchange	9/1/11	6/30/12		TBD
	Purchase computers and equipment	9/1/11	6/1/12		TBD
	Develop and adopt formal plan of operations	9/1/11	6/1/12		HIX Board + ED
Governance					
Objective: Determine structure and oversight of Exchange					
Milestone: Implement Exchange as public corporation *					
*	Develop governance and organizational structure for exchange*	12/1/10	complete		NL/OHPB
	Develop model legislation for exchange and insurance market reform: SB 99 + 91	10/1/10	complete		NL/Leg Counsel
*	Develop a governance model*	10/1/10	complete		OHPB
	Develop By-Laws for Board adoption	7/1/11	10/30/11		HIX + Board
*	Establish job descriptions and recruit an Exchange Board: Gov appoints; Senate confirms	5/1/11	10/1/11		HIX staff + Governor + Legislature
*	Begin national search for permanent Executive Director and appoint Interim Exchange Executive Director.	7/1/11	ongoing through Feb. 2012		Governor + Legislature

	Complete / On schedule / Delay / Issues/Stopped — Activities/Tasks — * Federal Requirement	START DATE	END DATE	STATUS	RESPONSIBLE
	Hold board meetings (36)	10/1/11	ongoing		Interim ED + Board
	Hire key executive staff: No Articles of Incorporation needed as authorizing legislation creates the Exchange as a corporation upon passage	7/1/11	12/31/11		Board and HIX staff
	Begin implementing exchange, on basis of legislative approval	2/1/12	3/1/12		Legis
	Final planning grant project report due to CCIIO	12/1/11	12/1/11		NL
Program Integration					
Objective: Achieve interoperability between the Exchange and other state programs to ensure seamless eligibility verification and enrollment processes, and coordination of insurance market regulatory functions as needed.					
*	Perform detailed business process documentation to reflect current state business processes, and include future state process changes to support proposed Exchange operational requirements *	1/1/11	pending federal guidance		HIX Team + Op. Planning contractor
Objective: Identify Eligibility Determination Issues					
	Assess eligibility determination issues under PPACA for exchange, CHIP, Medicaid etc	10/1/10	On going		SN
	Identify state agencies/legislative leaders to be involved in implementation	8/1/10	complete		NL
	Analysis of streamlining of process, in coordination with development of new enrollment systems	9/24/10	12/31/11		SN
	Until further guidance from HHS, state uses PPACA section 1413 to inform discussion and consideration of common enrollment elements of existing subsidized programs and elements of enrolling newly eligible individuals through health exchange	9/24/10	12/31/11		SN
*	Communication initiated with State HIT Coordinators, State Department of Insurance, and the State Medicaid agency, and hold regular collaborative meetings to develop work plans for collaboration *	9/1/10	ongoing		NL + SN

	Activities/Tasks	START DATE	END DATE	STATUS	RESPONSIBLE
	Complete / On schedule / Delay / Issues/Stopped — * Federal Requirement				
*	Execute an agreement with the state department of insurance that includes: (1) a determination of the roles and responsibilities of the Exchange and DOI as they relate to qualified health plans offered inside and outside the Exchange, and (2) a strategy for limiting adverse selection between the Exchange and the outside market, possibly including legislative changes to level the playing field *	6/1/11	12/31/11		Gregory Jolivette, Senior Policy Analyst + DOJ
*	Execute an agreement with the state Medicaid agency and others that includes (1) determination of the respective roles and responsibilities, (2) identification of challenges; (3) strategies for compliance with "no wrong door"; (4) operating procedures for interactions between the Exchange and other programs*	6/1/11	12/31/11		GJ + DOJ
	Collaborate on procurement and development of Exchange and Medicaid IT systems needed to facilitate no wrong door for eligibility determinations	12/22/10	ongoing		NL + SN
	Information Technology Systems				
	Objective: Plan for and develop Exchange IT systems--using a modular, flexible approach to systems development--that enable the organization to efficiently perform required functions.				
	Milestone: State begins development of detailed technical specifications and implementation of simplified streamlined eligibility determination and subsidy system, including electronic data interfaces with HHS				
*	Conduct a gap analysis of existing systems and end goal for systems development by 2014 *	2/1/11	complete		Wakely + HIX
	Assess federal guidelines against current eligibility	7/1/11	6/1/12		SN: penidng federal guidance
	Ensure coordination with state Medicaid programs and exchange	7/1/11	6/1/12		HIX
	Milestone: State begin evaluation process of streamlining procedures for enrollment through a health exchange and state Medicaid, CHIP and other health subsidy programs				
	Systems will ideally be functional prior to beginning of QHP procurement	2/1/11	12/31/11		HIX IT
	State subsidized programs shall participate in a data matching arrangement for determining eligibility for participation in the programs	7/1/11	6/1/12		HIX, OHA, DHS
*	Complete the review of product feasibility, viability, and alignment with Exchange program goals and objectives *	1/1/11	complete		HIX IT
*	Complete preliminary business requirements and develop IT architetectural and integration framework *	1/1/11	complete		HIX IT

