

**Enrollment Workgroup**  
**Draft Transcript**  
**September 15, 2011**

**Presentation**

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Good afternoon everybody and welcome to the Enrollment Workgroup. This is Federal Advisory call so there will be opportunity at the end of the call for the public to make comment. Workgroup members please identify yourselves when speaking.

Let me do a quick roll call: Sam Karp?

**Sam Karp. Co-Chair. California Health Care Foundation**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Farzad Mostashari?

**Farzad Mostashari. ONC**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Paul Egerman?

**Paul Egerman. Businessman**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Chris Ross? Jessica Shahin? Shelby Gonzales for Stacy Dean?

**Shelby Gonzales. Center on Budget & Policy Priorities**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Steve Fletcher? Reed Tuckson? Thomas Baden? Hank Kehlbeck? Robert Restuccia? Ray Baxter?

**Robert Arndt. Kaiser Permanente**

This is Bob Arndt, I'm sitting in for Ray.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Deborah Bachrach?

**Deborah Bachrach. Consultant**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Gopal Khanna?

**Gopal Khanna. Chief Information Officer. State of Utah**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**  
Ruth Kennedy?

**Ruth Kennedy, Louisiana Medicaid Department**  
Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**  
Anne Castro?

**Anne Castro, BlueCross BlueShield of South Carolina**  
Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**  
Warren Michaels? Wilfried Schobeiri?

**Wilfried Schobeiri, InTake1**  
Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**  
Terri Shaw? Sallie Milam?

**Sallie Milam, Chief Privacy Officer, State of Minnesota**  
Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**  
Eli Staub? Samantha Melkir?

**Samantha Melkir**  
Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**  
Bobbie Wilbur?

**Bobbie Wilbur**  
Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**  
Kristen Ratcliff?

**Kristen Ratcliff**  
Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**  
Beth Morrow? Then from CMS we have Julie Boughn and Ben Walker. Anand Basu are you on yet?

**Anand Basu, ONC**  
Yes.

**Judy Sparrow – Office of the National Coordinator – Executive Director**  
Thank you and I will turn it over to Sam Karp.

**Sam Karp, Co-Chair, California Health Care Foundation**

If you'll allow me before we start to recognize Judy Sparrow for the amazing work that she has done managing our entire process including this committee and workgroup. Judy is going to be retiring at the end of this month and we are sorry to see her go but she has earned it and I want to thank her for her

dedication. On behalf of the entire workgroup, thank you. You have the pleasure to work with and not sure how we would have gotten through all that we did without your support. Well-earned.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Thank you. I have enjoyed every moment.

**Sam Karp. Co-Chair. California Health Care Foundation**

Welcome to the Health IT Policy Enrollment Workgroup and thanks for hanging with us during the hiatus of the workgroup. I think as you'll remember at the end of June, Aneesh and I sent out an e-mail that suggested that we were waiting to understand what the continuing role the workgroup might play in providing guidance and ongoing recommendations to the HIT policy committee. With the publishing of the new eligibility and enrollment rules on August 12, it now appears that there is a role for us to play in helping to provide public input on the possibility or the need for standards, protocols or other guidance, to ensure that the new rules are seamless and centered like much of our work has been on the consumer.

We are happy to have everybody back on the phone and we have an agenda that has five items. We are going to hear a high level overview of the eligibility and enrollment regs and then an update on the NIEM work, the national information exchange model work that was a subject of much conversation during the workgroup and also the subject of one of our recommendations that was adopted by the Secretary. Third, we are going to hear an update from Terry Shaw on user experience project that actually grew out of the work that the enrollment workgroup did and forth, we will hear from Farzard about future direction of the workgroup and where he is going to identify a couple of specific areas where our input could be helpful and lastly we will open up conversation for public input.

So let's start first with the overview of the eligibility and enrollment regulation. I'm going to turn to Ben Walker and he will be assisted by Sarah Delone.

**Ben Walker. CMCS**

My name is Ben and I am part of the eligibility and enrollment team and have been working on the exchange and all its various elements. I am pleased to have the opportunity to spend a few minutes walking you all through the proposed eligibility rules that were released in mid-August. I'm happy to be joined by Sarah from CMCS who is one of the principle authors of the Medicaid proposed rule around eligibility as well as Julie Boughn, Deputy Director of CMCS and is a recent addition to the CMCS team and we are happy to have her on the exchange Medicaid site collectively.

As you are aware, we released a proposed rule in July dealing with the establishment of exchanges. It went through a lot of exchange functions and talked about the responsibility of qualified health plans as well as the overall structure of exchanges and establishment in that process. It established eligibility, in accordance with the statute, as a function of exchanges but we differed all the detail on eligibility into this latest package of rules which were released on August 12. These rules, and there are three altogether, the Medicaid proposed rule, the exchange proposal rule and the treasury proposed rule, build on more than a year of really close conversations with states, large and small businesses, consumer advocates and health insurance plans. I want to highlight the fact that we believe they incorporate and build on the recommendations of this workgroup as well. It was very helpful as we worked through our policy development process and continue to be helpful as we begin to translate that policy process into operation.

At a high level, the Medicaid and treasury NPRNs set out eligibility standards for Medicaid and premium tax credit. The Medicaid rule also includes a fair amount of modernization to the eligibility process for

Medicaid. For the exchange eligibility what the NPRM does it describes how those two different programs and benefits will be integrated through the single streamlined eligibility process that is called for as part of the Affordability Care Act.

A core goal in the Affordability Care Act is to expand access to high quality affordable health coverage by creating a simple, seamless path to coverage. It actually does that in two ways. First it has covered expansion both in Medicaid and through the creation of exchanges and premium tax credits and cost reductions to make coverage through exchanges affordable. It also creates a major shift in the way people access both existing forms of coverage as well as new coverage by creating a simple streamlined eligibility process that demands a modern, consumer experience and will serve as the gateway for millions of Americans to enroll in health insurance regardless of income. We believe that the key to the success of this new system is placing the consumer at the center of it. What we mean by that is, we are trying hard to keep the consumer as the primary actor in this process by making it easy to start and complete the eligibility and enrollment process, including by offering assistance through a variety of channels and by minimizing the time required for folks to come in, understand their choices and get coverage.

