Maryland Health Benefit Exchange Board of Trustees

November 12, 2014
1:00PM – 4:00PM
Maryland Department of Transportation
7201 Corporate Center Drive
Hanover, MD 21076

Members Present

Joshua M. Sharfstein, M.D.
Kenneth Apfel, M.P.A. (by phone)
Darrell Gaskin, Ph.D.
Jennifer Goldberg, J.D., LL.M.
Therese Goldsmith, J.D., M.S. (by phone)
Enrique Martinez-Vidal, M.P.P.
Thomas Saquella, M.A.
Ben Steffen, M.A.

Members Absent

Georges Benjamin, M.D.

Also in attendance: Carolyn Quattrocki, Executive Director at the Maryland Health Benefit Exchange (MHBE).

Opening and General Updates

Chairman Sharfstein welcomed everyone to the meeting.

Approval of Meeting Minutes

The Board reviewed the minutes for the October 21, 2014 and the October 23, 2014 Board meetings; no amendments were made. Commissioner Goldsmith motioned to approve the minutes, which was seconded by Mr. Martinez-Vidal. The Board voted unanimously to approve the October 21, 2014 and October 23, 2014 minutes.

IT Update

Isabel Fitzgerald, Secretary of the Department of Information Technology (DoIT), provided an update of the new IT system, which is on track to go live on November 15. Anonymous browsing of qualified health plans (QHPs) began on November 7, two days earlier than planned. As of November 12, 18,486 individuals used the anonymous browsing. The kickoff week will begin with an enrollment fair on November 15, where consumers will be able to submit applications for QHP coverage. On November 16, the Call Center will begin to accept applications. Connector Entities will start accepting applications on November 17, and local departments of health and social services will begin accepting applications on November 18. Consumers will be able to self-enroll in coverage through the Maryland Health Connection (MHC) website beginning on November 19. Secretary Fitzgerald reported that all of the IT milestones and activities have been completed; all that remains is the go-live scheduled for November 15.

Secretary Fitzgerald next provided an overview of the status of the 14 main areas of the IT system. The application, including a Spanish version, is complete and ready for use. The IT system was extensively tested with 3,501 user acceptance training scenarios, and no critical or high defects were found. Twenty-seven low or moderate defects have been deferred to future releases, and manual business processes have been developed to address these defects during this open enrollment. Full regression testing was completed in the production environment. Despite extensive testing, there will be unexpected events that arise during real-life use, and there may still be references to AccessCT, the Connecticut version of the IT system. On November 3, 200 people from Deloitte, Xerox, and the MHBE tested the system, using any scenario they wanted. This testing went very well, and no systematic issuers were found. This gives the IT team confidence that the system will perform well in a real world situation. The IT team completed 147 performance and 3 endurance tests. The average page response time is under two seconds. Certain

functions, however, are expected to take longer due to greater complexity, but are still within expected margins. Secretary Fitzgerald noted that the IT team was not able to test live with the federal hub, so there could be latency effects. However, the system performed well under simulated testing, using a "mirror" of the federal hub, so it is expected to perform well when it goes live and the actual federal hub is available. All of the hosting, staging, and production environments have been established and tested. If needed, capacity can be increased in less than two hours, and the hosting is being fully monitored this year. The IT team has established and smoke-tested a disaster recovery environment, which has asynchronous replication, so, if the system goes down, no more than two hours of data will be lost.

Secretary Fitzgerald next provided an update on carrier management. All carriers have renewed and signed off on their plans. The 834 enrollment transactions have been tested extensively with 150 unique scenarios, including 68 complex scenarios, and all of the carriers can perform common activities. The user acceptance training environment was opened to carriers, allowing carriers to create their own scenarios and follow those scenarios throughout the entire process. Fixes for four moderate defects—related to a consumer making multiple changes in one day—are being deferred to future releases. During the first week of open enrollment, 834 enrollment files will be manually inspected for extra quality assurance. Outstanding considerations for carrier management include renewals in the carrier system, 2014 interim changes, and the fitness of the carriers' systems, as the IT team has little visibility into carriers' changes or testing. A dedicated electronic data exchange (EDI) team will be addressing any issues that arise with the 834.

