IT and Implementation Committee Interoperability Analysis

In November 2012, COHBE and HCPF staff analyzed varying levels of interoperability between the Exchange and state systems. Given the extremely tight timeline to implement the Exchange by October 2013, the IT and Implementation Committee proposed to move forward with the ***Minimum*** interoperability alternative in order to reduce deployment risk. The ***Minimum*** alternative includes a set of features and functions that will provide a smooth and efficient customer experience.

The degree of interoperability is reflected in the amount of overlap between the Exchange systems, plans, business processes and the state's systems as shown in Figure 1. Increasing degrees of interoperability improve the consumer experience for a segment of the population, i.e. those who will likely move between private and public healthcare coverage. However, increasing degrees of interoperability also increase the overall complexity and coordination required and hence the schedule risk for the Exchange.

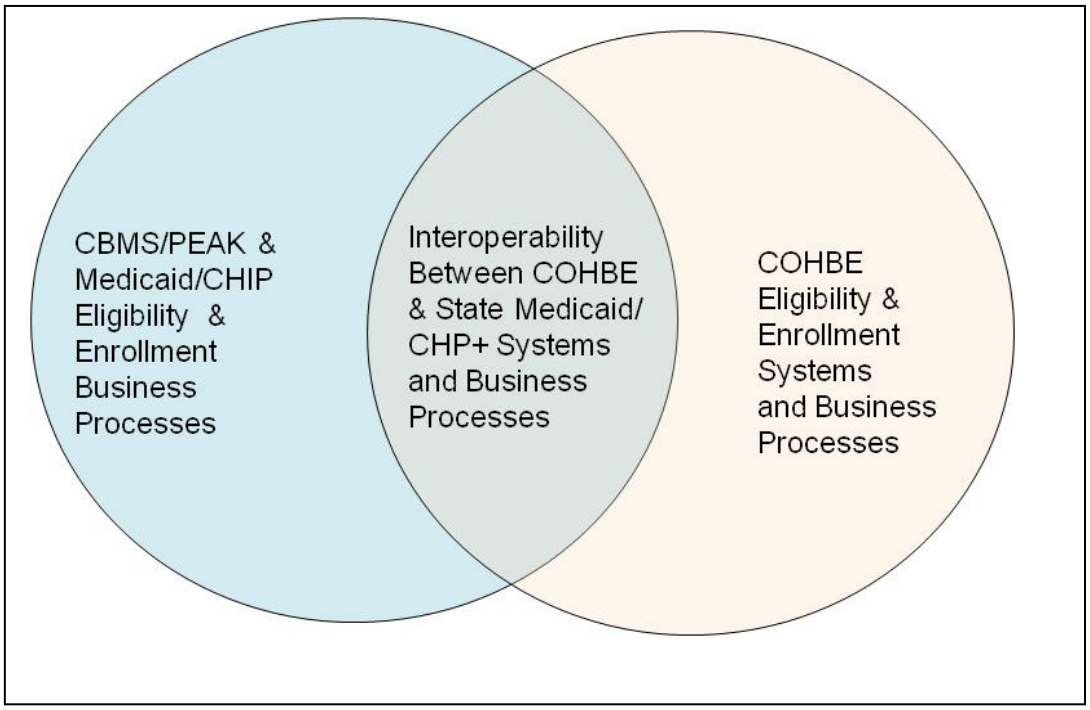


Figure 1 shows the high-level business concept and architecture for the Exchange and the state systems. The degree of interoperability is illustrated by the region between the Exchange and the state systems which share components, services, data, etc.

The analysis approach used is shown in Figures 3 and 4.