	Activities/Tasks	START DATE	END DATE	STATUS	RESPONSIBLE
	Complete Complete On schedule Delay Issues/Stopped * Federal Requirement				
*	Complete systems development life cycle implementation plan *	1/1/11	complete		HIX IT
	Develop electronic interfaces between state and HHS	7/1/11	6/1/12		HIX IT + HHS
	Ensure enrollment systems meet federal specifications	7/1/11	6/1/12		HIX IT + HHS
	Develop secure electronic interface between all state-subsidized programs	7/1/11	6/1/12		HIX IT
*	Complete security risk assessment and release plan *	4/1/11	12/31/11		HIX IT
*	Complete preliminary detailed design and system requirements documentation *	4/1/11	9/30/11		HIX IT
*	Finalize IT and integration architecture *	4/1/11	12/31/11		HIX IT
*	Complete final requirements documentation *	4/1/11	3/31/12		HIX IT
*	Complete preliminary and interim development of baseline system and review and ensure compliance with business and design requirements *	4/1/11	3/31/12		HIX IT
	Milestone: State develops IT/website infrastructure approach, develops and implements system solution to support Exchange goals, functions				
*	Complete final development of baseline system including software, hardware, interfaces, code reviews, and unit-level testing *	4/1/11	9/30/12		HIX IT
*	Complete testing of all system components including data, interfaces, performance, security, and infrastructure*	1/1/12	12/31/12		HIX IT
	Financial Management				
	Objective: Establish a financial management structure and accounting system that adheres to applicable provisions of generally accepted accounting requirements and ensures sound financial management of Exchange funds.				
*	Adhere to HHS financial monitoring activities for planning grant and under the Establishment Cooperative Agreement *	At receipt of grant: ongoing	12/31/14		OHA + HIX
	Preliminary financial modeling and analysis completed	3/1/11	complete		Wakely
	Develop financial systems (general ledger, accounts payable, payroll)	9/1/11	3/1/12		HIX

	Complete / On schedule / Delay / Issues/Stopped — * Federal Requirement Activities/Tasks	START DATE	END DATE	STATUS	RESPONSIBLE
	Develop funds flow model to identify future funding needs	9/1/11	3/1/12		HIX
	Develop ongoing budget for key IT systems	9/1/11	3/1/12		HIX
	Develop accounting and internal controls	9/1/11	3/1/12		HIX
	Begin defining financial management structure and the scope of activities required to comply with requirements	9/1/11	3/1/12		HIX
*	Establish a financial management structure and hire experienced accountants to support financial management activities of the Exchange *	9/1/11	6/1/12		HIX
Milestone: State applies for Federal grants for Development of Health Benefit Exchange.					
	Begin strategic plan for exchange in context of implementing PPACA	8/1/10	10/1/11		NL
	Establish exchange and begin the planning for Operations	1/1/11	3/1/12		NL
	Applied for and received planning grant	9/1/10	complete		NL
	Project team complete: contractor hired	1/1/11	complete		NL
	Contractor begins work on initial needs assessment, resource planning	1/1/11	complete		NL/team
*	Exchange legislation introduced, includes audit provisions (SB 99)*	2/1/11	complete		Legis
	Consumer Advisory Group meets quarterly	11/1/10	12/31/11		Jeremy Vandehey; Community Engagement Coordinator/ NL
	Steering Committee meets monthly	1/1/11	12/31/11		JV/NL
	Identification of ACA requirements that affect eligibility conducted	8/1/10	ongoing		SN
	Submit quarterly Planning Grant project report to CCIIO	1/31/11	12/31/11		NL
	Applied for and received IT innovator grant	12/22/10	complete		NL/OIS
	Begin expedited RFP process for IT vendor	2/15/11	complete		OIS + DOJ
	Begin work on IT grant	2/1/11	complete		OIS
	Determine whether to apply for Level 1 or Level 2 Implementation Grant, and begin grant application process	3/1/11	complete		NL/OHA ldrshp
	Initial needs and gap assessment, readiness assessment and infrastructure resource analysis completed	3/1/11	complete		Wakely
	Draft analysis of funding sources for exchange (plan for tracking, reporting, reconciling federal premium tax credits)	3/1/11	complete		Wakely

