District of Columbia
Health Benefit Exchange Design Review Narrative

Section 1.0: Legal Authority and Governance

1.1 Enabling Authority for Exchange and SHOP

On December 20, 2011, the Council of the District of Columbia passed legislation, The Health Benefit Exchange Authority Establishment Act of 2011 ("HBX Establishment Act"), to establish a state-based exchange that has the authority to operate an Affordable Insurance Exchange, including a Small Business Health Options Program (SHOP), compliant with the ACA and implementing regulations. The Mayor approved the legislation on January 17, 2012 and, following a congressional review period, the legislation became effective on March 2, 2012. The legislation creates the District of Columbia Health Benefit Exchange Authority (Authority) as an independent, quasi-governmental organization governed by a volunteer executive board of prominent health-care professionals.

1.2 Board and Governance Structure

The HBX Establishment Act established the HBX Authority Executive Board as the governing body for the HBX. The Executive Board consists of seven voting members and four ex-officio members. The ex-officio members are the directors of the Departments of Health, Health Care Finance, and Human Services as well as the Commissioner of the Department of Insurance, Securities, and Banking. The voting members, appointed by the Mayor on June 7, 2012, and approved by the D.C. Council on July 10, 2012, are as follows:

- **Dr. Mohammed Akhter**, former Director of the DC Department of Health
- **Henry J. Aaron, PhD**, Senior Fellow at the Brookings Institution
- **Leighton Ku, PhD**, Professor and Director of the Center for Health Policy Research, George Washington University
- **Khalid Pitts**, Director of Strategic Campaigns, SEIU
- **Kate Sullivan Hare**, Director, Policy Outreach and Public Affairs, Robert Wood Johnson Foundation
- **Diane C. Lewis**, Health Care Policy Consultant
- **Kevin Lucia**, Research Professor and Project Director, Health Policy Institute, Georgetown University

The voting Executive Board members were required to demonstrate experience in at least two of the following areas: individual or small employer health care coverage; health benefits plan administration; health care finance; administering a public or private health care delivery system; purchasing health plan coverage; prior experience in commercial insurance management; actuarial analysis; health care economics; human services administration; health care consumer interest advocacy; public health programs; or enrolling individuals into health benefit plans.

The HBX Establishment Act contains strong conflict of interest provisions. A member of the Executive Board and Authority staff must not be professionally connected to a health carrier or other insurer, an agent or broker, a health professional, a trade association of health carriers, or a health care facility or health clinic while serving. A health professional may only serve if he/she receives no compensation for rendering services. Additionally, for one year following the end of Executive Board membership or

Authority employment, an individual may not accept employment with any health carrier that offers a QHP through the Exchange. Finally, there are standard extensions of restrictions on abuse of position and prohibitions on acceptance of bribes or non-*de minimus* gifts. By-Laws were adopted by the DC HBX Executive Board on August 7, 2012. Article X of the By-Laws reference the conflict/ethics rules as set forth in DC Official Code 31-3171.10 and describes the process for disclosing such conflicts (both ethical and financial) publicly.

The Executive Board selection process began with an open solicitation for applications issued by the HRIC. The announcement was posted on the District's health reform website[1] and several announcements were made at multiple HRIC subcommittee meetings with stakeholders in attendance. All applications were forwarded to the D.C. Office on Boards and Commissions. The directors of the Departments of Health, Health Care Finance, and Human Services as well as the Commissioner of the Department of Insurance, Securities, and Banking conducted preliminary, in-person interviews with a selection of finalists as determined by the Deputy Mayor for Health and Human Services.

Section 2.0: Consumer and Stakeholder Engagement and Support

2.1 Stakeholder Consultation Plan

Description of the stakeholder consultation plan that addresses how consultation will occur on an ongoing basis with consumers, small businesses, State Medicaid and CHIP agencies, agents/brokers, employer organizations, and other relevant stakeholders as required under 45 CFR 155.130.

The District is committed to continuous stakeholder engagement throughout the planning and implementation phases to establish the District's Exchange. The District's newly created Executive Board holds monthly public meetings, which are scheduled in the evenings to achieve maximum participation, designed to address outstanding policy and programmatic decisions required to implement the District's Health Benefit Exchange. Additionally, the District continues to hold monthly, public meetings for its six Health Reform Implementation ~~S~~ubcommittees, including: Insurance; Information Technology; Communications; Medicaid Expansion and Eligibility; Operations; and Health Delivery Systems. All meeting times and locations along with minutes are posted on the District's Health Reform website. In addition, a schedule of meetings is emailed to interested stakeholders twice a month to ensure maximum participation at public meetings.

In May 2012, the District issued the inaugural edition of its "For Your Benefit" newsletter. The newsletter is issued monthly and focuses on District Agency activities related to health reform. It also includes information on upcoming meetings, job vacancies, solicitation for input on recommendations and analyses of various health benefit exchange activities conducted by the District, and other information that is felt would be beneficial to the target audience. The subscription list includes over 900 individuals, including stakeholders, carriers, District staff, and others who have registered to receive email updates on the Health Reform website.

Stakeholder consultation schedules, agendas, and feedback received.

All meetings that are open to the public are listed on the District's Health Reform website (healthreform.dc.gov). In addition, those individuals who have signed up to receive notifications receive

[1] http://healthreform.dc.gov

bi-weekly meeting schedules with dates, times, and locations of all meetings. Currently, the following meetings are open to the public:

- Health Benefit Exchange (HBX) Executive Board Meeting
- HRIC Insurance Subcommittee Plan HBX Market Working Group
- HRIC Insurance Subcommittee
- HRIC Communications Subcommittee
- HRIC Medicaid Eligibility and Expansion Subcommittee
- HRIC Health Delivery Subcommittee
- HRIC Operations Subcommittee
- HRIC Information Technology Subcommittee

The Health Benefit Exchange Authority Board hosts bi-weekly public meetings. Each Board meeting allocates a block of time for public stakeholder comments. Additionally, the meeting announcements contain contact information for those individuals who wish to submit comments electronically prior to the meeting.

Through its HRIC Subcommittees, the District has released for public comment recommendations on key decisions. These recommendations are sent out to the public through an email distribution list and are also posted on the health reform website. Two such recommendations are the Market Structure Recommendations developed by the HRIC Insurance Subcommittee and the Navigator Report, issued by the HRIC Exchange Operations Subcommittee. After public comments are received, the subcommittees finalize draft recommendations which are then presented for the Board.

The District continues its efforts in implementing its Strategic Communication Plan. One aspect of the plan involves utilizing social media platforms to target a wider population of District residents and stakeholders. These platforms include Facebook, Twitter, Flicker, YouTube, and other social media avenues where information on the implementation status of the Exchange as well as upcoming meetings and announcements can be highlighted.

The District is in the process of developing a new website for the Health Benefit Exchange Authority. The website will have the ability to allow those who are interested to request for the District to speak on the health benefit exchange to their group. In addition, the website will contain all pertinent information regarding the health benefit exchange, including upcoming meetings, meeting materials, additional resources, and a host of other information that the District feels is beneficial in educating its stakeholders. The website will be multi-lingual with the ability to translate content into five different five languages. The District has received comments and feedback on its current health reform website and has taken those comments into consideration in the design of this new website.

2.2 Tribal Consultation Plan

This activity is not applicable to the District of Columbia.

2.3 Outreach and Education

Description of outreach plan and targeted efforts that address each population or type of stakeholder, including those identified in 45 CFR 155.130.

As noted above, the District holds monthly subcommittee meetings to engage the public on various aspects of implementation of the Exchange.

In addition, a vendor will be hired for branding, education, and outreach support to the District's Health Benefit Exchange. This vendor will develop and create names, logos, and taglines for the District's Exchange and its offerings. The branding will be designed to allow for translation into multiple languages, and also take into account the needs of those individuals with disabilities, in order to reach the District's diverse population. The contractor will also design and implement a communications and marketing plan that identifies comprehensive strategies customized for targeted populations and subsets to maximize enrollment of eligible individuals, families, and small businesses into the exchange. The Exchange will also comply with the District's Language Access Act, which requires communications to be provided in the most common languages of District residents. Other activities include television and radio ads, signage, and other avenues that the marketing vendor recommends is appropriate for successful education and outreach.

The District will also work with its contractor, the Crider Group, to develop a social media platform to target a wider population of District residents. These platforms include Facebook, Twitter, and other social media avenues where information on the implementation status of the Exchange as well as upcoming meetings and announcements can be highlighted. Additionally, digital communications platforms along with mobile apps will be utilized for broader outreach.

2.4 Call Center

Description of the call center strategy for managing call volume.

Working with Compass Solutions, the District performed an analysis of the its requirements for an Exchange Call Center, including utilization of current and planned consumer assistance services to support the needs of the Exchange. The District has an all-encompassing vision to effectively and efficiently meet the ACA requirements using a multi-District agency framework, including the Department of Human Services, the Department of Insurance, Securities, and Banking, and the Office of Healthcare Ombudsman and Bill of Rights to meet the needs of the consumer. With this analysis as a guide, the District will procure a vendor to design and implement the call center in the District. The District recently released a Request for Information (RFI) to collect additional information to assist with the initial planning and design of the call center. Once responses are received, the District will develop recommendations for the proposed structure of the call center and present these recommendations to the Board.

Description of call center's plan for translation services.

The call center design will take into account the language requirements of the residents of the District and implement a call center that will ensure the Exchange complies with the District's Language Access Act, which requires communications to be provided in the most common languages of District residents.

2.5 Internet Web Site

Internet Web site URL address for the Exchange and SHOP, if different.

The Internet Portal will serve as the gateway for District residents seeking health benefit coverage, and other types of assistance in future releases. The Portal will allow all DC residents to submit an

application, view Marketplace information for eligible benefit coverage, enroll in various products, and access to contact details for Assisters or education and outreach tools. As the public-facing website, the Portal will serve as a key entry point for all user types and must be compliant with both the Americans with Disabilities Act (ADA) and the Rehabilitation Act Section 508 with accessibility from any device that has internet capabilities.

The District issued a Request for Proposal on July 12, 2012 to procure a Systems Integration vendor to provide and implement the District of Columbia Access System (DCAS). DCAS will be a state-of-the-art health and human services solution, providing the District's Health Benefit Exchange insurance marketplace, as well as a new integrated eligibility system for Insurance Affordability and human services programs with case management capabilities that span programs and agencies. Once this vendor is on board, the Internet Web site URL for the Exchange will be created. The District envisions that one URL will be used for both the Exchange and SHOP.

Description of Internet Web site operations plan.

Working with its System Integration vendor, the District will design a plan to transition the operations of the Exchange Internet Web site from the vendor to the District. Through a Memorandum of Understanding (MOU), the operations of the web site, including maintenance and responding to and resolving help desk tickets, will be transitioned to the District's Office of Chief Technology Office (OCTO). The specifics of this operations plan will be outlined by the System Integration vendor upon contract award.

2.6 Navigators

Description of plan for operating Navigator program.

The District recognizes the complexity of purchasing health insurance, especially for those who will be first-time purchasers. Working with the Crider Group, the District performed an analysis of the options and recommendations for the establishment of the Navigator program for its Health Benefits Exchange. The Crider Group solicited stakeholder input through focus groups and surveys, conducted literature reviews, and researched the practices of other states to determine alternatives that were available to the District in designing its Navigator program.

The findings and recommendations from this report will be used to guide the District in the design and implementation of the Navigator program. Using the recommendations outlined in the report, the District's HRIC Exchange Operations Subcommittee will finalize its recommendations for the structure of the Navigator Program and present them to the Board in early November 2012. The District plans to issue a Request for Proposal by the end of 4th quarter 2012 to procure a vendor that will design and implement its Navigator program, including determining the appropriate size and number of grants, developing the RFP, and assisting with the grant review process.

Documentation outlining progress in developing conflict or interest training standards.

The Crider Group's Navigator Report discusses the requirements for Exchanges to develop and disseminate a set of standards to be met by all Navigator grantees that are designed to prevent, minimize and mitigate any conflicts of interest, financial or otherwise, that may exist and to ensure that anyone who functions in the role of a Navigator has appropriate integrity. The District will procure a vendor to assist with design and implementation of its Navigator program. One of the responsibilities of

this vendor will be to ensure that the District meets all requirements outlined in the ACA as it relates to the design and implementation of a Navigator program, including training around conflict of interest standards.

Description of how the Exchange will ensure Navigators are appropriately trained to meet Exchange's conflict of interest, privacy and security standards.

As a part of the design and implementation of its Navigator Program, the District intends on creating a training curriculum required for all Navigators. The recommendations for the types of training the District may consider are included in the Crider Group's Navigator Report; however, the District will use procure a vendor that will design and implement the training program required for all Navigators. The District intends to award the contract for this vendor by the end of 4th quarter 2012.

Timeline and strategy for the Navigator program and making the program fully operational.

The District plans to issue a Request for Proposal in 4th quarter 2012 to procure a vendor that will design and implement its Navigator program, including determining the appropriate size and number of grants, developing the RFP, and assisting with the grant review process. Award of the contract is expected by the end of 4th quarter 2012. The District intends to work closely with this vendor to ensure that the Navigator program is fully functional prior to open enrollment in October 2013.

2.7 In-person Assistance Program

Description of plan for operating in-person assistance program distinct from the Navigator program.

The District has identified current consumer assistance activities by District agencies. The District's Department of Human Services currently delivers social services for District consumers through five decentralized service centers. The Office of Healthcare Ombudsman and Bill of Rights currently serves as the District agency that helps uninsured District consumers and District individuals insured by health benefits plans regarding matters pertaining to their health care coverage. The District's Department of Insurance, Securities, and Banking ensures that District consumers are protected from financial fraud and abuse by strictly enforcing consumer protection laws; are treated fairly; and have a wide selection of insurance, securities, and banking products and services from which to choose. The District's vendor, Compass Solutions, is currently in the process of completing a report on Consumer Assistance activities in the District and recommendations around consumer assistance needs related to the HBX. This report will include a detailed analysis of the current landscape of the District and gaps that exist in current Consumer Assistance activities, along with recommended solutions. The report will provide an overview of the current functions performed by the in-person assistors in the Economic Security Administration (ESA) and how to best leverage these assistors and assistor programs that exist in community organizations.

The District will procure a vendor to implement the recommendations for the required consumer assistance activities in each of the agencies described above. Accessibility requirements will partially be addressed by the District's IT vendor in the design of the web site and call center. Additional consumer assistance functions, such as outreach and education, will be identified and implemented by the marketing vendor.

Documentation outlining progress in developing conflict of interest training standards.

The District will procure a vendor, as described above, to implement the recommendations for the required consumer assistance activities. This vendor will be responsible for developing the conflict of interest training standards around the District's consumer assistance activities. The Consumer Assistance report generated by Compass will outline the training standards required for in-person assistors; however, the design will occur in parallel with the design of the training standards for the Navigator program to ensure uniformity in training.

Description of plan for ensuring in-person assistance program staff are appropriately trained to meet Exchange's conflict of interest, accessibility, and privacy and security standards.

Training of in-person assistance staff is described in question 2 above. In addition to the training outlined above, the System Integration vendor will also provide training and materials related to DCAS, the District's new eligibility and enrollment system. Conflict of interest, accessibility, and privacy and security standards will be developed by the SI vendor and be a part of the general training provided to staff and in-person assistors providing eligibility and enrollment assistance.

Timeline and strategy for funding the in-person assistance program and making the program fully operational.

The District's vendor, Compass Solutions, will finalize its report on Consumer Assistance activities in mid-4th quarter 2012. The District plans to procure a vendor, described above, to support design and implementation of its Consumer Assistance and Navigator programs, including determining the funding structure for both in-person assistors and Navigators, designing appropriate training standards/requirements, conducting trainings, determining the appropriate size and number of grants, developing the RFP, and assisting with the Navigator grant review process. The District intends to work closely with this vendor to ensure that both the In-Person Assistance program and the Navigator program are fully functional prior to open enrollment in October 2013.

2.8 Agents and Brokers

Description of strategy, including compensation policy, for agents/brokers and web brokers related to enrollment of individuals through the Exchange.

The District believes that agents and brokers (producers) have an essential role in the sustainability and success of the DC HBX, especially within the context of the small group market. The District completed an initial assessment through the Crider Group for how producers will interact with the DC HBX, including potential compensation structures and conflict of interest mitigation. The District has also worked with producers throughout implementation to incorporate their input and ideas into the design process.

This District will use a vendor to in refining and implementing the blueprint and developing a comprehensive structure for producers working with the HBX, including development of a licensure requirements and a comprehensive training regimen that encompasses privacy and security standards.

Description of policy for ensuring compliance with 45 CFR 155.130(d) and (e).

The District intends to issue a request for proposals for a vendor to design its Navigator program. This vendor will assist the District in refining and implementing the blueprint and developing a comprehensive structure for producers working with the HBX, including development of a licensure requirements and a comprehensive training regimen that encompasses privacy and security standards.

Description of policy for ensuring agents/brokers are appropriately trained and meet Exchange's privacy and security standards.

The District intends to issue a request for proposals for a vendor to develop a training curriculum for all agents and brokers that participate in the District's HBX. The District received initial recommendations on the training requirements of agents and brokers in the Crider Group's Navigator Report. These requirements, however, will be further refined once the structure of the Navigator program is fully determined. At this time, the District does envision that all agents and brokers complete some form of training to participate in the HBX.

Section 3.0: Eligibility & Enrollment

This section includes preliminary information regarding our plans for eligibility and enrollment in the Exchange and will be updated as plans are finalized.

3.1 Single Streamlined Application(s) for Exchange and SHOP

As part of the Eligibility and Enrollment D.C. Access System (DCAS) Process Flows, the District identified data fields that would be needed for the IAP and non-IAP applications. The District also reviewed the data fields published by CMS in early July 2012 and found them to largely match its expectations and needs for MAGI-based eligibility determinations as well as the identification of individuals needing further screening based on non-MAGI factors. District staff compiled a chart of all mandatory and option application data fields for Exchange, Medicaid, TANF, SNAP, and other human services programs. The District submitted comments to CMS in early September largely focused on ensuring the model application is structured in a way that states can quickly integrate non-IAP public assistance programs in the future. The District will review the model application, expected to be published by the end of 2012. Without seeing the model application, the District cannot make a binding commitment at this time, but our expectation is to use the online and paper versions of the Model IAP Application provided by HHS. Similarly, the District reviewed the SHOP data fields published by CMS in early July 2012 and the plan is to review the Model SHOP Application, expected to be published by the end of 2012, and ultimately make a final decision on adoption of the Model SHOP Application.

