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MARYLAND
HEALTHBENEFIT
EXCHANGE

December 1, 2015

The Honorable Edward J. Kasemeyer
Chairman
Senate Budget and Finance Committee
Miller Senate Office Building
3 West Wing
11 Bladen St., Annapolis, MD 21401

The Honorable Maggie McIntosh
Chairman
House Appropriations Committee
House Office Building, Room 121
6 Bladen St., Annapolis, MD 21401

Re: JCR 2015 (D78Y01.02) – Maryland Health Benefit Exchange System Integration

Dear Chairman Kasemeyer and Chairman McIntosh:

Pursuant to page 25 of the Joint Chairman's Report for 2015 Session, the Maryland Health Benefit Exchange (MHBE) submits this report on system integration. Specifically, the JCR required the MHBE, in consultation with the Department of Information Technology, to report on any plans to move toward a single point-of-entry system.

If you have any questions regarding this report, please contact me at 410-547-1273 or at carolyn.quattrocki@maryland.gov.

Sincerely,

Carolyn Quattrocki
Executive Director

cc: Cathy Kramer, DLS (Electronic)
Sarah Albert, DLS Library and Information Services (Mail)

MARYLAND HEALTH BENEFIT EXCHANGE

Integrated Eligibility Services – "One Door": A Report to the Chairmen of the Senate Budget and Taxation Committee and House Appropriations Committee

Maryland Health Benefit Exchange
December 1, 2015

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I. Introduction

The Chairmen of the Senate Budget and Taxation Committee and House Appropriations Committee's Narrative from the 2015 Joint Chairmen's Report on the Fiscal 2016 State Operating Budget (HB 70) and the State Capital Budget (HB 71) and Related Recommendations requests that the Maryland Health Benefit Exchange (MHBE) provide a report on system integration. Specifically, the MHBE must report on the following:

> The new eligibility determination information technology (IT) system of the Maryland Health Benefit Exchange (MHBE) does not currently offer the single point-of-entry for benefits determinations that had been the original long-term goal promised of MHBE's original system. Although the federal government has extended enhanced federal funding (90% Federal Medicaid Assistance Percentage) for IT system integration for an additional three years, it is unclear if the new platform can be the basis for the promised single point-of-entry system. The committee's request MHBE, in consultation with the Department of Information Technology, to report by December 1, 2015, on any plans to move toward a single point-of-entry system.

In accordance with this requirement, the MHBE submits this report to the Chairmen of the Senate Budget and Taxation Committee and the House Appropriations Committee.

II. Scope of Report

This report provides background information on the current implementation of the Health Benefit Exchange (HBX) system, a summary of the savings and benefits to Marylanders of integrating the State's eligibility and enrollment systems and processes into a single point of entry, and an approach, which could be employed if the decision were to be made to move forward with integration. This report does not reflect a current, comprehensive plan, which will require an in-depth and collaborative planning process to be undertaken together by the Department of Information Technology (DoIT), MHBE, the Department of Health & Mental Hygiene (DHMH), and the Department of Human Resources (DHR). This planning process would need to address the four components, which would be critical to successful integration, *i.e.* technology, funding, business impact and processes, and governance/project management.

III. History

Agencies

The State of Maryland leverages three separate agencies to support its various health and social services programs: the Department of Health and Mental Hygiene (DHMH), the Department of Human Resources (DHR), and the Maryland Health and Benefits Exchange (MHBE). Under Maryland law, the MHBE was established as a public corporation and a unit of the state government to run the State's health benefit exchange marketplace under the Patient Protection and Affordable Care Act.[1] The MHBE must perform at a minimum all functions required by the ACA,[2] which include:[3]

- Maintaining a website with standardized comparative information on qualified health plans (QHP) for consumers;
- Using a standardized format for presenting QHPs in the exchange; and
- Informing individuals of eligibility requirements for Medicaid and the Children's Health Program (MCHP), and enrolling individuals into these programs if the exchange determines that an individual is eligible, among other requirements.