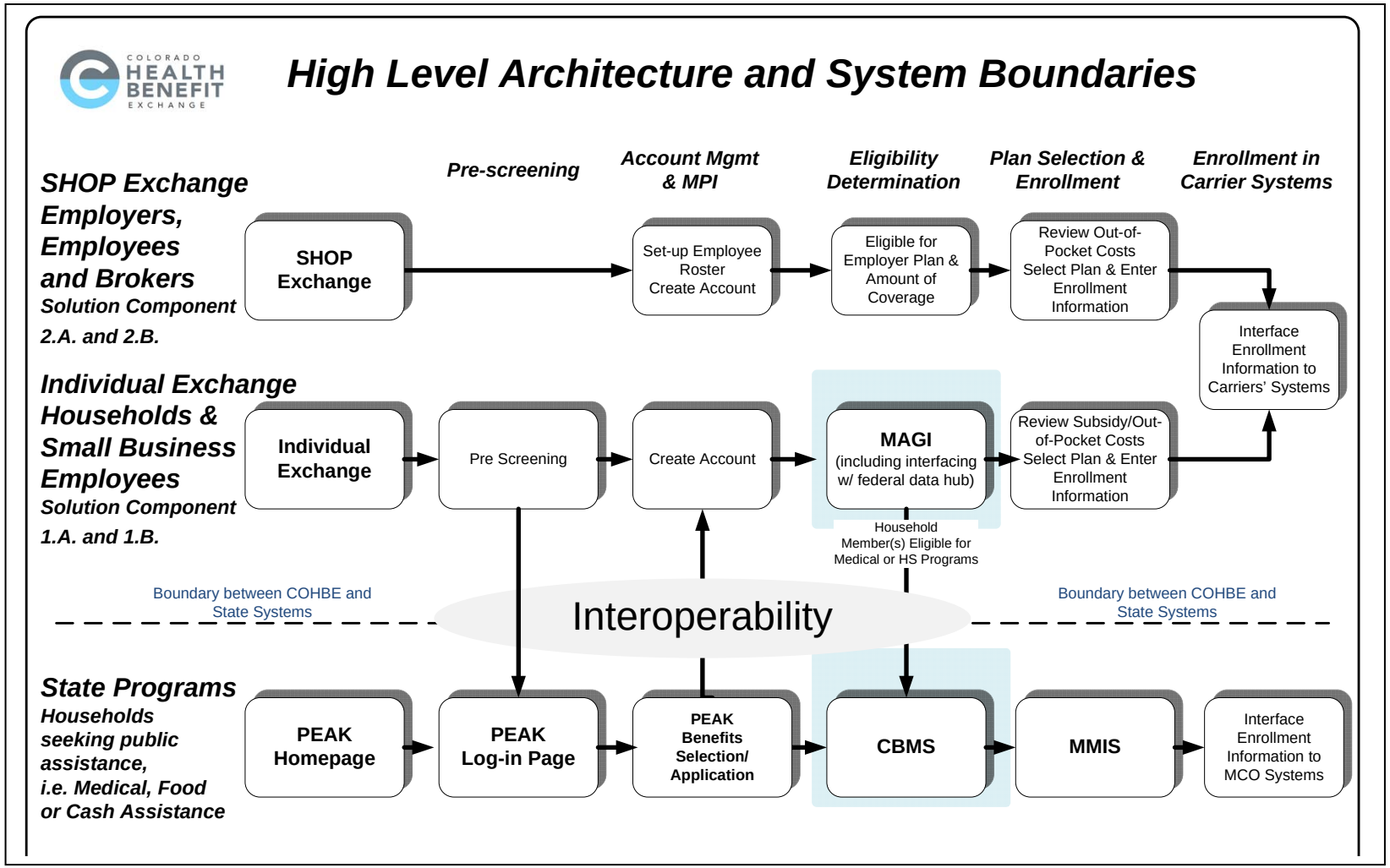
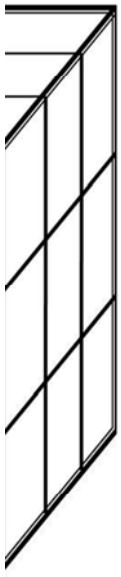


Figure 2. Interoperability region between the Exchange and the state systems.



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	Interoperability Level Examples		
Interoperability Feasibility Criterion	**Minimum**	**Moderate**	**Maximum**
Single/shared MAGI eligibility process for Private Insurance and Medicaid/CHP+	X	X	X
Single sign-on	X	X	X
Customer identification and data	X	X	X
Request only information needed for determining eligibility for healthcare	X	X	X
No wrong door for medical eligibility	X	X	X
Transfer data to CBMS if eligible for Medicaid/CHP+, no duplicative data entry	X	X	X
Provide links to non-medical eligibility processes and pre-populate with data previously collected during medical eligibility processes	X	X	X
Link and data population from Exchange to PEAK		X	X
Interface Exchange to CBMS for other medical and human services		X	X
Shared call center			X
Same carriers for some private and public plans			X
Interface from Exchange to MMIS for no touch for Family Medical and CHP+ enrollment			X

Figure 4 shows examples of the three interoperability alternatives. The level or degree of interoperability is additive from minimum to maximum.