U.S. Department of Health and Human Services
Office of Consumer Information and Insurance Oversight

Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges

California Application
Level I Establishment Grant

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Period of Performance
July 1, 2011 to June 30, 2012

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E. Project Narrative

The federal Affordable Care Act (ACA) seeks to create a more competitive health insurance marketplace through the creation of state-based health insurance exchanges by 2014. As envisioned at the federal level, state-based exchanges will be "a mechanism for organizing the health insurance marketplace to help consumers and small businesses shop for coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality.[1]" Federal goals for the Exchange include promoting efficiency, avoiding adverse selection, streamlined access and continuity of care, public outreach and stakeholder engagement, public accountability and transparency, and financial accountability.

In the Fall of 2010, California enacted the first state law in the nation establishing a health benefit exchange under the ACA, the California Patient Protection and Affordable Care Act (CA-ACA).[2] The CA-ACA included legislative intent for the creation of the California Health Benefit Exchange (California Exchange):

- Reduce the number of uninsured Californians by creating an organized, transparent marketplace for Californians to purchase affordable, quality health care coverage, to claim available federal tax credits and cost-sharing subsidies, and to meet the personal responsibility requirements imposed under the federal act [ACA];
- Strengthen the health care delivery system;
- Guarantee the availability and renewability of health care coverage through the private health insurance market to qualified individuals and qualified small employers;
- Serve as an active purchaser, including creating competitive processes to select participating carriers and other contractors;
- Require that health care service plans and health insurers [collectively carriers] issuing coverage in the individual and small employer markets compete on the basis of price, quality, and service, and not on risk selection; and,
- Meet the requirements of the federal act and all applicable federal guidance and regulations.

Since passage of the CA-ACA, California has made steady progress in developing and planning for the roll out of the Exchange as outlined in Section (b) of this application, despite dramatic and sustained state fiscal and budget challenges affecting all state programs, including health care programs.

The CA-ACA called for the California Exchange to be governed by a newly created state Board with members appointed by the Governor and the Legislature. In early 2011, the California Exchange Board was constituted, with all five members appointed; the Board has been meeting since April 2011. The Board elected the Secretary of the California Health and Human Services Agency (CHHS) as Chair, signaling its intention to actively coordinate and collaborate with existing state agencies involved in providing health coverage to California residents. The Exchange Board recruited an acting Administrative Officer to manage Board activities and progress, including recruitment of a full time executive officer and oversight of the submission of this Level I Establishment grant application.
California is ready to continue to continue its progress toward Exchange implementation through the next year. In order to secure the necessary resources to take the next steps, the California Exchange is

[1] *Initial guidance to states on Exchanges*. Department of Health and Human Services. Center for Consumer Information and Insurance Oversight. November 18, 2010.
[2] AB 1602, Chapter 661 and SB 900, Chapter 659, Statutes of 2010, collectively referred to here as CA-ACA.

submitting this application for a Level I Exchange Establishment grant for the period of July 1, 2011 to June 30, 2012 to continue planning and early implementation activities.

a. Demonstration of Past Progress in Exchange Planning Areas

Background Research

Since the September 2010 State Planning and Establishment Grant award, a substantial amount of research has been conducted and evaluated which will be critical to the design and sustainability of the California Exchange. For example, research and analyses has been conducted, and continues to be refined, to ensure that the most accurate estimates possible for the potential Exchange population and its demographics are available to the Exchange and state policymakers.

Exchange Board members and staff held multiple meetings over the planning period with researchers and key stakeholders to refine research topics, clarify assumptions and provide feedback. California has considerable academic, expert and philanthropic resources to support and conduct the research and analytical work required for implementation of federal health reform broadly, and the California Exchange specifically. Additionally, Exchange and CHHS staff and consultants held in-person meetings, conference calls, and conducted document review with counterparts in other Early Innovator states as well as with states submitting Level I Exchange Establishment grant proposals in March 2011. Much has been learned from these connections with other states, and at the same time, the Exchange Board and staff recognize the unique nature of California's size, demographic diversity, and the unique features of its public and private delivery systems, health insurance markets and regulatory environment necessitating California-specific research.

The following major California-specific research efforts have been conducted with review and consultation from the Exchange:

- *Eligibility for Medi-Cal and the Health Insurance Exchange in California Under the Affordable Care Act* (UC Berkeley Labor Center, August 2010);
- *Lower Taxes, Lower Premiums: The New Health Insurance Tax Credit in California* (Families USA, September 2010;)
- *Projecting the Impact of the Affordable Care Act in California* (Gruber and Long, Health Affairs, January 2011);
- *Small Employer ("SHOP") Exchange Issues* (Institute for Health Policy Solutions, and presentation to the Exchange Board, May 2011);
- *California's Individual and Small Group Markets on the Eve of Reform* (CHCF – Katherine Wilson, and presentation to the Exchange Board by Marian Mulkey, May 2011); and
- *The Potential Impact of the Affordable Care Act on California – The UC Berkeley/UCLA micro-simulation model for consumer health spending and affordability* (UC Berkeley Labor Center and UCLA Center for Health Policy Research, presentation to the Exchange Board, May 2011).

While projections from the available studies vary somewhat, UCLA Center for Health Policy Research estimates, based on data from the California Health Interview Survey (CHIS), indicate that as of the end of 2010 there were approximately 33.3 million Californians under the age of 65, including 7.1 million uninsured.[3] These data are similar to those developed in independent CHCF-sponsored research.[4] Figure

[3] UCLA California Health Information Survey.

1 (below) shows the sources of health insurance for all Californians.

Figure 1
Sources of Health Insurance Coverage in California, 2011[5]
California Health Care Foundation

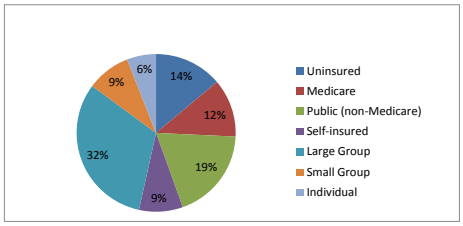
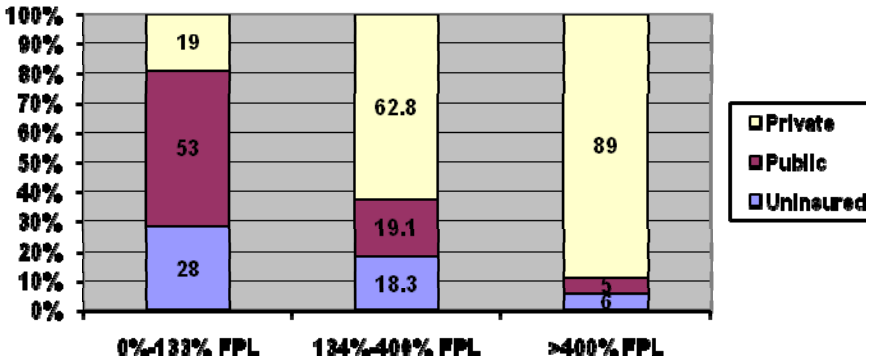


Figure 2 below shows the distribution of coverage and the percent uninsured by Federal Poverty Level (FPL), derived from the AskCHIS online search tool.[6] Public coverage dominates for the lowest income population, with private insurance dominant for persons at 134% FPL and above.

Figure 2
Coverage by Federal Poverty Level in California, 2009



Researchers have extrapolated the size of the potential exchange population in California, both subsidized and unsubsidized, and developed a range of projections for consideration and planning purposes. These projections are undergoing continuing refinement and sensitivity analysis and review by the Exchange. The University of California Berkeley Labor Center estimates the following regarding the potential Exchange population in 2016:

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[4] CHCF *California Health Care Almanac 2010: California's Uninsured.*
[5] – Staff analysis based on CHCF's *California's Individual and Small Group Market on the Eve of Reform* (K. Wilson).
[6] Based on data from the California Health Information Survey, 2009, AskCHIS online search tool.

- Up to 2.8 million Californians may be eligible for subsidized coverage through the Exchange. Of these individuals, up to 2.4 million individuals could be eligible for some level of subsidy, and an estimated 450,000 could be eligible for small group coverage offered by their employer with a premium tax credit.
- Up to 2.1 million people could potentially be eligible for individual coverage through the Exchange without subsidies. In addition, up to 3.3 million Californians could be eligible through small employers purchasing coverage through SHOP without premium tax credits.

Board and staff are continuing to work with external researchers and stakeholders to refine these estimates, perform sensitivity analyses, and test the robustness of assumptions. This research will continue during the Level I Establishment grant period.

Stakeholder Consultation

Stakeholders have been involved throughout the California Exchange planning process. From the beginning, stakeholders contributed through the legislative process to the CA-ACA and many worked for its passage last Fall. California expects to have enhanced Board and staff capacity to more fully engage and collaborate with diverse stakeholders during the period of the Level I grant.

The structure and operation to date of the California Exchange has built in mechanisms for stakeholder input. The California Exchange Board has been meeting in public session monthly or bi-monthly since April 2011 and has held five public meetings. Under the ACA, Exchange Board meetings are subject to the provisions of the state Bagley-Keene Open Meeting Act of 2004. Bagley-Keene requires public agencies to publicly notice meetings, prepare and post meeting agendas in advance, accept public testimony and conduct all meetings with a quorum of Board members in attendance in public. The Exchange Board has implemented the practice of incorporating stakeholder testimony regarding all Board agenda items, other than the limited exceptions for closed sessions related specifically to statutory exemptions in CA-ACA, such as contracting and personnel issues. Exchange Board members, CHHS and Exchange staff met regularly throughout the planning grant period on a one-on-one basis with organizations and individuals interested in the Exchange.

CHHS provided staff and administrative support to the Exchange for most of the planning grant period and during that time created and managed a public California Exchange website that posts background information, notices about upcoming and past California Exchange Board meetings and relevant meeting materials. California Exchange Board meetings are also now simultaneously Webcast to provide access to a much wider audience. Webcasting is continuing on an ongoing basis. In addition, stakeholders were provided an opportunity to contribute to the development of this grant application at the June 15, 2011 Board meeting and through a June 20, 2011 webinar conference call.

