

State of Vermont Department of Vermont Health Access

Health Care Reform Division

Health Benefits Exchange Planning and Implementation Proposal

Submitted by



University of
Massachusetts
UMASS Medical School

Requisition Number: 03410-103-12
November 30, 2011

333 South Street
Shrewsbury, MA 01545-2732
commed.umassmed.edu

DEPARTMENT OF VERMONT HEALTH ACCESS

APPLICANT INFORMATION SHEET

(To be included in the proposal packet)

**NOTE: This information sheet must be included as the cover sheet of the application being submitted. Be sure to complete this form in its entirety. Please fill out and attach a fw-9 to this form signed by the duly appointed signing official for your company.

Applicant Organization: University of Massachusetts Medical School
Contact Person: Judith Fleisher, M.M.H.S.
Title: Director, Grant Management and Program Development, UMass CHCF
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E-mail Address: Judith.Fleisher@umassmed.edu
Fiscal Agent (Organization Name): UMass - Commonwealth Medicine (CWM) Finance
FY Starts: July 1 FY Ends: June 30
Financial Contact Person: Ronald Beattie, Chief Financial Officer
Mailing Address: 333 South Street
Town, State, ZIP: Shrewsbury, MA 01545
Telephone: 508-856-1612 Fax #: 508-856-6100
E-mail Address: Ronald.Beattie@umassmed.edu
Federal Tax ID Number: 04-3167352

Whom should we contact if we have questions about this application?

Name Judith Fleisher Phone Number 617-886-8132

**Request for Taxpayer
 Identification Number and Certification**

Completed form should be given to the requesting department or the department you are currently doing business with.

Please print or type

Name (List legal name, if joint names, list first & circle the name of the person whose TIN you enter in Part I-See Specific Instruction on page 2)
 University of Massachusetts, Worcester

Business name, if different from above. (See Specific Instruction on page 2)

Check the appropriate box: Individual/Sole proprietor Corporation Partnership Other Exempt Payee-Section 115

Legal Address: number, street, and apt. or suite no.
 55 Lake Ave North

Remittance Address: if different from legal address number, street, and apt. or suite no.

City, state and ZIP code
 Worcester, MA 01655

City, state and ZIP code

Phone # () Fax # () Email address:

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instruction on page 2. For other entities, it is your employer identification number (EIN). If you do not have a number, see How to get a TIN on page 2.
 Note: If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.

Social security number
 OR
 Employer identification number
04-3167352
 DUNS
603847393

Vendors:
 Dunn and Bradstreet Universal Numbering System (DUNS)

Part II Certification

Under penalties of perjury, I certify that:

- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Services (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
- I am an U.S. person (including an U.S. resident alien).
- I am currently a Commonwealth of Massachusetts's state employee: (check one): No Yes If yes, in compliance with the State Ethics Commission requirements.

Certification instructions: You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply.

Sign Here **Authorized Signature** *Harvey E. Doral* **Date** *11/9/11*

Purpose of Form

A person who is required to file an information return with the IRS must get your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to give your correct TIN to the person requesting it (the requester) and, when applicable, to:

- Certify the TIN you are giving is correct (or you are waiting for a number to be issued).
- Certify you are not subject to backup withholding

If you are a foreign person, use the appropriate Form W-8. See Pub 515, Withholding of Tax on Nonresident Aliens and Foreign Corporations.

What is backup withholding? Persons making certain payments to you must withhold a designated percentage, currently 28% and pay to the IRS of such payments under certain

conditions. This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

If you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return, payments you receive will not be subject to backup withholding. **Payments you receive will be subject to backup withholding if:**

- You do not furnish your TIN to the requester, or
- You do not certify your TIN when required (see the Part II instructions on page 2 for details), or
- The IRS tells the requester that you furnished an incorrect TIN, or
- The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the Part II instructions on page 2.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

November 30, 2011

Jason Elledge
Grants Management Specialist
Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, VT 05495

RE: Requisition Number 03410-103-12 — Health Benefits Exchange Planning and Implementation

Dear Mr. Elledge,

The University of Massachusetts Medical School (UMass) is pleased to submit this proposal in response to your Request for Proposals for Health Benefits Exchange Planning and Implementation, Requisition Number 03410-103-12.

UMass has joined forces with the Georgetown University Health Policy Institute, UHealthSolutions, Small Business Service Bureau, KSE Partners, NovaRest Inc., the University of Vermont College of Medicine Area Health Education Center (AHEC) Program Office, and the state's three regional AHECs to provide the State with the resources needed for this crucial second year of Exchange planning and implementation. Together, our Exchange Team brings the expertise necessary to assist the State in all eight sections outlined in the RFP, and to ensure that all operational deadlines will be met.

The Project Leader for the Vermont Exchange Team is Judith Fleisher, M.M.H.S., Director of Program Development at UMass Medical School's Center for Health Care Financing. Judith brings 15 years of experience in Medicaid and Medicare programs, nine years of experience in client management, and project lead experience working with the states of Vermont, Massachusetts, New York, Pennsylvania, and Maine.

As per the RFP, we have included the following in our proposal submission:

- Four identical hard copies of the program proposal and one copy on CD
 - Information from the bidder
 - Quality of bidder's experience
 - Bidder's capacity to perform
 - Technical proposal/proposal specifications
 - Response to all eight sections in program specifications/scope of work
 - Program costs and budget
 - All required forms
 - Resumes of key staff
 - Appendices that include sample work

I hereby certify, by my signature below, that I am an official authorized to bind UMass to a contract. Please see the attachment to this letter for identifying information about our organization and subcontractors, as well as our request for alternative contract language.

If additional information is required, please contact:

Judith Fleisher, Director of Program Development

Phone: 617-886-8029

Email: Judith.Fleisher@umassmed.edu

Thank you for this opportunity to submit our proposal. We look forward to the prospect of providing the requested services to the Department of Vermont Health Access. We are confident that the Vermont Exchange Team can help the State build on the significant progress it has already made — and ensure that high-quality, affordable, and easy-to-access health care continues to be provided to all Vermont residents.

Sincerely,

A handwritten signature in cursive script that reads "Thomas Manning".

Thomas D. Manning, M.A., CAGS
Deputy Chancellor, Commonwealth Medicine
University of Massachusetts Medical School

Organization and Subcontractor Information

University of Massachusetts Medical School
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Judith Fleisher, M.M.H.S., Project Leader, Phone: 617-886-8029
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Organization type: Higher education, health care consulting

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Organization type: Higher education, health care consulting

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Organization type: Business outsourcing services

Small Business Service Bureau
Lisa Carroll, M.S., M.P.H., R.N., President
554 Main Street
Worcester, MA 01608
Phone: 508-770-0195
Organization type: Health care consulting

KSE Partners, LLP
Kevin Ellis, Partner
26 State Street, Suite 8
Montpelier, VT 05602-2943
Phone: 802-229-4900 x107
Organization type: Communications firm

NovaRest
Donna Novak, Principal
156 West Calle Guija
Sahuarita, AZ 85629
Phone: 520-908-7246
Organization type: Actuarial firm

UVM College of Medicine AHEC Program Office
Denis Barton, M.A., M.B.A., Director
1 South Prospect Street, Arnold 5
Burlington, VT 05401
Phone: 802-656-0030
Organization type: Health care outreach and education

Alternative Contract Language

In reviewing the “Contract Development” section of the Request for Proposal beginning on page 10, the University of Massachusetts Medical School would like to negotiate the following alternative contract language if awarded the contract.

Attachment C — Customary Provisions For Contracts And Grants, Item 6, p. 11 Independence, Liability

The University of Massachusetts Medical School is solely responsible for the performance of its obligations under this agreement and for any negligence, willful misconduct, or willful, wanton or reckless failure by its agents, employees, or independent contractors engaged in the performance of the obligations under this agreement. However, as a public entity, UMass cannot indemnify the State of Vermont, Department of Health Access, as we are prohibited from pledging the credit of the Commonwealth without a two-thirds vote of the Massachusetts Legislature, per Article 62 of the Massachusetts Constitution, as amended. The Massachusetts courts have construed statutory authorizations for public entities to enter into contracts as not authorizing indemnity clauses. *Lovering v. Beaudette*, 30 Mass.App.Ct. 665, 669 (1991); *Raisman v. Cunningham, Inc.*, Civil Action No. 93-5070-G (Super. Ct. 1995).

Attachment F — Agency of Human Services’ Customary Contract Provisions, Item 10, pp. 21-22

Intellectual Property/Work Product Ownership

All reports and documents submitted to the State by the University of Massachusetts Medical School (UMass) under the Contract (collectively, the “Work Product”) shall become the sole property of Vermont, and UMass hereby assigns to Vermont its copyright and any other intellectual property rights it has in such Work Product. UMass is the owner of all rights, title, and interest in and to any intellectual property developed by the University or its subcontractors prior to or independently of the Contract, or as a general purpose consulting tool for their use in performing the services hereunder, which may include algorithms, formulae, methodologies, and know-how (collectively, the “UMass Property”). To the extent that UMass Property is contained in any Work Product, UMass hereby grants to Vermont a fully paid, royalty-free, non-exclusive, non-transferable, worldwide, perpetual, assignable license to use, reproduce, distribute, modify, display, publicly perform, digitally perform, transmit, and create derivative works of such UMass Property included in the Work Product, but only to the extent necessary for Vermont to use the Work Product.

UMass shall be entitled to retain and keep a copy of reports submitted as part of the Work Product and consistent with the Contract. UMass shall only be permitted to disseminate such reports with the prior written approval of the State of Vermont.

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Quality of Experience

- *Bidder's current and past experience relevant to the tasks defined in the RFP, including descriptions of successful projects*
- *Appropriateness of references provided (Bidders must include at least three (3) business references, including the name and address of the organization and name, phone number, and email address of the project administrator most familiar with the bidder's performance)*
- *Experience working with Vermont and/or other state governments*

The University of Massachusetts Medical School (UMass) is pleased to submit this proposal for the State of Vermont's Department of Vermont Health Access's Health Benefits Exchange Planning and Implementation Request for Proposal (Requisition Number: 03410-103-12).

UMass recognizes the importance and complexity of planning and implementing a federally mandated American Health Benefits Exchange (the Exchange) in Vermont. We also understand that the State's approach to its Exchange is unique in that this Exchange is meant to serve a broader purpose. We appreciate that the State requires its Exchange to serve a majority of its residents by 2014 and to support the single-payer health care system that Vermont envisions.

To provide Vermont with what is needed for the second year of development, UMass has partnered with its business affiliate UHealthSolutions, Georgetown University's Health Policy Institute, Small Business Service Bureau, KSE Partners, NovaRest Inc., the University of Vermont College of Medicine Area Health Education Center (AHEC) Program Office, and Vermont's three regional AHECs to leverage our respective strengths and experiences to meet the State's short-term needs and long-term vision.

UMass Exchange Team Relevant Current and Past Experience

The UMass Exchange Team (the Exchange team) staff for this proposal will be led by UMass and its public health care consulting and operations division, Commonwealth Medicine. Commonwealth Medicine specializes in assisting state agencies and nonprofit health and human services providers in developing, implementing, evaluating, and operating their programs. With the experience and expertise of Commonwealth Medicine, UMass has served agencies in every New England state, including Vermont, and in a growing number of states outside of New England.

As a public institution, our mission is public service. Our approach is to build flexible, task-oriented service lines that cover a broad range of skills and knowledge necessary to administer programs that serve the public. UMass draws staff from both the public and private sectors, combining the advantages of each. We also leverage our position as an academic health sciences center at the forefront of health care delivery, informatics, and policy formulation.

UMass organized the New England states' coalition that recently was awarded the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), Center for Consumer Information and Insurance Oversight's (CCIIO) Early Innovator

1. INFORMATION FROM THE BIDDER

Cooperative Agreement grant, which funds the New England States Collaborative for Insurance Exchange Systems (NESCIES) project. As part of the grant, UMass has been working with Vermont and other New England states to create exchange technology components that meet the goals and requirements of the Affordable Care Act (ACA). The NESCIES project has made substantial progress. Our state partners are at an advanced readiness stage to meet ACA requirements and serve their health care marketplaces. UMass also participated in the development of the State of Massachusetts' 2006 universal health coverage law, particularly in the development of the Health Connector — the State's insurance exchange. These experiences have made us intimately familiar with the implementation, structure, and operations of state exchanges and an ideal partner for the State of Vermont.

UHealthSolutions is a nonprofit division of UMass that specializes in providing operational supports to health and human services agencies and providers. Among its key assets is a full-service call center that ministers to a number of public health programs. UHealthSolutions will set-up and staff the Vermont Exchange.

Georgetown University's Health Policy Institute (Georgetown) has worked extensively with state and federal agencies, state legislatures, Congress, and diverse stakeholders — including advocacy groups, employers, insurers, providers, and other key constituencies. This experience will assist Vermont in assessing options for the Exchange that reflect the State's goals for universal coverage, its marketplace, and the needs of its citizens.

Small Business Service Bureau (SBSB) brings a wealth of knowledge of state-sponsored health insurance. SBSB has a strong track record in implementing both public- and private-sector health care solutions, including experience in implementing integrated call centers and internet technology in high-security environments and under tight timelines. For over 30 years, SBSB cosponsored a group health insurance program for Vermont small employers with Blue Cross Blue Shield of Vermont.

Located in Montpelier, **KSE Partners** is a strategic communications firm that will provide stakeholder consultation, outreach, and education. KSE brings an intimate knowledge of Vermont and is an expert in facilitating outreach in a variety of rural and urban settings. Since 1987, KSE has been Vermont's leading communications firm for getting important information to targeted audiences.

The **University of Vermont College of Medicine (UVM-CM) Area Health Education Centers (AHEC) program** is a network of community and academic partners working through three AHECs and a central office at UVM-CM. The three AHECs cover the entire State of Vermont and possess a unique understanding of Vermont's health care and educational communities. The Vermont AHECs are crucial to our Exchange team for training expertise, outreach capacity, and connections with local health care systems.

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NovaRest, Inc., provides actuarial and management consulting services for state and federal insurance regulators. It will analyze the impact of the Exchange on the State's markets for health insurance and health care.

Experience Working With Vermont and State Governments

Taken together, our Exchange team has significant experience working in Vermont and other states. Every member of our team has extensive expertise working in or for the public sector.

For over 20 years, UMass has worked on projects large and small with state agencies in Vermont and other New England states — and also nationally. These partnerships have all had productive outcomes. In Vermont, UMass worked with Vermont Medicaid to capture unclaimed revenues. Through its New England Newborn Screening Program, UMass screens over 6,000 babies annually in Vermont. UMass has worked with the State to create legislation for pharmacy savings, and helped Vermont create a comprehensive Preferred Drug List program. This program helped the State dramatically reduce pharmacy expenditures and realize over \$7 million annually in supplemental rebate earnings.

Below are some examples of successful projects and service offerings in Vermont and other states.

Our Experience in Vermont

- **Clinical Pharmacy Services in Vermont**

In partnership with MedMetrics Health Partners, UMass has provided full-service clinical support for Vermont's publicly funded pharmacy programs since 2005. Over this period, Vermont has experienced the following:

- Expansion of the State's Preferred Drug List program by more than 80 percent
- Enhancement of the State's clinical pharmacy initiatives
- Substantial increase in the State's generic utilization rates
- Supplemental rebate earnings of over \$7 million annually since 2009
- Highly successful Specialty Drug Management and Diabetic Supply Management programs
- Collaboration on numerous legislative, regulatory, benefit design, and medical management issues

- **Vermont School-Based Claiming Services**

In October 2006, UMass assisted the State of Vermont in amending its existing school-based administrative activity time-study and claiming methodologies. Prior to this initiative, both the State and local school districts had realized very low revenue compared to the actual expenditures incurred because of low participation by the schools and a claiming methodology that did not account for all allowable costs. UMass prepared an appropriate Cost Allocation Plan, developed an effective administrative claiming methodology, and prepared time-study and claiming manuals to ensure compliance with CMS regulations and to minimize administrative burdens on providers. To date, over \$9

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million in federal revenue has been realized.

In May 2007, UMass implemented a web-based reporting system for school nurses for completing and filing screening and immunization reports. This system is user-friendly, making reporting much easier for school nurses. Data collection is streamlined through an online application that allows regional liaisons to monitor the progress of their districts and to troubleshoot any questions or issues that may arise. As a result, Vermont schools have realized the following revenue:

- FY 09: \$2.8 million
 - FY 10: \$4.1 million
 - FY 11: \$3.4 million to date
- **Vermont Newborn Screening**
The UMass New England Newborn Screening Program has a 22-year track record of successfully providing newborn screening services to the State of Vermont. UMass has long been a leader in the development, evaluation, and application of new technologies for public health screening. UMass provides newborn screening services to approximately 6,000 newborns annually in the state of Vermont, 74,000 in Massachusetts, 13,000 in New Hampshire, 12,000 in Rhode Island, and 12,500 in Maine.

Health Insurance Exchange Planning and Implementation

As part of the NESCIES project, UMass is leading an Interstate Collaborative Steering Committee, which is comprised of representatives from Connecticut, Massachusetts, Maine, New Hampshire, Rhode Island, and Vermont. The Interstate Collaborative Steering Committee will provide guidance and feedback to the Massachusetts Exchange development team to ensure that health insurance exchange components being developed for Massachusetts are consumer-friendly and cost-effective. An important goal is for these components to be available for adoption by other New England states, and nationally, so that states can make efficient use of resources as they develop their own exchanges. Currently, with an eye to making them serviceable for Vermont, UMass is developing a memorandum of understanding with Vermont to elicit its participation as an advisor on the Massachusetts systems integrator vendor procurement and the initial Massachusetts design of new systems to support the Health Connector.

Our partner SBSB has worked with the Commonwealth Health Insurance Connector Authority in Massachusetts to develop and administer the Commonwealth Choice program, the Connector's non-subsidized insurance products, and to guide sales and enrollment for the State's uninsured population.

Health Care System Reform

The Exchange team has comprehensive experience working with states to implement health system reform and complex public policies. Collectively and individually, team members have been leaders in the development and implementation of innovative health care system projects in the public sector and have extensive experience partnering with state agencies to provide

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technical support and assistance. Our services include payment and financing strategies, policy and program design, stakeholder engagement, and legal analysis.

- **Connecticut:** UMass provided staff support, research, and analysis to the Sustinet Board of Directors and its Advisory Committees and Task Forces, in collaboration with Anya Rader Wallack, when Connecticut was exploring whether to launch a public option health plan that would be available through the State's health insurance exchange.
- **Georgia:** Georgetown helped the State of Georgia implement its HIPAA access solution. This involved modeling the market impact and estimating the needed funding.
- **Illinois:** Georgetown worked with the State of Illinois to develop solutions to the problem of people being uninsured, by participating in a series of projects in the state, which included developing proposals and meeting with small employers throughout the state. Georgetown estimated the impact of various proposals on the market and implemented a third-share plan in St. Clare County.
- **Maine:** UMass worked closely with former Governor Baldacci's Office of Health Policy & Finance to plan implementation of the Affordable Care Act and assess its impact on Maine's policies and laws.
- **Massachusetts:** UMass played an integral role in crafting legislation that supported the State's health care reform transformation. Most recently, UMass developed a report, in partnership with the Blue Cross Blue Shield Foundation, that examines how national health care reform impacts Massachusetts.

UMass also manages the Massachusetts Health Care Training Forum (MTF) — quarterly meetings in five regions of the state — to provide accurate and timely information on the Massachusetts Medicaid Program (MassHealth), Commonwealth Care, and other public assistance programs to staff of health care organizations and community agencies. UMass also manages the Executive Office of Health and Human Services (EOHHS) outreach grant program that funds over 50 community-based agencies' efforts to promote health care reform outreach and enrollment across the Commonwealth.

- **New Hampshire:** UMass legal and financial policy experts have advised New Hampshire legislators, administrators, researchers and advocates on a broad range of health reform topics, including: uncompensated care policy, financing for hospital charity care, Medicaid and the Disproportionate Share Hospital program, options for expanded health access, eligibility for disability benefits and state responsibilities under the ACA.
- **South Carolina:** Georgetown helped the State of South Carolina develop potential solutions to its uninsured problems by conducting a series of meetings with stakeholders and by estimating the market impact of alternative proposals.
- **Multi-state Initiative:** Georgetown currently works with 10 states under a Robert Wood

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Johnson Foundation grant to assist with ACA insurance market-related implementation, including exchanges. The 10 states are Alabama, Colorado, Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island, and Virginia. The state teams include insurance commissioners and staff, Medicaid directors and staff, Governors' office staff, exchange directors, IT officers, and other state government officials. This work includes substantive, technical, and strategic hands-on assistance. Like Vermont, these states are grappling with common implementation issues and policy questions around exchanges, market reforms, and opportunities under the ACA for achieving universal coverage.

- **National Governors Association:** UMass provided findings and recommendations in two reports that reviewed health information technology and exchange policies.
- **National Academy of Social Insurance State Exchange Toolkit:** Georgetown contributed to core provisions of a model state law for establishing state insurance exchanges that comply with ACA. They also authored a paper evaluating options for exchanges to engage in active purchasing on behalf of consumers and small businesses.
- **HHS Center for Consumer Information and Insurance Oversight (CCIIO):** Georgetown conducted research into state regulation and law on coverage sold through associations. Georgetown also reviewed state laws regulating the sale of stop-loss insurance.
- **Robert Wood Johnson Foundation:** Georgetown is currently conducting a qualitative evaluation of private health insurance reforms as they are implemented in states participating in the Foundation's State Health Reform Assistance Network. The Foundation also provides support for an issue-brief series on topics related to implementation of the ACA, including an in-depth evaluation of state-based health insurance exchanges.
- **American Cancer Society Cancer Action Network:** Georgetown drafted a series of issue briefs on private insurance reforms under the ACA, with particular attention on the impact on cancer patients and survivors.

Insurance Administration

The Exchange team has considerable experience with insurance regulation and the insurance industry. Projects include:

- **Massachusetts Commonwealth Connector Authority:** SBSB is the sub-connector (third-party administrator) for the Commonwealth Choice program. Since 2007, SBSB has performed all exchange sales, service, billing, enrollment administration, and web development for non-subsidized individuals and small employers.

Medicare Buy-in Program: UMass manages the day-to-day operation of the Medicare Buy-in Program. In this capacity, UMass assisted in the design and development of the

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systems interface and data exchanges between the Social Security Administration and CMS. Massachusetts is a leader in ensuring that all eligible individuals are identified for Medicare Buy-in and that the corresponding premium payments are accurately billed by CMS to the state.

- **Massachusetts Insurance Partnership Program:** SBSB participated in the development and implementation of the Department of Medical Security Phase-in Initiative for this health insurance subsidy program for low-income workers; this project included developing an employer billing system that collects and applies premium payments from multiple sources for a single employee.

UMass manages the Insurance Partnership program on behalf of MassHealth. In this role, UMass manages the operational contractor, Employee Benefit Resources, monitors all aspects of the program for compliance with policies and procedures, and makes recommendations to MassHealth regarding program improvements.

- **Massachusetts Premium Assistance Programs:** UMass manages various premium assistance programs on behalf of MassHealth that include reviewing employer-sponsored health insurance plans for basic benefit coverage level, determining the cost-effectiveness of paying the employee's share of the premium, and managing the payments issued to the member for their share of the premium. UMass manages a call center for members with questions regarding their premium assistance payments.
- **Massachusetts Prescription Advantage Program:** SBSB, in partnership with UHealthSolutions, supports the state-sponsored drug insurance plan. SBSB developed and operates an automated billing and eligibility system for the program.

References

Reference Name: Robin Callahan, Deputy Medicaid Director for Policy & Programs
Organization: Massachusetts Executive Office of Health and Human Services, Office of Medicaid
Address: One Ashburton Place, Boston, MA 02108
Phone Number: 617-573-1745
Email Address: Robin.Callahan@state.ma.us

Background: *UMass has several current and past engagements with the Massachusetts Office of Medicaid (MassHealth), including supporting MassHealth in designing the Massachusetts State Demonstration to Integrate Care for Dual Eligible Individuals, developing and implementing the Money Follows the Person Planning Grant and Demonstration, preparing CHIP and 1115 Demonstration annual reports, evaluating the 1115 Demonstration program, and managing the Massachusetts Health Care Training Forum.*

Reference Name: Scott Devonshire, Chief Information Officer
Organization: Commonwealth Connector Authority
Address: 110 City Hall Plaza, Boston, MA 02108
Phone Number: 617-933-3081
Email Address: Scott.Devonshire@state.ma.us

Background: *UMass is working closely with the Commonwealth Connector Authority as part of the NESCIES project to design, develop, and implement a new, state-of-the-art health insurance exchange and integrated eligibility system for Massachusetts health care programs.*

Reference Name: Nicholas A. Toumpas, Commissioner
Organization: New Hampshire Department of Health and Human Services
Address: 129 Pleasant Street, Concord, NH 03301
Phone Number: 603-271-4334
Email Address: ntoumpas@dhhs.state.nh.us

Background: *In addition to what UMass has done to address New Hampshire's financing of uncompensated care, UMass provided assistance in structuring an effective collaboration between DHHS and the University of New Hampshire. UMass also helped DHHS fulfill a court order to reduce a large backlog of disability determinations, and has since assumed ongoing responsibility for significant aspects of New Hampshire's disability determination operations.*

Reference Name: Kathleen A. Dunn, Medicaid Director
Organization: New Hampshire Department of Health and Human Services, Office of Medicaid Business and Policy
Address: 129 Pleasant Street, Concord, NH 03301

1. INFORMATION FROM THE BIDDER

Phone Number: 603-271-9421

Email Address: kdunn@dhhs.state.nh.us

Background: *For the last several years, UMass has advised the State of New Hampshire on reforming its uncompensated care financing system, has developed disproportionate share (DSH) payment methods, and analyzed DSH payment amounts.*

Reference Name: Lorez Meinhold, Policy Director Health, Human Services and Education

Organization: Colorado Office of Policy and Research, Governor John Hickenlooper

Address: 136 State Capitol, Denver, CO 80203-1792

Phone Number: 303-866-5856

Email Address: Lorez.Meinhold@state.co.us

Background: *Georgetown is providing ACA implementation assistance to Colorado's Division of Insurance (DOI) and the Governor's office. In addition to providing help with ACA and other federal law interpretation, the assistance to date has included working with state exchange staff, DOI, and the Governor's office to develop a plan of implementation for exchange functions. This includes identifying opportunities to leverage existing resources and opportunities for memorandums of understanding among state agencies. The work has also included an assessment of DOI's implementation initiatives and developing a draft implementation plan for DOI.*

Reference Name: Lee Goldberg, Director of Health Policy

Organization: National Academy of Social Insurance (NASI)

Address: 1776 Massachusetts Avenue, NW, Suite 400, Washington, DC 20036-1904

Phone Number: 202-243-7288

Email Address: lgoldberg@nasi.org

Background: *Georgetown served as a consultant to NASI in the development of a toolkit for states on health insurance exchanges. Georgetown provided guidance on core areas of focus in planning and establishing an exchange, and drafted several provisions of a model state law to establish an exchange. Georgetown also partnered with NASI to develop a paper outlining options for a state exchange to engage in active purchasing on behalf of enrollees.*

Reference Name: Stephen Finan, Policy Director

Organization: American Cancer Society-Cancer Action Network (ACS-CAN)

Address: 901 E Street, NW, Suite 500, Washington, DC 20004

Phone Number: 202-661-5780

Email Address: Stephen.finan@cancer.org

Background: *Georgetown has provided a range of services for ACS-CAN, including running a database to support case workers in their national call center, researching*

1. INFORMATION FROM THE BIDDER

private insurance issues as they affect cancer patients and survivors, and drafting issue briefs and reports on health policy issues.

Reference Name: Roni Mansur, Chief Operating Officer
Organization: Commonwealth Connector Authority
Address: 110 City Hall Plaza, Boston, MA 02108
Phone Number: 617-933-3039
Email Address: Roni.Mansur@state.ma.us

Background: *Since 2007, SBSB has performed web development services for online enrollment and rate quoting, premium billing, collection and account reconciliation, inbound/outbound call center services, and broker management for the Commonwealth Choice program, the Connector's non-subsidized insurance products.*

Reference Name: Eric Schultz, President and CEO
Organization: Harvard Pilgrim Health Care
Address: 93 Worcester Street, Wellesley, MA 02481
Phone Number: 617-509-6051/617-509-6053
Email Address: eric_schultz@harvardpilgrim.org

Background: *For over 25 years, SBSB and its affiliated companies have provided sales, service, enrollment, and renewal processing, as well as all back-office operational services for Harvard Pilgrim Health Care's small employer population in Massachusetts and New Hampshire.*

Reference Name: Dr. John J. Neuhauser, President
Organization: St. Michael's College
Address: Box 1, One Winooski Park, Colchester, VT 05439
Phone Number: 802-654-2212
Email Address: JNeuhauser@smcvt.edu

Background: *As a member of the SBSB Board of Directors from 2007 to 2010, Dr. Neuhauser continues to be an active consultant to the Board.*

Reference name: R. Neil Vance, Ph.D., FSA
Organization: New Jersey Department of Banking and Insurance
Address: 20 West State Street, PO Box 325, Trenton, NJ 08625
Phone Number: 609-292-5427 ext. 50338
Email Address: Neil.Vance@dobi.state.nj.us

Background: *NovaRest, Inc., helped New Jersey DOBI redesign its rate review system. This included interviewing stakeholders and designing standardized templates for data submission. NovaRest also wrote filing instruction manuals, which are currently being tested, as well as rate-review manuals. In December, NovaRest will train DOBI staff and will later train carriers in the new process.*

1. INFORMATION FROM THE BIDDER

Reference Name: Genevieve M. Martin, Assistant Attorney General

Organization: Rhode Island Department of Attorney General, Chief Insurance Advocacy Unit

Address: 150 South Main Street, Providence, RI 02903

Phone Number: 401-274-4400 ext. 2300

Email Address: GMartin@riag.ri.gov

Background: *NovaRest, Inc., conducted a thorough analysis of the individual rate filing of Blue Cross and Blue Shield of Rhode Island. This included preparing pre-hearing testimony, reviewing other expert pre-filed testimony and expert reports, preparing for the hearing, and preparing a post-hearing brief. This process was successful in reducing the requested rate increase of 8.1 percent to 1.9 percent.*

1. INFORMATION FROM THE BIDDER

Capacity to Perform

- *Organizational capacity of the bidder, including subcontractors, as evidenced by organizational charts and description of organizational size and/or back-up capacity.*
- *Quality of staff assigned to this project, including subcontractor staff, as presented in resumes of key project staff (cost proposal must estimate the number of hours each key person will devote to this project)*
- *Ability of bidder to meet project schedule*

Organizational Capacity

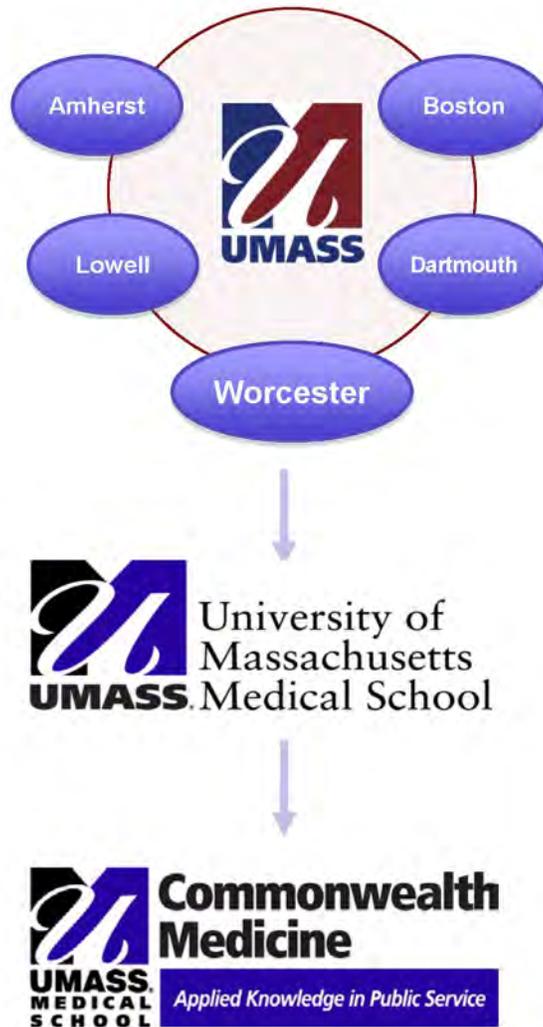
Our collaboration is strategic in its vision. Our team represents partners that not only have the immediate organizational capacity to undertake this important initiative, but also substantial institutional reserves to draw upon should backup be needed. Our regular work with states has given us the skills, the agility, and the culture of responsiveness necessary for fulfilling complex assignments from states. In other words, we are large enough to ensure the capacity for completing each task on time, and experienced and nimble enough to do it well.

UMass, the Team Lead, has over 6,800 employees. Home to Nobel Prize-winning research, UMass has a public service mission to improve health care delivery for the most vulnerable populations.

Commonwealth Medicine, the health care consulting and operations division of UMass, has over 1,600 employees and carries out the Medical School's public service mission by reaching beyond the traditional boundaries of academia to create innovative programs in administration, financing, clinical training, and policy research for public agencies and nonprofit providers.

1. INFORMATION FROM THE BIDDER

UMass Organizational Structure



The table on the following page demonstrates the organizational capacity and areas of expertise of the Exchange team.

1. INFORMATION FROM THE BIDDER

Organization/Capacity	Areas of Expertise
<p>UMass</p> <ul style="list-style-type: none"> • Over 6,800 employees; 1,600 within the Commonwealth Medicine division • Federal, private grants, and contracts exceeding \$200M • 20 state clients • Work in 22 countries 	<ul style="list-style-type: none"> • Health care reform • Health insurance exchanges • Health care financing • Health insurance and buy-in program administration • Health care policy and research • Pharmacy services
<p>UHealthSolutions</p> <ul style="list-style-type: none"> • Operational arm of UMass’s consulting division, Commonwealth Medicine • 140 employees • Offers services to six state government clients, over 20 municipalities in Massachusetts, and other public health, human services, and nonprofit organizations • Experience serving elderly, disabled, and underserved populations 	<ul style="list-style-type: none"> • Contact center services • Patient communications • Member education and outreach • Third-party administration • Operational consulting • Information technology
<p>Georgetown</p> <ul style="list-style-type: none"> • 5,000 employees • Federal, private grants and contracts exceeding \$240M • Experts working on this project focus with 10 state clients 	<ul style="list-style-type: none"> • Health care reform • Regulation of health insurance entities and products • Health insurance markets, including exchanges
<p>SBSB</p> <ul style="list-style-type: none"> • Sub-Connector for the Massachusetts Commonwealth Connector Authority since 2007 • Over 100 employees dedicated to health insurance exchange and intermediary operations • Dedicated web development team • 45-year history working with small employers and individuals • Operational center for several state-based health reform projects since 1986 	<ul style="list-style-type: none"> • SHOP exchange development and operations • Small employer and broker relations • Call center • Health insurance sales, service, and enrollment/billing operations • Health insurance carrier relationship management • Web portal development

1. INFORMATION FROM THE BIDDER

<p>KSE Partners</p> <ul style="list-style-type: none"> • 26 employees • 24 year history of work in Vermont • Provides single and multi-state public relations, government relations, communications, and multimedia marketing services 	<ul style="list-style-type: none"> • Strategic communications and government relations campaigns • Message development services • Strategic planning • Communications outreach and media planning • Event organizing services
<p>NovaRest, Inc.</p> <ul style="list-style-type: none"> • 7 employees • Federal, private contracts worth approximately \$1M • Current or previous work with 12 state government clients • Current or previous work in 20 states 	<ul style="list-style-type: none"> • Actuarial services, with a particular focus on health insurance
<p>Vermont AHECs</p> <ul style="list-style-type: none"> • 16.8 employees • Federal, state, private, and foundation grants and contracts, individual donors exceed \$2M • Southern Vermont AHEC works in Bennington, Rutland, Windham, and Windsor Counties of Vermont • Northeastern Vermont AHEC works in Caledonia, Essex, Lamoille, Orange, Orleans, and Washington • Champlain Valley AHEC works in Addison, Chittenden, Franklin, and Grand Isle 	<ul style="list-style-type: none"> • Primary health care workforce development • Health career exploration programming, workshops and summer learning experiences, for middle and high school students • Development and delivery of professional continuing education programs • Primary care statewide survey with 100 percent return rate • Annual outreach to all primary care practice sites in each region • Outreach to health and allied health professionals • Community needs assessments

Quality of Staff

The Exchange team recognizes the importance and complexity of the State's undertaking in planning for the design and implementation of its Exchange. When putting our team together, UMass assembled partners who recognize the State's unique strategy, understand the complexity involved, and appreciate the need to work closely and collaboratively with the State and its stakeholders.

The UMass Exchange Team

Resumes of project leads and biographies of all key staff members are included in the Biographies and Resumes section of this proposal.

Judith E. Fleisher, M.M.H.S.

UMass Exchange Team Project Lead

Ms. Fleisher will be the Project Lead for Vermont's Health Benefits Exchange Planning and Implementation initiative. Ms. Fleisher has over 16 years experience managing and directing projects that pertain to both the Medicaid and Medicare programs. Her areas of expertise include Medicaid eligibility policy and operations, with a focus on administrative simplification initiatives. Ms. Fleisher is currently the Senior Project Lead for the Robert Wood Johnson Foundation's Maximizing Enrollment Grant, which is in partnership with the Massachusetts Office of Medicaid (MassHealth). The objective of the Grant is to streamline policies and operations to ensure enrollment and retention in Medicaid, the Children's Health Insurance Program, and new or revised programs available under the Affordable Care Act. As part of this work, Ms. Fleisher developed a new streamlined annual review process for 13,500 elders residing in a nursing facility and 66,000 community elders, disabled adults, and children. She is also implementing an Express Lane Renewal process using SNAP (Food Stamps) data to renew Medicaid eligibility for 140,000 families. Ms. Fleisher is also a member of the Massachusetts Subsidized Insurance Workgroup, a subgroup of the Massachusetts interagency Affordable Care Act Implementation Task Force.

Prior to her current role, Ms. Fleisher managed benefit coordination projects for Massachusetts and led out-of-state provider recovery projects for Vermont, New York, Pennsylvania, and Maine. She also led an initiative and co-authored a report that documented insurance coverage, payment, and access issues for mental health services for elders in Massachusetts.

Prior to working at UMass, Ms. Fleisher directed business development initiatives related to State Pharmacy Assistance Programs, Medicare Part D, and Medicaid Managed Care pharmacy services. She also has five years in direct experience work for the Massachusetts Medicaid program. In this capacity, she oversaw provider relations and operations for the Commonwealth's Primary Care Case Management Program.

Jay S. Himmelstein, M.D., M.P.H.

Project Advisor

Dr. Himmelstein is a Professor of Family Medicine and Community Health, Quantitative Health

1. INFORMATION FROM THE BIDDER

Sciences and Internal Medicine at UMass. He also serves as Chief Health Policy Strategist at UMass and Senior Fellow in Health Policy for NORC at the University of Chicago, where he provides expertise in health information technology, health insurance exchange policy, public sector health delivery system reform, and state-based health care reform implementation. His professional career in research, policy development, and service is dedicated to improving health care and health outcomes for those served by the public sector.

Dr. Himmelstein leads the UMass Public Sector Health Information Technology and Exchange Policy Group. He is currently the Principal Investigator for the NESCIES project. He has been principal investigator on a number of other funded projects focusing on the potential for Medicaid and other human service programs to leverage investments in interoperable health information technology to improve outcomes and contain costs.

Dr. Himmelstein serves as a Senior Advisor to the Disability and Employment Policy Group for the UMass Center for Health Policy and Research and was the founding Director of Work Without Limits, a Massachusetts Disability Employment initiative — a \$21 million dollar grant through the Centers for Medicare and Medicaid Services. He is an elected member of the National Academy of Social Insurance and has served as an expert consultant the Social Security Administration, and to the Institute of Medicine, most recently as a member of the IOM Committee on Medical Evaluation of Veterans for Disability Compensation. He served as a Health Policy Fellow on the health staff of Senator Edward M. Kennedy from 1991 to 1992. Dr. Himmelstein serves on the editorial board of the *Journal of Occupational Rehabilitation* and has served an ad hoc reviewer for several peer reviewed journals including *Health Affairs*, the *Journal of the American Public Health Association*, the *Journal of the American Medical Association*, and *Health Care Finance and Review*. He currently serves on several nonprofit boards including the Massachusetts Health Care Policy Forum and the Health Foundation of Central Massachusetts.

During his career at UMass, Dr. Himmelstein has held numerous positions in research and academic administration including Director of the Occupational and Environmental Health Program (1988-1996), Robert Wood Johnson Foundation National Health Policy Fellow (1991-1992), Director of the Robert Wood Johnson Workers Compensation Health Initiative (1994-2000), Director of the Center for Health Policy and Research (1997-2007), Director of the Center for MassHealth Evaluation and Research (1997-2002), and Assistant Chancellor for Health Policy (1992-2007).

Dr. Himmelstein is board certified in internal medicine and occupational and environmental health/preventive medicine.

Michael Tutty, M.H.A., M.S.

Project Advisor

Mr. Tutty is the Director of the UMass Office of Community Programs (OCP) and the Project Director for the NESCIES project at UMass. Mr. Tutty is the primary point-of-contact for CCIIO for operational components of the NESCIES innovator grant and oversees reporting and review activities. He is responsible for ensuring deliverables are met for major subcontracts. He is a

1. INFORMATION FROM THE BIDDER

member of the NESCIES senior management team. Mr. Tutty is also facilitating the Affordable Care Act (ACA) Subsidized Workgroup at the request of MassHealth and the Connector to address key questions surrounding policy and business process decisions that must be resolved as Massachusetts implements changes initiated as a result of the ACA.

Mr. Tutty is involved in a wide range of health policy and community engagement projects at UMass. He is involved in improving health care for vulnerable citizens by building bridges between the community and UMass to leverage the Medical School's academic and community ties to develop, implement, and manage a range of complex educational, training, and technical projects. Mr. Tutty is also a member of the UMass Public Sector Health Information Technology and Exchange Policy Group. Prior to joining UMass, Mr. Tutty worked at the Boston Consulting Group (BCG), where he spent five years as a Senior Analyst in its Health Care Practice Group. Prior to BCG, he worked as a Senior Planning Analyst for Baystate Health System in Springfield, Massachusetts.

Mr. Tutty teaches a number of health policy courses. He is an Instructor in the Department of Family Medicine and Community Health at UMass and an adjunct professor at Clark University. Mr. Tutty is currently finishing his doctorate in public policy at UMass Boston.

Marc A. Thibodeau, J.D., M.S.

Project Advisor

Mr. Thibodeau is currently Executive Director of the Center for Health Care Financing at UMass. He has nearly 25 years of experience in health and human services, including 10 years as Assistant General Counsel at both the Massachusetts state welfare and Medicaid agencies. The Center is a 300-employee unit that is responsible for the management and operation of all of Massachusetts' third-party liability, federal claiming, public facility billing, program integrity, and coordination of benefits activities under an agreement with MassHealth, the state's Medicaid agency. The Center manages various Employer Sponsored Insurance access projects including the commercial premium insurance and insurance partnership programs, covering more than 80,000 individuals combined and, in addition, manages public premium assistance efforts through its administration of the Medicare Buy-in Program for the state. The Center maintains active engagements in more than a dozen states.

Mr. Thibodeau brings substantial experience in the management of complex information technology initiatives, with an expertise in financing and procurement aspects of such endeavors and federal compliance activities. He is the Principal Investigator for a Robert Wood Johnson Foundation grant in Massachusetts that is focused on maintaining enrollment across Medicaid, CHIP, and other health insurance programs. He continues to forge working relationships with other public medical schools nationally to help foster development of the Medicaid agency/medical school partnerships to facilitate transfer of clinical, research, and policy supports available at professional schools to state human service agencies.

Deborah Drexler, J.D.

Section 1 and Section 2 Lead

A health care attorney, Ms. Drexler has spent most of the last 16 years working for the Commonwealth of Massachusetts on various public benefit programs. She has particular expertise in health information technology projects, an expertise she began developing in 2002, when she participated in MassHealth's efforts to achieve compliance with HIPAA's administrative simplification transaction standards.

Ms. Drexler joined UMass in 2011. As Senior Director of Data Operations, she is responsible for the timely and efficient deployment of several major software applications — some for use by UMass clients and others for internal use — and for ensuring that data operations comply with all applicable laws, regulations, and contractual requirements.

Ms. Drexler currently serves on the Massachusetts Data Release Review Board, which reviews applications from researchers and others for access to the Massachusetts Health Care Claims Dataset. She was a major contributor to a report presented to the State Alliance of E-Health, February 2009, titled *Public Governance Models for a Sustainable Health Information Exchange Industry*.

Mila Kofman, J.D.

Section 3 and Section 8 Lead

Ms. Kofman is a nationally recognized expert on private health insurance. She and Katie Dunton (a member of our Exchange team) are currently working with 10 states under a Robert Wood Johnson Foundation project to assist states with ACA insurance market-related implementation, including exchanges. The state teams include insurance commissioners and staff, Medicaid directors and staff, Governors' office staff (and in one case the Lt. Governor), exchange directors (or equivalent), IT officers, and other state government officials. This work includes substantive, technical, and strategic hands-on assistance. Like Vermont, some of these states are grappling with many similar implementation issues and policy questions around Exchanges, market reforms, and opportunities under ACA to achieve universal coverage. Hands-on assistance includes providing an analysis of federal statutes and regulations on all federal laws including ACA and HIPAA (including ERISA, IRC, and PHSA). Part of the assistance also includes developing implementation plans to implement market reforms including exchange-related functions. This includes identifying interagency opportunities to leverage existing resources for required Exchange functions, developing MOUs that address interagency collaboration including certification of qualified health plans, navigators, call centers, and other essential functions under the ACA.

As the Superintendent of Insurance in Maine, Ms. Kofman implemented ACA areas with direct jurisdiction. This included working with all stakeholders, identifying carrier participation and market issues and implementation approaches. In 2010, she was appointed by the Governor to the Governor's Steering Committee on health reform implementation. The committee held meetings in public session with public input and comment on ACA implementation, including exploring the issues raised in this RFP. As a member of the National Association of Insurance

Commissioners (NAIC), Ms. Kofman was one of a few insurance regulators who was asked to focus on and lead ACA implementation (e.g., co-chairing a statutory working group on section 2715, chairing a task force responsible for drafting ACA compliance models, etc.). Maine also chaired one of the subgroups on exchanges and was a key member of the actuarial working group developing MLR standards.

Alexis Henry, Sc.D., OTR/L

Section 4 Lead

Dr. Henry is Senior Research Scientist in the Applied Policy Research Unit and a Research Assistant Professor in the Department of Psychiatry at UMass. Dr. Henry has over 30 years experience as a provider, educator, and researcher in the disability and rehabilitation field. Within UMass, she manages a large team of researchers, project directors, and research staff examining the intersection of health, disability, and employment for people with disabilities served by public programs.

Currently, Dr. Henry is the Principal Investigator for the Massachusetts Medicaid Infrastructure Grant (MIG) from the Centers for Medicare and Medicaid Services. In 2008, under the MIG, she oversaw a year-long statewide strategic planning effort engaging the full range of stakeholders, including state policy makers, service providers, employers, youth, and working age adults with disabilities and their family members to identify barriers and potential solutions to the problem of unemployment and under-employment of people with disabilities. This initiative – Work Without Limits – promotes employment opportunities and outcomes for people with disabilities through a broad-based communications and marketing efforts, consultation and technical assistance to providers and employers on issues related to disability employment, provider training on delivery of best practices (including train-the-trainer strategies), and policy support to state agencies including MassHealth and other disability-serving agencies, which includes the promotion of the Massachusetts Medicaid Buy-in Program for working adults with disabilities (the MassHealth CommonHealth program).

Recently, Dr. Henry and a research team under her direction conducted multiple focus groups with MassHealth members to inform the development of MassHealth’s integrated care demonstration for dual-eligible (Medicare and Medicaid) working age members. In 2011, Dr. Henry and colleagues published two papers examining the impact of health reform on people with disabilities.

Katharine London, M.S.