	Complete / On schedule / Delay / Issues/Stopped — * Federal Requirement **Activities/Tasks**	START DATE	END DATE	STATUS	RESPONSIBLE
	Analysis of risk mediation strategies completed	4/1/11	ongoing		RK
	Draft IT analysis completed	3/1/11	complete		Wakely
	Final needs and gap assessment, readiness assessment and infrastructure resource analysis completed	5/15/11	7/1/11		Wakely
	Additional financial modeling and analysis completed	5/1/11	7/1/11		Wakely
	Develop draft business operational plan	5/1/11	complete		Wakely
	Financial modeling and analysis finalized	6/1/11	7/1/11		Wakely
	Final IT analysis and recommendation completed	3/1/11	6/15/11		Wakely
	Final business operational plan completed	3/1/11	7/1/11		Wakely
	Complete analysis of ways to reduce information required in Medicaid eligibility determination to align with exchange requirements	2/1/11	9/1/11		SN
	Complete determination of whether additional statutory changes are required for exchange implementation.	6/1/11	8/1/11		Gregory Jolivette; Policy Analyst
	Develop a plan to ensure sufficient resources to support ongoing operations and determine if legislation is necessary to assess user fees	7/1/11	2/1/12		NL, RK, Board
	Assess adequacy of accounting and financial reporting systems	3/1/12	6/1/12		Board
	Conduct a third party objective review of all systems of internal control	6/1/12	8/1/12		Board
Oversight and Program Integrity					
Objective: Develop and implement oversight and program integrity activities to detect and prevent fraud, waste, and abuse and comply with related state and federal					
*	Develop a plan for the prevention of fraud, waste, and abuse *	7/1/11	3/1/12		Board
	Continue to work with Sec. of State's office on audit processes, protocols and reporting requirements		ongoing		HIX
	Expand planning process and hire staff for oversight and program integrity functions	10/1/11	12/31/11		Board
	Work with OHA + DHS + OIS to develop goals and protocols for a FWA program	1/1/12	ongoing		HIX
	Work with HIX IT to ensure IT system is configured to captrue and report FWA data	7/1/11	ongoing		HIX
	Establish rules + procedures for an external audit by a qualified auditing entity to perform an independent external financial audit of the Exchange	11/1/11	2/1/11		Board
	Milestone: Select audit firm to assess system of internal controls and key processes and systems				