The 8001 interface (the Medicaid interface) has been tested extensively from end to end. The IT team tested 335 scenarios and did not find any open high or critical defects. Secretary Fitzgerald reported that the computer-based training was provided to all participants, and the train-the trainer program helped refine the business processes. Instructor-led training is almost complete and will be finished by the go-live date —450 individuals will receive training in the final week. Training is required before access to the system is granted. Training included extensive scenarios-based training and specialized training for the level 2 help desk.

Secretary Fitzgerald reported that a change agent network of stakeholders was established for organization change management. The IT team mapped 176 business processes across the state. The IT team has worked to overcome negative perceptions from last year and providing access to the new system has inspired more confidence among the network. Secretary Fitzgerald noted that the Call Center is prepared for open enrollment with 348 trained representatives, which is more than last year. The tier 3 help desk is in place to provide technical assistance. Secretary Fitzgerald reported that the IT team developed an extensive incident management process. All of the handoffs and relationships between the different tiers and vendors have been mapped. The command center will monitor this for the first few weeks, and, if everything goes as expected, the standard incident management will be implemented around December 1.

Secretary Fitzgerald noted that the IT team will have to ensure that there is sufficient site support coverage for the concurrent enrollment fairs being held during the kick-off week. The launch for open enrollment is ready. The phased rollout starts with enrollment fairs on November 15, and self-enrollment will begin on November 19. This will maximize preparedness and minimize risk. Because this is a new system, operational items and issues will arise despite extensive planning. The IT team has a robust incident management process in place to quickly address issues that may arise. The next stage is transitioning from project to program. Secretary Fitzgerald noted that success is not synonymous with perfection; rather success is a well functioning website with a team that can quickly address any issues that may arise. All of these 14 areas are ready for the launch of open enrollment.

- Mr. Martinez-Vidal asked about the contingency plans if the connection with the federal hub does not function properly. Secretary Fitzgerald responded that the IT system was tested with the informal hub that was available for states to use, and a live connectivity test was successfully performed recently. These are good indicators that they system will function properly. However, if there is a problem with the federal hub, the contingency plan is to calculate the tax credits using local data. If a consumer's identity cannot be verified, then the consumer can try again later or the

consumer can contact the Call Center or a local department to verify the identity manually. Similarly, if a consumer's income cannot be verified through the Federal hub, then the consumers can upload verification of income. Secretary Fitzgerald noted that the Federal hub is currently live, and the IT system was able to connect to it last week. The IT will perform live on November 15.

- Ms. Goldberg asked about the training that still needs to be completed. Secretary Fitzgerald responded that training with 27 "super-users," who have a broader ability to perform functions, and other specialized training is scheduled and will be completed before open enrollment begins.
- Chairman Sharfstein noted that the test with real people performed on November 3 inspired much more confidence in the new system.

Maryland Health Quality and Cost Council

Chairman Sharfstein introduced the next speaker, Dr. Roger Merrill, the former Chief Medical Officer at Perdue Farms and a member of the Maryland Health Quality and Cost Council. Chairman Sharfstein explained that there has been a large growth of high deductible health plans in the private market. The Health Quality and Cost Council has been examining the scope of this trend and exploring alternatives, particularly value based insurance design (VBID). The Council has held multiple public meetings with experts advising the council on VBID, and a workgroup focusing on VBID was formed. Today, Dr. Merrill is presenting recommendations sent by the Council for the Board's consideration. This is an introduction, and no vote will be held.

Dr. Merrill provided an overview of VBID plans as an alternative to high deductible health plans. He noted that high deductible health plans have been used to control rising health care costs. In 2012, concerns were raised about the increased enrollment in high deductible plans and their effect on patient outcomes, especially low-income patients who cannot afford the high deductibles. High deductible plans encourage the use of expensive health care services independent of their health value over lower cost services that are known to be effective. In 2013, in response to this issue, the Council hired Mark Fendrick, the head of the University of Michigan VBID Center as a consultant to provide recommendations on promoting VBID in Maryland, and the VBID Committee was formed. Dr. Merrill noted that Perdue experimented with VBID plans for five years, so he has firsthand experience with how VBID plans work.