The System Integration (SI) Vendor Statement of Work includes requirements to develop business requirements and a data model tied to each HHS-required data elements, including data definitions, processing standards, and a data dictionary.

Similarly, the SI Vendor Statement of Work requires a testing plan for both the online and paper applications. This plan must include outreach to myriad community resources to identify application users, but will also include assisters and internal agency users that will be accessing the individual application incident to client contact over the phone or in-person. The District has already identified small business stakeholders that would be interested in providing user testing for the SHOP applications (employer and employee).

Consistent with 45 C.F.R. §155.405(c)(2), the District will accept applications in-person, by phone, by mail, or via an online portal. The online application will be available to applicants to use on their own behalf, or they will be able to apply using an authorized representative, Navigators, other types of assistors (such as staff at non-profit organizations), or even friends and family. This will be accomplished through specific roles with security and access controlled by the new system. Additionally, the online

application will incorporate real-time access to the federal and local data hubs and will utilize the federal identity proofing service. There are currently five (5) service centers in operation in DC handling paper applications. Policy discussions are underway between the Authority and DHS as to whether processing of paper applications (mailed or faxed) should be centralized in one center. Finally, the District will accept phone applicants via the call center.

Language Access and Translation

The District currently has language interpretation and translation services used by a number of agencies to support the Limited English Proficiency (LEP) population. The District has existing obligations under the DC Language Access Act to have all "vital documents" available in Spanish, Amharic, Mandarin, French, Vietnamese, and Korean. Additionally, the Act requires District agencies to track preferred language so that each can accommodate "emerging languages," defined as 3% of the population being served on 500 people (whichever is less).

In an effort to be cost-effective, District agencies generally do not print every document in all languages. Instead, a translated version is available on the website and the printed versions include taglines in all languages that give a brief summary of what the document is and instructions on who to call for assistance. The Authority plans to leverage these existing functions and, as mentioned above, encourage populations facing additional barriers can also seek service from non-profit and community based organizations that will be able to leverage the new system on their behalf.

Disability Access

The functions of the HBX will be fully compliant with Sections 504 and 508 as well as the Americans with Disability Act. The SI vendor Statement of Work requires the system to allow users with disabilities to still make use of its online capabilities. Additionally, the call center will be required to ensure phone access by users with disabilities.

3.2 Coordination strategy with Insurance Affordability Programs and the SHOP

The SI Vendor Statement of Work includes a requirement to develop the system processing rules, in coordination with DHCF, DHS, and the Authority, which will inform the operating procedures, policies and procedures, and/or protocols implemented by DHS and the Authority regarding application processing. However, District agencies have already engaged in extensive coordinated policy and process planning.

Coordination Approach

The coordinated efforts regarding Exchange eligibility and enrollment have occurred since September 2011 through the Eligibility and Enrollment Workgroup, a subsidiary of the Mayor's Health Reform and Implementation Committee (HRIC). The Workgroup is a joint effort of DHCF, DHS, and other agencies currently engaged in the Medicaid program. Among the Workgroup's notable accomplishments is the development of the workflow wireframes in DCAS for processing of the joint Exchange/Medicaid application. DHCF and DHS also jointly submitted an expedited Planning and Implementation Advanced Planning Document (PIAPD) to CMS and the Food and Nutrition Service (FNS). This coordinated effort will continue throughout the planning, design, and build process with the central goal of aligning processing procedures across the HBX, Medicaid/CHIP, and SHOP. For example, staff from the

respective agencies is in the process of finalizing MOUs between the Authority, DHCF, and DHS to ensure coordination in implementation and operations going forward.

Governance Strategy

The District is accomplishing coordination in large part through consolidation of eligibility and enrollment into one system, DCAS. However, the administering agencies retain policy authority over their respective programs; DHCF will set eligibility and enrollment policy and procedures for Medicaid, CHIP, and other locally funded health insurance programs, the Authority will set eligibility and enrollment policy and procedures for basic HBX and SHOP enrollment and APTC/CSR eligibility, and DHS will set policy and procedures for the human services programs it administers. DHS, conducting IAP and QHP eligibility determinations, must act in accordance with the policy directives from DHCF and the Authority on the respective programs.

Given that authority for the various programs in DCAS rests in different agencies, each agency has been and will continue to be committed to coordination so as to ensure smooth transitions between programs for beneficiaries. For the Authority's part, the current Authority staffing plan places the Eligibility and Enrollment Manager and the SHOP Manager under the Director of Operations, who will have responsibility for ensuring coordination between programs. The Eligibility and Enrollment Manager is also responsible for coordination with DHS to ensure compliance with DHCF and Authority eligibility and enrollment policy and procedures. As has been the practice during the planning and design phases of this project, representatives from each agency expect to consult with each other on a regular basis regarding policies with cross-program impact. To facilitate this coordination into the future, the D.C. Council appointed the directors of DHCF, DHS, Department of Health, and the Department of Insurance, Securities, and Banking as ex-officio members of the HBX Executive Board.

IAP & Non-IAP Application Acceptance

The District already operates under a "No Wrong Door" vision regarding applications for Medicaid and most other health and human service programs; DHS processes the applications. For Medicaid and other locally funded health care program, DHS acts pursuant to an MOU with DHCF. The HBX will be incorporated into this vision because DHS will continue to serve as the entity collecting and processing all IAP and non-IAP applications, whether received online, in-person, by mail, or by phone. By consolidating acceptance in one agency, there is no need to pass applications between agencies. To the degree they need application information, DHCF and Authority staff will have access to DCAS. Staff has completed the first drafts of the necessary Authority/DHS and Authority/DHCF MOUs and each is expected to be executed before the end of 2012.

The SI Vendor Statement of Work includes business requirements to process both the online and paper applications. Both will be available to applicants to use on their own behalf, or they will be able to obtain support from Navigators, other types of assistors (such as staff at non-profit organizations), or friends and family. This will be accomplished through specific roles with security and access controlled by the new system.

IAP & Non-IAP Application Processing

Starting on October 1, 2013, the District plans to operate through a single, streamlined application for all MAGI-based individual eligibility determinations[2]. DHS to be responsible for all application intake, other than SHOP, and the DCAS portal will execute the application process and produce eligibility results for QHP, APTC, CSR, and MAGI Medicaid/CHIP. In 2013 and 2014, DCAS will not be capable of processing applicants whose eligibility is being determined based on non-MAGI factors using pre-ACA rules. For these individuals, DHS will be responsible for processing the individual's application through the existing system, the Automated Client Eligibility Determination System (ACEDS). This processing can be initiated immediately following the DCAS process if the individual applied in-person or over the phone. If the application was in writing, the DHS worker may need to contact the applicant for more information (e.x. asset test) that is relevant to non-MAGI-based eligibility but not to MAGI-based eligibility. A similar process would occur when the application was online, though the worker would be prompted to take action through a dashboard of pending non-MAGI applications in DCAS rather than through manual processing of a paper application. An internal team of DHS staff has been focused since June 2012 on the interactions between ACEDS and DCAS that must occur between October 1, 2013 and September 30, 2014 when both systems will be operational with active Medicaid cases (see "ACEDS Interaction" below). This team will work with the SI vendor to secure the interfaces between the two systems during the build process.

IAP Eligibility Determinations

The HBX will enter into an agreement with the State Medicaid Agency (DHCF), through the option available in 45 C.F.R. §155.110(a)(2), making MAGI Medicaid eligibility determinations in accordance with its responsibility under 45 C.F.R. §155.305(c) but will be contracting with the State Medicaid Agency (DHCF), to perform this function. There is an existing MOU between DHCF and DHS under which DHS processes Medicaid applications and makes eligibility determinations. This MOU is in the process of being updated to ensure DHS continues to process both MAGI and Non-MAGI eligibility determinations in accordance with Medicaid policy set by DHCF. This arrangement minimizes changes from the current policies, procedures, and protocols and ensures Medicaid eligibility policy comes from one source, the State Medicaid Agency.

DHS is also responsible for determining basic eligibility for HBX participation as well as eligibility and amount calculations for APTCs and CSRs. By centralizing eligibility determinations in DHS, the crucial interplay between APTC/CSR eligibility and Medicaid eligibility is simplified. The same agency, DHS, determines eligibility for both using the same system, DCAS, and therefore the communication between the programs regarding eligibility is seamless.

ACEDS Interaction

During the period of October 2013 through September 2014, both DCAS and the existing health and human services eligibility determination system (ACEDS) will be operational. Thus, the two systems must continuously interact so as to 1) check existing enrollments, 2) communicate changes in enrollment triggered by DCAS, and 3) share income and other eligibility factor information. The design of the DCAS/ACEDS Integration effort is based on four premises. First, during Release I, ACEDS will remain the 'system of record' for all Medical Assistance reporting and interfacing to the Medicaid

[2] Whether this includes MAGI-based Medicaid determinations depends on whether the District chooses to apply for a waiver allowing it to apply SSA §1902(e)(14) before January 1, 2014. The District needs more information on this option.

Management Information System (MMIS). Second, because ACEDS will be retired when Release II is activated, every effort must be made to keep system changes to a minimum. Third, little or no changes will be made to the MMIS during Release I. Fourth, eligibility staff in DHS must continue to interview customers, certify eligibility and process changes. Because of the volume of customers currently being serviced in DHS service centers and the potential increase in workload that is expected as a result of the implementation of DCAS, every effort must be made to maintain the existing DHS business processes or minimize change.

Based on discussions with the principals associated with this project, knowledge of the ACEDS processes already in place, awareness of program requirements and recognition of the nature of the interactions between customer and agency, the processes listed below are the minimum requirements.

- Identifying to DCAS whether a client is known to ACEDS and whether client is currently eligible for Medicaid.
- Identifying to DCAS the client's Case Number and the current status of the case.
- Identifying to DCAS the client's income as known to ACEDS for the purposes of comparing against self-attestation based on the District's verification plan and "reasonable compatibility" standards.
- Updating client data based on information from DCAS.
- Creating cases in ACEDS based on DCAS eligibility determinations.
- Updating cases in ACEDS based on DCAS eligibility data.
- Adding and closing a person to an ACEDS case based on information from DCAS.
- Closing a case in ACEDS that was re-established in DCAS.
- Recording notices issued by DCAS.
- Issuing an initial and/or replacement Medical Assistance (MA) Card through DCAS.
- Identifying cases in ACEDS that are due for Recertification/Renewal and triggering passive renewal in DCAS.
- Moving ACEDS data to DCAS for interim changes through the "My Account" feature or periodic reporting.

The SI vendor is expected to begin work in early or mid-November 2012. During the first month of the project, this approach will be addressed in detail. Based on those discussions, it may be necessary to modify some aspects of the interface design as currently envisioned. In the meantime, staff work has begun on the detailed design specifications, programming, and testing. Further information on this work is available in the DCAS-ACEDS Integration General Design Document.

SHOP Application Acceptance and Processing

The Authority, and not DHS, will be directly responsible for processing SHOP applications, in all acceptable formats, from both employers and employees. Further detail of this process can be found in Section 6.1 of this narrative. However, in general, like an HBX applicant, SHOP employees can complete an application through the online portal and any verification necessary would be conducted by Authority staff using processes similar to those used by DHS staff for IAP applicants. Again, by using the same eligibility and enrollment system, eligibility workers administering Insurance Affordability Programs (Medicaid, APTC, and CSR) can access SHOP eligibility and enrollment information and take proper action.

3.3 Application, Updates, Acceptance and Processing, and Responses to Redeterminations

The SI vendor Statement of Work includes requirements regarding the system functional requirements and design as well as the development of test plan. This responsibility includes designing wireframes, business requirements, use cases, and test scenarios for accepting and processing user-entered application data and midyear updates via phone, mail, in-person, or online. This responsibility includes establishing baseline service-level agreements (SLAs) and/or performance metrics established for accepting and processing applications and midyear updates via phone, mail, in-person, or online.

Similarly, the SI vendor Statement of Work includes requirements to develop business requirements, policies and procedures, protocols, operating procedures, and use cases that describe how users can enter updates phone, mail, in-person, or online and how those updates will be processed. Customers can report a change or provide an update to any data element. Consistent with 45 C.F.R. §155.330, the HBX will re-determine eligibility following any reported change.

In the SI vendor Statement of Work, the District developed system functional requirements. Pursuant to the resulting contract, the SI vendor must develop a detailed system design and system test plan, including wireframes and test scenarios for accepting and processing user-entered application data and midyear updates via phone, mail and in-person. The HRIC Eligibility & Enrollment Workgroup will provide technical assistance in the design of use cases and test scenarios.

The District's general approach to acceptance and processing of SHOP employer and employee applications, updates, and responses to redeterminations in-person, online, via mail, and via phone is described in Section 6.1 of this narrative.

Call Center

Compass Solutions was engaged to perform an analysis of the District's requirements for an Exchange Call Center, including utilization of current and planned consumer assistance services to support the needs of the Exchange. The District has an all-encompassing vision to effectively and efficiently meet the ACA requirements using a multi-agency framework, including DHS, the Department of Insurance, Securities, and Banking (DISB), and the Office of Healthcare Ombudsman and Bill of Rights (OHCOBR) to meet the needs of the consumer. Additionally, the District is committed to a call center design that will take into account the language requirements of the residents of the District and will therefore implement a call center that will ensure the Exchange complies with the District's Language Access Act, which requires communications to be provided in the most common languages of District residents (Spanish and Amharic at a minimum).

Information from meetings with key individuals from the respective District agencies, along with operating statistics and a draft of the HBX Operational Business Model, were used to complete this assessment. The assessment provides the District with a proposed HBX Call Center operating structure, projected staffing and the associated cost, and options for organizing and implementing the operating structure proposed.

With the Compass analysis as a guide, the District will procure a vendor to implement the call center in the District. On October 4, 2012, the District released a Request for Information (RFI) to collect additional information to assist with the initial planning and design of the call center. Responses were due on October 19, 2012 and the District is in the process of evaluating the responses. Moving forward,

the District will develop recommendations for the proposed structure of the call center and present these recommendations to the HBX Governing Board.

Staffing Plans

By consolidating eligibility and enrollment in DHS, the same agency that currently handles eligibility for Medicaid and other human services programs, the District will be able to leverage existing resources by augmenting the training of existing eligibility workers while bringing on new staff. DHS plans to deploy staff to public venues such as libraries, grocery stores, public schools, and pharmacies. Additionally, DHS plans to leverage existing relationships with community stakeholders that can assist individuals and families through the application process. These stakeholders will undergo a "train the trainer" series so that they can reach out to their networks and create a multiplicative effect for the benefit of applicants.

DHS managers are currently in the process of working with Compass Solutions to plan for the peak enrollment months of September through December. Planning involves need mapping though geographic information services and asset mapping. Post-planning, DHS will identify hiring needs, particularly the process for hiring and training temporary workers for peak periods.

3.4 Notices, Data Matching, Annual Redeterminations and Response Processing

Notices

The SI vendor Statement of Work identifies the need to send plain language notices, which meet content requirements, to individuals and employers in a way that addresses the intended audience. Additionally, the requirements list the additional languages that must be supported (Spanish and Amharic at a minimum). The District intends to support electronic notices (distributed via e-mail, if indicated as an applicant or assistor preference) as well. As further clarification is provided by CCIIO, Authority and District staff will collaborate with the SI vendor to ensure federal requirements are met in a way that best serves the intended population.

Periodic Data Matching

The HBX will conduct additional periodic data matching in accordance with 45 CFR §155.330(d)(2). The SI vendor is required by contract to develop business requirements for retrieving, processing, and using matched data to re-determine eligibility.

Annual Redeterminations

The new system will conduct streamlined re-determinations, as defined in the ACA regulations, and will leverage federal and local interfaces and data exchanges to perform matches. When data sources do not provide results adequate to process automated re-determinations, the system will send pre-populated notices with as much data as is available and provide the applicant with at least 30 days to respond.

Response Processing

Leveraging the processes through which applicants can send in initial applications, the system requirements contained in the SI vendor Statement of Work include the functionality to process responses from individuals received online, by mail, in-person, or over the phone.

3.5 Verifications

Applicants using the paper application will be required to attest to all information relevant to an eligibility determination, though applicants not requesting financial assistance will not need to complete the entire application. However, for applicants using other methods that utilize the DCAS application screens (online, phone, in-person), the process will be tiered, asking only for that information that is needed for the particular determination. For example, if an applicant does not attest to District residency, the application process will end. Similarly, an applicant found to be eligible for Medicaid will not be prompted to answer further questions that are relevant only to an APTC/CSR determination.

In general, DCAS will leverage the new federal data hub as well as a number of other federal data sources (such as the new hire database) in order to support verifications. In addition, the District is developing a local data hub that will facilitate the sharing of data across DC agencies using an enterprise service bus. The new system will be able to leverage services provided by the local hub to perform verifications independently or in conjunction with federal sources and services.

These data matches will be used to verify application data, detect changes in eligibility criteria, and pre-populate annual redeterminations. Data collected through interfaces will also be used to detect fraud, waste, and abuse through the systems analytics capability.

The District's approach to verifications summarized below, including all verification data sources, was developed by a verification workgroup comprised of eligibility workers, quality control staff, managers, and policy staff from DHS and DHCF. Further refinement of the plan will occur as details of the federal hub become clearer and the SI vendor proceeds with the system build. Additionally, the SI vendor Statement of Work includes business requirements for the seven eligibility factors and requires flexibility in the verification process to adjust to circumstances post-deployment.