Section 5 and Section 7 Lead

Ms. London is a Principal Associate in the UMass Center for Health Law and Economics. Ms. London has over 20 years experience directing complex projects for government agencies. Her expertise includes health care policy development and analysis in the areas of health care financing, payment methodologies, rate development, cost containment, purchasing strategies, quality assessment, and delivery system reform. Ms. London directed the Massachusetts Health Care Quality and Cost Council’s initiative to collect health care claims data from fully insured Massachusetts health plans and to analyze health care quality and relative prices paid to health

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care providers; this work included many detailed discussions with providers and payers regarding health care payer practices, provider payments, and how these practices and payments were reflected in claims data. At the Massachusetts Attorney General's Office, she conducted in-depth analyses of individual health care providers' cost structures, revenues, and third-party payment arrangements. Earlier in her career, she analyzed health care costs and payment methods for the Massachusetts Health Care Task Force and the Massachusetts Division of Health Care Finance and Policy, and calculated rates under the Massachusetts All-Payer Rate Setting system at the Massachusetts Rate Setting Commission.

Ms. London has provided project management, facilitation, analytic support, and report writing to a number of high profile public/private boards and commissions responsible for developing health care initiatives and comprised of stakeholders representing diverse interests. Most recently Ms. London provided these services to help the Connecticut Sustinet Health Partnership Board of Directors, its eight subcommittees, and 160 individual participants to develop a public option health plan using the medical home model and alternative payment methods.

Ms. London holds a master's degree in health policy and management from the Harvard School of Public Health and a bachelor's degree in applied mathematics with biology from Harvard and Radcliffe Colleges.

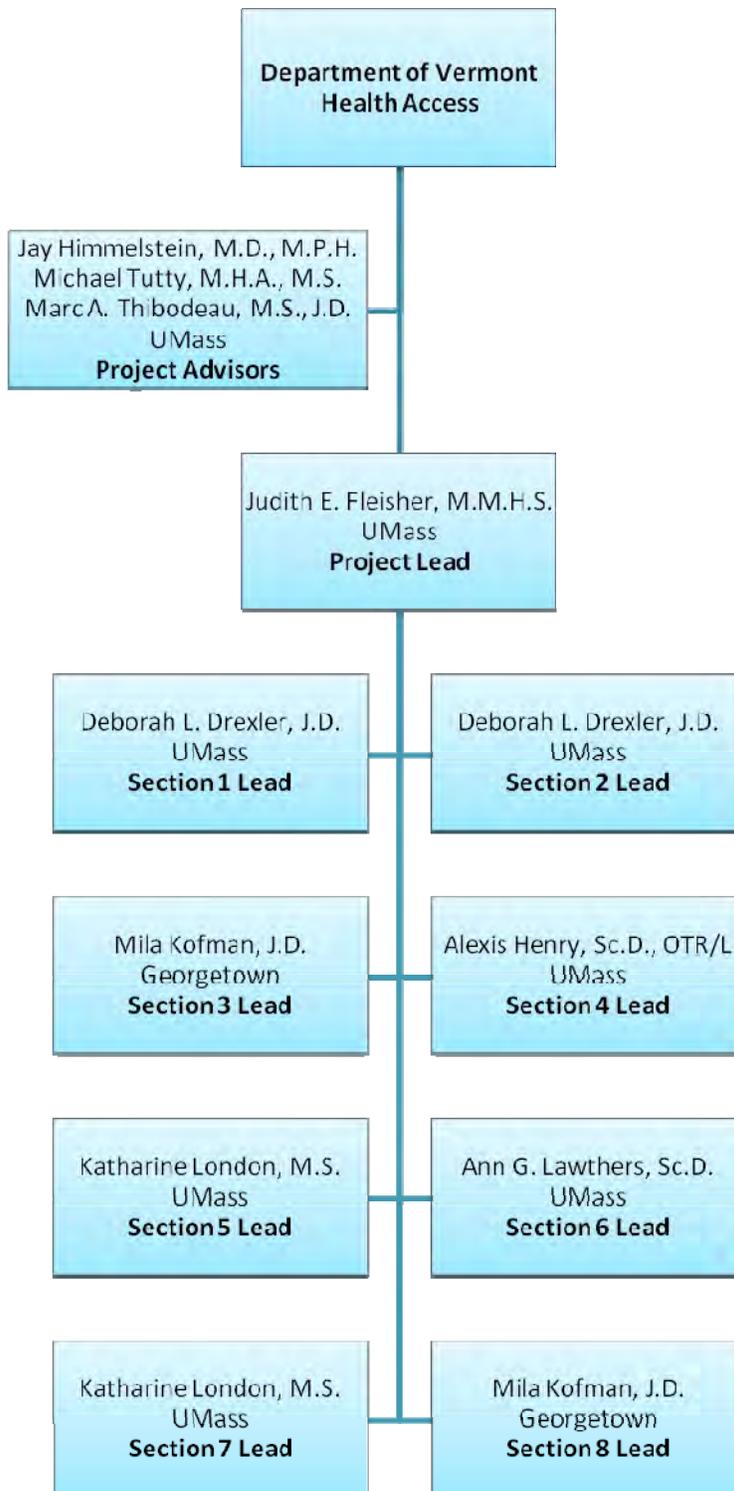
Ann G. Lawthers, Sc.D.

Section 6 Lead

Dr. Lawthers, an Assistant Professor in the Department of Family Medicine at UMass, has over 25 years experience in quality measurement, program design, and evaluation. Dr. Lawthers has taught quality methods and metrics both in the United States and abroad. For the past 10 years at UMass, she has been responsible for the design and implementation of multiple program evaluations, the most recent being the evaluation of the state's patient-centered medical home initiative.

1. INFORMATION FROM THE BIDDER

UMass Exchange Team Organizational Chart



1. INFORMATION FROM THE BIDDER

Ability to Meet Project Schedule

Vermont has laid out an aggressive timeline for meeting its goal of project completion by September 2012. We have built a team that will be up and running in January 2012 and will meet or exceed project milestones. If awarded this contract, our Exchange team is prepared to take on the completion of all eight sections.

Our project management approach is built upon our extensive experience working with Vermont and other states. We appreciate the operational and fiscal pressures faced by Vermont. The addition of ACA requirements, while beneficial to Vermont's citizens, adds to the already significant responsibilities of state staff. For this reason, our project management approach is centered on complete transparency and open communication. We will keep the State informed at all times on the status of each task and will communicate obstacles on a timely basis, making every effort to be judicious in our requests for Vermont staff time.

Project Lead Judith Fleisher was chosen because of her experience in successfully managing projects of similar size and scope.

Ms. Fleisher will implement the following key strategies:

- **Effective planning:** Successful projects start with a detailed and realistic project plan. We anticipate working closely with the State in early January to review and revise the key activities in our work plan so they are mutually agreeable and workable.
- **Weekly status meetings:** We anticipate utilizing weekly status meetings to keep Vermont staff up-to-date on all deliverables. We believe that this type of regular communication produces a variety of benefits, including the ability to redirect strategy, an opportunity to identify or reorder priorities, and an overall reduction in the State's time and effort for final approval. Minutes of each meeting will be developed and shared with all State and Exchange team members.
- **Monthly status reports and ad hoc reports:** Because the project spans just eight months, we anticipate delivering monthly status reports that detail each task and its progress toward completion. We also expect that the State may request ad hoc reports over the course of the contract, and we will work closely with staff to ensure we produce reports that speak directly to the State's needs.
- **On-site work:** In order for many of the section tasks to be performed effectively, our regular presence in Williston and Montpelier is necessary. Ms. Fleisher anticipates working closely with Vermont during the planning stages to develop a schedule of on-site activities that support this initiative. Vermont can be assured that our team is fully committed to this project.

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- **Corrective action plan:** Should Vermont ever feel that we are off-track with any of our deliverables, we will immediately draft a corrective action plan for the State's review and approval.

In the Project Timeline on the following pages, we detail the deliverables and anticipated dates for completion.

Health Benefits Exchange Planning and Implementation-VT Project Timeline

High Level Project Plan

Work Effort  Activity Duration

PROJECT TASKS	ACTIVITY OWNER	OTHER RESOURCES	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Convvene Project	JF	Team									
Project Strategy Development	JF	Team									
Initial meetings with team and VT leadership	JF	Team									
Review relevant materials	JF	Team									
Reach out to key stakeholders	JF	Team									
Convvene a work group to provide input	JF	Team									
Establish process	JF	Team									
Executive and Steering Committee review and approve plan	JF	Team									
Vet plan with key stakeholders	JF	Team									
Develop action plan for implementation	JF	Team									
Communication plan to all key stakeholders	JF	Team									
Section 1: Exchange Ops/Business Functions	DD	LC FJ									
A. Call Center	DD	LC FJ									
Review current call ctr contract, inventory call center functions	DD	LC FJ									
Review federal req. for call ctr., Exchange, other like Medicaid	DD	LC FJ									
Identify modifications current call ctr for full compliance Exchange	DD	LC FJ									
Draft amendment to contract with current call ctr vendor	DD	LC FJ									
B. Financial Management	DD	GB WC FJ									
Analyze current system, identify necessary modifications	DD	GB WC FJ									
Finalize year 1 estimates for dev all Exchange functions.	DD	FJ									
Finalize sustainability plan including revenue sources and amts	DD	GB									
C. Program Integrity	DD	MF									
Review existing polices/proc aimed preventing fraud,waste, abuse	DD	MF									
Review HHS auditing req and dev/modify procedures	DD	MF									
Assess existing programs, dev plan for enhancing existing programs	DD	MF JS FJ									
Dev procedures for independent audit, fraud detection, reporting HHS	DD	MF JS FJ									
Ensure program integrity functions aligned Medicaid and Exchange	DD	MF JS									
D. Exchange Staffing											
Develop job descriptions for Exchange positions	KB	LC DS									
Recommend management structure for Exchange Division	KB	LC DS									
E. Exchange Evaluation	DD	JG FJ									
Review the goals of Exchange and identify a few key indicators under each goal	DD	JG FJ									
Inventory health care data sources to determine how indicators will be measured	DD	JG FJ									
Identify any gaps in data needed and propose a method for obtaining the needed data	DD	JG FJ									
Develop a reporting template and define a process for periodic measurement	DD	JG FJ									
Produce a baseline data report prior to Exchange implementation	DD	JG FJ									
F. Level 2 Establishment Grant Application	JF	RS MT									
Develop project abstract, narrative, budget narrative, and other supporting docs for the application submittal	JF	RS MT									
Section 2: SHOP Exchange											
A. SHOP Exchange	DD	FJ									

Health Benefits Exchange Planning and Implementation-VT Project Timeline

High Level Project Plan

Work Effort  Activity Duration

PROJECT TASKS	ACTIVITY OWNER		OTHER RESOURCES	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	Conduct design meetings with employers and employees	DD		LC FJ	█	█						
Research models in use in other states	DD		LC FJ	█								
Develop a proposed SHOP model	DD		LC FJ		█	█						
Test the proposed model with small business representatives	DD		LC FJ		█	█	█					
Develop cost estimates for mandatory&optional SHOP fctns	DD		LC FJ		█	█						
Develop procedures and operational processes for the SHOP	DD		LC FJ		█	█						
B. Individual and Employer Responsibility Determinations	DD		FJ									
Review federal guidance and regulations in this area	DD			█	█							
Evaluate existing appeals functions in Medicaid and other State programs	DD		FJ	█	█							
Develop a detailed process to receive and evaluate exemption requests from individuals	DD		FJ			█	█					
Develop a process, with assistance from the State Department of Labor, to determine whether an employer is subject to a tax penalty based on the lack of an offer to employees of Minimum Essential Coverage	DD		FJ			█	█					
Define reporting requirements to individuals, employers, and the federal government based on decisions in these areas	DD		FJ LC				█					
C. Enrollment in Qualified Health Plans	DD											
Evaluate the existing enrollment and premium payment processes in publicly-funded programs, such as Catamount Health	DD		FJ	█	█							
Explore and evaluate enrollment/premium payment processes in use in other states	DD		FJ	█	█							
Conduct meetings with insurers and small businesses to understand potential enrollment barriers, and employees	DD		FJ LC		█	█						
Develop proposed enrollment procedures for individuals, employers, and employees	DD		FJ LC			█	█					
Develop billing and premium payment procedures for employers	DD		FJ LC				█	█				
Evaluate the option of allowing individuals to choose to pay premiums to the Exchange, and recommend whether the State should adopt this option	DD		FJ LC					█	█			
Section 3: Health Insurance Market Reform												
A. Analysis of Impact of Exchange on Outside Market	MK											
Analyze follow-up issues and questions and produce a report on any follow-up issues, estimated at	DN RD		NR	█	█	█	█	█	█	█	█	█
B. Risk-Leveling Programs												
Analyze federal law and regulations to determine the requirements and limits of all three programs	DN RD		NR	█	█	█	█	█	█	█	█	█
Determine if changes in state law are needed to implement the programs	MK		DN					█	█	█	█	█
Present program design options, with financial impacts and pros and cons of each, for the reinsurance and	DN RD		NR	█	█	█	█	█	█	█	█	█
Develop an implementation plan for the chosen reinsurance and risk adjustment program models,	DN RD		NR			█	█	█	█	█	█	█
Develop a process and methodology for meeting HHS's requirements for the risk corridor program	DN RD		NR			█	█	█	█	█	█	█
C. Certification of Qualified Health Plans (QHPs)												
Analyze federal law and regulations for QHPs, as well as State law	SC		MK	█	█	█	█	█	█	█	█	█
Develop certification criteria that includes federal and State requirements	SC		MK	█	█	█	█	█	█	█	█	█
Develop processes and procedures for certifying, recertifying, and decertifying plans, and estimate needed	SC		MK				█	█	█	█	█	█
Develop questionnaires and other information requests and a model contract for issuers that offer plans on	SC		MK							█	█	█
D. Consumer Satisfaction Surveys												
Propose appropriate consumer satisfaction standards and measures, including recommendations based on	ZZ			█	█	█	█	█	█	█	█	█
Design a consumer satisfaction survey process	ZZ			█	█	█	█	█	█	█	█	█
Develop the survey instrument	ZZ			█	█	█	█	█	█	█	█	█
Develop procedures and administrative resources for survey completion on an ongoing basis	ZZ			█	█	█	█	█	█	█	█	█
Develop specifications for posting the results on the website and reporting to HHS	ZZ			█	█	█	█	█	█	█	█	█
E. QHP Plan Design												
Complete a comparison of State mandates to the federally-defined EHB package	MK DN					█	█					
Complete an actuarial analysis of the cost to the State of maintaining existing mandates that are not included	DN RD		NR				█	█	█	█	█	█
Research other states to determine which states have similar mandates, and whether they intend to retain or	MK DN						█	█	█	█	█	█

Health Benefits Exchange Planning and Implementation-VT Project Timeline

High Level Project Plan

Work Effort ■ Activity Duration

PROJECT TASKS	ACTIVITY OWNER			OTHER RESOURCES			Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	Identify potential funding sources for retention of the State mandates	MK			DN										
Inventory the most utilized benefit plans in the State and determine the variations among those plan designs	MK	DN		RD											
Obtain employer, employee, and individual input on potential standardized plan features	MK	DN		NR											
Recommend one or more standardized plan designs at the silver, gold, and platinum levels and estimate the	DN	RD		MK											
Provide advice and written materials as requested to support the preparation of the February 15th report to	MK	DN		RD											
Section 4: Stakeholder Involvement and Outreach/Education (DHEP/CHPR, AHEC/CHPR)															
A. Navigator Program															
Develop certification criteria for Navigators, differentiating between Navigators serving individuals and those serving small businesses	GH			MT	LC										
Develop a certification process for Navigators	GH			LC											
Develop a training program for navigators, including a curriculum and training materials	GH			LC											
Develop the RFP and model contract	GH			LC											
B. Stakeholder Consultation															
Develop agendas and prepare briefing materials for 10 Joint Advisory Group meetings, at least six regional government programs	JG	MM		MT											
Schedule meetings and arrange rooms and refreshments for all meetings	JG	MM	PM	DZ	KE	VTA									
Provide minutes/summaries of the meetings	JG	MM	PM	DZ	KE	VTA									
Develop recommendations in key areas, including basic Exchange design, resulting from public input	JG	MM		PM											
C. Outreach and Education															
Develop a comprehensive outreach, education, and marketing campaign as described above	MN	PM				VTA	LC								
Implement and complete the first phase of the campaign in 2012	MN	PM		KSE	VTA	LC									
Section 5: Program Integration (CHLE)															
A. Integration of Existing Coverage Groups															
Develop a comprehensive integration strategy that includes the above-named programs and coverage options	SA			MK	LC										
Identify statutory changes necessary to achieve the integration strategy	SA	JF		MK	LC										
Develop a plan for integrating the Exchange Division with other DVHA functions	SA			LC											
Develop a plan for integrating the Exchange with the Medicaid eligibility function in DCF	SA			LC											
B. Administrative Simplification															
Review past and current simplification projects in the State, as well as any simplification efforts in other states, and national research in this area government programs	SA	RF		DD											
Research federal law to determine possible simplification opportunities	SA	JF		MK											
Poll providers to determine areas of greatest complexity from their perspective and preferences and/or priorities	SA	RF													
Develop an administrative simplification plan for the State, including an implementation plan and timeline, that identifies State law changes and/or waivers	SA	JF		MK	LC	DD									
Section 6: Quality and Wellness (CHPR, OCA, UHS)															
A. Quality Program and Rating System															
Inventory existing quality programs and initiatives in the State	AL														
Develop a plan for incorporating quality programs in the Exchange, including coordination with existing quality programs outside of the Exchange	AL														
Analyze federal guidance and regulations on quality rating	AL														
Develop a quality rating system for the Exchange that includes federally-required quality standards, as well as any additional standards the State wishes to include	AL														
Propose a method for displaying ratings that will be easily understandable by the general public	AL														
Develop a plan for rewarding plans that achieve quality goals	AL														

Health Benefits Exchange Planning and Implementation-VT Project Timeline														
High Level Project Plan														
Work Effort		Activity Duration												
PROJECT TASKS		ACTIVITY OWNER		OTHER RESOURCES		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
B. Wellness Programs														
Research existing programs in the State and in other states, including programs designed by insurers and employers		ML	JV			■	■	■	■	■				
Review evidence-based research on wellness programs		ML	JV			■	■	■	■	■				
Design a wellness program component to be included in the Exchange, including an implementation plan, timeline, and cost		ML	JL								■	■	■	■
Develop an integration plan for the Exchange's wellness programs and any programs that exist outside of the Exchange		ML	JV								■	■	■	■
Section 7: Payment Reform (CHLE)														
Document current payment levels used by commercial and public payers, payment methodologies, and variation in payments, both across payers and across providers within Vermont		KL	TF			■	■	■	■	■				
Catalog potential methodologies the state could employ for setting all-payer rates and assess potential approaches based on the state's goals and criteria		KL	TF	MK	LC	■	■	■	■	■				
Model the impact of implementing all-payer rates within the Exchange, and of applying those rates to public payers, including the identification of costs or savings to the State, to private payers, and to specific types of providers, individual institutions, or geographic areas.		KL	TF						■	■	■	■	■	
Develop a plan for implementing all-payer rates, including a plan for phasing in the all-payer rate setting methodology and rates, that best meet the state's goals and criteria.		KL	JF	MK	LC							■	■	■
Section 8: Universal Exchange (Georgetown)														
		MK	SC	KL		■	■	■	■	■	■	■	■	■
Closeout the Project														
Verify completion and accuracy of deliverables against documented and approved requirements														■
Ensure all key documentation and historical data is complete and archived														■
Attain final approvals and sign-offs														■
Conduct project closure process														
Identify, document and communicate lessons learned														■
Identify, document and communicate outstanding activities (if any) by responsible party														■
Project Closed														■

* Milestones/Deliverables

Owner/Support Key

AH	Alexis Henry	GB	Gerald Beaudreault	KE	Kevin Ellis	NEI	New England Index	SA	Stephanie Anthony
AL	Ann Lawthers	GH	Gretchen Hall	KL	Katharine London	NR	NovaRest	SC	Sabrina Corlette
DD	Deborah Drexler	JF	Judith Fleischer	LC	Lisa Carroll	PC	Project Coordinator	TF	Thomas Friedman
DN	Donna Novak	JG	John Gettens	MF	Mary Fontaine	PM	Project Manager	VTA	VTAHEC
DS	Deb Sawyer	JS	Jean Sullivan	MK	Mila Kofman	RD	Rick Diamond	ZZ	Zi Zhang
DZ	Diane Zeigler	JV	JoAnn Volk	ML	Monica Hau Hien Le	RF	Rachel Frazier		
FJ	Fred Jonas	KB	Kristine Bostek	MT	Michael Tutty	RS	Robert Seifert		

Section 1: Exchange Operations/Business Functions

- *Demonstration of understanding of the purpose and scope of this project*
- *Adequacy of management plan*
- *Identification of pertinent project issues*
- *Identification of potential problems*
- *Practicality and feasibility of proposal*

1.A. Call Center

Our Understanding of the Purpose and Scope

As the State moves forward with the development of an Exchange call center, it is important to understand how it will be different from the current call center for individuals enrolled in public health coverage programs. While similar in function, there are key distinctions that need to be readily identified and defined in order to begin Exchange call center operations during the spring or summer of 2013.

Federal regulations require that each state exchange maintains a toll-free call center for consumers, small employers, and others seeking information about the exchange. The Exchange call center will be the central point of communications for prospective and existing members purchasing Qualified Health Plans (QHP) through the Exchange. It will have the added responsibility of working closely with small businesses to make sure they understand how the Exchange call center works and the relevant ACA eligibility requirements. Vermont's small businesses will be especially interested in learning how they can obtain tax credits and participate in cost-sharing subsidies.

We understand that the State will likely expand its current call center to include the following customers:

- Agents and brokers
- Customers seeking insurance but who are not eligible for a subsidy
- Consumers eligible for subsidies based on total family income
- Small employers
- Medicaid enrollees
- Dr. Dynasaur enrollees
- Vermont Health Access Plan enrollees
- Catamount Health premium assistance enrollees

By expanding the current call center, the State is looking for ways to leverage current capacity and infrastructure. Formulating a plan that considers current operations is going to be crucial to the fiscal and operational success of the program. To achieve this task, the Exchange team will assess the current call center from both a contractual and operational viewpoint, conduct a review of federal call center requirements, identify modifications, and assist the State in drafting a contract amendment for the current call center vendor.

Project Tasks and Deliverables

Review current call center contract and inventory current call center functions

Start date: Upon contract award
End date: January 2012

Review federal requirements for a call center that will serve both the Exchange and other publicly-funded health care programs, such as Medicaid

Start date: February 2012
End date: March 2012

Identify modifications to the current call center necessary to assure full compliance with Exchange requirements, including additional staff and technology resources

Start date: March 2012
End date: April 2012

Draft an amendment to the contract with the current call center vendor

Start date: April 2012
End date: May 2012

Our Team

Lead

Deborah Drexler, UMass

Subject Matter Expert

Lisa Carroll, SBSB

IT Consultant

Fred Jonas, UMass

Approach and Relevant Experience

The Exchange team has significant experience managing and modifying call centers based on new regulations and evolving needs. Ms. Drexler will lead Section 1A and utilize the subject matter expertise of Lisa Carroll from SBSB.

Since 2007, SBSB has operated the Commonwealth Choice Call Center, the Massachusetts program that offers health insurance options for employers, families, and individuals through the Connector portal. During those four years, SBSB has handled close to a million inbound calls from a variety of callers including brokers, small businesses, individuals, and large businesses.

2. TECHNICAL PROPOSAL/PROGRAM SPECIFICATIONS

The Exchange team gained valuable experience by spearheading this early health insurance exchange. When assessing the State's current call center operations, the Exchange Team will consider the following lessons learned:

Each population has unique characteristics

The team understands that each population has unique characteristics and informational needs that must be considered when structuring a call center. We will work to identify these characteristics and needs, and use this information to refine the call center configuration and make recommendations for how inbound inquiries are answered.

Assessing team roles and responsibilities

Customer service staff need to be assigned based on experience and knowledge. For example, customer service representatives (CSRs) possessing commercial health insurance experience will be assigned to the small business and agent/broker team, and possibly to non-subsidized, individual consumers purchasing through the exchange. Staff with Medicaid experience will be assigned to consumers with subsidized insurance. By leveraging individual expertise, the State's citizens will receive the information they need to make sound choices, and the State will realize the financial and operational efficiencies of shorter phone calls.

Designing customer-centric solutions

We understand from past experience that it is crucial to focus on what is most important and user-friendly to the caller. For example, designing a toll-free number that is meaningful for the residents of Vermont is a valuable initial step. During our assessment, we will identify necessary modifications to the call center. One of these areas may be Interactive Voice Response (IVR) messaging, scripting, and call routing with the objective of delivering the inbound call to the appropriate team with a minimal wait time. We understand that each type of caller will have unique needs and that tailored responses will need to be developed. We will take these types of issues into consideration during our evaluation.

The Exchange team includes experts who were involved in the early exchange efforts of Massachusetts, legal specialists experienced in reviewing federal regulations, and staff who are skilled in assessing and modifying publicly-funded health care programs. By joining the skills and experiences of our team, Vermont will receive a clear assessment of the scope of services needed for the Exchange call center, appropriate contract language for a new contract or amendments to the current contract, a plan for structuring an expanded call center, and a thorough review of the federal requirements as they relate to an Exchange call center and other publicly funded programs. We will also provide recommendations for call center staffing, including an accounting of expected times of high volume, when the Exchange first becomes operational and during times of open enrollment of callers, for example.

Potential Challenges and Solutions

Conducting an in-depth assessment of the current call center structure and functions will be necessary in order to develop a thorough understanding and suggest modifications. Depending upon the current vendor's availability, this may be an area of potential challenge. The Exchange team will work closely with the State to formulate a workable plan.

2. TECHNICAL PROPOSAL/PROGRAM SPECIFICATIONS

By broadening the current call center, there will be the need to ensure that it is staffed correctly, with the flexibility to scale up and down as needed. We expect that during the initial “go-live” period, a large percentage of inbound calls will focus on requirements of the law that pertain to consumers. Over time, the nature of the calls will evolve to include ongoing account management, such as qualifying events for contract changes, eligibility re-determination, and open enrollment. Calls will increase during tax filing season, when consumers need information and assistance with reporting. While designing a call center that leverages current capacity, a certain amount of flexibility will be needed during rollout and peak times.

1.B. Financial Management

Our Understanding of the Purpose and Scope

State insurance exchanges need sophisticated financial and business controls for several reasons: (1) to ensure that revenues and expenses are tracked and managed appropriately; (2) to prevent and/or detect fraudulent or wasteful practices; and (3) to facilitate exchange transparency and accountability to the public.

Exchanges will engage in two main categories of financial transactions:

1. Collection of premium payments to remit to insurers
2. Collection of user fees or other revenues to fund exchange operations

The first category addresses a state exchange's role in premium payments. Federal regulations require every state exchange to serve as a single point of collection for all of a small business health insurance premiums — i.e., to collect premiums from small businesses and then submit those premiums to the insurers on the small business' behalf. Federal regulations allow — but do not require — state exchanges to serve the same function for individuals. States need to decide soon whether their exchanges will participate in the premium payment process for individuals, and then must develop financial processes and systems to protect the financial integrity of the premium payment transactions.

The second category pertains to the requirement that each state exchange must be financially self-sustaining. States have broad latitude in determining how to generate the revenues they will need to operate their insurance exchanges — from levying fees on insurers that offer products through an exchange, to increasing tobacco taxes, to committing appropriated funds. Again, states need to make decisions on these issues soon, so that the design of state exchange financial processes and systems can be finalized.

While designing these financial processes and systems, each state will also need to evaluate its existing financial management tools (such as Vermont's VISION Accounting System), and determine whether it is more efficient to adapt these existing tools for use in the Exchange, or to build or buy new ones.

Project Tasks and Deliverables

Analyze current system, building on work done in Year 1 of planning, by researching federal and state policies and requirements and identifying necessary modifications

Start date: December 2011
End date: March 2012

Finalize Year 1 cost estimates for development and operation of all Exchange functions

Start date: January 2011
End date: March 2012

Finalize a sustainability plan, including revenue sources and amounts

Start date: February 2012

End date: April 2012

Our Team

Lead

Deborah Drexler, UMass

Subject Matter Expert

Gerry Beaudreault and William Connors, UMass

IT Consultant

Fred Jonas, UMass

Approach and Relevant Experience

The Exchange team has had extensive experience with the financing of public programs, including state revenue maximization, federal financial participation claiming, and state finance laws. Drawing on these experiences, the team will work with Vermont officials to determine whether the Exchange should have an individual premium payment process. The team will collect information to inform this decision by interviewing other states, seeking guidance from federal sources, and calculating volume projections.

After finalizing both initial and longer-term cost estimates, the team will help the State evaluate options for revenue generation, including user fees, tax revenues, and appropriated dollars. The team will then evaluate all Exchange costs to determine which are attributable to Medicaid and CHIP, so that federal financial participation is claimed to the full extent allowable.

Finally, the team will evaluate the State's existing financial control systems and processes to determine whether these systems and processes can satisfy the needs of the Exchange. To the extent that they cannot, the team will recommend whether to build or buy the required enhancements.

Potential Challenges and Solutions

Segregating Exchange costs from Medicaid/CHIP costs is essential to maximizing federal revenue for the project, but will be challenging to implement. The Exchange team has significant expertise in identifying and capturing federal revenue in state programs and has a number of tools both manual and automated for doing so. Recognizing how crucial it is for state governments to claim all federal revenue to which they are entitled, the team will make this area a top priority.

2. TECHNICAL PROPOSAL/PROGRAM SPECIFICATIONS

Another potential challenge of this task is that, no matter how the State chooses to finance the Exchange, certain constituencies will be unhappy with the decision. The team will assist the State in developing strategies to minimize objections to the funding mechanism of choice.

1.C. Program Integrity

Our Understanding of the Purpose and Scope

The Affordable Care Act (ACA) requires state exchanges to keep accurate accounts of all activities, receipts, and expenditures, and to submit an annual report to the federal government covering them. The ACA also provides for annual federal audits for the exchanges. Finally, the ACA makes it clear that criminal penalties under the federal False Claims Act may apply to fraudulent activities and transactions made through a state exchange.

Many aspects of the new Exchange will potentially require program integrity measures. State exchanges are required to facilitate the premium payment process between small businesses and quality health plans (QHPs), and can opt to take a roll in the premium payment transactions between individuals and QHPs. It is important that the Exchange ensures the integrity of these financial transactions. The Exchange must also ensure that information about health plan financial performance and quality measures are truthful and accurate. Finally the Exchange must ensure that its eligibility determinations are protected from fraud, waste, abuse — and as much as possible — error.

Vermont has program integrity systems and processes already in place throughout its public benefit programs. The team will determine which of these existing systems and processes can be leveraged for the Vermont Exchange.

Project Tasks and Deliverables

Review existing policies/procedures aimed at preventing waste, fraud, and abuse

Start date: December 2011
End date: February 2012

Review HHS auditing requirements and develop/modify procedures to meet them

Start date: January 2011
End date: February 2012

Assess existing programs across several departments/agencies, review federal requirements, and develop a plan for enhancing existing programs and/or adding programs for the Exchange

Start date: February 2012
End date: March 2012

Develop procedures for an independent, external audit, fraud detection, and reporting to HHS on efforts to prevent waste, fraud, and abuse

Start date: March 2012
End date: April 2012

2. TECHNICAL PROPOSAL/PROGRAM SPECIFICATIONS

Ensure that program integrity functions are aligned between Medicaid and the Exchange to the extent allowable under federal law

Start date: March 2012

End date: April 2012

Our Team

Lead

Deborah Drexler, UMass

Subject Matter Experts

Mary Fontaine and Joan Senatore, UMass

IT Consultant

Fred Jonas, UMass

Approach and Relevant Experience

The Exchange team has extensive experience developing and implementing program integrity activities for state governments. In this project, Ms. Drexler and Mr. Jonas will first inventory all existing systems, policies, and procedures within the State — both automated and manual — designed to prevent and/or discover fraud waste and abuse, paying special attention to mechanisms existing within the Medicaid program. The team will evaluate which of these existing systems, policies, and procedures can be extended to the Exchange, and when new arrangements should be implemented. Where new systems, policies, or procedures are recommended, the project team will strive to identify automated solutions, and will recommend whether to build or buy such solutions.

In the same time, Ms. Fontaine and Ms. Senatore will evaluate which aspects of the State Exchange are at highest risk for fraud waste and abuse. These aspects might include health plan quality measures, health plan network adequacy, navigator funding, and premium collections and disbursements.

With this data in hand, the team will develop a comprehensive program integrity plan, along with an assessment of where existing systems, policies, and procedures can be used, and where new systems should be implemented. The team will identify other programs in the state that are already subject to federal audits, and evaluate whether these procedures can be used in the Exchange program integrity plan. Where new systems, policies, or procedures are recommended, the team will strive to identify automated solutions, and will recommend whether to build or buy such solutions.

Potential Challenges and Solutions

Overly burdensome program integrity mechanisms can have the unintended effect of reducing either individual access to the program or health plan participation. The team will carefully consider the potential for these and other unintended consequences.

1.D. Exchange Staffing

Our Understanding of the Purpose and Scope

State exchanges are a critical component of the ACA and represent a significant milestone in the evolution of health care delivery. An advancement of this magnitude will inevitably entail complexities and challenges for both the Exchange Division and consumers utilizing the Exchange. Success will depend on having the right people in place to lead and support this initiative through its implementation and ongoing operations. Foresight, industry understanding, flexibility, creativity, change management experience, project management experience, regulatory expertise, and strong communications and public relations experience are among the many qualities that the leadership team must possess. Public perceptions about the Exchange will begin to take shape on the first day of operations. Therefore, a consumer-oriented team dedicated to supporting the Exchange and serving its consumers is essential to success.

Project Tasks and Deliverables

Develop job descriptions for Exchange-related positions and assist with administrative work resulting from the recruitment process

Start date: May 1, 2012

End date: June 1, 2012

Recommend a management structure for the Exchange Division in DVHA

Start date: May 1, 2012

End date: July 1, 2012

Our Team

Lead:

Kristine Bostek, UHealthSolutions

Subject Matter Expert

Lisa Carroll, SBSB

Human Resources Consultant

Deb Sawyer, UHealthSolutions

Approach and Relevant Experience

The Exchange team will establish and vet projections regarding Exchange activities and analyze staffing models that will meet the needs of the Exchange. UMass and UHealthSolutions have extensive experience in recruiting, hiring, and training new personnel quickly. SBSB has worked with the Commonwealth Connector Authority (CCA) for almost five years and employs over 40 staff members dedicated to running the Commonwealth Choice Operations center. SBSB has also worked directly with CCA, including senior managers, giving SBSB direct experience with the qualifications and backgrounds of the staff necessary for operating an effective Exchange.

2. TECHNICAL PROPOSAL/PROGRAM SPECIFICATIONS

The team is proficient in adapting to the ongoing needs of an operation and altering strategies to best meet the needs of consumers. A workforce management process will forecast ongoing staffing needs. Our management team will convey the goals of the Exchange to all staff. While our forecasting process has proven to be accurate over time, we recognize the inherent need to adapt and change post-implementation, and the team will be ready to adjust this process to new challenges.

At a minimum, the Exchange will require a senior management structure to support the overall implementation and operation of the division. This team will include an Executive Director, Chief Operating Officer, Chief Information Officer, Chief Financial Officer, and General Counsel. These positions will be imperative to a successful launch and will lay the groundwork for an efficient and effective operation.

Potential Challenges and Solutions

Every organization impacted by or invested in health care reform is aware of the profound changes that must come to the delivery of health care. New legislation must be quickly recognized, understood, and implemented. The learning curve will be steep. Our team will have at its disposal the many professionals of UMass who are familiar with various aspects of state and national health care reforms, and the potential changes that might impact the Exchange and its staffing model.

1.E. Exchange Evaluation

Our Understanding of the Purpose and Scope

Once the Vermont Exchange is operational, State officials must have a mechanism to evaluate its performance. The Exchange team will develop an evaluation plan to determine this performance. A well-designed Exchange evaluation plan is critical for several reasons: (1) to ensure that the goals of the Exchange are being met; (2) to identify problems early before they have serious adverse consequences on individuals and employers; and (3) to maintain the public trust in the Exchange and those who administer it.

The evaluation plan will describe the methods and data that will be used to determine how well Exchange goals are being met. The team will define indicators that are clear measures of each goal. Taken as a whole, the indicators will provide a point-in-time snapshot of the Exchange's performance. By taking inventory of State data sources, the team will determine whether the data required to support each indicator is readily available from an existing source or if new data collection will be required. When new data collection is necessary, the team will assess various methods for collecting the data and propose the most efficient method. Potential methods include surveys, administrative reporting from operational systems or key-informant interviews. In addition to defining the indicators and the data sources, the team will also design and document the business processes necessary to implement the evaluation plan. This will include reporting templates and reporting schedules. Finally, the team will conduct a test run of the business processes and produce a 'pilot' indicator report prior to the Exchange implementation.

A well-designed evaluation plan will leverage existing sources of data to the maximum extent possible, and will collect new data efficiently. A well-designed plan will require — and will facilitate — nimble analyses, so that remedial action can be taken quickly. Finally, in the overall spirit of Exchange accountability and transparency, a well-designed evaluation plan will ensure that results of all evaluation activities will be clearly understandable to the public.

Project Tasks and Deliverables

Review the goals of the Exchange and identify a few key indicators under each goal

Start date: January 2012
End date: February 2012

Inventory health care data sources to determine how indicators will be measured

Start date: January 2012
End date: March 2012

Identify any gaps in data needed and propose a method for obtaining the needed data

Start date: January 2012
End date: March 2012

2. TECHNICAL PROPOSAL/PROGRAM SPECIFICATIONS

Develop a reporting template and define a process for periodic measurement

Start date: April 2011

End date: May 2012

Produce a baseline data report prior to Exchange implementation

Start date: June 2012

End date: September 2012

Our Team

Lead

Deborah Drexler, J.D., UMass

Subject Matter Lead

Jack Gettens, Ph.D., UMass

Information Technology Lead

Fred Jonas, UMass

Approach and Relevant Experience

UMass has extensive experience in evaluating public benefit programs, using methods ranging from consumer satisfaction surveys to process and outcome evaluations to experimental designs. The team has the capability to combine an academic approach with the latest technology to conduct evaluations that maximize accuracy and minimize costs.

There are many possible ways to evaluate an exchange, and careful initial planning will be the key to success. Dr. Gettens, Ms. Drexler, and Mr. Jonas will work closely with key State officials to inform the evaluation design.

The first and most important step in designing the evaluation plan will be specifying the indicators that will serve as measures for each Exchange goal. To do this, the team will first meet with key State officials to ensure that the team has an accurate understanding of each goal. The team will then assess the potential indicators that may be suitable as measures for each goal. We will base the assessment of each indicator on: (a) how well it measures the Exchange performance of the goal; and (b) whether it is practical and cost-efficient to gather the data necessary to support the indicator.

For example, an outcomes-based goal of the Exchange may be “to substantially reduce the number of working-age uninsured in Vermont.” A possible indicator is the percentage of working-age uninsured in Vermont. This indicator will be a good measure, provided it can be measured accurately and timely. The team will then assess the availability of data to support the measure — for example, evaluating existing state surveys (e.g., Behavioral Risk Factor Surveillance System survey) and national surveys (American Community Survey or Current

2. TECHNICAL PROPOSAL/PROGRAM SPECIFICATIONS

Population Survey). Based on our assessment of indicators and data sources, the team will propose the most suitable indicators and data sources. In addition to outcome goals, the Exchange may have operational goals as well, for example, “to process applications in an accurate and timely manner.” Similar to the outcomes goals, the team will assess potential indicators to measure timely and accurate processing and identify appropriate data sources. In this case, the data source will probably be the operational data systems of the Exchange.

Once the team has identified potential indicators and potential data sources, the team will review the proposed indicators and data sources with key State officials. Based on the review, the team will modify the indicators and data sources as appropriate.

After the indicators and data sources are finalized, the team will define the business processes to gather the data and generate the data sources. The business processes will be defined in business process workflow documents. The workflow documents will specify the following: (a) the indicator; (b) the data source for the indicator; (c) the logical rules for generating the indicator from the data; (d) the schedule for collecting or retrieving the data; (e) the person responsible for collecting or retrieving the data; and (f) the data collection template if required. The team will assemble the indicators, the data source definitions, and the business process workflows into a draft evaluation plan. The draft evaluation plan will be reviewed with key State officials. Based on the review, the team will modify the evaluation plan and produce a final plan.

The team will pilot test the evaluation plan prior to the Exchange implementation. This test will use the business processes and data sources as described in the evaluation plan to generate a baseline indicators report. The team plans to produce the baseline report in September 2012. The team anticipates that some data sources — for example, administrative data from the Exchange — may not yet be available. To compensate for data that is not yet available, the team will create sample data to represent the missing data.

We will generate a baseline report in a variety of formats tailored to the needs of different audiences, including the general public.

The project team will also explore ways to leverage Vermont’s existing information technology resources to conduct evaluation activities. If no existing IT resources are available in a particular area, the team will evaluate the feasibility of developing such resources.

When designing the evaluation plan, the team will recognize that the results from any one evaluative activity may influence the priority of other evaluative activities. The evaluation plan will be iterative and dynamic. For example, if a consumer survey reveals that there is little public knowledge of Navigators in Vermont, the evaluation plan should allow a more thorough evaluation of Navigator programs. Conversely, if the collected data shows that consumers are aware of Navigators and use them frequently, further evaluation of Navigator programs may be unnecessary. This approach will maximize the overall value of the State’s evaluation activities.

2. TECHNICAL PROPOSAL/PROGRAM SPECIFICATIONS

Potential Challenges and Solutions

A challenge will be to define data sources and business processes for collecting evaluation data when the Exchange is not yet operational and, in the case of some indicators, when the Exchange business processes related to the indicator have not yet been designed. While this will require effort, it also presents an opportunity to include requirements for evaluation into the design of Exchange operations. In many ways, this will be more efficient than retrofitting evaluation requirements into an existing operation. Our evaluation team will work closely with members of the overall project team and state officials responsible for the design of the Exchange operations, to ensure that the requirements for evaluation are included in the Exchange design.

1.F. Level 2 Establishment Grant Application

Our Understanding of the Purpose and Scope

Vermont officials expect to be ready sometime in calendar year 2012 to apply for a Level 2 Establishment Grant, as offered by the U.S. Department of Health and Human Services' Center for Consumer Information and Insurance Oversight (CCIIO), Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges, Funding Opportunity Number: 1E-HBE_11-004, CDFA: 93.525. The Level 2 Establishment grant is one of four key funding sources from the federal government to provide states with resources for implementing a state health benefits exchange. The application must demonstrate and document that the planning and development of the Vermont Exchange has made sufficient progress meeting the eligibility criteria to qualify for Level 2 funding.

The project narrative must describe the following:

- The progress Vermont has made in the 11 Exchange Establishment Core Areas
- An Exchange IT Gap Analysis
- The State's commitment to using IT standards when establishing the Exchange
- An evaluation plan

The grant proposal must also include a detailed Work Plan that covers all the tasks that must be undertaken through December 31, 2014. The Work Plan contains milestones and timeframes drawn from examples provided in the Establishment grant application. Some of these milestones must be completed in the timeframe provided. Development of the detailed Work Plan is a critical activity as this plan will be used to measure Vermont's progress during the project period.

A budget narrative is also required and must address the costs of the Exchange Core Areas, as well as the business operations of the Exchange. Justification on how each line item will support the proposed objectives, the Core Areas, and its alignment with the Work Plan is necessary and must be broken down on a quarterly basis. Included will be a description of how the proposal and the funding benefit Medicaid, CHIP, other human services programs, and the applicable cost allocation methodologies. Also, funds that support tasks under this Level 2 Exchange grant opportunity must be identified as "clearly distinct" from those available under the Level 1 grant.

Documents that describe working relationships between DVHA and other agencies, as well as any pending or actual contractual agreements, must be described. Also, key personnel, organizational charts, biographical sketches, roles, responsibilities, and qualifications of proposed staff must be included as an attachment to the applications.

Project Tasks and Deliverables

The project tasks described below are based on the intent to file the application for the Level 2 Exchange Establishment Grant by March 30, 2012. Should the DVHA determine that the appropriate submission date is June 29, 2012, all project tasks will be revised with new

2. TECHNICAL PROPOSAL/PROGRAM SPECIFICATIONS

completions dates and be submitted for approval by the DVHA.

Draft and obtain approval from the DVHA on a detailed project plan with dependencies for the development of the project abstract, narrative, budget narrative and for identifying and obtaining the other supporting documents for application submittal, including letters from the Governor, the State Medicaid Director, and the Commissioner of Insurance.

Start date: December 2011

End date: January 2012

Evaluate Vermont's Exchange planning progress to determine if the eligibility criteria for applying for a Level 2 Establishment grant have been met. Identify gaps and propose solutions.

Start date: December 2011

End date: January 2012

Review all Level Two Establishment grants already submitted and approved that are publicly available on HHS' Collaborative Application Lifecycle Tool (CALT). Provide recommendations to the DVHA regarding opportunities and strategy for Vermont's Level 2 Establishment grant application.

Start date: December 2011

End date: January 2012

Engage CMS CCIIO for guidance and technical assistance early and throughout the development of the grant proposal to ensure a successful application. Support Vermont with continued discussions and review with the CCIIO grant officers assigned. This includes attendance and participation in pre-application conference calls, obtaining direct assistance and providing drafts to the CCIIO grants officer on an iterative basis up to the time of final submission.

Start date: January 2012

End date: March 2012

Complete draft application and submit to the DVHA for approval.

Start date: January 2012

End date: February 2012

Submit the project abstract, narrative, budget narrative, and other supporting documents to <http://www.grants.gov> by the deadline of March 30, 2012.

Start date: March 2012

End date: March 30, 2012

2. TECHNICAL PROPOSAL/PROGRAM SPECIFICATIONS

Our Team

Lead

Judith Fleisher, UMass

Subject Matter Lead

Robert Seifert, UMass

Consultant

Michael Tutty, UMass

Approach and Relevant Experience

The Exchange team has extensive experience in preparing a successful application for federal funding. Through its partnership with the Massachusetts Executive Office of Health and Human Services, UMass has prepared and secured funding for three key initiatives that support Massachusetts with implementation of the Affordable Care Act. They are as follows:

Grant Name	Purpose	Dollar Value
<i>New England States Collaborative for Insurance Exchange Systems (NESCIES)</i>	The goal is to create IT components that are consumer-focused, cost-effective, reusable, and sustainable to operate Health Insurance Exchanges (HIXs) as a key element of health care reform. The approach is to create and build a flexible HIX IT framework in Massachusetts designed to connect consumers, small businesses, and health plans that can be tailored to the needs of the New England states and beyond.	\$35,000,000
<i>Money Follows the Person (MFP) Rebalancing Demonstration Program</i>	To support the state’s efforts to rebalance the long-term care system by paying an enhanced FMAP for activities that support transition of individuals from institution to community-based settings. Target populations include the elderly, people with intellectual, developmental or physical disabilities, mental illness, or those who have a dual diagnosis.	\$113,000,000
<i>State Demonstrations to Integrate Care for Dual Eligible Individuals</i>	To design a new model of integrating Medicare and Medicaid financing and services (e.g., acute, behavioral health, and long-term services and supports) for individuals ages 21-64 who are eligible for both programs.	\$1,000,000

2. TECHNICAL PROPOSAL/PROGRAM SPECIFICATIONS

Potential Challenges and Solutions

A critical component is ensuring that the progress of the development of Vermont's Exchange meets the eligibility and criteria for a Level 2 Establishment Grant. An evaluation to identify potential gaps and possible solutions conducted by January 2012 will allow for decision-making as to whether to apply for the grant in either March or June 2012.

Section 2: SHOP Exchange

- *Demonstration of understanding of the purpose and scope of this project*
- *Adequacy of management plan*
- *Identification of pertinent project issues*
- *Identification of potential problems*
- *Practicality and feasibility of proposal*

2.A. SHOP Exchange

Our Understanding of the Purpose and Scope

SHOP exchanges are subject to many of the same requirements as individual exchanges. For example, SHOP exchanges must provide a call center for small businesses, oversight and financial integrity, and eligibility determinations. SHOP exchanges have several additional requirements, including mandatory premium billing services for eligible employers. Because of the overlap of functions between individual exchanges and SHOP exchanges, it is our understanding that the State has decided to merge its SHOP Exchange with its individual Exchange.