Dr. Merrill explained that VBID plans are designed to engage members in their health through a benefit plan that promotes wellness, encourages access to high value clinical services, and discourages the use of low-value health services. The VBID plan promotes wellness by incentivizing primary and preventive care; incentives may be financial but often are in another form. The plan encourages the use of high-value services by removing financial or time barriers. High-value services include evidence-based treatment of medical conditions, such as high blood pressure, diabetes, asthma, depression, and congestive heart failure. Low-value interventions discourage the use of health services that have proven low or negative health value. Examples of low-value services include but are not limited to lower back surgery, angioplasty and stenting, nuclear cardiology, and sinus surgery. Dr. Merrill reported that the Council recommends at least three health wellness incentives be available to all plan members. There should be incentives to use high-value services that relate to at least three medical conditions. Dr. Merrill noted that Perdue Farms provided preventive care at a lower cost for seven common conditions. VBID plans should also provide disincentives to discourage low-value services for at least three medical conditions. Dr. Merrill cautioned that all incentives and disincentives in a VBID plan must be evidence-based, supported by professional organizations, and affect a meaningful number of members when implemented. The mandated preventive benefits under the Affordable Care Act will not be considered high-value services.

Dr. Merrill reported that there is substantial evidence that a balanced approach that encourage the use of high-value services and discourages the use of low-value services improves health and lowers cost. As a result of VBID plans, the health of Perdue's associates has measurably improved, and the costs of this group have declined to less than 40 percent of the national average.

Dr. Merrill reported that there are three options for the Board to consider. First, the Board could advise carriers of the VBID definition and encourage them to adopt the VBID for at least one of their plans.

Second, the Board could require that at least one QHP at each metal level meet the VBID definition. Third, the board could require all QHPs to meet the VBID definition. Chairman Sharfstein noted that the Board is aware that high deductible health plans are a challenge for consumers, and that possible alternatives, such as VBID plans, are available. Moving forward the Board will have the opportunity to consider these alternatives.

- Ms. Goldberg asked if consumers were involved in the council or committee. Chairman Sharfstein responded that a variety of stakeholders are involved in the committee, including a consumer advocate. The committee has also received feedback through the public comments period.
- Mr. Saquella asked if Perdue is self-insured or has an insurer. Dr. Merrill responded that Perdue is self-insured.
- Mr. Saquella asked how carriers have reacted to the VBID. Chairman Sharfstein responded that carriers have adopted a number of VBID features in different ways. The issue for the Council to consider was whether Maryland should adopt formal organization of VBID plans. He noted that the proposal allows carriers flexibility in selecting the medical conditions and treatments but there should still be transparency.
- Dr. Gaskin thanked Dr. Merrill for the presentation and stressed the importance of this issue. He asked if Perdue received pushback from employees when the VBID was implemented because, in the past, consumers have push backed against cost containment measures. Dr. Merrill responded that there was less pushback than expected; he received less than ten calls regarding the treatments being discouraged. He noted that the VBID plan will pay for a low-value procedure if it is medically appropriate. Perdue selected seven low-value services based on very clear evidence and received little pushback.
    - Dr. Gaskin asked if Perdue educated employees regarding the changes. Dr. Merrill responded that a little education was done, but it is difficult to educate their workforce. Perdue does provide an on-site clinic, so there is active involvement in their employees' health.
- Chairman Sharfstein noted that this was the introduction to VBID and that an appropriate next step may be for interested Board members to review all the information and come back to the Board with a suggested approach.
- Mr. Steffen asked if other states are using VBID features in their QHPs. Chairman Sharfstein responded that he is not aware of any states. Chairman Sharfstein noted that in the private sector, self-insured plans are utilizing VBID measures.
- Mr. Martinez-Vidal asked whether there is any analysis available regarding the VBID's reduction of premiums. Chairman Sharfstein noted that one of the issues to explore is how the VBID plans would translate from the private sector to the exchange.

Ms. Goldberg, Dr. Gaskin, Mr. Martinez-Vidal, and Mr. Apfel volunteered to continue to examine the VBID proposals.

Communications Update and Advertising Preview

Andrew Ratner, Director of Marketing and Outreach at the MHBE, provided an update on the marketing and outreach campaign. Mr. Ratner presented a sample commercial that is available on the MHC YouTube channel, and will run on television during open enrollment. The commercial features actual enrollees from last year instead of actors. The outreach for this open enrollment has been informed by last year's experiences, as well as consumer surveys and focus groups. A large challenge is educating consumers, particularly the target audience in a shorter timeframe, since open enrollment is only three months long this year. The main message of the outreach campaign is affordability, as that has been shown to be the largest concern and motivator of consumers. Anonymous browsing of QHPs began on November 9, and 1,000 consumers discovered the browsing before it was announced.