<u>Residency</u>

Due to its porous borders and high coverage thresholds as compared to Maryland and Virginia, the District has elected to require verification of residency. If an applicant self-attests to non-District residency, that attestation is accepted outright. However, if an applicant attests to District residency, that attestation is checked against trusted data sources, including the following:

- Residency confirmed in ACEDS
- Address information known to SSA and transmitted via the Benefits Data Exchange (BENDEX)
- D.C. Office of Tax and Revenue (local tax data)
- D.C. Housing Authority
- D.C. Department of Motor Vehicles
- D.C. Office of the State Superintendent of Education (public schools & charter schools)
- Maryland Department of Motor Vehicles
- Address information provided from earned and unearned income data sources

For individuals 18 years of age and younger, attestation of residency is accepted without further verification unless electronic data sources indicate information is not reasonably compatible. If the automated process has not established residency, and the applicant is over the age of 18, the applicant may submit physical documentation from the sources listed below.

- Active lease agreement or rent receipt in the applicant's name
- Recent (last two months) utility or phone bill
- State-issued photo ID with address
- Completed DCAS Residency Form or signed letter confirming residency

If the applicant attests to living with a friend or relative and this cannot be confirmed using the automated processes, he or she must have the residency form completed or a signed letter, including address and phone number, from the owner/renter with whom they are staying attesting that the applicant lives with them. If the applicant attests to homelessness or other circumstances suggesting that information needed to verify residency does not exist or is not readily available, then the applicant's attestation is accepted without further verification. Regarding homelessness, the applicant will have to attest to an intention to reside in the District. Additionally, information contesting the attestation, such as data from the Maryland DMV showing a non-District address, may trigger post-eligibility investigation.

Citizenship/Immigration

DCAS will not accept attestation of citizenship or status as a national. Instead, DCAS will utilize the SSA data match accessed via the federal hub and, if SSA cannot verify citizenship or status as a national, will utilize the U.S. Department of Homeland Security data match via the federal hub. Additionally, DCAS will utilize ACEDS data and other existing local data sources where citizenship or lawful presence has already been established. Ultimately, if unable to verify citizenship through any of these sources, DCAS will request and adjudicate paper documentation.

There are four tiers of citizenship documentation: primary, secondary, tertiary, and quaternary. If an applicant presents primary documentation, no other information will be required, since these documents verify citizenship and identity. Examples of primary documentation include a U.S. passport, certificate of naturalization, or certificate of citizenship. If an applicant presents secondary or lower tier documents, then an identity document must also be presented. Examples of secondary or lower tier documents include: a birth certificate or record, American Indian Card, Life or Health insurance record, etc. An official driver's license, certificate of Degree of Indian Blood, or other US American Indian/Alaska Native tribal document or any document described in section 274A(b)(1)(D) of the Immigration and Nationality Act may be presented as an identity document.

Incarceration

DCAS will accept an applicant's self-attestation as to incarceration unless it is inconsistent with an electronic data source approved by HHS for this purpose. Given prior experience, the District does not find the SSA Prisoner Update Processing System to be a reliable source because there is a financial incentive for facilities to update incarceration, but no incentive to update release. The District is reviewing the data available from the DC Department of Corrections, but is not prepared at this time to include this as a trusted data source.

Household Income

When an applicant applies online, in-person, or over the phone, DCAS will utilize a dynamic application process that pre-populates known income data and asks the applicant to either agree or disagree.

Consistent with 45 C.F.R. §155.320(c)(3)(ii), DCAS will start the income verification process by looking to tax return data for the prior two years. If this information shows the individual's income was above the Medicaid income eligibility threshold, it will be presented to the applicant to either agree or disagree as to whether it is an accurate projection of income for the benefit year. If tax data is not available, the applicant indicates the tax data is not an accurate projection, or if the tax data put anyone in the household below the Medicaid income threshold, the applicant will be presented with a current income worksheet pre-populated with trusted electronic data sources with which the applicant can agree or disagree. Attestations as to increases in income are automatically accepted. However, if the applicant asserts that any trusted data point has decreased by more than 10-percent, the applicant will be required to undergo alternative verification.

Earned Income - The trusted data sources for verifying earned income are the Internal Revenue Service Federal Tax Information (FTI), the Work Number, the Department of Employment Services (DOES) Quarterly Wage Data, Automated Client Eligibility Determination System (ACEDS), and the Public Assistance Reporting Information System (PARIS). The Office of Personnel Management (OPM) has been identified as a data source to verify federal employees' income information. We are seeking more information from CCIIO as to whether OPM will be a part of the Federal Data Hub for the purpose of sharing federal wage and retirement information. Conflicting data will be reconciled by allowing the most recent trusted data source to prevail over older data sources.

- The Work Number will be the first inquiry used to retrieve current monthly data from the previous two months. If information is available, DCAS will list the name of the employer(s), compute monthly earnings based on frequency of pay, and present findings in a pre-populated format to the individual. Based on the presented information, the individual will be asked to attest yes or no to the monthly income amount presented.

- If Work Number income information is not available, DCAS will query the Department of Employment Services (DOES) Quarterly Wage data to retrieve information from the most recent quarterly wage period. The information will be recalculated to reflect monthly income data. The pre-populated information will be presented to the individual and the individual will be asked to attest yes or no to the monthly income amount.

- Veterans and federal employment income information can be verified through PARIS data match. DCAS will present information to the individual to confirm if information is an actual reflection of current income.

- Income information available in ACEDS to determine eligibility for other public assistance programs to include TANF and SNAP will be queried by DCAS. The information provided in ACEDS will be cross-referenced to check for any discrepancies. If information is inconsistent, the individual will be asked for an explanation of the difference and, if reasonable, the application will be processed and changes will be made to other public assistance programs if needed. If the explanation is not reasonable, eligibility workers will require further verification.

Unearned Income - The trusted sources for verifying unearned income includes the Social Security Administration (SSA) data available through the Federal Data Hub, DOES Unemployment Insurance Benefits (UIB), the Office of the Attorney General's Child Support Income Data, TANF and Interim Disability Assistance (IDA) available in ACEDS, and other data sources that may be identified. The listed

unearned sources verify different types of unearned income. In the case of a conflict, the most recent data will be presented to the individual for verification.

Documentation – If the applicant disagrees with the trusted data sources, and attests to a lower income, there will be an inconsistency resolution period of 45 days (Medicaid/CHIP) or 90 days (Exchange) during which he/she must present documentation to DHS. Acceptable forms of earned income documentation include all pay stubs prior to month of application, electronic employer's income statement completed and signed by employer, register of customer's business payment (self-employment), and other data sources that may be identified in the future. Acceptable forms of unearned income documentation include an award letter from the federal or state agency verifying the receipt or termination of the income.

Does Not Exist/Not Reasonably Available - The District has identified the following circumstances in which information is not readily available or does not exist:

- Homelessness
- Domestic violence victim
- Employer moved to another state or country
- Closed business
- Employer will not release information
- Self-employed individuals
- Other circumstances as identified on a case-by-case bases and reviewed and approved by supervisory staff

In these situations, the individual must provide a reasonable explanation to explain why documentation is not available. If the explanation meets one of the above-mentioned categories, the eligibility worker will document in DCAS that the self-attestation will be acceptable under these circumstances. Notably, in the case of APTC and CSRs, the applicant will have to attest that they may be liable for repayment if the projection is incorrect.

<u>Household Size</u>

DCAS will review tax data, but will generally accept self-attestation of household size without further verification. There are many reasons an attestation of family size may go up or down from year to year, including the fact that many parents alternate claiming children as dependents. Therefore, attestations of family size for tax filers will be considered "reasonably compatible" unless there is contrary information in DCAS showing another tax filer claiming the same individual in his or her household. ACEDS, and eventually DCAS itself, will include household composition information for other programs. However, information that the child is living in another household will not trigger additional verification unless another person also attests that he or she will claim the child as a tax dependent or the applicant is a non-tax filer.

If data is ultimately considered not reasonably compatible, DCAS will request paper documentation. The following are primary sources that tax filers may use when two parents attest that they expect to claim the same child as a tax dependent (one of the following is sufficient):[3]

[3] *See* IRS Publication 501.

- IRS Form 8332 or similar statement, for divorce decrees or separation agreements that went into effect after 2008 (this releases the custodial parent's claim to the child's exemption).
- Pages from the divorce decree or separation agreement that went into effect between 1984 and 2009 that states both of the following: 1) the non-custodial parent can claim the child as a dependent without regard to any condition; 2) the custodial parent will not claim the child as a dependent for the year at issue.
- Pages from a pre-1985 decree of divorce or separate maintenance or written separation agreement that applies to the year at issue and states that the noncustodial parent can claim the child as a dependent, accompanied by evidence that the noncustodial parent provides at least $600 for the child's support during the year.
- IRS Form 2120 or similar statement of others who provide support to an adult dependent indicating that the others will not claim the adult as a dependent in the year at issue

When two tax filers attest that they expect to claim the same child as a tax dependent and both are parents of the child, two of the following sources can be used in lieu of a primary source. However, for tax filers, secondary sources cannot prevail over primary sources. Determinations will be made on a case-by-case basis when more than one parent presents two of the following sources. These sources will also be used to determine household composition for non-filers and for individuals who fall under exceptions to the tax household rules.

- School records
- Medical records
- Statements from non-relatives (no special consideration to professionals)
- Leases
- A court order or decree granting physical custody of a child. For tax filers, this may only be used if the order or decree does not address the right to claim the child as a dependent and the other parent has not presented an IRS Form 8332.
- Other evidence of custody as determined by service center supervisory staff.

Note that if the child will spend the same number of nights with each parent in the coming tax year, the parent who will have the higher adjusted gross income for the year can claim the child as a tax dependent. This could only occur if the child spent an odd number of nights during the tax year not with either parent.

In cases other than two parents attesting that they expect to claim the same child as a tax dependent, determinations will be made by applying the IRS rules on claiming tax dependents and considering evidence of the relationship, evidence of financial support, evidence of the claimed tax dependent living with the tax filer (if applicable) and evidence of the adjusted gross income of the persons who attest that they expect to claim the individual as a tax dependent (if applicable).

Indian Status

Consistent with 45 C.F.R. §155.350(c), DCAS will not accept self-attestation alone. Instead, DCAS will conduct a data match with any electronic data sources approved by HHS for this purpose and available through the Federal Data *Hub*. If no such source is available, DCAS will use documents that the District currently accepts as verification of Indian status. These documents are:

- INS Form I-551 with code S-13
- Unexpired temporary I-551 stamp in a Canadian passport or on INS Form I-94 with the code S-13
- A letter or other tribal document certifying at least 50 percent American Indian blood, as required by the Immigration and Nationality Act Section 289, combined with a birth certificate or other satisfactory evidence of birth in Canada
- Membership card or other tribal document demonstrating membership in a federally-recognized Indian tribe under section 4(e) of the Indian Self-Determination and Education Assistance Act

Additionally, the District may follow the policies used by other states to accept any formal documentation from a tribe, Indian Health Services (IHS), or the Bureau of Indian Affairs (BIA) that verifies a person is an American Indian. Examples of such verifications include, but are not limited to the following:

- A document issued by a federally-recognized American Indian/Alaska Native tribe, such as an enrollment or membership card, a tribal census document, or a document issued by a tribe indicating the person's affiliation with the Tribe
- A document issued by the IHS indicating that the person is eligible for IHS services as an American Indian
- A document obtained from the BIA recognizing the person as an American Indian

Eligibility or Enrollment in Public Minimal Essential Coverage (MEC)

DCAS will check its own records as well as legacy records in ACEDS to ascertain Medicaid eligibility or enrollment. Additionally, DCAS will utilize the federal service to determine eligibility or enrollment in any public MEC, particularly Medicare, Veteran's Administration (VA) benefits, and TRICARE. Eventually, the District hopes the federal service will check for Medicaid enrollment in other states.

Eligibility for and Enrollment in Employer-Sponsored MEC

DCAS will accept self-attestation without further verification, except when it is not reasonably compatible with other information provided on the application or in the records of the HBX. Eventually, the District hopes the federal service will check for employer-sponsored MEC.

Eligibility for Non-Employer-Sponsored Coverage

DCAS will interact with any electronic data source available on the federal hub. However, absent such information, DCAS will accept self-attestation, except when it is not reasonably compatible with other information provided on the application or in DCAS records.

Data Source Agreements

The SI vendor and District staff will work with federal partners to execute interconnection security agreements for the use of federal data sources. Additionally, District staff is reviewing existing agreements for the use of third-party data that is expected to transport to DCAS. Finally, connections

with local agency data sources will be accomplished through Memoranda of Understanding (MOUs) through the process required in D.C. Official Code § 1-301.01(k). Each will include performance metrics to ensure timely verifications.

Paperwork Processing Procedures

DHS is in the process of reviewing its existing policies and procedures regarding the processing of paper documents through the Document Imaging Management System (DIMS) and will be making any necessary revisions in consultation with the SI vendor.

3.6 Document Acceptance and Processing

Privacy

User access to the new system will be role-based and carefully controlled, so that users only have the ability to view or edit appropriate information. These new controls will allow the District to expand access by District staff and partner organizations in a way that is not currently possible, as the legacy system (ACEDS) does not have role-based access. The system will also log access requests and attempts to view unauthorized data for audit purposes.

Document Acceptance & Processing

DCAS will re-use an existing system, the Document Imaging Management System (DIMS), which was deployed by DHS on a pilot basis at one if its service centers in January 2011 and citywide in April 2011. DIMS, as part of DCAS, will allow authorized staff with appropriate roles and access to view document images. This system automates the scanning and tagging of incoming paper, whether by mail, fax, or in-person, and ensures each document is matched with the correct individual and household. Currently there are established workflows within DHS for the manual scanning, tagging, and indexing of documents. Once indexed, the document is assigned to the proper service center and public benefit program, assigned to a supervisor, and ultimately referred to an eligibility worker to take any necessary action based on the document. As part of the DCAS build and roll-out, there are plans to barcode documents with beneficiary information so that tagging and indexing is automatic. This barcoding may not occur by October 2013 and therefore the current manual process may continue. Finally, DIMS has the capacity to accept electronic documents uploaded by the client. While this functionality is not currently deployed, it will be part of DCAS.

3.7 Eligibility Determinations

Individual Eligibility

The SI vendor Statement of Work includes business requirements related to individual eligibility and requires the vendor to develop use cases for determination of eligibility for and enrollment in QHPs, APTCs, CSRs, and MAGI-based Medicaid. DHCF and DHS eligibility staff will assist in the development of use cases. The vendor must also develop final wireframes, test plans, baseline SLAs, and Performance Metrics. In general, DCAS will collect relevant information through the online portal, automated interfaces, and other sources (such as staff or partner organizations entering additional details). Collected data will be processed in the rules engine to perform eligibility determinations. At this time, the District intends to re-use calculators developed for other states and the FFE to determine MAGI for

Medicaid, APTC, and CSR purposes. In addition, applicants will have the option to not request financial assistance before enrolling in a QHP, which means their income information will not be collected and they will not be checked for Medicaid and APTC/CSR eligibility. These process flows were developed by DHCF, were based on process flows developed by the State of Oregon and those developed by CCIIO. These flows will be updated based on the SI vendor's build.

SHOP Eligibility

The SI vendor Statement of Work includes business requirements related to individual eligibility and requires the vendor to develop use cases for determination of SHOP eligibility and enrollment for both employers and employees. DISB staff will assist in the development of use cases. The vendor must also develop final wireframes, test plans, baseline SLAs, and Performance Metrics for the SHOP eligibility and enrollment system. In general, the new system will validate that employers meet eligibility criteria for participation in the SHOP. Utilizing details from the employer registration process, the new system will also be able to identify employees who are SHOP-eligible and are accessing the system for SHOP comparison and enrollment. The system will then route the employee to the appropriate screens where, if the system has deemed the individual SHOP eligible, he/she will be able to select from the plans their employer has identified as options. These process flows were developed by DISB, were based on HHS-developed process flows, and will be updated based on the SI vendor's build.

Program Coordination

DCAS, the unified system, will contain eligibility and enrollment information for the Individual and SHOP exchanges as well as for the Medicaid program. Authority and DHCF staff will have necessary role-based access to such information. DHS administers human services programs in the District and, starting in October 2013, will have access to DCAS to perform MAGI-based eligibility determinations. Then, starting in October 2014, Non-MAGI eligibility and eligibility and enrollment for human services programs will transfer to DCAS and the centralization of information across the Exchange, Medicaid, and human services programs will be complete.

3.8 Eligibility Determinations for APTC and CSR

Initial Application

The current HBX eligibility and enrollment process flows envision APTC/CSR eligibility determinations occurring after an individual has been determined ineligible for Medicaid/CHIP or when alternative verification is needed before making such determination and the individual wants to enroll in a QHP while such verification is occurring. The HBX will be utilizing the federal service for APTC/CSR calculation and determination. District staff is engaged in the CCIIO-led webinars on the subject. Staff is operating on the assumption that DCAS will pass an annual MAGI calculation and the benchmark second lowest cost silver-level premium to the federal service and the federal service will check for Public MEC eligibility and calculate a maximum APTC and CSR if appropriate. The result will be passed back to DCAS, at which point a user can explore available plans and adjust the APTC amount downward if they wish. Subject to further guidance on the federal service from CCIIO, the SI vendor is expected to develop business requirements and Standard Operating Procedures (SOPs).

Renewal or Reported/Received Change

If the HBX determines, at renewal or based on a change in eligibility pursuant to a periodic data match or self-reported change, that an individual is no longer eligible for Medicaid/CHIP, the HBX will trigger the APTC/CSR eligibility process using the federal service as described above. While the content of the notice to affected individuals will depend on the forthcoming CCIIO/CMCS regulations and guidance on notices, the District expects to unify the notice of Medicaid termination with a notice of APTC/CSR eligibility.

3.9 Applicant and Employer Notification

The SI vendor Statement of Work identifies the need to send plain language notices, which meet content requirements, to individuals and employers in a way that addresses the intended audience. Additionally, the requirements list the additional languages that must be supported (Spanish and Amharic at a minimum). The District intends to support electronic notices (distributed via email, if indicated as an applicant or assistor preference) as well.

The HRIC Eligibility and Enrollment Workgroup is generating a list of notices that may be needed in DCAS. The Workgroup will develop drafts in consultation with community stakeholders. As further clarification is provided by CCIIO, Authority and District staff will collaborate with the SI vendor to ensure federal requirements are met in a way that best serves the intended population. The HRIC Insurance Subcommittee will work with employers and the SI vendor to identify and generate notices to SHOP employers and employees.