Even with that decision made, there is still much design work to do to establish a successful SHOP Exchange. Despite the tight timelines, states must involve stakeholders in the design process — especially the small business community, insurance brokers, and agents who sell to the small group market. Buy-in from stakeholders is particularly critical, since small businesses will have a choice on whether to use the SHOP Exchange. Federal regulations do not require a small business' participation in the SHOP Exchange — doing so is completely voluntary. If the SHOP Exchange does not represent a cost and/or time savings for small businesses, they will not participate.

Project Tasks and Deliverables

Conduct design meetings with employers and employees

Start date: December 2011

End date: February 2012

Research models in use in other states

Start date: December 2011

End date: January 2012

Develop a proposed SHOP model

Start date: February 2012

End date: March 2012

Test the proposed model with small business representatives

Start date: March 2012
End date: April 2012

Develop cost estimates for mandatory and optional SHOP functions, taking into consideration additional staff, technology, and consulting/contracting needs

Start date: February 2012
End date: March 2012

Develop procedures and operational processes for the SHOP

Start date: March 2012
End date: April 2012

Our Team

Lead

Deborah Drexler, UMass

Subject Matter Expert

Lisa Carroll, SBSB

IT Consultant

Fred Jonas, UMass

Approach and Relevant Experience

The Exchange team recognizes that input from the small business community is crucial for the successful implementation of a SHOP Exchange. Accordingly, the team will schedule a series of focus-group meetings across the State to better understand the needs and preferences of small businesses and their employees. These focus groups will help the State choose which products and benefit designs to offer through the SHOP Exchange. (The team understands that meetings with small businesses will take place as part of the UMass response to Section 4. This team will work with the Section 4 team to coordinate meetings appropriately and determine if additional SHOP-focused meetings should take place to garner needed input to meet the State's objectives.)

The team will compare the data obtained through these focus groups with the data it obtains from researching SHOP-type websites used in other states. It will then work with Vermont officials to develop costs estimates and decide the following:

- Will the SHOP exchange calculate and display different employee contribution levels for different situations and plans?
- How many plans and levels will be available for any particular small business?

2. TECHNICAL PROPOSAL/PROGRAM SPECIFICATIONS

- Will the SHOP exchange contract with a third party for premium payment services or perform this service in-house?

Once this information is assembled, the team will work with Vermont officials to develop a model for the SHOP Exchange. This model will contain operational procedures, such as how the SHOP Exchange will verify an employer's stated number of employees, how the SHOP Exchange will collect and remit premiums, and how frequently the SHOP Exchange will allow insurers to make changes to their rates.

Once the design is finalized, the team will examine ways to pilot the proposed SHOP model with the small business community. Possible pilot test methodologies include showing focus groups a slide-show mockup of the planned screens and making a fully functional "beta" website available.

The team will then assemble the information gathered during the pilot test and make a final recommendation to state officials.

Potential Challenges and Solutions

Small businesses will demand good service from the SHOP Exchange — fast response times, accurate determinations, clean and intuitive user interfaces. The SHOP Exchange's ultimate success will much depend on delivering this high service-level the very first time an employer logs in. The project team recognizes this and will consider various techniques to ensure a positive first experience for every employer. These techniques might include conducting multiple user tests of the SHOP Exchange with user feedback being implemented between iterations; providing extra bandwidth and redundancies on the SHOP Exchange servers through the first year of operation; and/or doing independent third-party quality assurance reviews on eligibility determinations before the go-live date.

2.B. Individual and Employer Responsibility Determinations

Our Understanding of the Purpose and Scope

Section 1411 of the ACA requires state exchanges to certify whether an individual is exempt from the requirement to purchase insurance. Proposed rules on this process have not yet been issued. State exchanges may also be involved in determining whether an employer is subject to a tax penalty for failing to offer adequate insurance to its employees. (The logistics of this tax penalty are discussed in two Request for Comments recently issued by the Internal Revenue Service: Notice 2011-36 and Notice 2011-73.) The results of these determinations will, in many cases, need to be communicated to certain other public agencies.

Individuals and employers who are aggrieved by these determinations must be given appeal rights. It will be most efficient if state exchanges can build upon existing public benefit program appeals processes.

Project Tasks and Deliverables

Review federal guidance and regulations in this area

Start date: January 2012
End date: February 2012

Evaluate existing State appeals functions in Medicaid and other publicly-funded health care programs

Start date: January 2012
End date: February 2012

Develop a detailed process to receive and evaluate exemption requests from individuals

Start date: March 2012
End date: March 2012

Develop a process, with assistance from the State Department of Labor, to determine whether an employer is subject to a tax penalty based on the lack of an offer to employees of Minimum Essential Coverage

Start date: March 2012
End date: April 2012

2. TECHNICAL PROPOSAL/PROGRAM SPECIFICATIONS

Define reporting requirements to individuals, employers, and the federal government based on decisions in these areas

Start date: April 2012

End date: April 2012

Our Team

Lead

Deborah Drexler, UMass

Subject Matter Expert

Lisa Carroll, SBSB

IT Consultant

Fred Jonas, UMass

Approach and Relevant Experience

The Exchange team will first review the latest federal guidance and regulations on determining individual and employer responsibilities. The team will convene focus groups consisting of various stakeholders to solicit ideas on the best way to carry out these responsibility determinations and to disseminate the results to appropriate public agencies. Finally, the team will assess how the NESCIES project is building these functionalities, to determine whether Vermont should incorporate any of the NESCIES products into its own Exchange.

Once all this data is reviewed, the team will design alternative IT processes for handling individual and employer responsibility determinations. These processes will chart, at a high-level, the workflows necessary to make accurate individual and employer responsibility determinations. The workflows will inform the development of requisite online systems. Assuming that relevant federal regulations and guidance have been finalized, the team will assist Vermont officials in selecting one of the high-level IT designs. At that point, the project team will propose different management reporting mechanisms for evaluating the effectiveness of the determination process.

Any individual or employer who is aggrieved by a responsibility determination made by the Exchange must be given the right to appeal. The project team will inventory the existing appeal processes within state government and determine whether any of these processes can be applied. The team will also develop business process flows of how the appeals process might be initiated and tracked in an online application.

2. TECHNICAL PROPOSAL/PROGRAM SPECIFICATIONS

Potential Challenges and Solutions

Federal guidance and regulations on individual and employer responsibility determinations are still preliminary, and this can lead to a delay in beginning the work on this task. The project team will propose flexible and scalable design models that can accommodate changing federal requirements.

2. TECHNICAL PROPOSAL/PROGRAM SPECIFICATIONS

2.C. Enrollment in Qualified Health Plans

Our Understanding of the Purpose and Scope

Once an exchange determines that an individual is eligible to enroll in a Qualified Health Plan (QHP), it must be able to complete the following tasks:

- Allow the individual to select a QHP offered through the Exchange
- Enroll individuals in their selected QHP by engaging in electronic transactions as follows:
 - Transmit eligibility and enrollment information to the issuers of the selected QHPs to allow them to enroll these individuals in accordance with the selected preference
 - Receive information from QHP issuers acknowledging receipt of the eligibility and enrollment information
 - Conduct a monthly reconciliation of eligibility and enrollment information with each QHP issuer
- Provide individuals with several different methods of enrollment, including internet, phone, mail, or in person

State exchanges have more flexibility with premium payments made by individuals. A state exchange can choose not to take a role in the premium payment process, thus requiring individuals to submit payments to QHPs. Or a state exchange can choose to take an active role in the premium payment process, either facilitating or aggregating the premium payments. It is important that states make this decision as soon as possible so that the design of the enrollment systems can begin.

The enrollment process and premium payment mechanisms are important to simplifying the health insurance purchasing process. Early and careful planning for the enrollment function is the best way to ensure that the process is easy and intuitive.

Project Tasks and Deliverables

Evaluate the existing enrollment and premium payment processes in publicly-funded programs, such as Catamount Health

Start date: January 2012
End date: February 2012

Explore and evaluate enrollment/premium payment processes in use in other states

Start date: January 2012
End date: February 2012

2. TECHNICAL PROPOSAL/PROGRAM SPECIFICATIONS

Conduct meetings with insurers and small businesses to understand potential enrollment barriers, and develop options for simplifying the enrollment/premium payment process for employers and their employees

Start date: February 2012

End date: March 2012

Develop proposed enrollment procedures for individuals, employers, and employees

Start date: March 2012

End date: April 2012

Develop billing and premium payment procedures for employers

Start date: April 2012

End date: May 2012

Evaluate the option of allowing individuals to choose to pay premiums to the Exchange, and recommend whether the State should adopt this option

Start date: May 2012

End date: May 2012

Our Team

Lead

Deborah Drexler, UMass

Subject Matter Expert

Lisa Carroll, SBSB

Consultant

Michael Tutty, UMass

IT Consultant

Fred Jonas, UMass

Approach and Relevant Experience

The Exchange team will begin by inventorying existing enrollment and premium payment options in Vermont's publicly funded programs, such as Catamount Health, as well as in other states' programs. The team will use this inventory to determine which enrollment practices are most effective, easiest, and have the lowest overhead costs. The project team will then conduct focus groups with representatives from insurers and small businesses to obtain feedback on

enrollment practices.

The team will take this information and combine it with other available resources, such as the Enroll UX2014 Project, which is assisting states develop a human-centered approach to designing a health insurance exchange. It will also consult closely with the NESCIES team to share experiences and work on reusability of NESCIES components. The team will also determine how the Exchange will conduct standard electronic transactions, such as the ASC X12N 820 premium payment transaction. Using this information, the team will sketch a proposed system design for the enrollment function, featuring an efficient and scalable architecture that will result in a highly satisfactory online enrollment experience.

Directly related to the Exchange's enrollment function is the Exchange's role in premium collection and remittance. The project team will develop policies and procedures to invoice small employers with their monthly overall premium payments, collect those payments, and remit them to the correct QHP issuers. It will evaluate how costly it will be for the Exchange to also collect premiums directly from individuals and remit them to insurers — and the project team will assist the State in evaluating whether the cost of such a feature is outweighed by the convenience to the beneficiaries. Finally, the project team will provide a high-level system design for the premium payment and disbursement function, one that will integrate multiple disparate systems into the Exchange so that employees, employers, and vendors will have an easy way to purchase and manage health insurance online.

Potential Challenges and Solutions

The enrollment function is one of the more technically difficult responsibilities of the Exchange. Nonetheless, exchanges must be ready for the first open enrollment period in October 2013, and must ensure that the underlying IT system can accommodate a large initial demand. To forward this aim, the team will work closely with NESCIES to identify areas where what it is doing or what its individual states are doing can provide guidance or capacity.

Section 3: Health Insurance Market Reform

- *Demonstration of understanding of the purpose and scope of this project*
- *Adequacy of management plan*
- *Identification of pertinent project issues*
- *Identification of potential problems*
- *Practicality and feasibility of proposal*

3.A. Analysis of the Impact of the Exchange on the Outside Market

Our Understanding of the Purpose and Scope

This effort will build upon work Vermont has underway to assess the advantages and disadvantages for the State, employers, and individuals of various options for establishing a health insurance exchange. Vermont has used Robert Wood Johnson Foundation funding to assess the advantages and disadvantages of (1) allowing qualified health plans to be sold inside and outside the Exchange; (2) allowing nonqualified health plans that comply with the ACA to be sold outside the Exchange; and (3) the impact of the availability of supplemental plans on the individual and small group market. The results of these analyses are forthcoming, but will likely raise additional questions and issues. The Exchange team will work with state officials to identify follow-up issues and questions. The team will produce a report that analyzes those issues and questions, including approximately 150 hours of actuarial analysis. The report will also include recommendations to the state to help ensure market stability as the state establishes and operates an Exchange that can support its long-term vision of universal coverage.

Project Tasks and Deliverables

Analyze follow-up issues and questions and produce a report on any follow-up issues, estimated at approximately 150 hours of actuarial analysis

Start date: January 15, 2012
End date: September 9, 2012

Our Team

Lead

Mila Kofman, Georgetown

Subject Matter Expert

Mary Beth Senkewicz, Georgetown

Health Actuaries

Donna Novak and Rick Diamond, NovaRest

Research support

Georgetown Research Assistant

2. TECHNICAL PROPOSAL/PROGRAM SPECIFICATIONS

Approach and Relevant Experience

Team lead, Mila Kofman, J.D, is the former Superintendent of Insurance in Maine and a nationally renowned expert on insurance markets. Her organizational abilities, deep knowledge of federal and state insurance regulation, and thoughtful approach to problems will ensure Vermont receives the in-depth analysis and evidence-based recommendations it needs to determine the best policies for the Exchange. She is currently working with 10 states under a Robert Wood Johnson Foundation project to assist them with the ACA insurance market-related implementation, including exchanges. In addition to Ms. Kofman, the team includes Mary Beth Senkewicz, J.D., who has considerable state government experience as the former Deputy Commissioner for Life and Health in Florida. Ms. Senkewicz has been intimately involved in reviewing and analyzing the ACA and all regulations promulgated under the Act, and analyzing implications for the State of Florida and its insurance regulatory structure. The team will be supported by the work of health care actuaries Donna Novak and Rick Diamond, who between them have over 72 years of experience advising states and the federal government on actuarial issues relating to health reform and insurance markets. Ms. Novak leads the firm NovaRest, which specializes in helping state insurance regulators in analyzing the impact of insurance regulation on their market.

The team will begin its work with a thorough review of recent reports and analyses of the Vermont individual and small group insurance markets. The team will work closely with state officials to review findings, identify any necessary follow-up issues or questions, and assess any additional data needs. Once the team knows the follow-up issues that will require analysis, the team will conduct any necessary analysis, including approximately 150 hours of actuarial analysis. The team will provide the State with a report of findings and recommendations.

Potential Challenges and Solutions

For this part of the project, the team will need to work closely with the State to identify any follow-up issues arising from a recently commissioned study examining the stability of the individual and small group markets with and without the Exchange. Our understanding is that the report could inform decisions to be made during the State's 2012 legislative session. There is a risk that the team will not have time to identify, assess, and provide recommendations on critical issues prior to legislative action being taken. The team will need to work closely with Vermont officials to ensure that follow-up issues or questions are quickly identified and an action plan is developed to ensure that any policy decisions in 2012 are supported by evidence.

In addition, the team must react to the activities of others. There is always the risk in this situation that since the team does not participate in all activities, the team will be brought in without sufficient time or information to do our analysis. To mitigate this challenge, the team will stay in close contact with state officials, so that the team can track activities and project development, including the assumptions and the timing. The team will then make suggestions on how to help as the project evolves.

3.B. Risk-Leveling Programs

Our Understanding of the Purpose and Scope

This subsection deals with the three risk-leveling programs under the ACA, commonly known as the 3 Rs: reinsurance, risk corridors, and risk adjustment. The reinsurance and risk corridor programs will be transitional programs in effect for the three years 2014-2016, while the risk adjustment program will begin in 2014 and be ongoing. Also, the reinsurance program focuses on the individual market, while the other two programs will apply to both the individual and small group markets.

Project Tasks and Deliverables

Analyze federal law and regulations to determine the requirements and limits of all three programs

Start date: January 15, 2012

End date: April 15, 2012

Determine if changes in state law are needed to implement the programs

Start date: April 15, 2012

End date: July 15, 2012

Present program design options, with financial impacts and pros and cons of each, for the reinsurance and risk adjustment programs

Start date: January 15, 2012

End date: May 30, 2012

Develop an implementation plan for the chosen reinsurance and risk adjustment program models, including internal and external managerial models, required internal staffing, and cost estimates for implementation and ongoing administration

Start date: March 1, 2012

End date: July 15, 2012

Develop a process and methodology for meeting HHS's requirements for the risk corridor program

Start date: March 1, 2012

End date: July 30, 2012

Our Team

Lead

Donna Novak, NovaRest

Actuarial Analysis

Donna Novak and Rick Diamond, NovaRest

Subject Matter Experts

Mila Kofman, Mary Beth Senkewicz, and Katie Dunton, Georgetown

Approach and Relevant Experience

The Exchange team's general approach will be to follow the emerging regulations and guidance and use its expertise to advise the Vermont Exchange on the actuarial issues with implementation. The team will also interview stakeholders in Vermont to gather insight into the potential problems from those most directly affected by the new programs.

Specifically the team will complete the following:

Analyze federal law and regulations to determine the requirements and limits of all three programs

The team will conduct a legal analysis of the provisions of the ACA, as well as any federal rules (proposed or final) and any other guidance from HHS, including white papers, FAQs or fact sheets. The team will provide a summary of pertinent issues and questions for the actuarial experts and State officials.

Determine if changes in state law are needed to implement the programs

The team will review Vermont's insurance code and any regulations or BISHCA bulletins or guidance that could affect implementation of the 3 Rs. The team will identify provisions of law that may need to be amended or repealed to ensure successful implementation of the program. The team will also identify whether any new legal authority needs to be conveyed to BISHCA or other State agencies. The team will conduct this work in collaboration with State officials and ensure that our health actuaries are kept informed of our findings and recommendations on a regular basis.

Present program design options, with financial impacts and pros and cons of each, for the reinsurance and risk adjustment programs

The federal rule relating to these three programs has not been finalized. The rule as proposed provides considerable flexibility to states with respect to the reinsurance and risk adjustment programs. In general, the proposed rule sets forth a default option but allows states to vary several elements. For example, states will be able to modify the attachment point, reinsurance cap, and coinsurance rate specified in the proposed rule for the reinsurance program. The team will estimate the financial impacts and pros and cons of the federal default option as well as possible variations Vermont may want to consider. To do this, the team will model Vermont's individual market using data from the Vermont Healthcare Claims Uniform Reporting and

2. TECHNICAL PROPOSAL/PROGRAM SPECIFICATIONS

Evaluation System (VHCURES) if feasible, or alternatively, from data collected from insurers.

The risk adjustment program is not as fleshed out in the proposed rule. HHS has issued a white paper setting forth issues relating to this program and has asked for comments. This feedback will be used in finalizing the rule. The resulting program design will be the federal default, but the proposed rule permits states to adopt an alternative program subject to approval by HHS. A state cannot also opt for a risk adjustment program that has been approved for another state. Here again, once the rule is finalized, the team will estimate the financial impacts and pros and cons of the federal default option as well as possible variations Vermont may want to consider.

Develop an implementation plan for the chosen reinsurance and risk adjustment program models, including internal and external managerial models, required internal staffing, and cost estimates for implementation and ongoing administration

States will have a large number of possibilities for implementing the reinsurance program. States have the ability to expand the program beyond their “share” of the original estimate. States will want to determine the potential interaction between the reinsurance program and their current programs to support vulnerable populations, such as high risk mechanisms.

Although states have the ability to propose an alternative risk adjustment program to the one developed by HHS, they may find it more prudent to implement the HHS program, and propose an alternative one when or if experience suggests a better approach. The team has extensive experience with risk adjustment and can help the Exchange understand this program and how to best implement it.

Develop a process and methodology for meeting HHS’s requirements for the risk corridor program

Unlike the two programs discussed above, which are to be implemented by the states, the risk corridor program is strictly a federal program to be administered by HHS. The proposed rule does not impose any requirements on states. That said, the Exchange will have to understand any implications for the qualified health plans and general stability of the exchange due to the risk corridor program.

Potential Challenges and Solutions

The team sees two major challenges: lack of clarity of the regulations and lack of data for quantification. The team proposes the following:

- 1) To share ideas with other exchanges, which are facing the same challenges
- 2) To be in communication with HHS to get as much clarity as possible on the rules and regulations
- 3) To meet with health carriers in Vermont to gather ideas that will ensure a smooth process that everyone understands
- 4) To continue our professional work at the Academy of Actuaries and the National Association of Insurance Commissioners, where these same issues are being reviewed
- 5) To use Vermont-specific data sources, such as the Vermont All-Payer Claims Database (APCD)

2. TECHNICAL PROPOSAL/PROGRAM SPECIFICATIONS

It is not clear whether the State will need to amend State law prior to the end of the 2012 legislative session. If that is a possibility, the team will complete its analysis under a very tight timeframe, particularly if HHS does not soon promulgate final rules on the 3 Rs. Our solution to this challenge will be to work closely with State officials to determine what, if any, legislative changes will need to be made in the 2012 legislative session and to ensure that the team completes its analysis in time for the legislature to act.

3.C. Certification of Qualified Health Plans (QHPs)

Our Understanding of the Purpose and Scope

Vermont must develop standards for certifying qualified health plans (QHPs) that not only meet minimum federal standards but also the State standards that support Vermont's broader health reform goals. Once standards are established, the State must devise an appropriate process for certifying QHPs and monitoring their compliance with the standards over time. The State must also implement a process for recertifying and decertifying QHPs, including a process for a plan to appeal an adverse decision. Certification-related decisions and ongoing monitoring of QHPs will likely require considerable data submissions from carriers; the State will need assistance developing necessary questionnaires and/or other information requests. The State will also need a template contract for issuers that offer QHPs. Lastly, the State must be able to forecast the cost of implementing these processes in order to develop budgets and provide adequate staffing.

Project Tasks and Deliverables

Analyze federal law and regulations for QHPs, as well as State law

Start date: January 15, 2012
End date: February 15, 2012 (and contingent on having final rules from HHS)

Develop certification criteria that includes federal and State requirements

Start date: February 15, 2012
End date: April 15, 2012 (and contingent on having final rules from HHS)

Develop processes and procedures for certifying, recertifying, and decertifying plans, and estimate needed resources, particularly one-time recourses for the initial certification of issuers

Start date: April 15, 2012
End date: July 31, 2012

Develop questionnaires and other information requests and a model contract for issuers that offer plans on the Exchange

Start date: August 1, 2012
End date: September 1, 2012

Our Team

Lead

Sabrina Corlette, Georgetown

Subject Matter Experts

Mila Kofman, JoAnn Volk, Kevin Lucia, Mary Beth Sankewicz, and Katie Dunton, Georgetown

Research Support

Georgetown Research Assistant

Approach and Relevant Experience

The Exchange team has substantial expertise with the regulation of health insurance carriers and the products they sell. The team includes former state regulators who have hands-on experience working with carriers to ensure ongoing compliance with state and federal law, as well as a former federal regulator who led CCIIO's efforts to assist states with implementation of the ACA's insurance reforms. In addition, team members have conducted extensive research on issues affecting exchanges as envisioned under the ACA, including studies of state-based efforts to establish exchanges and improve competition and expand coverage. Of note, Georgetown's faculty has directed research and authored influential papers evaluating the role of an exchange as an "active purchaser" in the health care marketplace, with a particular focus on the ability of exchanges to drive quality improvements and delivery system reform.

The team will conduct the following activities:

- Review and analyze Act 48 and federal law, including all available guidance, formal and informal (final rulemaking, if available), to determine the minimum standards for certification of QHPs. Determine standards, such as network adequacy and marketing standards, in which the federal government is according the State flexibility.
- Establish a "baseline" assessment of State standards applicable to issuers in the individual and small group market, as well as Medicaid managed care organizations, including a review of any State standards for network adequacy, accreditation, quality improvement, and marketing. This will involve a review of State law, including statutes, regulations, and sub-regulatory guidance, as well as interviews with BISHCA regulators.
- Review existing BISHCA processes for ensuring compliance with state standards prior to approving a policy, as well as ongoing monitoring of products after they are sold. Determine which BISHCA standards and processes can be leveraged by the Exchange, and which will need to be added to either BISHCA or the Exchange's responsibilities.
- Work closely with State officials to develop a set of clear goals for the QHP certification process, to ensure that any standards in addition to federal and state law requirements are aligned with State priorities and flexible enough to accommodate the State's long-term vision for a Universal Exchange.
- Develop a cost-benefit analysis relating to certification requirements that exceed minimum federal and state requirements, in order to inform the development of the certification criteria for QHPs.
- Develop certification criteria for QHPs that reflect federal and State requirements and the State's priorities and goals for health care reform. The team will work closely with State

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officials to ensure that such criteria are flexible enough to allow for Exchange officials to negotiate with QHPs, including potential new market entrants, to ensure there is a sufficient mix of products that meet the needs of individuals and small business purchasers. In addition, the team will work with State officials to ensure that the criteria can be updated over time to meet the evolving needs of individuals, business owners, carriers and the State.

- In close coordination with State officials, the team will develop recommendations for the Exchange's approach to selecting and contracting with QHPs. While the State could choose to take all plans that meet the certification requirements, the team will research and provide a cost-benefit analysis for the State regarding contracting strategies that emphasize plan performance over time, particularly on critical State priorities such as cost efficiency, wellness and prevention, health outcomes, and clinical quality.
- Conduct interviews with State officials and representatives of insurance carriers that may participate in the Exchange to gather information regarding optimal processes and procedures for certifying plans. The team will take into account the need to balance a robust, proactive review with a process that is efficient and allows both carriers and individual and small business purchasers to make decisions in a timely manner.
- In collaboration with State officials, the team will delineate clear processes and procedures for the certification of QHPs. The team will leverage work it has done in other states that have already developed such processes and procedures, and include an assessment of those projects. In addition, the team will provide an estimate of the resources needed to conduct the initial certification of issuers.
- Again, in collaboration with State officials, the team will develop recommendations for processes to ensure that QHPs maintain compliance with certification requirements over time.
- Regarding recertification, the team will work with State officials to determine the appropriate frequency for conducting a review of QHPs that are eligible. In proposed federal rules, HHS notes that the recertification process should include a review of compliance with the criteria for initial certification, but can be less intensive than the initial review. HHS also notes that recertification can be an opportunity to make modifications to any agreements between the Exchange and issuers. The team will review existing State practices for renewing contracts with plans that participate in other State programs, i.e., the state employee benefits program and Catamount Health. The team will also review the extent to which other state exchanges have decided on an optimal frequency for review.
- The team will work with State officials to develop recommended additional metrics for recertifying QHPs, such as consumer satisfaction, timeliness of meeting reporting requirements, and action to meet quality improvement goals.

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- The team will delineate recommended procedures for recertifying QHPs. The recommendations will also include an estimate of needed resources for conducting the necessary reviews. The team will take into account the need for a process that balances a robust review with one that is efficient and timely.
- The team will also develop recommendations for procedures for the decertification of QHPs. Because decertification is essentially a decision to terminate a QHP from participation in the Exchange, the team will work closely with State officials to assess whether the Exchange has the authority to deploy less severe methods to sanction a QHP that has fallen out of compliance with certification standards. The team will leverage ongoing work it is performing with other State exchanges to recommend best practices, such as probationary periods, and monetary sanctions, as well as using consumer-facing strategies, i.e., red or yellow flags on the Exchange's plan comparison website.
- The certification, recertification, and decertification processes will require the Exchange to request, collect, and analyze considerable amounts of data from potential and participating QHPs. The team will leverage its work with other state exchanges to conduct an environmental scan of the data elements currently or proposed to be collected. The team will also assess the ongoing data collection efforts of other State purchasers (i.e., Catamount Health, Medicaid). This effort will help identify data collection requirements that all state programs will have in common, as well as potential additional elements that the Exchange will require. Working closely with state officials, the team will build a list of data elements that will be needed, as well as provide recommendations regarding the need to balance data requests with efficiency and cost concerns. The team will then draft any necessary questionnaires or data calls for issuers.
- Lastly, to develop a model contract for QHPs that ensures compliance with federal and state standards, the team will work closely with State officials to determine whether contracting will include a process by which the State issues a Request for Proposals (RFP) to which interested carriers may respond. In addition, the team will consult with State officials regarding the State's contracting goals, such as whether the State will seek to implement performance-based contracting, or align the Exchange's contracting strategy with the purchasing strategies of other State agencies. In drafting the model contract for QHPs, the team will work closely with State officials to ensure that it meets State goals and objectives.

Potential Challenges and Solutions

Vermont faces challenges in its goal of creating an Exchange that both meets federal standards and performs a broader set of functions to meet the State's goal of universal coverage from a single source. The team will work closely with State officials to identify these challenges, devise thoughtful and creative solutions, and execute the necessary strategies to overcome obstacles.

Some potential challenges include:

- *A concentrated insurance market.* Vermont’s insurance market is relatively concentrated. In the individual market, the largest carrier has an estimated 75 percent market share. To the extent the State determines that this carrier is a “must have” participant in the Exchange, it could limit the State’s ability to set certification standards that the carrier objects to, or to negotiate a performance-based contract.

The team will work closely with the State to devise certification criteria and a contracting process that can be flexible and adaptable to changing market conditions. The Exchange may need to accept all qualified plans initially, but may be able to take a more selective approach over time.

- *Resource requirements.* Establishing an Exchange that engages in active management of plans and products requires staff with market expertise and an ability to negotiate with carriers, and can be resource intensive. The Exchange will need to have an adequate budget to carry out necessary plan oversight and management functions.

The team will work with the state to ensure that the processes and procedures for certification, recertification, decertification, and plan contracting functions are streamlined and efficient.

- *Delayed or incomplete federal rules governing exchanges.* Development of criteria for QHPs that meet both federal and state requirements will depend on having final rules from HHS. These criteria will be used in developing certification, recertification, and decertification processes and procedures. If final rules are not released in time to meet the deadlines for deliverables as we have proposed, we will base our analyses and recommendations on the best and most current information available, as well as ongoing informal and formal consultation with HHS officials.

3.D. Consumer Satisfaction Surveys

Our Understanding of the Purpose and Scope

Periodically collecting data from consumers and reporting results to the general public is an important undertaking for the Vermont Exchange. Consumer experiences can be reported in surveys and summarized to assist other consumers in making choices, to help policymakers in designing plan benefits, to plan quality improvement efforts, and to monitor changes in performance over time. These efforts are best served by using survey instruments and protocols that have been tested and refined through vigorous use in real world settings. Assessments of health plan performance from consumers in the United States have been ongoing for over a decade using surveys developed by the Consumer Assessment of Healthcare Providers and Systems (CAHPS) in a series of surveys that ask consumers and patients to report on and evaluate their experiences with health care in various settings, including health plans, physician's offices, hospitals, and nursing homes. With funding from the Agency for Healthcare Research and Quality and in partnership with the National Committee for Quality Assurance, these surveys have met the challenge of providing reliable and valid information for consumers, policymakers, and providers.

The foundation of these surveys is a strong focus on empirically developed and rigorously tested questions that can be combined into reporting composites or individually. For example, the CAHPS Health Plan Survey asks members to report on how often consumers are able to get the medical care they need, how quickly medical care is obtained, how well doctors communicate with patients, how often the plan provides information about how the health plan works, and experiences with health plan's customer services. The CAHPS surveys have been developed and tested with members from Medicaid, Medicare, and commercial health plans.

The Vermont Exchange consumer surveys can rely on the CAHPS health plan surveys to provide a base for building a customized reporting structure to meet the needs of Vermonters. Our process for designing a survey reporting system will use the CAHPS core survey items along with selected HEDIS survey questions. To extend the scope of this survey tool, the team can add additional items that modify standard CAHPS questions to focus on the Exchange. For example, the CAHPS survey has supplemental questions that ask consumers to report on ability to obtain and use information about how their health plan works. These questions can be easily adapted to fit the needs of the Vermont Exchange.

The Exchange team proposes a two-step process to achieve the goal of ensuring that these questions apply to the Exchange. First, the team will coordinate with the Section 4 team to conduct key stakeholder interviews among state policymakers to ensure that the content validity of the proposed survey instruments is sufficient to serve the needs of the Vermont Exchange, including how consumers interact with the Exchange. Second, the team will conduct one round of pretest interviews with consumers to ensure that questions are uniformly understood and the overall survey burden is not great enough to negatively impact response to the survey.

Instrument

The CAHPS Health Plan Survey for this project can also be used by health plans to meet their

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needs for accreditation. The National Committee for Quality Assurance (NCQA) asks all plans seeking accreditation or providing quality measures (HEDIS) for public reporting to submit the results of an enhanced version of the CAHPS Health Plan Survey (also known as CAHPS 4.0H). The team can assist the Vermont Exchange in the process of meeting the stringent requirements of NCQA for using the survey for accreditation.

Administration

There are differences between the CAHPS Health Plan Survey 4.0 and the NCQA's version of CAHPS Health Plan Survey (4.0H), which includes the HEDIS supplemental items. We will conduct an in-depth review of the CAPHS and NCQA protocols and make appropriate recommendations to the Vermont Exchange. Our recommendations will include definition of children, sample size requirements, frequency of survey administration, data collection methods, survey completion criteria, and methods in calculating response rates and conducting case-mix adjustments of survey results.

Reporting Guidelines and Specifications

It is important to establish goals for the Consumer Satisfaction Survey reporting. Before developing guidelines and specifications, the team will first establish the goals through key stakeholder interviews and conversations with other relevant parties. The goals should clearly define the audience, areas to be reported (e.g., communication with doctor, claims processing, getting needed care, getting care quickly, etc.), and the format in which data is to be presented. How data are presented will have an impact on consumers' choice of health plans. During the key stakeholder interviews, the team will gather feedback on how best to report the data to reflect the value system of the Vermont Exchange and incorporate the feedback in our reporting guidelines.

Project Tasks and Deliverables

Propose appropriate consumer satisfaction standards and measures, including recommendations based on existing HEDIS and other satisfaction measurement programs

Start date: January 15, 2012
End date: April 30, 2012

Design a consumer satisfaction survey process

Start date: January 15, 2012
End date: March 20, 2012

Develop the survey instrument

Start date: January 30, 2012
End date: May 31, 2012

Develop procedures and administrative resources for survey completion on an ongoing basis

Start date: January 30, 2012
End date: May 31, 2012

Develop specifications for posting the results on the website and reporting to HHS

Start date: February 13, 2012
End date: September 9, 2012

Our Team

Lead

Zi Zhang, UMass

Project Managers

Carla Hillerns and Lee Hargraves, UMass

Approach and Relevant Experience

As an academic survey research center, UMass has engaged in a number of survey projects that are relevant to the proposed effort. Below are descriptions of current and recent projects.

- **Patient Experience Survey and Staff Satisfaction Survey for the Massachusetts Patient-Centered Medical Home Initiative, a partnership between the Massachusetts Executive Office of Health and Human Services and several health plans in Massachusetts.** The results of these surveys help answer critical evaluation questions such as: To what extent and how do practices become medical homes? To what extent do patients become partners in their health care? And what is the initiative's impact on utilization, cost, clinical quality, and patient and provider outcomes? Working with our colleagues at the Massachusetts Health Quality Partners (www.mhqp.org), the team adopted the recently released CAHPS Clinician and Group (CG) Patient-Centered Medical Home (PCMH) instruments for adults and children. These modifications include asking patients to report on chronic conditions and self-efficacy (i.e., confidence in taking care of their health conditions). In addition, the team is fielding a staff satisfaction survey comprised of questions from the TransForMed (<http://www.transformed.com/dataCollection.cfm>) Clinician and Staff survey to assess staff members' perceptions of practice climate and culture, along with use of electronic health records and disease management registries that are critical to implementation of patient-centered medical homes.
- **Patient Experience Survey for the Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grant.** The ultimate goal of this grant is to support the development and maintenance of an integrated approach to measurement and improvement across all settings of child health care delivery that will lead to transformational gains in children's health and outcomes. The team uses the

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CAHPS CG PCMH instrument to survey a sample of parents and guardians of children enrolled in the participating practices.

- **Vermont Choices for Care Consumer Satisfaction Pilot Survey.** UMass recently completed a pilot customer satisfaction survey of Vermonters participating in the state's Choices for Care program. UMass completed 184 CATI interviews with Choices for Care participants and surrogates, representing a 73 percent response rate and a cooperation rate of 86 percent. This survey had a low refusal rate of 10 percent over a three-week fielding period.
- **MassHealth Primary Care Clinician Plan Pay-for-Performance Survey.** UMass sent questionnaires to over 1,500 primary care physician practices participating in an incentive program run by MassHealth (Massachusetts Office of Medicaid). This web and mail survey established baseline measures on processes adopted by MassHealth primary care clinicians that promote the delivery of high quality patient care. The survey assessed primary care clinicians' systems to provide extended office hours, coordination of care, disease management registries, and other services that are central to developing a patient-centered medical home. This survey had an 80 percent response rate (1,218 out of 1,520 practice groups responding).
- **MassHealth Nursing Facility Pay-for-Performance Survey.** This survey collected baseline information on the existence and administration of specific facility processes, including falls prevention programs, mobility programs, staff retention/turnover, and transition planning (both transitions to acute care hospitals and to the community). This mailed survey was conducted in more than 400 nursing facilities in Massachusetts and had a 94 percent response rate (396 out of 422 facilities responding).
- **Board of Registration in Nursing Survey.** For this project, UMass collected mailed responses from over 1,000 nurses practicing in over 100 randomly selected nursing homes in Massachusetts to determine perceptions of their facilities' culture of safety and barriers to medication error reporting. This survey used telephone reminders to nursing home administrators and directors of nursing to increase nurses' participation and yielded a 40 percent response rate.

Potential Challenges and Solutions

One of the challenges is to maintain balance between keeping the CAHPS and NCQA measurements standards for health plan certification and collecting satisfaction data that are relevant to the Vermont Exchange. Our approach is to conduct key stakeholder interviews to assess the needs of the Vermont Exchange and to ensure that the content validity of the proposed survey instruments is sufficient to serve the needs. Some of the core and supplemental question sets can be customized for the Qualified Health Plans to be included in the Vermont Exchange. Should there be need to collect new data elements, the team can assist in developing new questions (not included in this scope).

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Maintaining reasonable response rates is key to unbiased and high quality data collection. The team will work with Vermont colleagues to examine if and when a mixed-mode approach, using a combination of mail surveys and telephone follow-ups, should be considered.

Collecting data on consumer satisfaction and health plan performance in a consistent fashion, particularly over the next three to five years, is crucial for the Vermont Exchange as changes in systems and payment structure evolve and other health care reform efforts take place. Through key stakeholder interviews, the team will identify core measures that should be collected consistently so that trend data can be established to assess changes over time.

3.E. QHP Plan Design

Our Understanding of the Purpose and Scope

The purpose of this task is to help Vermont officials identify which state-mandated health care benefits exceed the federally mandated benefits required of QHPs and determine whether to retain these additional state-mandated benefits. A primary consideration is financial, since the cost of any state mandates not included in the federally defined essential benefits will fall solely to the State. Although Vermont Act 48 requires a report to the legislature by February 15, 2012, describing a proposed minimum benefit package for use in the Exchange, the real work on this cannot begin until the federal government defines the essential benefits.

Project Tasks and Deliverables

Complete a comparison of State mandates to the federally defined EHB package

Start date: February 1, 2012, assuming HHS publishes a final rule by this date
End date: March 31, 2012

Complete an actuarial analysis of the cost to the State of maintaining existing mandates that are not included in the EHB package

Start date: April 1, 2012
End date: June 30, 2012

Research other states to determine which states have similar mandates, and whether they intend to retain or eliminate these mandates, and the research behind these decisions

Start date: April 1, 2012
End date: June 30, 2012

Identify potential funding sources for retention of the State mandates

Start date: July 1, 2012
End date: September 1, 2012

Inventory the most utilized benefit plans in the State and determine the variations among those plan designs

Start date: January 15, 2012
End date: April 30, 2012

Obtain employer, employee, and individual input on potential standardized plan features

Start date: March 1, 2012
End date: July 31, 2012

Recommend one or more standardized plan designs at the silver, gold, and platinum levels and estimate the premium costs for each plan design

Start date: February 15, 2012

End date: July 31, 2012

Provide advice and written materials as requested to support the preparation of the February 15th report to the legislature

Start date: January 15, 2012

End date: February 15, 2012

Our Team

Leads

Donna Novak, NovaRest; Mila Kofman, Georgetown

Health Actuarial Experts

Donna Novack, Rick Diamond, and other senior and junior staff at NovaRest

Research Support

Georgetown Research Assistant

Approach and Relevant Experience

The Exchange team includes members with expertise on federal and state benefit mandates, as well as senior health actuaries with extensive experience estimating the costs of mandated benefits. The analysis of the federally defined EHB package and existing state benefit mandates will be led by the former Superintendent of Insurance in Maine, and supported by former federal and state regulators with expertise in researching and analyzing state insurance laws. The actuarial work will be done by a team with over 72 years combined experience working on state mandated benefits.

Complete a comparison of State mandates to the federally-defined EHB package

The team will first conduct a thorough review of benefit mandates in Vermont. This will include looking specifically at requirements for health insurance products that cover services by specified providers and for special populations (when applicable), and coverage requirements for certain medical services and conditions. This review will be for individual, small group, and large group markets, as well as associations and other products. It is critical to have information about all markets due to cost shifting that may occur. This will help inform policy decisions. Once HHS defines the EHB as required by the ACA, the team will review and assess the implications for Vermont's mandates. It is unclear at this time how specific the federal EHB will be, so once a proposed federal rule is issued, the team will develop a crosswalk and work closely with Vermont officials to determine the implications for Vermont's existing mandates. This will include a legal analysis to determine if a mandate falls within the EHB package. An updated crosswalk will be necessary once the final federal rule is issued.

Furthermore, it will be critical to consider the decisions of the U.S. Office of Personnel Management (OPM) on multi-state plans. The ACA provides for OPM to have two multi-state plans in exchanges. As OPM moves forward in developing standards, it will be important to review those federal contracts for potential further clarity on EHB as well as potential product designs that may result in adverse selection and/or cost-shifting.

Complete an actuarial analysis of the cost to the State of maintaining existing mandates that are not included in the EHB package

NovaRest has extensive experience in estimating the costs of mandated benefits. Many states have processes requiring cost estimates when the legislature considers enacting a new mandated benefit. Maine, South Carolina, and New Jersey have contracted with NovaRest to develop these estimates. NovaRest has also provided estimates for private organizations such the Amputee Coalition of Nebraska and New York Small Business Coalition. NovaRest will use its proven approach and methodology consistent with cost-estimate reports produced for states.

Research other states to determine which states have similar mandates, and whether they intend to retain or eliminate these mandates, and the research behind these decisions

For almost a decade, the Georgetown team has maintained a 50-state database of laws and regulations relating to health insurance, including laws mandating coverage of specific benefits. The team will leverage this research to assess state laws that have mandates similar to Vermont's. However, not all states will have laid out plans for responding to the federal EHB, and it will be some time before many states make firm decisions about which mandates to retain and which to repeal. Thus, the team will initially focus on selected states that have a developed process for responding to the EHB. The team will conduct interviews with insurance regulators in those states to determine what data and criteria are likely to be used to assess their mandates. The team will also review any published research those states have commissioned to support their decisions. From those interviews and the research review, the team will draft a report with recommendations for Vermont officials regarding an open, fair, and evidence-based process for determining the fate of any benefit mandates.

Identify potential funding sources for retention of the State mandates

The team will work with State officials to develop recommendations for possible funding sources to support the continuation of State mandates. These recommendations will be informed by interviews with key stakeholders in the State, including issuers, providers, consumer and patient groups, and State officials. The team will also seek information about other states' approaches focusing on State officials in states that have many mandates. Ideas from other states will help inform our recommendations.

The Georgetown team has been working with state insurance regulators and other state officials for over a decade. Many states have used Georgetown's studies and research. The team's relationships with State regulators and policymakers makes it well positioned to obtain both public and other information being considered by states.

Inventory the most utilized benefit plans in the State and determine the variations among

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those plan designs

The team will work with State officials to identify the most utilized benefit plans in the State and obtain the necessary policy forms. The team will focus on benefit plans offered in the individual and small group markets, as well as policies sold through associations covering individual purchasers and/or small business members. The team will review those policy forms and draft a report detailing the variations among the plan designs.

Georgetown's team has extensive background on variations in product design. Team members have reviewed insurance contracts and produced reports analyzing how different health insurance policies work. Our research and published reports include coverage sold in the individual market, small group market, and federal employee benefits. These reports specifically examined variations in benefits (and implications for the out-of-pocket liability a patient may have). Our reports looked at coverage sold in Massachusetts (through the Connector), Maryland, Colorado, California, and other states.

Obtain employer, employee, and individual input on potential standardized plan features

The team will work with State officials to develop an open, inclusive, and transparent process for the development of potential standardized plan features. The debate over state mandates and the QHP benefit design has the potential to be highly politicized. Establishing a fair and inclusive process is critical to generating initial and long-term support for the decisions of State policymakers. In addition to receiving input from employers, employees, and individual consumers, the team will also recommend formal outreach to and inclusion of provider and health plan representatives. In general, the team has found that a multi-stakeholder, consensus-based process that is open to the public has the best chance of generating long-term public support. However, such a process can also be resource-intensive and time consuming, so the team will work closely with State officials to develop a process that works best for the State.

The team has extensive experience in building consensus among diverse stakeholders. Mila Kofman co-chaired an NAIC's ACA statutory working group whose members included providers, health plans, consumer and patient advocates, brokers, and state officials. Team member Sabrina Corlette was an appointed member of this working group. The group's consensus-based approach resulted in unanimous recommendations (adopted unanimously by the NAIC). The federal government used the group's products in their entirety in a proposed federal regulation.

Recommend one or more standardized plan designs at the silver, gold, and platinum levels and estimate the premium costs for each plan design

The team will refine the standardized plan designs based on the input from employers, employees and individuals, as well as provider and health plan representatives, and work with State officials to develop recommendations for standardized plan designs. The team's actuaries will then estimate the premium costs for each plan design using available data with respect to health care costs in Vermont. The team anticipates that the development of final recommendations for standardized benefit plans will be an iterative process, involving regular input and feedback from State officials, our actuarial experts, and if the budget permits, a second round of consumer focus groups.

The team has considerable experience with benefit design. As part of the Illinois project to implement a third-share plan for the uninsured, NovaRest helped develop the small employer benefit plan offered. Donna Novak has also designed benefit plans for many employers during her seven years as a benefits consultant.

Provide advice and written materials as requested to support the preparation of the February 15 report to the legislature

The team will work closely with State officials as recommendations for QHP plan design are developed, and will provide continued research, analysis, advice, and as necessary, written memos or reports to support the drafting of the February 15 report to the Vermont legislature.

Potential Challenges and Solutions

One of the challenges with this exercise compared to past estimates is matching the State's mandated benefits to the essential benefits. Many believe that the essential benefits definitions will not be detailed enough for a good comparison. For example, many state mandates are mandated providers rather than mandated services. It is doubtful that the essential benefits will include definitions by type of provider.

The team proposes the following:

- 1) To be in communication with other States that are facing the same challenges, with the goal of sharing ideas
- 2) To be in communication with HHS to get as much clarity as possible on the specific matching of state mandates to the essential benefits
- 3) To continue our professional work at the Academy of Actuaries and the National Association of Insurance Commissioners where these same issues are being reviewed
- 4) To request data from health carriers in Vermont
- 5) To use Vermont specific data sources such as the Vermont All-payer database, if it is detailed enough for this analysis

The team is also sensitive to the often highly politicized debate over benefit mandates. To the extent the debate over maintaining or repealing state mandates, or the development of a plan design for QHPs becomes politicized, it could hinder Vermont's efforts to establish a plan design that is evidence-based and affordable over the long term.

The team proposes the following:

- 1) To be in close and regular communication with State officials and stakeholders in the State to keep abreast of any developments
- 2) To work closely with State officials to establish an open, transparent, and inclusive process for making decisions about existing state mandates and the development of standardized QHP designs

Section 4: Stakeholder Involvement and Outreach/Education

- *Demonstration of understanding of the purpose and scope of this project*
- *Adequacy of management plan*
- *Identification of pertinent project issues*
- *Identification of potential problems*
- *Practicality and feasibility of proposal*

4.A. Navigator Program

Our Understanding of the Purpose and Scope

The ACA requires the Exchange to contract with Navigators to assist with enrollment. The Navigator program must be fully State funded and must provide grants to qualified individuals and/or organizations to educate and assist individuals and small businesses in enrolling in health coverage through the Exchange. Navigators will play an important role in educating and assisting consumers in working with the exchanges. In addition to serving as “outreach” coordinators, Navigators will provide impartial and objective information to health care consumers in the state of Vermont. Federal HHS draft regulations suggest that there will be a minimum of two types of Navigators.

The Exchange team will work with the State to develop a Navigator program model that takes into account the needed capacity for Navigators across the state and that establishes criteria for Navigators and guidance on meeting these criteria. Navigators will be identified through an RFP process for interested individuals or organizations, which UMass will devise in concert with the State. Considered will be organizations or individuals that focus on health care needs and that can respond to a diverse set of consumer needs for target populations (i.e. rural, elders, young adults). Applicants will have the option of bidding to serve either or both individuals and small businesses and also the option of bidding to serve all areas of the state or just particular regions.

