Migrating from the federally facilitated to a state-based marketplace:

Using structured processes to guide an efficient and successful conversion

February 2015

kpmginstitutes.com/government-institute
Contents

Introduction.................................................................................................................................2

Overview of the opportunity to move from the federally facilitated marketplace (FFM) to a state-based marketplace (SBM) ........................................................................4

KPMG’s six-step approach to migrate from the FFM to an SBM ..............................................6

Special considerations.............................................................................................................12

Final thoughts.........................................................................................................................14
Introduction

By the October 1, 2013, deadline each state had taken steps to fulfill its Patient Protection and Affordable Care Act (ACA) obligation to provide access to a Health Benefit Exchange (HBE) so that individuals can compare and purchase private health insurance or be enrolled in an expanded Medicaid program. While the federal government’s preferred approach was for each state to develop its own state-based marketplace (SBM), the majority of states opted to take advantage of an alternative provided by the statute and accept the federally facilitated marketplace (FFM) as their exchange either directly or through a partnership model. For some of these “FFM states,” adopting the FFM was simply an interim strategy based on their need for more time to consider or mobilize for the significant effort required to meet the tight time lines associated with implementing an SBM by October 1, 2013.

Understanding that this was likely to occur, the federal government designed its programs to provide grant funds to states supporting an HBE implementation through October 15, 2014, with the opportunity to use those funds for three years after the date of award. This extended funding provided FFM states an additional opportunity to implement an exchange model that may better fit the needs of the state than the FFM, which must meet the needs of all the states leveraging it. An SBM may also allow a state to maintain control over its healthcare ecosystem while providing it with a tool to drive healthcare innovation and reform.

It is also important to note that while the initial SBM states had only federal guidance to support their efforts, FFM states that may choose to convert have the opportunity to leverage the designs, road maps, and even systems developed by the existing SBM states to speed up their process, reduce their risks, and benefit from lessons learned by the SBM states during their implementations. While FFM states have great opportunities to rethink their health and human services (HHS) enterprise under a slightly more relaxed time frame and with more knowledge than the first wave of SBMs had, the time required to implement an SBM and the time-limited availability of the Center for Consumer Information and Insurance Oversight (CCIIO) establishment grants continue to make the prospect of such a project challenging.

Coincident to the SBM implementation opportunity, states also have an opportunity to leverage the existing federal Office of Management and Budget (OMB) Circular A-87, Cost Principles for State, Local and Indian Tribal Governments, waiver authority to fund enhancements across the HHS domain for large-scale transformation initiatives. This funding has been used by many states to enhance their integrated eligibility systems (IES) and other key cross-program assets, helping to maximize the waiver by getting 90 percent Medicaid modernization funding. The combination of these two funding sources provides what is likely a once-in-a-generation opportunity for states to transform their HHS enterprise into a more efficient, effective, and less costly arm of government. Fortunately for states that have not taken full advantage of this opportunity to date, access to the A-87 waiver to support modernization initiatives has been extended by three years, and 90/10 funding for Medicaid eligibility system modernization has been permanently extended.4

This white paper, developed by the KPMG Government Institute, in conjunction with KPMG’s Global Human & Social Services Center of Excellence, introduces an approach as well as tools that KPMG has developed specifically to provide states the opportunity to accelerate initiatives so that they may benefit from the opportunities available. Our research into leading practices was informed by working directly with 23 states (including the District of Columbia). This white paper is based on deep practical experience as to what can work in establishing a state exchange, while more broadly leveraging the opportunity for federal funds to modernize existing state-level HHS legacy systems.

This white paper:

• Provides an overview of the opportunity to move from the FFM to an SBM and the considerations in answering the question: “Why move from the FFM to an SBM?”
• Highlights the six steps in KPMG LLP’s (KPMG) approach to modernize state enterprise eligibility systems as part of development of an SBM
• Addresses special considerations, such as timing and complexity, compliance with federal guidance, implementation strategies, and planning requirements.