3.10 Individual Responsibility Exemptions

The HBX will be utilizing the federal service for Individual Responsibility Exemption determinations and payment exemptions. The District is awaiting federal rulemaking on the subject. However, we expect that DCAS will have a link from the main portal page to send the user to whatever federal site is launched for this purpose by CCIIO/HHS. This link will be just as prominently displayed as would a link to initiate an IAP application. The District would prefer for DCAS to serve merely as a referral service and that it be clear that any decisions on exemptions come directly from HHS and not through the DCAS notice system. Further, because the District does not need such information to perform its functions, there would be no need for DCAS to track or keep records of exemption processing.

3.11 Eligibility Appeals

The District anticipates publication of regulation and guidance on eligibility appeals for QHP, IAP, and SHOP participation. However, the Authority currently anticipates handing SHOP eligibility appeals from both employees and employers internally and contracting with the D.C. Office of Administrative Hearings (OAH) to handle QHP and IAP appeals. OAH is the independent agency which currently adjudicates eligibility appeals for Medicaid and other public benefit programs administered by DHS and DHCF. It is anticipated that OAH would handle appeals from individuals and employers relating to APTC/CSR as well as individual appeals related to basic eligibility for HBX participation. This approach creates efficiencies because of the interrelation between Medicaid eligibility and APTC/CSR eligibility. Without this efficiency, there could be separate entities coming to diverging conclusions as to whether an individual is eligible for Medicaid and thus ineligible for APTC/CSR or vice versa. Staff has engaged OAH leadership in discussions relating to this approach and OAH is prepared to execute an MOU with the Authority once details of the federal regulations on this subject are clear.

To accomplish this vision, the SI vendor Statement of Work requires system capabilities to ensure data transfer between OAH and DCAS. The Authority and OAH will develop workflow policies and procedures to ensure compliance with federal regulations. The technical staff at both DHCF and OAH is engaged in conversations about facilitating communication of appeals results and documents between the OAH Case Management System (eCourt) and DCAS.

Similarly, the District is awaiting federal regulation and guidance on the subject of SHOP appeals and will determine the appropriate policies and procedures to conduct these appeals once the requirements are known.

3.12 QHP selections and terminations, and APTC/CSR information processing

QHP Selection/Termination

The SI vendor Statement of Work includes the business requirements for accepting and processing QHP selections and terminations. The vendor is required to develop SOPs, wireframes, and process flows. However, the work conducted by the District thus far envisions that, once determined eligible through a combination of rules engine checks and data hub verifications, QHP applicants will be able to browse available health plans in the marketplace. When these users select a plan for enrollment, they will actually be triggering a process that ends when the carrier confirms that enrollment is complete. The enrollment process for SHOP plans will be similar to the process for individual plans in that confirmation from carriers will complete the cycle. SHOP applicants will only be able to choose from the plans that their employer has selected.

The District understands that QHP termination may be initiated by the carrier, the Exchange (through decertification), or an individual (through disenrollment). The District will work with the SI vendor to ensure that, if the plan is terminated by the carrier or the Exchange, enrollees will be notified and provided a special enrollment period to make a new plan election. If an individual chooses to terminate coverage, the individual will be disenrolled according to pre-defined disenrollment policies and procedures, which will include a warning of potential penalties associated with not having minimal essential coverage. This would be the process whether the enrollee was in an individual plan or a SHOP plan. However, in the SHOP market, enrollment can be terminated because the employer stops offering coverage or because the employee terminates employment. In the event that an employee terminates coverage, the employee will also follow predefined disenrollment policies and procedures for SHOP disenrollment, but employers will also be notified of an employee's disenrollment.

The Plan Management functionality described in the SI vendor Statement of Work includes the ability to interact with carriers, employers, HHS, and DISB to track and manage the process for reporting and reconciling plan terminations.

APTC/CSR Calculation & Processing

As described above, the District will utilize the federal service to calculate maximum APTC. The Financial Management functionality described in the SI vendor Statement of Work will include the ability to calculate actual APTC, within the bounds of the federally-calculated maximum APTC, based on the applicant's plan selection. Further work on this functionality, including testing, will occur as further details on the federal service become available and the DCAS design process progresses.

3.13 Electronically Report Results of Eligibility Assessments and Determinations

As envisioned in the SI vendor Statement of Work, DCAS will generate reports and files to be sent to CMS for verification and tracking. The frequency and data layouts have not been determined yet, but the District and the SI vendor will work on this with the applicable external parties, including IRS, HHS, and other federal entities, during the design phase. Similarly, DCAS will interface with carriers for reconciliation and reporting. The District will select a common data format to be used by all carriers, who may need to make minor modifications to their systems to achieve interface. The District will adhere to data transmission standards to minimize the impact upon carriers.

As described above, the State Medicaid Agency (DHCF) is a primary partner in the development and design of DCAS and would have all necessary access rights. Additionally, DCAS would interface with the District's Medicaid Management Information System (MMIS) using standard HIPAA-compliant formatting.

3.14 Pre-Existing Conditions Insurance Plan (PCIP) Transition Plan

The District has opted into the federally-managed PCIP. The District currently has very low enrollment due to the availability of other, lower cost safety-net plans in the District. However, the District awaits the Secretary's release of procedures to transition PCIP enrollees, as called for under 45 C.F.R §152.45. At a minimum, our call center staff and Navigator contractors will be available to help PCIP enrollees transition.

Section 4.0: Plan Management

Section 4.1 Appropriate Authority to Perform and Oversee Certification of QHPs

Enacted into law in early 2012, DC Code 31-3171.04 grants authority to the District of Columbia Health Benefits Exchange (DC HBX) Authority to both oversee and certify qualified health plans (QHPs). From DC Code:

(a) The Authority shall:

(1) Establish the American Health Benefit Exchange to assist qualified individuals in the District with enrollment in qualified health plans;

(2) Establish a SHOP Exchange through which qualified employers may access coverage for their employees and shall enable any qualified employer to specify a level of coverage so that any of its employees may enroll in any qualified health plan offered through the SHOP Exchange at the specified level of coverage;

(3) Certify plans as qualified health plans as set forth in § 31-3171.09 and make such plans available to qualified individuals and qualified employers, as required by the Federal Act, with effective dates on January 1, 2014; provided, that the Authority shall not make available any health benefit plan that is not a qualified health plan.

(4) Have independent personnel authority to hire, retain, and terminate personnel as appropriate to perform the functions of the Authority consistent with Chapter 6 of Title 1, including establishing compensation and reimbursement consistent with the District's wage grade and non-wage grade schedules;

(5) Have procurement authority independent of the Office of Contracting and Procurement, consistent with Chapter 3A of Title 2; except, that § 2-352.02(a), (b), (c), and (e) shall apply.

(6) Publish the average costs of licensing, regulatory fees, and any other payments required by the Authority, and the administrative costs of the Authority, on a website that is publically accessible, to educate consumers on these costs. This information shall include information on monies lost to waste, fraud, and abuse;

(7) Implement procedures for certification, recertification, and decertification, consistent with guidelines developed by the Secretary under section 1311(c) of the Federal Act and of this chapter, of health benefit plans as qualified health plans;

(8) Provide for the operation of a toll-free telephone hotline to respond to requests for assistance, utilizing staff who are trained to provide assistance in a culturally and linguistically appropriate manner;

(9) Provide for enrollment periods, as provided under section 1311(c)(6) of the Federal Act;

(10) Maintain a publically accessible website, through which enrollees and prospective enrollees of qualified health plans and dental plans may obtain standardized comparative information, including on health plan quality and performance, for such plans;

(11) Assign a rating to each qualified health plan offered through the exchanges in accordance with the criteria developed by the Secretary under section 1311(c)(3) of the Federal Act, and determine each qualified health plan's level of coverage in accordance with regulations issued by the Secretary under section 1302(d)(2)(A) of the Federal Act;

(12) Use a standardized format for presenting health benefit options in the exchanges, including the use of the uniform outline of coverage established under section 2715 of the PHSA;

(13) Conduct eligibility determinations, in accordance with section 1413 of the Federal Act for the Medicaid program under title XIX of the Social Security Act, the Children's Health Insurance Program under title XXI of the Social Security Act, or any other applicable District program pursuant to the policies and procedures established by the Department of Health Care Finance;

(14) Establish and make available, through a website that is publicly available, a calculator to determine the actual cost of coverage after application of any premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402 of the Federal Act, and, if feasible, which is designed to provide consumers with information on out-of-pocket costs for in-network and out-of-network services, taking into account any cost-sharing reductions;

Section 4.2 QHP Certification Process

The District has illustrated standard operating procedures for certifying QHPs according to minimum QHP requirements.

Plan management process flows designed by the District in March 2012 and continuously revised illustrate the District's QHP certification process. The following narrative explains the process in more detail. In addition, by the end of 2012 the District will have developed an MOU under which the Department of Insurance, Securities, and Banking (DISB) will perform the work of QHP certification and monitoring for the DC HBX.

District QHP Certification Process

The process will begin when the DC HBX requests a Notification of a Carrier Intent to Offer on DC HBX from the insurance carrier. Upon receipt of such notification the insurance carrier can chose to apply for inclusion in the DC HIX. If the carrier fails to apply for inclusion in the DC HBX an end event is triggered. Alternately, if the carrier submits a Notification of Carrier Intent to Offer on DC HBX application to DISB for inclusion in the DC HBX, the application is then evaluated by DISB.

DISB will then perform a validation which ensures that the carrier is consistent with the laws of the District of Columbia. If DISB, based on information contained in the carrier's Notice of Carrier Intent to Offer on DC HBX, fails to confirm validation the carrier is notified of DISB's findings in the form of a Notice of Non- Validation. When the carrier receives the Notice of Non-Validation from DISB the carrier can submit addition information for validation which will be considered for a subsequent validation review. If the carrier fails to submit additional information to DISB an end event is triggered.

Alternatively, if the carrier submits additional information to DISB it must be presented as a Notification of Carrier Intent to Offer on DC HBX. DISB will review the application and either review or deny validation. If DISB confirms validation a Carrier Account is created. DC HBX will then provide access to HIX for the carrier to submit a QHP Issuer Application. The carrier would then receive access to HBX and be able to assign roles.

Concurrently, the unit will store all prospective carrier application activity, regardless of whether the application receives validation. Information such as carrier account information, carrier access, and the QHP Carrier Application will all be processed and stored by the Plan Management Data Storage component.

Section 4.3 Plan Management System(s) or Processes that Support the Collection of QHP Carrier and Plan Data

The District has had no indication that any of the current health insurance carriers in either the small group or individual markets will be leaving upon establishment of the DC HBX and full enactment of ACA. The following list represents the carriers currently operating in the fully-insured small group market in the District:

- Aetna
- BlueCross Blue Shield CareFirst
- Guardian
- Graphic Arts Benefit Corporation
- Kaiser
- Principal
- Time
- United Healthcare

With regards to the number of health plans expected to participate in the DC HBX, we do not have an accurate estimate as of today (9/17/2012). Recommendations to the DC HBX, which are currently pending, call for passive selection.

<u>Plan Management System(s)</u>

The DC HBX will leverage NAIC's SERFF plan management module to support the business operations of plan management. DISB will continue to operate SERFF and pass along information to the DC HBX through an MOU (yet to be finalized).

The District is currently in the final stages of selecting a System's Integration vendor to build or DC HBX system. We anticipate having the vendor in place by late October 2012. Therefore, we are unable to further discuss the integration between the DC HBX system and SERFF.

Section 4.4 Ensuring Ongoing QHP Compliance

Plan Level

The District envisions leveraging the experience and infrastructure of both DISB and the Department of Health Care Finance's (DHCF) Office of the Ombudsman (Ombudsman) to ensure ongoing QHP compliance in the DC HBX.

DISB and the Ombudsman currently operate in tandem to resolve and adjudicate health insurance related consumer complaints. If the complaint involves a commercial health insurance plan, the consumer is directed immediately to the DISB Complaints Bureau which, under District law, has the authority to adjudicate commercial insurance complaints.

DISB currently uses NAIC's State Based System (SBS) to collect and analyze consumer complaints. We anticipate continuing to use this system alongside a CRM.

These processes will be integrated within the DC HBX's consumer Call Center to ensure a seamless delivery of services to those with complaints. The Call Center will be integrated and serve as a single point of entry for DC HBX related complaints.

Carrier Level

DISB currently perform annual oversight of health insurance carriers operating in the District through the rate filing and licensure processes. However, we are currently developing a more frequent monitoring regimen to meet the requirements of ACA.

It is envisioned that by the end of 2012 DISB, through an MOU with the DC HBX, will leverage additional staff resources afforded to us under rate review grant funds to perform ongoing monitoring of carriers and QHPs operating in the DC HBX insurance marketplace.

The District is currently evaluating potential sanctions that may be utilized by the DC HBX for non-compliance as well as a more detailed auditing strategy for periodic monitoring of QHP carriers.

Section 4.5 Support Carriers and Provide Technical Assistance

DISB has been working with stakeholders throughout 2011 and 2012. Various working groups have been created to engage participants in our transparent practices. Covered subjects include, but are not limited to:

- Network adequacy, quality rating and plan management business operations
- Stakeholder awareness of the insurance regulatory authority via an overview of ACA mandates and roles of DISB and the DC HBX Authority Board.

- QHP Requirements, EHB Selection, Stand-Alone Dental, ACA Regulatory Workbook, Plan Management Process Flows and Employer Plan Selection in SHOP, whereby stakeholders have been given an opportunity to give insight and provide feedback via comment periods.
- Work plans regarding grant application and HBX certification deadlines
- SERFF Plan Management module updates
- Transition of the Insurance Subcommittee to the DC HBX Authority Board

Under the auspices of the Mayor's Health Reform Implementation Committee (HRIC), the Insurance Subcommittee has begun conducting "one-on-one" meetings with District health insurance carriers. These meetings are currently scheduled to take place throughout September and October 2012. The goal of these meetings is to better understand the IT systems our carriers currently use and any anticipated challenges to implementation of the DC HBX.

Once our IT vendor is onboard and we complete this first round of meetings, we anticipate that, beginning in November 2012, we will be able to better explain the various components being built for the DC HBX and the carriers' interactions where appropriate.

The District anticipates carrier training/outreach for DC HBX interactions to begin in January or February 2013 and to be ongoing until the DC HBX formally launches on October 1, 2013. We will also be working with our neighboring states to capitalize on training/outreach synergies.

Section 4.6 Carrier Recertification, Decertification, and Appeals

General Approach to Recertification, Decertification, and Appeal of Decertification

In regards to the Exchanges capacity ensure QHP ongoing compliance with QHP Certification Requirements, DISB will conduct periodic analysis of provider compliance through an MOU with the DC HBX.

The agency will require the insurance carrier to provide periodic compliance reporting information to DISB. To ensure on-going insurance carrier compliance with QHP Certification Standards as well as Operational Compliance, DISB will conduct an analysis of the insurance carrier's Compliance Report to ascertain whether or not the QHP Certification Compliance.

If there is not a HBX Compliance issue the finding will be documented and filed, thus ending the event.

In the event that a HIX compliance issue(s) is identified, the compliance issue(s) will be addressed in accordance with the terms governing QHP's. DISB would then notify the insurance carrier of its findings. The insurance carrier would be given an opportunity to provide DISB with a written response to the HBX compliance issue(s) identified by DISB. DISB, upon receipt of the insurance carrier's response to the HBX compliance issue(s), will then evaluate the carrier response the HBX compliance issue.

If DISB is satisfied that the HBX compliance issue(s) is resolved the agency will notify the carrier of the agency's determination. The insurance carrier's receipt of DISB's notification will trigger an end event.

On the other hand, If DISB makes a determination that the HBX compliance issue(s) has not been resolved, DISB can take one of two steps: decertify the QHP; or continue to seek resolution of the HBX compliance issue(s) by notifying the insurance carrier that a HBX compliance response is required to further address the issue(s).

In the event that DISB officially decertifies the QHP's status its status is officially changed from certified to decertified. The carrier is notified of the status change in the form of a Decertification Notification. DISB will then perform number of tasks. First, the DISB will update QHP account information and notify other HIX business areas of the insurance carrier's QHP decertification. That will trigger an end event. DISB will also notify CMS of its decertification of the carrier's as a QHP. CMS will then receive and process either the Certification of Carrier or QHP Decertification which will also trigger an end event. Detailed criteria will be developed by early 2013.

DISB will also send notices to affected enrollees which will trigger an end event.

If the carrier decides to appeal DISB's decertification decision the carrier must submit the Appeal of Decertification to DISB. If DISB does not choose to overturn the decertification decision the agency will notify the insurance carrier of the appeal denial. The carrier must then notify enrollees that it has lost its certification to offer products on the HBX.

Also, if the carrier does not appeal the carrier must send a notice of decertification to affected enrollees.

At all levels and junctures information regarding the entire process will be stored into the Plan Management Data Storage component of the HBX.

The District envisions that carriers will have to be certified on an annual basis to be in compliance with DC HBX rules and regulations. This has not been formally addressed by the DC HBX Board or DISB, but will be part of our November 2012 QHP agenda.

Section 4.7 Timeline for QHP Carrier Accreditation

Both DISB and the DC HBX Executive Board are currently developing a comprehensive timeline for QHP carrier accreditation.

All major medical carriers operating in the District are accredited by NCQA, and with the exception of one carrier, those accreditations will not expire until mid-2014.

The District currently envisions that carriers will have to provide a copy of the accreditation certificate along with their annual certification/recertification filing. We anticipate allowing existing accreditations to fulfill our requirements through 2015 and we are currently reviewing NCQA's supplemental accreditation regimen for new entrants into the market.

As stated above, DISB, under an MOU with the DC HBX, will most likely require a copy of the accreditation certificate as part of the carrier QHP application, but we also reserve the right to additionally confirm accreditation status with the recognized accreditation entity.

Section 4.8 QHP Quality Reporting

Pending final guidance from HHS, we currently envision requiring District carriers to provide both HEDIS and CAPS data to the DC HBX through DISB as a means to eventually establish a District-specific quality metric.

Section 5.0: Risk Adjustment and Reinsurance

On October 3, 2012, the Exchange Executive Board voted to opt into the federal risk adjustment and reinsurance programs for 2014.