Project Tasks and Deliverables

Develop certification criteria for Navigators, differentiating between Navigators serving individuals and those serving small businesses

Start date: January 15, 2012
End date: March 1, 2012

Develop a certification process for Navigators

Start date: March 1, 2012
End date: September 9, 2012

Develop a training program for Navigators, including a curriculum and training materials

Start date: March 1, 2012

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End date: September 9, 2012

Develop the RFP and model contract

Start date: January 15, 2012

End date: September 9, 2012

Our Team

Leads

Alexis Henry, Gretchen Hall, and John Rochford, UMass

Subject Matter Experts

Michael Tutty, UMass; Lisa Carroll, SBSB

Project Management Support

TBD, UMass

Approach and Relevant Experience

In partnership with the State, the team will develop specific criteria for Navigators. Particular attention will be given to distinguish Navigators from Brokers so that consumers can use each resource appropriately. The team will delineate differences between Navigator certification and broker (Producer) licensing and make recommendations to the State regarding each requirement. After Navigator certification criteria have been clearly articulated, the team will work with the State to develop an RFP to identify organizations and individuals to serve as Navigators.

The team will work with the State to build capacities for Navigator training and certification. Initially, the team will develop both in-person and online versions of the Navigator training. The team anticipates that the first wave of Navigators will be trained and certified using the in-person version. Feedback from these initial in-person trainings can then be used to develop online training. An online training and certification system is necessary for maximum for the efficiency and sustainability of Navigators. As appropriate and feasible, this Navigator training system will be integrated with the training management system and call-center training. When circumstances warrant it, the in-person training curriculum can always be offered.

The curriculum will be developed with the understanding that Navigators must be knowledgeable in the following areas:

- Fundamentals of ACA and Vermont Act 48: individual responsibility
- Eligibility guidelines for Medicaid, CHIP, and subsidized insurance
- Benefit design of QHPs, including the cost-sharing requirements
- Procedures for applying for coverage, and using the web-based enrollment system
- Accessing the call center
- Facilitating health plan selection
- Premium tax credits and reduced cost-sharing obligations

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- Instructions for handling exceptions, denials, referrals, etc.
- Relevant consumer protection laws

Re-certification of Navigators on an annual basis is strongly recommended. UMass brings particular experience in training and certification development, having developed and implemented the Child and Adolescent Needs and Strengths (CANS) training program for Massachusetts. CANS is a behavioral health tool and this program highlights the scale for which UMass has developed a sustainable training and certification program. Over 14,000 individuals have been trained, with over 13,000 being certified, including 5,000 who have completed the re-certification process.

Program activities were very similar to those required for the Navigator program and included:

- Certification training program design and delivery
- Designed online registration, training, and certification capacity
- Refined certification exam in response to user feedback
- Provided ongoing technical assistance
- Customized supportive materials
- Delivered both web-based and distance learning programs
- Development of post-certification electives (on specialty topics)

Upon completion of certification, Navigators may be strategically placed in hospitals, clinics and other health care facilities, and community-based organizations where the uninsured or under-insured access care and should be equipped with necessary tools such as a computer to meet the needs of the consumer in a wide range of settings and locations. Since the implementation of health reform in Massachusetts, UMass has managed the grant (EOHHS Enrollment, Outreach and Access to Care Grant) funding 51 health and human service organizations that conduct outreach and enrollment services to enroll individuals into MassHealth and Commonwealth Care (Massachusetts subsidized insurance products). Lessons learned from this experience are relevant to the implementation of the Vermont Navigator program. For example, we found that people based within their communities are best suited to reach out to underserved individuals within those communities.

Potential Challenges and Solutions

1. A key challenge will be leveraging and coordinating messages and consumer advice between the Exchange call center and Navigators. To respond to this challenge, the team recommends that training and learning management for the Exchange call center and for Navigators be fully integrated. In addition to initial certification training, Navigators should have access to ongoing training and supports that are offered to the call center.
2. There is a range of perspectives on the role of Navigator. In Vermont, consultations with stakeholders have identified that nonprofit organizations are generally enthusiastic about the ACA and tend to perceive the role of Navigator as critical. In contrast, across the country, insurance brokers have voiced concerns about Navigator programs. One

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challenge will be to respond to insurance brokers' concerns while establishing clear roles and criteria for Navigators. For this task, it will be important to engage the Division of Insurance, the broker community, and health insurance carriers in defining certification criteria for Navigators to decrease criticism and objections to the Navigator role.

3. An integrated customer encounter documentation system must be developed. Early on, determinations will need to be made on documentation requirements and the use of reports and data of encounters for program evaluation and for follow-up with consumers.
4. Criteria for funding Navigators must be established, as well as procedures for monitoring their success rates based on actual enrollments. The mechanics of tracking this can be accomplished through a "How did you hear about us?" source code to the enrollment application.
5. A regulatory agency must be designated for overseeing the Navigator certification process. The team will build the online certification system to monitor and report regularly on the activities of certified Navigators.

4.B. Stakeholder Consultation

Our Understanding of the Purpose and Scope

As one of the Early Innovator grant recipients and a participant in the implementation of the 2006 Massachusetts universal health insurance reforms, UMass understands the importance of ongoing stakeholder engagement. As in Massachusetts, consulting stakeholders will be critical to the successful design and implementation of the Vermont Exchange and Vermont's entire reform agenda. Stakeholders must be kept informed of progress and issues, and they must also provide input. This input is critical to the early identification of flaws in the proposed Exchange design and implementation plans. Many problems will thereby be averted, better ensuring a successful launching of the Exchange. A process of systematically engaging Vermonters will also educate them on what an exchange is and does.

To ensure a successful rollout of an Exchange that meets ACA and Act 48 program goals, the Exchange team will conduct an array of meetings over the next year. The Joint Advisory Committee will meet at least 10 times, and there will be no fewer than six regional public forums and six regional small business forums. The formal Joint Advisory Committee was established under Act 48 to ensure all Vermont residents have access to quality health plans authorized and qualified to provide health insurance in the state. Another important change is the ACA's requirement that Medicaid's online application, eligibility determination, and enrollment renewals be integrated into the Exchange. The Joint Advisory Committee members include a range of stakeholders to ensure all necessary public and private needs are addressed. The regional public forums and small business meetings will engage, educate, and inform stakeholders about the Exchange and will provide important information to the DVHA about needs and concerns.

These meetings will comply with Vermont's Open Meeting Law and will provide ADA Title II accommodations. We will assist the State in identifying key stakeholders and ensuring their participation, developing meeting agendas and briefing materials, locating and reserving meeting locations, scheduling meetings, and providing refreshments. Meeting minutes will be taken during all meetings and a summary report for each meeting will be provided. These summary reports will help inform key area recommendations and Exchange design.

Project Tasks and Deliverables

Develop agendas and prepare briefing materials for 10 Joint Advisory Group meetings, at least six regional public forums, and at least six regional meetings with small businesses

Start date: January 15, 2012
End date: September 4, 2012

Schedule meetings and arrange rooms and refreshments for all meetings

Start date: January 15, 2012
End date: September 9, 2012

Provide minutes/summaries of the meetings

Start date: February 13, 2012
End date: September 9, 2012

Develop recommendations in key areas, including basic Exchange design, resulting from public input

Start date: January 30, 2012
End date: September 9, 2012

Our Team

Leads

Alexis Henry, Jack Gettens, and Marsha Mullaney, UMass

Subject matter experts

Michael Tutty, UMass; Lisa Carroll, SBSB

Local logistic support for stakeholder engagements

Diane Zeigler and Kevin Ellis, KSE
Vermont AHECs

Project Management Support

TBD, UMass

Approach and Relevant Experience

Dr. Gettens and Ms. Mullaney will provide stakeholder consultation oversight to ensure all deliverables are provided to the State in a timely manner. Dr. Gettens will provide subject matter expertise and work with the State to develop meeting agendas and briefing materials and will oversee the production of summary reports from stakeholder meetings. Ms. Mullaney will oversee all meeting logistics and will serve as the liaison to our logistics partners on the ground throughout the State.

For stakeholder consultation, the team will include Vermont-based KSE Partners, which will provide all local logistics support for Joint Advisory Committee meetings, public forums, and small business meetings. KSE, with particular expertise in driving important messages to targeted audiences in the State, will also work closely with UMass and the State to develop the outreach, education, and marketing campaign (described more below in Section 4C). KSE provided the entire public relations and messaging campaign for the 2009 same-sex marriage campaign in Vermont. KSE's experience also includes designing and managing Vermont-based and national marketing campaigns for radio, television and print. KSE delivers communications solutions in timely, targeted fashion in partnership with its clients. In particular, KSE will work to ensure that stakeholders representing key industries, such as insurance providers and brokers, health plans and others are engaged in stakeholder meetings. In addition, the regional Vermont

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AHECs will provide consultation to KSE Partners to ensure that stakeholder meetings are inclusive of other key stakeholders such as the full range of health service providers, sole proprietors, and small employers. The AHECs will participate in stakeholder sessions as needed and will incorporate the input from these meetings in the development of train-the-trainer curriculum for outreach and education (see Section 4C).

In an interactive process, the team will synthesize and integrate information gathered in all stakeholder meetings, providing ongoing feedback to the State, and will use this information to shape subsequent meetings. The feedback from these meetings will continue to inform Vermont's development of the Exchange, building on the results from earlier focus groups, interviews, and surveys with under- and un-insured individuals, not-for-profits, and small businesses. Public input and the NESCIES project will inform the team's designs.

Potential Challenges and Solutions

A potential challenge for this project will be achieving statewide stakeholder engagement. All Vermont residents and businesses need a high level of awareness and understanding about the opportunities and responsibilities related to the Exchange. Stakeholder consultation may be challenging because the time stakeholders have available for the project will be limited. To compensate for this limited time, the stakeholder consultation process must be efficient. To ensure this efficiency, the team will carefully prepare meeting agendas and briefing materials. The team will work with the State, key stakeholders, and key project staff to identify potential agenda items for each meeting. The agenda items will be assessed to determine the importance of each and its objective. Based on this assessment, the team will create draft agendas and briefing materials. The team will review these drafts with State officials to finalize agendas and briefing materials.

The team will work with the State, KSE, and Vermont AHECs to ensure key stakeholders, who have the ability to provide information and feedback, are involved in the stakeholder consultation process. Promptly after each stakeholder meeting, the team will provide a summary report of the stakeholders' concerns and feedback to the State. The team will include in these summary reports possible solutions to problems that are voiced in stakeholder meetings.

To ensure efficiency, we will summarize information solicited from stakeholders for key State officials and the team as a whole. To be useful, the information must be readily grasped and directed to individuals who can act on it. In addition to distributing meeting minutes, we will also target information pertinent to certain responsibilities to the persons who bear these responsibilities. If there are topics that require specific actions or decisions, we will track the progress of the actions or decisions.

4.C. Outreach and Education

Our Understanding of the Purpose and Scope

In partnership with KSE Partners, the Exchange team will manage the development of a comprehensive outreach, education, and marketing campaign for the implementation of the Exchange. The team will target the campaign primarily on consumers and employers. As required by the ACA, consumers will include everyone for whom the Exchange is pertinent, including individuals with disabilities, with limited English-speaking proficiency, or who face other challenges in enrolling. Employers are defined as Vermont small businesses.

The campaign will have multiple purposes. The first will be to alert Vermont residents that there is a campaign and what it offers. The team will develop strategies for directing consumers to the Health Care Ombudsman program and other resources at the Exchange, and to local resources for responding to their individual needs and questions. Due to the rural nature of much of Vermont, and the State's diverse communities, reaching consumers requires a number of communications vehicles and mechanisms. Creative assets such as informational brochures and a website will be developed. The team will also explore opportunities for public service announcements (PSAs) and advertisements on state, regional, and local broadcast networks. The team will also host public forums throughout the state. The team will ensure that the substance of all outreach activities is reviewed and approved by state staff. The team will work to ensure representation of key personnel at the forums and that questions and concerns are properly addressed.

In partnership with the Vermont AHECs, the team will develop a Master-Train-the-Trainer curriculum and provide training to Vermont AHEC staff, who will then offer trainings locally to the Health Care Ombudsman program, staff in community information and referral programs, state and regional call centers, health care providers, community health workers and benefit counselors, and other key stakeholder individuals and groups. The team will also provide training in large and small group meetings and present at local conferences and meetings.

Project Tasks and Deliverables

Develop a comprehensive outreach, education, and marketing campaign as described above

Start date: January 15, 2012

End date: July 15, 2012

Implement and complete the first phase of the campaign in 2012

Start date: July 15, 2012

End date: September 9, 2012

Our Team

Lead

Alexis Henry and Michelle Nowers, UMass

Marketing and communications consultants

Diane Zeigler and Kevin Ellis, KSE

Training (Train-the-Trainer) consultants

Vermont AHECs

Subject Matter Experts

Michael Tutty, UMass; Lisa Carroll, SBSB

Project Management Support

TBD, UMass

Approach and Relevant Experience

To ensure a successful marketing campaign, the team will work with the State to develop a comprehensive communications plan for the Exchange campaign. The people involved with branding and messaging must bring to these tasks a complete understanding of Vermont’s landscape — its media, demographics, political environment, culture, and health care stakeholders. KSE will make sure that all contractors have this understanding.

The pre-implementation phase of the planning will begin with a facilitated and coordinated branding process led by KSE. A core group of straightforward messages will be developed that communicate the scope of the Exchange to the key audiences (consumers and employers). Our team will advise the state on how messaging about the state’s single payer plan should be incorporated. Messaging will be tested on sample audiences and refined. During the pre-implementation phase, the team will draw on lessons learned from the marketing and public education effort undertaken to establish the exchange in Massachusetts.

A complete communications and media plan will be written during pre-implementation. The team will consult with the State to ensure that messages and materials are consistent with previous materials developed for Catamount Health. The team will collaborate with the Navigator program to ensure that Navigators are receiving a consistent message. Navigators will serve as “outreach” coordinators providing impartial and objective information to consumers.

Michelle Nowers will be the UMass liaison to KSE on the development of a comprehensive outreach, education, and marketing campaign. Ms. Nowers will oversee the production of the overall presentation of the Exchange and ensure all reasonable means are employed to disseminate it: print, television and radio advertisements, brochures, fact sheets, etc. Ms. Nowers will also serve as liaison to the Navigator program and stakeholder consultations to ensure consistent communication. Ms. Nowers has previously served in a similar capacity in Massachusetts, overseeing the implementation of a broad-based marketing and communications effort related to employment of people with disabilities in the state.

The first phase in the development of the marketing, outreach, and education campaign will also include the development of a train-the-trainer curriculum for the Exchange. The Vermont

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AHECs will develop the curriculum, provide a Master Trainer and will train two part-time (.5 FTEs) trainers at each of the three regional AHECs in Vermont. These trainers will then pilot the training program and materials developed for the Exchange with providers, employers, other front line organizations and individual Vermonters. Based on this pilot, the team will refine the training program and materials to facilitate clarity and to identify the best approaches for delivering the training and information (e.g., live, self-based web-based webinar, written brochures, etc.). Training materials will be designed so that they are accessible to individuals with disabilities, with limited English proficiency, or with limited internet access. Also, the team has expertise in health literacy to prepare written materials at a sixth-grade reading level and to translate them so that they are readily understood in other languages. These materials will also be made available in large print and Braille.

Ms. Nowers will also serve as the liaison to the Vermont AHEC partners, ensuring that the collateral materials developed for the communication and marketing campaign are available for the pilot training implemented by Vermont AHEC. UMass has extensive experience overseeing the development and implementation of provider training. For the past eight years, UMass has coordinated the efforts of the Massachusetts Health Care Training Forum, which provides accurate and timely information on MassHealth and other public assistance programs, to staff of health care organizations and community agencies that serve MassHealth members, the uninsured, and the underinsured.

Potential Challenges and Solutions

- Due to the rural character of Vermont and the dispersion of its uninsured individuals, a key challenge will be ensuring that all stakeholders are receiving consistent information. The team will utilize social media such as Facebook and Twitter to communicate “tidbits” of information and relevant announcements of events which has potential to reach to a large number of individuals.
- Due to the eight-month timeframe, effective marketing will require quick buy-in from all stakeholders. The team will rely on the expertise of KSE for effective outreach on a necessarily compressed schedule.

Section 5: Program Integration

- *Demonstration of understanding of the purpose and scope of this project*
- *Adequacy of management plan*
- *Identification of pertinent project issues*
- *Identification of potential problems*
- *Practicality and feasibility of proposal*

5.A. Integration of Existing Coverage Groups

Our Understanding of the Purpose and Scope

As a step toward building a single-payer health system, the State of Vermont intends to integrate and/or align a number of public and private programs and coverage options with its Exchange. These programs include Dr. Dynasaur (CHIP), Medicaid (including Medicaid waiver programs), LTC Medicaid, the Medicare-Medicaid Dual Eligible Demonstration project, Catamount Health, Vermont Health Access Plan (VHAP), employer-sponsored insurance premium assistance, various pharmacy assistance programs, association coverage, and coverage for public employees.

To accomplish this task, the Exchange team will assist the State to develop a comprehensive integration strategy, work with Vermont agency lawyers to identify changes in Vermont law necessary to achieve the integration strategy, and develop plans for integrating the Exchange with other DVHA functions and with the Medicaid eligibility function in DCF.

Project Tasks and Deliverables

Assist the state to develop, refine, and finalize a comprehensive integration strategy for public and private health coverage programs and options

Start date: January 17, 2012
End date: September 9, 2012

Identify statutory changes or federal approvals necessary to achieve an integration strategy

Start date: January 17, 2012
End date: July 31, 2012

Develop a plan for integrating the Exchange Division with other DVHA functions

Start date: June 1, 2012
End date: September 9, 2012

Develop a plan for integrating the Exchange with the Medicaid eligibility function in DCF

Start date: June 1, 2012
End date: September 9, 2012

Our Team

Lead

Stephanie Anthony, UMass

Legal and policy analysis

Julia Feldman and Rachel Frazier, UMass

Content experts

Lisa Carroll, SBSB; Sabrina Corlette and Mila Kofman, Georgetown; Robert Seifert and Jean Sullivan, UMass

Note: In addition to its team members, UMass has professionals with in-depth expertise in administering a wide range of health care programs and benefits. The project team will seek expert advice from these individuals as needed during the course of the project. UMass is also in the process of hiring additional policy analysts and associates who will be available to assist the team with research and analysis for this task.

Approach and Relevant Experience

Stephanie Anthony will lead Section 5A and will oversee, manage, and coordinate the efforts of all team members. Ms. Anthony will work closely with the Project Lead, Judith Fleisher, and other section leads to align with the overall project management plan and ensure that the UMass Exchange Team provides a seamlessly coordinated package of services. Ms. Anthony is currently the UMass lead supporting the development of Massachusetts' State Demonstration to Integrate Care for Dual Eligibles, which includes an effort to integrate a comprehensive set of Medicare, Medicaid, and supplemental services and Medicare and Medicaid financing for dual-eligible state residents ages 21-65.

The Exchange team has deep knowledge and experience administering and analyzing public programs, private insurance, and exchange functions required to address this intricate task. The team has extensive legal, financing, policy, and legislative experience relative to Medicaid and CHIP, Medicare-Medicaid dual-eligibility issues, as well as extensive state-based experience in the expansion of coverage to the uninsured and modeling systems for financing uncompensated care. The team's experience includes the design and establishment of Massachusetts' health insurance exchange (Connector); integration of eligibility determination and enrollment processes for Massachusetts Medicaid and subsidized insurance through the Connector; design and analytical support to develop State Demonstrations to Integrate Care for Dual Eligible Individuals in Massachusetts and Connecticut; and extensive experience obtaining federal waivers and other approvals.

Mila Kofman and her colleagues at Georgetown are nationally renowned experts on state and federal regulation of private health insurance. As former Superintendent of Insurance in Maine and a former regulator with the Department of Labor, Ms. Kofman has the expertise to identify and analyze effects of integration into the Exchange on the private health insurance market, and to develop strategies for mitigating those effects.

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Lisa Carroll administers a sub-Connector, the component of the Massachusetts exchange that brokers non-subsidized individual and small group insurance. She will draw on her experience to help the team identify and resolve barriers to integrating public and private programs into a single Exchange.

Develop a comprehensive integration strategy

This task will build upon preliminary work in this area, including an assessment of current health care benefit programs across the public and private sectors and the identification of integration opportunities, supported by Vermont's federal Exchange Planning Grant. The primary deliverable will be the comprehensive strategy for integrating the above-named programs and coverage options, particularly programs in the private insurance market, into the Exchange. The major tasks involved in completing this deliverable are described below.

The team will assist the state in assessing a number of factors in order to integrate or align public and private health benefit programs with the Exchange. For public programs, the team will identify issues and strategies to coordinate and align program eligibility and enrollment processes, business operations, and information technology. For private-sector programs, the team will identify issues and strategies to coordinate and align policies regarding the regulation and licensure of health insurance issuers, including consumer coverage appeals and complaints processes, insurance company financial solvency requirements, certification of plans, rate review, and market conduct. These strategies may include changes to policies, procedures, information technology systems, data sharing requirements, as well as the legal issues further discussed below.

Identify statutory changes or federal approvals needed

The team will analyze current state and federal statutory requirements and new or proposed federal rules that affect these programs to identify areas of overlap, interaction, synergy, and conflict. The ultimate goal of this integration is to streamline eligibility determinations and enrollment processes, and ensure continuity of care. Areas of potential focus for this analysis include program eligibility requirements, enrollment and disenrollment processes, covered services, cost-sharing requirements, care coordination opportunities, information systems (e.g., eligibility, claims, quality reporting), public disclosure requirements, and terminology.

The team will identify federal approvals necessary to achieve the integration strategy, and team members will work with Vermont agency staff to identify changes required in Vermont law. The team will also advise the State as to recommended approaches for obtaining necessary federal waivers or approvals.

Plan for integrating the Exchange with DVHA functions and the Medicaid eligibility function in DCF

UMass will develop a detailed plan for integrating the Exchange Division with other DVHA functions. This plan will address issues such as clinical services, coordination of benefits, program integrity, and information technology. UMass will also develop a plan for integrating the Exchange with the Medicaid eligibility function in DCF to ensure that the Exchange system

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is able to interface with various data sources to obtain and verify necessary eligibility information.

For the integration of eligibility data, Vermont could be in a position to use the products of the NESCIES project, which UMass leads and in which Vermont is a partner. UMass, in conjunction with the Massachusetts EOHHS and the Massachusetts Commonwealth Health Insurance Connector Authority, will be issuing a Request for Response (RFR) to solicit proposals from qualified systems integrators to design, develop, and implement a new, state-of-the-art Health Insurance Exchange (HIX) and Integrated Eligibility System (IES) for Massachusetts health care programs.

The Massachusetts HIX/IES will be designed and developed using a modular, reusable, and scalable architecture that incorporates open standards technology components so that it can be shared with other New England states, including Vermont. The work orders defined in the RFR include identifying reusable components and supporting the sharing of these components with select New England states. The NESCIES lead team is currently creating a memorandum of understanding (MOU) with Vermont to participate in the procurement and design stage of this effort.

Potential Challenges and Solutions

Integrating and aligning these diverse programs and coverage types could present a number of obstacles to overcome. Potential challenges could arise in several areas related to systems interoperability, maintaining collaborative state agency and stakeholder relations, concerns around the continued growth of and implications for association policies, and restrictions resulting from federal law, for example.

A part of its strategy, the team will identify any expected or unforeseen challenges in a timely manner, and will assist the State in developing strategies to mitigate adverse impacts and/or develop alternative solutions to achieve the state's goals.

5.B. Administrative Simplification

Our Understanding of the Purpose and Scope

Vermont seeks to reduce the administrative cost of providing health care in the state as part of an effort to lower health care costs while maintaining quality health care for its residents. With Establishment Grant funding, Vermont has a unique opportunity to incorporate strategies to coordinate, simplify, and streamline health care administration into its Exchange planning, particularly given its ultimate goal of creating a single-payer plan. The Exchange team will review State simplification projects together with the ACA provisions aimed at administrative simplification to identify areas of alignment, overlap, or conflict. The team will catalog simplification strategies that could help the State meet its goals, including opportunities identified by other states, through academic research, and through researching federal law. The team will poll providers to assess their perspectives and priorities on administrative simplification, and will use this information to help the State develop a comprehensive administrative simplification plan that results in meaningful simplification at the health care provider level.

Project Tasks and Deliverables

Review past and current simplification projects in the State, as well as any simplification efforts in other states, and national research in this area

Start date: January 17, 2012
End date: March 30, 2012

Research federal law to determine possible simplification opportunities

Start date: January 17, 2012
End date: March 30, 2012

Poll providers to determine areas of greatest complexity from their perspective and preferences and/or priorities

Start date: March 1, 2012
End date: May 31, 2012

Develop an administrative simplification plan for the State, including an implementation plan and timeline, that identifies any necessary State law changes and/or waivers of federal requirements, the estimated development costs to achieve the simplification strategy, and estimated long-term savings

Start date: May 1, 2012
End date: September 9, 2012

Our Team

Lead

Katharine London, UMass

Legal and policy research and analysis

Stephanie Anthony, Julia Feldman, and Rachel Frazier, UMass

Content experts

Lisa Carroll, SBSB; Sabrina Corlette and Mila Kofman, Georgetown; Deborah Drexler, Robert Seifert, and Jean Sullivan, UMass

Note: Again, UMass's team has access to other UMass professionals who have experiences and expertise in administering a wide range of health care programs and benefits. The project team will seek expert advice from these individuals as needed during the course of the project.

Approach and Relevant Experience

Katharine London will lead this task and coordinate the efforts of team members. Ms. London will work closely with the Project Lead, Judith Fleisher, and other section leads to align with the overall project management plan and ensure that the UMass Exchange Team provides a seamlessly coordinated package of services.

The Exchange team has extensive experience in an array of disciplines to meet this demanding task. Ms. London has led analytic and research support activities for a number of high-profile health care system transformation initiatives designed to meet multiple goals and the diverse interests of stakeholders, while navigating complex constraints, as well as diverse interests of stakeholders. Stephanie Anthony has extensive experience developing, managing and analyzing federal Medicaid waivers, state plan programs, and other programs and proposals to identify potential overlaps, interactions, and synergies. At Massachusetts Medicaid, she was the project lead for negotiating Medicaid waivers. Julia Feldman will draw on her two decades of experience in health law to provide advice on complying with federal law and regulations. Deborah Drexler is a health care attorney with particular expertise in health information technology projects, HIPAA compliance, and data operations compliance with applicable laws, regulations, and contractual requirements. Mila Kofman has deep knowledge of how states regulate entities and products, and is an expert on federal insurance regulation, including ERISA preemption issues that may be involved in incorporating self-insured groups in a Universal Exchange. Lisa Carroll has direct experience with the administrative challenges faced by insurers, purchasers of health insurance, and an Exchange. UMass will apply the combined knowledge of these experts, as well as other across UMass, to assist Vermont in developing a comprehensive plan for administrative simplification.

Vermont is dedicated to streamlining and simplifying health care administration as it undertakes a comprehensive strategy to integrate and align public and private health insurance in anticipation of all-payer rate settings and its Exchange. Taking a coordinated approach to these initiatives gives the State an unprecedented opportunity to implement strategies for standardizing

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and simplifying a broad spectrum of administrative tasks, including, but not limited to, eligibility determinations for state programs, enrollment in public and private insurance and coverage programs, verification of covered benefits, coordination of benefits across multiple payers, provider billing, coding, and payment methodologies, as well as grievance, appeals, and complaints processes. Together, these strategies can dramatically reduce administrative costs, while improving coordination of patient care.

In line with a Vermont-commissioned 2011 report, *Aligning Health System Reform Design* by Dr. Hsiao et al, Vermont should consider establishing a single database on insurance and benefit coverage for all residents, as well as a single fiscal intermediary that would adjudicate claims submitted by all providers on behalf of all commercial insurers and public coverage programs. Such a system would enable providers to resolve all coverage and billing issues through a single entity with uniform systems and requirements. As a result, health care providers could significantly reduce the resources they must devote to administrative tasks and could re-direct those resources to patient care. The team will provide data, information, and expert advice to the State to support its policy-making decisions in this area.

Review State projects and other opportunities

The team will review the State's past and current administrative simplification, including the Medicare-Medicaid dual eligible project and strategies to streamline insurer coding. The team will also catalog simplification strategies identified by other states and through academic research. The team will then assess the extent to which each opportunity would further the State's goals; identify areas of alignment, synergy, or potential conflict with federal requirements; estimate the level of effort required to implement the opportunity; and estimate potential administrative savings to the State. The team will note areas of uncertainty where future federal guidance could have a significant impact.

Research federal law

The team will conduct an in-depth analysis of the ACA provisions regarding administrative simplification, federal regulations, guidance, and other communications as they become available. The team will also consider provisions of HIPAA, ERISA, anti-trust requirements, and other federal laws that could provide possible simplification opportunities or could constrain State administrative simplification efforts.

Poll providers

The team will poll providers on their perceptions of what is or could be problematic, as well as on their preferences and priorities. The team will assist the State in obtaining input from providers in several different ways. For example, the State may wish to use one of the stakeholder meetings described in Section 4 to gauge the level of interest in potential opportunities at a systemic level. If so, the team would compile presentation materials and facilitate discussion on key issues that are identified.

To obtain more detailed feedback regarding opportunities, UMass proposes to hold several meetings around the State to discuss issues with hospitals and other large institutional providers, and separately, to discuss issues with small clinical practices. The team will work with the State

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to develop a series of questions to discuss with providers during each meeting. During the meetings, providers will be asked for examples of issues that are the most expensive or time-consuming for them, and recommendations on how these issues might best be addressed.

The team will then develop an electronic online survey to garner feedback from a broader set of providers. The survey will ask providers about issues raised during the focus groups and about opportunities identified through the earlier research. Respondents will have an opportunity to rate administrative issues in terms of their complexity, time, expense, and importance.

Develop an administrative simplification plan

The team will use the information gathered through these efforts to assist the State to develop a comprehensive administrative simplification plan. The team will help the State assess the opportunities relative to providers' needs and priorities, and to use that information to select strategies to meet the State's goals. The team will work with Vermont agency lawyers to identify any changes in State law that would be required to implement the administrative simplification strategies. The team would also advise the State as to any waivers that might be required of federal requirements and recommended approaches for obtaining such waivers.

The team will develop a plan for implementing selected administrative simplification strategies that would identify the steps required to implement the selected strategy, the entities (state government, payers, and providers) responsible for each step, and the timeline for completing each step. The team would estimate the cost to implement the strategy and the savings that could potentially be reaped, identify the entities that would incur the cost and reap the savings, and the point(s) in time when these costs and savings would be incurred. Finally, the team will suggest a strategy for balancing costs and savings equitably among government, private payers, providers, employers, and consumers.

Potential Challenges and Solutions

Administrative simplification is an enormous and far-reaching endeavor. Simplifying and streamlining health care processes can result in tremendous savings that can be redirected to other uses. However, these changes will pose significant challenges. Many different individuals and institutions with a variety of needs and perspectives will need to work together to accomplish the desired changes. In addition, a large number of people earn their livelihood by performing administrative tasks that will be streamlined or eliminated; these workers will need to be re-trained and re-deployed to perform tasks that will be required by a reformed health care system.

Section 6: Quality and Wellness

- *Demonstration of understanding of the purpose and scope of this project*
- *Adequacy of management plan*
- *Identification of pertinent project issues*
- *Identification of potential problems*
- *Practicality and feasibility of proposal*

6.A. Quality Program and Rating System

Our Understanding of the Purpose and Scope

A basic function of Exchanges, per proposed federal rule 155.200¹ states:

Quality Activities. The Exchange must evaluate quality improvement strategies and oversee implementation of enrollee satisfaction surveys, assessment and ratings of health care quality and outcomes, information disclosures, and data reporting pursuant to sections 1311(c)(1), 1311(c)(3), 1311(c)(4) of the Affordable Care Act.

The background comments assert:

The Exchange team anticipates future rulemaking on these topics, but proposes that the Exchange will have a role in the implementation, oversight, and improvement of the quality and enrollee satisfaction initiatives required by the Affordable Care Act. For this, it will be necessary to construct requirements for quality data collection, standards for assessing a QHP issuer's quality improvement strategies, and details on how Exchanges can assess and calculate ratings of health care quality and outcomes using methodologies.²

The team will develop a robust quality program for the Exchange that will meet ACA requirements for QHPs and will focus quality measurement and reporting on the goals identified in Act 48, including cost containment, quality of health care, and the promotion of health through prevention and healthy lifestyles.³

The process will begin by certifying health plans to be included in the Exchange. Each plan will be required to meet specific requirements to ensure access, quality, patient experience, and value. Based on the quality of its offerings, each plan will be assigned a rating consistent with standards established by CMS. Quality can also be pursued through plan selection and contracting by the Exchange.⁴ While Vermont's initial work must focus on meeting the minimum requirements of the ACA, exchange planning and implementation can also lay the groundwork to "reach beyond the federally-required minimum functions to assist in its payment reform, cost control, and

¹ **Federal Register** /Vol. 76, No. 136 / Friday, July 15, 2011 / Proposed Rules, page 41915.

² **Federal Register** /Vol. 76, No. 136 / Friday, July 15, 2011 / Proposed Rules, page 41875.

³ See Sec. 4, §. 1801 (b).

⁴ Volk, J, Corlette, "The Role of Exchanges in Quality Improvement: An Analysis of the Options," September 2011, available at <http://www.rwjf.org/files/research/72851qigeorgetownexchange20110928.pdf>

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administrative simplification initiatives as it moves toward a single-payer plan.”⁵

The team will start by inventorying existing quality programs of Vermont’s public- and private-sector payers, and by identifying gaps in existing quality data collection, measurement, and improvement programs. Next will come recommendations on integrating and coordinating the Exchange with these activities. The inventory will also be used to identify a core set of essential plan certification criteria to be used by the Exchange, as well as additional criteria relevant to Vermont’s goals for an all-payer rate setting system and single payer health care. This will permit the Exchange to score plans based on how well they meet the certification criteria. Developing the system for scoring involves reviewing federal recommendations for quality rating systems, incorporating best practices for rating systems used by other states or organizations, and designing a final rating system to meet the specific needs of the Exchange program.

Project Tasks and Deliverables

Inventory existing quality programs and initiatives in the State

Start date: January 15, 2012
End date: April 30, 2012

Develop a plan for incorporating quality programs in the Exchange, including coordination with existing quality programs outside of the Exchange

Start date: May 1, 2012
End date: June 30, 2012

Analyze federal guidance and regulations on quality rating

Start date: January 15, 2012
End date: March 31, 2012 (actual end date depends on release of final federal requirements for rating systems)

Develop a quality rating system for the Exchange that includes federally-required quality standards, as well as any additional standards the State wishes to include

Start date: April 1, 2012 (actual start and end dates depend on the status of federal rulemaking)
End date: May 31, 2012

Propose a method for displaying ratings that will be easily understandable by the general public

Start date: June 1, 2012
End date: September 9, 2012

⁵ Vermont Exchange Establishment Grant Request

Develop a plan for rewarding plans that achieve quality goals

Start date: May 1, 2012
End date: September 9, 2012

Our Team

Leads

Ann Lawthers, UMass and JoAnn Volk, Georgetown

UMass Office of Clinical Affairs Policy Analysts

Jillian Richard-Daniels, Rossana Valencia, and Jen Vaccaro, UMass

Georgetown Analyst

Sabrina Corlette, Georgetown

Approach and Relevant Experience

Activities include:

- **Planning:** Convening a (or leveraging an existing) multi-stakeholder planning committee to design the inventory framework.
- **Research:** Surveying existing quality programs in Vermont and summarizing the results; researching and summarizing federal guidance and regulations on quality rating systems when available; identifying best practice rating schemes used by other states or organizations.
- **Implementation Planning:** Recommending a strategy for operationalizing the rating system, including web reporting; identifying opportunities for quality improvement activities that go beyond the ACA and are consistent with Act 48 goals.

The first phase of work involves convening a multi-stakeholder planning committee to oversee the development of an inventory of quality programs and activities in Vermont. Ideally the committee will include representatives of state government, plans, employers, and consumers. An appropriate committee or subcommittee may already exist. The committee's charge will be to determine those measures of quality that should be captured in an inventory. The focus will be on plan-based and organization-based quality activities.

The following table displays examples of possible inventory domains:

2. TECHNICAL PROPOSAL/PROGRAM SPECIFICATIONS

Quality Domain	Why this is important
NCQA Accreditation	Plans that receive NCQA accreditation have gone through a rigorous review of their infrastructure, processes, and outcomes. Accreditation ensures a minimum level of quality.
NCQA Recognition, e.g., Patient-Centered Medical Home, Diabetes, Heart/Stroke, Back Pain	NCQA recognition programs also require rigorous review. Physician groups within a plan that achieve recognition have demonstrated a substantial commitment to quality.
State Requirements	<p>For example, BISCHA’s Consumer Protection and Quality Requirements for Managed Care Organizations and Medicaid Managed Care quality requirements from the Quality Assurance and Performance Improvement plan for Vermont Medicaid.⁶</p> <p>In addition to ACA plan certification requirements, plans participating in the exchange must also meet state requirements. To achieve a level playing field, align quality incentives across payers, and maximize the potential of the Exchange to meet Vermont’s quality goals, quality criteria should be consistent, to the extent possible, across plans operating within and outside the Exchange.</p>
Person-Centered Care	Consumer choice is an important value to be adopted by an Exchange. Choice extends beyond choosing a benefit package or provider, to whether the care delivered places the individual, and at the individual’s discretion, family members and others, at the center of the care team to ensure person-centered holistic planning and to promote independence.
Access	Access concerns permeate all aspects of health care quality and consumers value it. Access includes concepts of accessibility, availability, geographic access as well as cultural, linguistic, and organizational access.
Health and Safety	The health and safety domain captures how well an entity performs basic quality management functions: providing effective care in a safe and timely manner and achieving the best possible outcome for the individual. Typical measures of health focus on wellness and

⁶ See Rule H-2009-03 available at <http://www.bishca.state.vt.us/sites/default/files/REG-H-09-03.pdf> and the Vermont Medicaid Managed Care Quality Strategy available at <http://humanservices.vermont.gov/news-info/draft-ahs-quality-strategy/ahs-medicareid-managed-care-quality-strategy-draft/view>

Quality Domain	Why this is important
	prevention, acute care, and chronic condition management.
Comprehensive Care Coordination	Individuals with chronic health conditions often require services from numerous providers located in multiple care delivery settings. Coordinating care delivered by these disparate entities, as well as through transitions from one care setting to another, can be challenging for providers, consumers, and payers but is an important component of successful outcomes.
Administrative Simplicity	A health plan has achieved administrative simplification if it unifies policies, procedures, and administrative processes across settings and makes it easy for a member to find and access services and customer support.
Quality Improvement Programs	Plans that are serious about quality will have robust quality improvement programs with specific goals, objectives, and metrics for assessing progress towards goals.

Once the committee approves the inventory domains, a tool will be prepared to collect the data.

The second phase of this work, the research phase, involves UMass staff reviewing existing documents, assessing regulations, and conducting in-person interviews. The first deliverable for this phase is an inventory of health plan-related quality initiatives in the state of Vermont and recommendations for

- Leveraging existing Vermont quality activities to provide necessary information about health care quality and outcomes, including enrollee satisfaction, to the Exchange
- Identifying critical components of quality that the Exchange should use to rate and possibly certify plans
- Identifying gaps between what is available in Vermont and what is required by the ACA

The second deliverable for phase two is an analysis and summary of options for rating the quality of plans and recommendations for

- Metrics to use in rating and certifying plans, based on the finding from the inventory and from best practices
- Best practice methods for collecting, auditing and certifying data
- Methodology for summarizing and benchmarking data across plans, including information about quality improvement activities
- Reporting ratings to consumers and the Exchange via web or other mechanisms

The deliverable for the final phase of component 6A is a plan to implement a quality rating system. At a minimum the implementation plan must address:

2. TECHNICAL PROPOSAL/PROGRAM SPECIFICATIONS

- Gaps in current Vermont infrastructure for quality measurement and reporting as identified by the inventory and gap analysis
- Methods for collecting, auditing, and certifying data
- Procedures for data processing and scoring
- Reporting strategies that include web-based decision-support tools for consumers; and
- Integration with other activities in New England such as NESCIES

The team will address these and other implementation issues.

Both UMass and Georgetown have considerable experience in quality measurement and quality improvement. The MassHealth Quality Office (MQO) in the UMass Office of Clinical Affairs maintains a staff with considerable experience in environmental scan and literature reviews. The Director of the MQO's entire career has focused on developing and using quality metrics. The MQO produces the annual HEDIS report for MassHealth that includes a modified star rating system.⁷ The Georgetown partners from the Center for Health Insurance Studies have researched and published on quality improvement and insurance exchanges.⁴

Potential Challenges and Solutions

Planning Phase. Forming a committee to oversee the framing of the inventory ensures that there is buy-in to the goals and objectives of the inventory. In addition, the committee's experience and expertise will help refine the list of data elements to be included in the inventory. The best option for the committee will be to leverage an existing committee to guide the work or to build on existing structures, including the infrastructure for coordination among state agencies, the state exchange work group on integration of public health, quality improvement and wellness programs, and the Joint Medicaid/Exchange Advisory Committee. If such a committee does not already exist, the team recommends developing one in a manner that avoids duplication of existing work while ensuring broad representation.

Research Phase. A potential challenge for this phase of the work is the federal timeline for releasing additional guidance laid out in the July 15 rulemaking proposal. Ultimately, Vermont will need to align with federal requirements; however, research and exploration about best practices in other states and organizations can take place while waiting for federal rulemaking.

Implementation Design Phase. To be successful, the implementation plan must carefully integrate with other aspects of the Exchange development, especially the IT portion. Regular communication and face-to-face meetings will be used to ensure proper coordination between aspects of the project.

⁷ <http://www.mass.gov/eohhs/researcher/insurance/masshealth-annual-reports.html>

6.B. Wellness Programs

Our Understanding of the Purpose and Scope

Wellness programs have increasingly become a logical addition to traditional health care. Employers recognize the value of a healthy workforce, and wellness programs have been shown to impact utilization data and medical care costs. More recently, other health-related productivity losses, such as absenteeism and presenteeism (i.e., present at work but not performing at optimal levels due to a health condition), have increasingly become a concern of employers, thereby increasing the perceived return on investment (ROI) from wellness programs.

Vermont has expressed interest in requiring plans that participate in the Exchange to have significant wellness programs. The Exchange team will perform a thorough review of existing programs both within the state and in other states to gather evidence about the effectiveness of the various existing wellness programs. The metrics by which these programs are measuring success will be compared, as well as the setting, target population, and cost. Based on this review, the team will recommend wellness programs that the Exchange should encourage.

Project Tasks and Deliverables

Research existing programs in the State and in other states, including programs designed by insurers and employers

Start date: January 15, 2012

End date: May 31, 2012

Review evidence-based research on wellness programs

Start date: January 15, 2012

End date: May 31, 2012

Design a wellness program component to be included in the Exchange, including an implementation plan, timeline, and cost

Start date: June 1, 2012

End date: September 9, 2012

Develop an integration plan for the Exchange's wellness programs and any programs that exist outside of the Exchange

Start date: June 1, 2012

End date: September 9, 2012

Our Team

Leads

Monica Le and JoAnn Volk, Georgetown

UMass Office of Clinical Affairs Policy Analysts

Jillian Richard-Daniels, Rossana Valencia, and Jen Vaccaro, UMass

Georgetown Analyst

Sabrina Corlette, Georgetown

Approach and Relevant Experience

The activities for this component include:

- Conducting an environmental scan and literature review of the design and effectiveness of wellness programs
- Preparing a design document for integrating wellness programs into Exchange activities

Findings of the environmental scan and literature review will be ranked based on quality of evidence and the comparative effectiveness of wellness programs. Sources will include published literature and also the products of ACA initiatives:

- National Prevention, Health Promotion, and Public Health Council (Sec. 4001)
- Advisory Group of Prevention, Health Promotion, and Integrative and Public Health (Sec. 4001)
- Employer-based wellness Programs (Sec. 4303): CDC directed to study, develop tools to evaluate, provide technical assistance, develop capacity and recommendations for workplace wellness programs
- Effectiveness of Federal Health and Wellness Initiatives (Sec. 4402): Requires a HHS evaluation of all Federal health and wellness initiatives including a congressional report noting reasons for program success or failures
- Sense of Senate concerning Congressional Budget Office scoring (Sec. 4401): Methods to evaluate cost and outcome information associated with prevention programs are to be refined and improved in order to track and score the progress of these programs

In addition, the team will monitor demonstration programs directed towards health promotion and disease prevention. Demonstrations will be assessed for applicability, feasibility, and effectiveness within the context of Vermont's health care system. Such pilot programs include, but will not be limited to, the following:

- Demonstration Project Concerning Individualized Wellness Plan (Sec. 4206)
- Incentives for Prevention of Chronic Disease in Medicaid (Sec. 4108)
- Healthy Aging, Living Well: Evaluation of Community-Based Prevention and Wellness Programs for Medicare Beneficiaries (Sec. 4202)

2. TECHNICAL PROPOSAL/PROGRAM SPECIFICATIONS

A review of evidence-based literature, in conjunction with an update on recent projects that could show benefit will enable a wellness program design that is thoughtful and thorough as well as innovative in its approach.

The team will use these findings and analyses to design and implement a wellness program with three priorities:

- Strategies that have been shown to be effective (evidence-based)
- Strong focus on cost-benefits
- Ease of implementation and sharing of strategies and results

Transparency in the process will be key, with the ability of external programs to contribute information on developing a collaborative, expanded, evidence-based, cost-effective approach to preventive health.

The team is well-experienced in wellness initiatives. Dr. Le has a strong public health and health policy background, and is involved in a collaboration with the Massachusetts Department of Public Health in its Chronic Disease Systems Working Group, which will help the Department's Division of Prevention and Wellness establish a model framework for develop the statewide chronic disease plan to be released in June 2012.

In addition, UMass has had the leading role is designing a wellness program under Massachusetts' landmark health care reform law of April, 2006, MGL c. 118E sec. 54, and Chapter 61 of the Acts of 2007, Section 2, line 4000-0700. This section called for the Executive Office of Health and Human Services to design and implement a Wellness Program for MassHealth in concert with the Massachusetts Department of Public Health, and to provide incentives for beneficiaries who meet wellness goals. The targets included smoking cessation, diabetes screening for early detection, teen pregnancy prevention, cancer screening for early detection, and stroke education.

The MassHealth Wellness Program included two phases: 1) education and outreach about the importance of overall wellness and specific wellness activities; and 2) provision of specific incentives to encourage initiation and maintenance of wellness activities. Under the first phase of the MassHealth Wellness Program, MassHealth was able to conduct outreach and education to encourage members to:

1. Use tobacco cessation pharmacotherapy and counseling services to assist with attempts to quit smoking.
2. Participate in recommended screenings for breast, cervical, colorectal, and oral cancer.
3. Participate in recommended screening for diabetes.
4. Refill prescriptions, and take as prescribed, medications for treatment of the co-occurring conditions of hypertension, diabetes, and high cholesterol.
5. Participate in well-care visits with a primary care provider.
6. Participate in evidence-based teen pregnancy prevention programs.

2. TECHNICAL PROPOSAL/PROGRAM SPECIFICATIONS

7. Adopt healthy habits (such as making healthy food choices and participating in adequate physical activity) that are associated with risk reduction for certain medical conditions.

Additionally, provider training was conducted around strategies for enhancing communication and strengthening the patient-provider partnership.

Potential Challenges and Solutions

Wellness programs play an increasing role in health reform, are often employer-based, and potentially provide a strong foundation for self-efficacy. However, only a fraction of these programs have been formally evaluated, and measures of their effectiveness have been difficult to standardize. UMass is in a unique position to address the challenges of translating research into state policy by building upon the Massachusetts experience through a close relationship with government agencies that are primarily responsible for statewide wellness initiatives, such as the Massachusetts Department of Public Health. The team will keep abreast of federal policy around the standardization of the cost-benefit of wellness programs, while building upon strong organizational cost analytic capabilities within UMass.