CA-ACA also reinforces the federal goal of stakeholder input in exchange development and requires the Exchange Board to consult with stakeholders, including but not limited to: health care consumers enrolled in health plans; individuals and entities with experience in facilitating enrollment in health plans; representatives of small businesses and self-employed individuals; the state Medi-Cal Director; and advocates for enrolling hard-to-reach populations.

Governance

CA-ACA established the governance structure and the authorities and responsibilities of the Exchange Board. In addition, CA-ACA includes extensive conflict of interest provisions affecting Board membership and operations. CA-ACA establishes core staffing requirements and requires the Board to hire, at a minimum, a chief fiscal officer, chief operations officer, director for the Small Business Health Options (SHOP) Exchange, a director of health plan contracting, a chief technology and information officer, a general counsel, and "other key executive positions as determined by the Board."

The California Exchange Board convened for the first time on April 20, 2011 and as noted above, five meetings have already taken place with a calendar of monthly meetings set through the end of 2011. The Board appointed Patricia Powers as Acting Administrative Officer with additional staffing support provided by CHHS. CHHS commissioned and completed a salary survey through a contract with Towers Watson. A subcommittee of the Board is working to recruit the full-time Executive Director and Chief Counsel with consulting support from Cooperative Personnel Services Human Relations. In addition, a subcommittee of the Board provided guidance and direction in the development of this Level I Exchange Establishment Grant.

Program Integration

Coordination with other state health and human services programs

CHHS; the Department of Health Care Services (DHCS), California's Medicaid state agency, which administers Medi-Cal; the Managed Medical Risk Insurance Board (MRMIB), which administers California's Children's Health Insurance Program (CHIP), Healthy Families Program; and the Office of Systems Integration have been meeting internally and with key stakeholders during the planning grant period to discuss and begin to evaluate options for coordinating and streamlining eligibility and enrollment systems between existing public coverage programs and the Exchange. Additional information about the nature of these meetings and collaborations is included below in the section on information technology (IT) systems progress.

CHHS established an internal working group with these departments to serve as a resource to the Exchange on program integration opportunities and challenges going forward. DHCS and MRMIB provided public testimony at Exchange Board meetings on existing eligibility and enrollment programs and system elements. At multiple meetings, the Exchange Board heard testimony and received detailed information about existing state and local eligibility and enrollment programs from DHCS, county representatives and MRMIB.

Coordination with state health insurance regulators

In California, regulation of health care coverage is divided between two state departments, the California Department of Insurance (CDI) under the independently elected Commissioner of Insurance and the Department of Managed Health Care (DMHC) under the state Business, Transportation and Housing Agency. CDI regulates health insurance products covering 2.6 million Californians, primarily in PPO model coverage, including 2 million in individual coverage. DMHC regulates HMO and PPO products covering 21.6 million lives, including managed care plans providing coverage in Medi-Cal and Healthy Families.

The Exchange Board will need to actively coordinate and collaborate with both CDI and DMHC in the certification and monitoring of qualified health plans (QHPs) in the Exchange and on broader insurance

market reforms and issues, such as risk selection and benefit issues arising in health reform implementation. This collaboration has begun during the planning grant phase with the creation of a working group of state staff, including CDI and DMHC staff, available to consult and work with the Exchange on health plan management issues. CDI and DMHC provided testimony before the Exchange Board on existing regulatory roles and responsibilities and on the implementation of federal health reforms to date.

Exchange IT Systems

During the planning grant period, California made material progress in four key IT areas:

- Requirements analysis;
- Gap analysis;
- Collaboration; and
- Project planning.

Requirements Analysis

California devoted substantial effort to analysis of key documents, including in particular the relevant portions of the ACA, Department of Health and Human Services (DHHS) Guidance for Exchange and Medicaid Information Technology Systems, Versions 1.0 and 2.0, Exchange Business Architecture Supplements ("Blueprints"), Section 1501 Recommendations, Center for Medicare and Medicaid Services (CMS), Final Rule on Federal Funding for Medicaid Eligibility Determination and Enrollment Activities and the supporting guidance: *Enhanced Funding Requirements: Seven Conditions and Standards* . CHHS, Exchange staff and consultants have developed various summary presentations of requirements for use in stakeholder communications and begun engaging key stakeholders in the requirements elicitation process. In California, as in every state, the input of key stakeholders is a fundamental component of successful analysis and planning related to federal requirements and guidance. In addition, this work has been informed by detailed review of other states' grant applications, consultant reports and discussions with other state staff.

California recognizes that a clear understanding of federal requirements is critical to understanding the "to be" state in an accurate gap analysis and is a key element in supporting effective due diligence in assessing the applicability of models developed by Early Innovator States. The state’s objective is to develop a requirements specification that is adequate to support effective business process modeling and successful acquisition of vendor services to construct the necessary Exchange IT support in accordance with the timelines over the next year as outlined in this Level I grant application.

Gap Analysis

The gap analysis evaluates the disparity between a goal, or “to-be” state, and the current state. In the case of Exchange IT, the gap analysis is an iterative process driven in part by the evolving nature of the requirements and the ongoing evaluation of information about existing systems that may offer opportunities for reuse, sharing, or interoperability. To date, California's gap analysis has focused primarily on eligibility and enrollment functions, with detailed information gathering and analysis of the several existing systems that support eligibility and enrollment in public programs. More detail on the state’s IT gap analysis is included below in the Summary of Exchange IT Gap Analysis section.

Collaboration

The Exchange has been working in partnership with the DHCS (Medi-Cal) to acquire qualified technical consultants to support the analysis, design and planning tasks outlined in the Level I IT work plan. A competitive acquisition process for project management and business, technical and data architecture consultants is nearly complete, and consultants are expected to begin work in early July.

In addition, California is a participant, along with several other states, in the Enrollment User Experience (UX) 2014 project, a public-private partnership working to deliver design specifications to support a best-in-class user experience to help ensure that large numbers of eligible consumers successfully enroll in and retain coverage. The project goal is to provide a vision, core design, and interactive design elements for the federal government and states to adopt and execute a "first class" user experience for enrollment under ACA, in order to increase the number of eligible consumers who could more easily and efficiently enroll. Eight national and state foundations have formed a public-private partnership with the CMS to sponsor this project. The intended clients are state-based Exchanges and CMS.

Project Planning

The provisions of the ACA, the emerging guidance contained in various federal documents, the work of other states, and the establishment of California's Exchange, have informed the development of the project plans contained later in this grant application. These plans reflect California's considerable effort to integrate the various requirements and constraints as the state understands them to exist today, but are based first and foremost on a realistic assessment of the state's current state of readiness, and a firm commitment to meeting the objectives of the ACA and the implementation milestones set forth in the grant announcement.

Financial Management

During the planning grant phase, CHHS staff developed a short-term exchange staffing plan, including number and type of staff, salaries, job descriptions, and recruitment timeline. Additionally, the Exchange will contract with a state agency to obtain administrative support services starting July 2011.

CA-ACA also requires the California Exchange to ensure the operation and administration of the Exchange does not exceed the combination of federal funds, private donations and available funds. CA-ACA prohibits the use of any state General Fund dollars for Exchange activities unless specifically appropriated for that purpose. The Exchange will more fully develop the internal financial management and budget capacity and fiscal controls in partnership with the Department of Finance and the Legislature, through the Level I grant period as outlined in the next section.

Health Insurance Market Reforms

In 2010, California moved aggressively to enact state legislation implementing key provisions of the ACA affecting health insurance markets, including:

- California Health Benefit Exchange -- AB 1602 (Chapter 655 Statutes of 2010) SB 900 (C. 659)

  Creates the California Exchange; establishes the five-member governing board and describes the basic responsibilities and authorities of the Exchange;

- Premium rate review -- SB 1163 (C. 661))
  Requires all health insurance premium filings with CDI and DMHC to be reviewed and certified by an independent actuary to ensure premium costs are accurately calculated and all proposed rate increases to be posted on the carrier and regulatory websites making costs transparent. These consumer protections exceed what federal law requires under the ACA;

- Dependent coverage -- SB 1088 (C. 660)
  Prohibits carriers from setting the limiting age for dependent children covered by their parents' health insurance policy at less than 26 years of age;

- Coverage for children -- AB 2244 (C. 656)
  Implements the federal ACA prohibition on pre-existing condition limitations for children under age 19 and provides additional protections beyond federal law. Establishes a mandatory open enrollment period in the individual market, during which carriers can adjust rates for children based on health status, up to a maximum of two times the standards rate for a healthy child. Prohibits carriers from offering new individual policies to anyone in the state for five years if they fail to write new contracts for children on or after January 1, 2011;

- Coverage for preventive services -- AB 2345 (C. 657)
  Requires health coverage contracts and policies to cover preventive services as specified in the

  ACA with no cost-sharing; and

- Cancellation and rescission of coverage -- AB 2470 (C. 658)
  Prohibits California carriers from canceling insurance unless there is a demonstration of fraud or intentional misrepresentation of material fact. Exceeds federal law and requires carriers to continue coverage during the period of a consumer's appeal to CDI or DMHC for review of the decision to cancel or rescind coverage.

Both CDI and DMHC have responded with additional regulatory or policy guidance as necessary to further refine the requirements and clarify how specific provisions will be enforced. Early insurance reforms are in effect, including premium rate review, coverage for children, preventive services without cost sharing and limits on rescission. Both departments are working with policymakers and stakeholders to identify further state legislative changes and regulatory guidance that will be needed as additional ACA reforms are phased-in over the next several years. State agencies have been devoting extensive staff time and resources to evaluating federal requirements and guidance in comparison to state law. In the current 2011 legislative session, there are nearly two dozen bills in process that would implement and/or build on provisions of the ACA.

California also passed emergency legislation in 2010 to establish the California Pre-existing Condition

Insurance Plan (PCIP) for individuals who cannot obtain private coverage because of their health status or claims history (SB 227 (C. 31 of 2010) and AB 1887 (C. 32). PCIP is administered by the MRMIB which

also operates the state's existing high risk pool. PCIP opened for enrollment in October 2010 and, as of this writing, is providing health care coverage to more than 3,000 eligible Californians.

Providing Assistance to Individuals and Small Businesses

During the planning grant period, California began the process of enhancing the state's consumer assistance capacity and laying the foundation for comprehensive and coordinated consumer assistance services.