2 Partnership models of shared accountability allowed states to leverage or develop their own customer service capabilities to support client contacts to the FFM.
3 CCIIO is within the Centers for Medicare & Medicaid Services (CMS).
About the KPMG Government Institute
The KPMG Government Institute was established to serve as a strategic resource for government at all levels, and also for higher education and nonprofit entities seeking to achieve high standards of accountability, transparency, and performance. The Institute is a forum for ideas, a place to share leading practices, and a source of thought leadership to help governments address difficult challenges such as effective performance management, regulatory compliance, and fully leveraging technology.
For more information, visit us at www.kpmg institutes.com/government-institute/.
Overview of the opportunity to move from the FFM to an SBM

Why move from FFM to SBM?
All FFM states are now faced with the same question posed at the start of the process: Are we interested in implementing an SBM? While the initial decision to start with the FFM providing access to qualified health plans (QHPs) could have been motivated by many factors, a review of current needs and challenges can reveal new opportunities.

• Increased autonomy over delivery of health coverage – State HHS departments would benefit from increased control over the delivery of the full spectrum of health coverage in their state, maintaining a more consistent delivery between QHP and Medicaid services. By operating an HBE in-house, states also inherently retain total control over the review of rates and forms for the certification of QHPs, thereby retaining the primary relationship with insurance carriers in their state for this market.

• Reduced complexity in eligibility processes for HHS – States currently operating in an FFM environment are faced with participating in a varied determination process, where eligibility for Medicaid and other HHS programs is performed by the state, and eligibility for Advanced Premium Tax Credit (APTC) for QHPs is determined by the federal government. In “determination” states, the complexity of the process extends to the integration of Medicaid enrollment based on determinations performed by the FFM. This structure does not lend itself to a streamlined application process and relies on the account transfer process to determine the full range of benefits for which the applicant is eligible. At the time of publication of this white paper, this process was still not operating as efficiently as the federal government had envisioned. By operating an exchange within the state, this fractured application and eligibility determination process can be reset into a single, cohesive process.

• Funding to improve services and support transformation – Funding for the development of an SBM, in conjunction with extended availability of 90/10 funding provided by the Center for Medicaid and Children’s Health Insurance Program (CHIP) Services (CMCS), and the OMB Circular A-87 waiver supporting modernized integration of HHS eligibility functions, can collectively be used to build or integrate a variety of infrastructure capabilities. Investments to modernize business processes with business intelligence, content management, enterprise service bus, or master data management can be leveraged across HHS programs under these funding opportunities.

• Greater visibility to client base – As states look to gain a more comprehensive view of their clients, access to an individual’s activity and status on the SBM will add to the overall quality and value of an integrated case record. While this client information is theoretically available to the state from the FFM, having greater control, more immediate data sharing across programs, and increased confidence in the available information ultimately increases its utility.

• Enhanced client centricity through integrated consumer assistance – By moving to an SBM or a state partnership, FFM states simplify consumer assistance for their citizens by offering a single point of contact for applications, as opposed to the potential either-or options of contacting the FFM or the state and then being rerouted or transferred depending on program eligibility. States looking to maintain greater control over citizen (client) messaging, communications, and notice of changes and actions would benefit by retaining consumer assistance capabilities within the state. From the client’s perspective, their experience would be more predictable, and states would avoid the potential confusion associated with multiple contact points for a related set of services.

5 States that adopted the FFM model were provided the option of having the FFM determine Medicaid eligibility (determination states), or have the FFM provide a finding of potential eligibility (assessment states) with the states retaining the final determination decision.

6 Account transfer involves electronically sending application data between state Medicaid and FFM in order to feed corresponding eligibility and enrollment processes.
• On the whole, state-based exchanges have performed better – While both Healthcare.gov and some states’ SBMs attracted significant media attention for their late implementation and technical challenges, most SBMs have not received the same degree of media scrutiny for their implementations. Enrollment data continues to support the conclusion that SBMs have been more successful in enrolling their eligible populations both based on their average individual percentages of eligible populations enrolled, as well as collectively adjusted for population.7

Special programs and funding opportunities

The ACA stipulates that to operate an SBM, states must be able to determine eligibility for Medicaid, CHIP, premium tax credits, and cost-sharing benefits through the SBM in a streamlined and integrated fashion. To that end, the federal government put in place a number of mechanisms to promote integration both within these programs and across the broader HHS domain and to assist states with their implementation and compliance efforts. Current funding opportunities include the following:

1. In order to assist state Medicaid programs with their compliance activities resulting from the ACA, CMCS, has made permanently available special enhanced Federal Financial Participation (FFP) for states modernizing or replacing their Medicaid eligibility systems. Such projects are 90-percent federally funded provided that they meet specific conditions established by CMS.