Section 6.0: Plan Management

6.1 SHOP Compliance with 45 CFR 155 Subpart H

The DC HBX SHOP will facilitate the purchase of coverage of qualified health plans for the employees of small businesses. Although the DC HBX is currently considering a recommendation that would increase small group size to 2-100, the Health Benefit Exchange Authority Establishment Act of 2011 maintains the current definition of 2 to 50. The District's process to qualify employers to purchase SHOP QHP's will include employer size eligibility requirements in both the online DC HBX portal and in a manual determination procedure that is being developed and will be finalized by February 2013.

The District is currently planning for SHOP eligible employers, pursuant to section 1302(d)(1) of the ACA, the plan selection method by which an employer would select a metal level of coverage from which an employee could select any plan. Additional selection methods are under consideration by the DC HBX board and will be determined in late-2012 if needed.

In light of this model of plan selection, it is likely that the Department of Insurance, Securities, and Banking (DISB) will have to amend D.C. Code to prohibit carriers from establishing minimum employee participation rates for SHOP QHPs. DISB will be working with the NovaRest Actuarial Firm and Mitchell Williams lawyers (through Rate Review grant funding) over the next few months to review the entire D.C. Insurance Code to identify inconsistencies, obsolete provisions, and areas that need clarification pursuant to ACA.

The general approach to SHOP compliance with 45 CFR 155 Subpart H is as follows:

Eligibility Determination Process and Enrollment of Employees into QHPs
The process is initiated when the Exchange receives one of the following forms of communication (determinations): *Receive Final Appeal Decision Notice and Instructions* (DC SHOP 07.80); *Review Communications of Insurance Options* (DC SHOP 05.20); *Determine Employee Eligibility* (DC SHOP 12.30); and *Review Renewal Notice* (DC SHOP 17.20).

The Exchange will then *Initiate Qualification for Enrollment Period* (DC SHOP 13.01). The SHOP Employer Data Storage component transmits an Enrollment Period request from the Employee Roster. Simultaneously, employee account information is generated by the SHOP Employer/Employee Data Storage Components and transmitted back to DC SHOP 13.01, *Initiate Qualification for Enrollment Period*. The Employee's qualification status for an enrollment period is then determined. If it is determined that the employee qualifies for an enrollment period, that period then becomes both the employees initial enrollment period, as well as the employees annual enrollment period. This event triggers DC SHOP 13.10, *Provide Communication of Eligibility, Plan Selection Options, Costs* (as applicable). We envision the outcome is near real time. The Exchange then transmits the *Exchange Notice to Employee of Enrollment Period Options*. The employee will then be provided a period of review to *Review Eligibility Notice and Enrollment Period Options*. The timing of this process varies based on the Employee's response. At this point the employee may choose to return at a later time to enroll (or change enrollment) in a plan which would trigger an end event.

If the employee chooses to enroll, DC HBX SHOP gathers the Employee Account Information. *Employer Offerings, and Employer Contribution Information* is compiled (DC SHOP 13.20) to *Prepare Enrollment Questionnaire to Gather Employee Preferences*. This process is done in near real time. An Employee

Enrollment Questionnaire Response is generated. The District intends to finalize employer selection method by late November 2012. Currently, we envision only the ACA mandated metal level for Employers, therefore the Employee cannot select outside of the Level determined by the Employer. Next, DC SHOP 13.30 requires the Employee to complete the Enrollment Questionnaire and selects preferences. The Enrollment Questionnaire then enters DC SHOP 13.40 to *Determine Plan Availability and Calculate Plan Cost*. In order to accomplish this, the Plan Management Data Storage (Plan Availability and Plan Information) and the Rates and Benefits Data Storage report to DC SHOP 13.50 *Prepare Communication/ Comparison of Plans, Costs, & Employer Contributions Based on Employee Preferences* (as applicable). Simultaneously, DC SHOP 01.90 communicates Employer Plan Selection, and Employer Contribution information to DC SHOP- 13.50. Additionally, (SHOP 10.90) Employee age, zip code, tobacco usage, and other relevant information are communicated to DC SHOP 13.50Next, the Exchange sends Notice to Employee to Select Plan and Provide Payment Information which culminates into DC SHOP 13.60, *Evaluate/ Select Plans& Costs, Select Plan and Provide Payment Information* (as applicable). The Employee then evaluates and selects plans. An end event is triggered.

Next, the Employee may choose to take one of two actions: The Employee may elect to re-evaluate options based on the Employers coverage choices, which would direct the employee to DC SHOP 13.30, *Complete Enrollment Questionnaire and Select Preferences*, re-initiating the application process; or the Employee makes a plan selection and payment information is submitted by Employee, if applicable. DC SHOP 13.70, Process Employee Plan Selection, is initiated. The Employee Plan Selection is then communicated and stored into the SHOP Employee Data Storage. SHOP 13.03 is initiated, Provide Communication of Eligibility but Enrollment is not Permitted. SHOP 13.05, Review Eligibility Notice and Enrollment Period Restriction is initiated. The Employee may choose to return at a later time to enroll in a plan. An end event is triggered.

The Exchange initiates SHOP 13.70 if the Employee fails to select a plan before the time expires for plan enrollment an end event is triggered. If this occurs the Employee will be required to re-initiate SHOP 13.30, Complete Enrollment Questionnaire and Select Preferences. If time has not yet expired, the Determination of Monthly Employer Premium Contribution (FM 3.10) will be determined and current enrollment status will be updated, SHOP 14.10.

Enrollment of Employees into QHPs and Enrollment Periods

The DC HBX SHOP will have the capacity to offer Small Employers only QHPs that meet the requirements for the District's small group market. The DC HBX Board intends to provide any additional requirements (if applicable) by late-December 2012. DC 13 and DC 14 of the SHOP Process Flows provide a diagram of the process. At DC SHOP 13.70*, Process Employee Plan Selection*, the Exchange facilitates the Employee selection of a QHP. At this point the Employee's qualification period and eligibility have already been determined in the preceding stages of the DC 13 flow. DC SHOP 14.10, *Assess Current Enrollment Status*, follows and is the point at which the Employee's enrollment status is assessed. At this phase one of two actions can be taken. Qualified Health Plans are the only plans presented as an option. An Employee must either be currently enrolled in a QHP and be assessed for disenrollment from the QHP; or not be currently enrolled in a QHP and be assessed for enrollment into a QHP.

One possible occurrence arises if the Employee is currently enrolled in a Qualified Health Plan and is seeking disenrollment from that QHP. In this case, after the Exchange initiates DC SHOP 14.10, if there is no change to the existing QHP and nothing else is done. DC 18 SHOP Flows diagram shows the process when an Employee Decides to Drop Coverage.

The second possible occurrence arises after the Exchange assesses the Employee's current enrollment status for enrollment in a new Qualified Health Plan. DC SHOP 14.20 is initiated by the *Exchange, Prepare Communication to Issuer About Enrollment in Qualified Health Plan*. The Exchange then sends Exchange Notice to Issuer About Employee Enrollment in Qualified Health Plan. The Issuer then initiates DC SHOP 14.30, Process Employee Enrollment and Payment. The Issuer processes the initial payment and subsequently retrieves funds directly from the Employee's account. The funds located in the Employee's account may have come directly from the Employee or from their Employer. However, if the Exchange processed the initial plan payment, the Issuer retrieves funds directly from the Exchange, not the Employee account. After which, both the Issuer and the Exchange have to initiate a number of communications/ updates to the Insured/Employee.

The Issuer will then *Provide Welcome Package and ID Cards*, DC SHOP 14.60. The Employee may then *Utilize Health Services Provided through the Qualified Health Plan*, DC SHOP 14.70. The Employee continues using QHP Health Services. The Employee will return to the Exchange to self-report changes and perform annual eligibility and enrollment renewal.

The Exchange receives Process *Acknowledgement of Employee Enrollment from Issuer*, DC SHOP 14.40. There is a timeout in which the Employee is given a period of time (this period of time is to be determined) to communicate acceptance of the QHP. Upon the Employee's acceptance, the Exchange will *Prepare Notice to Employee of Successful Enrollment*, DC SHOP 14.65. The Employee Receives *Notice of Successful Enrollment*, DC SHOP 14.75. If the Employee acknowledges receipt the Exchange will then send *Exchange Notice to CMS of Employee Enrollment in Qualified Health Plan*. After which, DC SHOP 14.50 is initiated, *Process Employee Enrollment in Qualified Health Plan & Employer Participation in SHOP*.

Enrollment Period and Application Standards
The DC HBX SHOP will, *Initiate Plan Selection Due to Mid-Year Plan, Decertification or Non-Renewal*, DC SHOP 4.03. At this juncture, Employer account information is transmitted from the Process Management and the SHOP Employer Data Storage components to ensure the accuracy of information. DC SHOP 4.05 is triggered, and the DC HBX will *Prepare Communication to Employer of Plan Decertification or Non-Renewal*.

The compiled information is then sent to the Employer to *Review and Acknowledge Notice of Plan Decertification or Non-Renewal*. Next, this communication is sent to the Employer DC SHOP 4.07, to *Review and Acknowledge Notice of Plan Decertification or Non-Renewal*. The Employer then submits the acknowledgment back to the DC HBX, DC SHOP 4.10 *Prepare Communication of Uniform Enrollment Timeframe for the Employer*.

DC HBX then submits this communication back to the Employer. The Employer then Selects Uniform Enrollment Timeframe and Offering Selection (Level and/or Plan) it will offer its Employees. The Employer submits that information to the DC HBX SHOP and DC HBX SHOP will *Prepare Communication of Comparison of Plans, Costs and Relevant Information*, DC SHOP 4.35 and will subsequently submit that information to the Employer for review. At this juncture the Employer *Selects Metallic Level of Coverage*, DC SHOP-4.40, as well as *Plans*, DC SHOP 4.80. This information is compiled by DC HBX. The Employer may then *Select a Benchmark*, DC SHOP 4.45, or may choose to bypass DC SHOP 4.45. As noted in the previous question, the District intends to finalize all Employer selection processes by late-November 2012. Next DC Shop 4.50 is where the *Employer Must Declare Employer Contribution, Effective Dates and Payment Process* even if DC SHOP 4.45 is bypassed. The monthly premium invoice is then received and validated. This information is sent to DC HBX.

Next, DC HBX SHOP will Update Account with Selection/Participation Status. The Monthly Employer Premium Contribution will be determined. DC HBX will then *Notify CMS of Employer Participation in SHOP*, DC SHOP 4.57. CMS will then Process Notification of Employer Participation in SHOP. This information will be stored in the CMS Data Storage Component. Simultaneously, DC HBX SHOP will *Prepare Notification of Employer Participation in SHOP*, DC SHOP 4.60. That information will be sent to the *Employer to Prepare Renewal Notice for Employee*, DC SHOP 17.10. If a renewal is being initiated, DC SHOP-4.65 is triggered, *Review Enrollment Guidelines*. The Employer will then *Prepare Communication of Employer Insurance Options to Employees*, DC SHOP-05.10. An end event is triggered.

6.2 SHOP Premium Aggregation

Description of general approach to SHOP premium aggregation process

The District intends to utilize the services of a third-party vendor (TPA) to administer premium aggregation for the DC HBX SHOP and potentially the individual HBX market. District process flows largely reflect the flows provided by CCIIO with District specific adjustments.

The SHOP Employer and Employer & Employee Data Storage Components, along with the SHOP Employer Financial Management Data Storage Component send information to DC FM (Financial Management) 3.10, *Determine Monthly Employer Premium Contribution and Create Invoice*. The DC HBX SHOP initiates this process on a monthly basis. That information is then compiled into *an Invoice Small Business Employer*, DC FM 3.20.

The Small Business Employer will then *Receive and Validate Monthly Premium Invoice*, DC FM 3.40. If the invoice is incorrect the resolution process is initiated, DC FM 5.30. If the invoice is correct the *Small Business Employer will Pay Premium to HBX*, DC FM 3.50.

DC HBX will *Receive and Process Premium Payments*. The premium amount due and the premium actually paid will be stored in the SHOP Employer Financial Data Storage Component. DC HBX SHOP ensures the payment is correct. If the payment is not correct an Employer *Premium Discrepancy Resolution* is initiated, DC FM 5.15. If the payment is correct the Employer Payment is Received and Processed. An end event is triggered.

The Exchange will have a process for electronically managing non-payment or late premiums; including how and when notices are sent to employers. The process is as follows: An Issuer Discrepancies Report and Payment Information is sent from the Issuer to the Exchange. The Exchange initiates DC SHOP 19.30, *Process Issuer Discrepancies and Payment Information*. The discrepancies are reconciled by the Exchange and stored in the SHOP Employee Data Storage component. The SHOP Employee Data Storage Component sends that information, along with Employer Participation Information to DC SHOP 19.40, *Generate Report to CMS about Employee Enrollment in Qualified Health Plan & Employer Participation in SHOP*. The Report to CMS about Employee Enrollment in Qualified Health Plan & Employer Participation in SHOP serves as the Exchange Notice to CMS of Employee's Enrollment. That information is submitted to DC SHOP 19.50, *Process Periodic Report of Employee Enrollment in Qualified Health Plan & Employer Participation in SHOP*. It is anticipated that CMS then submits, electronically the information to the IRS in the form of a *Notice to IRS of Employee Enrollment in Qualified Health Plan to the IRS* in, DC SHOP 19.60, *Process Periodic Report of Employee Enrollment in Qualified Health Plan & Employer Participation in SHOP*. An end event is triggered.

The DC SHOP will also generate an electronic report that is electronically submitted to the IRS on a yearly basis, at the end of the calendar year. Employee and Employer information is transmitted from

their respective SHOP Data Storage components and submitted to DC SHOP 20.10, *Generate Annual Report to IRS About Employer Participation in SHOP Employee Enrollment in Qualified Health Plan* facilitates this process. The Exchange then electronically submits the *Annual Report on Employer SHOP Participation and Employee Enrollment to the IRS*, DC SHOP 20.40, *Process Annual Information Reports*, and the IRS performs tax accounting as appropriate. Simultaneously, the Exchange sends the Employee an Annual Information Return, DC SHOP 20.20, *Receive Annual Employee Information Return* which the Employee submits when filing taxes. The Annual Report on Employer SHOP Participation and Employee Enrollment is sent to the Employer in the form of an Annual Employer Information Return which the Employer submits when filing taxes.

Further, Periodic Participation & Enrollment Reporting and Reconciliation is rendered to the IRS via the Exchange. The Exchange, periodically (anticipated to be monthly) *Generates Report to Issuer About Employee Enrollment in Qualified Health Plan*, DC SHOP 19.10. The Report is submitted to the Issuer so that the Issuer may, DC SHOP 19.20, Process *Report on Employee Enrollment in Qualified Health Plan*. *Issuer Discrepancies Report and Payment Information* is submitted to the Exchange, DC SHOP 19.30. The Discrepancies are reconciled and stores in the SHOP Employee Data Storage Component. At that point DC SHOP 19.40 is initiated, *Generate Report to CMS About Employee Enrollment in Qualified Health Plan and Employer Participation in SHOP*. Exchange Notice to CMS of Employee's Enrollment is submitted to CMS. CMS will then Process Periodic Report of Employee Enrollment in Qualified Health Plan & Employer Participation in SHOP. CMS will submit this CMS Notice to IRS of Employee Enrollment in Qualified Health Plan. The IRS will then Process Periodic Report of Employee Enrollment in Qualified Health Plan & Employer Participation in SHOP. An end event is triggered.

The District is currently developing specific guidance and regulations for SHOP billing in collections. Without further federal guidance, the District will likely use similar practices for billing, arrears management, and termination that are currently employed in the small group market today. The DC HBX SHOP will likely require employers to pay premiums one month in advance of the next month coverage. A notice will be sent to the employer if payment in full is not received within two weeks of the first day of the coverage month and again a week later. If payment is not received by the first day of the next coverage month, the employer will be sent a notice that coverage for their employees is being terminated and will include information on how employees can enroll in the individual market of the DC HBX insurance marketplace. We expect that employers will perform the necessary payroll deductions in order to pay for employee premium contributions.

Premium Calculator

The DC HBX intends to establish a premium calculator, as described in 45 CFR 155.205(b)(6) to facilitate the comparison of available QHPs after the application of any applicable employer contribution in lieu of any advance payment of the premium tax credit and cost-sharing reductions. The creation of this calculator is included in the requirements for the DC Access System.

Terms and conditions for purchasing SHOP QHPs will be made available on the DC HBX website. Employees shopping for QHPs will be notified of any employer contribution that will go towards defraying the premium cost for that QHP. Employees will also be notified if their employer sponsored insurance is not affordable based on their household composition and income level. In the event that an employee's SHOP QHP options do not meet the affordability test, the employee will be directed to the individual side of the DC HBX insurance marketplace and the employer (or producer representative) will be contacted.

6.3 Electronically Report Results of Eligibility Assessments and Determinations for SHOP

Description of general approach to electronic reporting of SHOP eligibility assessments and determinations.

Information pertaining to eligibility assessments and determinations for the SHOP were included in our requirements related to our Systems Integrator (SI) procurement.

The SHOP Employer and Employer & Employee Data Storage Components, along with the SHOP Employer Financial Management Data Storage Component electronically send information to DC FM 3.10, *Determine Monthly Employer Premium Contribution and Create Invoice* for electronic billing of employers, receiving employer and employee contributions toward premiums, and making aggregated premium payments to issuers. The DC HBX initiates this process on a monthly basis. That information is then compiled into an *Invoice Small Business Employer*, DC FM 3.20.

The *Small Business Employer will then Receive and Validate Monthly Premium Invoice*, DC FM 3.40. If the invoice is incorrect the resolution process is initiated, DC FM 5.30. If the invoice is correct the *Small Business Employer will Pay Premium to HBX*, DC FM 3.50.

DC HBX will *Receive and Process Premium Payments*. The premium amount due and the premium actually paid will be stored in the SHOP Employer Financial Data Storage Component. DC HBX ensures the payment is correct. If the payment is not correct an *Employer Premium Discrepancy Resolution* is initiated, DC FM 5.15. If the payment is correct the Employer Payment is Received and Processed. An end event is triggered.