DMHC applied for and received a $4.1 million federal consumer assistance grant to expand consumer assistance programs operated by the DMHC Help Center and the Office of the Patient Advocate, a sister agency to DMHC. The stated goal in California's grant proposal is to provide a seamless Consumer Assistance Program (CAP) as a single point of entry for California consumers to obtain needed information about and assistance with health care coverage, regardless of the source of that coverage.

As of this writing, the CAP grant project is still underway and DMHC has requested a no-cost extension of the grant through October 2012, based on refinements and stakeholder input, to improve and expand the program. As proposed, CAP funds will be used to:

- Support website redesign and reorganization of the state health care reform website (www.healthcare.ca.gov), translate web materials into other languages and conduct consumer testing of the revised website content;
- Promote the DMHC-operated toll-free consumer assistance number and statewide website to help consumers with questions and complaints regarding health coverage, enrollment, and federal health care reform, including assisting consumers with filing complaints and grievances and "warm hand-off" referrals to appropriate state and federal agencies;
- Upgrade the communications system hardware and online functionality of the existing DMHC and CDI consumer assistance portals, including, for example, development of an online application for independent medical review of coverage and claims denials;
- Partner with local and/or statewide community-based organizations (CBOs) that provide consumer assistance on health coverage options and assist consumers in obtaining health care coverage and filing internal and external appeals. The CBOs will support the CAP in meeting the goal of providing one-on-one walk-in assistance to consumers, an option not currently available through the DMHC Help Center; and,
- Conduct data collection, tracking, and evaluation of the consumer assistance program for reporting to state and federal policymakers and to inform development of California's long term strategy for consumer assistance in the state.

DMHC submitted the first grant report for the six month period Oct. 15, 2010 – April 15, 2011 with the following information:

- 22,073 total records of consumer assistance actions submitted;
- 314 uninsured - referrals made to Medi-Cal, Healthy Families (CHIP), Medicare, Uninsured Help Line (referrals to brokers);
- 15,745 were privately insured consumers - referrals made to health center attorneys/staff, health plans, CDI, U.S. Department of Labor, MRMIB, or other appropriate resources;
- 4,336 were consumers in publicly-funded coverage - referred to health center staff or appropriate agency; and
- 1,678 were in other coverage (Medicare = 666; Self-Funded = 428; State, Local Government Plan = 584) – referred to health center staff or appropriate agency

DMHC has conducted education and training seminars on health reform topics for staff and external stakeholders, updated content on state websites, developed a new Help Center brochure and provided staff trainings on the ACA and CA-ACA and related programs. At this juncture, DMHC and the Exchange are working together at the staff level to identify next steps and potential longer term collaboration related to consumer assistance in the state. Further refinement and long term program options will be identified and considered as part of the Level I grant. CDI has established an internal team to focus on ACA implementation issues, provided staff and external training and updated its website to comply with the ACA. Both departments meet regularly to share information and compare processes as they each implement the ACA and CA-ACA. Finally, both departments participate in national forums, such as the National Association of Insurance Commissioners (NAIC), and provide comment and input related to NAIC deliberations on ACA provisions and pending and issued federal rules and guidance.

During the planning grant period, the Board also heard expert and public testimony related to the development of the SHOP program, including lessons learned in previous California programs, that will inform how the Board chooses to provide coverage and services, including consumer assistance services, to small employers as it develops the new SHOP program.

Business Operations/ Exchange Functions

During the planning grant time period, CHHS, the Exchange Board, staff and external consultants considered California's readiness across multiple business and operational components and Exchange functionalities. California reviewed and evaluated state and federal legislation, federal guidance and existing state programs and services. As a result of that planning and evaluation process, the Board determined that California should apply for a Level I Establishment grant (rather than Level II) and secure the resources for robust and comprehensive strategic, business and operational planning, including IT analysis and system design. During the Level I grant period, California will emphasize active research, analysis, planning, development and timely implementation related to the business operations and functions of the Exchange.

b. Proposal to Meet Program Requirements

California anticipates that the Level I Exchange Establishment grant funding requested in this application will support the state in moving to the next level of planning, development, and implementation for the California Exchange. During the Level I grant period California will begin developing core staff capacity and ensure sufficient talent and skills to support development and implementation of Exchange programs going forward. With an eye toward realistic long-term sustainability for the California Exchange, this application proposes to supplement Exchange staff with a complement of time-limited and issue-focused consultants and experts to research, analyze and make recommendations to the Exchange Board in critical core areas.

One of the main consultant supported activities early in the grant period will be development of a detailed and comprehensive business and operational plan. Over the one-year period of the grant the state will move to initial implementation in those areas with longer lead times, such as IT capacity and infrastructure development, and other core areas with time sensitivity identified through the business and operational planning process, to ensure that the state can meet federal goals and timelines for Exchange certification and operation.

California Health Benefit Exchange Level I Grant Objectives
➢ *Refine the vision and goals for the California Exchange consistent with state and federal law;* ➢ *Secure staff, consultant and expert resources, and actively engage stakeholders, to inform and support Exchange planning and implementation activities;* ➢ *Develop and initiate implementation of a three-year business and operational plan outlining the key tasks, milestones and timeline, including information technology(IT) infrastructure and functionality, necessary to achieve successful operation of the Exchange;* ➢ *Identify and begin to establish the systems and program capacity in core areas, such as IT development, to secure federal certification of the California Exchange by January 1, 2013; and,* ➢ *Prepare and submit a Level II Exchange grant application Spring 2012 to support full implementation and operation of the Exchange by 2014.*

Strategic Visioning

One of the first tasks for the California Exchange during the Level I grant period will be to engage the Board, staff, and stakeholders in a strategic visioning process. CA-ACA establishes the California Exchange as an active purchaser by requiring that it selectively contract with carriers, set specific participation criteria "in the best interests of qualified individuals and small employers," and contract with carriers to provide health coverage choices that offer the "optimal combination of choice, value, quality and service."

The next step will be to identify the policy objectives for the Exchange and consider the wide range of activities and approaches the Exchange could use to leverage higher-quality, more affordable insurance for individuals and small businesses.[7] The California Exchange has enormous potential to have an impact on coverage and delivery systems in the state given the large numbers of people likely to be served by Exchange programs.

By way of illustration, as part of the visioning process, the Exchange might explore to what extent the following activities identified by Georgetown University Health Policy Institute as choices and considerations for an "active purchaser" exchange, alone or in some combination, might serve as guideposts and core principles during development and implementation of California's Exchange:

- Setting carrier certification criteria that reflect state goals for population health, plan quality, delivery system reform, transparency or [strengthening the state's health care safety net];
- Using the selective contracting process to negotiate better prices and higher-quality from carriers;
- Leveraging quality improvement and delivery system reforms by encouraging and authorizing participating health plans to implement specific reform strategies and efficiencies;

[7] Corlette, Sabrina and JoAnn Volk. *Active Purchasing for Health Insurance Exchanges: An Analysis of Options*. National Academy of Social Insurance. Georgetown University Health Policy Institute. June 2011.

- Aligning with other large purchasers in the state, including Medi-Cal, Healthy Families and the California Public Employees Retirement System, to send consistent purchasing signals and establish common standards;
- Coordinating with policymakers and regulators on market rules and requirements affecting carriers outside the Exchange to limit adverse selection inside or outside the Exchange; or
- Leveraging consumer decision-making through better information and web-based decision tools. [8]

The strategic visioning process for the California Exchange will necessarily include consideration of core principles and opportunities for seamless coordination with public coverage programs, such as Medi-Cal and Healthy Families, and other state health and human services programs. The federal ACA requires an integrated exchange enrollment system that permits enrollment in Medicaid and CHIP through the exchange. Building on federal ACA goals and requirements, CA-ACA requires the Exchange to determine the criteria and process for eligibility and enrollment for Exchange coverage and to coordinate that process with state and local government agencies administering other health coverage programs in the state, including counties. The California vision for achieving these goals will inform Exchange program and systems development, including IT systems development, during the Level I grant period.

Starting with funding from the Exchange planning grant, the Exchange Board will hire consultants to support the visioning process, engage stakeholders and incorporate state-based expert resources. As just one example, CHCF is currently finalizing a series of issue papers developed with input from content experts based on three different visions for the California Exchange. These papers are anticipated to be available late Summer 2011, coinciding with the visioning process timeline.

Business and Operational Planning

One of the most significant and far-reaching activities during the Level I grant period will be California's development of a three-year robust and comprehensive business and operational plan for Exchange programs and functionality. The business and operational plan will set the course for program development, establish the path and timeline leading to full operation, and deal with the operational elements of core area 11 in the Level I grant application. The business and operational planning process will be in two parts as below. Part I will focus on eligibility and enrollment and Part II will work through remaining areas of Exchange operations.

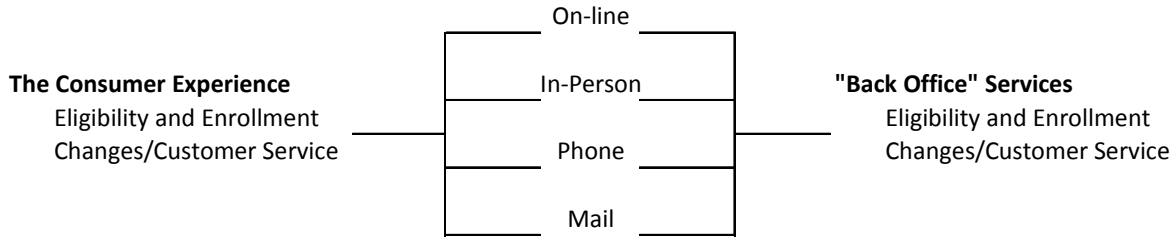
The business and operational plan will include, at a minimum:

- Analysis of federal and state mandates and reporting requirements across all Exchange activities, processes and structures;
- Specific operational systems and strategies, including IT systems and support, to implement an Exchange in compliance with all state and federal requirements;
- Timeline and process to demonstrate Exchange functionality by core area for purposes of federal certification by 1/1/13 and to ensure full implementation of Exchange operations by 1/1/14; and,
- Identification of additional resources and funding for full Exchange implementation to be included in California's Level II establishment grant application.

[8] This list incorporates several options outlined by Corlette and Volk, modified to include California-specific details and policy choices.

