Report of the Vermont State Auditor

November 18, 2015

VERMONT HEALTH CONNECT

Status of Planned Enhancements

Douglas R. Hoffer
Vermont State Auditor
Rpt. No. 15-09

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Douglas R. Hoffer
STATE AUDITOR

STATE OF VERMONT
OFFICE OF THE STATE AUDITOR

November 18, 2015

Addressees (see page 3 of letter)

Dear Colleagues,

The State's implementation of Vermont Health Connect (VHC) as its health insurance marketplace exchange as required by the Patient Protection and Affordable Care Act had a rocky start with customer complaints regarding errors in their accounts and legislative and media scrutiny regarding missing system functionality and reported costs. As a result, during its 2015 session, the legislature considered whether the State should continue the VHC system or migrate to the exchange operated by the Federal government. Act 58 (2015) set expectations for VHC to meet certain outcomes by specific dates, such as automated change of circumstances (COC) and qualified health plan (QHP) renewals processes in May and October 2015, respectively.

We conducted an audit of VHC's progress in implementing planned changes to provide status information for the legislature. Accordingly, this report addresses whether expected software changes were made, the VHC upgrades that are planned, and the status of the most recent VHC security plan of action and milestones. This is our second audit of VHC (*Vermont Health Connect: Future Improvement Contingent on Successful System Development Project,* April 14, 2015).

The State deployed several software changes to the VHC system since the end of May 2015 that generally implemented the COC and QHP renewal processes called for in Act 58. Overall, the result of these changes appears positive in that customer complaints regarding the execution of their changes have been fewer and significant operational improvements have ensued. Nevertheless, the true test will come during the on-going open enrollment period (November 1, 2015 to January 31, 2016).

Despite the improvements, problems remain with the VHC system. For example, the software changes completed earlier this year were also supposed to include other enhancements, such as automated processes to conduct Medicaid renewals and reconciliations between VHC, the insurance carriers, and the premium payment processor, that either were not implemented or implemented only in part.

The State has scheduled other major enhancements to the VHC system, but there are significant uncertainties that could disrupt these plans. Specifically, as of October 30, 2015, Exeter Group—the subcontractor to Optum that makes changes to the OneGate™ product that is a core component of the VHC system—is no longer supporting this software or providing professional services regarding its implementation. OneGate™ is a fundamental part of the VHC system and is comprised of five components: (1) eligibility screening for Medicaid and QHP subsidies, (2) application processing, (3) plan selection, (4) customer account maintenance, and (5) case management.

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The State and its contractors have taken, or are in the process of taking, actions to mitigate this decision by Exeter Group, but there remain known defects in the OneGate™ product and it is unknown whether the latest version of this product to be used in the next major software change contains additional defects. This latter point is particularly important since Exeter Group had to fix significant defects in OneGate™ after the deployment of the software changes that added the automated COC and QHP renewals processes.

As of October 30, 2015, Vermont's latest plan of action and milestones shows that the VHC system had 121 outstanding security weaknesses, of which three were high risk and 63 were moderate risk. High risk is defined as a threat event that could be expected to have a severe or catastrophic adverse effect on organizational operations, organizational assets, individuals, other organizations, or the nation. Moderate risk is defined as a threat event that could be expected to have a serious adverse effect on organizational operations, organizational assets, individuals, other organizations, or the nation.

Lastly, during the course of our audit we found that the Department of Vermont Health Access (DVHA) authorized contractors to perform work using a document called an "authorization to proceed" letter that is not authorized by the State's procurement policy. The use of the "authorization to proceed" letters has the effect of circumventing the approval processes in the State's procurement policy. This audit report contains recommendations to the DVHA commissioner to immediately stop the use of these letters or to obtain approval of their use by the Secretary of Administration. In responding to a draft of this report, the Secretary of the Agency of Human Services stated that DVHA would seek approval for these letters from the Secretary of Administration going forward.

I would like to thank the management and staff at VHC and the Department of Information and Innovation for their cooperation and professionalism during the course of this audit.

Sincerely,

Doug Hoffer
Vermont State Auditor

ADDRESSEES

The Honorable Shap Smith
Speaker of the House of Representatives

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President Pro Tempore of the Senate

The Honorable Jane Kitchel
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Joint Fiscal Committee

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Introduction

Vermont Health Connect (VHC)—the health insurance marketplace exchange required by the federal Patient Protection and Affordable Care Act—provides private marketplace health insurance (known as qualified health plans or QHP) and Medicaid to thousands of Vermonters.[1] At the time of its launch in October 2013, the VHC system lacked major functionality including the ability to process customer changes (called change of circumstances[2] or COC) or to renew customer policies in an automated manner. At the time of our April 2015 report on VHC,[3] these weaknesses remained.

During its 2015 session, the legislature considered whether the State should continue the VHC system or migrate to the exchange operated by the Federal government. Act 58 (2015) set expectations for VHC to meet certain outcomes by specific dates. In particular, VHC was to implement changes to the "back end" technology to support COC as of May 31, 2015 and perform automated renewals of QHPs by October 1, 2015. Act 58 also required the Secretary of Administration and the Chief of Health Care Reform to identify and explore alternatives to VHC. This analysis was completed in early November 2015.[4]

We conducted an audit of VHC's progress in implementing planned changes to provide status information for the legislature. Our objectives were to: (1) determine the extent to which expected requirements were implemented as part of VHC's Release 1 and Release 2AB through October 2015, (2) describe planned future VHC upgrades, and (3) summarize the most recent status of VHC's implementation of its security plan of action and milestones (POAM).