Mr. Ratner reported that Weber Shandwick is forming relationships with Spanish television channels, Afro American Newspaper, and other community organizations to reach minority audiences. There is greater use of social and digital media this year, including digital advertising on job search sites and on hundreds of youth-oriented online games and websites. More than half of visitors access the MHC website directly, while 25 percent access it through Google and other search engines. An email marketing campaign will be used to follow-up with additional assistance for website visitors. Pamphlets and factsheets in both

English and Spanish will be distributed to hospitals, social service agencies, community organizations, and retail stores. Mr. Ratner noted that social media outreach continues to be expanded through Facebook, Twitter, and YouTube, and the MHC social medial channels will be used to provide real-time customer support to improve consumer sentiment and relieve Call Center wait times.

Leslie Lyles Smith, Director of Operations at the MHBE, provided an overview of the Connector Entity outreach. Each Connector Entity must have at least four enrollment events during open enrollment, though many will have more. Connector Entities have completed targeted outreach, contacting consumers they assisted during the last open enrollment by either phone or letter. Connector Entities will operate enrollment storefront sites at locations through each region, as these were successful last year. A list of all of the enrollment sites will be available online. Ms. Lyles Smith noted that the local departments of health and social services may assist eligible individuals enroll in Medicaid. The Call Center and Connector entities are prepared for the launch. Insurance brokers are also prepared, and may participate in enrollment events. This year, the brokers have a new website with more functionality and are expected to be more engaged in the open enrollment process.

Maryland Health Connection Quality Report

Mr. Steffen provided an update regarding the MHC Quality Report. He thanked Charmaine Robinson, the head of the health plan performance guide effort at the Maryland Health Care Commission (MHCC). The QHPs offered through the MHC have a star designation based on a five-star rating system. This rating system is built off of MHCC's long-standing health plan performance guide. Plans are scored across six measures during the standard quality report, but the MHC uses a composite score, which is a weighted score. In order of descending importance, the composite score includes the following measures: health plan performance on clinical Healthcare Effectiveness Data and Information Set (HEDIS) measures; consumer satisfaction measures, including measures from the Consumer Assessment of Health Care Providers and Systems (CAHPS) survey; structural assessment on the scope of provider network; qualitative assessment on the types of quality improvement initiatives; and a method to estimate the ability of plans to address race, language, and cultural competency.

Mr. Steffen explained that information is not yet available for people enrolled in QHPs last year. Therefore, the ratings for the QHPs are based on information from health plans' total enrollment. All of the plans that had data available received a score between three to four stars. Two plans, Evergreen and Allsavers, did not exist in 2013, so no data were available to rate these plans. In future analysis, the focus will be on the population in the exchange, but the small sample of exchange enrollees will need to be balanced with all other health insurance enrollees in the state. Mr. Steffen noted that Michele Eberle, Executive Director of the Maryland Health Insurance Plan and Interim Director of Plan Management at the MHBE, made significant contributions to the quality report.

- Chairman Sharfstein asked if it is true that not all states have a star rating for their QHPs. Mr. Steffen confirmed that not all states have a star rating. He noted that there is an increased focus on consumer satisfaction ratings rather than on just the clinical HEDIS measures, and this will be a focus in future evaluations.
- Mr. Martinez-Vidal asked if a plan has to have above the 75 percentile of the national benchmark to achieve a five-star rating. Mr. Steffen confirmed that this is accurate.
- Mr. Martinez-Vidal then asked about the weak points that are preventing plans from achieving five stars. Mr. Steffen responded that there are different gaps in clinical measures across the plans and asked Ms. Robinson to elaborate. Ms. Robinson explained that all plan performance rates reported during the comprehensive quality report were used to calculate the star rating. This included 100 measures, with the clinical measures given the most weight. She reported that certain clinical measures, such as blood pressure goals and other preventive measures, had lower scores, which prevent a five-star rating. She added that the comprehensive quality report provides more detail on the measures and is available online.
    - Mr. Steffen noted that two more quality reports will be published this year. The MHCC is focusing on benchmarking Maryland against the best in country moving forward. Ms. Robinson noted that national benchmarks are available in the comprehensive quality report.