So, when we talk about the eligibility process and this follows the statute and you should see this reflected in our various rules, there are four components. First is the submission of the single streamlined application which is specified in the statute. It says that a person has to be able to submit this streamlined application through a variety of methods, online, phone, mail or in person. And with that and without the need for additional information, be able to receive a determination for all these various programs at the same time. There is no wrong place to go, you can get a determination for the exchange for tax credits for cost reduction for Medicaid, for basic health program if the state has one, within that single process. The second element is verification. The statute specifies and starts out by building this construct of the Secretary of HHS providing federal verification services which we are choosing to enact that language by creating a data services hub to provide a standardized, federally managed services that supports the eligibility work that exchanges and Medicaid agencies will need to do. We think that the data services help is really going to go a long way in helping us all get to the goal that we have in a short period of time that we have to accomplish it. And also, after standardization and some consistency through the process beyond the data services hub, what we read from the statute and what you'll see in our proposed rule, is a demand the verification process maximizes the use of electronic data sources wherever possible and be constructed in a way that it is conceived as part of a streamlined and eligibility process in that we are trying to, for the larger share of folks, be able to have them enter the eligibility process and leave with health coverage or with a plan selected in one session and streamlining verification is a key element to that.

One of the things you see, and we are interested in your comments in particular on the sections of our proposed rule, given all of your work and expertise in this area, you will see we solicit comments throughout our verification area. In many areas we have identified data sources, and in other areas we have left it open within this context of electronic versus paper. We have tried to insert some state flexibility so that states can build on experiences they have, in terms of working through the verification process, and being able to create something that accomplishes our twin goals of moving things quickly and making sure we have a high level of integrity in our process. We are interested in more thinking beyond all the great stuff you have done already on data sources, it could be leverage and also areas which we can further streamline the verification process. After the completion of the verification process, we have the determination. I wouldn't say much about this, but the idea is there is a single cascading eligibility determination which handles Medicaid and CHIP based on MAGI advanced payments and premium tax credit cost reduction and enrollment for exchange, all the same time. We have recognized in the rule

there are individuals for whom there will be more work to determine eligibility and with that, I mean the so-called magi groups within Medicaid. What we have done to streamline the process is conceive of a situation in which the streamlined process is able to screen those folks off, and shift them to the Medicaid agency for further screening while continuing to move them through the streamlined process so to the extent that they are eligible under the new rules for benefits and maybe they will get more based on long-term care status or something, the focus is getting health insurance to people now. We will continue to move them through the process while they get evaluated for additional benefits which will go a long way to make the process seamless and streamlined for as many people as possible. The last step is connecting people to coverage who are eligible. By this, we mean selection of a qualified health plan, delivery systems selection, plan selection under Medicaid and CHIP. We talked about this a little bit in the earlier rule, but for those of you who are familiar with the work, going on a user experience project, we are interested in creating a robust set of tools for consumers in the area of plan selection, and to be able to make sure they can make informed choices about what is out there.

So from there, I want to be sure that Sarah has time to talk about the Medicaid rule, within the exchange proposed rule on eligibility, what you will see is a two tier set of eligibility standards. We believe that if an individual has decided for whatever reason they do not want any financial assistance whatsoever then that should be an option for them, so there is kind of split at the beginning of the process that we propose that to the extent that an individual says, no, I want to pay fully out of my own pocket for premiums, I do not want to be screened, then there is a set of verifications that occurs. And an eligibility determination is made solely to determine eligibility for enrollment in the exchange. So the eligibility standards for those folks are citizen, national, lawfully present, the resident and service area of the exchange and not incarcerated other than incarceration paying the disposition of charges. And then there are those folks interested in financial assistance and we want to be able to do the cascading determination for all the various insurance affordability programs at once so that is when you'll see the rule go into a section where we talk about verification of access of other coverage, verification of income other key elements. I will not describe the detailed information about who is eligible and how that all works, but a couple of things to highlight where we are seeking particular comment, is that in talking to state, we know for example in verification income, people feel it is something in which we need to do some collaborative work. You will see in the proposed rule there is a lot in the section of verification of income and what it really is, is an attempt to describe the standards for Medicaid, which the affordable care act really moved much closer to what is established for advanced premium tax credits, although there are some differences around the margin. And then the description on how the standards work for the tax credit, which is something for the treasury rule. So the work we have to do, starting with this proposed rule and in the final rule, but also in the operational discussion today, is how do we take those two standards and put them together and use electronic data and make this a streamlined process that will be easy to navigate by folks. We know that states have a lot of experience in terms of drawing on disparate sources of data and applying logic to try to figure out the true answer. We also know that states have access to data sources which can be useful in this regard. This is one area in which we have a lot of interest from states and doing some collaborative work going forward and we appreciate your comment on how we can make it part of this streamlined eligibility process so we don't hold folks up and get them into the right place. The treasury rule, well let me talk about re-determination quickly and I will do the treasury rule and turn it over to Sarah.

### **Farzad Mostashari, ONC**

If I can interrupt you, I know Aneesh Chopra is with us now and has to leave. I just want to check with Aneesh if there are any words of wisdom or encouragement you would want to give the group before you have to go?

**Aneesh Chopra, Chair, Chief Technology Officer, Office of Science & Technology Policy**

Thank you, Farzard. I just want to say I'm very excited that now that we have the machinery of the rules of the road and the paths forward and moving in the direction that gives greater guidance as to how we can be helpful, I am pumped that this committee that delivered such an amazing amount of work early in this process is positioned to take the ball back and take home some of the things we started. I know you're getting into the weeds when I dialed in, but for many of you on the call, this is a new federal advisory committee experience for you. Some of you are new to government and you don't have the sense to where their activity leads to results, and now we are ready to rock 'n roll, based on the great work that was built as a foundation over the last year. Thank you for giving me the chance to say a word or two and for the group in general, when you are all fired up and enthusiastic about the paths forward, I cannot wait to get back to working with you guys on a specific set of activities. So Sam, please stick with us for the rest of this, I have to do a White House thing, so forgive me. This is far more exciting for me and I wish I could have stayed. Thank you and if anyone has a question for me, great, otherwise I will let you get back to your business. Thank you.