2. In addition, the federal government has extended its time-limited exception to the cost allocation requirements set forth in OMB Circular A-878 by three years (until December 31, 2018) to allow extra time for federally funded human services programs to benefit from investments in state eligibility systems by Medicaid and CHIP, and which can be integrated with state-operated exchanges. They achieve this by allowing states to leverage existing assets for other programs (without sharing in the common system development costs, so long as those costs would have been incurred anyway to develop systems for Medicaid and CHIP). Programs that would benefit include Temporary Assistance for Needy Families (TANF), Child Care Development Fund (CCDF), and Supplemental Nutrition Assistance Program (SNAP), among many others. Human services programs will be required to cover only the incremental costs of human-services-specific functions built on the shared infrastructure.9

The enhanced funding opportunities, combined with the cost allocation waiver, are likely a once-in-a-generation opportunity for states to transform their statewide HHS enterprise into a more efficient and effective delivery system while potentially achieving significant recurring cost savings to states through operational efficiencies. However, states have a limited amount of time to take advantage of this unique opportunity.

The following six-step approach leverages a structured and tested process based on the extensive experience KPMG has gained assisting 23 states in various capacities (including those states that have been most successful10), plus the federal government with their ACA implementation activities to date.

---


9 Partnership models of shared accountability allowed states to leverage or develop their own customer service capabilities to support client contacts to the FFM.

Through research into leading practices and practical application working with 23 states on their October 1, 2013 ACA readiness, KPMG developed a detailed approach and associated tools that helped states capitalize on this unique opportunity. Using these tools, states were able to successfully modernize their statewide HHS eligibility determination capabilities while establishing SBMs in an environment of time constraints and the significant business and technical complexity of standing up an exchange. This approach acknowledges that all FFM states are operating under some common federal parameters. It consists of six steps, which are enabled through a special tool we developed to facilitate HHS modernization initiatives and SBM implementation—the KPMG Enterprise Reference Architecture (KERA) for HHS:

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>Collect and apply federal guidance and approved SBM documentation, including CMS Exchange (ERA), Medicaid (MITA), and IES Reference Architecture models (NHSIA) as embedded into KERA</td>
</tr>
<tr>
<td>Step 2</td>
<td>Assess current-state assets for an HBE and IES by comparing current capabilities against the KPMG Reference Architecture</td>
</tr>
<tr>
<td>Step 3</td>
<td>Define high-level HBE and IES business and system requirements (KERA provides a starting point based on the federal requirements, as well as our experience with states’ ACA implementation, which allows the definition of requirements to occur much faster than if a state was starting from scratch)</td>
</tr>
<tr>
<td>Step 4</td>
<td>Estimate project costs (exchange, Medicaid, other HHS programs) and develop funding requests</td>
</tr>
<tr>
<td>Step 5</td>
<td>Develop detailed business operating and system designs</td>
</tr>
<tr>
<td>Step 6</td>
<td>Complete development, test case, and deployment planning</td>
</tr>
</tbody>
</table>

The knowledge reuse strategy includes the issuance by HHS of three “community” or sector reference architectures to expedite and guide planning, procurement, and systems integration efforts:

- The National Human Services Interoperability Architecture (NHSIA)
- A new release of the Medicaid Information Technology Architecture (MITA 3.0)
- The federal Exchange Reference Architecture (ERA)

In order to meet the tight funding window, state human services program managers will also need to leverage these “reuse” accelerators to:

- Clarify their vision and strategy for modernizing human services delivery

© 2015 KPMG LLP, a Delaware limited liability partnership and the U.S. member firm of the KPMG network of independent member firms affiliated with KPMG International Cooperative (“KPMG International”), a Swiss entity. All rights reserved. Printed in the U.S.A. The KPMG name, logo and “cutting through complexity” are registered trademarks or trademarks of KPMG International. NDPPS 302664
• Develop a high-level human services operating model and road map, identifying requirements and creating the design for a modernized eligibility system

• Oversee the implementation of a modernized system and the transformation of the service delivery model

Within the system’s development life cycle, states need accelerated planning, requirements determination, procurement, system design, and development and implementation activities. In order to expedite implementation, they are looking to substantially reduce the elapsed time that all of these activities normally take by a factor of three or four while simultaneously managing risk and stakeholder expectations. It will be important not to take shortcuts that jeopardize success of the project, but to implement new systems intelligently and adroitly, using leading practices.

This step includes leveraging the KERA business and system reference architecture that incorporates Medicaid and IES functions together with ACA implementation, including creation of an SBM. KERA incorporates detailed operating model and service delivery model patterns required to build and operate an SBM and integrates the business capabilities identified in the federal architectures (ERA and MITA 3.0). This toolkit facilitates executive decision making on:

• The scope of its SBM within a state’s modernization initiative

• An effective “home” of the SBM within its process vision for HHS program delivery, including shared state services and outsourcing of noncore activities

• High-level IT requirements for the HBE and for integrated eligibility

• The critical business and IT milestones necessary to implement its healthcare reform and modernization vision

The Integrated HHS Capability Reference Model, shown below in Figure 1, is aligned with—and extends the footprint of—the CCIIO business process model (ERA), MITA 3.0, and NHSIA frameworks. It includes defined “core business areas,” organized into three types of capabilities: management, core, and delivery.

• Management capabilities provide oversight management of enterprise resources.

• Core capabilities are the critical activities required to operate an SBM, or a Medicaid or human service program.

• Delivery capabilities manage a state’s touch points with clients and other stakeholders and are typically the entry points to the core capabilities.
This business framework provides FFM states with a structure by which to consider and plan for all of the business capabilities required to successfully and compliantly operate an SBM. Each state moving to an SBM will need to make design decisions among various operating model options, including:

- What parts of their existing organizations might perform SBM functions (for example, plan management)?
- What new organizational units might be needed to operate the SBM?
- Which capabilities represent the most logical opportunities to outsource SBM functions to service providers?

Some outsourcing strategies employed by the initial SBM states include some or all financial management functions, call center channel operations, and data center operations.

Each state will also need to define the governance structure for their exchange. Each SBM must have in place a governance structure that conforms to the requirements of the ACA and the regulations issued by CMS. The ACA provides states with the option of establishing an SBM within an existing state agency, within a new or existing quasigovernmental entity, or as a separate nonprofit organization. In addition, states could choose to partner with one or more other states to establish a regional exchange or to create more than one subsidiary exchange within the state. Regardless of its organizational form, the SBM must:

- Be publicly accountable and transparent
- Have technically competent leadership
- Take actions necessary to meet federal standards.