Appendix I contains detail on our scope and methodology. Appendix II contains a list of abbreviations used in this report.

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[1] The VHC operations director reported that the VHC system included 31,719 individuals enrolled in QHPs and 87,026 covered by Medicaid in September 2015.

[2] This report uses the term change of circumstances for both changes that are merely changes in information (name, address, phone number) and changes that are more complex and involve redetermination of eligibility (circumstances).

[3] *Vermont Health Connect: Future Improvement Contingent on Successful System Development Project*, (Rpt. No. 15-03, April 14, 2015).

[4] *Vermont Health Connect: Exchange Options for 2017* (November 2, 2015).

Highlights: Report of the Vermont State Auditor

Vermont Health Connect: Status of Planned Enhancements

(November 18, 2015, Rpt. No. 15-09)

Why We Did this Audit	Act 58 (2015) requires the Administration to meet certain deadlines to implement critical Vermont Health Connect (VHC) changes and to provide a recommendation on its future. We conducted an audit of VHC's progress in implementing planned changes to provide status information to the legislature. Our objectives were to: (1) determine the extent to which expected requirements were implemented as part of VHC's Release 1 (R1) and Release 2AB (R2AB) through October 2015, (2) describe planned future VHC upgrades, and (3) summarize the most recent status of VHC's implementation of its security plan of action and milestones (POAM).
Objective 1 Finding	VHC software change releases in May 2015 (R1) and October 2015 (R2AB) implemented some critical requirements as expected, but other functionality was not implemented. As called for in Act 58, as of October 2015, VHC implemented automated change of circumstances (COC) and qualified health plan renewals functionality, although manual intervention is needed to process some types of changes. In particular, five COC types require manual intervention because of a software defect or because they are not supported by the VHC software. In other cases, however, the manual intervention is for business reasons because the COC type is complicated or requires VHC to grant an exception to a standard business process. VHC's operations director estimated that 90-95 percent of changes can be made using the automated COC process. Other requirements contained in amendments 6 and 8 of the system integrator's contract (Optum) that were to be included in R1 and R2AB, respectively, were not fully implemented. For example, according to amendment 8, R2AB was to include a renewals process for Medicaid, but this change was not made. The State and Optum mutually agreed to the reductions in the R1 and R2AB scopes from those contained in amendments 6 and 8. Overall, the results of R1 and R2AB deployments appear positive, although the true test will come during the open enrollment period (November 1, 2015 to January 31, 2016), and problem areas remain. For example, in October 2015 Vermont's Office of the Health Care Advocate, which provides consumer assistance, reported that its COC cases have been reduced, but VHC billing issues have increased. Operationally, VHC has seen significant improvements. For example, in April we reported that (1) it took an average of 2.5 hours of VHC staff time to process a COC and (2) the backlog of unprocessed COCs was 7,256 as of March 9, 2015. Now, most types of changes can be entered by customers or be processed with limited VHC staff member intervention, and the inventory and backlog of changes has been greatly reduced. While it is too early to tell the extent to which the State will achieve operational improvements from Release 2AB, it is likely to be significant since the onerous manual processes utilized during the last renewal period will not be used. There are two operational areas that have had at least a temporary degradation after R1 deployment—enrollment file transmissions to the carriers (called the 834 file) and system maintenance and operations. VHC transmits an 834 enrollment file to insurance carriers with data about a household's enrollment information. The average number of 834 errors (i.e., customer records not successfully processed) more than doubled after R1 deployment, although in early October the number of errors began to decline. The number of open maintenance and operations tickets began to increase in early June 2015 and has remained at much higher levels than the four months prior to the deployment. In many cases, open tickets were the result of software releases deployed with uncorrected system defects.

Highlights (continued)