A key function of exchanges is to provide a single, streamlined application and eligibility determination process for all insurance affordability programs—Medicaid, MCHP, as well as advanced premium tax credits and cost-sharing reductions for QHPs. In order to comply with this requirement, DHMH submitted a Medicaid state plan amendment delegating authority to the MHBE for Medicaid eligibility determinations for income-based coverage groups, also called Medicaid eligibility based on Modified Adjusted Gross Income (MAGI) levels. The state plan amendment, approved by CMS, delegates this eligibility determination process to MHBE.[4]

DHMH and DHR continue to administer the other health and social services programs provided by the State, which include, but are not limited to, non-MAGI Medicaid, the Food Supplement Program (FSP), Temporary Cash Assistance (TCA), and the Maryland Energy Assistance Program (MEAP).

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[1] Insurance Article, § 31-102(b), Annotated Code of Maryland.
[2] Insurance Article, § 31-108, Annotated Code of Maryland.
[3] ACA § 1311(d)(4) (42 U.S.C. § 18031(d)(4))
[4] Maryland State Plan Amendment, Transmittal Number 13-0023-MM4 (June 18, 2014).

MHBE serves over 860,000 Maryland residents through QHP, MAGI Medicaid, and MCHP eligibility determinations and enrollments. DHMH and DHR serve another 1.1 million Maryland residents through non-MAGI Medicaid, TCA, and FSP.

Technologies

In order to administer the programs, or parts of programs, for which each agency is responsible, all three operate separate information technology systems. These systems each have separate hosting, maintenance and operations, and development contracts, despite the redundancies among them. These redundancies result in significant costs, which could be reduced through integration of the systems into a single application. Furthermore, DHR's infrastructure is a key part of the interaction between all three agencies, but it limits the ability of the agencies to deliver services due to its aging technology, which renders more difficult adapting to rapid regulatory changes, developing real time interfaces with the Federal Data Services Hub, etc.

Meanwhile, over the past two years, MHBE has developed a new marketplace application employing modern technology, which provides the ability to handle large volumes of data and numerous other benefits and advantages highlighted below in Table 1.

Table 1: Salient features of MHBE technology suite

#	Category	Capabilities
1	Infrastructure	• High capacity servers with multiple CPUs and virtual machines supporting consumer and worker portals. • High capacity database. • Separate databases for reporting and application database. • Staging environment available replicating production.
2	Application	• Fully integrated with Federal hub to verify the identity, income, and lawful presence in real time. • Working interfaces with MD insurance medical and dental carriers (834), MMIS (8001), and CMS (1095A/B, Bulk services, SSA, Medicare, VLP and IRS). • Efficient plan management to load SERFF plans data. • Auto renewals batches are available if consumer is eligible to auto renew his coverage. • Highly efficient content management system is available and fully integrated content management with consumer and worker portal for faster document processing and notice generation. • Work item generation and assignment is done to workers in real time based on the worker load.

#	Category	Capabilities
3	Modular	• The Maryland Health Benefit Exchange was designed and developed using a Service-Oriented Architecture (SOA), a structured software development lifecycle (SDLC), exposed application programming interfaces (APIs), agile development, documented interface control documents, and the use of a business rules engine. • It encourages modular, SOA development using a formal SDLC methodology. • It requires open interfaces and exposed APIs to exchange data with stakeholders, including data hubs. • Business rules engines separate business rules from core programming and define the number of business rules per business process and these business rules have been developed in human and machine-readable formats.
4	MITA	• The Maryland Health Benefit Exchange complies with the MITA condition as it includes self-assessments, roadmaps, a concept of operations, and business process models. • It was built with a MITA roadmap, which allows for periodic updates toward achieving goals. • It was built using business process models and concept of operations that align and support MITA maturity goals.
5	Industry Standards	• The Maryland Health Benefit Exchange's industry standards increase interoperability and level-sets expectations on usability and data sharing. • Section 508 of the Rehabilitation Act focuses on usability of a system by users with disabilities. • Section 1104 of the ACA is primarily based on HIPAA transactions standards including security and privacy as implemented using the Council for Affordable Quality Healthcare and the Committee on Operating Rules for Information Exchange operating rules. • Section 1561 of the ACA deals with data standards and interactions needed to support Health Insurance Exchanges (HIX) and eligibility and enrollment interactions. • The Maryland Health Benefit Exchange was designed and developed so that the system and its practices can be periodically updated to adhere to evolving industry standards. • The Maryland Health Benefit Exchange has development, testing, and risk mitigation plans in place to address the evolving industry standards.
6	Leverage	• The Maryland Health Benefit Exchange was designed and developed with the idea of the solution being shared, leveraged, and reused. • The system was built upon the idea of sharing development activities and reusing common solutions.