	Complete / On schedule / Delay / Issues/Stopped — * Federal Requirement **Activities/Tasks**	START DATE	END DATE	STATUS	RESPONSIBLE
	Objective third party review of all systems of internal control	3/1/12	6/1/12		HIX
	Assess adequacy of accounting and financial reporting system	3/1/12	6/1/12		HIX
	Assess adequacy of data security and bring up systems	3/1/12	6/1/12		HIX
	Test compliance with laws, regulations, contracts and grant agreement	3/1/12	6/1/12		HIX
Health Insurance Market Reform					
Objective: Implement health insurance market reforms of the Affordable Care Act.					
	Stakeholder consultation on market reform issues	8/1/10	10/1/10		OHFB
	Development of a plan to implement reforms	10/01/10	1/1/11		DCBS
	Passage of state legislation to implement reforms	2/1/11	6/30/11		Legis
	Issuance of regulations to Implement reforms	7/1/11	12/31/11		DCBS
	Continue to work closely with DCBS in identifying roles and responsibilities of each agency		ongoing		HIX + DCBS
Providing Assistance to Individuals and Small Businesses, Coverage Appeals, and complaints					
Objective: Develop and establish consumer service components and processes to ensure Exchange is responsive to consumer information needs and concerns					
	Coordinate with existing organizations and assure the following services are available: (1) help to determine eligiblity for public and private coverage; (2) help to file grievances and appeals; (3) provide information about consumer protections; and (4) collect data on inquiries and problems and how they were solved	8/1/11	ongoing		HIX Outreach Staff
	Exchange Board will establish an Individual and Employer Consumer Advisory Committee	1/1/12	3/1/12		Exchange Board
*	Analyze data collected by existing consumer assistance programs (Oregon Health Conncects) and report on plans use for information to strengthen qualified health plan accountability and functioning of the Exchange *	8/1/11	12/31/12		HIX Outreach Staff
	Work with Healthy Kids + FHIAP staff to assess requirements for Navigators	4/1/11	12/31/11		HIX + Healthy Kids+ FHIAP
	Transition Oregon Health Connects staff to Exchange	1/1/12	3/1/12		HIX + DCBS
*	Draft scope of work + protocols for building capacity to handle coverage appeals functions*	8/1/11	12/31/12		HIX Legal Staff
	Develop staffing plan for appeals and complaints	8/1/11	12/31/12		HIX Legal Staff
*	Establish protocols for appeals of coverage determinations including review standards and timelines and provision of help to consumers during the appeals process *	1/1/12	12/31/12		HIX Legal Staff

	Activities/Tasks	START DATE	END DATE	STATUS	RESPONSIBLE
	Complete / On schedule / Delay / Issues/Stopped — * Federal Requirement				
Exchange Business Operations A to O					
A. Certification of Qualified Health Plans					
Objective: Develop and implement clear standards and a process for certification of qualified health plans					
	Hire Plan Management Manager + Certification Analyst	7/1/11	11/1/11		Board
	Begin developing standards that will be required for certification of a qualified health plan	11/1/11	2/29/12		HIX Plan Management Manager + staff
	Determine whether and what waivers Oregon may need to request to include CCO's under the Exchange	4/1/11	9/30/11		Pending federal guidance HIX staff; Board
	Submit CCO waivers to HHS:Anticipated approval timing = 6 months	10/1/11	3/31/12		HHS
	Develop a clear certification policy including a timeline for application submission, evaluation, and selection of qualified health plans	1/1/12	2/29/12		HIX Plan Management Manager + staff
	Actively engage stakeholders in the development of the solicitation for proposals , through meeting, conferences, webinars, and other forums designed to gather stakeholder input	2/1/12	3/31/12		HIX Plan Management Manager + staff
	Develop a strategy and timeline for the integration of staff and IT systems needed to receive applications, evaluate data from insurers, and notify insurers of the result of the solicitations for applications for qualified health plans	2/1/12	3/31/12		HIX Plan Management Manager + staff
	RFP issued	5/1/12	7/31/12		HIX Plan Management Manager + staff
	Responses due	8/1/12	8/1/12		HIX Plan Management Manager + staff
	Plan selection and notification	8/2/12	9/30/12		HIX Plan Management Manager + staff
	Contract Negotiation + Execution	10/1/12	11/30/12		HIX Plan Management Manager + staff
B. Call Center					
Objective: Establish a call center that reflects the highly consumer-focused mission of the Exchange and accommodates the hearing impaired.					
	Work with Oregon Health Connect, State Consumer Assistance Program, to collaborate on interim call center functions	5/1/11	1/1/13		HIX staff
	Oregon Health Connect referral staff hired	7/1/11	10/31/11		HIX staff
	Identify requirements for call center functions, including in-house and outsourced	9/1/11	11/1/11		HIX staff
	Develop transitional plan	11/30/11	5/30/12		HIX staff