**Sam Karp, Co-Chair, California Health Care Foundation**

Back to you Ben.

**Ben Walker, CMCS**

Just a couple more things and I will turn it over to Sarah. The statute describes the idea of a re-determination process. We've spent a lot of time talking to Medicaid to glean state experiences on best practices in that area. We have proposed in the rule is an annual re-determination process that focuses on the exchange going out and trying to grab what information is available and telling a person this is what we know about you and if that person does not respond assuming that information is correct and moving on. That is an area and a strategy that is proven to increase retention and we appreciate your comments on whether we have nailed it or not. Another thing that area is, we are very sensitive to the need around the tax credit and reconciliation, to try to maintain accurate eligibility during the year both to make sure that people get as much as they are entitled and they do not wind up in a situation where they have to pay something back. We do not prescribe a lot of data matching during the year for the exchange, and if that is something you think is important, we want to hear thoughts on it and how you think it can be done in a way that is not invasive on folks and on the folks that have to do the data matching as well. What you're going to see in the treasury ? when you look at it is the eligibility standards for the premium tax credit. You should, we hope, be able to read the treasury rule and read the exchange rule together and say yes they exchange rule really implements this treasury rule. The treasury rule has all the details, computation and tax credit and eligibility requirements and the exchange rule explains how that is going to be woven into the eligibility process. So what you'll see is the standards, the income eligibility, and other eligibility factors for the tax credit and also a fair amount of detail on computation. One thing we were impressed by with the treasury IRS folks, are all the examples they put in their rule. So I encourage you to take a look at those examples, because for me personally they do a great job of illustrating how some of these complex rules are going to work in the real-world. Before I turn it over to Sarah, I want to say, we really appreciate your close read and comments, but we need other folks to put all these three rules down, read them together and ask if this is a streamlined, seamless eligibility process. Is it going to work in terms of maximizing access to coverage by removing barriers from folks in getting in? If you find gaps and I am sure you will, please let us know in the written comments and those are due October 31 and send them to all of us. The more we have to chew on for the final rule, the better off we will be. I am happy to report to you today and work with Sarah who is really one of the geniuses in CMCS on all things eligibility process in terms of understanding what the as is is and the to be and how to get from one place to the other. She's a tremendous partner. With that said, Sarah.

## **Sarah Delone**

Thank you, Ben. That was very kind. It has been a great partnership and will continue to be. I know we do not have a lot of time and you guys have a packed agenda, I will reiterate the plea for your comments, questions, and thoughts in the next couple of months through dialogue and written comments which we need if we are going to make any changes to the proposed rule. We recognize that we did not get it perfect. You have our best thinking but we need those written comments to make actual changes to make it better in the final regulation. What I will try to do is very quickly, at least provide a framework and a road map for the Medicaid MPRN that is out there, and encourage anyone as you're reading it, as you have particular questions as to why we are proposing it that you need to understand in order to give us the comments or move forward in whatever other work, please do not hesitate to e-mail or call and we can have a conversation about that to get into the details of whatever it is you need to understand better. All the aspects of the Medicaid MPRN are focused and designed to achieve the vision that Ben sketched out around creating a seamless and coordinated system of reportable coverage. There are 3 ways in which the Medicaid MPRN attacks that goal. One is, and it is required by the ACA, expands access to Medicaid the creation primarily but not exclusively through the creation of the new eligibility group for adults under age 65. A lot of the regulations are geared toward simplifying the Medicaid eligibility rules in different ways. Some of those are driven by expressed statutory provisions in the affordable care act and others are places where we saw opportunity to either codify or simplify existing policies or rules and make some changes that are geared toward supporting the achievement of that vision. And the third are some express rules in the MPRN needed to establish what are the Medicaid agencies or CHIP agencies roles and responsibilities in establishing a seamless system of coverage of eligibility, determination and enrollment. Some of those are policy questions and some are process issues in the regs, but they are directly geared at what does the Medicaid agency have to do to make the system work.

The other thing to say at a high level is, we really tried, and I think to a large degree this is true, the rules in many different areas build on state successes and things that different states have been out in front of. Whether it is applying for coverage online, whether it is the more data driven verification systems, whether it is a more automated renewal process, we were able to draw on and are trying to set the bar nationwide for some of the innovative practices that states have embarked in in the last 5-10 years. Going into a bit of detail into each of the three themes of our regulation, the first was expanding the access of coverage. The affordable care act creates an across-the-board eligibility of no less than 133% of the federal poverty level for individuals under age 65 and provides 100% federal financing to start with, and phasing down to 90% federal financing for newly eligible individuals in that group. The enhanced federal funding is only for individuals who would not be eligible under today's rules. So we have proposed in the rule some different approaches to enable states to claim that enhanced funding without having to run people through a dual eligibility system to figure out if there eligible under the new rules and if they were eligible under the old rule. That is a piece from the state fiscal perspective that is included in the proposed rule. We did a lot in terms of trying to simplify Medicaid and CHIP eligibility rules. It mentioned that Medicaid eligibility, and most people, myself being a rare exception, turn around and run in the other direction. It is extremely complex. We did a lot in the rule and we hope to do more in the future to simplify the Medicaid rules. We consolidated eligibility categories to make – some cover 50 to 60 eligibility groups today. We made some proposals to simplify that and make one eligibility group for pregnant women, one for kids, one for parents and caretakers as well as a new eligibility with group for adults. We implement the new financial methodology rules using modified adjusted gross income to determine Medicaid eligibility in that it promotes alignment of the methods and processes that will be used to adjudicate eligibility for Medicaid, CHIP and the exchanges. We established a new income test for Medicaid eligibility and CHIP eligibility to promote this similar process so that people are treated the same regardless of whether or not an exchange is adjudicated in eligibility or a Medicaid agency is adjudicating eligibility. We do have significant regulations in one area in which we worked long and hard with our partners. We have had