California Exchange Business and Operational Plan Components		
Part I **Eligibility and Enrollment Systems**	▪ Eligibility screening ▪ Eligibility appeals ▪ Enrollment and disenrollment ▪ Call center and web site eligibility and enrollment functions ▪ Applications and notices ▪ Seamless eligibility /enrollment with Medi-Cal, Healthy Families and other state health programs ▪ IT systems to support eligibility and enrollment ▪ SHOP functionality for enrollment	July 2011- October 2011
Part II **Other Exchange Functionalities**	▪ Call center consumer assistance functions ▪ Website functionality for benefit and cost comparison, cost calculator, complaints, benefit and coverage appeals and consumer assistance ▪ Adjudication of appeals ▪ Administration of individual responsibility, tax credits and cost-sharing reductions ▪ Employer liability notifications and appeals ▪ Reporting to the Internal Revenue Service ▪ SHOP functionality contingent on design	Nov 2011 - Jan 2012

An overarching goal of the business and operational plan will be to identify and refine the steps necessary to reach the level of consumer experience throughout all Exchange interactions as contemplated in state and federal law. For example, the figure below illustrates the role of the Exchange in presenting a seamless and multi-entry point eligibility and enrollment experience so that the various complex systems and program requirements are as seamless as possible for the consumer.



Background Research

California will continue to conduct, commission, and evaluate background research and analyses to inform Exchange development and operations. The state is fortunate to have access to significant resources and expertise available to address policy and information challenges as they arise, including the University of California, numerous policy and research centers and philanthropic organizations engaged in health policy research and analyses. In addition, the Exchange will continue to participate in national forums and state-oriented programs and information sharing opportunities to keep up with and be able to benefit from research conducted nationally and in other states.

Examples of just some of the research that will be available in the near future and during the Level I grant include:

- More detailed assessments and profile information on the health status and demographic profile of potential Exchange enrollees being spearheaded by the UCLA Center for Health Policy Research;

- *Briefing – Exploring the Financial Feasibility of a Basic Health Program in California* (CHCF/Mercer, report forthcoming July 2011) and further analysis of the Basic Health Plan option and the implications for California coverage programs, including the Exchange, which will be commissioned and supported by CHCF;

- *Continuity for (Former) Medi-Cal Enrollees in the California Health Benefit Exchange: Background and Alternative Approaches* (Institute for Health Policy Solutions, forthcoming June 2011);

- *Assessment of California Health Benefit Exchange: Multiple Perspectives (Assertive Purchaser; Consumer Destination; and Catalyst for System Change)* (California HealthCare Foundation (CHCF) – multiple authors, forthcoming July 2011);

- *Consumer Perspectives on Enrollment Pathways for Health Coverage in California* (CHCF -- Lake Research Partners, forthcoming August 2011);

- *The Affordable Care Act Coverage System in California: How to Most Effectively Cover CHIP-Eligible Children* – Analysis to explore implications of possible coverage alternatives permitted under current law, including coverage within the Exchange, for children who currently qualify for the Healthy Families Program. (Urban Institute commissioned by the 100% Campaign, forthcoming September 2011).

Stakeholder Consultation

The Exchange Board is committed to transparency and accountability. As stated above, the Exchange structure, with a public Board subject to state open meeting laws has built in opportunities for stakeholder involvement. The Level I grant will enhance the state's ability to provide regular forums, supported group meetings and planning sessions to enable more rigorous input from diverse stakeholders. During the period of the Level I grant California will implement the following strategies for stakeholder consultation:

- Planning groups organized by key issue and project during the development of the business and operational plan;
- Specifications in all Exchange scopes of work requiring contracting consultants to include and manage a stakeholder process on the specific issue or topic they are reviewing, including identifying the appropriate stakeholders for the topic in consultation with Exchange staff;
- Webinars, conference calls and other electronic and in-person means to solicit input from a wide and diverse set of stakeholders, including up to five Board meetings or other stakeholder meetings to be held outside of Sacramento with opportunities to receive input from the public and community stakeholders throughout the state;
- Regular one-on-one meetings between individual and organizational stakeholders, Board members and staff, consistent with public meeting laws, as issues arise; and
- Sensitivity throughout these activities to linguistic and cultural diversity among partners, stakeholders and potential Exchange enrollees.

During the Level I grant, the Exchange will contract with consultants to assist and facilitate stakeholder meetings as issues arise and will also contract for consultants to develop and recommend to the Board specific strategies and approaches to maximize stakeholder input over the long-term operation of the Exchange.

Consultation with federally recognized tribes

The California Exchange will engage in consultation with federally recognized Indian tribes in a manner similar to the process adopted and approved by CMS in California's Medicaid state plan. California's Indian health care delivery system consists of a network of primary care clinics funded by the federal Indian Health Services to provide care to American Indians and other underserved populations identified in the clinic charter/mission. There are seven urban Indian health programs operated by non-profit Boards of Directors, and 31 tribally operated health programs, currently participating in the Medi-Cal program.

The California Exchange will conduct initial outreach to the Indian health programs currently participating in Medi-Cal for the purpose of identifying their interest and concerns relating to health care reform and implementation of the California Exchange. The Exchange will also work to identify other Indian tribal organizations and programs that could ultimately be involved in providing services through Exchange programs to seek their input and to open an ongoing dialogue with them.

The Exchange will direct all appropriate communications to Tribal Chairpersons as officially listed on the Federal Bureau of Indian Affairs website and update contact information on a semi-annual basis. The Exchange will use a variety of methods of sharing information with tribal organizations to seek their input on Exchange planning and implementation activities. The methods will include but are not limited to written communication, webinars, face-to-face meetings and stakeholder meetings via teleconference.

Legislative and Regulatory Action

The Level I grant will support staff and consulting capacity within the Exchange to conduct timely review of federal regulations and guidance which may affect Exchange programs or operations. In addition, the grant will also expand the capacity of the Exchange to identify and analyze proposed state legislation and regulations. The Exchange will review legislative proposals and advise the state Legislature and the Administration on the impact of specific proposals on the Exchange and recommend legislative directions that will most effectively support Exchange operations and activities. CA-ACA both authorizes and requires the Exchange to respond to requests for information from the state Legislature and to provide testimony and comment on proposed legislation or policy issues.

Dedicated legal and policy staff will also help the Exchange to identify and pursue state legislative and regulatory changes necessary for Exchange operations. Exchange staff and consultants will coordinate with the program integration working groups -- coordinating with state health and human services programs and with state insurance regulators -- to identify legislative or regulatory changes in programs outside of the Exchange that will enhance collaboration, coordination and integration among the Exchange and other programs as envisioned in federal law.

Governance

California was the first state to define and establish the governance structure for the Exchange under the provisions of the ACA, and California's Exchange Board is operational. CA-ACA includes extensive statutory authority and responsibility for the Exchange and the Exchange Board, and includes rigorous

conflict of interest provisions. CA-ACA clarifies the powers and duties of the board governing the Exchange relative to the administration of the Exchange, determining eligibility and enrollment in the Exchange, and certifying and arranging for coverage with QHPs.

During the Level I grant period, the Board will continue to meet in public session and adhere to all state open meeting and conflict of interest laws. The Board will comply with state and federal reporting and public disclosure laws and will actively maintain a web site for posting of agendas, meeting materials and other public information. The Board and staff will evaluate on an ongoing basis the need for Board operational policies, rules or bylaws.

The Level I grant will allow the state to recruit and hire executive management and staff, as well as experts and consultants, to support the development and implementation of the Exchange.

Program Integration

Program integration is a critical element in successful Exchange implementation and central to developing the consumer friendly and seamless experience for health coverage in the state as envisioned in the ACA. Exchange program operations will be developed with this in mind with active and ongoing collaboration with state and local agencies. Significant resources and attention during the Level I grant will be dedicated to assessing and implementing opportunities for integration with other state coverage programs and with CDI and DMHC in their regulation of health plans.

In preparation for the submission of the Level II grant, the Exchange will work to develop the required agreements clarifying roles and responsibilities between the Exchange, DHCS and MRMIB, and clarifying roles and responsibilities between the Exchange, CDI and DMHC. To facilitate the agreements, the Exchange will engage consultants and seek stakeholder input to assess existing public and private programs and regulatory requirements and to identify opportunities for coordination and integration.

Coordination with other state health and human services programs

The business and operational planning process and the IT systems design and implementation will be developed in close consultation and coordination with existing state programs, including Medi-Cal and Healthy Families. During the Level I grant period, the state will document detailed business processes for current state programs, develop a baseline assessment of existing state coverage programs and through the business and operational planning process identify and address the implications of the existing programs for IT system design.

CA-ACA requires the Exchange Board to coordinate its eligibility and enrollment process with DHCS and MRMIB and to develop processes to coordinate with county systems of eligibility for Medi-Cal and with the entity administering Healthy Families, including but not limited to, processes for case transfer, referral and enrollment through the Exchange of eligible persons. CA -ACA requires the Exchange Board to collaborate with DHCS and MRMIB, to the extent possible, to allow an individual the option to remain enrolled with his or her carrier and provider network in the event the individual experiences a loss of eligibility of premium tax credits and becomes eligible for the Medi-Cal program or the Healthy Families Program, or loses eligibility for the Medi-Cal program or the Healthy Families Program and becomes eligible for premium tax credits through the Exchange. The provisions of the ACA and the CA-ACA make coordination and collaboration with state agencies offering health coverage a core activity and priority of the Exchange. The state and federal frameworks place the emphasis on the consumer experience and consumer access to coverage with the burden on the systems and programs they will rely on to do the coordination in their behalf.

The Exchange will continue to meet with its partners at CHHS and with key stakeholders during the Level I grant period to discuss and evaluate options for coordinating and streamlining eligibility and enrollment systems between existing public coverage programs and the Exchange. Additional information about the nature of these meetings and collaborations is included below in the section on IT systems development.

Coordination with state health insurance regulators

The Exchange Board will need to actively coordinate and collaborate with both CDI and DMHC in the certification and monitoring of QHPs in the Exchange and on broader insurance market reforms and issues, such as risk selection and benefit issues arising in health reform implementation. This collaboration will continue during the Level I grant period through Exchange collaboration with the working group of state staff, including CDI and DMHC staff, available to consult and work with the Exchange and stakeholders on health plan management issues. Health plan management issues are addressed in greater detail below.