Objective 2 Finding	There are several major efforts planned to improve system functions related to exchange requirements, although significant uncertainties regarding these efforts remain. For example: • The State decided to deploy other major software change releases in December 2015 and, tentatively, February 2016. As of November 6, 2015, the State and Optum had not signed a contract amendment consistent with this decision. Moreover, the ability of the State and Optum to implement future changes has been made more difficult by an Optum subcontractor's decision to stop supporting the OneGate™ product—a core component of the VHC system—on October 30, 2015. This subcontractor will also no longer provide professional services to support VHC's implementation of OneGate™. The State and its contractors have taken, or are in the process of taking, actions to mitigate this decision by the Optum subcontractor. • The VHC system is not in compliance with Medicaid's billing requirements, and delinquent Medicaid accounts in the VHC system have not been terminated. The State requested that its VHC premium processor, Benaissance, provide a quote to implement a Medicaid billing solution. As of November 6, 2015, no decision on whether to implement the Benaissance proposal had been made. • The VHC system's functionality to implement the federally required Small Business Health Options Program (SHOP) did not work, so the State opted to have small employers enroll directly with the VHC carriers for the 2014, 2015, and 2016 plan years. The State decided to contract for a SHOP solution to handle plan year 2017 and intends to seek bids from vendors who have successfully implemented SHOP in other states. As of October 26, 2015, the State was working on SHOP bid documentation and requirements. Concurrently, the State is considering seeking a waiver from the Centers for Medicare and Medicaid Services (CMS) to exempt the State from implementing this system functionality.
Objective 3 Finding	Vermont submitted its latest VHC system security POAM to CMS on October 30, 2015, listing 121 remaining outstanding security weaknesses, of which three were high risk and 63 were moderate risk. CMS defines high risk as a threat event that could be expected to have a severe or catastrophic adverse effect on organizational operations, organizational assets, individuals, other organizations, or the nation. Moderate risk is defined as a threat event that could be expected to have a serious adverse effect on organizational operations, organizational assets, individuals, other organizations, or the nation.
Other Matter	During the course of the audit, we became aware that the Department of Vermont Health Access (DVHA) was not complying with the State' procurement policy, Bulletin 3.5. In particular, between July and October 2015, DVHA's Commissioner signed agreements that authorized two contractors (including Optum) to perform work in anticipation of a contract amendment. As of November 6, 2015, DHVA had not signed contract amendments pertaining to these agreements. Bulletin 3.5 does not authorize or even mention these types of arrangements, and there is no evidence that DVHA sought approval from the Secretary of Administration to use such documents to procure services.
Recommendations	Because the objectives of this report were to provide a status update for information purposes, we are not making recommendations pertaining to our three objectives. We are making recommendations pertaining to DVHA's non-compliance with the State's procurement policy.

Background

The federal Patient Protection and Affordable Care Act requires the establishment of health insurance marketplaces (also called exchanges) in each state to assist consumers and small businesses in comparing, selecting, and enrolling in private market insurance plans. These exchanges were intended to provide a seamless, single point-of-access for individuals to enroll in health plans, apply for income-based financial assistance, and, as applicable, obtain an eligibility determination for other health coverage programs, such as Medicaid. States could elect to establish and operate their own exchange or rely on the federal exchange operated by CMS.

Vermont elected to develop its own exchange, VHC, which went live on October 1, 2013. VHC had a rocky start and was subject to customer complaints regarding errors in their accounts and legislative and media scrutiny regarding missing system functionality and reported costs.

Problems with the VHC implementation led the State to transition to a new system integrator—Optum—as of October 1, 2014. The state has three contracts with Optum related to VHC: (1) VHC system design, development, and implementation activities, (2) VHC maintenance and operations, and (3) hosting services. Other vendors also play a critical role. For example, until recently, as a subcontractor to Optum, Exeter Group, Inc. provided software changes to the OneGate™ Health Insurance Exchange, which is a core component of the VHC system.[5] In addition, the State contracts with Benaissance to provide premium payment processing and with Archetype Consulting, Inc. to provide reporting capabilities.

The following explains the terminology used in this report. There are many VHC components, which include several integrated commercial-off-the-shelf products as well as interfaces with other systems (both internal and external to the State). For purposes of this report, we generally do not distinguish between the different VHC technical components; instead we use the term "VHC system" to improve readability. In addition, there are several State entities that work together to provide critical VHC system and operational support, including the Agency of Human Services' Department of Vermont Health Access and Department for Children and Families and the Agency of Administration's Department of Information and Innovation (DII). In September 2014, the Governor required all department and agency resources responsible for portions of VHC to report through a single chain of

[5] As of October 30, 2015, Exeter Group stopped providing support services to OneGate™.

command. Unless we judged it important to a particular issue, we use the terms "the State" and VHC in the report rather than distinguish a specific organizational entity or combination of entities.

Objective 1: Automated COC and QHP Renewal Processes Generally Implemented, but Other Functions Were Not

VHC's R1 and R2AB software change releases deployed in May 2015 and October 2015, respectively, generally addressed the expected outcomes in Act 58 (2015), namely, to support automated COC and QHP renewals processes. However, these software releases did not fully implement the requirements contained in the State's contract with Optum. Nevertheless, it appears that R1 and R2AB have reduced customer complaints regarding the execution of their changes and led to significant operational improvements. The true test of the effectiveness of R1 and R2AB will be how well the VHC system and operations work during the on-going open enrollment period. Two operational areas—the submissions of enrollment files to the carriers and system maintenance and operations—have been at least temporarily degraded since the implementation of R1.

Status of Implementation of Act 58 VHC Outcome Requirements

Section C.106.2 of Act 58 (2015) contains the following VHC expected outcomes:

- On or before May 31, 2015, the VHC vendor shall deliver an information technology release providing the "back-end" of the technology supporting COC[6] changes.
- On or before October 1, 2015, the VHC vendor shall deliver an information technology release providing for the automated renewal of qualified health plans.
- On or before October 1, 2015, VHC customer service representatives shall begin processing new COC requests received in the first half of a month in time to be reflected on the next invoice and shall begin processing requests for changes received in the latter half of the month in time to be reflected on one of the next two invoices.

[6] For purposes of this report, we are using the term COC to include both changes in circumstances and changes in information.

VHC deployed R1 during the last weekend in May 2015 and R2AB during the first weekend of October 2015, which included automated COC and renewals processing, respectively. In addition, changes to the software product to address critical defects found during R1 and R2AB testing were implemented on August 24, 2015 and October 21, 2015, respectively.