Closed Session[1]

Chairman Sharfstein announced that the Board would be moving into a closed session. He explained that the purpose of the closed session is to obtain legal advice and comply with a specific statutory requirement that prevents public disclosures about a particular proceeding or matter. Topics to be discussed include:

- Obtaining legal advice regarding the contractual obligations for potential funding of Health Care Access Maryland (HCAM) enrollment unit services;
- Obtaining legal advice regarding a potential emergency procurement related to the Project Management Office (PMO);
- Obtaining legal advice regarding contractual modifications to two Xerox contracts;
- Obtaining legal advice regarding potential modification to the NavMP contract, one of the project management office contracts;
- Obtaining legal advice on the modification of memoranda of understanding (MOUs) with other government entities, specifically the Connecticut training MOU;
- Obtaining legal advice on a potential task order award to Deloitte; and
- Discussing closed meeting minutes.

Mr. Apfel motioned to move into closed session, which was seconded by Mr. Martinez-Vidal. The Board voted unanimously to move into closed session. For topics discussed and actions taken, please see the Statement for Closing a Meeting dated November 12, 2014.[2]

Voting Session

Chairman Sharfstein noted that the first motion for the Board to consider is whether to authorize a maintenance, operations, and enhancement task order with Deloitte. The original contract with Deloitte provides the option for a task order for maintenance, operations, and other services. Secretary Fitzgerald believes a task order for six months, ending June 30, 2015, is necessary because Deloitte has successfully developed the new system. After the task order ends in six months, Secretary Fitzgerald will lead a competitive procurement for maintenance of the system. This task order has three services. It includes level one services, consisting of basic software support with 1,100 hours a month at an amount not to exceed $1,003,106. The second item is level one operations, which includes operations support and system testing at $344,903 a month, for a total not to exceed amount of $2,586,774 through June 30, 2015. The third item is level two support service enhancement, which is the ability to implement large enhancements, at an amount not to exceed $2 million. Service enhancements are at the sole discretion of the MHBE and based on available funding. The total not-to-exceed amount for the task order is $5,589,880.

Mr. Apfel motioned to adopt the recommendation, which was seconded by Mr. Martinez-Vidal. The Board voted unanimously to adopt the recommendation.

Chairman Sharfstein noted that the second action for the Board to consider is an extension of the PMO contracts. The PMO performs many activities including testing the code, organization change management, incident management, system testing, electronic data interchange support, managing the Medicaid system, security policies, network configuration, and overseeing the schedule. The Board previously extended the PMO through the end of December. Secretary Fitzgerald is recommending reducing the PMO from seven vendors to five. She is also recommending extending it into the next calendar year with the option of two six-month extensions after that. The PMO will become smaller and more efficient as the IT system moves into the next stage. Chairman Sharfstein noted that all of the PMO contract modifications are being done under the Board's emergency procurement authority because it

[1] State Government Article § 10-508(a)(7) allows a closed session to consult with counsel to obtain legal advice. State Government Article § 10-508(a)(13) allows a closed session to comply with a specific constitutional, statutory, or judicially imposed requirement that prevents public disclosures about a particular proceeding or matter.

[2] Statement for Closing a Meeting, 11/12/2014. *Available at:* http://marylandhbe.com/wp-content/uploads/2014/11/Closed-Meeting-Statement-111214.pdf.

would be an intolerable risk to hire new vendors who are not as familiar with the system, considering the system is just starting. Each of these PMO vendors trace back to competitive procurement, and the rates are not changing. As such, Chairman Sharfstein requested a motion to extend the following contracts:

- Arkenstone Technologies, which runs organization change management and incident management, for an amount not to exceed a $362,515.
- Software Consortium, which is involved with network configuration, firewall infrastructure, and hosting support for an amount not to exceed $285,500.
- TMI Solutions, which handles security issues and ensures that policy, procedures, and documentation are up to date, for an amount not to exceed $198,200.
- Navigator Management Partners, or NavMP, provides program managers, trainers, and business process change management consultants as well as performs work assignment management, program management, schedule management, and plan management. The extension is for an amount not to exceed $5,242,000.
- J. Cain & Company is responsible for quality assurance testing, some of critical electronic data interchange with plans, and reporting. The extension is for amount not to exceed $1,315,800.