many conversations about verification, rules and processes and we have a set of proposed rules around verification, which in some ways as a practical matter, do not feel different than the most modern states do today that really try to advance the bar. Similar to what Ben said earlier, they create a real focus and an emphasis and priority that is given to electronic data matching to verify whenever possible. We also will require Medicaid agencies to verify information through the federal hub, a system of verification to be established by the Secretary of HHS where such verification is possible. But where it is not, we established an expectation that if electronic data is available, states will access the data to verify eligibility and only where electronic data is not available or is not reasonably compatible with what someone is claiming their situation to be, would we then permit states to request other forms of documentation. We would welcome, I think when you read the exchange proposed rule and you read the Medicaid proposed rule around verification, in some senses it reads as if they are very different processes. We do not think that is the case. We would welcome more conversations with folks who want to dig in and help us out with the verification process to make sure it is right and see if there are ways we need to make changes to make sure the verification processes – they do not need to be identical for the exchange versus Medicaid, but they need to work smoothly and coordinate together. We would welcome some close reads and thinking about that to make sure we are accomplishing that. It is extremely important to achieving the goal of a coordinated seamless system overall. So we would welcome more conversation and your input on that. And then, we also want to propose a more streamlined and reliance on available information electronically for our renewal process requiring either that if states have information available to them through the electronic data matching, to confirm someone's ongoing eligibility at a regular renewal point without contacting the individual at all that they do so. If they need to get more information then they provide a person with a pre-populated form for completion and return. Finally, just to mention the changes to CHIP eligibility, I don't think we can say what we're doing simplifies CHIP eligibility, because the rules for CHIP are pretty simple today and this was a struggle for us, because states value the flexibility they have with the CHIP program. But the overriding need for alignment and coordination to a large extent prevailed in our discussions. In many different ways, whether it is the use of a single application, which is required under the statute or renewal process, the verification process, then specific methodologies for implementing modified adjusted gross income, CHIP we use the same rules as Medicaid in order to promote that complete alignment and coordination between all three programs.

**Kristen Ratcliff ONC**

Maybe we should open it up to see if there are any questions.

**Sarah Delone**

That sounds fine, and I know it is hard to explain the rule in 10 minutes or less. Hopefully it gives people a flavor and if there is a need for more a more deliberate, slower process for answering questions, we can work something out.

**Sam Karp, Co-Chair, California Health Care Foundation**

So while we have Sarah and Ben on the phone, let me entertain questions from workgroup members.

**Steve Fletcher, Chief Information Officer, State of Utah**

It sounds like really good information there. How do you want comments back? Do you want to this distributed to the states, do you want just comments from the working group, or how do you want to get this information out for comment?

**Ben Walker, CMCS**

Just to be clear, so the proposed rules have been disseminated. We are looking for written comments. The way the rule process works in order for us to make changes from a proposed rule to a final rule, it is

really helpful and critical that we formally receive written comments to support those changes through the formal comment process. So if you take a look at the proposed rules there are a few ways to comment. There is mail, the scan and upload capability, and we would appreciate comments from any and all configurations of stakeholders. So if individual states want to put comments together, or groups, that is excellent. Sarah, do you want to add to that?

**Sarah Delone**

We have to act on comments and have to have them in writing. If it helps to have conversations to figure out what you want your comments to be, we are available to figure that out within the constraints of 24 hours a day seven days a week, to do that. At the end of the day we need those comments in writing. I don't think states need the responsibility to disseminate those, but if there are particular people who would have valuable input for us, please point them to the NPRMs, make sure they are reading it and collaborating and getting us their comments too.

**Farzad Mostashari, ONC**

The reason to present today was to help provide to the committee members with an update and inform our work around the standards for the systems and eligibility enrollment and how they connect to the other pieces of the puzzle. So this is to get a better understanding. Less so in terms of, as they said, all of you have an interest and are welcomed to comment formally on those rules. Our committee's work is really not to provide recommendations and feedback on those regulations, we are the recipients of the policies that are established through those regs.

**Sarah Delone**

Yes but that said, as you are thinking about what does this mean for your work, if there is a way in which what's proposed either creates a barrier or actually really helps, that is very valuable information for us to know, both informally and formally. Formally being the written comments and informally being the conversations that we have short of formal comments to the rule making. It is a dynamic process in terms of between the proposed rule and the final rule. You all and states are grappling with, they have to start building their systems and thinking about operationalization of the rules at all sorts of different levels now before the final rules are out but those conversations and those thought processes could help to inform a better final rule at the end of the day. So I am encouraging you to think about the two, hand-in-hand, even though it is not your formal charge, some feedback from you all as you're thinking about what these rules mean for your work, could help us to create a better final regulation.

**Sam Karp, Co-Chair, California Health Care Foundation**

Thank you. Any other questions for Sarah or Ben? Deborah, are you out there? I am surprised we are not hearing from Deborah. Let me thank Sarah and Ben. It is helpful to get the overview and those of you who haven't looked at the regs there are over 300 pages of regulations. It often requires a break and a couple of Advil to get through them. They are quite comprehensive and go a long way towards maximizing seamlessness across the coverage continually. Congratulations to you all for getting the regs out as comprehensive as they are and providing the direction that they do. We will be talking very specifically about areas within the regs where we think our group can be specifically helpful. We will do that later in this agenda. So thank you both for taking the time to brief us.

**Sarah Delone**

I commend you a glass of wine instead of an Advil.

**Sam Karp, Co-Chair, California Health Care Foundation**

Okay, thanks. We will move to the next item on our agenda which is an update on NIEM work.

**Anand Basu, ONC**

Thank you. Kristen, do you want to give an update on the 1561 modeling work that you've been doing?

**Unidentified Man**

Excuse me, before we begin, if anybody is listening through their computer speakers please mute your computer speakers so we can prevent the echoing in the room. Thank you.

**Kristen Ratcliff, ONC**

Sam, can you hear me?

**Sam Karp, Co-Chair, California Health Care Foundation**

Yes.

**Kristen Ratcliff, ONC**

Before we get to NIEM, Julie, are you on the phone?

**Julie ?**

Yes.

**Kristen Ratcliff, ONC**

In addition to the regs that has come out, there is an additional letter that I want to make sure the workgroup is aware of that was released on cost allocation guidance and how cost can be allocated for human services. Julie can you get a quick update?