These deployments generally implemented the expected automated COC and QHP renewals processes called for in Act 58. In the case of the COC implementation, there remain types of these changes that require some manual intervention by VHC staff. Specifically, of the 34 types of COCs identified by VHC, the "back-end" technology (i.e., available for use by VHC staff) for 26 types (76 percent) was fully automated while 8 (24 percent) need some degree of manual intervention by VHC staff in order to process correctly. Such intervention may be significant, such as the use of a manual workaround to add a newborn, while others require little effort (e.g., the removal of a household member may require a staff member to resend a file to the carriers). Five of the COC types require manual intervention because of a software defect or because they are not supported by the VHC software. In other cases, however, the manual intervention is for business reasons because the COC type is complicated or requires VHC to grant an exception to a standard business process. VHC's operations director estimated that 90-95 percent of changes can be made using the automated COC process. Appendix III summarizes the automation status for 34 types of COCs identified by the VHC operations unit.

VHC has not yet implemented processes to determine whether it is meeting Act 58's expectations that it make customer changes in a timely manner. VHC is in the process of developing reports to track the performance in the processing speed of new COC requests. These reports are expected to be available in November 2015.

Status of Implementation of Optum Contract Requirements

Consistent with Act 58, amendment 6 of the Optum contract required that the "back-end" of an automated COC process be implemented by the end of May 2015 (R1). Amendment 8 of the Optum contract required the implementation of an automated QHP renewals process, as called for in Act 58, be completed by October 2015 (R2AB). The amendments also required Optum to implement other functional changes to the VHC system as part of R1 and R2AB.

While some of the enhancements required by amendments 6 and 8 were implemented as expected, others were partially implemented or were not implemented at all. Table 1 lists selected contractually required functional enhancements and describes their implementation status as of the end of

October 2015. The State and Optum mutually agreed to the reductions in the R1 and R2AB scopes from those contained in amendments 6 and 8.

Table 1: Summary of Implementation of Selected Contractually Required R1 and R2AB Enhancements as of the End of October 2015

Enhancement per Optum Contract	Status in October 2015	Comment
Release 1 (Due May 2015 per Amendment 6)		
Automated COC to the extent supported by OneGate™ software version 3.3.2.10[a] (changes to be made by VHC staff, not directly by customers, which was not required until R2AB as described below)	Partially implemented	Manual intervention by VHC staff is needed for five COC types because the VHC software either does not support automated processing or there is a software defect (see Appendix III). One of these types (addition of a newborn) is not included in OneGate™ software version 3.3.2.10, so it was not required to be deployed as part of R1. VHC's operations director estimated that 90-95 percent of changes can be made using the automated COC process. This enhancement area in contract amendment 6 also included requirements for prorated billing and refunds, but these were not implemented.
Notices for eligibility decisions and COC	Implemented	
ACCESS[b] integration and defect correction	Partially implemented	A defect pertaining to how an individual under the age of 19 with children is treated under Medicaid requirements was not implemented.
Reconciliation of VHC, carriers, and Benaissance systems	Not implemented	The State decided that the solution delivered by Optum did not meet its reconciliation needs. The State plans to have its VHC reporting contractor (Archetype) develop an automated tool to perform this function in 2016 instead. As of November 6, 2015, there was no contract in place with Archetype to perform this work.
Eligibility and enrollment requirements to the extent supported by OneGate™ software version 3.3.2.10[a] • Eligibility history • Medicare eligible • Alternate address • Social security number and temporary social security number • Exemption processing • Exemptions to the 5-year bar for non-citizens[c]	Partially implemented	Implemented • Exemptions to the 5-year bar for non-citizens[c] • Medicare eligible (partially implemented) Not Implemented • Eligibility history • Alternate address • Social security number and temporary social security number • Exemption processing

Enhancement per Optum Contract	Status in October 2015	Comment
Release 2AB (Due October 2015 per Amendment 8)		
Automated renewal processing for QHP and Medicaid[d]	Partially implemented	An automated renewals process was implemented for QHP, but not Medicaid. A Medicaid renewal process is expected to be in VHC's next major software change release (Release 2C). Contract amendment 8 also included the implementation of a billing process compliant with Medicaid rules as part of this enhancement area, but this was not implemented. See Objective 2 for more information on Medicaid billing.
COC customer service (changes can be made by customers via the VHC website)[d]	Partially implemented	23 of the 34 COC types could be made by customers on the VHC website in October (see Appendix III for a list of those changes). VHC has not estimated the number of changes that customers will submit through the VHC website, but the VHC operations director indicated that she thought that with the addition of income changes to the self-service process (November 1, 2015), about three quarters of all customer changes could be made by customers themselves via the VHC website rather than by VHC staff.
Billing/payment enhancements: • Receipt for online payment • Payment audit log • Stop duplicate payment for the same month • State cost sharing reduction adjustments from carriers for terminated individuals • Recurring payment • Additional payment fields • Payment history • Medicaid and QHP payment hierarchy	Partially implemented	Implemented • Receipt for online payment • Payment audit log • Stop duplicate payment for the same month • Recurring payment • Additional payment fields (5 of 32 requirements) • Payment history (13 of 78 requirements) Not Implemented • State cost sharing reduction adjustments from carriers for terminated individuals • Additional payment fields (27 of 32 requirements) • Payment history (65 of 78 requirements) • Medicaid and QHP payment hierarchy
Integration with CMS to reformat and transmit 834 enrollment files	Not implemented	In late September 2015 CMS informed VHC that it was changing its strategy for this requirement, so this is on hold pending CMS guidance.