Exchange IT Systems

IT system assessment, design and development will be a major component activity during the Level I grant period. A fundamental assumption of this grant application is that California does not have a preconceived notion of the high-level technical design of Exchange IT systems at this time, and that the preliminary gap analysis does not suggest a compelling business case for a definitive configuration.

California's approach to developing the necessary IT support for establishing a State-operated Exchange, as reflected throughout this Level I grant, uses a timeline framework based upon the following line of reasoning:

- Most Exchange functionality must be operational by the third quarter of calendar 2013, therefore, most system development must begin in early 2012;
- California lacks the resources to undertake system development efforts of this magnitude using state staff, therefore the services of contractors will be required; and
- Acquisition of contractor resources must take place during the second half of 2011.

Given the foregoing, the immediate IT challenge before California is to support development of an Exchange business and operational plan that will provide answers to the questions necessary to permit creation of the business requirements and architectural and integration framework. These elements will inform the development of an IT approach, an acquisition strategy and one or more vendor acquisition processes to be conducted in late 2011.

This first phase of the Level I IT activity, already begun, is targeted for substantial completion in September 2011 and encompasses ongoing analysis of requirements and development of alternatives, identification of business decision criteria, recommendations and a selected approach for IT that supports the business and operational plan of the Exchange. In this phase, major activities include:

- Ongoing analysis of the regulations and guidance that will continue to emerge from DHHS in 2011;
- Participation in the development of the business and operational Plan;
- Consultation with partners within state government, in particular the DHCS (Medi-Cal program) and the MRMIB (Healthy Families program);
- Consultation with stakeholders outside of state government, in particular consumers, employers, and health plans;

- Completion of the detailed evaluation of existing California systems that may support or interface with Exchange business functions;
- Evaluation of the possibilities for using or otherwise benefiting from components developed by Early Innovators, other states and the UX 2014 Project. Opportunities are expected to extend beyond software components to include analysis and design artifacts, acquisition strategies and documents, and lessons learned;
- Evaluation of products and services available from private sector vendors and other entities;
- Synthesis of the analysis results and findings into a small number of feasible alternatives that reflect distinct feasible approaches to IT support for the operation of the Exchange in California; and
- Evaluation, informed by business decision criteria, and selection of a business/operational approach and supporting IT strategy for California.

As a result of this analysis and planning process, key business questions about the roles and responsibilities of existing government agencies, the feasibility of different IT solutions, and program and system integration will be resolved, thereby establishing a framework for enterprise architecture and high-level technical design. This will allow California to begin to formulate answers to technical questions critical to the Level 2 grant application scheduled for submission in Spring 2012, for example:

- The approach to IT support for the in-person, telephone and by-mail customer experiences;
- The approach to IT support for Navigators and hot-line operators;
- The approach to IT support for SHOP participants, both employers and employees;
- The role of new software components, adapted or enhanced components and commercial off-the-shelf software (COTS);
- The approach to integration and interoperability with Medi-Cal, Healthy Families and the proposed federal hub; and
- The approach to integration and interoperability with other specific state health and human services programs, beyond Medi-Cal and Healthy Families.

Based upon this work, the next phase of Level I activity will be the acquisition of the necessary services to implement IT support for the Exchange business operations approach**.** This would include:

- Developing an acquisition strategy to implement the selected approach that reflects the results of the evaluation of available systems components and services described above. This could include acquisition of services to develop new or adapt existing software, build out components designed in an Early Innovator environment or by the Enrollment UX 2014 project, purchase COTS components, purchase turn-key services or hybrid approaches.

- Conducting one or more expedited acquisitions for various types of services, the exact nature of which could vary widely, as noted above, depending upon the results of the first phase. Acquisition would include development of solicitation documents, solicitation of proposals, evaluation and selection, and contract negotiations and execution, with state and federal approval processes conducted at the appropriate points in the process. It will be critical that expedited acquisition processes be employed by all parties.

- Issuing, to the extent applicable, change order specifications for existing State systems based upon the selected approach to integration/interoperability and the roles and responsibilities identified for each entity under the Exchange business and operational plan.

Given a target for having development and implementation vendor staff at work in the first quarter of 2012, some of their activities will occur during the period of this grant. Given the foregoing, however, it

is not possible to elaborate in advance on those activities which will depend on the strategic and business and operational decisions made in the first six months of the Level I grant period. The IT work plan included with this application includes a skeletal work plan for the second half of the grant period and highlights some of the applicable milestones set forth in the grant application and assumes program startup review and possibly design reviews would occur during this period.

Financial Management

As a state Board, working closely with the Department of Finance and the Legislature, the Exchange will be responsible for managing federal grant funds and any other revenue sources, and developing a long range sustainability plan starting in 2015. CA-ACA provides the Exchange with the necessary authority to administer and manage Exchange finances including:

- Authority to recruit executive staff in a manner necessary to attract and retain individuals of superior qualifications;
- Authority to make expenditures and the requirement to keep accurate accounting of all activities, receipts, and expenditures, and to annually report on those expenditures to DHHS;
- Requirement to annually report to the state Legislature on the implementation and performance of Exchange functions, including the manner in which funds were expended and the progress toward state requirements for the Exchange, as well as responding to legislative requests for information about Exchange expenditures;
- Requirement to establish and maintain a prudent reserve in the California Health Trust Fund (Fund), the special fund created under the CA-ACA for Exchange revenues;
- Contingent implementation of CA-ACA based on a determination by the Exchange Board that sufficient financial resources exist or will exist in the Fund, pursuant to a detailed process for financial projections and comparison of expected expenditures with available revenues;
- Requirement to annually assess and report on the impact of the Exchange's operations and policies on other publicly funded health programs administered by the state, including potential cost shifts or cost increases affecting those programs; and
- Requirement for the Exchange to maintain enrollment and expenditures that do not exceed the amount of revenues available, including federal funds, and if sufficient revenue from non-state General Funds is not available to pay Exchange expenditures to institute appropriate measures to ensure fiscal solvency.

The Level I grant will provide the resources to the Exchange to establish the internal financial and accounting systems as well as internal policies, procedures and protocols to manage day-to-day operations and expenditures and comply with all state and federal financial and grant reporting requirements. CA-ACA requires the Board to hire a chief fiscal officer and a chief operations officer to supervise and manage Exchange finances and operations. The Level I grant will provide the resources to recruit and hire the key staff necessary to meet the financial management obligations of the Exchange.

CA-ACA established the basic framework for sustainability of the Exchange and requires the Exchange Board to assess a charge on QHPs as reasonable and necessary to support the development, operation and prudent cash management of the Exchange. During the Level I grant period, the Exchange will engage consultants to make specific recommendations regarding health plan assessments to sustain Exchange operations starting in 2015, including evaluation of the potential impact on premiums and competitiveness of health plans participating in the Exchange.

Oversight and Program Integrity

During the Level I grant period, the Exchange will be able to build staff capacity to ensure its ability to comply with annual auditing requirements imposed under state and federal law. The Exchange will engage external consultants to develop a comprehensive plan to prevent waste, fraud and abuse in Exchange programs with specific milestones for staff implementation of the plan.

Health Insurance Market Reforms

As reported in the section on Exchange progress, California acted quickly to pass legislation to implement the earliest ACA health insurance market reforms and is in the process of implementation and enforcement. There is much still to do. Both CDI and DMHC are actively engaged in identifying the additional legislative and regulatory authority and enforcement that will be necessary for California to fully comply with ACA market reforms. There are currently nearly two dozen bills moving through the California Legislature on ACA implementation, many of which are focused on health insurance market reforms, including legislation to conform California's small employer access law to federal requirements, medical loss ratio standards, and legislation to establish a basic health plan option in California.

The Exchange does not currently have staff to analyze and comment on pending state legislation but will need to build that capacity during the Level I grant period. With sufficient legal and policy staff and/or consulting expertise the Exchange will be able to identify and work with policymakers and stakeholders regarding state legislation and regulatory implementation of federal market reforms. The Exchange will work collaboratively with CDI and DMHC to evaluate the impact of federal reforms on California markets and on the ability of the state to establish a viable and sustainable Exchange given the potential risk mix inside and outside of the Exchange.

CA-ACA included state authority and requirements related to health insurance carriers both inside and outside of the Exchange. Specifically, CA-ACA:

- Requires carriers participating in the Exchange to offer and sell on a guaranteed issue basis at least one product in each of the five coverage levels outlined in the ACA;
- Authorizes the Board to require carriers in the Exchange to offer additional products within each of the five coverage levels;
- Requires carriers in the Exchange to guarantee issue to individuals and small employers outside the Exchange all products available to individuals and small employers inside the Exchange;
- Requires carriers offering individual coverage but not participating in the Exchange to offer at least one standardized product designated by the Exchange in each of the four levels of coverage in the ACA and prohibits carriers outside the Exchange from offering the catastrophic level of coverage; and
- Authorizes the Board to determine the minimum requirements a carrier must meet to participate in the Exchange.

During the Level I grant period, the Board will evaluate, in consultation with CDI and DMHC, and with stakeholders, the best strategies and potential mechanisms beyond the measures included in CA-ACA to level the playing field across markets and options to mitigate adverse selection against the Exchange. The Exchange Board will engage consultants to review and consider risk selection issues unique to California markets, which will include the identification of additional legislative or regulatory remedies that could enhance the leveling of risk inside and outside the Exchange. In addition, the Board will look to research and analyses conducted in other states and at the federal level that may be helpful.

Consumer Assistance -- Providing Assistance to Individuals and Small Businesses

Consumer assistance is foundational to all Exchange operations. Every aspect of Exchange planning and implementation will necessarily impact the quality and effectiveness of services provided to individuals and small businesses getting coverage through the Exchange. A core goal and purpose of the Exchange in both state and federal law is to make the consumer experience of obtaining and maintaining their health coverage easier and to provide assistance to diverse consumers as it is helpful to them, in the setting and with the services that can most effectively support them in getting the health care they need.