The cost of wellness programs must be balanced with health plan and employer interest as well as consumer demand. Thus, any successful implementation will require a feedback mechanism for program benefits. The team will build that mechanism.

While some studies place the cost effectiveness of wellness programs at a 6:1 ROI, the evidence behind these calculations is questionable. The characterization of program benefits has been more recently expanded to include workplace productivity measures in addition to medical costs and health care utilization. Federal agencies are still reviewing how the cost impact of wellness programs is defined. UMass, because of its breadth and engagement with Massachusetts wellness initiatives, will provide the best available expertise to develop an approach suited to the needs and specific challenges of Vermont.

Section 7: Payment Reform

- *Demonstration of understanding of the purpose and scope of this project*
- *Adequacy of management plan*
- *Identification of pertinent project issues*
- *Identification of potential problems*
- *Practicality and feasibility of proposal*

Our Understanding of the Purpose and Scope

The State of Vermont plans to develop an all-payer rate setting strategy to achieve a number of health system improvement goals. In particular, the State wishes to use all-payer rate setting as a component of and a step toward establishing a single-payer health system. The Exchange team will build on Vermont's hospital payment documentation efforts to describe more finely the full range of payment levels and methodologies currently in use in the State and identify additional payment methodologies that might meet the State's needs. The team will then assess the potential payment methodologies based on the State's goals and criteria and will model the financial impact of implementing all-payer rate setting methodologies and payment rates. Finally, the team will assist the state to develop a plan for phasing in the all-payer rate setting methodology and rates.

Project Tasks and Deliverables

Document current payment levels used by commercial and public payers, payment methodologies, and variation in payments, across both payers and providers within Vermont

Start date: January 17, 2012
End date: June 15, 2012

Catalog potential methodologies the State could employ for setting all-payer rates and assess potential approaches based on the State's goals and criteria

Start date: January 17, 2012
End date: June 15, 2012

Model the impact of implementing all-payer rates within the Exchange, and of applying those rates to public payers, including the identification of costs or savings to the State, to private payers, and to specific types of providers, individual institutions, or geographic areas

Start date: April 2, 2012
End date: August 10, 2012

Develop a plan for implementing all-payer rates, including a plan for phasing in the all-payer rate setting methodology and rates that best meets the State's goals and criteria

Start date: July 2, 2012
End date: September 9, 2012

Our Team

Lead

Katharine London, UMass

Legal and policy research and analysis

Julia Feldman and Rachel Frazier, UMass

Financial analysis and modeling

Katharine London, Thomas Friedman, Senior Associate TBD, and Policy Analyst TBD, UMass

Subject matter experts

Jean Sullivan and Robert Seifert, UMass

Note: UMass staff includes additional individuals with deep knowledge and expertise in administering a wide range of health care programs and benefits. The project team will seek expert advice from these individuals as needed during the course of the project. UMass is also in the process of hiring additional policy analysts and associates who will be available to assist the team with research and analysis for this task.

Approach and Relevant Experience

UMass has extensive experience evaluating complex financial systems and developing proposals that meet a number of system improvement goals, align with federal requirements, and balance the needs of consumers, employers, providers, payers, and state government. For example, UMass helped the Massachusetts Long-Term Care Financing Advisory Committee develop strategies for making mechanisms for financing long-term services and supports affordable and available to all residents, while assuring quality of care and limiting financial pressure on the state financing system. UMass is also working with the Massachusetts EOHHS to promote establishment of accountable care organizations (ACOs) and to develop alternative payment methods, such as global and bundled payments.

Earlier in her career, Ms. London calculated all-payer rates under the all-payer rate setting system in place in Massachusetts in the 1980s and early 1990s. She was a principal professional and manager at the Massachusetts Division of Health Care Finance and Policy, the agency that conducted the financial analyses that informed Massachusetts' 2006 reforms.

1. Document payment levels

The team will draw on its experience in evaluating payment levels used by commercial and public payers in New Hampshire and Massachusetts, as well as work that others have done previously in Vermont, to document payment levels and variations in payments across payers and providers in Vermont. UMass is currently performing a similar analysis for the New Hampshire Insurance Department, and Ms. London previously conducted similar analyses for the

2. TECHNICAL PROPOSAL/PROGRAM SPECIFICATIONS

Massachusetts Health Care Quality and Cost Council. The team expects that many of the same analytic and data challenges the team has encountered and overcome in the New Hampshire and Massachusetts will arise in Vermont as well.

UMass will begin by developing an Analytic Plan that identifies the required data elements and the algorithms that will be applied. The analysis will rely on data from the Vermont Healthcare Claims Uniform Reporting and Evaluation System and the Vermont Uniform Hospital Discharge Data Set, as well Medicare and Medicaid rates and fee schedules. The team will evaluate payment levels and variation in payments to hospitals, physicians, and other provider types identified by the State. UMass expects to work closely with Vermont agency staff to ensure that the analysis meets the State's statutory requirements, policy goals, and budget limitations.

Rather than evaluating individual payment rates for specific service codes (such as a new patient visit or a hip replacement), the team proposes to evaluate aggregate levels of payment by payer, by provider, by geographic region, and by type of care provided. The team will develop payment indices for inpatient hospital care, outpatient hospital care, and other ambulatory care providers specified by the State. Inpatient care payment indices will be based on payments per case-mix adjusted discharge (adjusted using Diagnostically-Related Group [DRG] weights). Inpatient comparisons can be made in total or by categories of inpatient care (e.g., medical, surgical, maternity, and behavioral health). Ambulatory care payment indices will be based on payments per Ambulatory Payment Group or similar grouping method. Ambulatory care comparisons can also be made in total or by categories of care (e.g., emergency care, significant procedures, primary care, radiology, and laboratory). In this analysis, payments will include total payments made by the payer to the provider and out of pocket payments made by the patient.

2. Catalog of payment methodologies

H.B. 202 directs the Green Mountain Care Board to “approve payment methodologies that encourage cost-containment; provision of high-quality, evidence-based health services in an integrated setting; patient self-management; access to primary care health services for underserved individuals, populations, and areas; and healthy lifestyles.” Reports to the legislature on Act 128 advise that a unified rate methodology will simplify and strengthen provider incentives to maintain quality care and cut health care costs. The team will use its expertise in payment methodologies to help the State move forward toward a unified payment methodology structure.

The team proposes to survey major commercial payers in Vermont to document the payment methodologies they use to pay health care providers in Vermont. The team will begin by identifying the appropriate individual to complete the survey for each of the major payers, including Blue Cross and Blue Shield of Vermont, The Vermont Health Plan, Connecticut General Life Insurance Company (CIGNA), MVP Health Insurance Company, MVP Health Plan, United Healthcare, and Aetna. These payers together represented 99.7 percent of total premium revenue in Vermont in 2010. The team will conduct individual phone interviews with these individuals to identify the payment methodologies the payers use for hospital and physician services, as well as other provider types identified by the State (e.g., laboratory, radiology, and behavioral health). The team will then send a written summary of the information obtained in the

interview to each payer's representative for verification.

In addition to understanding existing methodologies, the team will build on work already completed in Vermont to develop a comprehensive catalog of methodologies the state might employ for setting all-payer rates. Rate setting methodologies include fee-for-service methodologies, such as inpatient hospital DRG payments, all-inclusive per diems or per discharge payments, as well as ambulatory care fee schedules based on indexes such as Medicare fee schedules, the Resource Based Relative Value Scale, and ambulatory patient groups. Potential methodologies also include alternatives being explored nationally, such as global payments, bundled payments, episode-based payments, risk-sharing, shared savings, pay for performance, and variations to capitated payments, as well as methodologies commonly used internationally, such as global budgets, regional caps, and cost-effectiveness benchmarks.

The team will then assess these potential all-payer rate setting methodologies in terms of the incentives and disincentives that they create for various sectors of the Vermont health care system, and likely effects on key factors such as health care prices, utilization, administrative costs, delivery systems, quality of care, and consumer satisfaction. The team will also evaluate how well methodologies align with other components of health reform in Vermont. For example, methodologies that rely on regional and community cooperation might align better with existing organizational and delivery structures than methodologies that rely on providers building new structures such as ACOs. The team will use this information to assess the extent to which each potential methodology will further the State's goals to:

- Control health care cost increases
- Assure greater equity in payments from carriers and between the public and private sectors
- Assure greater equity across health care providers in payments
- Rationalize and simplify payment methodologies across payers
- Allow for the financial sustainability of efficient and effective providers
- Implement common approaches to payment innovation to improve health system efficiency and quality of care

The team will apply its financial, policy, and legal analysis skills to assess how easily each payment methodology can be configured to meet all of the State's criteria, that is, that the payment methodology achieves the following:

- Produces payment rates that are closely related to the cost of services delivered
- Minimizes or eliminates the shifting of costs from payer to payer
- Is coordinated with Medicare payment policies and innovations in Medicare payment
- Is consistent with Vermont's policies related to payment reform, and the political environment
- Accommodates and promotes competitive approaches and solutions within an overall framework of consistent incentives, standards, and reasonable rules overseen by a regulatory authority

2. TECHNICAL PROPOSAL/PROGRAM SPECIFICATIONS

- Reaches the simultaneous goals of achieving cost reduction and quality improvement
- Results in an increase in the overall value of care provided for the dollar expended
- Promotes a higher degree of equity, predictability, stability, and fairness in the payment of provider services
- Aligns and conforms with the ACA and Medicare Rules and Regulations

The team will also assess the extent to which each payment methodology builds on and integrates structures already in place in Vermont, including the hospital regulatory system, the Blueprint for Health, and community health teams. The all-payer rate setting methodology must be coordinated with other aspects of health care reform in Vermont, including Exchange planning; delivery system reform; efforts to improve quality, safety, and wellness; administrative simplification; and integration of physical health care, behavioral health care, and long-term services and supports.

The team will recommend all-payer rate setting methodologies that best meet the State's goals and that are configured to meet the State's criteria. UMass will assist the State in reviewing its options and selecting a preferred methodology.

3. Model the impact of all-payer rates

The team will then model the impact of implementing all-payer rates within the Exchange and of applying those rates to public payers, including the identification of costs or savings to the State, private payers, and specific types of providers, individual institutions, or geographic areas. The analysis will estimate the total costs incurred or savings reaped if all payers adjusted their rates to the same payment level, for example, to the level of provider cost plus a uniform margin. The team will aggregate results by payer, by provider type, and by geographic area. Because this modeling analyzes variation in payment levels, the team can conduct the modeling independently from and simultaneously with the assessment of specific payment methodologies. The analysis will also consider the effect that an all-payer rate setting system might have on health insurance markets in Vermont.

4. Implementation plan

The team will assist the state to develop a strategy for implementing an all-payer model, including a plan for phasing-in the all-payer rate setting methodology and rates. The implementation strategy will focus on Vermont's preferred all-payer rate setting methodology, if one has been selected, or will include the team's recommended methodologies. The implementation plan will address the infrastructure required to implement all-payer rates, the entities (state government, payers, and providers) required to implement this infrastructure, and the required time and administrative cost. The plan will address the process for moving from the current variation in payment levels to all-payer rates, any recommended exceptions or adjustments, and a strategy for balancing costs and savings equitably among government, private payers, providers, employers, and consumers.

2. TECHNICAL PROPOSAL/PROGRAM SPECIFICATIONS

Potential Challenges and Solutions

The analysis of current payment levels and methodologies will depend on obtaining timely access to accurate data from Vermont health care datasets and from commercial payers. If Vermont-specific data is not available, the team can provide similar data from New Hampshire and Massachusetts and make adjustments to approximate Vermont levels.

Configuring a rate-setting methodology to meet all of the State's goals and criteria is a challenging task. The preferred methodology may depend on the development of new software tools and infrastructure, and may need to be adjusted as it is phased-in.

Section 8: Universal Exchange

- *Demonstration of understanding of the purpose and scope of this project*
- *Adequacy of management plan*
- *Identification of pertinent project issues*
- *Identification of potential problems*
- *Practicality and feasibility of proposal*

Our Understanding of the Purpose and Scope

Vermont officials are pursuing design options for a Universal Exchange that will ultimately assist residents in receiving coverage from a single source. State officials must develop strategic planning and analytic capacity to ensure that the Universal Exchange is sustainable and meets the needs of Vermonters. The planning and design tasks will include the following:

- Determining the nature and timing of necessary law changes and intergovernmental actions
- Studying the coverage characteristics of the Vermont population and assessing market dynamics
- Testing the perceptions of Vermont residents and key constituency groups
- Modeling the impact of proposed reforms
- Assessing the Exchange's capacity to introduce and manage quality improvements and delivery system reforms
- Developing a process to share information with stakeholders and receive input
- Determine the staffing and resource needs of a Universal Exchange
- Developing a business operations plan

It is the team's understanding that, if it receives federal grant support, the State will take the lead in planning and executing the above eight tasks. The Exchange team will assist State officials by providing advice, legal research support on federal and state law, and strategic support with all of these elements. The team's support will include hands-on, real-time assistance from subject matter experts to help the State accomplish the planning and design tasks identified above.

Project Tasks and Deliverables

Develop a Universal Exchange design that encompasses all of the elements described in RFP

Start date: January 15, 2012
End date: September 9, 2012

Our Team

Lead

Mila Kofman, Georgetown

Subject Matter Experts

Kevin Lucia, Sabrina Corlette, JoAnn Volk, Mary Beth Senkewicz, Katie Dunton, and HPI Senior Faculty, Georgetown; Jean Sullivan, Stephanie Anthony, Julia Feldman, Katharine London, and Robert Seifert, UMass

Research Support

Georgetown Research Assistant

Approach and Relevant Experience

Team lead Mila Kofman, J.D., brings considerable experience to this component of the project. As former Superintendent of Insurance in Maine and a nationally renowned expert on private health insurance, Ms. Kofman has a deep knowledge of how the states regulate entities and products. In addition, as a former regulator with the Department of Labor, she is an expert on federal insurance regulation, including ERISA preemption issues that may be involved in incorporating self-insured groups in a Universal Exchange. She will be supported in the necessary research, analysis, and drafting of any requested reports by a team of former federal and state insurance regulators and health policy experts.

The team will also benefit from UMass expertise in public programs, including successful state efforts to obtain federal Medicaid and Medicare waivers; design and establishment of the first health insurance exchange (Connector) in Massachusetts; integration of eligibility determination for Massachusetts Medicaid and subsidized insurance through the Connector; and early planning for Maine's Exchange. UMass has extensive legal, financing, policy, and legislative experience relative to Medicaid and CHIP, Medicare-Medicaid dual-eligibility issues, and extensive state-based experience in expansion of coverage to the uninsured and modeling systems for financing uncompensated care. UMass is also well-versed in public procurement requirements.

The team believes the eight planning and design tasks outlined in Section 8 will provide a critical underpinning for the establishment and operation of a Universal Exchange. To achieve maximum efficiencies, the team will leverage the work done by other project team members on the key components of designing and operationalizing an Exchange, as described in Sections 1-7 of the RFP. In performing these tasks, the team will take into account Vermont's goals for the Universal Exchange; in turn, our work on Sections 1-7 will inform our efforts on Section 8.

For example, the team will ensure that the stakeholder consultation efforts outlined in Section 4 integrate the work needed to test the perceptions of Vermont residents and key constituency groups regarding a Universal Exchange. Similarly, the team will ensure that the program integration and administrative simplification tasks outlined in Section 5 are performed with an eye towards achieving a Universal Exchange, so that the work can be leveraged as the State builds an Exchange with a broader mission and scope than envisioned under the ACA. The bottom line is that the tasks outlined in Section 8 of this RFP are inextricably linked with the foundational work required in Sections 1-7. Therefore, the team is committed to delivering an integrated set of products and services that are responsive to immediate objectives, flexible enough to adapt to long-term goals, and build upon work already performed.

2. TECHNICAL PROPOSAL/PROGRAM SPECIFICATIONS

In addition to establishing a Universal Exchange, to achieve the goal of creating a single-source universal coverage, the State must overcome important obstacles such as the Employee Retirement Income Security Act of 1974 (ERISA) – a federal law regulating private job-based coverage, with broad preemption of state-based reform efforts, as well as federal health coverage programs where the federal government is negotiating, paying and reimbursing for medical care and services (Medicare, Veterans Administration, CHAMPUS, Federal Employees Health Benefits Plan, etc.). If Green Mountain Care is to provide coverage for all Vermonters as envisioned in Act 48, then it will be necessary to explore options for waivers under ACA as well as under Medicare (e.g., similar to Maryland’s Medicare waiver for hospital rates) and Medicaid.

Also, building a Universal Exchange with capability to purchase (or provide coverage) and negotiate on behalf of all Vermonters will initially require the Exchange to attract private employers. Providing services that help employers comply with federal laws such as COBRA, HIPAA, and ERISA will be essential. It will also be critical to develop incentives for employers to participate in the Universal Exchange, e.g., negotiating better provider rates and better coverage costs than employers otherwise will achieve by self-funding or purchasing insurance. Early on, the Exchange must develop ways to lessen the potential for adverse selection.

The team will support State officials in planning and executing all the identified tasks and will provide recommendations on the additional items identified above. The team’s approach will include discussions with State officials as well as State stakeholders so that the team can craft advice in response to emerging needs and priorities. These discussions will also inform our legal and policy research and recommendations. The team will work with federal regulators, as requested by State officials, to help address any barriers under federal law. As noted above, the team will ensure that the planning and design work associated with the Universal Exchange is closely coordinated with the work being conducted under Sections 1-7 of this RFP.

The team has extensive experience with ERISA and state-based reform efforts. For example, Ms. Kofman, as Superintendent of Insurance in 2010 and in response to a request from Secretary Solis (U.S. Department of Labor) and Secretary Sebelius, led a group of states in talks with federal regulators, discussing ways to address ERISA issues. She had testified on ERISA issues before the U.S. Congress. Ms. Kofman and the Georgetown team have studied state reform efforts dating back to the early 1990s. Team members also assisted in drafting insurance-related provisions of the ACA, with a focus on preserving States’ ability to implement and enforce stronger consumer protections than the federal minimum. Composed of former state and federal regulators with experience implementing ACA, the team is well positioned to assist the State in establishing a Universal Exchange. The team will be supported by experts in federal and state public programs such as Medicaid, CHIP, and Medicare.

Potential Challenges and Solutions

The team identifies the following challenges associated with planning and designing a Universal Exchange:

- *Timing.* The state has considerable work to do to establish and operationalize an Exchange that can be certified by HHS as meeting federal standards by January 2013.

2. TECHNICAL PROPOSAL/PROGRAM SPECIFICATIONS

This is a short time frame, during which the State will have to satisfy federal requirements while laying the foundation for the Universal Exchange envisioned in Act 48. To address this challenge, the team will:

- Communicate regularly with officials from other States that have moved forward with Exchange planning, to ensure Vermont is benefiting from other States' experiences and not duplicating efforts where it is not necessary to do so.
 - Communicate regularly with federal officials to prioritize tasks and deadlines.
 - Provide expert and strategic guidance to State officials to ensure that the design and operational rules for the Exchange are sufficiently flexible to allow for the subsequent modifications and reforms necessary to build the Universal Exchange.
 - Ensure that this work builds upon and does not duplicate effort expended under Sections 1-7 of this RFP.
- *Potential inconsistencies.* Some of the federal requirements for state exchanges may not be consistent with Vermont's longer term objectives for a Universal Exchange. For example, the ACA requires state exchanges to accept Multi-State Plans as QHPs, if they have been certified by the U.S. Office of Personnel Management. To address this challenge the team will
 - Communicate regularly with federal and state officials to ascertain how the State can be accorded greater flexibility. In some cases, this may be through formal or informal guidance, but needed latitude can also be pursued through programmatic waivers, either under the ACA or other federal programs.
- *ERISA preemption.* ERISA is a federal law that establishes standards for health and other benefits provided by private employers to their workers. ERISA's broad preemption, superseding state laws, has created significant obstacles to states. Important considerations must be made both to avoid adverse selection for SHOP exchanges and dumping into exchanges for individuals. For example, adjusted community rating (an approach under ACA to prohibit health and gender based discrimination and limit age discrimination in premiums) assumes that the cost of insuring people with high or chronic medical needs will be spread over a pool of healthy and unhealthy people. However, ERISA allows employers to self-insure. When employers self-insure, they don't participate in the insurance pool where the cost of claims is spread over a large population that buys insurance. Neither small group market reforms nor SHOP exchanges can succeed if only businesses with older or unhealthy workers participate, while other businesses with healthier or younger employees choose to self-insure. Furthermore, self-insuring employers buy "stop-loss" insurance that protects the employer from significant claims. Stop-loss insurance is not regulated as health insurance and is exempt from standards that apply to health insurance both under federal law and under state insurance law. Because of a number of court decisions, when a state regulates stop-loss insurance strictly, it is likely to be challenged.

2. TECHNICAL PROPOSAL/PROGRAM SPECIFICATIONS

The team will work with State officials to analyze these issues and, if requested, will produce a report assessing them and recommending policies to minimize adverse selection.

- The team will explore options with State officials and assist Vermont in discussions with federal officials at the U.S. Department of Labor, the U.S. Treasury Department, and the U.S. Department of Health and Human Services to identify strategies for addressing ERISA-related obstacles.

Program Cost

Schedule A: Summary Program Costs

Itemize your program costs

Rate Chart

Section	Proposed Rate
Section 1: Exchange Operations/Business Functions	\$321,312
Section 2: SHOP Exchange, Individual and Employer Responsibility, and Enrollment	\$186,374
Section 3: Health Insurance Market Reform	\$677,752
Section 4: Stakeholder Involvement and Outreach/Education	\$605,833
Section 5: Program Integration	\$398,370
Section 6: Quality and Wellness	\$89,560
Section 7: Payment Reform	\$206,093
Section 8: Universal Exchange	\$315,830
TOTAL	\$2,801,124

Itemized Budget

The following is an itemized budget with rates divided by Section and Subsection, along with a detailed budget of expense calculations. An Excel spreadsheet of this budget is included on the proposal CD.

Section 1

	Annual Salary	Hourly Pay Rate	A. Call Ctr			B. Finl Mgt			C. Prog Integrity			D. Exch Staffing			E. Evaluation			F. Est Grant App			Total:		
			FTE	Hours	\$'s	FTE	Hours	\$'s	FTE	Hours	\$'s	FTE	Hours	\$'s	FTE	Hours	\$'s	FTE	Hours	\$'s	FTE	Hours	\$'s
Staffing :																							
Marc Thibodeau	204,000	\$ 98.08	0.003	4	400	0.003	4	400	0.003	4.08	400	0.003	4.08	400	0.003	4.08	400	0.003	4.08	400	0.018	24	2,401
Judy Fleisher	122,000	\$ 58.65	0.004	5	319	0.004	5	319	0.004	5.44	319	0.004	5.44	319	0.004	5.44	319	0.026	35.36	2,074	0.046	63	3,669
Jay Himmelstein	224,798	\$ 108.08	0.003	4	441	0.003	4	441	0.003	4.08	441	0.003	4.08	441	0.003	4.08	441	0.003	4.08	441	0.018	24	2,646
Michael Tutty	127,718	\$ 61.40	0.003	4	251	0.003	4	251	0.003	4.08	251	0.003	4.08	251	0.003	4.08	251	0.003	4.08	251	0.018	24	1,503
Deb Drexler	140,000	\$ 67.31	0.027	37	2,490	0.054	74	4,980	0.088	120.22	8,092	0.027	36.99	2,490	0.088	120.22	8,092	-	-	-	0.286	388	26,143
Gerald Beaudreault	137,135	\$ 65.93	-	-	-	0.258	351	23,169	-	-	-	-	-	-	-	-	-	-	-	-	0.258	351	23,169
William Connors	142,667	\$ 68.59	-	-	-	0.258	351	24,104	-	-	-	-	-	-	-	-	-	-	-	-	0.258	351	24,104
Joan Senatore	114,444	\$ 55.02	-	-	-	-	-	-	0.010	13.87	763	-	-	-	-	-	-	-	-	-	0.010	14	763
Mary Fontaine	158,000	\$ 75.96	-	-	-	-	-	-	0.051	69.36	5,269	-	-	-	-	-	-	-	-	-	0.051	69	5,269
John Gettens	81,615	\$ 39.24	-	-	-	-	-	-	-	-	-	-	-	0.308	418.88	16,436	-	-	-	-	0.308	419	16,436
Robert Seifert	131,600	\$ 63.27	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.011	14.96	947	0.011	15	947	
	\$ -		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	\$ -		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
sub-total Salaries			0.040	55	3,901	0.584	795	53,664	0.163	221.14	15,535	0.040	54.67	3,901	0.41	556.78	25,939	0.046	62.56	4,112	1.283	1,744	107,051
Fringes @ 33.83%					1,320			18,155			5,255			1,320			8,775			1,391			36,215
sub-total Salaries/Fringes					5,220			71,819			20,790			5,220			34,714			5,503			143,266
Consultants :																							
a SBSB	\$ 120.00			457	54,898								150.63	18,075							608.11	72,973	
b U Health Solutions	\$ 90.00			267	24,053								177.36	15,962							444.61	40,015	
c Fred Jonas	\$ 105.00					50	5,250		50	5,250					80	8,400					180.00	18,900	
d																							-
Other expenses :																							
a Travel							2,000			1,500						1,500							5,000
b																							-
c																							-
d																							-
e Facility					131		1,910			532				131		1,338			150				4,193
Overhead cap @ 13%					10,959		10,527			3,649				5,121		5,974			735				36,965
Total :				779	95,262		845	91,505		271	31,721		383	44,509		637	51,926		63	6,389		2,977	321,312

Section 2

	Annual Salary	Hourly Pay Rate	A. SHOP Exchange			B. Indiv & ER Resp			C. Enrollment in Qual HP's			Total:		
			FTE	Hours	\$'s	FTE	Hours	\$'s	FTE	Hours	\$'s	FTE	Hours	\$'s
Staffing :														
Marc Thibodeau	204,000	\$ 98.08	0.003	4	400	0.003	4	400	0.003	4.08	400	0.009	12	1,200
Judy Fleisher	122,000	\$ 58.65	0.004	5	319	0.004	5	319	0.004	5.44	319	0.012	16	957
Jay Himmelstein	224,798	\$ 108.08	0.003	4	441	0.003	4	441	0.003	4.08	441	0.009	12	1,323
Michael Tutty	127,718	\$ 61.40	0.003	4	251	0.003	4	251	0.003	4.08	251	0.009	12	752
Deb Drexler	140,000	\$ 67.31	0.102	139	9,337	0.102	139	9,337	0.102	138.72	9,337	0.306	416	28,011
	\$ -													
	\$ -													
	\$ -													
	\$ -													
	\$ -													
sub-total Salaries			0.115	156	10,748	0.115	156	10,748	0.115	156.40	10,748	0.345	469	32,243
Fringes @ 33.83%					3,636			3,636			3,636			10,908
sub-total Salaries/Fringes					14,384			14,384			14,384			43,151
Consultants :														
a SBSB		\$ 120.00		244	29,270		55	6,581		275	33,053		574	68,904
b Fred Jonas		\$ 105.00		150	15,750		150	15,750		150	15,750		450	47,250
c														-
d														-
Other expenses :														
a Travel					1,500			1,500			1,500			4,500
b														-
c														-
d														-
e Facility					376			376			376			1,128
Overhead cap @ 13%					7,966			5,017			8,458			21,441
Total :				550	69,246		361	43,607		582	73,521		1,493	186,374

Section 3

	Annual Salary	Hourly Pay Rate	A. Anal Outside Mkts			B. Risk Leveling			C. Cert of QHP's			D. Satisfaction Survey			E. QHP Plan Design			Total:		
			FTE	Hours	\$'s	FTE	Hours	\$'s	FTE	Hours	\$'s	FTE	Hours	\$'s	FTE	Hours	\$'s	FTE	Hours	\$'s
Staffing :																				
Marc Thibodeau	204,000	\$ 98.08	0.003	4	400	0.003	4	400	0.003	4.08	400		-	-		-	-	0.009	12	1,200
Judy Fleisher	122,000	\$ 58.65	0.004	5	319	0.004	5	319	0.004	5.44	319		-	-		-	-	0.012	16	957
Jay Himmelstein	224,798	\$ 108.08	0.003	4	441	0.003	4	441	0.003	4.08	441	0.003	4.08	441	0.003	4.08	441	0.015	20	2,205
Michael Tutty	127,718	\$ 61.40	0.003	4	251	0.003	4	251	0.003	4.08	251	0.003	4.08	251	0.003	4.08	251	0.015	20	1,253
Zi Zhang	108,489	\$ 52.16		-	-		-	-		-	-	0.132	179.52	9,363		-	-	0.132	180	9,363
Lee Hargraves	109,703	\$ 52.74		-	-		-	-		-	-	0.176	239.36	12,624		-	-	0.176	239	12,624
Carla Hillerns	68,010	\$ 32.70		-	-		-	-		-	-	0.308	418.88	13,696		-	-	0.308	419	13,696
	\$ -			-	-		-	-		-	-		-	-		-	-		-	-
	\$ -			-	-		-	-		-	-		-	-		-	-		-	-
sub-total Salaries			0.013	18	1,411	0.013	18	1,411	0.013	17.68	1,411	0.622	845.92	36,375	0.01	8.16	691	0.667	907	41,299
Fringes @ 33.83%					477			477			477			12,306			234			13,971
sub-total Salaries/Fringes					1,888			1,888			1,888			48,681			925			55,270
Consultants :																				
a Georgetown University		\$ 142.47		405	57,694		1,110	158,085		1,245	177,406		52	7,381		1,451	206,757		4,263	607,323
b																				-
c																				-
d																				-
Other expenses :																				
a Travel														2,000						2,000
b																				-
c																				-
d																				-
e Facility					42			42			42			2,033			20			2,180
Overhead cap @ 13%					3,501			251			251			6,853			123			10,979
Total :				423	63,125		1,127	160,266		1,263	179,587		898	66,948		1,459	207,825		5,170	677,752

Section 4

	Annual Salary	Hourly Pay Rate	A. Navigator Program			B. Stakeholder Consultants			C. Outreach/Educ			Total:		
			FTE	Hours	\$'s	FTE	Hours	\$'s	FTE	Hours	\$'s	FTE	Hours	\$'s
Staffing :														
Marc Thibodeau	204,000	\$ 98.08	0.003	4	400	0.003	4	400	0.003	4.08	400	0.009	12	1,200
Judy Fleisher	122,000	\$ 58.65	0.004	5	319	0.004	5	319	0.004	5.44	319	0.012	16	957
Jay Himmelstein	224,798	\$ 108.08	0.003	4	441	0.003	4	441	0.003	4.08	441	0.009	12	1,323
Michael Tutty	127,718	\$ 61.40	0.003	4	251	0.003	4	251	0.003	4.08	251	0.009	12	752
Gretchen Hall	75,417	\$ 36.26	0.440	598	21,697		-	-		-	-	0.440	598	21,697
Alexis Henry	110,160	\$ 52.96	0.044	60	3,169		-	-	0.045	61.20	3,241	0.089	121	6,410
TBA Curriculum Developer	75,000	\$ 36.06	0.440	598	21,577		-	-		-	-	0.440	598	21,577
TBA Training & Cert Mgr	75,000	\$ 36.06	0.440	598	21,577		-	-		-	-	0.440	598	21,577
Marsha Mullaney	71,056	\$ 34.16		-	-	0.264	359	12,265		-	-	0.264	359	12,265
John Gettens	81,615	\$ 39.24		-	-	0.264	359	14,088		-	-	0.264	359	14,088
Michelle Nowers	58,822	\$ 28.28		-	-		-	-	0.176	239.36	6,769	0.176	239	6,769
TBA Project Manager	70,000	\$ 33.65		-	-	0.220	299	10,069	0.220	299.20	10,069	0.440	598	20,138
sub-total Salaries			1.377	1,873	69,431	0.761	1,035	37,833	0.454	617.44	21,490	2.592	3,525	128,754
Fringes @ 33.83%					23,488			12,799			7,270			43,558
sub-total Salaries/Fringes					92,919			50,632			28,760			172,312
Consultants :														
a SBSB		\$ 120.00		42	5,000		54	6,500		39	4,700		135	16,200
b Kimball Sherman Ellis Partners								36,000			90,000			126,000
c American Sign Language, Braille								10,000						10,000
d Regional AHECS (3)											171,600			171,600
Other expenses :														
a Travel					1,800			15,400			2,350			19,550
b Meeting rooms (Vermont)								8,000						8,000
c Print & production								4,000						4,000
d														-
e Facility					4,501			2,488			1,484			8,473
Overhead cap @ 13%					13,549			17,293			38,856			69,698
Total :				1,914	117,769		1,089	150,313		657	337,751		3,660	605,833

Section 5

	Annual Salary	Hourly Pay Rate	A. Integration of Existing Groups			B. Admin Simplification			Total:		
			FTE	Hours	\$'s	FTE	Hours	\$'s	FTE	Hours	\$'s
Staffing :											
Marc Thibodeau	204,000	\$ 98.08	-	-	-	-	-	-	-	-	-
Judy Fleisher	122,000	\$ 58.65	0.003	4	239	0.003	4	239	0.006	8	479
Jay Himmelstein	224,798	\$ 108.08	0.003	4	441	0.003	4	441	0.006	8	882
Michael Tutty	127,718	\$ 61.40	0.003	4	251	0.003	4	251	0.006	8	501
Jean Sullivan	193,800	\$ 93.17	0.044	60	5,575	0.044	60	5,575	0.088	120	11,151
Donna Kymalainen	47,849	\$ 23.00	0.132	180	4,130	0.132	180	4,130	0.264	359	8,259
Stephanie Anthony	137,717	\$ 66.21	0.220	299	19,810	0.044	60	3,962	0.264	359	23,772
Julia Feldman	145,000	\$ 69.71	0.088	120	8,343	0.132	180	12,515	0.220	299	20,858
Katharine London	124,440	\$ 59.83	-	-	-	0.220	299	17,900	0.220	299	17,900
Robert Seifert	131,580	\$ 63.26	0.132	180	11,356	0.070	96	6,057	0.202	275	17,413
TBA Senior Assoc	96,000	\$ 46.15	0.106	144	6,628	0.114	156	7,181	0.220	299	13,809
TBA Senior Assoc	96,000	\$ 46.15	-	-	-	0.220	299	13,809	0.220	299	13,809
TBA Sr Research Policy Analyst	69,000	\$ 33.17	0.572	778	25,806	-	-	-	0.572	778	25,806
TBA Sr Research Policy Analyst	69,000	\$ 33.17	-	-	-	0.572	778	25,806	0.572	778	25,806
Deb Drexler	140,000	\$ 67.31	-	-	-	0.044	60	4,028	0.044	60	4,028
sub-total Salaries			1.303	1,772	82,580	1.602	2,178	101,893	2.904	3,950	184,473
Fringes @ 33.83%					27,937			34,470			62,407
sub-total Salaries/Fringes					110,517			136,364			246,881
Consultants :											
a Carroll Consulting		\$ 120.00		333	39,992		165	19,775		498	59,767
b Georgetown University		\$ 122.97		163	20,000		163	20,000		325	40,000
c											-
d											-
Other expenses :											
a Travel					400			600			1,000
b											-
c											-
d											-
e Facility					4,258			5,236			9,494
Overhead cap @ 13%					20,172			21,057			41,228
Total :				2,267	195,339		2,506	203,032		4,773	398,370

Section 6

	Annual Salary	Hourly Pay Rate	A. Quality Program & Rating			B. Wellness programs						Total:					
			FTE	Hours	\$'s	FTE	Hours	\$'s	FTE	Hours	\$'s	FTE	Hours	\$'s			
Staffing :																	
Marc Thibodeau	204,000	\$ 98.08	0.003	4	400	0.003	4	400	0.003	4.08	400	0.009	12	1,200			
Judy Fleisher	122,000	\$ 58.65	0.004	5	319	0.004	5	319	0.004	5.44	319	0.012	16	957			
Jay Himmelstein	224,798	\$ 108.08	0.003	4	441	0.003	4	441	0.003	4.08	441	0.009	12	1,323			
Michael Tutty	127,718	\$ 61.40	0.003	4	251	0.003	4	251	0.003	4.08	251	0.009	12	752			
Ann Lawthers	133,213	\$ 64.04	0.132	180	11,497		-	-		-	-	0.132	180	11,497			
Rossana Valencia	51,193	\$ 24.61	0.176	239	5,891		-	-		-	-	0.176	239	5,891			
Gabriel Malseptic	42,007	\$ 20.20	0.176	239	4,834		-	-		-	-	0.176	239	4,834			
Monica Le	147,000	\$ 70.67		-	-	0.088	120	8,458		-	-	0.088	120	8,458			
Jillian Richard-Daniels	66,759	\$ 32.10		-	-	0.264	359	11,524		-	-	0.264	359	11,524			
Jennifer Vaccaro	43,024	\$ 20.68		-	-	0.132	180	3,713		-	-	0.132	180	3,713			
sub-total Salaries			0.497	676	23,633	0.497	676	25,106	0.013	17.68	1,411	1.007	1,370	50,150			
Fringes @ 33.83%					7,995			8,493			477			16,966			
sub-total Salaries/Fringes					31,628			33,599			1,888			67,115			
Consultants :																	
a Georgetown		\$ 122.97		49	6,000		33	4,000					81	10,000			
b														-			
c														-			
d														-			
Other expenses :																	
a Travel														-			
b														-			
c														-			
d														-			
e Facility					1,625			1,625			42			3,292			
Overhead cap @ 13%					4,323			4,579			251			9,153			
Total :				725	43,576		708	43,803		18	2,181		1,451	89,560			

Section 7

	Annual Salary	Hourly Pay Rate	A. Payment reform									Total:		
			FTE	Hours	\$'s	FTE	Hours	\$'s	FTE	Hours	\$'s	FTE	Hours	\$'s
Staffing :														
Marc Thibodeau	204,000	\$ 98.08	0.003	4	400	-	-	-	-	-	0.003	4	400	
Judy Fleisher	122,000	\$ 58.65	0.004	5	319	-	-	-	-	-	0.004	5	319	
Jay Himmelstein	224,798	\$ 108.08	0.003	4	441	-	-	-	-	-	0.003	4	441	
Michael Tutty	127,718	\$ 61.40	0.003	4	251	-	-	-	-	-	0.003	4	251	
Jean Sullivan	193,800	\$ 93.17	0.044	60	5,575	-	-	-	-	-	0.044	60	5,575	
Donna Kymalainen	47,849	\$ 23.00	0.132	180	4,130	-	-	-	-	-	0.132	180	4,130	
Julia Feldman	145,000	\$ 69.71	0.044	60	4,172	-	-	-	-	-	0.044	60	4,172	
Katharine London	124,440	\$ 59.83	0.220	299	17,900	-	-	-	-	-	0.220	299	17,900	
Robert Seifert	131,580	\$ 63.26	0.070	96	6,057	-	-	-	-	-	0.070	96	6,057	
TBA Senior Assoc	96,000	\$ 46.15	0.352	479	22,095	-	-	-	-	-	0.352	479	22,095	
TBA Associate	96,000	\$ 46.15	0.396	539	24,857	-	-	-	-	-	0.396	539	24,857	
TBA Sr Research Policy Analyst	69,000	\$ 33.17	0.176	239	7,940	-	-	-	-	-	0.176	239	7,940	
TBA Policy Analyst	50,000	\$ 24.04	0.396	539	12,946	-	-	-	-	-	0.396	539	12,946	
		\$ -		-	-		-	-		-		-	-	
sub-total Salaries			1.843	2,507	107,082	-	-	-	-	-	1.843	2,507	107,082	
Fringes @ 33.83%					36,226								36,226	
sub-total Salaries/Fringes					143,308								143,308	
Consultants :														
a Georgetown University		\$ 122.97		122	15,000							122	15,000	
b SBSB		\$ 120.00		165	19,775							165	19,775	
c													-	
d													-	
Other expenses :														
a Travel													-	
b													-	
c													-	
d													-	
e Facility					6,026								6,026	
Overhead cap @ 13%					21,984								21,984	
Total :				2,794	206,093	-	-	-	-	-		2,794	206,093	

Section 8

	Annual Salary	Hourly Pay Rate	A. Universal Exchange						Total:				
			FTE	Hours	\$'s	FTE	Hours	\$'s	FTE	Hours	\$'s		
Staffing :													
Marc Thibodeau	204,000	\$ 98.08	0.003	4	400	-	-	-	-	0.003	4	400	
Judy Fleisher	122,000	\$ 58.65	0.004	5	319	-	-	-	-	0.004	5	319	
Jay Himmelstein	224,798	\$ 108.08	0.003	4	441	-	-	-	-	0.003	4	441	
Michael Tutty	127,718	\$ 61.40	0.003	4	251	-	-	-	-	0.003	4	251	
Jean Sullivan	193,800	\$ 93.17	0.035	48	4,460	-	-	-	-	0.035	48	4,460	
Donna Kymalainen	47,849	\$ 23.00	0.035	48	1,101	-	-	-	-	0.035	48	1,101	
Stephanie Anthony	137,717	\$ 66.21	0.070	96	6,339	-	-	-	-	0.070	96	6,339	
Katharine London	124,440	\$ 59.83	0.070	96	5,728	-	-	-	-	0.070	96	5,728	
TBA Senior Assoc	96,000	\$ 46.15	0.070	96	4,419	-	-	-	-	0.070	96	4,419	
TBA Associate	80,000	\$ 38.46	0.035	48	1,841	-	-	-	-	0.035	48	1,841	
Thomas Friedman	69,360	\$ 33.35	0.070	96	3,193	-	-	-	-	0.070	96	3,193	
Policy Analyst	69,000	\$ 33.17	0.035	48	1,588	-	-	-	-	0.035	48	1,588	
sub-total Salaries			0.435	592	30,081	-	-	-	-	0.435	592	30,081	
Fringes @ 33.83%					10,176							10,176	
sub-total Salaries/Fringes					40,257							40,257	
Consultants :													
a Georgetown University		\$ 122.97		2,185	268,731						2,185	268,731	
b												-	
c												-	
d												-	
Other expenses :													
a Travel												-	
b												-	
c												-	
d												-	
e Facility					1,423							1,423	
Overhead cap @ 13%					5,418							5,418	
Total :				2,777	315,830	-	-	-	-		2,777	315,830	

FTE Summary

Section:	1		2		3		4		5		6		7		8		Total :	
	FTE	\$'s	FTE	\$'s	FTE	\$'s	FTE	\$'s	FTE	\$'s	FTE	\$'s	FTE	\$'s	FTE	\$'s	FTE	\$'s
Marc Thibodeau	0.018	2,401	0.009	1,200	0.009	1,200	0.009	1,200	-	-	0.009	1,200	0.003	400	0.003	400	0.060	8,003
Judy Fleisher	0.046	3,669	0.012	957	0.012	957	0.012	957	0.006	479	0.012	957	0.004	319	0.004	319	0.108	8,615
Jay Himmelstein	0.018	2,646	0.009	1,323	0.015	2,205	0.009	1,323	0.006	882	0.009	1,323	0.003	441	0.003	441	0.072	10,583
Michael Tutty	0.018	1,503	0.009	752	0.015	1,253	0.009	752	0.006	501	0.009	752	0.003	251	0.003	251	0.072	6,013
Deb Drexler	0.286	26,143	0.306	28,011					0.044	4,028							0.636	58,182
Gerald Beaudreault	0.258	23,169															0.258	23,169
William Connors	0.258	24,104															0.258	24,104
Joan Senatore	0.010	763															0.010	763
Mary Fontaine	0.051	5,269															0.051	5,269
John Gettens	0.308	16,436															0.308	16,436
Robert Seifert	0.011	947															0.011	947
Zi Zhang					0.132	9,363											0.132	9,363
Lee Hargraves					0.176	12,624											0.176	12,624
Carla Hillerns					0.308	13,696											0.308	13,696
Gretchen Hall							0.440	21,697									0.440	21,697
Alexis Henry							0.089	6,410									0.089	6,410
TBA Curriculum Developer							0.440	21,577									0.440	21,577
TBA Training & Cert Mgr							0.440	21,577									0.440	21,577
Marsha Mullaney							0.264	12,265									0.264	12,265
John Gettens							0.264	14,088									0.264	14,088
Michelle Nowers							0.176	6,769									0.176	6,769
TBA Project Manager							0.440	20,138									0.440	20,138
Jean Sullivan									0.088	11,151			0.044	5,575	0.035	4,460	0.167	21,187
Donna Kymalainen									0.264	8,259			0.132	4,130	0.035	1,101	0.431	13,490
Stephanie Anthony									0.264	23,772					0.070	6,339	0.334	30,111
Julia Feldman									0.220	20,858			0.044	4,172			0.264	25,029
Katharine London									0.220	17,900			0.220	17,900	0.070	5,728	0.510	41,528
Robert Seifert									0.202	17,413			0.070	6,057			0.273	23,470
TBA Principal Assoc (non-ID)									0.220	13,809							0.220	13,809
TBA Senior Assoc									0.220	13,809			0.352	22,095			0.572	35,904
TBA Sr Research Policy Analyst									0.572	25,806			0.176	7,940	0.070	3,193	0.818	36,939
TBA Sr Research Policy Analyst									0.572	25,806							0.572	25,806
Ann Lawthers											0.132	11,497					0.132	11,497
Rossana Valencia											0.176	5,891					0.176	5,891
Gabriel Malseptic											0.176	4,834					0.176	4,834
Monica Le											0.088	8,458					0.088	8,458
Jillian Richard-Daniels											0.264	11,524					0.264	11,524
Jennifer Vaccaro											0.132	3,713					0.132	3,713
TBA Associate													0.396	24,857	0.070	4,419	0.466	29,276
TBA Sr Research Policy Analyst														0.035	1,841	0.035	1,841	
TBA Policy Analyst													0.396	12,946	0.035	1,588	0.431	14,534
	1.283	107,051	0.345	32,243	0.667	41,299	2.592	128,754	2.904	184,473	1.007	50,150	1.843	107,082	0.435	30,081	11.077	681,132

Schedule B: Detail of Expenses

In narrative form explain how figures for salary, benefits, phone, mileage, buildings, and facilities were determined.

The budget identifies all direct costs related to the scope as described in each Section in the RFP. The budget was prepared consistent with the University's Grant compliance and accounting requirements. Proposed salary costs were developed using actual annual salary rates for each employee factored by the time and effort (full time equivalent: FTE) contributed to work on this proposal. The FTE percent for each contributing employee has also been expressed in hours worked for each of the sub-sections contained in this proposal. Fringe benefits are calculated on salary expense at 33.83% consistent with the Commonwealth of Massachusetts employee benefits policy as it relates to the University of Massachusetts Medical School.

A sub-award to Georgetown University is budgeted to reflect key participation in Section 3: Health Insurance Market Reform, and Section 8: Universal Exchange. All other Consultants are contributing effort to this proposal in a 'contract for services' capacity.

UMass travel expense reflects employee travel to Vermont (440 miles round trip with one overnight) to conduct business and outreach with the State of Vermont, stakeholders, and other related parties. Meeting Room expenses reflect costs to conduct outreach with stakeholders.

Facility costs are calculated based on an annual cost of \$4,998 per employee and factored by the number of FTE's engaged for the 170 day duration of this proposal.

Schedule C: Allocation Methods

In narrative form, describe your method for allocating your administrative costs (not to exceed 13%).

Indirect costs are capped at 13 percent and levied on all direct costs except the sub-award to Georgetown University. Indirect costs, capped at 13 percent, reflect the cost of Executive administration, Human Resources (including benefits administration and payroll), Accounting (including budgeting, payables, billing and reporting), and Legal and Compliance review. The University's Federally authorized rate at 34.5 percent is significantly higher than Vermont's capped rate for this proposal at 13%. The University is willing to forego its higher rate in the interest of partnering with the State of Vermont to support the development of critical health care reform initiatives.

Schedule D: Related Party Disclosure

In narrative form, disclose all related party relationships including cost purpose and approval process.

UHealthSolutions is an affiliate of the University of Massachusetts Medical School. It was formed under Chapter 180 of the Massachusetts General Laws and is exempt from taxation under Section 501 (c) (3) of the Internal Revenue Code. Previously known as Public Sector Partners,

2. TECHNICAL PROPOSAL/PROGRAM SPECIFICATIONS

its Articles of Organization were amended in October 2011, to change its name to UHealthSolutions. UHealthSolutions was organized to provide administrative and consulting services to state and local governments that provide health care and health related services. UHealthSolutions works closely with UMass Medical School's Commonwealth Medicine division providing it with administrative and technical support for many of Commonwealth Medicine's clients.