#	Category	Capabilities
7	Business Results	• The Maryland Health Benefit Exchange was designed and developed to enable an effective and efficient business process and business results to support desired business outcomes. • It was designed and developed to provide a world-class consumer experience with a high-quality Maryland Health Benefit Exchange degree of automation and high quality customer service for applicants, beneficiaries, and plans. • The Maryland Health Benefit Exchange is highly automated in systematic processing of applications, eligibility determinations, and enrollments including the ability to submit and manage interactions through the Internet and to self-manage and monitor accounts and history electronically. • The Maryland Health Benefit Exchange periodically evaluates the operational system against established service-level agreements and key performance indicators. Failure of these service levels and performance indicators result in a plan of action with milestones.
8	Reporting	• The Maryland Health Benefit Exchange's reports are automatically generated with appropriate audit trails. • The Maryland Health Benefit Exchange's reports produce and expose electronically accurate data necessary for oversight, administration, accountability, evaluation, integrity, and transparency, and continuous improvement.
9	Interoperability	• The Maryland Health Benefit Exchange allows the provisioning of outreach and enrollment assistance services and provides interoperability with the MD Medicaid program to share business services and produces a seamless and efficient customer experience. • The Maryland Health Benefit Exchange was designed and developed to be interoperable with DHR and DHMH's systems.

IV. Current Business Operations

The current state of business operations for the delivery of health and social services programs in Maryland is complex, with significant duplications and inefficiencies. Health and social services programs are accessed through more than six different categories of entry points, and each point is limited in the services it can provide. While Maryland offers support and services for Primary and Specialty Care, Long Term Care, Behavior Health and Substance Abuse, Hospital, Pharmacy, and TCA & FSP services, there is no single point of entry to this entire suite of capabilities.

As with their IT systems, these redundancies within the various agency business processes and support services also require duplicative expenditures and increased costs. For example, currently, there is over $86 million in funding for four different agencies and over 800 staff members who claim responsibility for some portion of MAGI Medicaid. Streamlining this workforce and funding, along with additional unification and alignment of redundant services – such as print contracts and call center costs – could result in significant cost savings for the State and improved consumer services and support for Marylanders.