**Julie ?**

Yes, there are some potentially some interesting work that the committee can do around this cost allocation memo. Just to give you a lay of the land, in times past, predating me and Medicaid, which is my experience in the Medicaid office at CMS is now 5 weeks long, eligibility systems would be generally reimbursed by the Medicaid program at 50/50, meaning 50% from the Medicaid program and 50% from the State. As the work to implement the affordable care act, it became clear that states would need to work on in many cases, but not all the cases that Sarah talked about, many cases the eligibility systems for Medicaid programs and CHIP programs and human services programs in the states are ancient and rickety as we say in the IT arena. So the original enhanced funding announcement that was done last year, basically said to states that Medicaid would pay at the federal matching rate of 90% for modernizing eligibility systems for Medicaid and CHIP. The exchange grants will pay for 100%. So the states are going to build an eligibility and enrollment system for Medicaid, CHIP and the exchanges, that type of funding is available from the federal government but they have to meet the 7 standards and conditions that are spelled out in our IT guidance document. A couple of those are of note. First, it has to be that experience that Ben and Sarah were describing and that we have laid out in the regulations. Another one of the 7 is you have to point out that you have to have some hope that you will meet that dates that are laid out in the affordable care act, specifically the January 2014 date. The letter that Kristen is referring to is a separate one. That says to states that for a limited time, through 2015, OMB is going to issue a waiver to circular A87 which required any program who is participating in a system development project has to pay its fair share. For those of you who do not know what I am, my experience is largely in IT, and so from that bias perspective, this is brilliant because it enables states to build systems with shared services that can be shared across almost any system that requires an eligibility determination. Not all the services and business rules are the same, but a lot of the elements of an eligibility determination are the same. So the cost allocation memo that came out is really important guidance for us because it is the first time the

federal government has done something like this. I think it is an important opportunity and a challenge for us and the way I described this we really can't screw this up. The way that for your committee can help us think about this is, to think about eligibility determinations and enrollment functions as a set of shared services that are common among health and human services programs and one of the things that might be unique to human services programs because if they are more unique to the human services side then those services have to pay for that part of the development. It can become very challenging to look at a system development project and say, this project is for these things and this part is for other things. That is an interesting angle that the committee may want to take a look at and look at that letter we put out there, as well as our IT guide 2.0, and if you have any guidance as we are going about implementing this new cost allocation policy, we welcome it.

**Sam Karp, Co-Chair, California Health Care Foundation**

Thank you, Julie. We agree about the significance with the letter. The original charge of this workgroup was to look at facilitating enrollment across Health and Human Services programs, so this is right in our wheelhouse so to speak, and I think we will be discussing later as to how we can provide input and guidance to this particular effort. One thing I will tell you, and I will open it up for questions, is I have heard a certain amount of excitement in states about the letter and the allocation. I did hear that the 2015 deadline was pretty tight, so some initial feedback to you on things that I heard. But again, it is quite a significant development. I will open it up to any questions people may have. Okay, I am not hearing any. Thank you again Julie. Kristin, can we move on to talk about NIEM? Do you want to give the overview on the status of 1561 recommendations around NIEM?

**Kristen Ratcliff, ONC**

I will start and then turn it over to Anand to give you a bit more information. As you know, we did some initial work around NIEM last year that was published with our recommendations as attachment B. That attachment focused on a set of core data elements that we thought was necessary for the verification of eligibility information. It was not specific to certain data exchange, because at that time we did not have much information on what the data exchanges would look like so we focused on the core data elements. That was published with our recommendations in September. As guidance has trickled out this past year, we have done some additional work. The first effort, and I have probably mentioned this before, we did some additional work in April and May of last year to build on the initial analysis that was completed. We reviewed the information that was in attachment B of our recommendation and reviewed the use case and domain models, coordinated elements analysis verification systems interfaces what we know about them in existing standards. We developed a principle-based approach for eligibility and enrollment data element standardization, which included data types and links. We got a little bit further than we did in our initial round, in that we got down to data types and links. We did some additional work to gather existing data standards or requirements for verification systems, and we looked at what FSA has available regarding their transaction systems and the data elements they require. We looked at the Postal Service, which provides a standardization API for address, we looked at PARIS, the EVVS system, the IEVS system and the national directory or NDNH. We also extended the analysis to additional data elements which included marital status, which we heard in the first round of feedback that was important. We developed and defined the use cases to develop some models. We did not get as far as to develop and IEPD because any of you who have done this kind of technical work you know that in order to get to the IEPD level, you need to have a particular data exchange in mind. I will turn it over to Anand and to say that our next step in order to get to those IEPDs is to look at some data exchanges that are outlined in the NPRM and Anand will tell you the next steps we will embark on. That's what we have done so far on NIEM to date. So, Anand, if you want to take it from there.

**Sam Karp, Co-Chair, California Health Care Foundation**

Kristen, can you remind everyone in IEPD is?

**Kristen Ratcliff. ONC**

It is a guidebook and the technical specifications of what you need to actually implement it. It is the recipe for what you need your system to do in order to implement the main standards.

**Anand Basu. ONC**

Thank you, I can add a little bit to what you talked about. We, at the office of standards and interoperability have been responsible of looking into establishing and managing an actual NIEM health domain within the NIEM framework to which we will add these 1561 exchanges if one were to come about. A domain and NIEM is not just a domain model, but it also includes the stakeholders who participate in these exchanges. So NIEM currently has a number of different domains, including justice, maritime, treasury, and so on. We would add a health domain to that and populate that health domain with some of the 1561 work that Kristin just talked about. To make that happen, we have identified a number of exchanges with CMS and other agencies. Then we are going to use the model developed so far to take the data elements that have been identified and package them into the individual IEPDs that build a particular exchange. To add to what Kristin said, an IEPD is a compendium off the use case model that defines the exchange and XML schema that enumerates the values and any additional documentation all wrapped together in a zip file, which is the highest level. So we have been working with HHS health domain PMO, CMS, and IRS and other agencies to start the process of establishing the health domain as well as identifying using one of these exchanges as our foundational exchange for the health domain. I do not have anything else to add. We can continue to present our progress to this workgroup if they would like to review the work that we have done so far.