Dr, Gaskin motioned to authorize the contract extensions, which was seconded by Mr. Steffen. The Board voted unanimously to authorize the contract extensions.

Chairman Sharfstein noted that the third motion for the Board to consider is a modification to the contract with NavMP, the largest PMO vendor, for this year. NavMP has been logging more hours than expected in support of training across the state, including training for the level two helpdesk, which was not originally planned. While the rates will not change, the current contract for this calendar year is for $3.5 million; the modification would increase this amount by $700,000 for a total of $4.2 million.

Mr. Martinez-Vidal motioned to authorize the contract modification, which was seconded by Dr. Gaskin. The Board voted unanimously to authorize the contract modification.

Chairman Sharfstein noted that the forth action for the Board to consider is the approval of a fuller description of a previously approved contract with J. Cain and Company. At the time the contract was approved, all resources were not correctly listed. The resources include a project manager, two testers, one specialist in reporting, and one specialist in insurance company transactions. Chairman Sharfstein noted that the previously approved budget is correct and the work has been performed correctly; the motion is just to approve the more accurate list of resources.

Ms. Goldberg motioned to adopt the motion, which was seconded by Mr. Steffen. The Board voted unanimously to adopt the motion.

Chairman Sharfstein noted that the fifth action for the Board to consider is whether to authorize an amendment to the Connecticut training MOU. Connecticut has sent a team of health insurance exchange trainers, which has been a great help to Maryland. Secretary Fitzgerald recommends extending the contract with an increased amount not to exceed of $300,000, instead of $225,000, as previously approved.

Mr. Saquella motioned to adopt the motion, which was seconded by Ms. Goldberg. The Board voted unanimously to adopt the motion.

Chairman Sharfstein noted that the sixth motion to consider is whether to authorize the cancelation of a previously approved emergency procurement with HCAM and replace it with a grant to HCAM to provide a dedicated enrollment support unit. HCAM is a Connector Entity that has been providing specialized assistance with life event changes in the current system, such as adding a new baby to a plan. The grant would be for $547,163 and would not change HCAM's work.

Mr. Apfel motioned to adopt the recommendation, which was seconded by Ms. Goldberg. The Board voted unanimously to adopt the recommendation.

Chairman Sharfstein noted that the last two motions for the Board to consider are modifications to the contract with Xerox. The first motion relates to Xerox's hosting solution. Xerox originally put forth its hosting solution proposal using repurposed hardware based on an inaccurate list of hardware from Noridian. The MHBE had to purchase additional hardware, and there were unexpected, but minor, software issues. The total amount of new hardware and software was $1.47 million, but the increase in the five-year hosting budget is only by $992,886.65 because Xerox came under their overall not-to-exceed amount. The increase is largely related to the need to purchase additional hardware due to Noridian's inaccurate list.

Mr. Steffen motioned to authorize the modification, which was seconded by Dr. Gaskin. The Board voted unanimously to adopt the modification.

The second Xerox contract modification for the Board to consider is whether to authorize the extension of a task order regarding the maintenance of the new front-page of the MHC website. The new, simpler design of the front page allows the MHBE to save money, which is partly due to the contributions of an individual hired through the Xerox contract. Secretary Fitzgerald recommends continuing this resource for an additional 1,100 hours at the same rate, for an amount not to exceed $135,300. This would extend support of the website through May 31, 2015. Chairman Sharfstein noted that this will reduce the amount the MHBE had previously spent.

Mr. Martinez-Vidal motioned to authorize the extension of the task order, which was seconded by Mr. Saquella. The Board voted unanimously to adopt the recommendation.

Commissioner Goldsmith was not present for the voting session.

Finance Committee

Mr. Saquella reported that the Finance Committee met on October 1 and will meet again on December 3 to hear staff recommendations. The committee hopes to recommend options regarding contract strategy and processes for discussion during the December Board meeting. More information will be sent to the Board by early December.

Adjournment

Chairman Sharfstein thanked the Board for their hard work and adjourned the meeting.