[a] OneGate™ is a core component of the VHC system.
[b] ACCESS is the State's legacy integrated eligibility system.
[c] This change allowed eligible immigrants to be found to have met the citizenship requirements for the type of Medicaid eligibility that is based on modified adjusted gross income.
[d] The amendment states that Optum will not be responsible for performing custom development to the OneGate™ product.

There remain outstanding software defects from the R1 and R2AB deployments. As of October 22, 2015, VHC reported that there were 150 outstanding defects, of which six were classified as severity 1, or "critical."

This type of defect impacts an essential business process, critical system/service, or “must have” requirement for which there is no acceptable workaround. For example, one of the severity 1 defects related to a termination not being communicated to Benaissance. There were also 59 outstanding severity 2, or “high,” defects that also relate to an impacted essential business process, critical system/service, or “must have” requirement, but for which there is an acceptable workaround. An example of such a defect is when a customer meeting the age requirement to be removed from Medicaid was terminated in the VHC system, but the termination was not correctly communicated to ACCESS, the State’s legacy eligibility system.

Impact of Changes on VHC Customers and Operations

Thus far, improvements to VHC customers’ experiences as a result of the deployment of R1 and R2AB appear patchy. The most recent report of the Vermont Office of the Health Care Advocate[7] indicates that COC complaints are down.[8] Between the first and third quarter of calendar year 2015, the Advocate reported that they had received 39 percent fewer cases from VHC customers pertaining to COC issues (although the number of COC cases were still higher than during June – September 2014). The VHC director of operations also reported that it is taking less time to close most customer change requests than before the implementation of R1.

Nevertheless, the Health Care Advocate also reported an increase in customer complaints about QHP billing and payment problems, including customers not receiving invoices, having their coverage delayed, and being incorrectly terminated because they were not credited for payments they had actually made. These are some of the same types of customer complaints as before the R1 and R2AB deployments and demonstrate that VHC’s problems are only partially solved with having automated COC and QHP renewals capability. In particular, as we reported in April 2015, VHC’s design of its premium payment processing contributed to customer hardship and carrier difficulties. We recommended that VHC reconsider how it performs premium payment processes. In response to our recommendation, VHC plans to explore other options to how it performs premium payment processing, but has deferred this effort until 2014 and 2015 reconciliation activities between the State, the carriers, and Benaissance have been completed.

[7] The Office of the Health Care Advocate, part of Vermont Legal Aid, Inc., provides consumer assistance to Vermonters on questions and problems related to health insurance and health care.

[8] *Quarterly Report July 1, 2015 to September 30, 2015 to the Agency of Administration* (Chief, Health Care Advocate, October 21, 2015).

The State's QHP open enrollment period began November 1, 2015 and ends January 31, 2016. During this period, the thousands of QHP customers can make changes to their plans as well as add or remove household members or report other changes.[9] This will be the true test of the extent to which R1 and R2AB have improved customer's experiences with the VHC system.

In general, it appears that R1 changes have resulted in significant operational improvements. This is particularly the case for the implementation of the automated COC functionality. In April, we reported that (1) it took an average of about 2.5 hours of VHC staff time to process a COC and (2) the backlog of unprocessed COCs was 7,256 as of March 9, 2015.[10] Now, most types of changes can be entered by customers or be processed with limited intervention by VHC staff members. This is significant as VHC receives about 125 change requests per day. As of October 21, 2015, VHC reported that its open COC inventory[11] was down to 818 (49 of these cases constitute the "COC backlog" of changes that were outstanding prior to September 1, 2015).

Blue Cross Blue Shield and MVP Health Care have also indicated that there have been improvements. In characterizing the improvements in mid-October 2015 testimony before the House Committee on Health Care, a representative from Blue Cross Blue Shield stated that "where we are right now and where we were last year is dramatically different," while acknowledging that there is still work to be done.

It is too early to tell the extent to which the State will achieve operational improvements from Release 2AB, since the QHP renewal period just began. Nevertheless, it is likely to be significant because the last renewal period required a laborious process to renew QHP customers that involved manually withdrawing a customer's account and manually re-entering all of the information into a new account. If customers made changes to their 2015 plan, the State had to execute the withdrawal and re-entering process again.

This onerous process will not be utilized during the current renewal period. Beginning on October 28, 2015, most VHC QHP renewals were sent to the

[9] VHC Medicaid-only customers must also undergo an annual renewal process, but it is not on the same cycle as QHP renewal. The VHC system does not currently support Medicaid renewals.

[10] According to the Chief of Health Care Reform, at the time of R1 deployment the COC inventory was as high as 10,200.

[11] The COC inventory numbers constitute the number of households with outstanding requests. A household may have multiple outstanding requests.

carriers via a "passive" renewal file.[12] This file contained the 2016 version of customers' QHP plans, which the carriers will use to effectuate coverage for the 2016 plan year.[13] Customers can choose to change their plans and/or report changes, such as adding a household member using the automated COC process.