UHealthSolutions is a subsidiary of Worcester City Campus Corporation (WCCC). The WCCC was organized to foster, promote and support the University of Massachusetts Medical School. The University of Massachusetts is the sole member of the WCCC, and the WCCC is the sole member of UHealthSolutions.

Biographies and Resumes

Biographies

Project Lead

Judith E. Fleisher, M.M.H.S.

Project Advisors

Jay S. Himmelstein, M.D., M.P.H.

Michael Tutty, M.H.A., M.S.

Marc A. Thibodeau, M.S., J.D.

Section 1 and Section 2 Lead

Lead: Deborah Drexler, J.D.

Section 3 and Section 8 Lead

Lead: Mila Kofman, J.D.

Section 4 Lead

Lead: Alexis D. Henry, Sc.D., OTR/L

Section 5 and Section 7 Lead

Lead: Katharine London, M.S.

Section 6 Lead

Lead: Ann Lawthers, Sc.D.

Project Team

Stephanie Anthony, J.D., M.P.H.

Gerald Beaudreault, B.A.

Kristine Bostek, M.H.A.

Lisa M. Carroll, M.S., M.P.H., R.N.

William Connors, M.B.A.

Sabrina Corlette, J.D.

Rick Diamond, B.A.

Katie Dunton, J.D., M.P.A.

Kevin Ellis

Julia Feldman, J.D.

Mary C. Fontaine, B.S.

Rachel Frazier, J.D., M.P.H.

Thomas Friedman, M.P.A.

John Gettens, Ph.D.

Gretchen Hall, M.Ed.
Lee Hargarves, Ph.D.
Fred Jonas, B.A.
Monica Hau Hien Le, MD, M.P.H.
Kevin Lucia, M.H.P., J.D.
Marsha Mullaney, B.S.
Donna Novak, M.B.A.
Michelle Nowers, B.A.
Jillian Richard-Daniels, M.S.
John Rochford
Debra Sawyer, SPHR
Robert Seifert, M.P.A.
Joan Senatore, M.B.A.
Mary Beth Senkewicz, J.D.
Jean Sullivan, J.D.
Jen Vaccaro, M.P.H.
Rossana M. Valencia, M.P.H.
JoAnn Volk, M.P.P.
Diane Zeigler
Zi Zhang, M.D., M.P.H.

Resumes

1. Judith E. Fleisher, M.M.H.S., UMass
Vermont Exchange Team Project Lead
2. Jay S. Himmelstein, M.D., M.P.H., UMass
Project Advisor
3. Michael Tutty, M.H.A., M.S., UMass
Project Advisor
4. Marc A. Thibodeau, M.S., J.D.
Project Advisor
5. Deborah Drexler, J.D., UMass
Sections 1 and 2 Lead
6. Mila Kofman, J.D., Georgetown
Sections 3 and 8 Lead
7. Alexis D. Henry, Sc.D., OTR/L, UMass
Section 4 Lead

8. Katharine London, M.S., UMass
Sections 5 and 7 Lead
9. Ann G. Lawthers, Sc.D., UMass
Section 6 Lead

Project Lead

Judith E. Fleisher, M.M.H.S.

Ms. Fleisher will be the Project Lead for Vermont's Health Benefits Exchange Planning and Implementation initiative. Ms. Fleisher has over 16 years experience managing and directing projects that pertain to both the Medicaid and Medicare programs. Her areas of expertise include Medicaid eligibility policy and operations, with a focus on administrative simplification initiatives. Ms. Fleisher is currently the Senior Project Lead for the Robert Wood Johnson Foundation's Maximizing Enrollment Grant, which is in partnership with the Massachusetts Office of Medicaid (MassHealth). The objective of the Grant is to streamline policies and operations to ensure enrollment and retention in Medicaid, the Children's Health Insurance Program, and new or revised programs available under the Affordable Care Act. As part of this work, Ms. Fleisher developed a new streamlined annual review process for 13,500 elders residing in a nursing facility and 66,000 community elders, disabled adults, and children. She is also implementing an Express Lane Renewal process using SNAP (Food Stamps) data to renew Medicaid eligibility for 140,000 families. Ms. Fleisher is also a member of the Massachusetts Subsidized Insurance Workgroup, a subgroup of the Massachusetts interagency Affordable Care Act Implementation Task Force.

Prior to her current role, Ms. Fleisher managed benefit coordination projects for Massachusetts and led out-of-state provider recovery projects for Vermont, New York, Pennsylvania, and Maine. She also led an initiative and co-authored a report that documented insurance coverage, payment, and access issues for mental health services for elders in Massachusetts.

Prior to working at UMass, Ms. Fleisher directed business development initiatives related to State Pharmacy Assistance Programs, Medicare Part D, and Medicaid Managed Care pharmacy services. She also has five years in direct experience work for the Massachusetts Medicaid program. In this capacity, she oversaw provider relations and operations for the Commonwealth's Primary Care Case Management Program.

Project Advisors

Jay S. Himmelstein, M.D., M.P.H.

Dr. Himmelstein is a Professor of Family Medicine and Community Health, Quantitative Health Sciences and Internal Medicine at UMass. He also serves as Chief Health Policy Strategist at UMass and Senior Fellow in Health Policy for NORC at the University of Chicago, where he provides expertise in health information technology, health insurance exchange policy, public sector health delivery system reform, and state-based health care reform implementation. His professional career in research, policy development, and service is dedicated to improving health care and health outcomes for those served by the public sector.

Dr. Himmelstein leads the UMass Public Sector Health Information Technology and Exchange Policy Group. He is currently the Principal Investigator for the NESCIES project. He has been principal investigator on a number of other funded projects focusing on the potential for Medicaid and other human service programs to leverage investments in interoperable health information technology to improve outcomes and contain costs.

Dr. Himmelstein serves as a Senior Advisor to the Disability and Employment Policy Group for the UMass Center for Health Policy and Research and was the founding Director of Work Without Limits, a Massachusetts Disability Employment initiative — a \$21 million dollar grant through the Centers for Medicare and Medicaid Services. He is an elected member of the National Academy of Social Insurance and has served as an expert consultant the Social Security Administration, and to the Institute of Medicine, most recently as a member of the IOM Committee on Medical Evaluation of Veterans for Disability Compensation. He served as a Health Policy Fellow on the health staff of Senator Edward M. Kennedy from 1991 to 1992. Dr. Himmelstein serves on the editorial board of the *Journal of Occupational Rehabilitation* and has served an ad hoc reviewer for several peer reviewed journals including *Health Affairs*, the *Journal of the American Public Health Association*, the *Journal of the American Medical Association*, and *Health Care Finance and Review*. He currently serves on several nonprofit boards including the Massachusetts Health Care Policy Forum and the Health Foundation of Central Massachusetts.

During his career at UMass, Dr. Himmelstein has held numerous positions in research and academic administration including Director of the Occupational and Environmental Health Program (1988-1996), Robert Wood Johnson Foundation National Health Policy Fellow (1991-1992), Director of the Robert Wood Johnson Workers Compensation Health Initiative (1994-2000), Director of the Center for Health Policy and Research (1997-2007), Director of the Center for MassHealth Evaluation and Research (1997-2002), and Assistant Chancellor for Health Policy (1992-2007).

Dr. Himmelstein is board certified in internal medicine and occupational and environmental health/preventive medicine.

Michael Tutty, M.H.A., M.S.

Mr. Tutty is the Director of the UMass Office of Community Programs (OCP) and the Project Director for the NESCIES project at UMass. Mr. Tutty is the primary point-of-contact for CCIIO for operational components of the NESCIES innovator grant and oversees reporting and review activities. He is responsible for ensuring deliverables are met for major subcontracts. He is a member of the NESCIES senior management team. Mr. Tutty is also facilitating the Affordable Care Act (ACA) Subsidized Workgroup at the request of MassHealth and the Connector to address key questions surrounding policy and business process decisions that must be resolved as Massachusetts implements changes initiated as a result of the ACA.

Mr. Tutty is involved in a wide range of health policy and community engagement projects at UMass. He is involved in improving health care for vulnerable citizens by building bridges between the community and UMass to leverage the Medical School's academic and community ties to develop, implement, and manage a range of complex educational, training, and technical projects. Mr. Tutty is also a member of the UMass Public Sector Health Information Technology and Exchange Policy Group. Prior to joining UMass, Mr. Tutty worked at the Boston Consulting Group (BCG), where he spent five years as a Senior Analyst in its Health Care Practice Group. Prior to BCG, he worked as a Senior Planning Analyst for Baystate Health System in

Springfield, Massachusetts.

Mr. Tutty teaches a number of health policy courses. He is an Instructor in the Department of Family Medicine and Community Health at UMass and an adjunct professor at Clark University. Mr. Tutty is currently finishing his doctorate in public policy at UMass Boston.

Marc A. Thibodeau, M.S., J.D.

Mr. Thibodeau is currently Executive Director of the Center for Health Care Financing at UMass. He has nearly 25 years of experience in health and human services, including 10 years as Assistant General Counsel at both the Massachusetts state welfare and Medicaid agencies. The Center is a 300-employee unit that is responsible for the management and operation of all of Massachusetts' third-party liability, federal claiming, public facility billing, program integrity, and coordination of benefits activities under an agreement with MassHealth, the state's Medicaid agency. The Center manages various Employer Sponsored Insurance access projects including the commercial premium insurance and insurance partnership programs, covering more than 80,000 individuals combined and, in addition, manages public premium assistance efforts through its administration of the Medicare Buy-in Program for the state. The Center maintains active engagements in more than a dozen states.

Mr. Thibodeau brings substantial experience in the management of complex information technology initiatives, with an expertise in financing and procurement aspects of such endeavors and federal compliance activities. He is the Principal Investigator for a Robert Wood Johnson Foundation grant in Massachusetts that is focused on maintaining enrollment across Medicaid, CHIP, and other health insurance programs. He continues to forge working relationships with other public medical schools nationally to help foster development of the Medicaid agency/medical school partnerships to facilitate transfer of clinical, research, and policy supports available at professional schools to state human service agencies.

Section 1 and Section 2 Lead

Deborah Drexler, J.D.

A health care attorney, Ms. Drexler has spent most of the last 16 years working for the Commonwealth of Massachusetts on various public benefit programs. She has particular expertise in health information technology projects, an expertise she began developing in 2002, when she participated in MassHealth's efforts to achieve compliance with HIPAA's administrative simplification transaction standards.

Ms. Drexler joined UMass in 2011. As Senior Director of Data Operations, she is responsible for the timely and efficient deployment of several major software applications — some for use by UMass clients and others for internal use — and for ensuring that data operations comply with all applicable laws, regulations, and contractual requirements.

Ms. Drexler currently serves on the Massachusetts Data Release Review Board, which reviews applications from researchers and others for access to the Massachusetts Health Care Claims Dataset. She was a major contributor to a report presented to the State Alliance of E-Health,

February 2009, titled *Public Governance Models for a Sustainable Health Information Exchange Industry*.

Section 3 and Section 8 Lead

Mila Kofman, J.D.

Ms. Kofman is a nationally recognized expert on private health insurance. She and Katie Dunton (a member of our Exchange team) are currently working with 10 states under a Robert Wood Johnson Foundation project to assist states with ACA insurance market-related implementation, including exchanges. The state teams include insurance commissioners and staff, Medicaid directors and staff, Governors' office staff (and in one case the Lt. Governor), exchange directors (or equivalent), IT officers, and other state government officials. This work includes substantive, technical, and strategic hands-on assistance. Like Vermont, some of these states are grappling with many similar implementation issues and policy questions around Exchanges, market reforms, and opportunities under ACA to achieve universal coverage. Hands-on assistance includes providing an analysis of federal statutes and regulations on all federal laws including ACA and HIPAA (including ERISA, IRC, and PHSA). Part of the assistance also includes developing implementation plans to implement market reforms including exchange-related functions. This includes identifying interagency opportunities to leverage existing resources for required Exchange functions, developing MOUs that address interagency collaboration including certification of qualified health plans, navigators, call centers, and other essential functions under the ACA.

As the Superintendent of Insurance in Maine, Ms. Kofman implemented ACA areas with direct jurisdiction. This included working with all stakeholders, identifying carrier participation and market issues and implementation approaches. In 2010, she was appointed by the Governor to the Governor's Steering Committee on health reform implementation. The committee held meetings in public session with public input and comment on ACA implementation, including exploring the issues raised in this RFP. As a member of the National Association of Insurance Commissioners (NAIC), Ms. Kofman was one of a few insurance regulators who was asked to focus on and lead ACA implementation (e.g., co-chairing a statutory working group on section 2715, chairing a task force responsible for drafting ACA compliance models, etc.). Maine also chaired one of the subgroups on exchanges and was a key member of the actuarial working group developing MLR standards.

Section 4 Lead

Alexis Henry, Sc.D., OTR/L

Dr. Henry is Senior Research Scientist in the Applied Policy Research Unit and a Research Assistant Professor in the Department of Psychiatry at UMass. Dr. Henry has over 30 years experience as a provider, educator, and researcher in the disability and rehabilitation field. Within UMass, she manages a large team of researchers, project directors, and research staff examining the intersection of health, disability, and employment for people with disabilities served by public programs.

Currently, Dr. Henry is the Principal Investigator for the Massachusetts Medicaid Infrastructure

Grant (MIG) from the Centers for Medicare and Medicaid Services. In 2008, under the MIG, she oversaw a year-long statewide strategic planning effort engaging the full range of stakeholders, including state policy makers, service providers, employers, youth, and working age adults with disabilities and their family members to identify barriers and potential solutions to the problem of unemployment and under-employment of people with disabilities. This initiative – Work Without Limits – promotes employment opportunities and outcomes for people with disabilities through a broad-based communications and marketing efforts, consultation and technical assistance to providers and employers on issues related to disability employment, provider training on delivery of best practices (including train-the-trainer strategies), and policy support to state agencies including MassHealth and other disability-serving agencies, which includes the promotion of the Massachusetts Medicaid Buy-in Program for working adults with disabilities (the MassHealth CommonHealth program).

Recently, Dr. Henry and a research team under her direction conducted multiple focus groups with MassHealth members to inform the development of MassHealth’s integrated care demonstration for dual-eligible (Medicare and Medicaid) working age members. In 2011, Dr. Henry and colleagues published two papers examining the impact of health reform on people with disabilities.

Section 5 and Section 7 Lead

Katharine London, M.S.

Ms. London is a Principal Associate in the UMass Center for Health Law and Economics. Ms. London has over 20 years experience directing complex projects for government agencies. Her expertise includes health care policy development and analysis in the areas of health care financing, payment methodologies, rate development, cost containment, purchasing strategies, quality assessment, and delivery system reform. Ms. London directed the Massachusetts Health Care Quality and Cost Council’s initiative to collect health care claims data from fully insured Massachusetts health plans and to analyze health care quality and relative prices paid to health care providers; this work included many detailed discussions with providers and payers regarding health care payer practices, provider payments, and how these practices and payments were reflected in claims data. At the Massachusetts Attorney General’s Office, she conducted in-depth analyses of individual health care providers’ cost structures, revenues, and third-party payment arrangements. Earlier in her career, she analyzed health care costs and payment methods for the Massachusetts Health Care Task Force and the Massachusetts Division of Health Care Finance and Policy, and calculated rates under the Massachusetts All-Payer Rate Setting system at the Massachusetts Rate Setting Commission.

Ms. London has provided project management, facilitation, analytic support, and report writing to a number of high profile public/private boards and commissions responsible for developing health care initiatives and comprised of stakeholders representing diverse interests. Most recently Ms. London provided these services to help the Connecticut Sustinet Health Partnership Board of Directors, its eight subcommittees, and 160 individual participants to develop a public option health plan using the medical home model and alternative payment methods.

Ms. London holds a master’s degree in health policy and management from the Harvard School

of Public Health and a bachelor's degree in applied mathematics with biology from Harvard and Radcliffe Colleges.

Section 6 Lead

Ann G. Lawthers, Sc.D.

Dr. Lawthers, an Assistant Professor in the Department of Family Medicine at UMass, has over 25 years experience in quality measurement, program design, and evaluation. Dr. Lawthers has taught quality methods and metrics both in the United States and abroad. For the past 10 years at UMass, she has been responsible for the design and implementation of multiple program evaluations, the most recent being the evaluation of the state's patient-centered medical home initiative.

Project Team

Note: the UMass Center for Health Law and Economics is in the process of hiring a Senior Associate who has in-depth knowledge of and experience developing payment methods for public sector payers and a Policy Analyst with extensive data analysis expertise. These two new staff members will support the UMass team to complete Section 5 and Section 7 deliverables.

Stephanie Anthony, J.D., M.P.H.

Ms. Anthony will provide expert policy and legal analysis of federal laws and regulations affecting program integration and will serve as a content expert on Medicaid, Medicare, and dual eligibles. Ms. Anthony is a former Deputy Medicaid Director and former Director of Federal and National Policy for the Massachusetts Office of Medicaid. She is directing UMass's support for the Massachusetts State Demonstration to Integrate Care for Dual Eligible Individuals. Ms. Anthony has led and coordinated several initiatives to design comprehensive waiver or demonstration programs, including Section 1115 Demonstration long-term services and supports rebalancing models and Money Follows the Person operational protocols. She has extensive experience developing, managing and analyzing federal Medicaid waivers and state plan programs and other programs and proposals to identify potential overlaps, interactions, and synergies. Ms. Anthony has also served on the Center for Consumer Information and Insurance Oversight (CCIIO)'s Objective Review Committee for Cooperative Agreements to Support Establishment of State-Operated Health Insurance Exchanges.

Ms. Anthony previously worked as a senior policy analyst for the Economic and Social Research Institute in Washington, D.C., and as a legal advisor and policy analyst for the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. She began her career as a law clerk at the law firm of Drubner, Hartley, O'Connor, & Mengacci in Waterbury, Conn.

Ms. Anthony holds a law degree from St. John's University, a master's degree in public health from Yale University, and a bachelor's degree in English from Boston College.

Gerald Beaudreault, B.A.

Mr. Beaudreault is Principal Director of Federal and State Claiming at the UMass Center for Health Care Financing.

Mr. Beaudreault joined UMass in 2003 as Managing Director of Federal and State Claiming. In his current capacity, he leads the Federal and State Claiming team in managing projects focused on accessing all available federal reimbursement for qualifying public expenditures and ensuring compliance with applicable federal laws, regulations, and policies for his assignments. He specializes in Medicaid and the Children's Health Insurance Program financing.

Prior to joining UMass, Mr. Beaudreault served as Director of Revenue for the Massachusetts Medicaid Agency. During his 10-year tenure, he managed federal reporting, revenue collections, budgeting and accounting activities for the multi-billion dollar agency.

Mr. Beaudreault has more than 30 years experience in health care finance and financial management in the public sector. His experience extends from managing a decentralized revenue operation for two large human service agencies to specialized consulting assignments dedicated to program financial efficiency, regulatory compliance, and knowledge transfer.

Kristine Bostek, M.H.A.

Kristine Bostek is responsible for the oversight, planning, development, and execution of business development and communications for UHealthSolutions. As Senior Director of Communications and Business Development, she oversees market research, locates sources of new business development, creates and steers marketing communication campaigns, and develops growth strategies.

Kris is a key member of the UHealthSolutions strategic business planning team. Her background in operations, communications, and growth planning helps to guide the direction of the company's line of services. Prior to joining UHealthSolutions in 2006, Kris served as Director of Operations for UnitedHealth Group in Westborough, Mass., for three years.

She was a Vice President at UnumProvident Corporation, formerly the Paul Revere Insurance Company, from 1999 to 2003. In that role, she helped develop enhanced communication protocols to improve marketing of customer care to client companies and brokers. She also initiated the first claimant survey with UnumProvident. While with Unum, Kris implemented claim management and return-to-work strategies that supported company growth and financial goals while achieving best-in-class performance.

Kris holds a bachelor's degree in economics from Saint Michael's College in Vermont and a master of health administration from Clark University in Worcester. She is currently on the board of several not-for-profits, serving as Board Chair for Children's Friend, a private, not-for-profit serving children and families in Central Massachusetts.

Lisa M. Carroll, M.S., M.P.H., R.N.

Ms. Carroll is President of Small Business Service Bureau, Inc, Carroll Enterprises, Inc. She is the organization's strategist behind consulting, customer service, information technology, and administrative services. Ms. Carroll is also responsible for implementing the Massachusetts Commonwealth Choice program, in partnership with Commonwealth Health Insurance Connector Authority.

A registered nurse with graduate degrees in Nursing and in Public Health from Boston University, Ms. Carroll has been involved in a broad range of health care issues including the financing of care, quality improvements and health promotion and disease prevention within the community. As an advocate for accessible, affordable health insurance for the small business community, Ms. Carroll has appeared before the U.S. Congress, various state legislatures, and public forums for the National Association of Insurance Commissioners, America's Health Insurance Plans and the National Conference of Insurance Legislators.

In the early days of health reform in Massachusetts, Ms. Carroll served as Assistant Commissioner for the Department of Medical Security and was responsible for policy development and operating programs to provide access to basic health benefits for over 200,000 uninsured and underinsured state residents. With an annual state appropriation of \$400 million, initiatives included the Children's Medical Security Plan, the Medical Security Plan, the CenterCare Program and the Labor Shortage Initiative.

William Connors, M.B.A.

Mr. Connors has more than 30 years of financial-program management experience in the human-services field, with extensive experience in development and growth of profitable new business.

In his role as Director of Business Development at the UMass Center for Health Care Financing, Mr. Connors is responsible for all aspects of developing and maintaining effective key agency relationships. Utilizing his business administration background, he oversees the process of management of business development activities to ensure UMass maximizes its short, medium and long-term opportunities. Mr. Connors is responsible for the strategic management process and leads strategic discussion and manages strategic initiatives.

Sabrina Corlette, J.D.

Ms. Corlette is a research professor and project director at HPI. She leads research on state and federal regulation of private health insurance plans and markets and implementation of new insurance market rules under the Patient Protection and Affordable Care Act (ACA). Ms. Corlette has studied health policy and health insurance issues for 17 years. She is currently working on projects to monitor changes to state insurance laws as a result of the ACA and has produced several recent research papers addressing state insurance markets as they are affected by federal requirements. For example, she has conducted a comprehensive study of insurance departments' authority and practices in the regulation of individual and small group health insurance rates. She has also authored three influential studies on state insurance exchanges,

including an in-depth examination of the existing Utah and Massachusetts exchanges, an

exploration of the concept of the exchange as “active purchaser” on behalf of individual and small business enrollees, and an assessment of the exchange as a lever to drive quality improvement and delivery system reform. In addition, she serves as a consultant to the National Academy of Social Insurance (NASI) and drafted several sections of a model state law to establish a health insurance exchange. Ms. Corlette currently serves as a consumer representative to the National Association of Insurance Commissioners (NAIC) and as such helped shape language for NAIC’s model state laws on insurance exchanges and the ACA’s early insurance reforms. She serves as an appointed member to NAIC’s statutory working group charged with developing the standard summary of benefits form and the uniform enrollment form required under federal law.

Prior to joining the Institute faculty, Ms. Corlette served as an attorney at the law firm Hogan Lovells (formerly Hogan & Hartson LLP), where she advised clients on health care law and policy relating to HIPAA, Medicare and Medicaid. Earlier in her career she served as a professional staff member for the U.S. Senate Health, Education, Labor and Pensions (HELP) committee, during which time she drafted and advanced legislation on public health, insurance reform and health care privacy. Ms. Corlette is a member of the D.C. Bar Association and received her J.D. with high honors from the University of Texas at Austin and an A.B. with honors from Harvard University.

Rick Diamond, B.A.

Mr. Diamond has 37 years of experience as a health actuary. For the bulk of his career, he was Chief Life & Health Actuary for the Maine Bureau of Insurance, where he was deeply involved in health reform issues at the state level, as well as at the federal level through the National Association of Insurance Commissioners (NAIC). Until September 2011, he chaired the NAIC’s Health Care Reform Actuarial Working Group, charged with all actuarial issues relating to federal health reform. He has continued to closely monitor the activities of this group since his retirement from the Maine Bureau of Insurance, as the group works on issues relating to the reinsurance, risk corridor, and risk adjustment provisions of the Affordable Care Act.

Katie Dunton, J.D., M.P.A

Ms. Dunton is an assistant research professor at the Health Policy Institute at Georgetown University. She is a senior researcher on health insurance reform issues, including assistance to states on implementation and the impact of Affordable Care Act implementation on private markets, including work with Mila Kofman (a member of this team) on a ten state initiative under a Robert Wood Johnson Foundation Grant. As Communications and Outreach Director for the Maine Bureau of Insurance, she played a vital role in enhancing consumer access to insurance information, including information about Maine’s rate review process and Bureau services. Working with contractors and interested parties, Ms. Dunton created an outreach and education strategy to involve more consumers in a meaningful way, increasing transparency and

promoting consumer participation and a better understanding of the process. During her tenure, Ms. Dunton shifted outreach planning to target specific populations, to ensure that they received information they needed about the Bureau's services.

Prior to joining the Bureau of Insurance staff, Ms. Dunton was a legislative aide for the Maine Legislature. She assisted with policy development and in communicating with constituents and outside agencies on state programs and pending legislation.

Kevin Ellis

An award-winning former journalist, Mr. Ellis heads a communications practice that positions clients for success with the media, political community or in public campaigns. He provides strategic counsel to companies and nonprofits nationwide in message development, crisis management, PR and social media. Formerly a reporter with newspapers in Tennessee, Washington, D.C. and Burlington, Vermont, he covered Congress, the White House, national political campaigns and environmental/energy policy. He is a graduate of Amherst College.

Julia Feldman, J.D.

Ms. Feldman will provide advice on complying with federal law and regulations and will work with Vermont agency lawyers to ensure proposed solutions are consistent with Vermont's policies related to pay reform. Ms. Feldman is an attorney with more than two decades of prior experience practicing health care law in both the public and private sectors. She focuses her health law and policy work on state health care payment and system delivery reform, Medicaid, compliance and contract review, managed care, disproportionate share, and the uninsured. She has been providing guidance on these topics to the Massachusetts Executive Office of Health and Human Services and the Massachusetts Health Care Quality and Cost Council's Committee on the Status of Payment Reform.

Prior to joining the Center for Health Law and Economics, Ms. Feldman was a member of the health care transactions unit of the Boston law firm, Krokidas & Bluestein. There, she represented a variety of health care, education, and government entities, as well as individual physicians and allied health professionals, in transactions, corporate and regulatory compliance, reimbursement issues, corporate matters, legislation, and tax-exempt financing.

Earlier in her career, Ms. Feldman worked for more than a decade in the Office of the General Counsel of the Commonwealth's Division of Medical Assistance and the Executive Office of Health and Human Services. In that role, she advised senior management on legal questions related to Medicaid regulations, contracts, policy, state plan amendment, federal waiver, and reimbursement issues. She also advised on the design and implementation of complex service delivery and reimbursement programs, with particular emphasis on disproportionate share funding and payments as well as managed care programs. Ms. Feldman launched her career at large law firms in Boston, New York, and Washington, D.C.

Ms. Feldman also serves as chair of the American Health Lawyers Association's Accountable Care Organization (ACO) task force committee on organization and governance and she writes and lectures on health care reform, managed care contracting, and other areas of health law and

policy for professional and academic organizations, such as the Boston Bar Association Health Law Section, Massachusetts Medical Law Reporter, Boston University School of Law, the Heller Graduate School at Brandeis University, and Amherst College.

Ms. Feldman holds a law degree from Columbia University School of Law, where she was editor of the *Journal of Law and Social Problems*. At Amherst College, she earned a bachelor's degree in English, graduated Phi Beta Kappa and magna cum laude, and was awarded the John Woodruff Simpson Fellowship in Law.

Mary C. Fontaine, B.S.

Ms. Fontaine, currently the Deputy Director of the Center for Health Care Financing, joined UMass in 2000 as Director of Benefit Coordination and Program Integrity. In that capacity, she led consulting services in the area of Medicaid program integrity and third party liability. She successfully managed cost savings and recoveries of more than \$3 billion annually and the development of savings initiatives for various state agencies across the country.

She is currently responsible for the UMass Center for Health Care Financing's operations and consulting services. Her program integrity experience dates back to 1983 when she was the manager of the Provider Review Unit for the Massachusetts Division of Medical Assistance and was the liaison with the Attorney General's Medicaid Fraud Control Unit. While at the Massachusetts Division of Medical Assistance she participated in the policy and program development of the Massachusetts health care reform act. She was also responsible for managing the premium assistance programs and insurance partnership programs that leveraged employer sponsored health insurance.

Rachel Frazier, J.D., M.P.H.

Ms. Frazier will conduct legal and policy research to ensure proposed solutions conform with the ACA and Medicare rules and regulations. Ms. Frazier previously conducted legal and policy research and drafted legal memos and issue briefs for the National Senior Citizens Law Center, the WilmerHale Legal Services Center, and the AARP Foundation Litigation Health Unit.

Ms. Frazier holds a law degree and master's degree from Harvard University, and a bachelor's degree in Psychology from Whitworth University.

Thomas Friedman, M.P.A.

Mr. Friedman will analyze payment levels and variations in payments across Vermont payers and providers. Ms. London and Mr. Friedman are currently engaged by the New Hampshire Insurance Department to analyze factors that may affect variations in prices that commercial health insurers pay New Hampshire health care providers. Mr. Friedman is also working with the New Hampshire Department of Health and Human Services to develop disproportionate share hospital payment methods and rates, in conformance with state policies and federal law and regulation. Mr. Friedman previously analyzed medical claims experience, discount rates, and premiums and developed strategic health care policies for large employers at a national actuarial firm.

John Gettens Ph.D.

Dr. Gettens has more than five years of applied research and evaluation experience in health policy and health services. He has conducted research on health care reform topics and recently published two health care reform articles, a study of the effects of the Massachusetts health care reforms on persons with disabilities and an assessment of the potential effects of the national health care reforms on persons with disabilities. In addition, Dr. Gettens has recent experience in stakeholder consultation having completed a focus group study of Massachusetts residents who are dually eligible for Medicaid and Medicare. Dr. Gettens has experience in the implementation and operations of state programs having held a senior management position in New Hampshire state government where he directed a division responsible for the administration of Medicaid eligibility in addition to the administration of the Temporary Assistance for Needy Families, Food Stamp and State Supplement programs. Dr. Gettens also has extensive knowledge of Medicaid eligibility having lead a team on the logical design of an automated, cascading Medicaid eligibility determination computer system for the State of Maine.

Gretchen Hall, M.Ed.

Ms. Hall is the Director of Program Development for the Massachusetts CANS Training team. In this position, Ms. Hall spearheaded the development and directed the implementation of two comprehensive training programs in Massachusetts: 1) Strategic Training to Enhance Permanency Solutions (STEPS) program for the Department of Children and Families, and 2) the Child and Adolescent Needs and Strengths (CANS) assessment certification training and support program in Massachusetts. Ms. Hall brings 20 years of experience in instructional program design and delivery, incorporating multimedia education formats, developing curriculum to meet certification criteria, and implementing best practices for teaching and learning for adult learners. Additionally, she is the author of *The Role of the Health Care Insurance Exchange in the Affordable Care Act*.

Lee Hargraves, Ph.D.

Dr. Hargraves is a Senior Scientist for the Office of Survey Research and Research Associate Professor of Family Medicine and Community Health at UMass. He is a nationally recognized leader on the development and use of survey methods to assess health care quality from patients' perspectives. Dr. Hargraves' research has contributed to national efforts to document racial and ethnic disparities in health care. While at UMass for Studying Health System Change (Washington, DC), he directed two rounds of the Community Tracking Study's Household Survey of over 50,000 individuals. Dr. Hargraves was Senior Survey Scientist at the Picker Institute, Boston. In addition to directing the Institute's survey development, sampling, and reporting activities, he was an original co-investigator on the Harvard University team for the CAHPS® (Consumer Assessment of Healthcare Providers and Systems) project, which was sponsored by the Agency for HealthCare Research and Quality. Dr. Hargraves contributed to the CAHPS reporting and instrument development teams that focused on how to best report survey data to consumers. He also contributed to CAHPS survey development in conducting psychometric analysis of version 2.0 of the CAHPS health plan survey. He is currently focusing on the treatment of disparities in health care as an opportunity for improving health care quality.

He is leading evaluation of staff satisfaction for the Massachusetts Patient-Centered Medical Home Initiative.

Fred Jonas, B.A.

Mr. Jonas has spent the last 14 years designing, developing, deploying, and managing always-available, high-volume, consumer-facing web applications for a variety of non-profit and commercial organizations. He has worked in senior management roles, managed networks and systems at data centers, and created, programmed, marketed, and sold successful commercial software products that are currently used in countries all over the world.

Most recently, Mr. Jonas has focused his management and technology skills on solving problems in the health care and social services fields, including helping UMass develop systems to track Medicaid-related administrative expenditures, Third Party Appeals, and Interdepartmental Service Agreements.

Monica Hau Hien Le, M.D., M.P.H.

Dr. Le works directly with MassHealth in programs that affect the Medicaid population, including the development of novel payment systems, such as bundled payment for currently unreimbursed services that would prevent asthma exacerbations (Children's High-Risk Asthma Bundled Payment Demonstration Program). She was involved in the first Chronic Care Collaborative involving medical residency training, and focused on patient empowerment within the context of chronic care management. Dr. Le was principally involved in a review of a commercial wellness program and its applicability to the Massachusetts state Medicaid population. Dr. Le has a strong public health and health policy focus, and will be involved in a collaboration with the Department of Public Health in its Chronic Disease Systems Working Group Work Group which will help the Massachusetts Department of Public Health Division of Prevention and Wellness establish a model framework for developing the statewide chronic disease plan to be released in June 2012.

Kevin Lucia, M.H.P., J.D.

Mr. Lucia is a research professor and project director at Georgetown's Health Policy Institute. Mr. Lucia recently returned to HPI after leading the State Market Rules Compliance Team within the Office of Oversight, Center for Consumer Information and Insurance Oversight (CCIO), Center for Medicare and Medicaid Services (CMS).

Mr. Lucia has over 10 years of experience as a legal researcher and private health insurance expert specializing in analyzing the market reforms of the Affordable Care Act (ACA). He is an expert in the legal interaction between state and federal law as it relates to the regulation of private health insurance. He is currently working on a number of research projects related to state compliance and enforcement of the market rules of the ACA as applied inside and outside the exchange. He works extensively with state regulators, policymakers, advocacy groups and other researchers to identify pragmatic solutions to complex policy questions related to the implementation of the ACA.

Mr. Lucia's prior research focused on the regulation of health insurance sold through associations and other types of group purchasing arrangements, proliferation of fraudulent health insurance coverage, insolvencies of state licensed MEWAs, regulation of the use of genetic information during individual market underwriting, state limitations on balance billing and state external appeal laws.

Marsha Mullaney, B.S.

Ms. Mullaney brings extensive project management experience with public programs and IT initiatives to her current role on the New England States Collaborative Insurance Exchange Systems ("NESCIES") project, an Early Innovator recipient, providing preliminary research on federal Exchange requirements and writing and reviewing project documents in support of the Massachusetts Exchange development. Previously Ms. Mullaney managed the Massachusetts Health Care Training Forum (MTF). MTF works in partnership with the Massachusetts Executive Office of Health and Human Services, Office of Medicaid (MassHealth) to provide timely updates on MassHealth and other public programs to the health care community which serves MassHealth members, the uninsured, and underinsured. These updates are provided through five regional state-wide meetings held quarterly, regular e-mail updates, and the MTF website.

Prior to joining UMass in 2006, Ms. Mullaney worked for Hewlett Packard as an IT Project Manager where she managed and participated on projects to drive operational efficiency and cost reduction for the (North and South America) Command Center Operations organization responsible for providing 24x7 Level 1 incident detection, validation, resolution, elevation, and escalation management for both HP and commercial network (LAN/WAN), platform (servers/OS), internet (LD, firewall, URL), and application production (SAP, backup) support.

Ms. Mullaney earned a B.S. in Business Administration from Emmanuel College, Boston, MA, and is currently enrolled in the Clark University's Master of Public Administration with an expected graduation date of May 2013.

Donna Novak, M.B.A.

Ms. Novak has 35 years of experience as a health actuary. She regularly advises state and federal regulators on insurance market reform, carrier business affiliations, and Medicaid Risk rates. She regularly serves as the primary speaker at actuarial workshops, congressional staff briefings, and association conferences on many technical topics including Risk Based Capital, Insurance Market Reform, and Insurance Cost Projections. She has advised federal and state policy makers on health insurance market reform including the effect of state mandated benefits, rate review of state rate filings, and actuarial support of numerous state financial examinations. She has been engaged by HHS to advise them on actuarial issues relating to the implementation of the ACA, and was appointed to the HHS CO-OP Advisory Board. She plays a leading role at the American Academy of Actuaries, including Vice President of the Financial Practice Council, and Chairman of the Medical Subgroup of the Health Risk based Capital Work Group. Ms. Novak has also worked closely with the Blue Cross Blue Shield Association to determine the actuarial impact of insurance reforms on a state and national level. She has twelve years of commercial carrier experience, including as the Director of Group Department Strategic Projects, responsible for

managing interdepartmental strategic projects and coordinating cost-effective implementation of all new marketing products from the data processing systems and administrative procedures perspective, including production of administrative manuals.

Michelle Nowers, B.A.

Ms. Nowers is the Disability Health and Employment Policy Unit's Program Manager for Communications, leading all communication and marketing activities for the Work Without Limits (WWL) Initiative, a Massachusetts Disability Employment Initiative. One activity included a successful partnership with the U.S. Department of Labor regarding the Massachusetts "What Can YOU Do?" campaign, launched in April 2011. Ms. Nowers also leads the implementation and continued development of the WWL website and coordinates the development and dissemination of all collateral and product development for WWL.

Jillian Richard-Daniels, M.S.

Ms. Richard-Daniels will be responsible for working with stakeholders to design the inventory of quality programs and then to oversee the conduct of the inventory. In addition, Ms. Richard-Daniels will apply her considerable project management skills to working with Dr. Lawthers on the recommendations for an implementation plan. Ms. Richard-Daniels is an experienced writer, project manager and qualitative methods specialist.

John Rochford

Mr. Rochford, of New England INDEX and UMass, will oversee the technical development of the Navigator certification system. New England INDEX is a technical developer of online curricula, including certification-based trainings. INDEX has developed and hosted online courses that employ multimedia and interactive content, all of which are accessible to people with disabilities. INDEX has staff for application development, technical project management and instructional design. INDEX's online learning projects have included: Massachusetts Patient-Centered Home Initiative, Massachusetts Child and Adolescent Strengths and Needs (CANS) training and certification program, and graduate programs in Behavioral Intervention in Autism.

Debra Sawyer, SPHR

Ms. Sawyer has expertise in all aspects of human resources management and employee relations. She joined UHealthSolutions in 2002 and implemented the human resources function within the organization. As Director of Human Resources, she is responsible for all human resource activities for the organization.

Prior to joining UHealthSolutions, Ms. Sawyer held progressively challenging human resources positions, including staffing coordinator, employee relations manager, director, and corporate integrity officer.

Ms. Sawyer holds a bachelor's degree in management from Curry College in Milton, Mass., and an associate's degree in business management from Fisher College in Boston.

Certified as a senior professional in human resources (SPHR), Ms. Sawyer is also a member of the Society of Human Resource Management and the Northeast Human Resource Association.

Robert Seifert, M.P.A.

Mr. Seifert will provide expert policy advice on the ACA, health economics, and health insurance markets, as well as assistance presenting complex material in easily understood formats. Mr. Seifert has done work analyzing state and national health care reform, writing about MassHealth — Massachusetts' Medicaid program — and assisting the Commonwealth in efforts to improve the delivery and financing of services to people with complex health care needs, including those needing long-term services and supports and those who are dually eligible for Medicare and Medicaid. Mr. Seifert recently co-wrote reports examining the implications of the ACA for Massachusetts and analyzing private and public health care spending before and after Massachusetts health reform.

He also has assisted the Maine Governor's office and Maine's Advisory Council on Health Systems Development with its early Exchange planning, as part of a team consulting on Exchange options, insurance market, Medicaid, payment reform, quality, and transition of existing Maine programs. Mr. Seifert has served on the Center for Consumer Information and Insurance Oversight (CCIIO)'s Objective Review Committee for Cooperative Agreements to Support Establishment of State-Operated Health Insurance Exchanges. He is also a policy consultant to the New England States Collaborative Insurance Exchange Systems (NESCIES) "innovator" project supported by CCIIO.

Mr. Seifert is a former Executive Director of the Massachusetts Medicaid Policy Institute, where he engaged researchers and managed projects and the dissemination of research through publications and public forums. Through his role at MMPI, Mr. Seifert also served as a member of the Massachusetts Health Care Quality and Cost Council and the MassHealth Payment Policy Advisory Board. Prior to working for MMPI, he was Policy Director of The Access Project. Earlier in his career, Mr. Seifert spent seven years at the Massachusetts Rate Setting Commission, later called the Division of Health Care Finance and Policy. He has additional government experience at the federal and municipal levels, having worked at both the U.S. Department of Health and Human Services and the New York City Human Resources Administration.

Mr. Seifert holds a master's degree in public affairs from Princeton University and a bachelor's degree in economics from Wesleyan University.

Joan Senatore, M.B.A.

Ms. Senatore is Director of Provider Compliance for the UMass Center for Health Care Financing. Ms. Senatore joined UMass in 2002 as Director of Provider Compliance. In her current role, she is responsible for the development of Medicaid recovery initiatives focusing on the assessment of provider regulatory compliance through algorithm development, data analysis and audits. Ms. Senatore also manages the identification and recovery of provider fraud, waste and abuse as well as improper payments to MassHealth providers for the Executive Office of

Health and Human Services.

Prior to joining UMass Medical School, Ms. Senatore was Manager of Fraud and Abuse for the Commonwealth of Massachusetts Office of Medicaid where she coordinated all provider and member fraud activities. She also served as liaison to the Office of the Attorney General, Medicaid Fraud Control Unit on provider fraud issues and to the Bureau of Special Investigations, Department of Revenue on member fraud matters. Ms. Senatore has more than 26 years of experience in the provider integrity arena and is responsible for identifying and implementing cost savings initiatives to enhance revenue dollars. Ms. Senatore is known nationally for her work in the area of program integrity and in 2011 was elected Vice President of the National Association for Medicaid Program Integrity (NAMPI) and assumed the role of President in 2011 when the current President resigned. She has served as NAMPI's Treasurer for the past six years. She is a member of the Board of Directors of the Boston Chapter of Certified Fraud Examiners and previously served as Chapter President from 2001-2002. She is on the faculty of the Medicaid Integrity Institute, a training facility for States' Program Integrity staff in Columbia, South Carolina. She was recently awarded a Distinguished Service Award for her work at the Institute.

Mary Beth Senkewicz, J.D.

Ms. Senkewicz has 20 years of experience in state regulatory health insurance and health policy issues, and is a nationally recognized expert in the field. In her most recent position as Deputy Insurance Commissioner for Life and Health in the State of Florida, Ms. Senkewicz has been intimately involved in reviewing and analyzing the Affordable Care Act and all regulations promulgated under the Act, and analyzing implications for the State of Florida and its insurance regulatory structure. She has been actively involved in the National Association of Insurance Commissioners and its work in assisting the states with ACA implementation issues. She has also served several terms as the chair of the National Committee on Quality Assurance's Public Sector Advisory Council, keeping abreast of the latest developments in the quality arena. She served 11 years as the NAIC's Chief Health Policy Counsel, working with the states on HIPAA implementation in the mid-90s, and all federal issues related to the regulation of health insurance, including ERISA interpretation. Her years with the NAIC made her quite familiar with a multiplicity of state laws, including all mandated benefits throughout the states. As Deputy Commissioner in Florida, she supervised the Life and Health Rates and Forms business unit, and was actively involved in the forms (contracts) and rate approval process. Ms. Senkewicz is an excellent writer and is known for her incisive analysis of state and federal law.

Jean C. Sullivan, J.D.

Ms. Sullivan will provide overall guidance on managing relations with federal oversight agencies, and designing new legal and financing models for coverage and health access. Ms. Sullivan's award-winning contributions to each of Massachusetts' Health Care Reform initiatives over the last two decades have made her one of the leading experts in Medicaid demonstration projects and program reform. She has extensive experience managing relations with federal oversight agencies, and designing new legal and financing models for coverage and health access.

From 2003–2006, Ms. Sullivan advised the Executive Office of Health and Human Services regarding the design components of the state’s landmark health reform model launched in 2006, including the legal and financial architecture for expansion groups now covered under the Connector Authority. Previously, Ms. Sullivan helped secure federal approvals and renewals of the state’s Title XIX Medicaid demonstration project expansions and reform initiatives. She has particular expertise in financing and structuring programs for the uninsured and safety net hospitals. Beginning in 2007, she developed and founded the Center for Health Law and Economics (CHLE) to pursue policy development work with States interested in reform and improvement of their publicly operated health programs. The Center has had many past and current client engagements in the arena of state and national health reform policy analysis and implementation, including work with the States of Connecticut, Rhode Island, Maine and New Hampshire. The CHLE is also part of the project team for the New England States Collaborative Insurance Exchange Systems (NESCIES) grant, a \$35 million Early Innovator Grant from the US Department of Health and Human Services.

Most recently, Ms. Sullivan is working extensively with New Hampshire health policy foundation, the Insurance Department and the Department of Health and Human Services to restructure the funding and payment systems for Uncompensated Care. For the past two years, she has briefed and advised New Hampshire state agency officials, legislators, policymakers, researchers and advocates on several health reform topics which involve policy and cost analysis, redesign of health care programs, and impact analyses of reform opportunities under the Patient Protection and Affordable Care Act.

Ms. Sullivan is a four-time recipient of the Manuel Carballo Governor’s Award for Excellence in Public Service, Massachusetts’ highest level performance recognition award. She is widely consulted by legislative leaders, policy researchers, state agency officials, health advocacy organizations, board directors, and health care provider executives for her expertise in federal and state Medicaid laws, disability benefits, and all aspects of Medicaid federal financial participation (FFP) rules and policies. She has been an invited speaker on the topics of Massachusetts and Federal Health Care Reform at several national conferences in the recent past and is a guest lecturer with the University of Massachusetts Medical School and its Graduate School of Nursing.

Jen Vaccaro, M.P.H.

Ms. Vaccaro will support both the quality inventory and the environmental scan of quality rating programs. At the UMass Office of Clinical Affairs, she has designed and conducted inventories and environmental scan as well as policy analyses. Ms. Vaccaro’s work shows an appreciation for the challenges facing individual’s seeking medical care within a fragmented system.

Rossana M. Valencia, M.P.H.

Ms. Valencia will be responsible for collaborating on the quality program inventory. Ms. Valencia is an experienced interviewer and policy analyst. At Beth Israel Deaconess Medical Center, she conducted numerous interviews for a study of elderly women and their medical decision-making around mammography screening and follow-up. At the Office of Clinical Affairs, she has designed and conducted inventories and environmental scan as well as policy

analyses.

JoAnn Volk, M.P.P.

Ms. Volk is a Research Professor at HPI, where she directs research on private health insurance, with a particular focus on implementation of the health insurance reforms and state insurance exchanges enacted under the ACA. She has 12 years of experience in health policy. At HPI, Ms. Volk has authored a number of research papers that will support her work on this project, including an analysis of health insurance exchanges as levers for quality improvement and delivery system reform. She has also co-authored an in-depth examination of the Utah and Massachusetts insurance exchanges and an exploration of the exchange as an “active purchaser” on behalf of enrollees. In addition, Ms. Volk has recently completed research and drafted an issue brief for the Robert Wood Johnson Foundation on workplace wellness incentive programs as permitted under the ACA (publication pending).

Prior to joining HPI, Ms. Volk managed health care policy and advocacy for the AFL-CIO.

There she focused on private health insurance regulation, particularly employer-sponsored

coverage. In that capacity, she worked with U.S. Congressional staff on the employer responsibility, state insurance exchange and tax subsidy provisions of the PPACA, as well as the tax subsidies for laid off workers under the Health Coverage Tax Credit and the Retiree Drug

Subsidy for employers under the Medicare Modernization Act. Before coming to the AFL-CIO,

Ms. Volk was a senior analyst with Abt Associates, doing research on state-based efforts to

cover the uninsured and state high-risk pools. Ms. Volk also has experience in state government,

having served as a senior aide to the Speaker of the New York State Assembly. She holds an M.P.P from Johns Hopkins University with a concentration in health policy.