CA-ACA enacts many of the specific consumer assistance requirements and approaches in the ACA including the requirement that the Exchange operate a toll-free hotline and Internet website, present coverage and benefits in standardized formats, and develop and make available cost of coverage calculators accessible by consumers. In addition, CA-ACA requires the Board to ensure that the Exchange provides interpretation and language assistance services, including a toll-free hotline for hearing and speech impaired persons and to make available Exchange materials in plainly worded, easily understandable formats and in prevalent languages.

During the Level I grant period, the Exchange will engage in the following activities to support the planning and development of effective consumer assistance services and programs:

- Make changes to the existing Exchange web site early in the Level I grant period, coordinating with CHHS on the state's health care reform web site, and develop other tools and information to begin educating the public about health care reform and the future availability of the Exchange;

- Develop the business and operational plan for Exchange functionality, including related IT functionality, primarily focused on consumer assistance services, including: call center and web site functionality with the ability for consumers to apply for and enroll in coverage through multiple entry points; understand, compare and select from among the coverage options available; submit appeals and complaints; and be screened and enrolled in public coverage programs for which they are eligible;

- Dedicate a full time Exchange staff person to ensuring that Exchange programs and services, across the board, top-to-bottom, are culturally and linguistically appropriate for California's ethnically, linguistically and socially diverse populations and the demographic profile of individuals likely to enroll in coverage through the Exchange, as well accessible for people with disabilities;

- Work collaboratively with the existing CAP program through DMHC, and in coordination with affected state agencies, including DHCS and MRMIB, to move toward further integration and collaboration on consumer assistance across state programs and services and to analyze the data being collected as a resource to inform the development of Exchange programs and health plan accountability measures;

- Engage consultants, working with the Board and stakeholders, to assess and inventory state and local, public and private consumer assistance resources in the state and to make recommendations to the Board for a long-range statewide approach to consumer assistance services consistent with federal goals and requirements;

- Engage consultants to make recommendations to the Board on the structure and design of the SHOP, including the level and type of targeted assistance services that would be most beneficial

to small employers and their employees; and

- Develop the framework and include in the Level II grant application sufficient funding for appropriate consumer focused statewide assistance program(s).

Navigator Program

CA-ACA requires the Exchange Board to establish a navigator program and to set standards and compensation for navigators that will perform the following activities. Staff and consultants will engage with stakeholders in developing options for the navigator program.

- Conduct public education activities to raise awareness of the availability of QHPs;
- Distribute fair and impartial information concerning enrollment in QHPs, and the availability of premium tax credits;
- Facilitate enrollment in QHPs;
- Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman or any other appropriate state agency or agencies, for any enrollee with a grievance, complaint, or question regarding his or her health plan, coverage, or a determination under that plan or coverage; and
- Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange.

During the Level I grant period, the Exchange Board will engage consultants to review and assess existing public and private programs and services performing functions similar to the roles and responsibilities proposed for the navigator program, as envisioned in state and federal law, and to make recommendations to the Board for development of a navigator program by the end of the Level I grant period. Stakeholder input will be solicited as part of this process.

Health Plan Management

CA-ACA requires the board to establish and use a competitive process to select participating carriers in the Exchange. In order to be ready for open enrollment in mid-to late 2013, the Exchange will need to begin during the Level I grant period to establish the standards and the process for certification of QHPs. CA-ACA gives the Exchange clear state authority to determine the minimum requirements a carrier must meet to participate in the Exchange and the standards and criteria for health plan selection. As stated in the section on health insurance market reforms, CA-ACA also establishes standards for categories of product offerings for carriers inside and outside the Exchange, and authorizes the Exchange Board to require carriers to offer additional products. CA-ACA also requires the Board to ensure that QHPs meet specific standards that mirror federal requirements including that QHPs submit justifications for any premium increase prior to the increase and make available for DHHS, state regulators and consumers specified disclosure information about policies and coverage contracts.

Since California has two state agencies regulating health insurance coverage, the Exchange will need to work directly and collaboratively with both CDI and DMHC in defining and developing QHP certification standards and market rules. CA-ACA requires carriers participating in the Exchange to “have a license or certificate of authority from, and be in good standing with, their respective regulatory agencies.”

During the period of the Level I grant, the Exchange will do the following to prepare for certification and selection of QHPs:

- Engage consultants to work with the Board, state regulators and stakeholders to evaluate existing state and federal standards for health plans and those specific to QHPs and to make recommendations for QHP certification standards;

- Develop the standards, process and compliance monitoring activities related to certification, decertification and recertification of QHPs;

- Engage Board members, staff, state regulators, experts and consultants in the process for selection of QHPs and develop a solicitation template and timeline;

- Seek internal and external guidance, including review of federal guidance, recommendations from the National Association of Insurance Commissioners and the work of other states, to identify the best strategies in Exchange design and operations to mitigate adverse selection while providing sufficient choice and value of coverage for consumers; and,

- Review and evaluate pending federal guidance on essential health benefits, requirements for QHPs and health plan quality rating standards to incorporate and consider the standards as they emerge.

The ACA includes both permanent and temporary mechanisms to manage and mitigate health insurance risk for QHPs inside the Exchange and to some extent for carriers outside the Exchange as follows:

- Requires DHHS to establish the criteria and methods, and states to implement, a *risk adjustment* program beginning in 2014 for individual and small group plans intended to redistribute total payments across carriers to account for the relative risk of the people they enroll;

- Requires each state to establish a temporary reinsurance program for the three year period 2014-2016; and

- Establishes a temporary, federally administered risk corridor program for three years (2014-2016) for QHPs offered in exchanges.

During the Level I grant period, the Exchange will participate in and monitor national discussions and analytical work related to the risk programs and identify California-specific issues that emerge and require targeted research and analysis. In 2012, the Exchange expects to begin developing a strategy and process to collect baseline data from carriers in California and to incorporate key elements of the risk mechanisms into the certification and QHP selection process. California has significant state resources and expertise on these issues, including CalPERS, the Pacific Business Group on Health and the state's large Medi-Cal and Healthy Families programs. The Exchange will reach out to and engage with these agencies, state regulators and other stakeholders to inform its design and implementation of risk adjustment and reinsurance.

California will also regularly communicate with other states on these issues to share resources and information, including Washington state, which is engaging a national expert on risk issues. Level I grant resources will support staff to work on these issues and consultants to advise the Board on national resources and issues unique to California's health insurance markets.

Outreach and Education

CA-ACA requires the California Exchange to undertake activities to market and publicize the availability of health care coverage and federal subsidies through the Exchange through outreach and enrollment activities that assist enrollees "in the least burdensome manner," including populations that may experience barriers to enrollment, such as the disabled and those with limited English language proficiency.

Consistent with state and federal requirements, during the Level I grant period, the California Exchange will assess and evaluate the communications, public education, marketing and outreach needs related to Exchange programs and health care reform implementation generally. Special consideration will be given to cultural and linguistic diversity. The Exchange will engage consultants to work with the Board, affected state agencies and stakeholders to identify and focus group test potential communications and outreach tools for implementation in advance of the open enrollment period in 2013. Based on consultant recommendations, the Exchange will develop the preferred approaches and will draft a solicitation(s) for implementation of the various elements of the communications, outreach and marketing plan. The Board will include in the Level II grant application the elements of the plan and a request for sufficient resources to support a statewide approach aimed at securing and maintaining Exchange enrollment and facilitating near-universal coverage across programs as envisioned in the ACA.

Employer Relationships

During the Level I grant period, the business and operational plan will include consideration and recommendations for development of the Exchange functionality necessary to comply with federal and state requirements related to employer liability and appeals.

SHOP Exchange

CA-ACA requires the Exchange Board to establish the SHOP program separate from the Board activities related to the individual market and to do all of the following:

- Hire a director of the SHOP; and
- Collect premiums and administer all other necessary and related tasks, including, but not limited to, enrollment and plan payment, in order to make the offering of employee plan choice as simple as possible for qualified small employers.

During the Level I grant period, the Exchange will engage consultants, experts and stakeholders to consider the design and implementation options for SHOP to maximize the viability and effectiveness of the program. The project to evaluate and recommend a SHOP design will consider the array of services that might be provided to attract and support small employers and their employees to the program. In addition, the analysis will evaluate potential design and operational considerations to mitigate against adverse selection initially and over time. California has significant experience and history related to small employer purchasing programs which can yield important information and lessons learned for the SHOP design. As the Board develops SHOP design, it will incorporate into the business and operations plan and the IT development work the related functionalities to support SHOP services for employers and employees.

c. Summary of Exchange Initial IT Gap Analysis

A gap analysis evaluates the disparity between a goal, or “to-be” state, and the current state. In the case of Exchange information technology, the gap analysis is an iterative process driven in part by the evolving nature of the requirements and the ongoing evaluation of information about existing systems that may offer opportunities for reuse, sharing, or interoperability. It evaluates the gap between the requirements of the "to-be" state - the operational Exchange - and the capabilities available in current systems - given the fact that nothing exactly like the Exchange is in operation today, but understanding that existing systems do perform similar functions.

California's initial work on the gap analysis has focused primarily on eligibility and enrollment functions, with detailed information gathering and analysis of the several systems that support eligibility and enrollment in public programs in the State. As part of this process, the analysis has touched upon, but by no means completed, analysis in related areas such as plan management and call center support. In addition, current systems are being evaluated in terms of their compliance with prevailing and emerging industry standards.

The current systems evaluated thus far in the gap analysis process fall into three main categories:

- Websites designed for use by the public in submitting applications for Medi-Cal, Healthy Families, and other public benefit programs;
- Medi-Cal eligibility determination and case management systems; and
- The Healthy Families eligibility determination and case management system.

In addition, the analysis incorporates reference to the Medi-Cal Eligibility Data System (MEDS) which consolidates information on all individuals receiving public benefits in California into a central database, and performs a variety of functions based upon that information.

Material gaps exist between these systems capabilities and the requirements for support of functions related to QHPs - providing information, comparing plans and costs, etc. In addition, employer functions necessary for operation of the SHOP Exchange have no directly analogous functions in the public program systems.

This summary of the gap analysis begins with discussion of the "to-be" state, is followed by descriptions of the current systems, and concludes with a summary of the gaps.