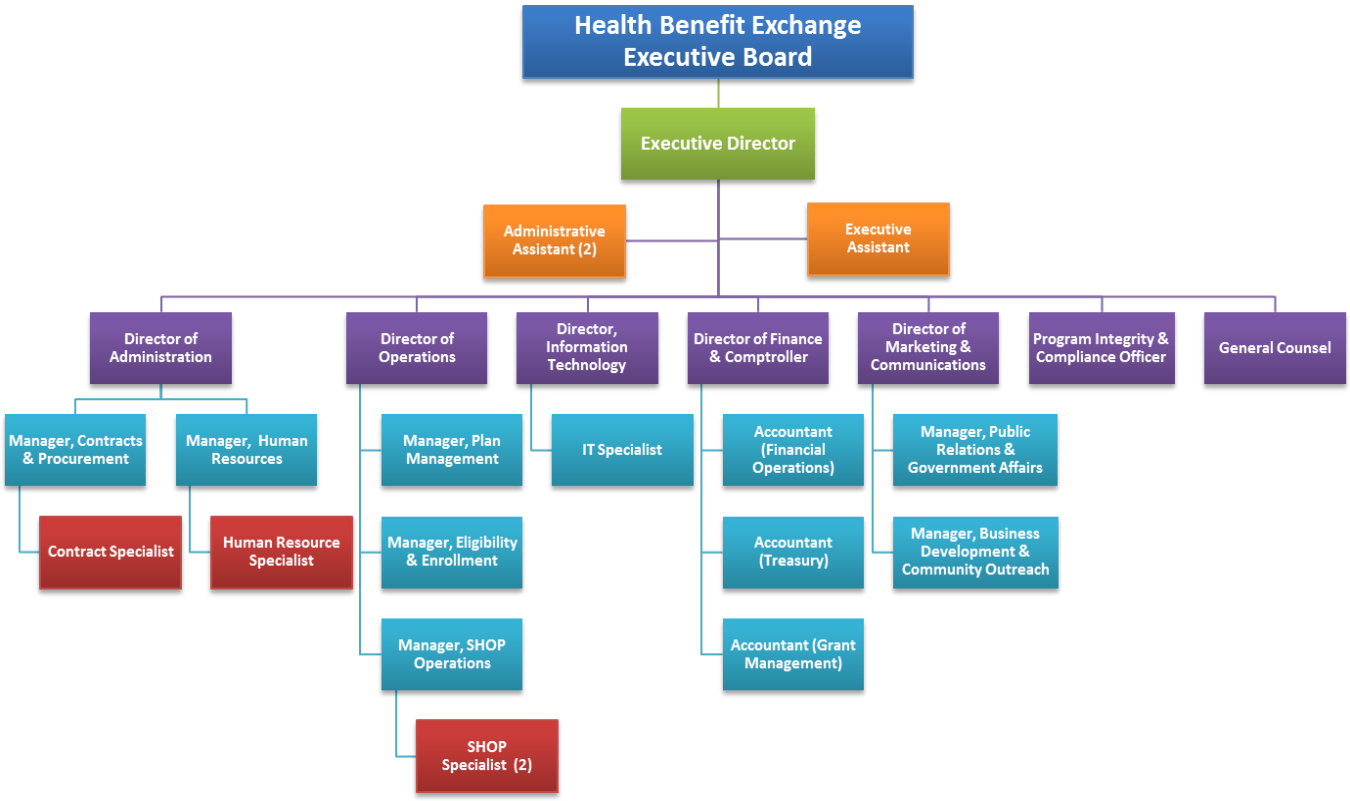
Section 7.0: Organization and Human Resources

7.1 Organizational Structure and Staffing Resources to Perform Exchange Activities

The current staffing plan for the Health Benefit Exchange (HBX) Authority consists of 26 FTEs focused on performing or overseeing the required functions of the HBX. This number does not include staff for outsourced services, such as the call center representatives, QHP certification, and eligibility workers. The District HBX will be led by an Executive Director who reports directly to the Health Benefits Exchange Authority Executive Board. The senior management team will consist of Directors for Administration, Operations, Finance, Marketing and Communications, and a General Counsel.

Individual and SHOP Exchanges will be part of the same organization with shared administrative functions. Senior level positions will be hired first to support implementation, with additional staff hired on a rolling basis prior to the Exchange becoming fully operational. A draft organizational chart, position descriptions, qualifications, and hiring timeframe are included below.

Organizational Chart:



Staff Plan:

Position Title	**Estimated Start Date**	**Annual Salary**	**Time**	**Months**	**Amount Requested**
Executive Director (Vacant)	4th Q 2012	$179,096	100%	27	$518,778
Job Description Responsible for leading and directing all aspects of the Health Benefit Exchange Authority (Authority), including strategic direction, operations, and financial management. Works closely with the Executive Board and senior leadership of the Authority to establish strategic direction, execute the mission, and fulfill all statutory responsibilities of the Authority.					
Minimum Qualifications Master's Degree in Health Administration, Business Administration or a related field with Fifteen (15) years of progressive senior level management experience in the insurance industry and/or with an integrated health care delivery system or a combination of experience in the private sector and in government at the Deputy or Commissioner level responsible for Medicaid, Medicare or other public health programs.					

Position Title	**Estimated Start Date**	**Annual Salary**	**Time**	**Months**	**Amount Requested**
Director of Administration (Vacant)					

	4th Q 2012	$117, 942	100%	27	$341,637

Job Description

Responsible for managing the human resource and other administrative functions as well as developing and overseeing strategic relationships and contractual arrangements with consultants and outsourced vendors, including District agencies. Also leads the strategic development process and manages the Authority's progress toward its strategic plan. Reports to the Executive Director.

Minimum Qualifications

Master's Degree in Health Administration, Business Administration or a related field with Ten (10) years of progressive management experience in human resources and procurement and contracting.

Position Title	**Estimated Start Date**	**Annual Salary**	**Time**	**Months**	**Amount Requested**
Director of Operations (Vacant)	1st Q 2013	$130,874	100%	24	$338,852

Job Description

Responsible for managing all of the daily operations, including SHOP and all operational issues for outsourced services, including those provided by District agencies; and leading the establishment of HBX policies and procedures. Manages and increases the effectiveness and efficiency of all operational related business functions for the HBX. Also oversees the Navigator Program in a matrix relationship with the Director of Marketing and Communications. Reports to the Executive Director.

Minimum Qualifications

Master's Degree in Health Administration, Business Administration or a related field with Ten (10) years of progressive operations experience at the senior level in the insurance industry and/or with an integrated health care delivery system or a combination of experience in the private sector and in government at a management level responsible for Medicaid, Medicare or other public health programs.

Position Title	**Estimated Start Date**	**Annual Salary**	**Time**	**Months**	**Amount Requested**
Director of Finance/Comptroller (Vacant)	1st Q 2013	$117,942	100%	24	$305,370

Job Description

Responsible for overseeing the actuarial, finance, and accounting operations of the HBX. Coordinates, analyzes and reports financial performance to senior management and the Executive Board. Manages outsourced financial management operations with vendor. Reports to the Executive Director.

Minimum Qualifications

Certified Public Accountant (CPA) with Bachelor's or Master's Degree in accounting or management with minimum of ten (10) years of progressive financial and accounting management experience with a background and knowledge of accounting and financial principles in a not-for-profit organization.

Position Title	**Estimated Start Date**	**Annual Salary**	**Time**	**Months**	**Amount Requested**
Director of Marketing & Communications (Vacant)	1st Q 2013	$117, 942	100%	24	$305,370

Job Description

Responsible for leading the planning, development and implementation of all marketing strategies, communications, and public relations activities, both external and internal. Directs the work of the marketing, communications and public relations staff and contractors. Also oversees the Navigator Program in a matrix type relationship with the Director of Operations. Reports to the Executive Director.

Minimum Qualifications

Bachelor's degree or higher in Communications, Marketing, Business with marketing emphasis, public relations, community development, or the equivalent. Seven (7) years of progressive experience in directing and managing the Marketing and/or Communications function, preferably in a nonprofit healthcare setting.

Position Title	Estimated Start Date	Annual Salary	Time	Months	Amount Requested
Director of Information Technology (Vacant)	1st Q 2013	$117, 942	100%	24	$305,370

Job Description

Responsible for the overall technology strategy for the Exchange, managing initiatives in coordination with the DCAS Maintenance organization (Integration Vendor or DHS/OIS). Manages the relationship with the Systems Integration (SI) Vendor and OCTO for HBX technical operations and enhancements, working with IT leaders in the carrier community as appropriate. Coordinates with the various business owners in the Exchange Authority to manage DCAS functionality, including QHP/subsidy eligibility, the exchange marketplace and SHOP, financial management, plan management, and consumer assistance. Reports to the Executive Director.

Minimum Qualifications

Bachelor's degree in computer science or related field with a minimum of seven (7) years in information technology in the health insurance industry. At least three years (3) managing IT projects and supervising technical resources across multiple SDLC (system development life-cycle) phases. Understanding of the ACA regulations and their impact on technology standards and security/privacy considerations. PMP Certification required.

Position Title	Estimated Start Date	Annual Salary	Time	Months	Amount Requested
General Counsel (Vacant)	4th Q 2012	$136,982	100%	27	$396,789

Job Description

Responsible for managing all legal aspects of the Authority and the HBX. Creates and maintains Memorandum of Understanding (MOU) and other contracts and agreements with outsource vendors, including District agencies, consultants and other contractors. Responsible for maintaining board related documents such as bylaws. Provides guidance to Executive Board and HBX leadership on legal matters. Reports to the Executive Director.

Minimum Qualifications

Juris Doctorate required with membership in District of Columbia Bar Association. A successful track record of at least seven (7) years experience providing legal advice on corporate law, health law and managed care law issues, including contract law.

Position Title	Estimated Start Date	Annual Salary	Time	Months	Amount Requested
Program Integrity & Compliance Officer (Vacant)	1st Q 2013	$108,895	100%	24	$281,945

Job Description

Responsible for leading the development of the HBX Compliance Program, including the establishment of written policies and procedures to manage fraud risks for the HBX, including prevention and detection. Develops mandatory training for the Authority staff, Executive Board, vendors, partners, insurance carriers, and other third parties. Works closely with the Department of Insurance, Securities and Banking (DISB) to ensure prompt handling of reported cases. Reports to the Executive Director.

Minimum Qualifications

Master's Degree in Health Administration, Business Administration, Finance or a related field with eight (8) years related experience in the areas of compliance and/or fraud prevention, detection and investigation.

Position Title	Estimated Start Date	Annual Salary	Time	Months	Amount Requested
Manager, Human Resources (Vacant)	4th Q 2012	$106,254	100%	27	$307,781

Job Description

Responsible for managing the human resource services, policies and programs within the Authority, including recruitment and staffing, performance management and improvement, compensation and benefits, and employee relations. Reports to the Director of Administration.

Minimum Qualifications

Master's Degree in Human Resources, Labor Relations or Business Administration with at least five (5) years experience working in human resources and a solid understanding federal, state, and local employment laws.

Position Title	Estimated Start Date	Annual Salary	Time	Months	Amount Requested
Manager, Contracts & Procurement (Vacant)	2nd Q 2013	$106,254	100%	21	$241,291

Job Description

Develops and implements sourcing strategies for current and near-term supply and service requirements. Tracks, documents, and enhances, as needed, the competitive process. Conducts annual sourcing planning, negotiates large and/or complex contracts, issues RFPs, and develops vendor performance standards. Reports to the Director of Administration.

Minimum Qualifications

Bachelor's or Master's Degree in Business Administration, Health Care, a related field with at least five (5) years of experience managing, developing, and negotiating contracts. Experience in purchasing and procurement, preferably in a healthcare setting.

Position Title	Estimated Start Date	Annual Salary	Time	Months	Amount Requested
Manager, Public Relations &					

Government Affairs (Vacant)	2nd Q 2013	$106,254	100%	21	$241,291
Job Description Responsible for managing all of the Authority's public relations issues. Prepares effective press releases and information for media kits to communicate information. Establishes and maintains working relationships with both government officials and media representatives. Coordinates legislative efforts by working with state, local and federal government as well as the media. Conducts research, monitors, and tracks legislation and changes. Reports to the Director of Marketing and Communications.					
Minimum Qualifications Bachelor's or Master's Degree in Public Relations, Communications and/or Journalism with five (5) years or more of public relations experience. Superior verbal and written communication skills.					
Position Title Manager, Business Development & Community Outreach (Vacant)	**Estimated Start Date**	**Annual Salary**	**Time**	**Months**	**Amount Requested**
	2nd Q 2013	$106,254	100%	21	$241,291
Job Description Responsible for developing and facilitating relationships between relevant community stakeholders; developing and managing outreach programs and activities; identifying business opportunities, and maintaining extensive knowledge of current market conditions for the HBX; and maintaining the image and identity, including the use of logos and signage for the HBX. Reports to the Director of Marketing and Communications.					
Minimum Qualifications Master's degree related to community service, education or public relations required with a minimum of five (5) years experience in program development, business development and/or community outreach.					
Position Title Manager, Eligibility & Enrollment (Vacant)	**Estimated Start Date**	**Annual Salary**	**Time**	**Months**	**Amount Requested**
	2nd Q 2013	$106,254	100%	21	$241,291
Job Description Responsible for managing the day-to-day operational relationship with DHS/ESA to design and improve processes for determining eligibility for HBX customers; collaborating with insurance carriers to design and improve processes for enrollment through DCAS; strategizing with all parties to improve enrollment processes; and resolving all enrollment related issues for the HBX. Reports to the Director of Operations.					
Minimum Qualifications Master's Degree in Health Administration, Business Administration or a related field with five (5) years of operations experience in the health insurance industry or in government for Medicaid, Medicare or other public health programs.					
Position Title	**Estimated Start Date**	**Annual Salary**	**Time**	**Months**	**Amount Requested**

Manager, Plan Management (Vacant)	2nd Q 2013	$106,254	100%	21	$241,291

Job Description

Responsible for leading the process to evaluate QHP certification criteria annually, managing the day-to- day operational relationship with DISB; designing and improving processes for managing the certification, decertification and recertification of QHPs; strategizing with all parties to improve plan management; and resolving plan management related issues for the HBX. Reports to the Director of Operations.

Minimum Qualifications

Master's Degree in Health Administration, Business Administration or a related field with five (5) years of operations experience in the health insurance industry or in government for Medicaid, Medicare or other public health programs.

Position Title	Estimated Start Date	Annual Salary	Time	Months	Amount Requested
Manager, SHOP Operations (Vacant)	2nd Q 2013	$106,254	100%	21	$241,291

Job Description

Responsible for implementing SHOP growth strategies, managing the day-to-day operations for small business HBX services and ensuring compliance with Federal regulations for SHOP. Reports to the Director of Operations.

Minimum Qualifications

Master's Degree in Health Administration, Business Administration or a related field with five (5) years experience in managing group health plans or related management experience in the healthcare insurance industry.

Position Title	Estimated Start Date	Annual Salary	Time	Months	Amount Requested
Contract Specialist (Vacant)	2nd Q 2013	$70,259	100%	21	$159,550

Job Description

Responsible for supporting the contracts and procurement process. Formulates and coordinates procurement proposals. Evaluates or monitors contract performance to determine necessity for amendments or extensions of contracts, and compliance to contractual obligations. Reports to the Manager of Contracts & Procurement.

Minimum Qualifications

Bachelor's Degree in Business Administration, Health Care, a related field or equivalent experience with a minimum of 24 semester hours in accounting, law, business, finance, contracts, purchasing, economics, industrial management, marketing, quantitative methods, organization and management. Three (3) years of experience working with contracts and a working knowledge of contractual terminology and negotiation.

Position Title	Estimated Start Date	Annual Salary	Time	Months	Amount Requested

Accountant, Financial Operations (Vacant)	2nd Q 2013	$81,242	100%	21	$184,491

Job Description

Responsible for developing, maintaining, and analyzing budgets; preparing budget reports; analyzing business operation trends, costs, revenues, financial commitments, and obligations, to project future revenues and expenses; and preparing, examining, and analyzing accounting records, financial statements, and other financial reports to assess accuracy, completeness, and conformance to reporting and procedural standards. Reports to the Director of Finance.

Minimum Qualifications

Bachelor's degree in Business Administration, Finance, Accounting or a related field with three (3) years of full-time or equivalent experience as a professional accountant, at least 18 months in a health care organization or program. Knowledge of Federal and State auditing methods and common financial reports and analyses found in health care agencies.

Position Title	Estimated Start Date	Annual Salary	Time	Months	Amount Requested
Accountant, Treasury (Vacant)	2nd Q 2013	$81,242	100%	21	$184,491

Job Description

Responsible for performing various cash, disbursement and accounting activities within the various financial systems, bank reconciliations, audit inquiries, and backup of other core treasury functions; maintaining accurate records of the HBX cash transactions and ensuring that such records are complete and in compliance with HBX policies and regulatory requirements; and preparing financial statements. Partners with internal and external auditors to ensure that financial controls and procedures are adequate and functional. Reports to the Director of Finance.

Minimum Qualifications

Bachelor's degree in Business Administration, Finance, Accounting or a closely related field with three (3) years of full-time or equivalent experience as a professional accountant, at least 18 months of which was in a health care organization or program. Knowledge of Federal, State and County auditing methods and common financial reports and analyses found in health care agencies

Position Title	Estimated Start Date	Annual Salary	Time	Months	Amount Requested
Accountant, Grant Management (Vacant)	2nd Q 2013	$81,242	100%	21	$184,491

Job Description

Responsible for managing the financial grant process for the Navigator Program. Also responsible for the operations of post- award grant administration and related accounting duties, serves as the appropriate principal contact for grants and contract accounting functions, performs grant-related post-award functions, including budget and expense analysis, periodic invoicing, financial reporting, labor distribution changes and associated communications. Reports to the Director of Finance.

Minimum Qualifications

Bachelor's degree in accounting or related field with a minimum of five (5) years in accounting and/or grants administration. A working knowledge of Federal Acquisition Register (FAR), Code of Federal Regulations (CFR) and OMB Administrative and Cost Circulars pertaining to non-profits.