Figure 1: KERA: Integrated HHS Capability Reference Model

- Resource Management
  - Procurement
    - Contractor Management
    - Contractor Information Management
    - Contractor Interaction Management
    - Contractor Communication and Outreach
  - Financial
    - Accounts Payable
    - Accounts Receivable
    - EBT Card Management
  - Business Partner Management
    - Business Partner Relationship Management
    - Business Partner Information Sharing
- Program & Service Management
  - Program Management & Operations
    - Program Policy & Planning
    - Human Services Design
    - Service Operations
    - Compliance & Risk Management
  - Provider Management
    - Provider Information Management
    - Provider Eligibility and Enrollment
    - Provider Communication and Outreach
- Program & Service Management
  - Program Management & Operations
    - Program Financial Management
    - Health Plan Design
    - Performance Management & Reporting
- Program & Service Management
  - Program Management & Operations
    - Program Policy & Planning
    - Human Services Design
    - Service Operations
    - Compliance & Risk Management
- HHS Program Core
  - Women, Infants & Children (WIC)
    - WIC Food Purchase Benefits Provision
    - Nutritional Education & Counseling
  - SNAP
    - SNAP Food Purchase Benefits Provision
    - SNAP Food Purchase Benefits Provision
  - TANF
    - Cash Benefits Provision
    - Provision of Counseling to Support Employment
- Child Welfare
  - Assessments/Investigations of Child Maltreatment
  - Foster Care Placement/Independent Living
  - Counseling/Educational Services
  - Child Welfare Financial Assistance
- Medicaid
  - Health Coverage
- Health Benefits Exchange
  - Broker Coverage Agreement
  - QHP and Issuer Management
  - HHS Program Core
  - Service Transaction Processing
    - Premium Processing
    - Payment Processing
    - Claims Processing
    - Rebates, Recovery & Settlement
    - Issuer Payment Transfers
- Delivery
  - HHS Client Management
    - HHS Client Eligibility and Enrollment
    - Case Information Management
    - Care Coordination
    - HHS Client Assessment
    - HHS Client Referral
    - HHS Client Communication and Outreach
- Relationship Management
  - Stakeholder Communications
    - Stakeholder Notification
    - Stakeholder Outreach
    - Public Alert
  - Stakeholder Support
    - Transaction Support
    - Inquiry Response

© 2015 KPMG LLP, a Delaware limited liability partnership and the U.S. member firm of the KPMG network of independent member firms affiliated with KPMG International Cooperative (“KPMG International”), a Swiss entity. All rights reserved. Printed in the U.S.A. The KPMG name, logo and “cutting through complexity” are registered trademarks or trademarks of KPMG International. NDPPS 302664
Step 2: Assess current-state assets for HBE and IES against federal requirements

The next step supports the HHS requirement that before applying for federal exchange funding, a state must first have performed a gap analysis on its existing IT assets to determine whether it has reusable assets to meet state HHS modernization and SBM requirements. Also, since an SBM is a new capability within the health insurance market, and since many legacy HHS systems are based on obsolete technology, most states must look to the IT market for potential modernization solutions and must analyze IT design options. It became apparent in our work with states that tools designed expressly for this purpose are essential. Therefore, we incorporated federal guidance into KERA to enable both comparison of current-state system capabilities against federal requirements to identify gaps and rapid analysis of IT design options. The tool supports the following key roles:

- IT gap analysis tool to assess current systems
- “Vendor-fit” solution gap analysis tool to assess potential solutions available on the market including vendor solutions and other state-based solutions

Figure 2 below illustrates the logical software services reference model for an integrated state HHS enterprise. This model was developed based on the three federal reference architectures as well as our work in several states. A software services reference model identifies the set of the software components and services needed to enable SBM operations or integrated eligibility operations.
Additionally, a gap analysis tool can help states assess the reusability of their IT assets by comparing existing physical IT assets to the logical business and technical components in the integrated HHS component model. The tool will need to be flexible so that it can be configured to the scope of a given state’s modernization effort: integrated eligibility, SBM, or both.

Finally, states need to use a vendor-fit gap analysis tool to help assess suitability of software vendor products—(at the physical level)—against the specified business and technical components in the integrated HHS component model—(at the logical level.) This tool can also be used to support development of requests for information (RFIs) and requests for proposals (RFPs) as states procure their systems. Moreover, preloading the gap analysis tools with the appropriate scope of requirements helps ensure that state IT staff can produce target physical design options for modernization systems, based on reuse of existing assets, deployment of vendor offerings, or both. In summary, the tools help ensure that these design options are aligned with federal guidance and can be produced rapidly and consistently.

**Step 3: Define high-level HBE and IES business and system requirements**

The next step is to define SBM and IES business and system requirements. Leading practices and our experience in working with many states on their SBM and HHS systems have shown the importance of developing requirements traceability matrices (RTMs) that align with federal requirements. A traceability matrix lists a set of requirements that identifies the automation support required by one or more programs such as the SBM, Medicaid, SNAP, or TANF. These requirements are maintained in matrix format to help programs manage their requirements at the procurement, contracting, and testing stages.