**Kristen Ratcliff. ONC**

The only thing that I would add to what has been said, building on what Julie said, this is an area of intersection with human services and the administration for families and children has already started some NIEM work in this area. So we are working closely with them in addition to CMS to bridge the gap between the implementation of main standards and the health domain and the implementation of them in the Human Services domain.

**Anand Basu. ONC**

Yes we are working with them.

**Henry ?**

I stepped out at the meeting and I just wanted to add that, I do not think we will have time to go into a lot of detail, but I think we both agreed that we need to lay out a work plan that identifies specific steps toward NIEM adoption and the inclusion of NIEM and how some of the interfaces will be defined and developed relative from a plan perspective and Medicaid and exchange perspective. We should get together pretty soon to lay out at work plan. Do you agree?

**Kristen Ratcliff. ONC**

I agree.

**Jitesh Sacheev**

Hi Kristen.

**Kristen Ratcliff. ONC**

For those of you that don't know, Jitesh actually worked on the April and May initial review of attachment B.

**Jitesh Sacheev**

Thank you and one thing we talked about was possibly connecting with some of the pilot states or early adopter states as the next step. Has there been any thought on that?

**Kristen Ratcliff, ONC**

I am probably not the best to ask about that. Henry, can you speak to what is going on in the innovator states in regard to NIEM?

**Henry ?**

I think they are looking for guidance and some additional level of specificity. So within that work plan you have to take some of the initial work that Anand that has already identified as early mappings to existing data standards that may appear in one of the domains. But I think we have to put out some specifications relative to specific IEPDs or IEPDs that exist within an interaction that requires data moving back and forth between 2 data exchange partners, like exchange and plan or exchange and hub and give that to the innovator states. Like right here in Massachusetts, they have accommodated and put placeholders for being NIEM compliant and to follow the 1651 recommendations. But when it comes down to the specific IEPD level for the exchange, they are looking for guidance from us.

**Sam Karp, Co-Chair, California Health Care Foundation**

So thank you everyone. Let me ask if there are any specific questions about what you have heard? We are making progress on a variety of fronts. I am not hearing any. We will move on.

The next agenda item is to hear presentation from Terri Shaw, as you remember along with Bryan Sivak, co-chaired our Tiger team on consumer engagement. This is a project that grew out of the conversation around consumer engagement and how the exchanges were going to be able to implement a first-class user experience.

**Terri Shaw**

It is great to be back together with everybody and give you an update about this project which really did grow out of the work of the Tiger Team and were very helpful in getting this idea launched. I am happy to be able to give you an update and it is great moment to be talking to you because we have just come out of very intense couple of days where we had all of the project partners, a group of about 80 people together for an intense but fun couple of days and a highly progressive couple of days to review where we are with the design and gather a lot of excellent feedback. We had such great participation from people from CMS, CMCS and a very robust of several folks from different states and got a lot of great feedback that we are on the cusp of incorporating and refining.

So, first of all in review, and will have some discussion about this project, very early in its stages the objectives of the project are to provide federal and state governments with a human centered user experience design. Going right out of the work from this workgroup we put consumer right at the center of the process of enrollment under the affordable care act. As part of that the objective is to help individuals and families understand and connect with the coverage that they are eligible for and support their enrollment decisions so they can be engaged and the drivers of the process and ultimately to help ensure that large numbers of eligible consumers do successfully enroll in and retain their coverage over time. So, moving forward, the project is truly a public/private partnership that have great participation from the team at CMS who have been working with us along the way. We have a group of funders led by the CA Health

Care Foundation and Sam Karp that have provided the funding and resources for the project. We are also working with 11 participating states and they are really a great group and diverse set of states that are at various stages of implementation, from an innovator to some are deciding how to approach implementation. We had robust participation from all of these states at our recent workshop and it was tremendous to have that diversity of expertise in the room. The other key partner in this effort is our design partner IDEO, which is a world-class design, engineering and innovation firm. They are world renowned for being innovative in design and they are crucial partner for us. So the project is really focused on the individual market, meaning the user experience for all insurance affordability programs for individuals. For Medicaid, CHIP, tax credits, cost sharing reductions and as details of the basic health program emerge we will incorporate that as well. We are focused on the individual perspective and the family perspective as opposed to the shock experience. We are in the process of expanding our scope to include the design for the shock user experience as well. It is in development now and for the past 5 months we have focused on the individual experience. We are looking at the entire spectrum of the enrollment experience, including eligibility, enrollment, plan selection and retention. So that entire spectrum of enrollment activities is part of ?. Of course the design is primarily about the online portal. The portal recognizes the importance of having support along the way in the ways that work for them and is consistent with our enrollment workgroup recommendations. We are incorporating into the design consideration for the needs of people to have in-line assistance as needed but also to connect with assistance live, in-person assistance in their community or through phone or submit materials by mail. But also to provide an experience that allows people to transition among those pathways as they perhaps start on-line and realize they want to go into an office to get some in-person help, we want to provide a seamless user experience. The design also contemplates the need to support for diversity of Americans who will be seeking to enroll and retain their coverage over time. The design and participation need to support for consumers limited literacy, limited English proficiency, people with disabilities. The design effort is vendor neutral. The core project will be delivering design products and specifications, not code. There will be specifications in all the elements and behind those specifications will be available for sophisticated vendors to be able to use to incorporate into their implementation. So it is vendor neutral.

