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STATE OF VERMONT
LEGISLATIVE JOINT FISCAL OFFICE

Memorandum

To: Members, HROC and Joint Fiscal Committee;
Speaker of the House, Senate President Pro Tempore
From Stephen Klein, Catherine Benham, Stephanie Barrett and Nolan Langweil
Re: Reporting on Vermont Health Connect (VHC) Implementation
Date: July 24, 2015

Context:
Section C.106.1 of Act 58 (Big Bill) of 2015, calls for an independent analysis of the Vermont Health Connect (VHC) information technology systems by the Joint Fiscal Office. [1] This analysis is to begin in July, be repeated in September and October, and be done "at other times that are appropriate." As this is the first of these reports, we welcome any ideas or suggestions for content in future reports.

This report provides the July 2015 analysis of the exchange activity and is based upon:

- Review of the administration reports submitted through July 22, 2015;
- Independent Verification Vendor (IVV) reports through July 2015;
- Discussions with the Administration and Gartner Group relative to the aforementioned reporting;
- Review of other analysis and reports of Exchange operations generally.

The VHC has had a rocky start, similar to the experience of other state-based exchanges nationally. In Vermont and around the country there have been considerable questions as to whether the state-based exchange makes sense for financial and operational reasons. In light of the recent King v. Burwell decision, which clarified that subsidies could be offered through federally-facilitated exchanges, one of the key reasons for independent state-based exchanges fell away. The argument that federally-facilitated exchanges, or components of it, are efficient may be strengthened as the full costs of operating state-based exchanges are identified. On the other

[1] *INDEPENDENT REVIEW OF VERMONT HEALTH CONNECT*
(a) The Chief of Health Care Reform shall provide the Joint Fiscal Office with the materials provided by the Independent Verification and Validation (IVV) firms evaluating Vermont Health Connect. The reports shall be provided in a manner that protects security and confidentiality as required by any memoranda of understanding entered into by the Joint Fiscal Office and the Executive Branch. The Joint Fiscal Office shall analyze the reports and shall provide information regarding Vermont Health Connect information technology systems to the Health Reform Oversight Committee, the Joint Fiscal Committee, the Speaker of the House of Representatives, and the President Pro Tempore of the Senate in July, September, and October 2015 and at other times as appropriate.

hand, under the ACA, states have the opportunity to pursue a 1332 waiver which will allow states to explore innovative alternatives to the current health benefit exchange structure.[2] The state-based exchange also offers an opportunity for states to unify their health care programs and other benefits in a way that may be difficult with a federally-facilitated exchange model. Vermont has taken this integrated approach for its exchange, unlike some states that have established separate exchanges often though independent authorities.

While this debate regarding federal versus state based exchanges will continue for the foreseeable future, currently the primary focus in Vermont and other states is the full operational capacity of the exchange. VHC has made strides toward full operational readiness but substantial issues remain. The Joint Fiscal Office's three reports required by C. 106.1 of Act 50 will be focused primarily on the operational aspects of the exchange, while the October report will take a broader look at the budgeting and ongoing cost estimates for the VHC and its relationship to other major Agency of Human Services (AHS) information technology (IT) projects that are underway.

Summary/Overview:
As of June 2015, 213,378 Vermonters were enrolled in either Medicaid for Children and Adults (141,173) or qualified health plans (72,206). Of the 34,103 Vermonters enrolled in qualified health plans as individuals (i.e. not through an employer), nearly two-thirds (65%) of them receive financial help to reduce the cost of their monthly premium. As of late 2014, 3.7% of Vermonters were uninsured, the second lowest rate in the nation. The current status of the exchange will be discussed in three areas: 1) Project Scope and System Issues, 2) Timing and Schedule, and 3) Budgetary Concerns.

1. Project Scope and System Issues

- The broad plan for AHS information technology is to create a Health and Human Services Enterprise (HSE) platform that provides the infrastructure for various projects, including: VHC, Integrated Eligibility (IE), Medicaid Management Information System (MMIS,) and the Health Information Exchange (HIE) for public health. In order for VHC to be successful, the HSE platform infrastructure must work. Concerns about the HSE platform include:
    - Transition of hosting from CGI to Optum – there is risk that this transition could impact timelines
    - Prioritization and coordination of the work so the HSE platform will work for VHC - The HSE manager is being included in VHC project planning.
    - This transition was mentioned in the Gartner IVV report as an area of high risk, medium probability and potentially high impact. The administration is monitoring this and developing contingency plans.