Diane Zeigler

Ms. Zeigler is VP of Web Strategies and Client Affairs for KSE Partners and currently directs web marketing and PR campaigns for clients. She has managed both earned and paid media campaigns on a local and national scale. In addition, she has served as executive producer of television and radio spots, project manager for major website overhauls, and has extensive experience in managing e-marketing and traditional PR campaigns. She is also a formerly nationally touring singer/songwriter/guitarist and the winner of 8 national songwriting awards.

Zi Zhang M.D., M.P.H.

Dr. Zhang is the Director of the Office of Survey Research in the Center for Health Policy and Research and an Assistant Professor of Family Medicine and Community Health at UMass. He oversees all aspects of the Office's work — from survey design, sampling, and protocol development to data collection, data analysis and reporting. Prior to joining the Center for Health Policy and Research in 2009, Dr. Zhang spent nearly 14 years at the Massachusetts Department of Public Health, serving most recently as director of the Health Survey Program. In that role, he directed all aspects of the Massachusetts Behavioral Risk Factor Surveillance System (BRFSS) and significantly expanded the state's public health surveillance capacity. Dr. Zhang served on the BRFSS Working Group at the Centers for Disease Control and Prevention (CDC), representing 13 states in the Northeast U.S.

Judith E. Fleisher, M.M.H.S.

Summary of Experience

Fifteen years experience in Medicaid and Medicare programs. Nine years experience in client management. Project lead and project manager for initiatives in the states of New York, Pennsylvania, Massachusetts, Vermont, and Maine. Directed initiatives related to the Children's Health Insurance Program, State Pharmacy Assistance Programs, Medicare Part D, and Medicaid Managed Care pharmacy services. Five years in direct experience work for the Massachusetts Medicaid program.

Professional Experience

University of Massachusetts Medical School
Center for Health Care Financing — Charlestown, MA
Director, Program Development

2009-Present

Senior Project Lead for \$1 million dollar grant awarded to the Massachusetts Office of Medicaid and the University of Massachusetts Medical School to increase enrollment and retention for children in Medicaid and CHIP. Report to the Office of Medicaid Chief Operating Officer on all grant related activities. Oversee improvement plan and work plan. Lead work team to develop a streamlined annual eligibility review process for Medicaid members which includes utilizing third party data sources to verify income. Develop work flow process for a new administrative annual review process for certain elders residing in a nursing facility. Represent Office of Medicaid at annual grantee meetings in Washington, DC. Work with Office of Medicaid Policy and Outreach and Education staff to engage external stakeholders such as providers and advocates in grant activities. Manage and coordinate data submission of quantitative evaluation component with grant vendor. Ensure compliance with all conditions of the grant including financial and programmatic reporting

Direct staff overseeing and managing Medicare Appeals for Home Health contracts with the State of New York and the Commonwealth of Pennsylvania

Benefit Coordination Consulting
Senior Associate

2005-2009

Client and project manager for contract with the New York Office of the Medicaid Inspector General to oversee all aspects of the State's participation in the Center for Medicare and Medicaid Services Third Party Liability Demonstration Project for Home Health Services. Ensure all activities meet project timelines. Lead the legal, clinical and operation team. Assist the State of New York with policy analysis and decision-making

Led Medicare Appeals for Home Health Initiative on behalf of the Commonwealth of Pennsylvania. Client manager and project manager. Oversaw all activities including policy recommendations, ongoing collaboration with the Pennsylvania Home Care Association and other stakeholders, assisting staff with updates for the Secretary. Directed operations. Facilitated weekly client meetings which include agenda development, meeting summaries and ensuring all follow-up activities. Presented at provider training sessions

For the Massachusetts Executive Office of Elder Affairs prepared a report of availability of insurance coverage for elders with a mental health conditions. Report included Medicaid, Medicare and the largest private HMO coverage definitions, limits, rules of service delivery as well as the results of interviews with providers, advocates and reimbursement experts

Participate in Business development activities including sales presentations, RFP submission, and business planning and marketing committees

Public Sector Partners, Inc.
Program Development Unit — Worcester, MA
Director

2004-2005

Reported to the Chief Executive Officer to oversee all new business initiatives from project development through implementation. Supervised staff of three senior project managers

Led the work team to identify and develop of new business initiatives related the Medicare Modernization Act of 2003, Medicare Part D

On behalf of the Executive Office of Elder Affairs, led the development of member education materials associated with a \$2.7 million dollar federal grant to outreach and educate Prescription Advantage members on benefit and program changes as a result of Medicare Part D

Oversaw the development of Project Task Orders for all projects associated with the \$25 million dollar contract with University of Massachusetts Medical School. Includes scope development and budget negotiation

Developed and managed process for responses to Request for Proposals (RFP). Responsible for process from RFP identification through proposal submission

Senior Program Development Associate

2002-2004

Oversaw the development and implementation of a Medicare Appeals initiative for the New York State Department of Health that generated \$163 million dollars in revenue for the State. Led work group to design operational program policies and procedures and to develop a database for tracking and valuation. Worked with providers to resolve customer service needs. Presented at provider trade association meetings. Acted as contract liaison and manage all requests for data and information

Led the development and implementation of a Medicare Part B Drug Recovery initiative for the States of Maine and Vermont. Acted as client manager and lead client work group for each state to design a state-specific program. Oversaw the development of project materials. Managed sub-contractors regarding provider services support and data management, analysis and reporting. Facilitated resolution of provider issues. Ensured all contract deliverables were met

Successfully developed and implemented the provider customer service operation that supported 1400 pharmacies for a Medicare Part B Drug Recovery initiative for the State of Texas. Oversaw the implementation of all operations including hiring and training staff, telecommunications and computer set-up, and communication tracking and reporting. Ensured accurate and timely responses to questions regarding Medicare Part B drug coverage requirements. Designed operational process for tracking and reporting telephone, fax and e-mail communication

Project managed the application for the Center for Medicare and Medicaid Services Drug Discount Card. Authored the corporate requirements section. Coordinated and edited authors of remaining sections. Ensured application was submitted and received by the deadline

Collaborated with the North Carolina State Department of Health and Human Services revenue maximization contractor to develop and implement a Medicare Appeals initiative. Co-led the development of a pilot program. Oversaw data analysis and clinical project support

Partners HealthCare System, Community Benefit Programs

2000-2002

Medicaid Operations — Boston, MA

Manager

Oversaw the resolution of Medicaid operations issues for Massachusetts General Hospital and Brigham Womens Hospital. Identified and addressed issues to improve Medicaid operations and reimbursement. Collaborated with the both administrative and clinical departments and the systems-wide support departments, such as finance, billing and information systems, to better manage the care and reimbursement of the Medicaid populations

Acted as liaison to Massachusetts Medicaid and other public entities to address policy and procedural issues. Communicated Medicaid policy changes to Partners entities. Responded to requests for information and facilitated resolution of issues between Massachusetts Medicaid and Partners hospitals and hospital-licensed health centers. Reviewed and revised enrollment and registration policies and procedures

Co-led a collaborative hospital and payer workgroup to address operational issues related to a Medicaid managed-care plan. Led a system-wide workgroup to address plan-specific enrollment issues. Oversaw data analysis and work with plan and hospital staff to identify and implement improvement strategies

Participated in the development of analytic strategies for determining opportunities for increased Medicaid revenue, and for the evaluation of operations improvement strategies

Massachusetts Division of Medical Assistance

Primary Care Clinician Plan

Provider Relations and Operations — Boston, MA

1997-2000

Assistant Director

Directed Provider Relations and Operations Unit for the Massachusetts Medicaid managed care program covering 450,000 members. Managed network of 1300 primary care provider practices, which included individual, group, community health center, and hospital outpatient department practices. Responsible for all network management and operational issues including claims, member and provider enrollment

Contract manager for network management services vendor that provided provider profiling and related quality improvement initiatives and provider relations activities through a telephone hotline, regional informational meetings and a newsletter

Procured, negotiated and implemented \$3.4 million network management services contract with no break in service. Wrote Request for Responses, led bidders' conference, chaired selection committee, and negotiated contract with selected bidder

Oversaw provider profiling initiative, which included Profile Report development and production, training, site visits, and development and implementation of practice-based quality improvement activities. Supported Quality Management Unit with the implementation of program quality improvement activities in the primary care provider network. Participated in the development of quality improvement activities

Public speaking in state and national forums

Health Benefits Management Program — Boston, MA
Manager, Provider Relations
Manager, Medicaid Operations

1985-1997

Oversaw enrollment process and operations of an enrollment broker contract responsible for the enrollment of 8,000 to 10,000 members per month into the Medicaid Managed Care Program

Implemented and coordinated contract deliverables. Directed enrollment policy and protocols. Chaired committees that supported ongoing program goals and improvement projects including the implementation of a monthly training program for customer service staff

Directed and managed vendor's responsibility as the member services department for the state-administered managed care program. Oversaw the development and implementation of member education projects, materials and communications

Public speaking in state and national forums

Pioneer Institute for Public Policy Research — Boston, MA
Operations Manager

1993-1995

Oversaw all phases of financial operations. Managed budget with seven cost centers. Included accounting, budgeting, cost control, cash management, financial reporting, conducting monthly budget meetings, and reporting financial condition to the Board of Directors

Oversaw publishing process of public policy research publications from manuscript submission to distribution. Coordinated cover design, editing, desktop publishing and printing. Secured a wholesale agreement with a nationwide distribution company. Increased publication sales by 25%

Evaluated research proposals submitted for a competition to improve government services. Assessed the feasibility of proposals, outlined the direction of proposed research, and recommended proposals for finalist status

Additional Professional Experience

Alternative Home Inc. — Newton Corner, MA
Management Consultant

June 1993-Aug. 1993

Brandeis University — Waltham, MA
Teaching Assistant

June 1993-Aug. 1993

CASCAP — Cambridge, MA
Counselor

Sept. 1991-June 1992

McLean Hospital — Belmont, MA
Research Intern

Jan. 1991-Aug. 1991

Oona's, Inc. — Cambridge, MA
Manager

1985 -1991

Education

Brandeis University — Waltham, MA
The Heller Graduate School
Master in Management of Human Services

1993

Jay S. Himmelstein, MD, M.P.H.

University of Massachusetts Medical School
Center for Health Policy and Research
222 Maple Avenue/Higgins Building
Shrewsbury, MA 01545

Curriculum Vitae

Current Positions

University of Massachusetts Medical School — Worcester, MA Department of Family Medicine and Community Health <i>Professor</i>	1997-Present
University of Massachusetts Medical School — Worcester, MA Commonwealth Medicine Center for Health Policy <i>Chief Health Policy Strategist</i>	2007-Present
University of Chicago — Chicago, IL National Opinion Research Center <i>Senior Fellow</i>	2009-Present
University of Massachusetts Medical School — Worcester, MA Work Without Limits Initiative <i>Founding Director</i>	2009-Present

Previous Positions

University of Massachusetts Medical School <i>Assistant Chancellor for Health Policy</i>	1992-2007
University of Massachusetts Medical School Center for Health Policy and Research <i>Founding Director</i>	1996-2007
Robert Wood Johnson Foundation Workers' Compensation Health Initiative <i>National Program Director</i>	1995-2003
University of Massachusetts Medical School Occupational and Environmental Health Program Department of Family Medicine and Community Health <i>Director</i>	1988-1997
University of Massachusetts Medical School Department of Family Medicine and Community Health <i>Associate Professor</i>	1988-1997
University of Massachusetts Medical School	1983-1988

Department of Family Medicine and Community Health
Assistant Professor

University of Massachusetts Medical School 1990-1995
New England Center for Occupational Musculoskeletal Disorders
Director

Senate Labor and Human Resources Committee, Washington, DC 1991-1992
Robert Wood Johnson Health Policy Fellow

University of Massachusetts Medical School 1985-1989
Joint Harvard School of Public Health
Residency in Occupational Medicine
Co-Director

University of Massachusetts Medical School 1983-1986
Occupational and Environmental Health Program
Chief of Clinical Services

Education

Johns Hopkins University — Baltimore, MD 1974
B.A.

University of Maryland Medical School College — Park, MD 1978
M.D.

Harvard School of Public Health — Cambridge, MA 1980
M.P.H., Occupational Health

Harvard School of Public Health — Cambridge, MA 1982
M.S., Physiology

Postdoctoral Training

Internship and Residencies

Eastern Maine Medical Center — Bangor, ME
Rotating Internship

Harvard School of Public Health
and Peter Bent Brigham, Hospital
Occupational Medicine — Boston, MA 1979-1981
Residency

Mount Auburn Hospital 1981-1982
Primary Care Internal Medicine — Cambridge, MA
Junior Assistant Resident

Mount Auburn Hospital 1982-1983
Primary Care Internal Medicine — Cambridge, MA
Senior Assistant Resident

Licensure and Certification

Massachusetts Medical License Registration	1980-Present
Maryland License Registration	1978-1983
Maine License Registration	
Certification by American Board of Internal Medicine	1983
Certification by American Board of Preventive Medicine (Occupational Medicine)	1984

Academic Appointments

Harvard Medical School (Peter Bent Brigham Hospital) Clinical Research Fellow in Medicine	1979-1981
Harvard Medical School (Mount Auburn Hospital) Clinical Fellow in Medicine	1981-1983
University of Massachusetts Medical School Department of Family and Community Medicine Assistant Professor	1983-1988
Clark University Center for Energy, Technology and Development (CENTED) Senior Research Associate	1983-1988
Harvard School of Public Health Lecturer in Occupational Medicine	1985-1993
University of Massachusetts Medical School Department of Family and Community Medicine, and Department of Medicine Associate Professor	1988-1997
University of Massachusetts Medical School Department of Family Medicine and Community Health, and Department of Medicine, Professor	1997-present

Hospital Privileges

University of Massachusetts Medical Center

Committee Participation

State and National

National Academy of Social Insurance (NASI) Standing Committee on Health Policy, Board Member	2009-Present
Massachusetts State Health Policy Forum, Board Member	2005-Present
Institute of Medicine Study Panel on Disability Determination in the Veterans Benefit System, Member	2006-2007
Social Security Advanced Benefits Expert Consultant Panel, Consultant	2006-2007
Public Health Council of the Massachusetts Department of Public Health, Member	1988-1992
Agency for Health Care Policy and Research, Health Care Training Study Section, Member	1998-2002

University of Massachusetts Medical Center

Ambulatory Care Service Committee	1984-1986
Departmental Personnel Action Committee (elected), Chair	1988-1989

Other Committees

Health Foundation of Central Massachusetts, Inc., Board Member	2009-Present
Worcester District Medical Society, Board Member	2009-Present
Central Massachusetts Physicians for Social Responsibility, Co-Director, Steering Committee	1986-1991
Worcester Department of Public Health, Scientific Review Committee	1986-1987
University of Massachusetts Medical Center	1994-1995
Chair of Faculty Task Force on Health Policy and Health Services Research	
Worcester Community Foundation, Corporator	1994-1999

Memberships

American Public Health Association, Member	1983-Present
Physicians for Social Responsibility, Member	1983-Present
American College of Physicians, Member	1984-Present
American College of Occupational and Environmental Medicine, Fellow	1987-Present
International Commission on Occupational Health, Member	1994-Present
Academy Health, Member	1996-Present
National Academy of Social Insurance (NASI), Elected Member	1998-Present

Extramural Funding

Dr. Himmelstein has received over thirty five extramural funding awards from a variety of foundations and agencies since 1985 totaling over \$48,670,000.

Publications

Dr. Himmelstein has authored or co-authored over 42 articles in Peer-Reviewed Journals.

Abstracts and Presentations at National or International Scientific Meetings

Dr. Himmelstein has presented or co-presented over 35 times, nationally and internationally.

National and Regional Educational Presentations

Dr. Himmelstein has presented or co-presented over 50 educational presentations regionally and nationally.

Guest Editor, Book(s) and Book Chapters

Dr. Himmelstein has been a guest editor twice, authored a book, below, and contributed chapters to 20 books.

Books

Dembe, A., S. Fox, and J. Himmelstein, eds. *Improving Workers' Compensation Medical Care: A National Challenge*. Beverly Mass: OEM Press, Inc. April 2003.

Technical Reports and Non-Peer Reviewed Articles

Dr. Himmelstein has authored or co-authored over 50 technical reports and non-peer reviewed articles.

Editorial Board

Journal of Occupational Rehabilitation

Ad Hoc Reviewer

Health Affairs

Health Care Financing Review

Journal of the American Public Health Association

Archives of Internal Medicine

Journal of Occupational and Environmental Medicine

Health Services Research

American Journal of Industrial Medicine

Scholarly Service of National Scope

1. National Institute for Occupational Safety and Health Grant Review Committees, 1990, 1992, 1993
2. National Institute for Occupational Safety and Health, Health Services Research, Research Agenda Setting Committee, 1997.
3. Agency for Health Care Policy and Research, Invited Expert Panelist on Musculoskeletal Outcomes Research, 1997.
4. National Academy of Social Insurance, Academy's Steering Committee on Workers' Compensation, 1997 to present.
5. American Medical Association, Steering Committee, Revision of AMA Guidelines to Permanent Impairment, 1997
6. Agency for Health Care Policy and Research, Health Care Training Study Section, Member 1998-2000
7. Institute of Medicine, Member for the Committee on Medical Evaluations of Veterans for Disability Compensation, April 2006 - April 2007
8. Social Security Administration, Expert Consultant on Accelerated Benefits Demonstration, March 2006 – March 2007

Michael Tutty, M.H.A., M.S.

University of Massachusetts Medical School
Commonwealth Medicine
Center for Health Policy and Research
Director of Office of Community Programs

Relevant Project Experience

University of Massachusetts Medical School New England States Collaborative Insurance Exchange Systems — Worcester, MA <i>Project Director</i>	2010-Present
University of Massachusetts Medical School Office of Community Programs, Center for Health Policy and Research — Worcester, MA <i>Director</i>	2008-Present
University of Massachusetts Medical School Center for Health Policy and Research — Worcester, MA <i>Director Academic Services</i>	2007-2008
University of Massachusetts Medical School Department of Family Medicine and Community Health — Worcester, MA <i>Instructor</i>	2005-Present
University of Massachusetts Medical School Center for Health Policy and Research <i>Senior Project Director</i>	2003-2007
Boston Consulting Group — Boston, MA <i>Senior Analyst</i>	1998-2002
Baystate Health System — Springfield, MA <i>Senior Analyst</i>	1996-1998
University of Massachusetts Medical School — Worcester, MA <i>Researcher Analyst</i>	1995-1996

Education

University of Massachusetts — Boston, MA Master of Science in Public Policy – 2009 Ph.D. in Public Policy – Projected Spring 2011 Approved Dissertation – “Health Reform Challenges: Understanding Low-Income Massachusetts Residents Who Remain Uninsured”	
Clark University/University of Massachusetts Medical School — Worcester, MA Master of Health Administration	1996
Western New England College — Springfield, MA Bachelor of Arts in Government	1994

Certifications

University of Massachusetts Boston	2004
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Practical Project Management

Health Insurance Association of America 1999
Managed Healthcare Professional

Academy for Healthcare Management 1999
Certified Professional

Honors

Foster G. McGaw Scholarship 1994

David A. Barrett Health Administration Scholarship 1994

Pi Sigma Alpha National Honor Society 1993

Teaching

University of Massachusetts Medical School
Community Health Clerkship/Health Policy and Politics in Massachusetts 2004 – Present
The Realities of the U.S. Health Care System 2004 – Present
Interclerkship on Health Policy and the Practice of Medicine 2006 – Present
Perspectives on Health Care Delivery in the 21st Century 2006

Clark University
United States Health Care Policy (MPA3030) 2010 – Present

Other

Massachusetts Executive Office of Health and Human Services' (EOHHS)
Management Certificate Program 2007 - 2009
Using Data for Decision Making

Northeastern University 2006
Dimensions of American Health Care
Guest lecturer

Funded Research

Contributor: Various health policy and evaluation projects, University of Massachusetts Medical School's Center for Health Policy and Research (2003 – present)

Technical Reports and Presentations

Cabral L, Clements C, **Tutty M**, Bhang E, Muhr K, Pitzl C, Gomes M. *Evaluation of the MassHealth Enrollment and Outreach Grant Program*. February 2010.

Masters E, **Tutty M**. *1115 Waiver: Annual Report 2006*. December 2006.

Graves J, Masters E, **Tutty M**. *1115 Waiver: Annual Report 2005*. December 2005.

Alfreds S, Kirby P, Pearlman J, Masters E, **Tutty M**, Hurwitz D. *MassHealth Dental Third Party Administrator Cost Comparison and Benefit Analysis*. December 2005.

Tutty M, Alfreds S, Himmelstein J. *Understanding the Health Information Technology Landscape in Massachusetts*. August 2005.

Strother H, Graves J, Hurwitz D, **Tutty M**, Callahan R, Anthony S. *MassHealth 1115 Demonstration Project: Evaluation Design*. August 2005.

Alfreds S, Cabral L, **Tutty M**. *340B Pharmacy Evaluation*. February 2005.

Alfreds S, **Tutty M**, Green L, Allen J, Goldsmith R, Gadson, H, O'Brien, J, Scerbo M. *MassHealth MCO Encounter and Financial Data Validation Project: Encounter Data Validation Tools*. December 2004.

Graves J, **Tutty M**. [1115 Waiver: Annual Report 2004](#). November 2004.

Hurwitz D, Carpenter N, Coleman M, **Tutty M**, Alfreds S, Graves J, Gilbert J: Essential Community Provider Initiative: Enhancing Access, Quality, and Cost Effectiveness of Health Care for MassHealth Members and Other Low-Income Residents. October 2004.

Payne C, Savageau J, **Tutty M**, Nowers M. The HIV Expansion of the MassHealth 1115 Waiver: Member Satisfaction Survey: Winter 2003/2004. October 2004.

Alfreds S, Laszlo A, **Tutty M**, Banks S, Sesay, M, Lim C, Vargas-Rameriz M. MassHealth Caseload and Expenditure Analysis. August 2004.

Hurwitz D, Carpenter N, Graves J, Alfreds S, **Tutty M**, Peters P, Bannister L, Willrich Nordahl K, Pressman E. MassHealth Delivery System Redesign: Community Health Center Capacity Assessment. June 2004.

Laszlo A, **Tutty M**, Awesh G, Coleman M, Graves J: MassHealth Basic Report. February 2004.

Peter P, Willrich K, Bannister L, Norton M, Green L, Himmelstein J, Hurwitz, D, **Tutty M**. MCO Re-procurement Strategic Planning Meeting. December 2003.

Clifford C, Graves J, Tutty M. State Children's Health Insurance Plan (SCHIP) - Annual Report 2003. December 2003.

Clifford C, Graves J, Tutty M. 1115 Waiver: Annual Report 2003. November 2003.

Hurwitz D, Tutty M, Shaffer D. Pricing and Purchasing: Strategic Planning Retreat. August 2003.

Tutty M, Anderson M, Stewart-Pagan K, O'Conner D, Hurwitz D, Hashemi L, Zhang Y, Stein C. Initial Analysis of MassHealth Data: Identifying Cost Savings Opportunities. July 2003.

Simoni-Wastila L, Banks S, Carpenter N, Lawthers A, Tutty M. Evaluation of DMA Prescription Drug Cost-Savings Initiatives. January 2003.

Reports

Laszlo A, Strother H, Tutty M, Masters E, Seifert R, Himmelstein J. *Pathways to Public Health Insurance Coverage for Massachusetts Residents*. December 2007.

Alfreds S, Tutty M, Himmelstein J, et al. *Establishing a Foundation for Medicaid's Role in the Adoption of Health Information Technology: Opportunities, Challenges, and Considerations for the Future*. AHRQ Publication No. 07-0046. Rockville, MD: Agency for Healthcare Research and Quality. April 2007.

Strother H, Tutty M, Masters E, Seifert R, Turnbull N, Himmelstein J. *Pathways to Public Health Insurance Coverage for Massachusetts Residents*. December 2006.

Strother H, Tutty M, Seifert R. *Pathways to Public Health Insurance Coverage for Massachusetts Residents: Prescription Drug Coverage Supplement*. December 2005.

Fitzpatrick S, Hurwitz D, Kirby P, Laszlo A, Masters ET, Tutty M. *Analysis of House Bill 2663 and Senate Bill 1260 As Related to Nurse Staffing Part II: Estimated Costs to Hospitals and Public Agencies and Impact on Nursing Workforce Development*. September 30, 2005.

Fitzpatrick S, Hurwitz D, Kirby P, Laszlo A, Masters ET, Tutty M. *Analysis of House Bill 2663 and Senate Bill 1260 As Related to Nurse Staffing Part I: Comparative Analysis and Policy Implications*. August 12, 2005.

Strother H, Tutty M, Jarzobski, D, Seifert R, Turnbull N, Himmelstein J. *Pathways to Public Health Insurance Coverage for Massachusetts Residents*. June 2005.

Hooven F, Tutty M, Long L, Hashemi L, Olin L, Zhang J, Alfreds S, Himmelstein J, Turnbull N. *Policy Report: Understanding MassHealth Members with Disabilities*. Massachusetts Medicaid Policy Institute. June 2004.

Von Knoop C., Lovich, D. Silverstein, M, Tutty, M. *Vital Signs: E-Health in the United States*. Boston Consulting Group, January 2003.

Presentations/Posters

Himmelstein J, Tutty M, Keays S. *New England States Collaborative Insurance Exchange Systems (NESCIES)*, Clinical & Translational Sciences Research Retreat, Shrewsbury, MA. May 20, 2011.

Tutty M. *Health Reform Challenges: Understanding Low-Income Massachusetts Residents Whom Remain Uninsured*, American Public Health Association, Denver, CO. November 8, 2010.

Tutty M, Morris L. *Language Services Improvement Collaborative*, American Public Health Association, Denver, CO. November 7, 2010.

Tutty M, Morris L. *Utilization of Trained Medical Interpreters: Results of a Survey*, American Public Health Association, San Diego, CA. October 25-29, 2008.

Tutty M. *Health Information Technology & Transparency: Track Chair*, 15th Annual Medicaid Managed Care Congress, Baltimore, MD. June 13-15, 2007.

Tutty M. *Medicare Part D: Understanding the Process of Policymaking*. Academy Health 2007 Annual Research Meeting. Orlando, FL. June 3-5, 2007.

- Tutty M, Henry A, Kirby P, Murray S, Olin L. *Impact of the Medicare Part D Drug Policy on Dual Eligible Adults with Serious Mental Illness*. Academy Health 2007 Annual Research Meeting. Orlando, FL. June 3-5, 2007.
- Alfreds S, Tutty M, Himmelstein, J. *Establishing a Foundation for Medicaid's Role in Supporting Health Information Technologies and Health Information Exchange*. Academy Health 2006 Annual Research Meeting. Seattle, WA. June 25-27, 2006.
- Kirby P, Hurwitz D, Tutty M. *Measuring the Potential Impact of Mandatory Nurse-Staffing Ratios on Hospitals in Massachusetts: Initial Estimates and Methodological Challenges*. Academy Health 2006 Annual Research Meeting. Seattle, WA. June 25-27, 2006.
- Tutty M. *Health Information Technology: Is Medicaid Keeping Pace?* National Medicaid Congress, Washington, DC. June 4-6, 2006.
- Himmelstein J, Tutty M, Alfreds S. *Medicaid, Health Information Technology, and the Safety Net*. Realizing Benefits of Health Information Technology for Community Health Centers: What is Needed and How it Gets Done Conference, Washington DC. November 8, 2005.
- Alfreds ST, Laszlo A, Tutty M, Banks S. *Forecasting Eligibility Caseload in Medicaid Population Groups*. Academy Health 2005 Annual Research Meeting. Boston, MA. June 26-28, 2005.
- Seifert R, Tutty M. *Pathways to Public Health Insurance Coverage for Massachusetts Residents*. Blue Cross Blue Shield of Massachusetts Foundation Connecting Consumers with Care & Within Reach Grantee Workshop. Natick, MA. June 28, 2005.

Peer Reviewed Articles

- Alfreds S, Tutty M, Savageau J, Young S, Himmelstein J. *Clinical Health Information Technologies and the Role of Medicaid*. Health Care Financing Review. Winter 2006-2007, Volume 28, Number 2.

Marc A. Thibodeau, M.S., J.D.

Mr. Thibodeau is the Executive Director of the Center for Health Care Financing at the University of Massachusetts Medical School. In this role, Mr. Thibodeau has executive responsibility, in collaboration with the state Human Services Secretariat (EOHHS) Revenue Management Unit, for the provision of a comprehensive array of revenue and cost savings activities conducted on behalf of 11 state agencies. These activities include all third party liability, benefit coordination, public facility and federal claiming and program integrity initiatives with a combined revenue and savings target in excess of \$4 billion annually.

Mr. Thibodeau has expanded out-of state engagements to include work in 12 states including Vermont, New Hampshire, Rhode Island, New York, Ohio, Pennsylvania, Virginia, California, Utah, Washington, Connecticut and Hawaii

Relevant Project Experience

University of Massachusetts Medical School Center for Health Care Financing *Executive Director*

2006-Present

Responsible for direction of the operations, administration, and consulting arm of the Center, as well as determining organizational and programmatic direction

Responsible oversight of all in and out-of-state financial services projects

Determines Center strategy, business opportunity, budgeting requirements; monitors federal claiming activity; and presents to federal oversight agencies

Serves as a member of the Executive Leadership Team at the University of Massachusetts Medical School

Federal Revenue *Managing Director*

1998-2006

Manage client relationships for out-of-state projects

Responsible for publications, contract negotiation/development, and marketing

Senior supervisory responsibility for school-based-claiming programs conducted by the Center in four states

MassHealth Program, Massachusetts Division of Medical Assistance *Assistant General Counsel*

1994-1998

Performed legal staff duties at the state Medicaid agency

Advised the Division on matters relating to Medicaid revenue enhancement

Provided legal support to the agency's information systems, internal controls, and pharmacy and nursing home units

Conducted procurements and developed contracts with vendors and other state agencies

Massachusetts Department of Public Welfare *Assistant General Counsel*

1988-1994

Advised the agency regarding the Food Stamp, Medicaid, AFDC, and Refugee programs

Conducted procurements and authored contracts with public and private parties

Represented the Commonwealth before administrative agencies and in state courts

Education

Massachusetts Institute of Technology

Master of Science in Political Science

Master's Thesis: "Food as a Political Resource: Chicago and Detroit Examined"

Boston College Law School

Juris Doctorate

Articles Solicitations Editor, Boston College International & Comparative Law Review, 1979-1980

Admitted to the Massachusetts Bar, January, 1981

Admitted to the United States District Court for the District of Massachusetts, 1990

Boston College

Bachelor of Arts in History, Phi Beta Kappa

Deborah L. Drexler, J.D.

University of Massachusetts Medical School
Center for Health Care Financing
Senior Director, Data Operations

Professional Experience Summary

Health care attorney and information technology professional with broad experience in both provider and payer environments. Particular expertise in public payer programs; health care billing compliance; privacy and security matters; legal implications of electronic health data exchange; labor and employment law. Experienced in managing internal staff as well as outside counsel.

Relevant Project Experience

University of Massachusetts Medical School
Center for Health Care Financing — Charlestown, MA
Senior Director, Data Operations

Jan. 2011-Present

- Provide leadership and strategic direction in all matters relating to the Center's information practices
- Supervise the Center's information staff, including developers, quality assurance engineers, business analysts, project managers and others, and oversee the Center's information software development projects
- Work with other Center leaders to develop information technology strategies and to prioritize information security initiatives and spending
- Oversee the development of incident response protocols; investigation of privacy and security breaches; and implementation of necessary remedial action
- Direct the development of operational processes to transport sensitive financial and personal information into and out of the Center, and to process and safeguard sensitive information while it is in the Center's custody
- Ensure that CHCF business operations satisfy all applicable regulatory, statutory and contractual requirements
- Identify new business opportunities, and establish and maintain relationships with out-of- state clients and vendors

Steward Health Care (formerly Caritas Christi Health Care System)
Vice President and Chief Compliance Officer

March 2009-Dec. 2010

- Established and oversaw a compliance program for a large integrated health care system consisting of 6 hospitals; a 400-physician group practice; a home care and hospice corporation; an independent diagnostic testing facility; a self-insured employee health benefit plan; and related entities
- Handled all compliance related issues for the system including Medicare and Medicaid billing; Stark, false claim and anti-kickback issues; patient privacy; information security; workplace safety; and environmental practices
- Oversaw government investigations and settlement agreements
- Managed compliance related litigation

University of Massachusetts Medical School
Commonwealth Medicine — Worcester, MA
Director, Office of Compliance and Review

2003-2009

- Established, staffed and managed a compliance program for the health services affiliates of UMass Medical School, a 2000-employee enterprise serving public and private sector clients nationwide
- Worked closely with business leaders to minimize the negative impact of regulatory and statutory requirements on business operations
- Drafted and reviewed contracts
- Oversaw corporate procurement and contracting process
- Monitored legal and regulatory developments and mitigate impact on business operations

Commonwealth of Massachusetts
MassHealth Program — City, State
Assistant General Counsel

1995-2003

Advised Massachusetts Medicaid program (MassHealth) about compliance with state and federal labor and employment laws and with its collective bargaining agreements

Ensured MassHealth compliance with HIPAA regulations

Served as Privacy and Security Officer

Drafted business associate contracts, third-party data use agreements, trading partner agreements, and organization-wide data protection policies and procedures

Managed provider fraud matters

Handled matters brought before the Massachusetts Commission against Discrimination, Civil Service Commission and Division of Labor Relations

Conducted bargaining sessions with employee unions

Testa Hurwitz & Thibault
Associate Attorney

1992-1995

Advised communications, biotechnology, health care, financial and other corporate employers in labor and employment matters. Represented corporate employers in litigation before state and federal courts and agencies and in collective bargaining and other traditional labor law matters. Reviewed and drafted contracts and agreements

Education

Northeastern University
J.D., School of Law

Boston University
B.S., Business Administration (cum laude), School of Management

Professional Activities

Author, *Personal Health Records: A Primer*, Worcester Medicine, Worcester District Medical Society, September/October 2010

Author, *Achieving a Nationwide Health Information Infrastructure: A New Approach*, Health Lawyer News, American Health Lawyers Association, March 2009.

Contributor, *Public Governance Models for a Sustainable Health Information Exchange Industry*, report presented to the State Alliance of E-Health, February 2009.

Lecturer, University of Massachusetts Medical School, various seminars on information management and compliance Issues for medical students, faculty members, and other groups, ongoing.

Presenter, *What Medical School Educators Need To Know About HIPAA*, Webcast, International Association of Medical School Educators, January 2005.

Member, Advisory Board, HIPAA Certified, LLC, Framingham, Massachusetts.

Author, *HIPAA: Understanding the Impact on Government*

Other Activities

Bassist, Parkway Symphony Orchestra, Norwood MA, November 2010-Present.

Volunteer Water Sampler, Charles River Watershed Organization, January 2010-Present.

Board Member and President, Clearbrook Homeowners Association, Lincoln NH, September 2000-August 2006.

Mila Kofman, J.D.

Georgetown University Health Policy Institute
Research Professor

Highlights

Mila Kofman rejoined the faculty at Georgetown University Health Policy Institute in July 2011. A nationally recognized expert on private health insurance markets, Kofman focuses on working with states and all stakeholders to implement health insurance reforms. Her approach is informed by hands-on experience as the Superintendent of Insurance in Maine implementing health insurance reforms, being a former federal regulator working with states to implement HIPAA reforms of the 1990s, studying state-based reform efforts and markets, and working with employer purchasing coalitions seeking to leverage purchasing power for sustainable financing of medical care.

From March 2008 to May 2011 as the Superintendent of Insurance in Maine, Kofman oversaw a multi-billion dollar insurance industry, heading an agency with over 70 staff and a multi-million dollar budget. A gubernatorial appointee, she was nominated and first confirmed in 2008, and in 2010 was renominated and unanimously reconfirmed to a new term. Her effective alliances with business groups, the insurance industry, consumer and patient advocates, physicians, trial attorneys, and sister state agencies helped to improve the state's insurance market for both consumers and companies. The property and casualty market improved its ranking to third best in the nation. Kofman was successful in her priority legislative initiatives with some having passed unanimously. She also successfully undertook agency restructuring. She realigned resources to clear backlogs and improve services to the regulated community; created a market conduct examination unit responsible for ensuring compliance with the state's laws; created a formal and more effective enforcement process, going from a few to dozens of active enforcement cases; and improved consumer services processes making it easier for consumers to get help. Kofman improved transparency and government accountability by holding public hearings around the state on health insurance rates, efforts that were recognized by the White House and served as a model in other states.

In addition to serving on the Governor's Steering Committee on health reform implementation in 2010, Kofman served in key leadership positions at the National Association of Insurance Commissioners (NAIC). She was elected Secretary/Treasurer of the northeast zone and served on the NAIC's Executive Committee, she chaired the Health Insurance Regulatory Framework Task Force (responsible for ACA changes to NAIC models), co-chaired the Consumer Information Working Group (statutory working group under ACA with diverse membership of regulators, industry, consumers, physicians, agents, and other stakeholders), and was a member of the (B) Health Insurance and Managed Care Committee, the Exchanges Working group, the Executive Committee's Professional Health Insurance Advisors Task Force, and Anti-Fraud Task Force. She was also a member of the Life Insurance and Market Regulation committees. She held the NAIC seat on URAC's Board of Directors.

From 2001 to 2008, Kofman was an Associate Research Professor and Project Director at the Georgetown University Health Policy Institute. She studied state private health insurance market reforms, regulation, products (including alternative products like discount cards), and financing strategies. In addition to more than 30 peer reviewed publications, her work included papers on group purchasing and private-public purchasing partnerships (pre-cursors to exchanges). She led ground breaking research on associations, which continues to be used widely. Ms. Kofman was the first in the nation to document the third cycle of health insurance scams (a report published by BNA) – research that informed a GAO study and a subsequent Congressional hearing. She has testified before the U.S. Senate, the U.S. House of Representatives, and state legislatures. She also served as an expert witness in civil and criminal cases. Kofman served on the NAIC Consumer Participation Board of Trustees for 6 years, the Board of Directors for URAC for 5 years, and was co-editor for the Journal of Insurance Regulation for 3 years. In 2007, she was recognized by the American Council on Consumer Interests and was the 2007 Esther Peterson Consumer Policy Forum Speaker.

Ms. Kofman was a federal regulator at the U.S. Department of Labor (1997-2001). She worked on legislation and implemented HIPAA and related laws. She was honored with the Labor Secretary's Exceptional Achievement Award. In 2000, she was appointed Special Assistant to the Senior Health Care Advisor to the President at the White House to work on legislative and regulatory initiatives -- the Patient's Bill of Rights, long-term care insurance, nursing home reform, and ERISA reform.

As a national expert on health insurance, Kofman was asked to serve and served on Kerry's Presidential Campaign Policy Committee on Coverage and Access and was a Health Policy Advisor to the Clark Presidential Campaign.

She has appeared on NPR, CNN, CBS Evening News, ABC News and has been cited in BusinessWeek, Consumer Reports, the NY Times, the Wall Street Journal, the Washington Post, the LA Times, the Chicago Tribune, Forbes, US News & World Report, AM Best, AP, and other press.

Ms. Kofman holds a J.D. from Georgetown University Law Center and a B.A. in Government and Politics from the University of Maryland (*summa cum laude*).

Professional History

Georgetown University Health Policy Institute, July 2011 to present -- Project Director and Research Professor.

Bureau of Insurance, Maine, March 2008 to May 2011 – Superintendent of Insurance

Georgetown University Health Policy Institute, Nov. 2001 to March 2008 -- Project Director and Associate Research Professor (Assistant Research Professor through Dec. 2005).

Major funding sources included: The Commonwealth Fund, Kaiser Family Foundation, the Robert W. Johnson Foundation (HCFO program), the California HealthCare Foundation, the Academy Health State Coverage Initiative, the Kellogg Foundation, the Organization for Economic Cooperation and Development, the Blue Cross Blue Shield Association, Florida State Office of Insurance Regulation, the Congressional Research Service, the American Diabetes Foundation, and the American Cancer Society.

Office of Health Plan Standards & Compliance Assistance, EBSA (formerly Pension and Welfare Benefits Administration), U.S. Department of Labor, Oct. 1997 to Oct. 2001 -- Advisor for Health Law and Policy. Advised the Assistant Secretary and career officials on health care policy, federal legislation, and private market reforms. Led an inter-agency team of attorneys and policy analysts implementing HIPAA-related amendments. In March 2000, was honored with the Secretary's Exceptional Achievement Award.

White House Domestic Policy Council, Sep. to Nov. 2000 (detail)– Special Assistant to the Senior Health Policy Advisor to the President.

Worked with stakeholders and political and career executive agency officials, and Congressional staff on legislative and administrative strategy to advance Administration goals. Successfully expedited a regulation affecting over 130 million people with job-based health coverage. Negotiated resolution to highly complex policy and legal issues among three federal departments. Coordinated rollout including drafting the President's radio address, executive order, press paper, and talking points for the President and White House staff on the regulation, as well as briefings for Congressional staff, consumer groups, state regulators, and other stakeholders.

Institute for Health Policy Solutions, Aug. 1996 to Oct. 1997, Counsel for Health Policy and Regulation -- Advised clients on employee benefits (ERISA), taxation (IRC), business, and state health law issues. Worked with health insurance purchasing coalitions (HIPCs) and small businesses. Drafted a report analyzing state health insurance law in all U.S. states and territories.

National Association of Insurance Commissioners, Mar. 1996 to Aug. 1996, Law Clerk.

Government Affairs Office, MEDTRONIC, INC., Jun. 1995 to Aug. 1995, Legislative Intern.

Law Office of Reginald W. Bours, Jun. 1994 to Aug. 1994, Law Clerk.

American Bar Association, Jun. 1994 to Aug. 1994, Legal Intern.

Maryland State Senate, Sen. Paula Hollinger, 1992 legislative session, Legislative Intern.

Education

Georgetown University Law Center — Washington, DC

1996

Juris Doctor

Honors: Dean's List.

Journal: Managing Editor of the *Georgetown International Environmental Law Review*.

Activities: Law Center Peer Advisor, 1994-95; Law Center Administrative Matters Committee, 1993-94; Equal Justice Foundation Bachelor of Arts in Government and Politics, May 1993, *summa cum laude*, Univ. of Maryland at College Park, College Park, MD

Honors

Phi Beta Kappa (elected Junior year)

Phi Kappa Phi Fellow, 1993-94

Dean's Scholar (highest academic honor at UMCP) 1993

Pi Sigma Alpha National Political Science Honor Society

Keynote Speaker at 1993 Women's Studies Certificate Graduation

Maryland Senatorial Scholar

Bar Membership

Admitted to practice law in Maryland (inactive) and the District of Columbia (inactive).

Community

Health Policy Advisor to John Morrison, Montana U.S. Senatorial Campaign 2006
Policy Committee for Coverage and Access, Kerry Presidential Campaign 2004
Health Policy Advisor to the Clark Campaign 2004

Director, Inverness Forest Association Board of Directors 2002– 2003

Founder and Chair, Potomac Master Plan Committee, Inverness Forest Association 2001– 2002

Mentor, Georgetown University Law Center Public Interest 1997– 2001

Volunteer, American Red Cross, Disaster Relief Program 1992– 1995

Election Chief Judge, Board of Supervisors of Elections for Montgomery County 1993– 1997

Advisor, B'nai Brith Youth Organization 1990– 1993

A list of key note addresses, congressional testimony, speeches, and presentations is available upon request.

Reports, Published Articles, and other Publications 2003– 2007

Karen Pollitz and Mila Kofman, Georgetown University, and Alina Salganicoff and Usha Ranji, Kaiser Family Foundation, Maternity Care and Consumer-Driven Health Plans, KFF, June 2007 (available at <http://www.kff.org/womenshealth/upload/7636.pdf>).

Mila Kofman, Kevin Lucia, Eliza Bangit, and Karen Pollitz, *Association Health Plans: What's All the Fuss About*, Volume 25, Number 6, Health Affairs 1591 (November/December 2006).

Mila Kofman, Jennifer Libster, and Elisa Fisher, *Discount Medical Plan Organizations: Past, Present, and Future in Florida and in Other States*, Georgetown University Health Policy Report to the State of Florida, Office of Insurance Regulation (November/December 2006).

Mila Kofman and Karen Pollitz, *Health Insurance Regulation by the States and the Federal Government: A Review of Current Approaches and Proposals for Change*, Vol. 24, Issue 4 Journal of Insurance Regulation 77 (Summer 2006).

Mila Kofman, Kevin Lucia, Eliza Bangit, and Karen Pollitz, *Association Health Insurance: Is It Time to Regulate This Product?* Vol. 24, Issue 1 Journal of Insurance Regulation 31 (Fall 2005).

Mila Kofman, *Association Health Plans: Loss of State Oversight Means Regulatory Vacuum and More Fraud*, Georgetown University Health Policy Institute (July 2005).

Mila Kofman, *HSAs: A Great Tax Shelter for Wealthy Healthy People but Little Help to the Uninsured, Underinsured, And People with Medical Needs*. 7 Virtual Mentor, Ethics Journal of the American Medical Association 7 (July 2005) (invited op-ed article).

Mila Kofman and Jennifer Libster, *Turbulent Past, Uncertain Future: Is it Time to Reevaluate Regulation of Self-insured Multiple Employer Arrangements?* Vol. 23, Issue 3 Journal of Insurance Regulation 17 (Spring 2005).

Mila Kofman, *Discount Medical Cards: Leading the Way to Inexpensive Care or Potential Fraud?* Managed Care Interface April 2005 (invited guest article).

Karen Pollitz, Eliza Bangit, Kevin Lucia, Mila Kofman, Kelly Montgomery, and Holly Whelan, *Health Insurance and Diabetes: The Lack of Available, Affordable, and Adequate Coverage*, 23 Clinical Diabetes 88 (April 2005).

Mila Kofman, Eliza Bangit, and Jennifer Libster, *Discount Medical Cards – Market Innovation or Illusion?* (Commonwealth Fund March 2005).

Karen Pollitz, Eliza Bangit, Kevin Lucia, Mila Kofman, Kelly Montgomery, and Holly Whelan, *Falling Through the Cracks: Stories of How Health Insurance Can Fail People With Diabetes*, Georgetown University Health Policy Institute and American Diabetes Association (Feb 2005).

Mila Kofman, Eliza Bangit, and Kevin Lucia, *Multiple Employer Arrangements: Another Piece of a Puzzle, Analysis of Form M-1 Filings*, Vol. 23, Issue 1 Journal of Insurance Regulation 63 (Fall 2004).

Mila Kofman, *Issue Brief: HSAs: Issues and Implementation Decisions for States* (State Coverage Initiatives Vol. V No. 3 Sept. 2004).

Mila Kofman and Karl Polzer, *Federal Association Health Plans – Will This Proposal Remedy the Health Insurance Crisis?* 5 Policy, Politics & Nursing Practice 167 (Aug. 2004).

Mila Kofman and Jennifer Libster, *New York: A Case Study on Private Market Reforms, History, Impact on Public Programs, and Other Issues*, a report to Organization for Economic Cooperation and Development (spring 2004).

Mila Kofman, Eliza Bangit, and Kevin Lucia, *MEWAs: The Threat of Plan Insolvency and Other Challenges* (Commonwealth Fund March 2004).

Mila Kofman & Lee Thompson, *Issue Brief: Consumer Protection and Long-Term Care Insurance: Predictability of Premiums*, Georgetown U. Long-Term Care Financing Project, Mar. 2004.

Mila Kofman and Karl Polzer, Opinions Commentary, *Disassociate from this plan*, Modern Healthcare, Feb. 2004 (invited guest column).

Mila Kofman and Karl Polzer, *What Would Association Health Plans Mean for California?: Full Report* (California HealthCare Foundation Jan. 2004).

Mila Kofman and Karl Polzer, *Insurance Markets: What Would Association Health Plans Mean for California* (California HealthCare Foundation Jan. 2004).

Mila Kofman, Kevin Lucia, and Eliza Bangit, *Issue Brief: Health Insurance Scams: How Government Is Responding and What Further Steps Are Necessary* (Commonwealth Fund Aug. 2003).