There were two operational areas that have had at least a temporary degradation after R1 deployment—the 834 enrollment file and system maintenance and operations processes.

834 Enrollment File

VHC transmits an 834 enrollment file to the insurance carriers with information about a household's enrollment information. An 834 error means that a customer's transaction has not been successfully processed. According to data provided by VHC, prior to R1 deployment there was an average of 177 errors per day in the 834 enrollment file in 2015. Subsequent to R1 deployment through October 12, 2015, the average number of errors per day was 419. More recent data (October 1, 2015 to October 12, 2015) suggests that the number of 834 errors is trending downward. Most of the post-R1 834 errors are characterized as "SLA" or service level agreement errors in which the carrier has neither effectuated nor rejected the enrollment transactions.[14] The remaining errors generally reflect transmission or data issues with the file or that the enrollment data does not meet the business requirements for the transaction.

During a legislative hearing in mid-October 2015, a representative from Blue Cross Blue Shield stated that the 834 enrollment file errors for COC transactions sent to this carrier had stabilized at about 10 percent of the total number of such transactions transmitted. The representative added that in a fully automated process the percentage of errors would be expected to be in the "low single digits."

[12] As of October 29, 2015, a VHC project manager reported that about 77 percent of households had been transmitted to the carriers via the passive file process. VHC and Optum were working to correct errors to transmit other household cases to the carriers via this process. Those households in which the passive file process cannot be used (i.e., there are errors that must be corrected) are being renewed manually.

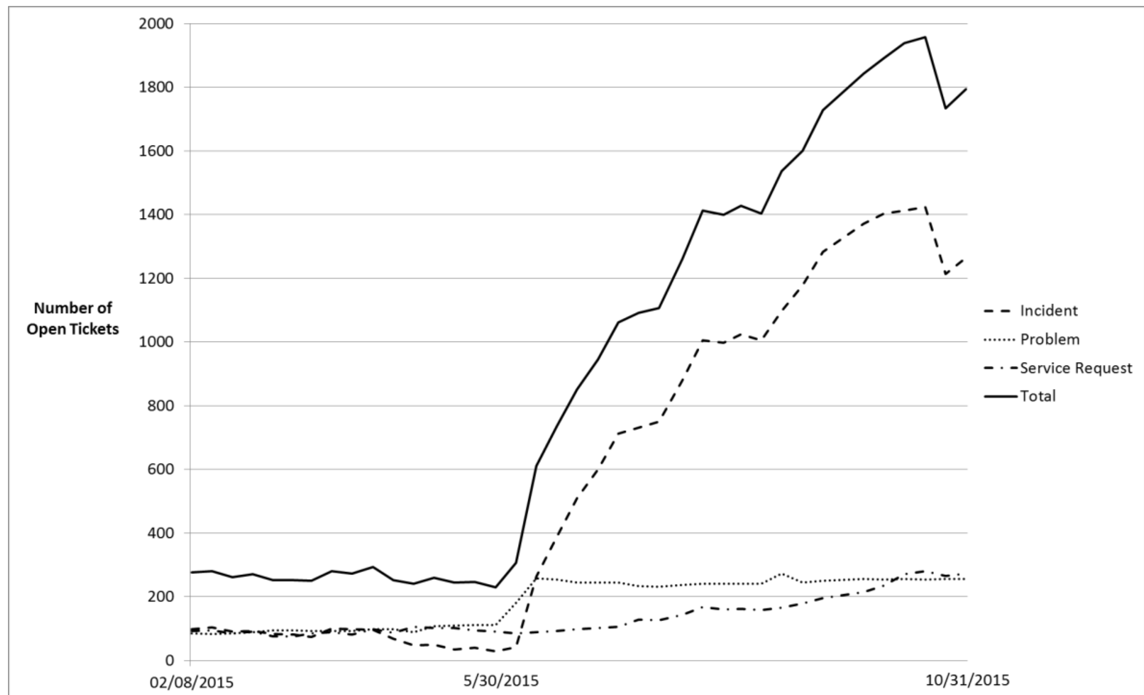
[13] Effectuation is when a carrier enters and activates enrollee information into its system.

[14] Contractually, the carriers are expected to respond within 24 hours after the 834 electronic file is transmitted, confirming that coverage has been effectuated, rejecting the transaction, or requesting more time.

Maintenance and Operations Processes

Figure 1 illustrates that the number of open maintenance and operations tickets began to increase in early June 2015, after the implementation of R1, and has remained at much higher levels than the four months prior to the deployment. Tickets are summarized in three categories: incidents, problems, and service requests. An *incident* is an unplanned interruption or reduction in the quality of an IT service. For example, a user may be unable to log in or an unexpected error may have occurred while processing a transaction. A *problem* is defined as an underlying root cause of one or more incidents or a defect introduced into the production environment by a software release. According to an Optum spreadsheet of problem tickets, about half of this type of open ticket (142 of 260 as of October 28, 2015) resulted from software releases deployed with uncorrected system defects (called a "leaked defect"). Examples of "leaked defect" problem tickets are anomalies on the customer portal or the system assigned a QHP to an individual who had obtained Medicare. Service requests are minor changes that are discretionary or non-discretionary.