For example, for the states we have worked with:

1. Business requirements matrices are aligned with the business process and information models from MITA, NHSIA, and the ERA.

2. Technical requirements are aligned with the Medicaid Seven Conditions and Standards as well as MITA, NHSIA, and ERA technical specifications and standards.

These matrices accelerate the development of RFIs, RFPs, contracts, and test plans by providing a thorough and federally aligned set of requirements that program managers can review for applicability to their states’ circumstances. A thorough and detailed requirements matrix for a given state program can take several months to develop from scratch, review with subject-matter experts, achieve sign-off, and only then align with federal guidance. With RTMs, that are aligned to the comprehensive federal architectures a program manager can reduce the effort to a few weeks.

**Step 4: Estimate project costs (exchange, Medicaid, and other HHS programs) and develop funding requests**

Step 4 includes the estimation of project costs associated with the exchange, Medicaid, and other HHS programs based on exchange funding FFP and enhanced FFP available for IES systems. Once the project costs are estimated, a state can request funding via a Level 2 Exchange Establishment Grant for the SBM-attributable portion of the request and an Expedited Advance Planning Document (EAPD) for the Medicaid- and CHIP-attributable portions to receive the enhanced FFP described earlier.

Modernization project executives must be able to produce reasonably accurate cost estimates and a high-level road map of the IT implementation project to establish their operations within the aggressive funding timing windows. Once the functional complexity of the IT system that an exchange project requires is understood, KPMG’s HHS modernization experience has demonstrated the value of applying a tool aligned with the federal reference architecture guidance to estimate both implementation costs and operations and maintenance (O&M) costs and then schedule an IT implementation road map. At the same time, how much of the total cost of SBM implementation is eligible for establishment grant funding and what portion is attributable to Medicaid, CHIP, and other state HHS programs will need to be determined.

The “cost modeling” tool focuses on three key variables to estimate design, development, and implementation (DDI) costs:

- Functional complexity, as measured by the number of function points
- Productivity factors of the implementation strategy, including a reuse strategy, as measured by days of effort per function point
- Resource mix, as measured by percentage of internal versus external resources and blended cost of each

Again, leading practices and our experience in working with states on DDI cost estimating have shown the value of the cost modeling tool, including additional algorithms to estimate business and IT staff time spent on project management, procurement, and user acceptance testing. We have also found it most beneficial for the cost model tool to be prepopulated with a number of assumptions that shape the road map and resulting cost estimates for a given state. The value of using such a tool has been confirmed through various approved Level 2 Exchange Establishment Grants, EAPD budgets, and subsequent CMS/CCIIO gate review discussions.

11 CMS’s Seven Conditions and Standards include the incorporation of the following conditions: Modularity, MITA alignment, industry standards, leverage and reuse of existing assets, business results achievement, reporting, and interoperability.
For example, to calculate the total portion of the budget to be allocated to FFP versus SBM funding, the KERA cost allocation tool analyzes three key factors:

- The population of users who would be accessing Medicaid or human services directly rather than through the SBM
- The software functions that would be used uniquely by Medicaid, human services, the SBM, or shared by multiple programs
- The function point count for shared functions versus program-specific functions.

Using these factors, the tool computes the percentage of overall IT implementation costs that should be allocated to an exchange Establishment Grant (100 percent) versus the enhanced FFP associated with the non-SBM areas. Moreover, preloading the cost model and cost allocation tools with exchange content helps ensure that states can produce—with a matter of a few days or weeks—DDI schedules, estimates, and cost allocations that are highly defensible. The tools help confirm that these estimates and allocations are aligned with federal guidance and can be produced rapidly and consistently from one state to another to generate defensible estimates and plans.

**Step 5: Develop detailed business operating and system designs**

Once funding submissions have been approved, and CMS has accepted the SBM approach and strategies, the state must begin to articulate the details of how it will put the high-level designs into practice. For a system integrator to be successful at implementing the desired solution, whether it is leveraging an existing system or not, it will require detailed design documents that explain how the business and system requirements of the state will be implemented.

At the detailed level, this will include clearly articulating organizational accountabilities, establishing business operating policies and protocols, developing business process work flows, and establishing expected automation boundaries for each of the in-scope systems that will be required to meet the business needs.