V. Opportunity for Growth

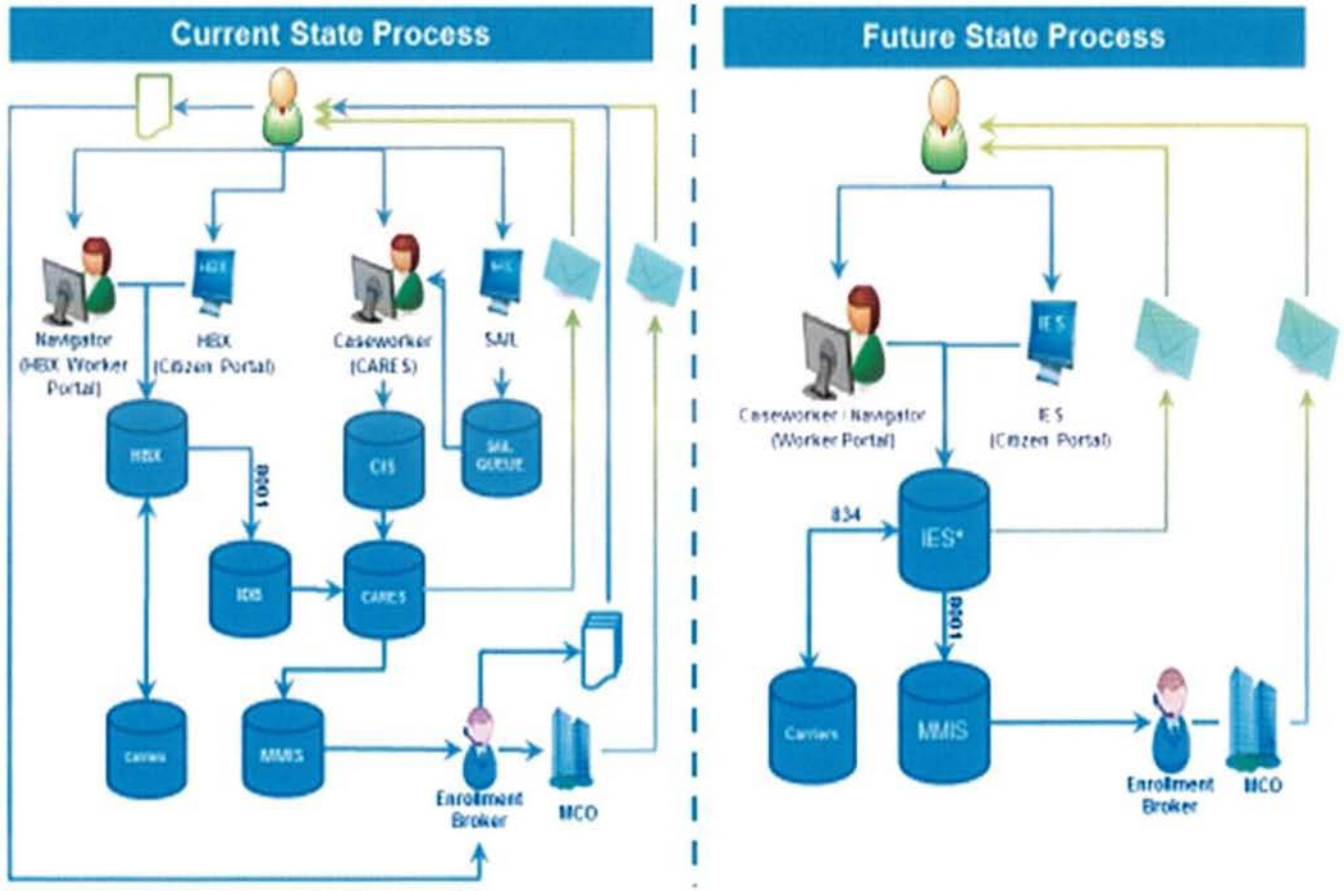
Administrative Simplification

With a modern IT platform, which could provide the basis for an integrated health and human services eligibility application, the State has a landmark opportunity to reduce costs and improve the operations of the health and social services programs it provides to its citizens. DHMH, DHR, and MHBE can create an online environment with a single point of entry and a more streamlined network of in-person support. By shifting and consolidating resources, the State can better support IT innovation, better align its consumer assistance workforce, and consolidate its call centers, printing services, and other components of the business processes, which support its health and social services programs. These increased efficiencies and enhanced consumer assistance services will in turn provide the State an effective means to reduce costs.

Figure 1: Administrative simplification opportunity

Currently, the DHR has three separate systems (CARES, CHESSIE, CSES[5]) that support thirteen different programs. MHBE has an additional system (HBX) that supports three more programs, and both the HBX and CARES have an interface to Maryland's MMIS system, which under federal law must be run by the single-state Medicaid agency, which is DHMH. The IT potential to create an Integrated Eligibility System that encompasses all of these programs would allow for significant improvements for the citizens of Maryland. For example, by integrating the CARES system into the HBX, it would be possible to significantly improve operational flow between agencies.

Figure 2: Simplified Administrative Operations:



[5] CARES (Client Automated Resources Eligibility System)
CHESSIE (Children's Electronic Social Services Information Exchange system)
CSES (Child Support Enforcement System)