Figure 1: Number of Open Maintenance and Operations Tickets between February 8, 2015 and October 31, 2015, Based on Weekly Optum Summary Reports



Objective 2: Changes Planned, but There Are Significant Uncertainties to Address

The State expects to make several major changes to system functions pertaining to exchange requirements, but as of early November 2015, there were significant uncertainties that could disrupt these plans. Some of these changes involve upgrades to the VHC system. However, as of October 30, 2015, Exeter Group—the subcontractor to Optum that makes changes to the OneGate™ product that is a core component of the VHC system—is no longer supporting this software or providing professional services regarding its implementation. While Exeter Group provided the State with the most recent version of OneGate™ expected to be used in the next major release, Release 2C (R2C), there is no certainty that this version will work as intended. Indeed, the R1 and R2AB implementation efforts required Exeter Group to fix significant defects after deployment. The State and its contractors have taken, or are in the process of taking, actions to mitigate the impact of Exeter Group's action, but this situation puts planned and future VHC upgrades at significant risk. The State also expects to make other changes pertaining to ensuring compliance with the Patient Protection and Affordable Care Act, Medicaid rules, and data security standards. These other changes anticipate building or using systems other than the VHC system. The implementation dates and costs of these changes are currently unknown.

Upgrades to VHC System

Amendment 8 to the State's contract with Optum requires another major software change release this calendar year (R2C). Examples of the requirements in this release per amendment 8 are: (1) eligibility and enrollment enhancements, (2) additional notices, and (3) case management improvements. In addition, there are enhancement areas originally scheduled to be implemented in R1 and R2AB that were deferred to R2C, such as Medicaid renewals.

On October 30, 2015, the State decided to split R2C into two phases. Phase I, scheduled to go live on December 21, 2015, is to include Medicaid renewals, eligibility and enrollment enhancements, and billing enhancements, among other changes. Phase II is tentatively scheduled to be implemented in mid-February 2016 and is supposed to include additional functional and non-functional requirements, such as case management. These changes will require a contract amendment with Optum as its current amendment terminates on December 31, 2015. As of November 6, 2015, the State and Optum had not signed an amendment extending the contract's period of performance nor reached agreement on the cost of this amendment.

On October 30, 2015, Exeter Group, a subcontractor to Optum, stopped supporting the OneGate™ product and will no longer provide professional services to support VHC's implementation of OneGate™. On the same day, Exeter Group delivered its last version of OneGate™, which is expected to be used to implement R2C. OneGate™ is a fundamental part of the VHC system and is comprised of five components: (1) eligibility screening for Medicaid and QHP subsidies, (2) application processing, (3) plan selection, (4) customer account maintenance, and (5) case management.

The State and its contractors have taken, or are in the process of taking, actions to mitigate this decision by Exeter Group. In particular, the Commissioner of the Department of Vermont Health Access signed an amended licensing agreement in which the source code was provided to the State and allows the State and its contractors to use and modify this code in perpetuity without royalty fees.[15] In addition, Optum and other VHC contractors are seeking to try to employ individuals who worked on the VHC system for Exeter Group.

Nevertheless, this action by Exeter Group adds great uncertainty to the future delivery of VHC upgrades. While Exeter Group delivered OneGate™ version 3.3.2.11, which is to be used for R2C, this version has not been tested by Optum or the State and there may be software defects to be remediated. Indeed, Exeter Group had to fix significant defects in OneGate™ after the R1 and R2AB deployments. Moreover, as of October 22, 2015, Exeter Group was listed as the responsible party for fixing 47 of the 150 defects from prior deployments. Some of the open maintenance and operations tickets are also associated with OneGate™ defects, and Exeter Group staff played a key role in investigating incidents. As of November 6, 2015, it is unknown the extent to which the former Exeter Group resources previously utilized to support the VHC system will be available to remediate known and potential defects.

In addition to the planned changes to the VHC system, there are other requirements that have not yet been implemented. Specifically, enhancement areas in Optum's contract amendments 6 and 8 were broken down into detailed requirements. Many of these requirements were deemed out of scope from R1 and R2AB and were labeled as candidates for a future release. An example of such a requirement is the establishment of a hierarchy for applying partial payments, as called for by Administrative Rule.[16] No

[15] The State paid $1,078,000 for the software license and support for OneGate™ for the period February 11, 2015 to February 10, 2016. As of November 3, 2015, the State had not decided whether to seek reimbursement for the services that are not being provided.

[16] Department for Children and Families Bulletin No. 14-04 §64.05(b)(1)(i).

decision has been made as to when, or if, the requirements labeled as candidates for a future release will be implemented. These decisions will also be affected by the decision of Exeter Group to no longer provide professional services to support VHC's implementation of OneGate™. According to a VHC information technology official, most of the deferred requirements were dependent on future product delivery by Exeter Group.

Other Expected Changes

There are other changes that are in process whose solution may be outside of the current VHC system or whose implementation may largely rest with contractors other than Optum.