The "to-be" state: Exchange requirements

Exchange requirements, based upon the provisions of the ACA, are being clarified by DHHS and additional clarification is anticipated. In addition to the Grant Announcement, key federal guidance is contained in DHHS Guidance for Exchange and Medicaid Information Technology Systems, Versions 1.0 and 2.0, Exchange Business Architecture Supplements ("Blueprints"), Section 1561 Recommendations, CMS's Final Rule on Federal Funding for Medicaid Eligibility Determination and Enrollment Activities, and the supporting guidance: Enhanced Funding Requirements: Seven Conditions and Standards. The work of other states, and California’s own work in evaluating all available information permits initial organization and modeling of the requirements to an extent where a productive evaluation of "gaps" can be undertaken.

Many of the federal requirements are intended to support DHHS's emphasis on the customer experience, and the availability of real-time eligibility determination for most applicants. In terms of the "gap," it is evident that while many of these functions are available for the public programs in current automated systems, none of these systems were developed with the performance objective of real-time eligibility determinations.

Current systems performing similar functions in California today

Exchange staff and consultants evaluated the systems described below for the initial gap analysis.

Publicly available websites:

- BenefitsCalWIN - supports application initial submission and other client self-service functions for Medi-Cal and other public programs in 18 counties;
- C4Yourself - supports application initial submission and other client self-service functions for Medi-Cal and other public programs in 39 counties;
- Health-e-App/Public Access - supports initial application submission and other client self-service functions for Healthy Families, statewide; and
- YourBenefitsNow! supports application initial submission and other client self-service functions for Medi-Cal and other public programs for residents of Los Angeles County.

Medi-Cal and Healthy Families eligibility determination and case management systems:

- CalWIN - supports county administration of Medi-Cal and other public programs in 18 counties;
- C-IV - supports county administration of Medi-Cal and other public programs in 39 counties;
- LEADER - supports county administration of Medi-Cal and other public programs in Los Angeles county; and
- MAXe2 - supports statewide administration of the Healthy Families program.

It is noteworthy that very few of the actual technology components - software and hardware - for these systems are under direct control of the State. While MAXe2 is operated under contract to a State government agency - MRMIB - it is a proprietary system operated by an administrative services contractor, MAXIMUS, Inc. The county Medi-Cal eligibility systems and websites are all maintained and operated by vendors under contracts with the counties. Though not necessarily a technology "gap," this arrangement could be a source of complexity in terms of its impact on planning for fully functioning California Exchange business operations and IT systems.

In addition, MEDS consolidates information on all individuals receiving public benefits in California into a central database, and performs a variety of functions based upon that information. MEDS and its related systems meet the need for consolidated, current and accessible information on beneficiary eligibility in an environment where eligibility is determined on a decentralized basis, mostly by county welfare departments. The data maintained within the MEDS database originates from counties, state agencies, federal agencies, and non-governmental organizations, such as health plans. Access to the database is provided to county, state and contractor staff involved in the administration of health and human services programs.

The sections that follow highlight California's preliminary gap analysis summary, using subsets of the to-be functionality in three categories:

- Publicly available websites;
- Offline automated support functions; and

- Standards and technical architecture.

Gap summary: publicly available websites (as noted above)

California's several websites that provide opportunities for clients to submit applications for Medi-Cal, Healthy Families and other public programs provide a variety of client self-service functionality. The first of these publicly available websites became available in 2007. Each of the websites now offers somewhat different functionality, and each is in a continuous state of enhancement. Additional features aimed at providing more online services to clients and enhancing client communication with the programs are implemented regularly. All of the websites provide information on public programs and offer individual account establishment and initial application submission. The website for Healthy Families also offers plan selection and initial premium payment functionality.

The table below highlights current capabilities in key functional areas necessary for successful Exchange website implementation.

Website Functionality Initial Gap Highlights		
"To-Be"	**Current public website functionality**	
Key Exchange website functionality	Medi-Cal (bemefitscal, BenefitsCalWIN, C4Yourself, YourBenefitsNow)	Healthy Families (Health-e-App)
Online plan comparison and selection functions • Rank and compare plans based on individual preferences • Calculate premiums and out of pocket expenses • Select and enroll in plans • Disenroll from plans • Enable plan inquiry on information such as plan rating, premium information, tax credit, free choice voucher status	No	Supports plan selection and premium payment for applicants screened into Healthy Families
Provide information on public programs	Yes	Yes
Set up and maintain individual accounts	Limited	Yes
Enable individuals to apply for coverage	Limited	Yes
Enable individuals to submit changes/ manage continuity of coverage	Limited	No
Online verifications • Verify identity for individuals • Verify income, residency, citizenship and other information, using trusted third-party sources • Verify eligibility requirements with DHHS and other state third party data sources	No	
Online eligibility determination • Determine eligibility for tax credits • Determine eligibility for reduced cost-sharing • Determine eligibility for Medicaid (both initial and ongoing eligibility) • Determine eligibility for exemption for individuals • Determine eligibility for qualification as a small business • Redetermine eligibility based upon verified changes, as appropriate	No	
Client Inquiry • Enable individual inquiry on information such as eligibility, plans, premiums, tax credits, appeal status, primary care provider	Yes, as applicable to public programs	No
Navigator Support • Enable navigator inquiry • Enable navigators to assist individuals, complete annual enrollment and annual renewals	No	Third-party assisters supported, as applicable to the program
Employer/SHOP functions • Set up accounts for employers and select plans by tiers and apply contributions • Facilitate enrollment by employers for employees or enroll them directly • Enable employer inquiry on information such as employer appeal status, annual enrollment period, premium payment amounts	No	

The principal gaps in this area can be summarized as follows:

- **Support for new program eligibility determinations.** As is true elsewhere, system logic to support premium tax credits, reduced cost-sharing, Modified Adjusted Gross Income (MAGI) processing and other ACA-specific functionality does not exist in our current systems.

- **Integration of QHP-related functionality**. Current public program websites have no functionality to support reviewing and comparing QHP information online, and making related cost calculations. Health-e-App does offer functionality to support plan selection and initial premium payment for Healthy Families managed care plans.

- **Online, real time eligibility determination and information verification.** The design of these systems did not contemplate online, real time eligibility determination. Additionally, and to some degree as a consequence, no online verification of customer submitted information is provided.

- **Support for SHOP and employer related functions.** With no analogous function in the public program environment, these systems offer no functionality in this area.

While other gaps have been noted in the analysis, none rise to the level of significance of those summarized above. For example, while functionality analogous to Navigator support does not currently exist for the Medi-Cal websites, it is currently being developed, and the long history of application assistors using the website in the Healthy Families program provides a relevant model. Likewise, expanded functionality for submitting coverage and managing the renewal process are in development for the current systems.

Gap summary: offline automated functions required to support ACA requirements

California's existing Medi-Cal eligibility systems function within integrated welfare eligibility systems that serve multiple programs. These systems possess robust functionality supporting client intake, eligibility determination, correspondence and notifications, financial, reporting and other administrative and client service functions. The users of these systems are full-time specialists who interface between clients and the system's functionality. The capabilities shown in the next table are not online, real time customer-facing system features. They have been investigated and are shown here because some of these capabilities could serve as a basis for California Exchange IT support. For example, some functions, such as reporting, are not primarily online, real time functions. More significant perhaps, some functions, such as the COTS rules engine product used in one system for Medi-Cal eligibility determination, could serve as a basis for a rules processing service to be used by the Exchange and others for real time eligibility determination.

As noted above, the proprietary MAXe2 system supports statewide administration of the Healthy Families program. As such, it performs client intake, eligibility determination, correspondence and notifications, financial, reporting and other administrative and client service functions for that program. The Healthy Families business model, however, based upon a simplified application that is for the most part submitted online or by mail, with centralized call center support and more direct interfaces to health plans has resulted in an automation model that more closely matches, in some respects, the federal vision for the Exchange.

The table that follows highlights current capabilities in key functional areas necessary for successful implementation of Exchange IT support functions.

Supporting IT Functions Initial Gap Highlights			
	Current eligibility, enrollment and ongoing case management system functionality (systems not used by the public)		Comments
	Medi-Cal (CalWIN, C-IV, LEADER)	Healthy Families (MAXe2)	
Process changes	Yes	Yes	
Process applications for coverage	Yes	Yes	
Verifications • **Verify identity for individuals** • **Verify income, residency, citizenship and other information, using trusted third-party sources** • **Verify eligibility requirements with DHHS and other state third party data sources**	Yes, for current programs, with both manual and automated processes	Yes, for current programs, with both manual and automated processes	MEDS serves as the nexus for much of the automated verification support in the current environment.
Eligibility determination	Yes - limited to current programs	Yes - limited to current programs	
• **Determine eligibility for tax credits**	No	No	
• **Determine eligibility for reduced cost-sharing**	No	No	
• **Determine eligibility for Medicaid (both initial and ongoing eligibility)**	Yes - current programs	No	
• **Determine eligibility for exemption for individuals**	No	No	
• **Determine eligibility for qualification as a small business**	No	No	
• **Redetermine eligibility based upon verified changes, as appropriate**	Yes - current programs	Yes - current programs	
Client Information Inquiry • **Enable individual inquiry on information such as eligibility, plans, premiums, tax credits, appeal status, primary care provider**	Yes - current program information	Yes - current program information	
Navigator Support • **Enable navigator inquiry** • **Enable navigators to assist individuals, complete annual enrollment and annual renewals**	No	Yes – certified assistors program	
Financial Management • **Execute premium payment and minimum medical loss ratio rebate processing and tracking** • **Process premium payments from individuals and send them to health plans** • **Apply advance premium tax credits to premium calculations** • **Track currency/delinquency, tax credit administration, cost-sharing**	No	Partial - limited to premium payments to managed care programs. No tax credit, cost-sharing or free choice functionality.	Partial - Premium payments to Medi-Cal managed care programs handled by MEDS. No tax credit, cost-sharing or free choice functionality