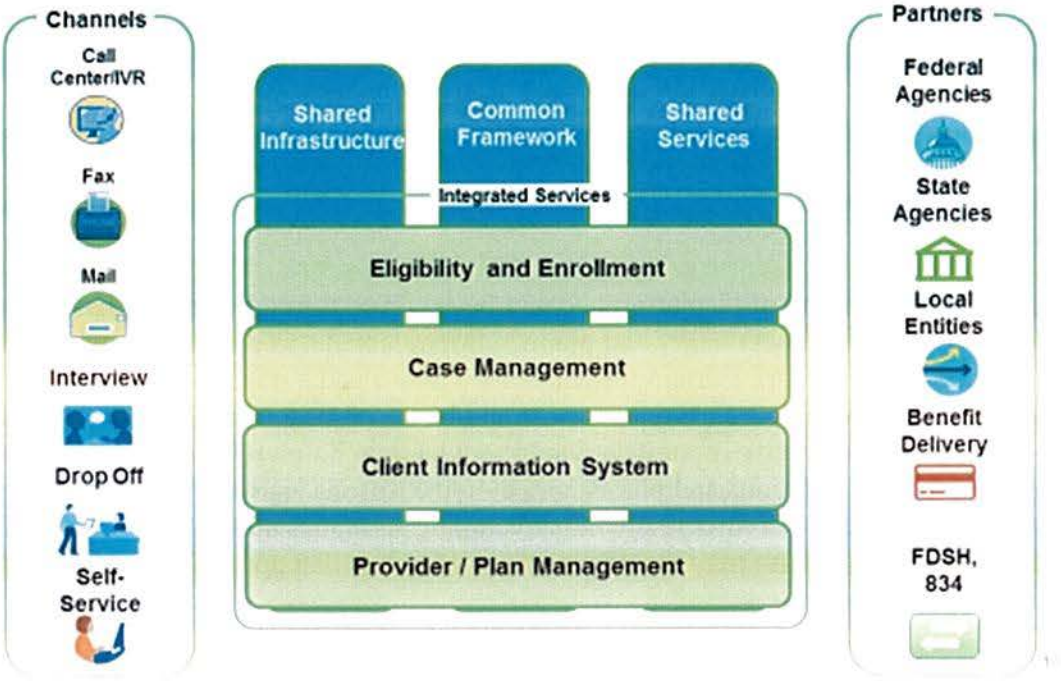
Table 2: Administrative simplifications envisaged in the future "one-door" approach as compared to current state of operations

#	Current State	Future State
1	Workers need to submit application in different systems based on benefit that citizen is looking for.	There will be a single streamlined application for intake of all health and human services programs in the State of Maryland leading to improvement in worker efficiency and user experience.
2	Workers need to verify same documents twice if citizen is applying for multiple program across the system.	There is a single streamlined application to verify the documents and most of the existing documents could be reused for verification.
3	There are separate call centers and business operations based on the agency and type of functionality provided by agency.	Call center and business operations could be consolidated across multiple agencies in a single point of entry system.
4	There is no consumer portal to enroll in Non MAGI-Medicaid or other social services programs like TCA, FSP, child support and energy assistance.	There is an opportunity to use HBX consumer portal to enroll in Non MAGI-Medicaid or other social services programs like TCA, FSP, child support and energy assistance programs.
5	Enrolling into Medicaid is a multi-step process and it takes approximately 5-7 weeks to complete the enrollment.	Medicaid eligible residents shall have an opportunity to select the MCO plans in the system leading to immediate enrollment.

Information Technology Integration

The state can achieve these benefits for Marylanders through an integration of both the IT systems determining eligibility and facilitating enrollment, and the business processes that support and provide the requisite consumer assistance for the online eligibility and enrollment system. MHBE's partners in health care and human services eligibility leverage the same channels of communication (*i.e.* call center, e-mail, fax, etc.), which connect to their various applications and systems. By creating a shared infrastructure, a common framework, and sharing these services throughout the various unconnected agencies, Maryland can integrate Eligibility and Enrollment services, Case Management, Client Information Services, and Provider/Plan Management. In the current environment, with resources and funding declining across agencies, the streamlining and unification of efforts is particularly important.

Figure 3: Service integration view



From a system/software development standpoint, this approach reduces risk and provides stability to build future solutions. Compliance and security are improved through tighter controls over repository access, and it takes advantage of a unified method of authentication, authorizations, and auditing tools. Hardware upgrades to meet the increasing demands of a larger user base becomes easier to address through the use of platform-independent code, which then enables rapid deployment and the integration of new technologies. Much of the functionality and assets currently in use by MHBE can be reused to reduce costs. Additionally, by consolidating disparate systems, the State can improve maintenance through segmented and modularized code for each system.

One Door – Program Integration

The real beneficiary of integration is the citizen. Creating IT infrastructure that supports a more streamlined "no wrong door" approach improves customer experience when seeking publicly financed health care and other social services. Improved data quality and analytics can lead to

faster and better-informed decision making. Unifying the system also means improving the response time with respect to federal, legislative and desired program changes.

Realizing the full potential of system integration, however, will not be possible without also integrating and streamlining the work processes and consumer assistance services which must support enrollment into health and social services programs. From an IT perspective, the technological challenges to integration across agencies can be met. Yet moving to an integrated platform must also be accompanied by a corresponding effort to streamline, coordinate and align agencies' operations in order to increase efficiencies and decrease costs.