Position Title	Estimated Start Date	Annual Salary	Time	Months	Amount Requested
IT Specialist (Vacant)	2nd Q 2013	$81,242	100%	21	$184,491

Job Description

Responsible for leading projects to support, maintain and improve HBX functions, serving as the Business Analyst representing the Exchange Authority. Assists the Manager of Information Technology in performing his/her duties to enhance HBX capabilities in DCAS. Works with OCTO to coordinate shared IT services for the exchange (email, desktop, network, print, etc). Reports to the Director of Information Technology.

Minimum Qualifications

Bachelor's degree in computer science or related field with a minimum of five (5) years in information technology, including at least one year of experience working with the application platform and tools in use by the Exchange Authority. Two (2) years of experience with IT security related to healthcare and/or insurance. PMP Certification preferred.

Position Title	Estimated Start Date	Annual Salary	Time	Months	Amount Requested
SHOP Specialist (2) (Vacant)	3rd Q 2012	$70,259	100%	18	$137,189

Job Description

Responsible for supporting SHOP operations, providing enrollment assistance and other consumer assistance to employers and employees. Reports to the SHOP Manager of Operations.

Minimum Qualifications

Bachelors Degree with a minimum of three (3) years customer relations experience in the health insurance industry.

Position Title	Estimated Start Date	Annual Salary	Time	Months	Amount Requested
HR Specialist (Vacant)	2nd Q 2013	$70,259	100%	21	$159,550

Job Description

Responsible for completing and supporting projects related to the human resource needs of the HBX and supporting the Manager of Human Resources. Reports to the Manager of Human Resources.

Minimum Qualifications

Bachelor's degree in Human Resources or related field with a minimum of three (3) years experience.

Position Title	Estimated Start Date	Annual Salary	Time	Months	Amount Requested
Administrative Assistant I (Vacant)	1st Q 2013	$47, 283	100%	24	$122,423

Job Description

Responsible for enhancing the Executive Director's effectiveness by providing administrative support, performing clerical functions such as preparing correspondence, receiving visitors, arranging

conference calls, and scheduling meetings. Also provides administrative support to the Executive Board. Reports to the Executive Director.

Minimum Qualifications

High school graduate with five (5) years or more administrative assistant experience. Knowledge of MS Office products and ability to learn other software packages as needs arise.

Position Title	Estimated Start Date	Annual Salary	Time	Months	Amount Requested
Administrative Assistant II (Vacant)	2nd Q 2013	$47, 283	100%	21	$107,374

Job Description

Responsible for enhancing the Executive Director's effectiveness by providing administrative support, performing clerical functions such as preparing correspondence, receiving visitors, arranging conference calls, and scheduling meetings. Also provides administrative support to the Executive Board. Reports to the Executive Director.

Minimum Qualifications

High school graduate with five (5) years or more administrative assistant experience. Knowledge of MS Office products and ability to learn other software packages as needs arise.

Position Title	Estimated Start Date	Annual Salary	Time	Months	Amount Requested
Executive Assistant (Vacant)	4th Q 2012	$57,006	100%	27	$165,126

Job Description

Responsible for providing a wide range of administrative and executive support. Maintains executive's appointment schedule by planning and scheduling meetings, conferences, teleconferences, and travel. Prepares invoices, reports, memos, letters, and other documents, using word processing, spreadsheets, presentation software, databases, or information management support. Monitors, responds to and distributes incoming communications. Conduct research, assembles and analyses data to prepare reports and documents. Represents the executive by attending meetings in the executive's absence. Reports to the Executive Director.

Minimum Qualifications

Five (5) or more years of experience supporting at the executive level. Excellent calendar management skills, including the coordination of complex executive meetings. Strong knowledge of MS Office, including Word, Excel, PowerPoint and Outlook. Experience scheduling travel arrangements for management products and ability to learn other software packages as needs arise.

Section 8.0: Finance and Accounting

8.1 Long-term Cost, Budget, and Management Plan

The District is completing a financial management plan through a contract with Compass Solutions. This plan details exactly how the Exchange will manage and monitor finances and reporting to ensure fiscal and program integrity and comply with all federal requirements. The District will implement this plan with the assistance of consultant services to establish policies and procedures, as well as the

procurement of a vendor to process financial transactions. Finance and accounting staff will also be hired for the Exchange authority to oversee the financial vendor and all Exchange financial operations.

Model budget detailing expected operating costs, revenues, and expenditures.

The District contracted with Compass Solutions to provide a detailed examination of the operational model of the Exchange and the associated costs, as well as to identify preliminary sustainability options for the Exchange post-2014. This includes assessing the resources, needs, and gaps to develop a financial management structure for the Exchange. This model projects revenue and expenses over the next five years and estimates the resources the Exchange will need to fund ongoing operations. The model allows for flexibility so as the structure of the Exchange market is finalized and the design of the Exchange becomes more detailed, the model is easily adapted to reflect these details. The cost and revenue projections discussed here reflect the current recommendation from the Insurance Subcommittee that all individual and small group plans are consolidated in the Exchange.

Details on estimates long-term costs and revenue can be found in Table 1, below. The total estimated per member, per month (PMPM) to operate the DC HBX is approximately $17 in 2014 (in order to build reserves) and approximately $12 in each year thereafter. The operating expenses include setting aside reserve funds for contingencies. The plan assumes that the HBX Authority will build a funded reserve over several years with an ultimate minimum of twelve (12) months or three hundred sixty five days (365) of operating expenses for contingencies.

Description of the methods Exchange will use to generate revenue and how the Exchange will address any financial deficits.

Working with Compass Solutions, the District modeled the following primary revenue sources 1) an assessment on all major medical insurance carrier premiums in the District, 2) a non-participation assessment fee on major medical insurance carriers who service the small group and individual markets outside of the HBX, and 3) a carrier assessment on all premiums inside the HBX. Assessing all health premiums in the District market at a rate of 0.63%-1.3% spreads the costs across a much wider swath of the market and reduces the possibility of a large negative impact on the cost of individual and small business coverage in the Exchange, thereby encouraging coverage. This is the revenue model included in Table 1, below. Assessing only premiums on individual and small group coverage on the consolidated business in the Exchange would result in assessment two and a half times the size of the broader assessment. In a unified market, as currently planned by the DC HBX, an assessment for non-participation would not apply. This is a very preliminary analysis of one potential option proposed by a vendor, which will be updated as additional analysis is completed.

The District continues to explore the feasibility of revenue streams from other sources as well. Ultimately, it is likely that a combination of fees on plans inside and outside of the Exchange will be used. However, a broad-based assessment on medical premiums appears to be the most feasible primary source of revenue for the reasons described above. Other potential sources of revenue include:

- HBX consumer fees;
- HBX Carrier fees;
- Advertising fees on the web portal;
- Broad-based taxes; and
- Provider fees.

The District is currently in the process of determining how to be address financial deficits. Working with its vendor, Compass Solutions, the District has received a draft financial management plan that includes discussion of key financial management processes, financial reporting and monitoring, and fiscal stability monitoring. The District will implement various controls to ensure constant monitoring and oversight of the Exchange's budget. Staff, including a Director of Finance/Comptroller as well as several staff-level Accountants will be brought on board to monitor financial sustainability of the Exchange. Additionally, using Level Two Grant funds, the District will work with a vendor to develop revenue over expense modeling to ensure financial stability of the Exchange. Deficits are also addressed in Question 1 above. The Operational Business Model developed by Compass Solutions assumes that the HBX Authority will build a funded reserve over several years with an ultimate minimum of twelve (12) months or three hundred sixty five days (365) of operating expenses for contingencies. This model is designed to mitigate the likelihood of budget deficits in the Exchange.

Table 1. Long-Term Operational Costs and Revenue for the DC Health Benefit Exchange

Key Statistics:	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
Projected Enrollment	-	-	*184,500*	*184,250*	*184,500*	*184,250*	*184,750*
Carrier Assessment Rate	-	-	*0.6300%*	*1.2600%*	*1.2700%*	*1.2700%*	*1.3000%*
Expenses PMPM	-	-	*11.45*	*10.95*	*11.07*	*11.09*	*11.27*
Total PMPM (Including Reserves)	-	-	*17.10*	*11.85*	*11.98*	*12.00*	*12.19*

	2012	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
Total Expenses:	**$ 2,307,085**	**$ 16,212,075**	**$ 25,349,261**	**$ 24,205,644**	**$ 24,507,823**	**$ 24,524,279**	**$ 24,978,693**
Salaries and Wages	$ 115,075	$ 2,065,776	$ 2,617,483	$ 2,617,483	$ 2,617,483	$ 2,617,483	$ 2,617,483
Fringe Benefits	$ 26,467	$ 475,128	$ 602,021	$ 602,021	$ 602,021	$ 602,021	$ 602,021
Outsourced Services	$ -	$ 4,776,691	$ 14,172,700	$ 14,424,396	$ 14,787,124	$ 15,067,092	$ 15,391,785
IT and Webportal Maintenance	$ 654,533	$ 371,747	$ 3,014,502	$ 4,104,660	$ 4,132,124	$ 3,858,143	$ 3,973,887
Navigator Grants	$ -	$ 184,520	$ 738,000	$ 737,000	$ 738,000	$ 737,000	$ 739,000
Consulting Services (non IT)	$ 1,380,000	$ 7,140,000	$ 2,700,000	$ -	$ -	$ -	$ -
Outreach and Marketing	$ -	$ 900,000	$ 1,200,000	$ 1,400,000	$ 1,300,000	$ 1,300,000	$ 1,300,000
Equipment & Supplies	$ 76,350	$ 25,350	$ 21,600	$ 26,600	$ 26,600	$ 26,600	$ 26,600
Facilities & Maintenance	$ 54,660	$ 225,199	$ 231,955	$ 238,914	$ 246,081	$ 253,463	$ 261,067
Other Administrative (incl. Travel)	$ -	$ 47,664	$ 51,000	$ 54,570	$ 58,390	$ 62,477	$ 66,850

	2012	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
Total Revenue:	**$ 2,307,085**	**$ 16,212,075**	**$ 37,850,266**	**$ 26,195,149**	**$ 26,522,165**	**$ 26,539,973**	**$ 27,031,736**
Federal Grant	$ 2,307,085	$ 16,027,555	$ 24,611,261	$ -	$ -	$ -	$ -
Carrier Assessment on Health Insurance Medical Premiums	$ -	$ -	$ 13,239,005	$ 26,195,149	$ 26,522,165	$ 26,539,973	$ 27,031,736
District Appropriations	$ -	$ 184,520	$ -	$ -	$ -	$ -	$ -

Funded Reserves:	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
Target Annual Deposit Amount	$ -	$ -	$ 12,501,005	$ 1,989,505	$ 2,014,342	$ 2,015,694	$ 2,053,043
Target Days of Expenses to Collect	-	-	180	30	30	30	30
Accumulated Reserves if target is collected	*$ -*	*$ -*	*$ 12,501,005*	*$ 14,490,510*	*$ 16,504,852*	*$ 18,520,546*	*$ 20,573,589*
Estimated Days of Reserve	-	-	*180*	*219*	*246*	*276*	*301*

Section 9.0: Information Technology

9.1 Compliance with HHS IT Guidance

Description of any areas of significant variation between the Exchange's technology and system functionality and HHS IT guidance.

As described in detail in the District's Level II Establishment Grant, the DC Access Solution (DCAS) solution will be designed and developed upon the Seven Standards and Conditions mandated by CCIIO: Modularity, MITA Alignment, Re-use, Industry Standard Alignment, Support of Business Results, Reporting and Seamlessness & Interoperability. As of the drafting of this document, there are no areas of significant variation between the Exchange's technology and system functionality and HHS IT guidance.

Once implementation is underway, the following documents will ultimately confirm or validate compliance with HHS' IT guidance:

- Requirements document
- Contingency Recovery plan
- System Design document
- Interface Control document
- Database Design document
- Physical Data model
- System Security plan
- Logical Data model
- Business Rules logic

9.2 Adequate Technology Infrastructure and Bandwidth

As a result of where the project exists within the lifecycle, the relevant documentation has not been completed. As referenced in the District's SI vendor RFP (DC-HIX-RFP dated 7/12/12), documentation that will contain the appropriate level of detail on adequate technology infrastructure and bandwidth include:

- System Design document
- Service Level Agreements
- Technical Architecture Diagrams
- Release plan
- Implementation plan
- Contingency/Recovery plan

9.3 IV&V, Quality Management and Test procedures

Description of front-end system engineering work, including IT and quality assurance processes and IV&V services to validate requirements, business process and development of the Exchange.

As per the Quality Management plan, quality procedures and processes have been drafted and will be shared with the SI vendor once it has been awarded. These procedures and processes will also be shared with the IV&V vendor NET November 1, 2012. The IV&V vendor will provide the following the services for validating requirements:

a) Evaluate and make recommendations on the project's process and procedures for managing requirements.

b) Verify that the confirmation of system requirements results in clear, well-defined, understood and documented modifications.

c) Evaluate the allocation of system requirements to hardware and software requirements.

d) Verify that software requirements can be traced through design, code and test phases to verify that the system performs as intended and contains no unnecessary software elements.

e) Verify that requirements are under formal configuration control.

f) Assist in the negotiation of requirements changes.

Additionally, the IV&V vendor will provide services for validating the development of the Exchange:

a) Verify that design requirements can be traced back to system requirements.
b) Verify that all design products are under configuration control and formally approved before detailed design begins.
c) Verify that design requirements can be traced back to system requirements and high level design.
d) Verify that all design products are under configuration control and formally approved before coding begins.
e) Execute audits of code documentation to evaluate for quality, completeness (including maintenance history), and accessibility.
f) Verify that developed code is kept under appropriate configuration control and is easily accessible by developers.
g) Evaluate the project's use of software metrics in management and quality assurance.

Test plan

A comprehensive test plan will be developed by the SI vendor NET December 1, 2012. It is expected that the overall testing approach will include QA teams that encompass manual and automated testing across system and integration testing cycles, and adopt a risk-based approach for test coverage. This will take into consideration defect management, knowledge management, project management and change management. Generally, verification and validation capabilities will be built upon key methodologies that include V-model testing, reviewing test coverage through a comparison with the requirements traceability matrix, implementing Risk-Based Testing (RBT) and testing early (and often) to focus on defect prevention.

IV&V reports, Quality Management section in the PMP

As evidence that requirements, design, and test artifacts have undergone a thorough IV&V process by an independent third party, the Monthly IV&V Review report (MRR) will provide the results of a detailed evaluation and assessment of the requirements management activities of DCAS. Specifically:

a) Verify that the system requirements satisfy Federal and District regulations;
b) Evaluate the allocation of system requirements to hardware and software requirements;
c) Verify that software requirements are being traced through design, code and test phases;
d) Verify that all requirements are under formal configuration control;
e) Verify that all stakeholders have bought-in to all changes which impact project objectives, cost or schedule;
f) Verify that key stakeholders have been involved in prototyping of the user interface and static web portal presentations.

Additionally, Weekly Status reports (WSR) from the IV&V vendor will provide a brief summary status of QA activities to include:

a) Project Management;
b) Requirements Validation;
c) Requirements Specifications;
d) Requirements Traceability Matrix;
e) Detailed System Design;
f) Test Management;
g) Data Conversion;
h) Release Management;
i) Defect Management;
j) Configuration Management;
k) Change Management.

Furthermore, and specifically, with respect to testing, the IV&V vendor is required to develop a Test Management plan. The contents will include, but are not limited to detailed descriptions of the validation and verification approach of DCAS testing phase, and details pertaining to the following:

a) UAT Strategy and Plan
    i. Approach;
    ii. Timing;
    iii. Activities involved;
    iv. Scope of coverage from a functional perspective.
b) UAT Procedures Guide
    i. Goals & objectives;
    ii. Roles & responsibilities;
    iii. Tech techniques and methods;
    iv. Work product templates;
    v. Sample scenarios and cases;
    vi. Participant guidelines.
c) UAT Reports
    i. Executive summaries for reporting progress and results;
    ii. Detailed reports on progress and results;
    iii. Test reports on performance and results.

9.4 Project Management

Updates to the following documents reflect all aspects of DCAS project management.

1. Project Schedule
2. Risk Register
3. Communication matrix
4. Change Management plan
5. Configuration plan
6. Staff management plan
7. Financial report
8. Performance management plan
9. Performance measures

10. Quality Management plan
11. Training plan
12. Release plan

9.5 Stakeholder Requirements Definition process

Business Requirements

The initial business requirements documentation was completed in May 2012 and provided to CCIIO for review. The initial thirty days of the system implementation will constitute the requirements confirmation phase of the project. An updated business requirements document can be submitted NET December 31, 2012.

For requirements confirmation, numerous stakeholder teams/groups have been identified across the aforementioned agencies that are directly involved in implementing, operating and administering the Exchange. With the SI vendor team providing the structure and methods, stakeholder team members will explore various techniques to gather stakeholder and customer requirements through joint application development (JAD) workshops, one-on-one interviews, and in-depth subject-matter discussions.

Use Cases of User Stories

Use cases are graphical depictions of how the system should respond under various conditions to a request from an actor, end user or stakeholder. As detailed, each use case is a scenario that describes a sequence of steps with each step having one or many actions or outcomes. While they may be modified during the design, development and test phases, it is anticipated that the initial, formal drafting of the DCAS use cases will be completed NET December 31, 2012.

Business Rules

As the project captures and implements policies and actions detail that will ultimately drive, systematic use case execution, these business rules will be formally developed across the requirements confirmation and design phases. It is anticipated that the initial, formal draft will be completed NET January 31, 2013.

9.6 Requirements Analysis Process

As with business requirements documentation, the initial system requirements were completed and captured in May 2012 and provided to CCIIO for review. For system implementation, the requirements confirmation phase will occur across the initial thirty days of system implementation. An updated system requirements document can be submitted NET December 31, 2012.

9.7 Architectural Design Process

As documented in our preliminary schedule, DCAS will not exit its design phase until NET February 28, 2013. The deliverables below include the preliminary planned due date as included in DCAS-HBX-RFP dated 7-12-12. These dates will most likely be adjusted into February in anticipation of SI vendor onboarding in November.