[2] See http://www.commonwealthfund.org/publications/issue-briefs/2015/apr/innovation-waivers-and-health-reform and http://www.cnbc.com/2015/07/22/states-shuttering-obamacare-exchanges-but-should-they.html

Optum, which is the service and technical consulting arm of United Health Care, is responsible for hosting the HSE platform as well as development and design work for the VHC. VHC gets its data-base services, enterprise content and identity management from the HSE platform.

- A new dental provider, Dentegra Insurance Company, may be added to the exchange if the company gets the approvals it needs from the Department of Financial Regulations (DFR) and the Department of Vermont Health Access. The administration is concerned that adding a new provider while the IT system is under development could be problem; diverting resources from other needed work and significantly increasing workloads and it will likely not be added before open enrollment. The process and timing of adding insurers needs to be clarified.

- There are a number of additional issues with the exchange which will need to be addressed but have been postponed for the immediate time. These issues include:
    - Treatment of small business plans under the exchange (SHOP): It is likely that this will be done in a manner to minimize both its cost and impact on exchange operations. The legislature did not fund this component of the exchange.
    - Whether or not it continues to make sense for VHC to do billing remains an area under review: Carriers are responsible for dunning, but not collections, and terminations. The State may consider a different model in which carriers perform all billing functions, and the State coordinates with them on payment of Vermont Premium Assistance and Vermont cost sharing. The carriers and the state have agreed to delay this discussion until after 2014 and 2015 reconciliation and the performance of the current model post-system upgrades is evaluated.

- There are some changes in key personnel which could impact the system. Mike Morey from DII, who has been very involved in the VHC system development, is leaving for a private sector positon. Dan Smith, Deputy Chief Information Officer at AHS, is retiring.

2. Timing and Schedule

- The ability to do change of circumstances in-house is a critical step for VHC. Although the capacity was added at the end of May, its rollout involves training staff. Addressing the backlog has been ramping up in the initial months. The backlog has been reported as follows:
    - May 26th backlog - 10,272
    - July 6th Backlog - 7,372
    - July 22 backlog - 6,509

  Substantial elimination of the backlog by October will require continuing to increase capacity to address these cases. The goal is to eliminate the backlog by October 2015, before the start of the new open enrollment.

- There has been an increase in premium transaction errors since the May system upgrades. These are called "834" errors. The July 22nd report indicates that there were over 1,000 of such errors in early 2014 and that number had dropped to 20 by the end of May before the upgrade. The July 22nd Report indicated the number was just under 300. It is expected that this number will drop as improvements are made to the software. This will be important as the system moves toward open enrollment.

- Reconciliation of billing for FY 2014 and FY 2015 is under way
    - Initial reconciliation of FY 2014 cases is almost complete with estimates of potential state cost being just under $2 million in state funds. The FY 2015 reconciliation is still in progress.
    - Efforts are being made to reduce root causes of discrepancies and create an automated reconciliation processes.
    - System revisions are underway to allow for better premium payment processing and acceptance of payments with small differences to actual bills. The hope is to have this completed by October.

- Maintenance of performance metrics for call centers and system access
    - Call center and system functionality has remained strong. In the past month the telephone wait times have risen to 31 seconds from 12 seconds but it is too early to say if this is a trend. Page load time continues down and is at its fastest point in the past three months at an average wait of .5 seconds.

3. Budgetary Concerns

a. Development

- In June, the CMS approved the Implementation Advance Planning Document (IAPD) submitted by the Health Services Enterprise Project Management Office. This is a unit of the AHS Central Office led by Stephanie Beck who manages the HSE. With this approval came approval of all contracts through the Optum contract Amendment 6. Amendment 6 covers work for the period February 22 to June 30, 2015. However, the Center for Medicaid Services (CMS) stated that any activities completed between the execution and approval dates will be reimbursed by the Center for Medicaid and CHIP Services (CMCS) at a reduced rate (down to about 55% essentially Medicaid match). This means that Vermont will not receive expected 90%-10% money for the 65% of the project costs attributed to CMCS during that preapproval period of the project. These decisions create unbudgeted state costs. The estimate related to Amendment 6 specifically is $862,000. The total amount of lost funding because of no enhanced match could reach $2.7 million.

b. Sustainability planning and long term costs

- State costs for ongoing operations of the various elements of the exchange may change from levels projected by the Administration early in the legislative session. There should be better information in the September reports. For reference :

	Governor's original FY 2016 Submission	FY 2016 as passed- revised	Revised Sustainability Budget submission to CMS
QHP	$ 8,084,664	$ 5,038,783	??
MAGI	$43,708,776	$37,339,540	??
State Fund Total	$27,740,501	$21,630,374	??
Grand Total	$51,793,501	$42,378,322	??

- Long term costs for maintaining the exchange will be addressed more in the October report.