Our timeline is on the slide in front of you. We are right now at the stage of just finishing up the initial design. The initial design phase key moment in the end of the stage was the design workshop that we just had at the beginning of this week. From there we will be turning to the design refinement stage where we will be developing design specifications as well as a functional prototype that will help to illustrate the design and how it should look and feel and operate for the consumer. We also have a robust to communication plan to explain how these pieces fit together and key things that will need to be kept in line as implementation goes forward. So the first phase of the project was a research phase where the ideal team of researchers intensive interviews with individual consumers in their homes in three different communities in different communities in Ohio and California. You will see here the brief highlights of findings from the research. These are really intensive sessions in the homes of consumers of various types, learning about their experiences with insurance, the enrollment processes, the challenges of keeping insurance over time and other things. This research is grounding and the user perspective is a key driver throughout the project. From the research, we came up with some design principles. The key principles for moving forward are that the consumer wants to have direction. Give me direction to help me move through the process. Keep me moving through it and give me what I need in the way I need it to get me through the process and be a good neighbor. Give me guidance along the way and suggest shortcuts available to me, if it seems I am getting off track, put me back on track. Also from the research, from the behavioral segmentation, I won't go through these different icons in detail, but the notion here is that people who come to the enrollment experience were very different approaches and mindsets. The design we developed needs to be able to address all these different approaches. Everything from people who want their hand held all along the way and want you to take as much action off their plate and some who

want the system to get out of their way and then the information so that they can make the decision themselves. So we have to meet people where they are and help them the way that works for them. There is the role of the ? which is really the core piece of focus for the design effort to be mindful of the important ? that can play and make sure that this works for them.

So the core work of the project over the last 7 to 8 weeks has been to develop high-level system flow and wireframes to put the logic and then the wireframes that provide format and layout of the key data elements and features and functionality within the site. A lot of our effort has been to focus on this and this will be an intensive focus of the discussion that we had two days earlier this week. We had great feedback on did we get the right data elements and going forward is it logically organized. The design is also looking at multiple channels as I mentioned, and at federal requirements designed for people to apply on paper, from their computer, from touch screen tablets, kiosks, live conversation by telephone or in-person. We are also looking at the incorporation of mobile channels. So we are looking at all these different channels for facilitating the user experience. Our next step is to get into the design refinement phase to develop the final deliverables to share with all of the states. We have the 11 participating states are working with us and we want these deliverables to be available to any state who wants to use it to help implement their exchange or streamlined enrollment practice. We want to develop more robust tools in the process. More to come about that. The other thing is that we have just launched at the beginning of the week a website to provide more information about the project. The URL is on your screen and we encourage all of you to take a look at that and let us know what you think. If you have any questions, I of course would be happy to talk with you. With that, Sam, do you want to take it back over?

**Sam Karp, Co-Chair, California Health Care Foundation**

Are there any questions that people have for Terri? Okay, we'll move to the last item on the agenda.

**Shelby Gonzales**

Actually, it took me a while to get off mute. I'm hearing a lot of static. We are getting a lot of static. I know there was a lot of work done in that Tiger group which was one of the driving forces for the work that Terri is doing. I know there was a lot of work and thought in terms of how to make sure this experience for consumers with lots of different needs, including limited English proficiency and disabilities and such what our thinking was about what that would look like. I think it is great this project is moving forward and helping to define what that might look like. I'm also wondering if there is any plan or action that might be happening in CMS to issue guidance or maybe it is accompanying guidance as this product is delivered. I guess it could be a question to the group as well; do we plan on doing something as a group to encourage that to take place?

**Sam Karp, Co-Chair, California Health Care Foundation**

I think that is a good question to raise, and I'm going to use it as part of a segue to talk about the future direction of the work group, if you do not mind. I think we're going to talk about what the workgroup should be doing and we heard the overview of the new regulations, and we have specific ideas going in and we will entertain that as well. Farzad, do you want to walk us through some ideas around future directions.

**Farzad Mostashari, ONC**

Recognizing that a lot of what we're doing today is catching up. We have not met for a while, and I think there is a lot of information to update folks on about the continuation of the NIEM work in terms of developing specifications for the data elements that we already identified as part of the core verification service. We heard an update on the consumer project and we will talk more about where that implication and how to extend that. Most importantly, we are getting more clarity in terms of how the different pieces of the puzzle fit together, in terms of the eligibility enrollment system and through the regulations we are

understanding some of the policy choices made. The next step is in terms of understanding how, on the implementation of the different pieces, everything from eligibility and plan selection and financial operation verification and data exchanges that need to happen outside of the exchanges, we will all start to get more clarity in terms of what are the critical interfaces within those touch points, as we move beyond just verification service, which is very clear from a policy perspective and we knew we could start working on that. More of those interfaces and the need for those interfaces and a priority to those interfaces will become clear. This moves into an intensive phase of actual standards work, around developing the implementation specifications and running them through the NIEM process to be sure the data elements and standards are consistent with other standards developed as part of the healthcare and ? system. That work is going to be one important thing on the horizon that would be coming, particularly as we start figuring out the different pieces of machinery and how they all fit together. Potentially, there is more clarity in terms of partnerships between federal and state, federal exchange and the state activities between them. That is one area of activity.

The second area of activity which is suggested by the idea work is to think about the user interface and the wireframes. To really make this fly, and to be able to separate out the different presentation layers from the underlying data, the issue of what are the application program interfaces or APIs into the databases that potentially this presentation layer and, this is quite interesting, other third-party applications can plug into whether they are navigators, agents or other third-party applications that want to make use of some of the same underlying information. That is an intriguing area that we have thought of and we would like to hear your thoughts as to whether that would be something worth our group starting to consider from a policy perspective and a business perspective, but also from a technology and standards perspective.

In the third area which I would like your input on, is this group really started and some of the vision behind the 1561 standards was around the interfaces with social services and we have had discussions about that before. The work that we have done serves that but we have not really marched along in terms of thinking about, again the policy, but also the technology and business issues around how the machinery for the exchanges once built could be reused at the state level for social service applications. So that I think will in time become more and more clear and important, but would like to hear your thoughts on that as well.

I do want to give one more update. The committee, when we are talking about exchanges of information between exchanges gave the guidance we should consider putting the patients literally in the center of information exchange, of having the patient receive their information and be able to carry it business to consumer back to business as opposed directly from business-to-business. On Monday, we actually launched a consumer ehealth strategy alongside some folks who are doing a lot with blue button. There is a broader movement afoot in terms of recognizing that patients have a right to their own information and that makes them better partners in managing their health and their healthcare finances. So a tip of the hat for having the foresight to move us in 1561 work down a patient centered, consumer centric approach to information exchange which was an inspiration to some of the work happening now in terms of health plans, like United and CMS giving patients access to their own administrative information as well as healthcare providers. Let me pause there and ask for comment on the 3 broad areas of activity that I can see us potentially engaging in and then we'll talk a little bit about the process.