Documenting a target technical architecture and the detailed system designs necessary is then essential to support an implementation that will meet a state’s needs and expectations.

This requires a gap analysis of current state against the target architecture and a road map of technical initiatives necessary to implement the changes. These requirements are used for a number of critical tasks that support the overall effort, including:

1. Selection and procurement of a software solution
2. Development of a statement of work for a systems integrator
3. Input to detailed design and development work of the integrator
4. Development and implementation of user acceptance test plans.

**Step 6: Complete development, test case, and deployment planning**

The issues and risks of development, testing, and deployment of an SBM solution do not differ significantly from those associated with any complex system. Each individual business component is complicated in its own right, and all must operate together to respond to a wide array of application and enrollment scenarios. As such, comprehensive documentation is a critical success factor to be able to trace expected outcomes through each component of an SBM solution.

Reusable applicant and client scenarios need to be associated with the state’s technical architecture to develop a detailed plan for designing, developing, testing, and implementing each software release throughout the system development life cycle (SDLC). Fortunately, there is a high degree of similarity between use cases, test cases, and deployment plans between states, and therefore, a large percentage of reuse is possible.

For example, development plans for various technology platforms have already been stress tested through the implementations of other states. These can be improved upon based on their experiences. Plus, since multiple states have already considered the variety of challenges in determining eligibility for Modified Adjusted Gross Income (MAGI) Medicaid and APTC, testing scenarios that represent these complexities are available and would require a relatively small percentage of adaptation to accommodate differences in state-based rules.
Timing and complexity

IESs and SBMs are large and complex in their own right. States can expect to invest $50 to $100 million or more for each exchange system. Additionally, the implementation of an IES can cost up to $150 to $300 million in related IT investment projects and could normally take a state 5 to 10 years to complete. However, the time-limited exception window to take advantage of the special federal funding is closing fast:

1. Submissions for SBM funding will no longer be accepted with the November 15, 2014 deadline having passed.
2. When considering timing alternatives, establishing their project time lines, and hiring appropriate resourcing states will need to evaluate whether they expect to target open enrollment for 2016 or 2017.

The federal government suggests that states use a phased approach to their modernization efforts, such that once the healthcare components of the eligibility determination system are operational, they can then add the additional requirements necessary to include the other federally funded HHS programs such as SNAP or TANF.12

For states that chose to implement an SBM in the first wave for October 1, 2013 operation, timing from visioning to implementation took between 18 and 36 months to be ready for “Day 1.” However, none of the implemented SBMs were stable or achieved all expectations by October 1. All exchanges were released with significant gaps in capabilities. It is therefore estimated that the full time frame should incorporate an additional nine months, expanding the total time to 27 to 45 months.

We believe that any state that chooses to undertake implementation of an SBM at this time will experience a late-mover advantage by incorporating all the learning, designs, plans, and potentially even the software tools of the initial implementers. States wishing to implement an SBM can leverage an existing solution developed by another state or a vendor.

Compliance with federal guidance

In order for CMS to begin a dialogue on the establishment of an SBM, states must have been given the authority to create the exchange under an appropriate state mandate, including an appropriate governance structure to oversee and have accountability for it.

To leverage Medicaid-enhanced FFP and SBM establishment grant funding, a state requires a mandate empowering the documentation of requirements that meet federal standards and guidelines. These mandatory federal standards and guidelines include:

1. The Medicaid Seven Conditions and Standards
2. Alignment with federal reference architectures: MITA and ERA. Where integration with other HHS programs is planned, alignment with NHSIA will also be encouraged.

In order to support these federal standards, CMS and CCIIO require all SBM states to pass a series of gate reviews to demonstrate alignment of their designs and plans. In order to pass these reviews, the first wave of SBM implementations relied almost exclusively on architecture guidance published by CMS, which included detailed work flows and use cases for a number of requirements, including such processes as MAGI, screening, and eligibility information verification from a federal data hub. However, new SBM states have access to all approved documentation from each state through CMS’s Collaborative Application Lifecycle Management Tool (CALT), which was established to promote reuse.