VI. The Path Forward

The vision of the integration of IT platforms could be achieved through a multi-phased approach that leverages the current functionality and planned improvements as a foundation for expansion to support additional programs. Certain functionalities may also be implemented in a concurrent fashion across the multiple phases. Each phase would be developed, tested and implemented in an iterative fashion. The iterative approach would provide maximum return on investment and help us structure future iterations and phases based on the lessons learned from prior iterations. Each phase would include activities related to developing strategies and high-level plans for subsequent phases. Each phase may include multiple iterations that go through end-to-end development and testing phases.

Phase One: Laying the Foundation:

A strong foundation will involve building system components and functionalities required to successfully implement subsequent phases. Table 3 below describes various system changes targeted for implementation during this phase. These enhancements will begin to provide benefits to the program on their own and will act as a foundation for upcoming phases.

Table 3: Planned enhancements under Phase 1 of "one-door" approach and potential operational impacts

#	Enhancement	Description	Operational Considerations
1	Retroactive Medicaid	Individuals can apply at any time and get up to 3 months of retroactive Medicaid coverage if they have outstanding medical	Low operational impact. Workers need to be trained to use this functionality.

#	Enhancement	Description	Operational Considerations
		bills from that time period and are found eligible for that time period. HBX requires an applicant to apply for retroactive coverage when they initially apply for benefits. If an applicant fails to indicate that they want to apply for retroactive coverage, the system does not allow them to apply for retroactive coverage at a later date. These cases require manual intervention in order to provide the consumer with the correct coverage. This enhancement will focus on providing the consumer or caseworker with the ability to request Retro Medicaid during the normal change reporting process.	
2	Medicaid Age Out and Postpartum	Consumers under the following circumstances must be terminated from the system at the end of their birth month: an MCHP recipient turns 19, a former foster care child on Medicaid turns 26, a Medicaid recipient turns 65 and no longer qualifies under the Medicaid expansion, or a woman eligible only due to pregnancy has reached the end of her postpartum coverage. The HBX will not automatically terminate these cases at the end of the month. Daily reports are generated and distributed to state agencies. Caseworkers use the reports to manually rerun eligibility and send new determination notices to the affected consumers. DHR and DHMH staff will close these cases manually.	Medium operational impact. This functionality potentially reduces the need for manual intervention.

#	Enhancement	Description	Operational Considerations
		This enhancement will create the functionality to detect these situations and automatically process the transactions within the HBX and then notify the consumer of their new eligibility and notify MHBE of the transactions conducted.	
3	MCO Online Plan Selection	Currently, when Medicaid Eligible consumers complete their application, they are shown a message on the screen that they will be sent a packet in the mail for them to select their Medicaid coverage plan carrier. This enhancement will provide HBX with the functionality to allow the Medicaid consumer to continue to their MCO plan selection similar to the QHP plan shoppers. This has two immediate benefits to the consumer: 1) It will allow them to complete their enrollment in one interaction, if they desire. 2) It will reduce the waiting time for the packet to be mailed.	Major operational efficiency. This enhancement has three immediate benefits to Medicaid and the Exchange: 1) It will reduce or eliminate the postage fees for sending MCO packets in the mail. 2) It will reduce call volume to the CSC and the Enrollment Broker 3) It will reduce multiple caseworker bookings when consumers require a caseworker's assistance. Needs to be discussed with the DHMH and devise a strategy to streamline the MCO enrollment.
4	CIS Interface and Eligibility Status Check with MMIS	The HBX does not provide a real time interface with the MMIS system to verify Medicaid coverage. In order for caseworkers to accomplish this task, they must manually do it. They pause their work in the HBX and then switch to their MMIS system to conduct the inquiry. Caseworker time is extremely precious and this manual effort expends valuable time.	This functionality potentially reduces the manual work and minimizes the time it takes to enroll the citizens into the Medicaid programs. Also any citizens already enrolled in ABD/LTC[6] can be identified through the

[6] ABD (Aged, Blind and Disabled)
LTC (Long Term Care)