Mila Kofman, Kevin Lucia, and Eliza Bangit, *Proliferation of Phony Health Insurance: States and the Federal Government Respond* (BNA Plus Fall 2003).

Mila Kofman, Eliza Bangit, and Kevin Lucia, *Insurance Markets: Group Purchasing Arrangements: Implications of MEWAs* (California HealthCare Foundation July 2003).

Mila Kofman, *Fact Sheet: Private Long Term Care Insurance*, Georgetown University Long-Term Care Financing Project, May 2003.

Mila Kofman, *Issue Brief: Group Purchasing Arrangements: Issues for States* (State Coverage Initiatives, Vol. IV, No. 3 April 2003).

Mila Kofman, *Health Insurance Scams Promoted Through Associations: A Primer* (The Insurance Receiver, Vol. 11, No. 3 Sept. 2002).

Consumer Alert: American Benefit Plans et al. (unlicensed health plan shut down by the government), Apr. 8, 2002 (available at www.healthinsuranceinfo.net).

Consumer Alert: Employers Mutual LLC (unlicensed health plan shut down by the government), Feb. 13, 2002 (available at www.healthinsuranceinfo.net).

Renewal Premiums: What Protections Do People Have? News You Can Use, Mar. 2002 (available at www.healthinsuranceinfo.net).

Co-authored state-specific consumer guides on health insurance (available at www.healthinsuranceinfo.net).

Alexis Davis Henry, ScD, OTR/L

University of Massachusetts Medical School
Disability, Health and Human Policy Unit
Director

Relevant Project Experience

University of Massachusetts Medical School Center for Health Policy and Research — Worcester, MA <i>Consultant</i>	2002-2005
Massachusetts Department of Mental Health Central Office <i>Project Manager for Rehabilitation Services</i>	1996-1997
Worcester State College Department of Occupational Therapy — Worcester, MA <i>Academic Fieldwork Coordinator</i>	1988-1994
Boston University Sargent College — Boston, MA <i>Graduate Research Assistant</i>	1991-1994
McLean Hospital Depression Treatment Unit — Belmont, MA <i>Rehabilitation Coordinator</i>	1982-1988
Greater Lynn Community Mental Health Center — Lynn, MA <i>Occupational Therapist for Outpatient Services</i>	1981-1982
Solomon Carter Fuller Mental Health Center — Boston, MA <i>Occupational Therapist for Adult Day Treatment Program</i>	1980-1981

Academic Appointments

Disability, Health and Employment Policy Unit (since 2011) <i>Director</i> <i>Research Associate Professor of Psychiatry</i>	2009-Present
University of Massachusetts Medical School Center for Health Policy and Research — Worcester, MA <i>Research Assistant Professor of Psychiatry</i> <i>Adjunct Assistant Professor</i>	2005-2009 2005-2006
Department of Rehabilitation Sciences <i>Assistant Professor</i>	2000-2005
Boston University Sargent College of Health and Rehabilitation Sciences — Boston, MA <i>Adjunct Research Assistant Professor of Psychiatry</i>	2000-2005
University of Massachusetts Medical School Center for Mental Health Services Research — Worcester, MA <i>Director, Rehabilitation Research Core</i> <i>Research Assistant Professor of Psychiatry</i>	1995-2000
University of Massachusetts Medical School — Worcester, MA	1994-1995

Assistant Professor

Worcester State College Department of Occupational Therapy — Worcester, MA <i>Instructor</i>	1988-1994
Boston University Sargent College — Boston, MA <i>Adjunct Clinical Instructor in Occupational Therapy</i>	1981-1982

Education

Boston University Sargent College — Boston, MA ScD, Therapeutic Studies	1994
Boston University Sargent College — Boston, MA MS	1983
Tufts University — Grafton, MA BS, Occupational Therapy	1980

Awards and Achievements

Selected Recent Articles and Book Chapters

- Henry, A. D., & Lucca, A. (2004). Facilitators and barriers to employment: The perspectives of people with psychiatric disabilities and employment service providers. *WORK: A Journal of Prevention, Assessment, & Rehabilitation*, 22, 169-182.
- Henry, A. D., Lucca, A. M., Banks, S., Simon, L., & Page, S. (2004). Inpatient hospitalizations and emergency service visits among participants in an Individual Placement and Support (IPS) model program. *Mental Health Services Research*, 6, 227-283.
- Hinden, B. R., Biebel, K., Nicholson, J., Henry, A., Katz-Leavy, J. (2006). A survey of programs for parents with mental illness and their families: Identifying common elements to build the evidence base. *Journal of Behavioral Health Services and Research*, 33, 21-38.
- Henry, A. D., Hooven, F., Hashemi, L., Banks, S., Clark, R., & Himmelstein, J. (2006). Disabling conditions and work outcomes among enrollees in a Medicaid buy-in program. *Journal of Vocational Rehabilitation*, 25(2), 107-117.
- Henry, A.D., Banks, S., Clark, R., & Himmelstein, J. (2007). Mobility limitations negatively impact work outcomes among Medicaid enrollees with disabilities. *Journal of Occupational Rehabilitation*, 17, 355-369.
- Nicholson, J., Hinden, B. R., Biebel, K., Henry A, D., & Katz-Leavy, J. (2007). A qualitative study of programs for parents with serious mental illness and their children: Building practice-based evidence. *Journal of Behavioral Health Services & Research*, 34(4), 395-413.
- Henry, A. D., Gallagher, P., Stringfellow, V., Olin, L., Hooven, F., & Himmelstein, J. (2007). Notes from the Field: Contemporary Strategies for Developing Surveys of People with Disabilities. *The MassHealth Employment and Disability Survey*. In T. Kroll, D. Kerr, P. Placek, J. Cyril & G. Hendershot (Eds.), *Towards Best Practices for Surveying People with Disabilities*. Volume 1. (pp. 127-146). Hauppauge, NY: Nova Science Publishers.
- Hashemi, L., Henry, A.D., Ellison, M. L., Banks, S., Glazier, R., & Himmelstein, J. (2008). The relationship of Personal Assistance Service utilization to other Medicaid payments among working-age adults with disabilities. *Home Health Care Services Quarterly*, 27(4), 280-298.
- Ellison, M. L., Samnaliev, M., Henry, A. D., Beauchamp, J. S., Shea, A., & Himmelstein, J. (2008, October). How do employment outcomes of Medicaid Buy-in participants vary based on prior Medicaid coverage? An example from Massachusetts. *Working with Disability – Work and Insurance in Brief*. Number 8. Washington DC: Mathematic Policy Research, Inc.
- Smith, E., Henry, A. D., Zhang, J., Hooven, F., & Banks, S. (2009). Antidepressant adequacy and work status among Medicaid enrollees with disabilities: A restriction-based, propensity score-adjusted analysis. *Community Mental Health Journal*, 45, 333-340.
- Long-Bellil, L., & Henry, A. D. (2009). Promoting employment for people with disabilities: Update on the Ticket to Work and Work Incentives Improvement Act. *Occupational Therapy Practice*, 14(7), CE1-CE8.
- Henry, A. D., Long-Bellil, L., Zhang, J., & Himmelstein, J. (2011). Unmet need for disability-related health care services and employment status among working age adults with disabilities in the Massachusetts Medicaid program. *Disability and Health Journal*. First published online on June 20, 2011 as doi: 10.1016/j.dhjo.2011.05.003.

- Gettens, J., Henry, A. D., & Himmelstein, J. (2011). Assessing healthcare reform: Potential effects on insurance coverage among persons with disabilities. (2011). *Journal of Disability Policy Studies*. First published online on August 5, 2011 as doi:10.1177/1044207311416584.
- Gettens, J., Mitra, M., Henry A. D., & Himmelstein, J. (in press). Have working-age persons with disabilities shared in the gains of Massachusetts health reform? *Inquiry*.
- Gettens, J., Henry, A. D., Laszlo, A., & Himmelstein, J. (in press). The prospect of losing benefits and the work decisions of participants in disability Programs: A cross-program comparison. *Journal of Disability Policy Studies*.
- Laszlo, A., Henry, A. D., Goldsberry, J., & Lapine, K. (in press). Creating employment opportunities for people with disabilities in health care: The Bristol Employment Collaborative. *Work: Journal of Prevention, Assessment and Rehabilitation*.

Selected Recent Technical Reports

- Tutty, M., Henry, A. D., Murray, S., & Kirby, P. (2008). Understanding the impact of Medicare Part D on non-elderly dual eligible adults with serious mental illness with disabilities. Final report. Center for Health Policy and Research, Commonwealth Medicine, University of Massachusetts Medical School
- Henry, A. D., Brumbaugh, R., Mone, M., Castro, M., & Hashemi, L. (2008). The Services for Education and Employment Technical Assistance Project: SEE program fidelity site visit evaluation report. Final report for Massachusetts Department of Mental Health, conducted under the Massachusetts Medicaid Infrastructure and Comprehensive Employment Opportunities (MI-CEO) Grant. Center for Health Policy and Research, Commonwealth Medicine, University of Massachusetts Medical School.
- Ellison, M. L., Henry, A. D., Glazier, R., Norton, G. (2009). Employment-supportive Personal Assistance Services. Final report for Office of Medicaid (MassHealth), Executive Office of Health and Human Services, conducted under the Massachusetts Medicaid Infrastructure and Comprehensive Employment Opportunities (MI-CEO) Grant. Center for Health Policy and Research, Commonwealth Medicine, University of Massachusetts Medical School.
- Henry, A. D., Fesko, S., Laszlo, A., Kramer, J., Tonakarn-Nguyen, A., (2009). Supporting Massachusetts' Executive Branch to Become a Model Employer of People with Disabilities: Findings from Focus Groups with ADA Coordinators, Hiring managers and Employees with Disabilities. Prepared for Commonwealth of Massachusetts Human Resources Division. Shrewsbury MA: Center for Health Policy and Research, University of Massachusetts Medical School.

Funded Grants and Contracts

- Co-Investigator. The Massachusetts Medicaid Infrastructure and Comprehensive Employment Opportunities (MA MI-CEO) Grant. Centers for Medicare and Medicaid Services, \$2.1 million annually. J. Himmelstein, PI. 2005-2007.
- Principal Investigator. The Services for Education and Employment Technical Assistance Project. Supplemental Project conducted under the MA MI-CEO grant (J. Himmelstein, PI). Centers for Medicare and Medicaid Services, \$250,000. 2006-2007.
- Principal Investigator. The Impact of the Medicare Part D Drug Policy on Dual Eligible Adults with Serious Mental Illness. University of Massachusetts Medical School, Commonwealth Medicine Mini Grant Initiative. \$35,944. 2006-2007.
- Co-Principal Investigator. The Massachusetts Medicaid Infrastructure and Comprehensive Employment Opportunities (MA MI-CEO) Grant, 2008-2011. Centers for Medicare and Medicaid Services. \$3.8 million (2008); \$5.6 million (2009). J. Himmelstein, PI.
- Principal Investigator. Work Incentives Planning and Assistance (WIPA) Grant – BenePLAN. Social Security Administration. \$97,075 (12/2008-3/2009); \$294,728 (4/2009-3/2010).
- Principal Investigator (March 2011-present). Massachusetts Medicaid Infrastructure and Comprehensive Employment Opportunities Grant; 2008-2011. Centers for Medicare and Medicaid Services (DHHS 1QACMS030234/01); \$5.6 million for 2009; \$6.3 million for 2010; \$5.5 million for 2011. (J. Himmelstein, PI through February 2011)
- Principal Investigator. Work Incentives Planning and Assistance Grant (BenePLAN). Social Security Administration (14-W-50106-1-02 and 14W-50106-1-03); 4/09-3/10 \$294,728; 4/10-6/11, \$368,410.
- Site Project Director. Social Security Administration (subcontract from Abt Associates, Inc); Benefit Offset National Demonstration (BOND) – Implementation of Work Incentives Counseling (WIC) and Enhance Work Incentives Counseling (EWIC) for the Northern New England Site. \$4 million 2010-2017.
- Principal Investigator. Massachusetts Rehabilitation Commission (ISA/Contract); Convening a Universal Design/Assistive Technology Summit for Massachusetts. 2011, \$200,000.
- Principal Investigator on subcontract. Center for Medicare and Medicaid Services (ISA/Subcontract from Office of MassHealth); Development of an Integrated Care Model for Dual-Eligible MassHealth Members – Member Focus Groups. 2011, \$50,000.

Katharine London, M.S.

Professional Experience

University of Massachusetts Medical School
Center for Health Law and Economics — Charlestown, MA
Principal Associate

2009-Present

Member of senior leadership team of a university-based center providing consulting services in health economics and public policy analysis to government and not-for-profit clients. Projects include:

New Hampshire Insurance Department Medical Rate Analysis

July 2011-Present

Evaluate the variation in prices paid by commercial health insurance carriers to New Hampshire health care providers. Analyze the variance attributable to the relative proportion of Medicare, Medicaid, and uninsured patients, to the sickness and complexity of patient populations, and to other factors.

Massachusetts Pediatric Asthma Bundled Payment Demonstration Program

Feb. 2011-Present

Lead an effort to design, implement, and evaluate a bundled payment system for high-risk pediatric asthma patients enrolled in the Massachusetts Medicaid program, designed to ensure a financial return on investment through the reduction of costs related to hospital and emergency department visits and admissions.

Connecticut Sustinet Health Partnership

May 2010-Jan. 2011

Provided project management, facilitation, analytic support, and report writing to help this public-private Board of Directors and 8 advisory committees (comprised of 160 individuals) develop a public option health plan using the medical home model and alternative payment methods.

Massachusetts Long-Term Care Financing Advisory Committee

July 2009-Nov. 2010

Provided project management, facilitation, analytic support, and report writing to help this advisory committee develop short-term and long-term recommendations for improving options for financing the costs of long-term services and supports.

Reforming Reform

Sept. 2009-June 2010

Analyzed the effects in Massachusetts of the Patient Protection and Affordable Care Act's provisions regarding disproportionate share hospital financing and the excise tax on high cost health insurance plans.

Massachusetts Health Care Quality and Cost Council — Boston, MA

2007-2008

Executive Director

Directed staff, policy development, and operations for this 16 member public-private Council.

Established statewide goals to improve health care quality, to contain health care costs, and to reduce racial and ethnic disparities in health care in Massachusetts. Drafted the Council's Annual Report listing specific tasks for each health care sector in order to meet the statewide goals.

Collected data from 22 commercial health insurers and built a dataset containing all health care claims data for all Massachusetts residents covered by a fully insured Massachusetts-based health plan. The dataset incorporated payments made under a wide range of payment methodologies and served as the foundation for the Massachusetts All-Payer Claims Dataset.

Designed and launched a consumer-friendly health care quality and cost information website, www.mass.gov/myhealthcareoptions, the first in the nation to display hospital-specific quality and cost information simultaneously.

Guided the Council and its Committees to establish strategic direction; developed and implemented the Council's communications strategy.

Served as a liaison between the Council, its 30 member Advisory Committee, and other key constituencies.

Directed the Council's administrative functions: managed the Council's \$1.9 million budget; drafted and promulgated 3 complex regulations; procured and managed 8 vendor contracts.

Massachusetts Office of the Attorney General — Boston, MA

2003-2007

Director of Health Policy

Advised the Massachusetts Attorney General and Assistant Attorneys General on health policy matters, payment methods, rates, purchasing strategies, and other health care components of legal cases.

Implemented the Attorney General's health care priorities in coordination with the Office's Divisions of Public Charities, Insurance, and Consumer Protection and Anti-Trust.

Identified financially distressed hospitals and health plans and ensured they developed viable turnaround plans.

Analyzed the effects of potential mergers and acquisitions on the health care market.

Distributed legal settlement funds to health care charities.

Received the Attorney General's Award for Excellence, 2006.

Massachusetts Division of Health Care Finance and Policy — Boston, MA

2001-2003

Director, Office of Special Policy Initiatives

1996-2001

Policy Development Manager

Advised the agency Commissioner and the Secretary of Health and Human Services on health policy issues. Directed complex, high-profile projects that crossed department and agency lines.

Massachusetts Health Care Task Force (2000-2002): Directed staff support and analysis of private and public payment rates and methods, provider cost, utilization and financial status trends in the hospital, nursing home, pharmacy, and other sectors. Task Force members included the Governor, Attorney General, legislative leaders, other high level government officials, CEOs of major hospitals and health plans, and leaders of professional organizations and advocacy groups.

Special Commissions on Uncompensated Care (1997 and 2002): Directed staff support and analysis for two Commissions composed of representatives from government, health care providers, payers, business and consumers and charged with revising the Commonwealth's policies and procedures for financing uncompensated care.

Developed policy for the Massachusetts Uncompensated Care Pool, a \$345 million fund that paid for health care services for low income uninsured and under-insured individuals.

Implemented a \$100 million surcharge on payments to hospitals and an electronic system to collect patient-level Uncompensated Care eligibility and claims data for the 350,000 patients served by the Pool.

Massachusetts Rate Setting Commission

Boston, MA

Assistant Manager

1993-1996

Senior Policy Analyst

1992-1993

Policy Analyst

1990-1991

Calculated maximum allowable private sector charges under Massachusetts' All-Payer Rate Setting system.

Developed pricing methods and calculated payment rates for Massachusetts Medicaid, workers' compensation, Uncompensated Care Pool, and Medicaid disproportionate share.

Developed and analyzed policy options, drafted regulations, summarized and critiqued testimony presented at public hearings, and recommended final regulations to Commissioners.

Evaluated the effects of proposed legislation on hospital costs, utilization, access, rates of payment, financial status, and market structure.

Education

Harvard School of Public Health — Boston, MA

1990

Master of Science, Health Policy and Management

Concurrent coursework at Harvard's Kennedy School of Government and MIT's Sloan School of Management

Selected Publications

- Report to the Connecticut General Assembly from the Sustinet Health Partnership Board of Directors, January 2011. (co-author and analyst)
- Securing the Future: Report of the Massachusetts Long-Term Care Financing Advisory Committee, November, 2010. (co-author and analyst)
- My Health Care Options website, www.mass.gov/myhealthcareoptions, launched December 2008. (staff director, co-author, and editor)
- Massachusetts Health Care Quality and Cost Council's [first] Annual Report, April 2008. (staff director, primary author, lead analyst, and editor)
- Attorney General Tom Reilly's 10 Practical Tips for Non-Profit Hospital Boards, October, 2004. (co-author)
- Report of the Special Commission on Uncompensated Care, December 27, 2002. (staff director, co-author, lead analyst, and editor)
- Cai, J., A. Lischko, and K. London, "Do Medicaid Patients Use More Inpatient Resources?" presented to the Academy Health Annual Research Meeting, June 25, 2002.
- Massachusetts Health Care Task Force. (analytic staff director)
- Final Report, 2002
- 11 Interim Reports, June 2000 – November 2001
- Uncompensated Care Pool, FY 1999 [first] Annual Report, Massachusetts Division of Health Care Finance and Policy, March, 2000. (project manager, lead analyst, and editor)
- Weissman, J.S., P. Dryfoos, and K. London, "Income Levels of Bad-Debt and Free-Care Patients in Massachusetts Hospitals", *Health Affairs*, July/August 1999, 18:4 pp. 156-166.
- The Impact of Medicare Provisions in the Balanced Budget Act of 1997 on Massachusetts Health Care Providers, Consumers and Medicaid: A Report to the Senate Committee on Ways and Means, House Committee on Ways and Means and Joint Committee on Health Care, Massachusetts Division of Health Care Finance and Policy, May 1998. (project manager and lead analyst)

Ann G. Lawthers, Sc.D.

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ann.lawthers@state.ma.us
(617) 210-5169 – phone

Center For Health Policy and Research
University of Massachusetts Medical School
333 South Street
Shrewsbury, MA 01545
(508) 856-7624 – phone

Education

Harvard School of Public Health Sc.D. in Health Policy & Management	1986
Harvard School of Public Health S.M. in Health Policy & Management	1979
Wellesley College A.B. in Music	1974

Academic Appointments

University of Massachusetts Medical School, Worcester, MA Department of Family Medicine <i>Assistant Professor</i>	2000-Present
Harvard School of Public Health Department of Health Policy and Management Center for Quality of Care Research and Education <i>Lecturer</i>	1990-2001
Harvard School of Public Health Department of Health Policy and Management <i>Research Associate</i>	1986-1990

Major Professional Activities

University of Massachusetts Medical School, Shrewsbury, MA Center for Health Policy and Research Evaluation and Measurement <i>Senior Director</i>	2007-Present
University of Massachusetts Medical School, Boston, MA MassHealth Office of Clinical Affairs <i>Director of Clinical Policy and Projects</i>	2005-Present
University of Massachusetts Medical School, Shrewsbury, MA Center for Health Policy and Research <i>Senior Project Director</i>	1999-2005

American Accreditation Health Care Commission/URAC "Development of Standard Performance Measures for Workers Compensation MCOs" (RWJ-funded) <i>Measurement Leader</i>	1998-2001
Harvard School of Public Health "MAJIC Project" (Making Advances Against Jaundice in Infant Care – AHCPR funded) <i>Investigator</i>	1998-2001
Harvard School of Public Health Quality Component, "Strengthening Local Government in Health: Poland Project," Data for Decision Making Center, <i>Component Leader</i>	1996-1999
Harvard School of Public Health and Beth Israel Deaconess Medical Center "Screening Quality of Care Using Administrative Data" (AHCPR funded) <i>Investigator</i>	1995-1998
Harvard School of Public Health Center for Quality of Care Research and Education <i>Associate Director</i>	1994-1999
CONQUEST Computerized Needs-oriented Quality Measurement Evaluation System and QMNET (Quality Measurement Network) project <i>Co-developer</i>	1994-1997
Harvard School of Public Health "DEMPAQ Project" (Development and Evaluation of Methods to Promote Ambulatory Care Quality – AHCPR funded) <i>Investigator and Research Director</i>	1990-1993
Harvard Medical Practice Study" "Investigator and Pilot Study Project Director"	1986-1990
Boston University Health Policy Institute <i>Senior Health Policy Analyst</i>	1982-1986
Stewart Design Group, Boston, MA <i>Consultant for Strategic Planning</i>	1981-1982
Massachusetts Department of Public Health 1980-1981 Determination of Need Program Program Analyst/Assistant Director	
Massachusetts Department of Public Health Office of State Health Planning <i>Senior Planner</i>	1979-1980

Awards

Dissertation Support Award, Health Services Improvement Fund 1985-1986

Peer Reviewed Journal Publications

- Lawthers, AG, Pransky GS, Peterson LE, Himmelstein, JH, Rethinking Quality in the Context of Persons with Disability. *International Journal for Quality in Health Care* 2003, 15(4): 287-299.
- Lawthers AG, McCarthy EP, Davis RB, et al. Identification of in-hospital complications from claims data. Is it valid? *Medical Care* 2000; 38(8): 785-95.
- Lawthers AG, Róžański BS, Niżankowski R. Using patient surveys to measure the quality of outpatient care in Kraków, Poland. *International Journal for Quality in Health Care* 1999 11(6): 497-506.
- Lawthers AG, Moentmann SJR, Palmer RH. Education to improve the quality of clinical care in group practice. *Journal of Ambulatory Care Management* 1996; 19(4): 64-76.
- Marjoribanks T, Good MJD, Lawthers AG, Peterson LM. Physicians' Discourses on Malpractice and the Meaning of Medical Malpractice. *Journal of Health and Social Behavior* 1996; 37(2): 163-178.
- Parente ST, Weiner JP, Garnick DW, Richard TM, Fowles JB, Lawthers AG, Chandler P, Palmer RH. Developing a quality improvement database using health insurance data: a guided tour with application to Medicare's National Claims History file. *American Journal of Medical Quality* 1995; 10(4): 162-176.
- Lawthers AG. Medical malpractice and the myth of the bad apple. *Journal of Medical Practice Management* 1995; 11(2): 83-88.
- Fowles JB, Lawthers AG, Weiner JP, Garnick DW, Petrie DS, Palmer RH. Agreement between physicians' office records and Medicare Part B claims data. *Health Care Financing Review* 1995; 16(4): 189-199.
- Weiner JP, Parente ST, Garnick DW, Fowles JB, Lawthers AG, Palmer RH. Variation in office-based quality: a claims-based profile of care provided to Medicare patients with diabetes. *JAMA* 1995; 273: 1503-1508.
- Lawthers AG. The future of quality in healthcare. *Journal of the Association for Quality in Healthcare* 1995; 2(3): 83-97.
- Lawthers AG, Palmer RH, Garnick DW, Fowles JB, Weiner JP. Designing and using measures of quality based on physician office records. *Journal of Ambulatory Care Management* 1995; 18(1): 56-72.
- Garnick DW, Lawthers AG, Moentmann SJR, Fowles JB, Weiner JP, Palmer RH. An affordable system for reviewing medical records from physicians' office. *Joint Commission Journal of Quality Improvement* 1994; 20(12): 679-694.
- Garnick DW, Fowles JB, Lawthers AG, Parente ST, Palmer RH. Focus on Quality: Profiling physicians' practice patterns. *Journal of Ambulatory Care Management* 1994; 17(3): 44-75.
- Lawthers AG, Palmer RH, Edwards JE, Fowles JB, Garnick DW, Weiner JP. Developing and evaluating performance measures for ambulatory care quality: a preliminary report of the DEMPAQ project. *Joint Commission on Quality Improvement* 1993; 19(12): 552-565.
- Leape LL, Lawthers AG, Brennan TA, Johnson WG. Preventing medical injury. *QRB* May 1993: 144-149.
- Localio AR, Weaver SL, Landis JR, Lawthers AG, Brennan TA, Hebert LE, Sharp T. Identifying adverse events caused by medical care: Degree of physician agreement in a retrospective chart review. *Annals of Internal Medicine* 1996; 125(6): 457-464.
- Localio AR, Lawthers AG, Begtson JM, Hebert LE, Weaver SL, Brennan TA, Landis JR. Relationship between malpractice claims and cesarean delivery. *JAMA* 1993; 269(3): 366-373.
- Lawthers AG, Localio AR, Laird NM, Lipsitz SR, Hebert LE, Brennan TA. Physician perceptions of the risk of being sued. *Journal of Health Politics, Policy and Law* 1992; 17(3): 463-482.
- Johnson WG, Brennan TA, Newhouse JP, Leape LL, Lawthers AG, Hiatt HH, Weiler PC. The economic consequences of medical injuries: Implications for a no-fault insurance plan. *JAMA* 1992; 267: 2487-2492.
- Localio AR, Lawthers AG, Brennan TA, Laird NM, Hebert LE, Peterson LM, Newhouse JP, Weiler PC, Hiatt HH. Relation between malpractice claims and adverse events due to negligence: Results of the Harvard Medical Practice Study III. *NEJM* 1991; 325: 245-251.
- Leape LL, Brennan TA, Laird NM, Lawthers AG, Localio AR, Barnes BA, Hebert LE, Newhouse JP, Weiler PC, Hiatt HH. The nature of adverse events in hospitalized patients: Results of the Harvard Medical Practice Study II. *NEJM* 1991; 324: 377-384.
- Leape LL, Brennan TA, Laird NM, Lawthers AG, Hiatt HH. Adverse events and negligence in hospitalized patients. *Iatrogenics* 1991; 1: 17-21.
- Brennan TA, Leape LL, Laird NM, Hebert LE, Localio AR, Lawthers AG, Newhouse JP, Weiler PC, Hiatt HH. Incidence of adverse events and negligence in hospitalized patients: Results of the Harvard Medical Practice Study I. *NEJM* 1991; 324: 370-376.
- Brennan TA, Hebert LE, Laird NM, Lawthers AG, Thorpe KE, Leape LL, Localio AR, Lipsitz SR, Newhouse JP, Weiler PC, Hiatt HH. Hospital characteristics associated with adverse events and substandard care. *JAMA* 1991; 265: 3265-3269.

Medical Practice Study Group. Patients, Doctors, and Lawyers: A Study of Medical Injury, Malpractice Litigation, and Patient Compensation in New York State. Cambridge, MA: Harvard University, 1990.

Hiatt HH, Barnes BA, Brennan TA, Laird NM, Lawthers AG, Leape LL, Localio AR, Newhouse JP, Peterson LM, Thorpe KE, Weiler PC, Johnson WG. A study of medical injury and medical malpractice. NEJM 1989; 321(7): 480-484.

Lawthers-Higgins AG, Taft C, Hodgman J. The impact of certificate of need on CT scanning in Massachusetts. Health Care Management Review 1984; 9(3): 71-79.

Technical Reports

Ouellette, R, Lawthers AG, Zhang, Jianying et al. MassHealth Managed Care Organization Clinical Topic Review Project 2004, Prepared by the Center for Health Policy and Research in collaboration with the Division of Medical Assistance, January 2005.

Ouellette R, Lawthers AG, Leung G. MassHealth Managed Care HEDIS 2003 Report, Prepared by the Center for Health Policy and Research in collaboration with the Division of Medical Assistance, December, 2004.

Lawthers AG, Zhang, Jianying et al. MassHealth Managed Care Organization Clinical Topic Review Project 2003, Prepared by the Center for Health Policy and Research in collaboration with the Division of Medical Assistance, March 2004.

Lawthers AG, Leung G. MassHealth Managed Care HEDIS 2003 Report, Prepared by the Center for Health Policy and Research in collaboration with the Division of Medical Assistance, December, 2003.

Lawthers AG, Atherton ME et al, MCO Program Performance Monitoring Report, Prepared by the Center for Health Policy and Research in collaboration with the Division of Medical Assistance, August 2003.

Lawthers AG, Coleman M et al, Depression in Nursing Facility Seniors, Prepared by the Center for Health Policy and Research in collaboration with the Division of Medical Assistance, April 2003.

Lawthers AG, Atherton ME et al. MassHealth Managed Care Organization Clinical Topic Review Project 2002, Prepared by the Center for Health Policy and Research in collaboration with the Division of Medical Assistance, March 2003.

Atherton ME, Lawthers AG, et al. MassHealth Managed Care HEDIS 2002 Report, Prepared by the Center for Health Policy and Research in collaboration with the Division of Medical Assistance, November, 2002.

Lawthers AG, Atherton ME et al. MassHealth Managed Care Organization Clinical Topic Review Project 2001, Prepared by the Center for Health Policy and Research in collaboration with the Division of Medical Assistance, May 2002.

Lawthers AG, Atherton ME et al. MassHealth Managed Care HEDIS 2001 Report, Prepared by the Center for Health Policy and Research in collaboration with the Division of Medical Assistance, March 2002.

Lawthers AG, Atherton ME et al. MassHealth Managed Care Organization Clinical Topic Review Project 2000, Prepared by the Center for Health Policy and Research in collaboration with the Division of Medical Assistance, January 2001.

Fowler FJ, Stringfellow VL, CSR, with DMA and CMER – Profile of Member Experience with Health Plans and Getting Health Care: Results of the 2000-2001 MassHealth Managed Care Member Survey, October 2001

Lawthers, AG, Pransky GS, Peterson LE, Himmelstein J, Quality and Patient Safety: Issues for Children and Adults with Disability, A paper prepared for the Agency for Healthcare Quality and Research (AHRQ) and presented to a meeting on the "Status of Health Services Research Associated with Disability" April 9 & 10, 2001 Rockville, MD.

Fowler FJ, Stringfellow VL, CSR, with DMA and CMER – Profile of Member Experience with Health Plans and Getting Health Care: Results of the 1999-2000 MassHealth Managed Care Member Survey, Fall 2000

Lawthers AG, Róžański BS. "Quality of Outpatient Services in Kraków ZOZ." Harvard-Jagiellonian Consortium for Health, May 1998

Lawthers AG, Róžański BS. "A Report on the Quality of Ambulatory Services in the Kraków Gmina." Harvard-Jagiellonian Consortium for Health, May 1998

Lawthers AG. External quality monitoring and internal quality improvement. Polish International Conference on Quality in Health Care, Krakow, Poland, 1997.

Palmer RH, Lawthers AG, Banks NJ, Peterson LM, Caputo GL, Sokoloff SM, Lyons MD, Delaney CA. CONQUEST 1.0 Overview of Final Report and User's Guide. Produced under Contract #282-91-0070, AHCP, April 1996. AHCP, Pub. No. 96-N009.

Palmer RH, Lawthers AG, Delozier J, Banks NJ, Peterson LM, Duggar B. Final Report. Understanding and Choosing Clinical Performance Measures for Quality Improvement: Development of a Typology. Contract Report to the Department of Health and Human Services, AHCPR Contract #282-92-0038, January 31, 1995, AHCPR Pub. No. 95-N001 and 95-N002.

Palmer RH, Lawthers AG, Edwards JE, Fowles JB, Garnick DW, Weiner JP. Final Report. DEMPAQ: A project to Develop and Evaluate Methods to Promote Ambulatory Care Quality. Produced under HCFA Contract #500-89-0624, November 15, 1993.

Books and Monographs

Lawthers AG and Palmer RH. "In Search of a Few Good Performance Measures: CONQUEST and the Typology of Clinical Performance Measures." In *Quality Managed Care: Models for Assessing Performance and Delivery*. Faulkner and Gray, 1997.

Lawthers-Higgins AG. Determining hospital surgical staff size and composition. Unpublished doctoral thesis, 1986.

Other Publications

Lawthers AG, "Quality Measurement and the Health Care Manager", *Zdrowie I Zarządzanie* 1999; 1(3): 17-23.

Selected Presentations

"Measuring to Improve Quality," EOQ Conference on Quality, Budapest, Hungary, 1998

"Indicators for External Quality Monitoring," Polish International Conference on Quality in Health Care, Kraków, Poland, 1997

"Begin With the End in Mind: Incorporating Performance Indicators into Guideline Development and Implementation." Zitter Group Implementing Practice Guidelines, Orlando, FL, 1996.

"Quality/Performance Measures," AHCPR User Liaison Program, Philadelphia, PA, 1996.

"Where Can Organizations Go To Find Tools To Measure Quality? Computerized Needs-Oriented Quality Evaluation System," Institute of Medicine, National Roundtable on Health Care Quality, Washington, DC, 1996.

"Selecting Clinical Performance Measures," Health Outcomes Conference, Boston, MA, 1996.

"International Experience Relevant to Quality Assurance," Strengthening Local Government Conference, Kraków, Poland, 1996.

"Quality Monitoring in the Office-based Practice," American College of Preventive Medicine, Orlando, FL (1996) and Scottsdale, AZ (1995).

"Adapting and Using CONQUEST for Pediatric Populations." National Association of Children's Hospitals and Related Institutions, Orlando, FL, 1995.

"Classifying and Comparing Clinical Performance Measures." Faulkner and Gray, Tampa, FL, 1995.

"Methods of Measuring and Reporting Plan Performance for Persons with Disabilities." AHCPR User Liaison Program, Portland, OR, 1995.

"Performance Monitoring of Patient Care for Diabetes: Results from the Project to Develop and Evaluate Methods to Promote Ambulatory Care Quality (DEMPAQ), American Diabetes Association, Atlanta, GA, 1995.

"Develop of a Typology for Clinical Performance Measures." AHSR, Chicago, IL, 1995.

"Quality Measures for Ambulatory Care, the Typology Project." American Medical Review Research Center, Washington, DC, 1995.

"A Framework for Measuring Quality." Joint Commission for the Accreditation of Healthcare Organizations, Chicago, IL, 1994.

"The Future of Quality in Healthcare." Association for Quality in Healthcare, London, England, 1994.

"DEMPAQ: Developing and Evaluating Methods to Promote Ambulatory Care Quality." GHAA, Washington, DC, 1993.

"Ambulatory Care: Audit and Feedback." University of Arkansas Area Health Education Centers. Little Rock, AR, 1993.

"Profiling Physician Practice Patterns: The DEMPAQ Project." APHA, Washington, DC, 1992.

Teaching

"Improving the Quality of Health Services," 10 day course, International Health Systems Group, Harvard School of Public Health, Course Director, October 2002, June 2004, August 2005, August 2006, October 2007.

"Quality Improvement in Health Care", 5 day course, American University of Beirut – World Bank Flagship Course, Beirut, Lebanon, June 2005

Epidemiology for Medical Students module, University of Massachusetts Medical School, Fall 2003, Fall 2004

"Quality Management in Decentralized Systems", 1 day session as part of 14 day course: "Making Decentralization Work: Tools for Health Policy Makers and Managers", International Health Systems Group, Harvard School of Public Health, 2000 - 2009

"Training in Clinical Practice Guidelines and Service Quality," 10 day course, International Health Systems Group, Harvard School of Public Health, Cairo, Egypt, October 1999

"Quality Improvement Tools and Techniques," 6 day course, International Health Systems Group, Harvard School of Public Health, Cairo, Egypt, December, 1998

"Using Microsoft Access to Analyze and Report Data", 3 day course, International Health Systems Group, Harvard School of Public Health, Kraków, Poland, October, 1998

"Training in Quality for Teams," 5 day and 3 day course, International Health Systems Group, Harvard School of Public Health, Kraków, Poland, October, 1998

"An Introduction to Quality", 1 day course, International Health Systems Group, Harvard School of Public Health, Kraków, Poland, May, 1998

"Technical Skills Workshop," 2 day course, International Health Systems Group, Harvard School of Public Health, Kraków, Poland, May, 1998

HPM 256c "Clinical Quality Measurement for Quality Improvement." Co-teacher, Harvard School of Public Health, 1996, 1997, 1998, 1999

HPM 256c "Clinical Quality Measurement for Quality Improvement." (Contributing Lecturer with R. Heather Palmer as Principal Faculty), Harvard School of Public Health, 1993, 1994, 1995.

"Assessing Clinical Quality in Managed Care Organizations: Using Clinical Practice Guidelines for Quality Improvement." 3 day course. Harvard School of Public Health, Office of Continuing Professional Education, 1996, 1997.

"A Framework for Assessing Quality in the Delivery of Preventive Services" and "Tools for Measuring and Improving: Practice Guidelines and Indicators." 1 day course. Preventative Services Agenda Course, Joint Commission of the Accreditation of Healthcare Organizations, 1995.

Appendices

Required Forms

1. Vermont Tax Certificate and Insurance Certificate
2. Certifications and Assurances
3. Summary of Funds
4. Certificate of Liability Insurance
5. Worker's Compensation Insurance Statement
6. Automotive Liability Insurance Statement

Attachments

NOTE: Attachments are included separately on the proposal CD.

1. Press Release: *Massachusetts Receives \$35.6 million Grant to Support Technology Infrastructure for Health Reform*
2. New England States Collaborative for Insurance Exchange Systems website screenshot
3. Vermont AHEC Letters of Commitment
4. *Re-Forming Reform: What the Patient Protection and Affordable Care Act Means for Massachusetts* – by UMass for the Blue Cross Blue Shield Foundation
5. *Designing an Exchange: A Toolkit for State Policymakers* – by the National Academy of Social Insurance in partnership with Georgetown University Health Policy Institute
6. *The Massachusetts and Utah Health Insurance Exchanges: Lessons Learned* – by Georgetown University
7. *Securing the Future: Report of the Massachusetts Long Term Care Financing Advisory Committee* – produced by UMass on behalf of the Massachusetts Long-Term Care Advisory Committee

REQUEST FOR PROPOSAL
Health Benefits Exchange Planning and Evaluation

This form must be completed and submitted as part of the response for the proposal to be considered valid.

The undersigned agrees to furnish the products or services listed at the prices quoted and, unless otherwise stated by the vendor, the Terms of Sale are Net 30 days from receipt of service or invoice, whichever is later. Percentage discounts may be offered for prompt payments of invoices; however, such discounts must be in effect for a period of 30 days or more in order to be considered in making awards.

VERMONT TAX CERTIFICATE AND INSURANCE CERTIFICATE

To meet the requirements of Vermont Statute 32 V.S.A. subsection 3113, by law, no agency of the State may enter into extend or renew any contract for the provision of goods, services or real estate space with any person unless such person first certifies, under the pains and penalties of perjury, that he or she is in good standing with the Department of Taxes. A person is in good standing if no taxes are due, if the liability for any tax that may be due is on appeal, or if the person is in compliance with a payment plan approved by the Commissioner of Taxes, 32 V.S.A. subsection 3113. In signing this bid, the bidder certifies under the pains and penalties of perjury that the company/individual is in good standing with respect to, or in full compliance with a plan to pay, any and all taxes due to the State of Vermont as of the date this statement is made.

Bidder further certifies that the company/individual is in compliance with the State's insurance requirements as detailed in section 21 of the Purchasing and Contract Administration Terms and Conditions. All necessary certificates must be received prior to contract issuance. If the certificate of insurance is not received by the identified single point of contact prior to contract issuance, the State of Vermont reserves the right to select another vendor. Please reference this RFP# when submitting the certificate of insurance.

Insurance Certificate: Attached Will provide upon notification of award: (within 5 days)

Delivery Offered _____ Days After Notice of Award

Terms of Sale _____

Quotation Valid for 120 Days _____

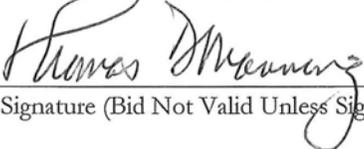
Date: November 30, 2011

Name of Company: UMass Medical School

Telephone Number: 508-856-6577

Fed ID or SS Number: 04-3167352

Fax Number: 508-856-6100

By: 
Signature (Bid Not Valid Unless Signed)

Name: Thomas D. Manning
(Type or Print)

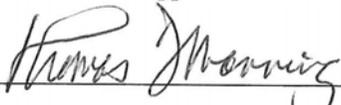
This is NOT AN ORDER

All returned quotes and related documents must be identified with our request for quote number.

CERTIFICATIONS AND ASSURANCES

I/we make the following certificates and assurances as a required element of the bid or proposal to which it is attached, understanding that the truthfulness of the facts affirmed here and the continuing compliance with these requirements are conditions precedent to the award or continuation of the related contract(s):

1. The prices and/or cost data have been determined independently, without consultation, communication or agreement with others for the purpose of restricting competition. However, I/we may freely join with other persons or organizations for the purpose of presenting a single proposal or bid.
2. The attached proposal or bid is a firm offer for a period of 120 days following receipt, and it may be accepted by the DVHA without further negotiation (except where obviously required by lack of certainty in key terms) at any time within the 120 day period.
3. In preparing this proposal or bid, I/we have not been assisted by any current employee of the State of Vermont whose duties related (or did relate) to this proposal, bid or prospective contract, and who was assisting in other than his or her official, public capacity. Neither does such a person nor any member of his or her immediate family have any financial interest in the outcome of this proposal or bid. (Any exceptions to these assurances are described in full detail on a separate page and attached to this document).
4. I/we understand that the DVHA will not reimburse me/us for any costs incurred in the preparation of this proposal or bid. All proposals or bids become the property of DVHA.
5. * I/we understand that any contract(s) awarded as a result of this RFP will incorporate terms and conditions substantially similar to those attached to the RFP. I/we certify that I/we will comply with these or substantially similar terms and conditions if selected as a Contractor.
6. I hereby certify that I have examined the accompanying RFP forms prepared by: J. Fleischer for the funding period beginning 01/01/12 and ending 09/30/12 and that to the best of my knowledge and belief, the contents are true, and correct, and complete statements prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

Signature:  Date: November 30, 2011

Title: Deputy Chancellor, Commonwealth Medicine

* Please see Letter of Submittal for specifics.

SUMMARY OF FUNDS
(to be included in the proposal packet)

Organization Name University of Massachusetts Medical School Commonwealth Medicine Division

Fed ID # 04-3167352

Summary of Funds received during your current fiscal year

Significant awards received between July 1, 2010 to June 30, 2011

Source of Funds	Contract/grant total award	Briefly describe activities supported by these funds
CMS	New England States Collaborative Insurance Exchange Systems / \$35M	Create flexible health insurance exchange IT framework
CMS	Money Follows the Persons Rebalancing / \$1M	Support transition of individuals from institution to community-based settings
CMS	Integrate Care for Dual Eligible's / \$0.4M	Design new model integrating Medicare and Medicaid financing and services
CMS	MICEO 2011 / \$5.2M	Create public/private partnership to maximize work opportunities for people with disabilities
Abt Associates/SSA	Benefit Offset National / \$4.0 M	Encourage working-age SSDI beneficiaries to increase their income
Income total	\$45.6 million Grants	



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
05/03/2011

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER MARSH USA, INC. 99 HIGH STREET BOSTON, MA 02110 Attn: Boston.Certrequest@marsh.com Fax 212-948-4377	CONTACT NAME: PHONE (A/C, No, Ext): _____ FAX (A/C, No): _____ E-MAIL ADDRESS: _____ PRODUCER CUSTOMER ID #: _____														
S04033-Bost-GL-11-12 INSURED UNIVERSITY OF MASSACHUSETTS C/O: OFFICE OF THE TREASURER 333 SOUTH STREET, SUITE 450 SHREWSBURY, MA 01545-4176	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center;">INSURER(S) AFFORDING COVERAGE</th> <th style="text-align: center;">NAIC #</th> </tr> </thead> <tbody> <tr> <td>INSURER A : Lexington Insurance Company</td> <td style="text-align: center;">19437</td> </tr> <tr> <td>INSURER B :</td> <td></td> </tr> <tr> <td>INSURER C :</td> <td></td> </tr> <tr> <td>INSURER D :</td> <td></td> </tr> <tr> <td>INSURER E :</td> <td></td> </tr> <tr> <td>INSURER F :</td> <td></td> </tr> </tbody> </table>	INSURER(S) AFFORDING COVERAGE	NAIC #	INSURER A : Lexington Insurance Company	19437	INSURER B :		INSURER C :		INSURER D :		INSURER E :		INSURER F :	
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COVERAGES **CERTIFICATE NUMBER:** NYC-004485200-10 **REVISION NUMBER:** 5

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR VVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS								
A	GENERAL LIABILITY <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR GENL AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC			004055483 SIR: \$100,000	05/01/2011	05/01/2012	EACH OCCURRENCE \$ 2,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000 MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 4,000,000 PRODUCTS - COMP/OP AGG \$ 4,000,000 \$								
	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> NON-OWNED AUTOS						COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$ \$								
	UMBRELLA LIAB <input type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DEDUCTIBLE \$ RETENTION \$						EACH OCCURRENCE \$ AGGREGATE \$ \$ \$								
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N N	N/A				<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">WC STATU-TORY LIMITS</td> <td style="width: 50%;">OTH-ER</td> </tr> <tr> <td>E.L. EACH ACCIDENT</td> <td>\$</td> </tr> <tr> <td>E.L. DISEASE - EA EMPLOYEE</td> <td>\$</td> </tr> <tr> <td>E.L. DISEASE - POLICY LIMIT</td> <td>\$</td> </tr> </table>	WC STATU-TORY LIMITS	OTH-ER	E.L. EACH ACCIDENT	\$	E.L. DISEASE - EA EMPLOYEE	\$	E.L. DISEASE - POLICY LIMIT	\$
WC STATU-TORY LIMITS	OTH-ER														
E.L. EACH ACCIDENT	\$														
E.L. DISEASE - EA EMPLOYEE	\$														
E.L. DISEASE - POLICY LIMIT	\$														

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)
 EVIDENCE OF COVERAGE

CERTIFICATE HOLDER UNIVERSITY OF MASSACHUSETTS C/O: OFFICE OF THE TREASURER 333 SOUTH ST, SUITE 450 SHREWSBURY, MA 01545	CANCELLATION SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE of Marsh USA Inc. William G. Cornish <i>William G. Cornish</i>
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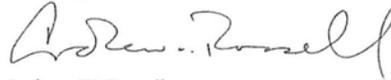
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To Whom It May Concern:

The University of Massachusetts, as an entity of the Commonwealth of Massachusetts, is self-insured for Worker's Compensation in accordance with Chapter 152 of the Massachusetts General Laws.

If you have any questions or concerns, please contact me at (774) 455-7590.

Sincerely,



Andrew W. Russell
Director of Risk Management
And Insurance



To Whom It May Concern:

Please be advised that as of May 1, 2002 the University of Massachusetts became self-insured in accordance with Chapter 258 of the Massachusetts General Laws for automobile liability with respect to vehicles that are owned by the University.

If you have any questions or concerns please call me. I can be reached at 774-455-7588.

Sincerely

A handwritten signature in black ink that reads "Andrew Russell". The signature is fluid and cursive, with the first and last names being clearly legible.

Andrew Russell
Director of Risk Management
and Insurance