**Sam Karp, Co-Chair, California Health Care Foundation**

Comments on what Farzad laid out.

**Farzad Mostashari, ONC**

The 3 are: one, continuing the work in defining standards around the interface specifications and the NIEM work around the different pieces of the machinery. Second, is considering delving into APIs into the data, both for the presentation layers and third-party application. And third, is continuing the exploration of how these can help with innovation with social service agencies.

Are we on mute all over?

**Sam Karp. Co-Chair. California Health Care Foundation**

I wasn't sure if it was just you and I on, but this is an unusually quiet workgroup session. Anne, are you on?

**Anne Castro. BlueCross BlueShield of South Carolina**

Yes, I am on and I'm happy with what I'm hearing and ready to move forward.

**Sam Karp. Co-Chair. California Health Care Foundation**

Anne, let me ask you about the issues of APIs. One area that comes up for me is thinking about the role of brokers in SHOP. As I understand it, many brokers that you sought for application that are actually tied into the health plans they represent. Is this an area that you think is right for work and thinking about APIs that could navigators, but brokers as well?

**Anne Castro. BlueCross BlueShield of South Carolina**

Absolutely and for the first line of determining whether someone should be sent to the exchange path or not, any information to help direct people to the appropriate path would be critical to the agent, navigators, community organizations, even to payers. There still will be an insurance marketplace outside the exchange and that ability to help traffic cop people to the proper places is what I see as being a direct relationship with.

**Sam Karp. Co-Chair. California Health Care Foundation**

Thank you. Others?

**Lynn Jordan. USDA Food and Nutrition Service**

I want to express appreciation for the third point about integration with other social service agencies. I know SNAP has been mentioned throughout the discussion in the last several months, but we're still kind of on the periphery so talking more about integration would be very appreciated.

**Sam Karp. Co-Chair. California Health Care Foundation**

Okay thank you. On that point, one of the things I hear many states talking about is that they are struggling with vertical integration to start. How are they going to integrate their Medicaid program and CHIP program, especially in states with they have separate Medicaid and CHIP programs. With subsidy programs they can choose to have the basic health program and then I hear people talking about horizontal integration. This potential second phase to try to get the vertical integration done and certified by January 2013, but the second phase which I thought when we heard about the cost allocation memo earlier from Julie, provided a lot of incentive for the states to think about how then, do they integrate human service programs. Farzad, as you mentioned, one was part of the original task and statutory requirements that created this workgroup, and it is something that would terrific to pursue. Other comments?

**Farzad Mostashari. ONC**

From the process and structure point of view, at least some of the work moves from policy and design discussions into the hard-core standards after the NIEM process. The usual pathway is go to a workgroup

of the standards committee and then up to the full standards committee and then to me and then to the secretary. I think I would like to discuss with you, and it is something we also have to discuss with the standards committee chairman, for us to in essence create a twin 1561 group on the standards side with many of the members of this group who are more technically gifted, shall we say, than I am. Who can get into the very specifics of the standards and interface implementation and giving those recommendations for approval or not to the standards committee. That is just to let you know that if you have been chasing in these meetings, and that the discussions are not technical enough, there will be a workgroup for you.

**Sam Karp. Co-Chair. California Health Care Foundation**

Do you see this as being another workgroup or a technical Tiger team out of this workgroup?

**Farzad Mostashari. ONC**

I think from an administrative standpoint, each workgroup has to report to one of the FACAs. We currently report to the policy committee and so this would create a twin that in many ways could function as a Tiger team to this committee, but would have independent standing to make recommendations directly to the standards committee.

**Sam Karp. Co-Chair. California Health Care Foundation**

Okay, thank you for the clarification. Any other comments or questions that people have on this area? I think Farzad is correctly suggesting the reconvening of this workgroup is to get updated but this last topic suggests at least 3 areas and Shelby, I do not want to ignore the issues you raised about further potential guidance on some of the recommendations that came out of the consumer engagement committee that could be taken further in respect to ensuring that application and the process an application for enrollment is done in a way that meets some of the tests of the consumer engagement work that we did.

**Farzad Mostashari. ONC**

Judy, would you like to open it up for public comment?

**Sam Karp. Co-Chair. California Health Care Foundation**

Welcome any members of the public. Are there any questions or comments?

**Operator**

We do have one question.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

If you could identify yourself please.

**Carol Bickford, American ? Association**

Thank you to Judy Sparrow for her service to the ONC in these initiatives over the past years. Number 2 is there is reference to the cost allocation guidance letter during the discussion about NIEM. Could you share where that might be located and if it is in the public domain? The third thing is in relation to IDO and CHCF and the consumer project are the lessons learned and the recommendations and content associated with the findings, going to be integrated into the ehealth consumer initiative? It seemed as the conversation was going along that many of the insights and recommendations would have significant application to that space and since we have signed on to be non-data partners in this initiative it would seem that some of those resources would be helpful in our consumer education initiative.

**Farzad Mostashari. ONC**

Very interesting suggestion, Carol. In terms of the cost allocation document, we will have our staff will forward that to you. There must be a link to it from the CMS website and will identify that. It is intriguing

that the idea of taking about the lessons learned around from the 1561 user interface work and looking to see what applies in terms of Health IT more broadly is a lovely idea and one we will take up with you.

**Sam Karp. Co-Chair. California Health Care Foundation**

We do intend to make all of the human practice research that was conducted in this project publicly accessible.

**Carol Bickford, American ? Association**

Awesome, thank you.

**Operator**

There are no further comments.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Okay, thank you Sam.

**Sam Karp. Co-Chair. California Health Care Foundation**

Thank you to everyone and to members of the workgroup. Kristen, we do not have another meeting on the calendar do we?

**Kristen Ratcliff. ONC**

No we do not, but I think we will look for one in the next 4 to 6 weeks and hopefully that can be Judy's parting gift to us.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

I would love to do that.

**Sam Karp. Co-Chair. California Health Care Foundation**

Any final comment? We will be back in touch shortly.