Supporting IT Functions Initial Gap Highlights			
	Current eligibility, enrollment and ongoing case management system functionality (systems not used by the public)		Comments
administration, and data exchanges with other state and federal systems • **Track and apply free choice vouchers to premium calculations** • **Manage premium aggregation** • **Manage funding**			
Administration • **Track and enforce the resolution of individual complaints, appeals, and grievances** • **Manage the quality of the user experience** • **Manage the performance of the program** • **Fraud detection**	Yes - current programs	Yes - current programs	
Correspondence & Notifications • **Notify individual of eligibility for Medicaid, CHIP, premium tax credits and cost-sharing** • **Notify individual of appeal decisions** • **Notify individuals and plans of premium, tax credits, plan rating, certification status**	Yes - current programs	Yes - current programs	
Call Center • **Enable individual service via call center** • **Enable employer specific service via call center** • **Enable specific service to navigators and brokers via call center** • **Provide individual service via online help, chat, that is integrated with call center** • **Provide employer service via online help, chat, that is integrated with call center** • **Provide specific service to navigators and brokers via online help, chat, that is integrated with call center**	Partial - current systems support county-level call center operations for current programs and clients, but these features are not used by all counties. Currently no chat or similar functions.	Yes - current systems support call center operations for current programs and clients. Currently no chat or similar functions.	
Reporting	Partial - limited to current programs	Partial - limited to current programs	
• **Perform mandatory reporting for state and federal agencies**	Yes	Yes	
• **Enable additional analytical reporting agencies through the data warehouse, as appropriate**	No	No	

Supporting IT Functions Initial Gap Highlights			
	Current eligibility, enrollment and ongoing case management system functionality (systems not used by the public)		Comments
• **Support risk adjustment analysis via data received from health plans**	No	No	
• **Support cost analysis**	No	No	
Plan Management • **Rank and compare plans based on individual preferences** • **Calculate premiums and out of pocket expenses** • **Select and enroll in plans** • **Disenroll from plans** • **Enable plan inquiry on information such as plan rating, premium information, tax credit, free choice voucher status** • **Track the ratings and performance of the health plans participating in the exchange** • **Manage the process of plan certification, recertification and decertification** • **Manage the quality rating of plans**	Partial: Medi-Cal managed care plan selection is via paper forms or person-to-person interaction.	Partial: Plan selection and initial premium payment available online	MEDS maintains statewide data for premium processing interface with Medi-Cal managed care plans and performs premium processing. The Health Care Options (HCO) contractor manages the Medi-Cal managed care selection process.
Employer Management • **Set up accounts for employers and select plans by tiers and apply contributions** • **Facilitate enrollment by employers for employees or enroll them directly** • **Enable employer inquiry on information such as employer appeal status, annual enrollment period, premium payment amounts** • **Enable employers to pay premiums, track employer tax credits, and apply free vouchers** • **Track and resolve employer appeals and grievances for employer liability of payment** • **Notify employers of employees eligibility for advanced premium tax credit where employer does not provide minimum essential coverage or coverage is not affordable**	No	No	

Apart from the issue of online versus offline, understanding that the analysis is reviewing automated logical functionality, the principal gaps in this area parallel those described above:

- **Support for new programs eligibility determination, financial, reporting and other administrative processing.** As is true elsewhere, system logic to support premium tax credits, reduced cost-sharing, MAGI processing and other ACA-specific functionality does not exist in our current systems;

- **Integration of plan management functionality.** Current public program systems have no functionality to support robust management of a QHP program. Medi-Cal managed care program has system support for premium processing, as does the Healthy Families program; and

- **Support for SHOP and employer related functions.** With no analogous function in the existing public program environment, these systems offer no functionality in this area.

The systems discussed above were developed independently and at different times. Their architectures vary, due largely to the different time periods during which they were conceived, designed and developed. While California has a wealth of functionality upon which to build, the individual systems' differentiating factors will present a challenge to creating an integrated, interoperable technical environment to support the Exchange, Medi-Cal and Healthy Families in the short run. In the longer run, the state is contemplating program restructuring and will have to undertake system refreshes that will provide opportunities to rethink and simplify the IT solution that supports the eligibility processes of the exchange and other health and social services programs.

Applicable Standards

California is committed to adhering to the principles and standards set forth by HHS to the fullest extent possible in the development of Exchange, Medi-Cal and Healthy Families systems. Our most recently developed system, C-IV, has been largely developed with such standards in mind, or are, like CalWIN and MAXe2, purposefully upgrading or migrating toward such standards as changes, enhancements and new interfaces are developed. The following paragraphs discuss examples of California's current systems' positioning to support the envisioned standards and technical architecture.

California's eligibility systems use Extensible Markup Language (XML) for interfaces with partners that support XML and for internal Service Oriented Architecture (SOA) communications. Currently no interface partners utilize the National Information Exchange Model (NIEM). California’s systems can accommodate conformance to NIEM standard in a variety of ways, generally by extending their XML communications, providing a consistent basis for exchanging information with multiple partners, using a standardized vocabulary.

The C-IV system makes use of a commercially available Business Rules Engine. Configurable Business Rules reside in rules sets that are kept separate from the core programming and transactional system code. The Business Rules Engine is accessed via an Application Programming Interface (API) to execute the rules and can be exposed as a service, as necessary to exchange information and results. In addition, MAXIMUS, provider of Healthy Families' MAXe2 system, is migrating to a rules engine-based service.

California's integrated eligibility systems, which include Medi-Cal processing, do not process HIPAA transactions. These systems do, however, meet HIPAA standards for Security Officer and hardware, software and transmission security, training, records and information access, incident response, contingency and emergency operations plan, and monitoring of information access. Healthy Families does transmit 834 files and is in the process of transitioning to the 5010 format.

With respect to accessibility for individuals with disabilities, CalWIN and MAXe2 have been evaluated and are in the process of addressing Section 508 compliance issues. C-IV currently meets all applicable requirements of Section 508.

Each of our eligibility systems was designed and developed to address the eight best practices of the Fair Information Practices (FIP) guidelines to safeguard consumer information. The guidelines published in Internal Revenue Service (IRS) pub 1075 – Tax Information Security Guidelines for State and Local Agencies are similar to those required by HIPAA, with which we already comply. California is committed to extending our existing security controls and policies as necessary to comply with the applicable IRS 1075 guidelines, to ensure that Federal Tax Information is protected at all points where it is received, processed, stored and/or maintained.

With respect to Federal Information Processing Standards, our systems employ compliant encryption of data-in-transit, and audit logs and are migrating toward increased security that will exceed these requirements. California is committed to adapting our systems as necessary to meet or exceed these standards.

California is well positioned to develop systems that adhere to applicable standards. In addition, any systems components that may be acquired will be evaluated for compliance and integration potential based upon the applicable standards and reference architecture at the time.

d. Evaluation Plan

The evaluation approach for the California Exchange Establishment Level I grant will have two distinct components: evaluation of core area grant supported activities and separate evaluation of the IT-related tasks and supporting activities.

The grant supported activities in federal core areas will be implemented through a combination of newly recruited state staff and consultant resources as outlined in the project narrative and work plan. One of the most significant and far-reaching activities during the Level I grant period will be California's development of a three-year robust and comprehensive business and operational plan for Exchange programs and functionality. Over the one-year period of the grant the state will move to initial implementation in those areas with longer lead times, such as IT capacity and infrastructure development, and other core areas with time sensitivity identified through the business and operational planning process, to ensure that the state can meet federal goals and timelines for Exchange certification and operation.

The Level I grant period activities will position the State to gather information, evaluate options, and make the policy decisions that will inform the state's submission of a Level II Exchange Establishment Grant in Spring 2011 to support full implementation of the California Exchange by 2014.

Major milestones for evaluation of core area activities will include:

- Assurances that all identified activities are concluded on a timely basis, consistent with the work plan. This includes timely production of solicitation proposals and selection of contractors as appropriate, and continuing oversight and input into their work;

- Review of the performance of both outside consultants and internal California Exchange staff

- Continued stakeholder engagement across the spectrum of core areas as the planning process develops further;

- Continued interagency coordination and cooperation in the development of policies and procedures that will provide the most seamless possible user experience in the implementation of core area functionality and IT support; and

- Prudent financial management and budgeting of project resources.

Evaluation of IT Progress

Evaluation of IT progress during the first two phases of the Level I grant period will focus on completion of approved project deliverables in accordance with the approved schedule. The major milestones will be the IT strategy supporting the Exchange business/operational plan, and the solicitation documents setting forth the System Development Lifecycle (SDLC) and applicable service level agreements for Exchange IT development and ongoing operations. Critical to this approach is the formal identification of the stakeholders that must approve each deliverable leading up to the beginning of the third phase, commencement of the detailed design, development and implementation (DD&I) of Exchange IT systems by vendor staff.

To support successful DD&I, the building blocks of effective evaluation must be put in place during the planning phase, included in vendor(s) contractual scope of work, and implemented by the Exchange Project Management Office staff and supporting consultants. These building blocks include:

- **SDLC.** Adherence to a formal System Development Lifecycle (SDLC) methodology. The methodology will be informed by federal standards, as well as State standards set forth by California's Office of the Chief Information Officer (OCIO). In addition, we will apply the appropriate components of California's IT Oversight Framework[9] to ensure an independent evaluation of project progress, quality and risk throughout DD&I.

- **Deliverables**. Formal SDLC methodologies include the production of specific deliverables for each phase aimed at permitting the Exchange to assess progress toward achieving the IT goals. We routinely require such deliverables at regular intervals in large project, so that large expenditures of time, human or financial resources do not occur without regular assessments of progress and quality.

- **Deliverable Baselines.** Measurement baselines for deliverables will be established by "Deliverable Expectation Documents." The baseline documents are themselves contractually required deliverables. This approach has been applied successfully on many California IT projects and definitively establishes a baseline against which each DD&I deliverable may be evaluated.

- **Requirements Traceability and Independent Verification and Validation (IV&V).** An additional evaluation component during the DD&I phase, anticipated to be appropriate for a project of this magnitude, will be independent V&V, conducted in accordance with IEEE standards and based upon a rigorous program of requirements traceability initiated at the beginning of the DD&I phase.

[9] www.cio.ca.gov/Government/IT_Policy/pdf/SIMM_45_IT_Project_Oversight_Framework_03092011.pdf

- **Service Level Agreements governing ongoing operations**. Whatever the configuration of the ongoing roles and responsibilities for Exchange operations, all participants will be subject to documented service level agreements (SLAs). SLAs will be developed for the key indicators of Exchange ongoing operational performance and will include specific definitions of the measurement methodologies to be implemented and measures to be reported for ongoing evaluation of Exchange IT performance.