#	Enhancement	Description	Operational Considerations
		This enhancement will leverage the eligibility files received from the transaction set to create a real time interface with the MMIS system to verify Medicaid coverage.	status check to make them ineligible at HBX
5	Establishing direct interface of Medicaid transactions (8001) with MMIS	Currently, the Medicaid 8001 transactions do not have a direct interface with MMIS. A consumer's IRN (Individual Recipient Number) in CIS (Customer Information System) must be associated with the consumers in the 8001 transaction created by HBX. An IDB (Interim Database) was built with the primary purpose of completing the registration process and resolving identity issues so that the HBX 8001 file could be successfully processed by MMIS. On a nightly basis, the IDB sends the 8001 files to CIS where it performs some additional processing and then CIS will send the HBX 8001 file to DHMH for processing. This enhancement will remove this interim database solution currently in place and will provide for a direct interface with MMIS.	Medium operational impact and DHMH team needs to change its operations to accept data directly from MHBE. This functionality will minimize the time taken to enroll citizens into the Medicaid programs.
6	ECMS Integration	The Exchange currently uses the FileNet system for document management that came integrated with the CT exchange system. However, the State of Maryland exchange system was standardized on the ECMS document management system prior to HBX launch. In some cases, this caused duplicative work for the caseworkers for scanning and locating supporting application documents.	Significantly improves the operational efficiency. Currently workers are uploading the documents into two systems if the citizens receive benefits from DHR and MHBE. After the integration, workers will need to upload only into one common repository.

#	Enhancement	Description	Operational Considerations
		This enhancement will integrate the document management system and eliminate duplicate work at the field level.	

Operational Impact: These enhancements will effectuate operational changes that will impact multiple agencies. Many operational activities currently performed in isolation can be consolidated into a centralized operating model. Concurrent with system implementation, these operational changes will also be taken into account, and collaboration among affected agencies will be necessary to optimize the operating model for maximum efficiency.

Estimated Duration: Approximately 10 – 12 months.

Planning session: Collaborate with DHR and DHMH agencies to devise a strategy to move forward with the subsequent phases. Planning and discussion with the relevant stakeholders related to Information Technology (IT) and Business Operations. IT and Business Operations will need to work together to realize the full benefit of the one door concept.

Phase Two: One door for health insurance coverage.

The goal of this phase is to streamline and consolidate data collection, eligibility determination and enrollment for all health insurance applicants under MAGI or Non-MAGI guidelines. Table 4 below describes the key system components to be modified to facilitate this integration. This phase would also target the conversion of existing eligibility and enrollment information of the Non-MAGI population to HBX, so that the families do not need to re-submit applications for health coverage. Upon completion of this phase, the following Non-MAGI programs would be integrated with HBX:

- ✓ Aged, Blind, Disabled
- ✓ Aged, Blind, Disabled Long Term Care
- ✓ Families and Children Long Term Care
- ✓ Women's Breast and Cervical Cancer – W track
- ✓ Foster care and Adoption Subsidies
- ✓ Refugees Medicaid Assistance
- ✓ Home and Community Based Services Waivers and PACE

Table 4: Planned enhancements under Phase 2 of "one-door" approach and potential operational impacts

#	Enhancements	Description	Operational Consideration
1	Data Collection enhancements	Current HBX system to collect additional household information that is necessary to determine MAGI eligibility. Integration of Non-MAGI eligibility determination will require collection of additional information about the household. In this phase, system capability to collect information based on program selection will also be incorporated.	Major operational efficiencies. A consolidated call center staff with right skill-sets is required to handle these programs. Needs to be discussed across the impacted agencies.
2	Eligibility Determination and Enrollment Change to incorporate Non-MAGI Rules	Current HBX system performs real time eligibility determination under MAGI guidelines. During this phase of implementation the eligibility determination module has to be enhanced to incorporate Non-MAGI rules.	Major operational efficiencies. More streamlined eligibility determination, leading to better compliance with policy.
3	Conversion to bring existing Non-MAGI population to HBX	Current HBX system holds the data for MAGI population. The conversion activity scoped in this phase will bring the application, eligibility and related information to the HBX system. This will eliminate the need to re-enter application and hence minimize operational impact.	Major operational efficiencies. Either citizens or workers are not required to enter the data again into the system.

Operational Impact: This phase would impose significant operational changes. The operational activities needed for MAGI and Non-MAGI groups can be consolidated into a single stream of work. During the course of this phase, operational redesign will be considered a

priority. As part of the operational impact analysis, impact to any other data collection systems such as SAIL would be assessed.

Estimated Duration: Approximately 18 – 20 months.