	Complete / On schedule / Delay / Issues/Stopped — Activities/Tasks — * Federal Requirement	START DATE	END DATE	STATUS	RESPONSIBLE
	Hire and/or contract for services	6/1/12	12/1/12		HIX staff
	Call center operational	1/1/13	ongoing		HIX staff
C. Exchange Website and Calculator					
Objective: Develop a website that surprises and delights, allows consumers to make informed health coverage decisions, and meets federal requirements.					
	Participate in user experience project	5/1/11	1/1/12		IT Innovator Grant
*	Begin developing requirements for system and program operations, including requirements related to online comparison of QHPs; reqts related to online application; premium tax credit and cost sharing reduction calculator ; linkages to other state programs. *	4/1/11	complete		IT Innovator Grant
*	Begin systems development*	4/1/11	complete		IT Innovator Grant
*	Submit content for informational website to HHS for comment*	7/1/11	9/30/11		IT Innovator Grant
D. Quality Rating System					
Objective: Implement the federally-designed quality rating system for qualified health plans.					
	Use the federal quality rating system developed by HHS in development of draft contracts for qualified health plans	11/1/11	2/29/12		pending federal guidance
	Hire Evaluation Analyst	11/1/11	3/31/12		ED + Board
	Work with stakeholders to incorporate Oregon-specific measures into rating system	11/1/11	6/30/12		pending federal guidance
	Include quality rating functionality in system business requirements for the exchange website	3/1/12	12/31/12		
	Complete system development of quality rating functionality	1/1/13	3/31/13		
	Complete testing and validation of quality rating functionality	3/31/13	6/30/13		
E. Navigator Program					
Objective: Plan, develop and implement a Navigator Program.					
	Work with Healthy Kids + FHIAP staff to assess requirements for Navigators and develop training	4/1/11	12/31/11		HIX staff + Healthy Kids + FHIAP
	Determine targeted organizations in the state who would qualify to function as Navigators	10/1/11	1/1/12		HIX Outreach Coordinator
	Conduct preliminary planning activities related to the navigator program including developing high-level milestones and timeframes for establishment of the program	2/1/12	6/30/12		HIX Outreach Coordinator

	Activities/Tasks	START DATE	END DATE	STATUS	RESPONSIBLE
	Complete / On schedule / Delay / Issues/Stopped — * Federal Requirement				
F. Eligibility Determinations					
Objective: Develop and implement an integrated eligiblity and enrollment system that meets the program requirements of the Exchange as well as other state programs.					
	Begin coordination with agencies administering other Applicable State Health Subsidy Programs (OASHSPs)	9/1/10	complete		HIX + IT Innovator Grant
	Begin coordination with the state Division of Insurance + Medicaid + OIS	9/1/10	complete		IT Innovator Grant
*	Begin developing requirements re interfacing and integrating enrollment transactions and eligibility referrals, coordination of appeals, coordination of applications and notices, managing transactions, communicating the enrollment status of individuals. *	4/1/11	complete		IT Innovator Grant
*	Begin system development*	4/1/11	complete		IT Innovator Grant
*	Complete system development and prepare for final user testing*	10/1/12	12/31/12		IT Innovator Grant
G. Enrollment Process					
Objective: Develop and implement an integrated eligiblity and enrollment system that meets the program requirements of the Exchange as well as					
*	Hire staff and begin developing policy and operational requirements for systems and program operations including providing customized plan information to individuals, submitting enrollment transactions to QHP issuers, receiving acknowledgements, and submitting relevant data to HHS*	7/1/11	ongoing		HIX staff
*	Begin systems development*	1/1/12	9/30/12		HIX staff
*	Complete system development and prepare for final user testing*	10/1/12	12/31/12		HIX staff
H. Applications and Notices					
Objective: Integrate federally-developed forms and customize as needed for Oregon's Exchange.					
	Review federal requirements for applications and notices, begin customizing federal applications and notices as allowable				pending federal guidance
	Application forms and notices complete		3/31/13		HIX staff
I. Exemptions from Individual Responsibility Requirement and Payment					
Objective: Develop and implement a system to process and grant exemptions from the individual responsibility requirement.					
*	Begin developing requirements for systems and program operations, including accepting requests for exemptions, reviewing and adjudicating requests, and exchanging relevant information with HHS*	4/1/11	ongoing		work has been initiated, however federal guidance is pending
*	Begin systems development*	1/1/12	9/30/12		