Implementation strategies

FFM states may choose not to move entirely to an SBM in one jump, but may instead look at developing customer assistance capabilities as an interim step on the way to SBM adoption. To fast-track either a new SBM implementation or to a partnership, each FFM state has two viable alternatives for developing their business and technical capabilities:

12 States which adopted the FFM model were provided the option of having the FFM determine Medicaid eligibility (determination states), or have the FFM provide a finding of potential eligibility (assessment states) with the states retaining the final determination decision.
**New development** – States could select one of the primary vendors who have experience working with current SBM states, and who best address their business and system requirements. It is assumed that such solutions have been adapted to overcome initial issues, and will need to be further customized to address state-specific operations.

**Existing solution reuse** – One of CMS’s fundamental principles is to encourage reuse of developed tools. This can be interpreted as anything from taking an instance of individual components of an SBM, to having individual states partner to share tools and operations of SBM capabilities.

**SBM and IES planning requirements**

To leverage enhanced funding for IES modernization initiatives and exchange funding, each state must provide evidence that it has performed appropriate assessment, design, planning, and estimating work, including:

- Assessing the potential for reuse of its existing IT assets
- Defining clear business and IT blueprints for the architecture of its system
- Developing a road map for the overall implementation horizon
- Creating a defensible estimate of business and IT costs
- Allocating costs appropriately to federal funding sources, based on the exchange, Medicaid, and other HHS programs.

The high-level blueprint, road map, and estimating phase of a large IT-enabled transformation initiative typically takes several months to execute. As noted earlier, the availability period of the federal funding requires human services agency managers and their program partners to execute this work in a very aggressive time frame. This requires an approach that can help expedite the process, while ensuring that planning is credible and meets the needs of the state and the federal government.
Final thoughts

States still have a unique window of opportunity to modernize and integrate their ACA compliance strategy with the determination of their citizens’ eligibility for social services programs. By leveraging available federal funding for HHS modernization, states can truly transform their operations to be more effective and efficient. However, even with the recent extension of enhanced funding and the cost allocation waiver, the time available to take advantage of these funding opportunities must be used efficiently. As such, states wishing to benefit from this opportunity must act quickly and “fast-track” several of the required planning and analysis steps in order to create effective and defensible blueprint and funding request documents that serve as solid foundations for the eventual deployment of a “no wrong door” approach to providing social services.

Our experience in working with states already on this journey shows that by following the approach outlined in this white paper, the time needed to complete many of the planning and implementation activities required by the federal government and important to successful projects can be reduced as much as 50 to 70 percent, which is critical at this juncture. To expedite the planning, analysis, and grant/EAPD development steps, states can benefit from a “battlefield-tested” approach, including established tools and experience in successfully navigating such projects.
Proposal to serve True, Inc.
Contact us

Paul Hencoski  
Principal  
U.S. Lead Partner – Health and Human Services  
Global Chair – Human and Social Services  
212-872-3131  
phencoski@kpmg.com

Harvey Levin  
Lead Director  
Health and Human Services  
Domain & Health Benefit Exchanges  
401-225-4832  
hblevin@kpmg.com

Vince Vienneau  
Lead Director  
KPMG Enterprise Reference Architecture (KERA)  
617-515-6464  
vovienneau@kpmg.com

David Pondillo  
Lead Director  
Integrated Eligibility  
518-427-4705  
dpondillo@kpmg.com

This white paper was developed by the KPMG Government Institute in conjunction with KPMG’s Global Human & Social Services Center of Excellence.

About the KPMG Government Institute

The KPMG Government Institute was established to serve as a strategic resource for government at all levels, and also for higher education and nonprofit entities seeking to achieve high standards of accountability, transparency, and performance. The Institute is a forum for ideas, a place to share leading practices, and a source of thought leadership to help governments address difficult challenges, such as effective performance management, regulatory compliance, and fully leveraging technology.

For more information, visit us at www.kpmginstitutes.com/government-institute/.

Jeffrey C. Steinhoff  
Executive Director  
703-286-8710  
jsteinhoff@kpmg.com