Phase Three: One door for health programs, FSP and TCA

The goal of phase 3 is to integrate data collection and real time eligibility determination for FSP Cash (TCA) and MEAP applications. The current system capabilities as well as those built in earlier phases would build the foundation for this phase. Key areas of changes are similar to that in phase 2 and outlined in the Table 5 below.

Table 5: Planned enhancements under Phase 3 of "one-door" approach and potential operational impacts

#	Enhancements	Description	Operational Consideration
1	Data Collection enhancements	Before inception of this phase, the system will have capability to collect information based on the programs selected by constituent. During this phase additional data elements needed for FSP and TCA will be added to the system.	Major operational impact. Data for multiple services already available in database, leading to operational efficiencies.
2	Eligibility Determination and Enrollment Change to incorporate FSP and TCA Rules	Before inception of this phase, system will be capable of determining eligibility under MAGI and Non-MAGI guidelines. During this phase of implementation the eligibility determination module has to be enhanced to incorporate FSP and TCA rules.	Major operational impact. More streamlined eligibility determination, leading to better compliance with policy.
3	Conversion to bring existing FSP and	By the inception of this phase HBX system will hold the data for	Major operational impact.

#	Enhancements	Description	Operational Consideration
	TCA population to HBX	MAGI/Non-MAGI population. The conversion activity scoped in this phase will bring the application, eligibility and other information to HBX system. This will eliminate the need to re-enter application and hence minimize operational redundancies.	Major operational efficiencies. Either citizens or workers are not required to enter the data again into the system.

Operational Impact: This phase would introduce significant operational changes. The operational activities needed for health care and other social services programs could be consolidated to a single stream of work. During the course of this phase, operational redesign will be considered a priority. As part of the operational impact analysis, impact to any other data collection systems such as SAIL would be assessed.

Estimated Duration: Approximately 12 – 14 months.

Phase Four: One door for all social service programs

The goal of phase 4 is to integrate data collection and real time eligibility determination for remaining social services applications. The current system capabilities as well as those built in earlier phases will build the foundation for this phase. Key areas of changes are similar to that in phases 2 and 3 and are outlined in Table 6 below. This phase would integrate the following social services programs into HBX:

- ✓ Children's Electronic Social Services Information Exchange system (CHESSIE)
- ✓ Child Support Enforcement System (CSES)

Table 6: Planned enhancements under Phase 4 of "one-door" approach and potential operational impacts

#	Enhancements	Description	Operational Consideration
1	Data Collection	Before inception of this phase, the	Major operational

#	Enhancements	Description	Operational Consideration
	enhancements	system will have capability to collect information based on the programs selected by constituent. During this phase additional data elements needed for CHESSIE and CSES will be added to the system.	impact. Data for multiple services already available in database, leading to operational efficiencies.
2	Eligibility Determination and Enrollment Change to incorporate CHESSIE and CSES Rules	Before inception of this phase system will be capable of determining eligibility health, FSP and TCA. During this phase of implementation the eligibility determination module will be enhanced to incorporate CHESSIE and CSES rules.	Major operational impact. More streamlined eligibility determination, leading to better compliance with policy.
3	Conversion to bring existing CHESSIE and CSES population to HBX	By the inception of this phase HBX system will hold the data for health, FSP and TCA population. The conversion activity scoped in this phase will bring the application, eligibility and other information to HBX system. This will eliminate the need to re-enter application and hence minimize operational redundancies.	Major operational impact. Major operational efficiencies. Either citizens or workers are not required to enter the data again into the system.

Operational Impact: This phase would impose significant operational changes. The operational activities needed for health care and other social services programs could be consolidated into a single stream of work. During the course of this phase, operational redesign will be considered a priority. As part of the operational impact analysis, impact to any other data collection system such as SAIL would be assessed.

Phase duration: Approximately 12 – 16 months.

VII. Conclusion

Should Maryland want to move toward integration of the multiple agency IT systems and businesses processes, which currently support the State's health and human services programs, this report sets forth a potential path. With the HBX, the State now has a modern platform capable of providing the foundation for a fully integrated system, and the benefits to consumers and long-term cost savings to the State would be considerable. In order to build on that platform, and to effectuate the realignment of business processes and consumer assistance services necessary to succeed and realize the full potential of integration, however, the four agencies involved must first undertake a collaborative, comprehensive planning process. This process must address all components of a successful integration effort, including project governance, IT development, business processes, and funding. MHBE is able and willing to participate in such an initiative, should it be decided to proceed.