	Activities/Tasks	START DATE	END DATE	STATUS	RESPONSIBLE
	Complete Complete / On schedule / Delay / Issues/Stopped — * Federal Requirement				
*	Complete system development and prepare for final user testing*	10/1/12	12/31/12		
J. Premium Tax Credit and Cost-Sharing Reduction Administration					
Objective: Develop and implement a system to administer the premium tax credit and cost-sharing reductions					
*	Begin developing requirements for systems and program operations including relevant information to QHP issuers and HHS to stop, start or change the level of premium tax credits and cost-sharing reductions*	4/1/11	ongoing		work has been initiated, however federal guidance is pending
*	Begin systems development*	1/1/12	9/30/12		
*	Complete system development and prepare for final user testing*	10/1/12	12/31/12		
K. Adjudication of Appeals and Eligibility Determinations					
Objective: Develop and implement a system to adjudicate appeals					
	Begin developing business processes and operational plan for appeals functions	6/1/12	ongoing		pending federal guidance
	Establish resources to handle appeals of eligibility determinations including training on eligibility requirements	6/1/12	ongoing		
L. Notification/Appeals of Employer Liability for Employer Responsibility Payment					
Objective: Develop and implement a system to adjudicate employer appeals					
*	Begin developing requirements for systems and program operations including coordination of employer appeals of individual eligibility, and submission of relevant data to HHS*	4/1/11	ongoing		work has been initiated, however federal guidance is pending
*	Begin systems development*	1/1/12	9/30/12		
*	Complete system development and prepare for final user testing*	9/30/12	12/31/12		
M. Information Reporting to IRS and Enrollee					
Objective: Develop and implement a system for reporting information to the IRS abd enrollees					
*	Begin developing requirements for systems and program operations including capturing data used in enrollment process; submitting relevant data to HHS for later use in information reporting; capacity to generate information reports to enrollees.*	4/1/11	ongoing		work has been intiated, however federal guidance is pending: HIX IT grant
*	Begin systems development*	1/1/12	9/30/12		work has been intiated, however federal guidance is pending: HIX IT grant
*	Complete system development and prepare for final user testing*	10/1/12	12/31/12		
N. Outreach and Education					
Objective: Develop and implement a strategy for outreach and education that includes stakeholders and consumer focus testing, as well as a process					

	Complete / On schedule / Delay / Issues/Stopped — * Federal Requirement Activities/Tasks	START DATE	END DATE	STATUS	RESPONSIBLE
	Hire key communication + outreach staff	7/1/11	3/31/12		ED + Board
	Perform market analysis to assess outreach/education needs	9/1/11	ongoing		HIX Chief Communication Officer + staff
	Develop outreach and education plan to include key milestones and contracting strategy	2/1/12	ongoing		HIX Chief Communication Officer + staff
	Distribute outreach and education plan to stakeholders and HHS for input and refinement	4/1/12	7/1/12		HIX Chief Communication Officer + staff
	Develop a toolkit for outreach to include educational materials and information	4/1/12	12/31/12		HIX Chief Communication Officer + staff
	Develop performance metrics and evaluation plan	5/1/11	ongoing		HIX Chief Communication Officer + staff
	Design a media strategy and other information dissemination tools	4/1/12	9/1/12		HIX Chief Communication Officer + staff
	Focus test materials with key stakeholders and consumers and make refinements based on input	1/1/12	8/1/12		HIX Chief Communication Officer + staff
	Submit final outreach and education plan to HHS	9/30/12	9/30/12		HIX Chief Communication Officer + staff
O. SHOP-specific Functions					
Objective: Develop and implement systems for small business use of the Exchange.					
	Research the design and approach of the SHOP Exchange and whether it will be merged with the individual market exchange	9/1/10	1/1/11		NL + DM
	Hire SHOP Manager	7/1/11	11/1/11		ED + Board
*	Begin developing requirements for systems and program operations*	4/1/11	complete		HIX staff + IT
*	Begin systems development*	4/1/11	complete		HIX staff + IT
*	Complete systems development and begin user testing*	10/1/12	12/31/12		HIX staff + IT