1. Systems Design document (1/31/13)
2. Interface Control document (1/31/13)

3. Database Design document (1/31/13)
4. Logical Data model (1/31/13)
5. Physical Data model (1/31/13)
6. Data Management plan (1/31/13)
7. Implementation plan (5/31/13)
8. Data Conversion plan (4/30/13)
9. Contingency/Recovery plan (1/31/13)
10. Manuals and Training Materials (5/31/13)
11. User manuals (5/31/13)
12. O&M manuals (5/31/13)
13. Training materials (5/31/13)

As the beginning of design approaches, the completion dates upon which the drafts for the architectural design documents listed above will be determined. At that time, these drafts will be submitted to CCIIO for the purposes of the Establishment Design

Section 10.0: Privacy and Security

10.1 Privacy and Security Policies and Procedures for the Exchange's Activities

Description of the Security and Privacy plan for Exchange, including Privacy and Security Standards, Policies, and Procedures for Exchange activities.

The DCAS shall be built on a single, comprehensive and integrated security and privacy framework based upon a System Security Plan that implements several federal and District security and privacy policies including, but not limited to:

- Federal Information Security Management Act (FISMA) of 2002
- Health Insurance Portability and Accountability Act (HIPAA)
- Health Information Technology for Economic and Clinical Health Act (HITECH) of 1996
- Privacy Act of 1974
- Affordable Care Act (ACA) of 2010, Section 1561 Recommendations
- Safeguarding and Protecting Tax Returns and Return Information (26 U. S, C. 6130 and related provisions)
- e-Government Act of 2002
- National Institution of Standards and Technology (NIST) Special Publications (SP) including Publication 1075 data safeguards for IRS. NIST's Special Publications are available at: http://csrc.nist.gov/publications/PubsSPs.html and a guide to implementing the HIPAA Security Rule can be found at: http://csrc.nist.gov/publications/PubsFIPS.html
- National Security Agency (NSA) Security Recommendation Guides
- NIST SP 800-41 Guidelines on Firewalls and Firewall Policy
- NIST SP 800-44 Guidelines for Securing Public Web Servers
- NIST SP 800-45 Guidelines for Electronic Mail Security
- NIST SP 800-52 Guidelines for the Selection and Use of Transport Layer Security (TLS) Implementations
- NIST SP 800-53 Recommended Security Controls
- SP 800-55 Security Metrics Guide for Information Technology Systems
- NIST SP 800-83 Guide to Malware Incident Prevention and Handling

- NIST SP 800-77 Guide to IPsec VPNs NIST SP 800-100 Information Security Handbook
- NIST SP 800-88 Media Sanitization Guide
- NIST SP 800-100 Information Security Handbook
- NIST SP 800-113 Guide to SSL VPNs

The Exchange will establish and implement written policies and procedures regarding the Privacy and Security standards set forth in 45 CFR 155.260(a)(g) and based upon NIST 800-53 framework by the end of the Analysis and Design phase which is anticipated to be no earlier than February 7, 2013.

The District of Columbia Healthcare Benefits Exchange policies shall comply with Privacy and Security Standards by supporting Policies and Procedures that are or shall be defined in the System Security Plan, information Security Risk Assessment, Privacy Impact Assessment, Data uses, Data Exchange, and Interconnection Security Agreement, and System or Record Notice (SORN). The Information Security Risk Assessment, Privacy Impact Assessment, Data Uses, Interconnection Security Agreements, and System or Record Notice drafts are anticipated to be complete by the end of the Analysis and Design phase no earlier than February 7, 2013.

The Information Security Risk Assessment (ISRA) Plan shall describe the approach to managing a list of threats and vulnerabilities, an evaluation of current security controls, their resulting risk levels, and any recommended safeguards to reduce risk exposure. The ISRA will also support risk management through the evaluation of risk impact upon the enterprise security model. The draft Information Security Risk Assessment Plan is anticipated to be complete by the end of the Analysis and Design phase no earlier than February 7, 2013.

Overall, however, the Authority will monitor the Privacy and Security activities of its partners and users in the policy categories of:

- Use and Disclosure of Personally Identifiable Information
- Individual Tax Return Confidentiality
- Security Standards (Other administrative, physical and technical safeguards designed to protect systems and the information therein)

The DC Access System (DCAS) will conform to the Draft Privacy Impact Assessment provided in March, with an update expected by February 2013.

DCAS will interface with State and Federal systems and the HBX will ensure that all interfaces meet all security, privacy, and HIPAA regulations. The interfaces listed in the SSP represent the initial interfaces that will be required by the HBX. Several of these interfaces will be phased out as the HBX solution matures. At this time the resolution of information within some internal District of Columbia systems, and information related to policies and standards regarding the Federal Hub, IRS Wage and Salary references are still undergoing development and change. This section will be updated as these items are resolved.

DC Access System (DCAS) is a new system under development and currently in the planning phase. As work on the Privacy Impact Assessment, (PIA), progresses the requirement regarding the creation of a DCAS SORN Number is expected to be completed by February 2013.

10.2 Safeguards based on HHS IT Guidance related to Exchange Activities

Description of any Exchange activity-related HHS IT Guidance

The Exchange has defined and shall implement safeguards that (1) ensure the critical outcomes in 45 CFR 155.260(a)(4), including authentication and identity proofing functionality, and (2) incorporate HHS IT requirements as applicable as referenced in attachment J25 of the DCAS Systems Integration Vendor solicitation number CW16474 Security and Privacy Framework Security Principles section. Updates will be provided by February 2013.

10.3 Description of Safeguard Protections for Federal Information

The measures in the Safeguard Procedures Report (SPR) will build upon the System Security Plan (SSP), which in turns builds upon the Privacy Impact Assessment and FIPS PUB 199. These documents explain the controls that will be built in to the system design and system architecture which shall be fully detailed in draft submission by February 2013.

District HBX and its SI vendor will continue to develop the SSP and SPR, along with the Information Security Risk Assessment (ISRA) and other security components.

10.3a: The Exchange will develop adequate safeguards in place to protect the confidentiality of all Federal information received through the Data Services Hub, including but not limited to Federal Tax Information.

10.3b: The District's Exchange Authority intends to request and obtain an IRS letter of acceptance and approval on the Safeguard Procedures Report by Q2 2013. The District intends the Safeguard Protections for Federal Information protect it as if the information remained in IRS's hands.

These safeguards will be implemented by the District agencies and their contractors receiving federal tax information will protect the confidentiality of return information and be periodically reviewed by Safeguards personnel to ensure they meet the safeguarding requirements of IRC 6103(p)(4). The intended safeguards include employee awareness programs, proper disposal, secure storage and computer security among others.

The District expects to complete the SPR by the end of the Analysis and Design phase no earlier than February 7, 2013.

Section 11.0: Oversight, Monitoring, and Reporting

11.1 Routine Oversight and Monitoring of the Exchange's Activities

Description of oversight and monitoring plan for Exchange, including any specific protocols for quality monitoring of Exchange activities (e.g., E&E, Plan Management).

The District has developed a draft Program Integrity (PI) Plan for financial and program oversight. Specific protocols for quality monitoring of Exchange activities will be developed based on this plan by the first quarter of 2013. This PI plan will be revisited now that the Exchange Authority and Executive Board is in place; however, it provides a framework for the creation of the necessary oversight and monitoring policies and procedures.

In accordance with 45 CFR Part 155.200, the Exchange will evaluate quality improvement strategies and oversee implementation of enrollee satisfaction surveys, assessment and ratings of health care quality and outcomes, information disclosures, and data reporting in accordance with sections 1311(c)(1),

1311(c)(3), and 1311(c)(4) of the Affordable Care Act. For the period of Q4 2012 through Q1 2014, the District intends to procure consulting assistance as we continue with our Program Integrity (PI) planning and implementation efforts.

Per the draft plan, the Exchange intends monitor the PI activities of its partners and users. The following describes the initial audit strategies.

- QHPs: The Authority will review and audit compliance plans and PI plans for all insurers that participate on the HBX. This review will consist of an initial inventory of all participating plans and an initial review to assure that all plans have a satisfactory compliance and PI plan in place. Subsequent audits include auditing plans for compliance with QHP requirements. The Authority will meet on an ad-hoc basis with PI professionals from the QHP to review and align program integrity policies.

- Navigators/Brokers/Agents/Assisters: The Authority will complete an inventory of all parties supporting the community outreach, consumer education and eligibility and enrollment into products and programs. These individuals and entities will be subjected to random audits of their capability and capacity to provide required services and whether they have (or could easily establish) relationships with employers, employees, and customers likely to be eligible to enroll in a QHP. The audits will also evaluate the question of conflicts of interest and certifications requirements, if they are established.

- Consumers: The Authority along with DHS has the responsibility for eligibility determinations. Authority will review the DHS program integrity policies and procedures and provide results of reviews at the ad-hoc meetings with DHS.

- Employers: In the first year of operation, the Authority will conduct a review of a random sample of employer applications to ensure that the employers are eligible for participation and that the submissions are accurate, complete, and verifiable. At this time, the Authority will not be able to identify employers who would be at high risk of providing inaccurate information; therefore, targeted reviews are not scheduled for the first year. At the completion of the first year of operations, the Authority will conduct a review of the random audits completed and create a risk-based targeted audit plan. Reviews will include data validation and confirmation of the accuracy of the information.

- Employees: The Authority will random audits of employer submitted premiums to ensure amounts submitted accurately reflects employee portion of the premium. The Exchange Authority may hire an independent consulting firm to perform this task.

Generally, the District plans to implement periodic samplings of data for quality assurance on eligibility determinations and enrollments. The following are methods will be used:

a) Analytics;
b) Pattern matching;
c) Flagging potentially fraudulent cases (so that case managers and other authorized system users are aware of the investigation);
d) Random sampling (to detect duplication).

Per the developed system requirements, it is expected that analytics software (with the ability to detect patterns that may not be noticed by human reviewers will increase the amount of unusual activity detected) will be leveraged for this effort.

Finally, the Authority will maintain an emphasis on both fraud and abuse prevention and detection and will evaluate the current audit strategy, criteria, and protocols on a semi-annual basis. This assessment includes:

a) Providing updates or additional information concerning the fraud and abuse policies;
b) Reviewing and evaluating the effectiveness of internal controls and audit activity;
c) Identifying of new risks, gaps in oversight and mitigation opportunities; and
d) Identifying and assessing additional strategies to implement in response to evolving State and federal regulations.

11.2 Track/Report Performance and Outcomes Metrics Related to Exchange Activities

Description of any Exchange activity-related performance metrics that Exchange intends to track for internal purposes as part of ongoing quality controls and improvement plan.

The District intends to procure consulting assistance for program integrity plan implementation. The development of activity-related performance metrics in order to track SHOP activities and overall performance will be one of many tasks included in the corresponding statement of work.

11.3 Uphold Financial Integrity Provisions Including Accounting, Reporting, and Auditing Procedures

Indication of the financial or accounting standards with which the Exchange is in compliance (e.g., Government Accounting Standards Board, Government Accountability Office (GAO) Government Auditing Standards (Yellow Book); OMB Circular A-123 "Management's Responsibility for Internal Control").

As per the District's draft Program Integrity plan, the Exchange Financial Management governance structure will include a Financial Manager that will:

a) Support the development of annual financial statements in accordance with Generally Accepted Accounting Principles (GAAP);
b) Work with the US Department of Health and Human Services to support annual audits per ACA section 1313(a)(3); and
c) Confirm all financial measures, best practices and standard accounting practices are being followed.

Additional procedures related to the financial and accounting standards to be used in the Exchange will be developed through consulting assistance as described above.

Description of general approach to upholding financial integrity provisions

The District's Draft Program Integrity Plan includes financial and program oversight designed to promote transparency and prevent mismanagement of Establishment and operating revenue funds. Fraud and abuse prevention are elements of the PI plan, as are audits and financial oversight.

The Exchange Financial Manager (Chief Financial Officer) will be responsible for the monitoring all financial aspects of the Authority, and will confirm proper use of Federal and District funding in the

implementation and operations, and provide any necessary financial reporting to relevant parties. This position will be filled by an individual from the Office of the Chief Financial Officer of the District government, which will provide additional oversight. The Exchange Financial Manager will:

a) Report to the Exchange Board as well as HHS on the financial health of the Authority during the operations;
b) Support the development of annual financial statements in accordance with Generally Accepted Accounting Principles (GAAP);
c) Work with the External Auditor to confirm all data is available, and to confirm that the Authority is adhering to the financial controls established by the External Auditor;
d) Work with the US Department of Health and Human Services to support annual audits per ACA section 1313(a)(3);
e) Confirm all financial measures, best practices and standard accounting practices are being followed;
f) Perform oversight activities of the prospective Financial Management vendor.

Also, the services of an independent external auditor will be used to measure the Exchange's financial health and adherence to the controls established. The external auditor will:

a) Attest to the accuracy of the financial health of the Authority on, at least, a semi-annual basis;
b) Independently assess internal controls for thoroughness within the Authority;
c) Confirm all Authority work is adhering to established internal controls in place;
d) Keep all key stakeholders apprised of Authority's financial health on at least a semi-annual basis;
e) Identify areas where the Authority is not adhering to any internal controls, and provide recommendations to address these shortcomings.

Section 12.0: Contracting and Outsourcing Agreements

12.1 Contracting and outsourcing agreements

Existing Contractor Support

The District has contracted with multiple vendors to support planning and implementation of the D.C. Health Benefit Exchange (HBX). These contractors and their services are listed below.

Compass Solutions has provided a team of experts to perform the following activities:

- Assist with program integration through identification and implementation of necessary memorandums of understanding (MOUs) between District agencies and the Exchange.
- Perform a comprehensive analysis of the District's requirements for an Exchange Call Center including utilization of current and planned consumer assistance services and call centers to support the needs of the HBX.
- Develop the financial management structure and accounting procedures for the HBX.
- Provide analysis related to the District's market structure and Exchange benefits and offerings. Work with the Department of Health Care Finance, the Department of Insurance and Banking, and the Department of Human Services to develop an operational business model detailing the functions and costs associated with each module in the HBX.

- Develop recommendations for the District's Consumer Assistance program.

The Crider Group has provided technical assistance and staff support, performing the following tasks:

- Development of a Strategic Plan for Health Care Reform Communications, including short and long-term strategies to properly communicate relevant information related to the District's Health Insurance Exchange to all stakeholders in accordance with stakeholder perspectives.
- Support to District and Authority staff implementing the Strategic Communications Plan.
- Identification of areas of the DC Municipal Regulations (DCMR) where amendments may be needed to implement the DC Health Insurance Exchange as well as District decisions regarding functions of relevant District agencies.
- Development of draft by-laws, charter, and policies for the HBX Executive Board and Authority.
- Produce document containing recommendations of possible navigators, definition of roles, and operational structure.
- Review and draft Health Reform related documents and materials as need upon request of the Health Care Reform and Innovation Administration (HCRIA).
- Develop and conduct training and development actions regarding the Department's health care initiatives.

Accenture Consulting has provided the following technical support:

- Developing requirements for the DC Access System (DCAS).
- Assisting in the development of the Request for Proposals to procure a System Integration vendor.
- Providing Independent Verification and Validation (IV&V) services to support the implementation of DCAS.

Planned Contractor Support

At this point, the District has identified the following functions for which contractor support may be procured using Level II grant funds:

- Design and roll-out of an outreach and education campaign.
- Building and potential operation of an integrated call center.
- Design and implementation of a Navigator program.
- Design and implementation of Broker policies and agreements.
- Design and implementation of change management for new integrated eligibility and enrollment processes.
- Implementation of plan management functions, including QHP certification, decertification, and ratings.
- Implementation of financial management services.
- Design and implementation of the program integrity plan.
- Design Small Business Health Option Program (SHOP) operations, including the development of policies and procedures and assistance with implementation of SHOP.
- Development of organizational and human resources strategic plan, including performance management system.

RFPs will be released, considered, and awarded in accordance with the Contracting and Procurement Policies and Procedures adopted by the HBX Executive Board on October 3, 2012.

District Agency Support

In an effort to control costs while improving operational efficiency, the HBX Authority intends to leverage functionality and capabilities already found in existing District agencies for some Exchange functions. To this end, the HBX plans to engage in a series of MOUs with District agencies to achieve various required Exchange functions. This approach will ensure the streamlined delivery of services to District residents. The currently envisioned list of MOUs is as follows:

- ***Exchange and DHCF*** – The Department of Health Care Finance (DHCF) is the single State Medicaid Agency responsible for Medicaid determinations. The requirements placed on the Exchange to conduct such determinations for individuals applying for Medicaid based on Modified Adjusted Gross Income (MAGI) will be delegated to DHCF which in turn will sub-contract with DHS. An existing MOU between DHCF and the Department of Human Services (DHS) to conduct Medicaid eligibility determinations will be modified to reflect this relationship.

- ***Exchange and DISB*** – The Department of Insurance, Securities and Banking (DISB) will conduct certification, recertification, and decertification of plans operating in both the SHOP and the Individual marketplace. Second, the agency will determine both employee and employer eligibility for SHOP participation. Third, DISB will conduct ongoing Plan Management functions, including Quality Ratings, under the policy and procedures proscribed by the Authority. Finally, in collaboration with the Office of Health Care Ombudsman and Bill of Rights (OHCOBR), DISB will adjudicate coverage disputes between individuals and QHPs.

- ***Exchange and DHS*** – DHS, through its Economic Security Administration (ESA), will conduct Exchange, APTC, and CSR eligibility determinations based on federal policies and others proscribed by the Authority. This MOU streamlines eligibility functionality within ESA, which already contracts with DHCF to conduct Medicaid eligibility determinations and will continue to do so after Exchange implementation.

- ***Exchange and OAH*** – The responsibilities placed on the Exchange to adjudicate individual eligibility appeals submitted both by individuals and their employers will be contracted to the Office of Administrative Hearings (OAH). This streamlines eligibility appeals since OAH already contracts with DHCF to conduct Medicaid eligibility appeals and therefore has the expertise to handle QHP, APTC, and CSR eligibility appeals.

First drafts of all the MOUs referenced above have been completed and review within the relevant agencies has begun. Each is expected to be executed by early 2013, though more complete drafting of the Exchange/OAH MOU is awaiting publication of the eligibility appeals regulations from CCIIO.