Medicaid Billing

Medicaid premiums apply only to customers of Dr. Dynasaur, which is a program for children and pregnant women. Upon the receipt of Medicaid premium payments, the premium payment processor, Benaissance, remits them to the State. The VHC billing process does not comply with Medicaid rules, and delinquent Medicaid accounts in the VHC system have not been terminated for non-payment. According to a Benaissance official, 1,147 of the 5,334 Dr. Dynasaur customers (22 percent) in the VHC system were delinquent as of the end of February 2015. Without timely terminations from the program, such Dr. Dynasaur customers remain covered when they should not be, and the State could be paying claims for these individuals.[17] In contrast, according to a VHC operations official, Dr. Dynasaur customer accounts in the State's legacy integrated eligibility system (ACCESS) are terminated if the premium is not paid.

VHC requested a quote from Benaissance to implement a solution to the Medicaid billing issue. As of November 6, 2015, the State was considering Benaissance's response and no decision on whether to implement the Benaissance proposal had been made.

Small Business Health Options Program (SHOP)

The Patient Protection and Affordable Care Act requires that all states create an exchange or marketplace where small employers can shop for and purchase health coverage for their employees. When VHC went live in October 2013, it included front-end data capture and small business eligibility functionality based on an early, unproven version of the OneGate™ product.

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[17] Though jointly financed by states and the federal government, individual states are primarily responsible for ensuring Medicaid payments are appropriate.

Significant defects were soon found and the State opted to implement a contingency plan in which small employers were told to enroll directly with the VHC insurance carriers rather than via the VHC system. Accordingly, small employers have directly enrolled with the carriers for the 2014, 2015, and 2016 plan years. While this solution has been allowed by the Federal government on a transitional basis, it is out of compliance with the Patient Protection and Affordable Care Act.

The State intends to contract for a SHOP solution for plan year 2017 and seek bids from selected vendors who have successfully implemented SHOP in other states. As of October 26, 2015, the State was working on SHOP bid documentation and requirements.

The State is also considering seeking a waiver from CMS that would avoid having to implement a SHOP system. The process of seeking the waiver is expected to run on a parallel track as the procurement process. According to the Administration, this parallel track is needed because the waiver review and renewal process can take six months to over a year and CMS could decline the State's waiver request.

PCI Compliance

VHC customers can make payments via bank draft, debit or credit cards over the phone or online, or by mailing a check or money order. For those that are paying via debit or credit card, it is important that this information be secure. The PCI Data Security Standard[18] provides an actionable framework for developing a robust payment card[19] data security process, including prevention, detection, and appropriate reaction to security incidents. VHC's premium payment processor, Benaissance, is certified as compliant with this PCI standard. In addition to processing, it is important that the transfer and storage of payment card data be secure. In early September 2015, the State switched hosting vendors from CGI to Optum, but the VHC application stack (the hardware and software that process, transfers, and stores payment card data) housed at the new hosting site has not been assessed for compliance with the PCI Data Security Standard. As of late October 2015, the VHC security specialist considered the likelihood of unauthorized payment card

[18] The PCI Security Standards Council is an open global forum, launched in 2006, that is responsible for the development, management, education, and awareness of the PCI Security Standards. The Council's five founding global payment brands—American Express, Discover Financial Services, JCB International, MasterCard, and Visa Inc.—have agreed to incorporate the PCI Data Security Standard as the technical requirements for each of their data security compliance programs.

[19] For purposes of the PCI Data Security Standard, a payment card is defined as any payment card/device that bears the logo of one of its five founding members.

disclosure due to the application stack issue to be of low probability (defined by VHC as the measure of certainty that an event or risk will occur) because of enhanced compensating security measures. The State is pursuing options for dealing with this issue, including an option in which payment card data would bypass the hosting site and be transmitted directly to Benaissance, but as of October 30, 2015 had not reached a decision on a solution.

Objective 3: Status of Vermont's Security Plan of Action and Milestones (POAM)

Vermont's latest POAM, submitted to CMS on October 30, 2015, shows that the VHC system had 121 remaining outstanding security weaknesses, of which three were high risk and 63 were moderate risk.[20] These weaknesses were discovered during independent security reviews by external organizations, as well as by Optum or the State.

Oversight of VHC's security is carried out by several organizations. At the Federal level, CMS is charged with overseeing the exchanges as well as operating the Federal Data Services Hub with which the VHC system exchanges data to verify applicant information, such as social security numbers and income data. To gain access to the Federal Data Services Hub, states must obtain an "authority to connect."[21] CMS has defined a minimum set of security requirements that state exchanges must address, called the Minimum Acceptable Risk Standards for Exchanges. CMS required states to submit security documentation, including a POAM. For each security weakness, the POAM includes a description, assigns a risk level, describes the resources needed for remediation, and tracks it to completion. CMS requires the POAM to be updated quarterly.

At the State level, DII is charged with submitting the VHC POAM to CMS. This department is also the State organization charged with overseeing VHC's security activities. In this role, DII assigned an information security specialist to the VHC project to (1) monitor VHC's compliance with federal

[20] CMS defines *high risk* as a threat event that could be expected to have a severe or catastrophic adverse effect on organizational operations, organizational assets, individuals, other organizations, or the nation. *Moderate risk* is defined as a threat event that could be expected to have a serious adverse effect on organizational operations, organizational assets, individuals, other organizations, or the nation. *Low risk* is defined as a threat event that could be expected to have a limited adverse effect on organizational operations, organizational assets, individuals, other organizations, or the nation.

[21] CMS issued the latest "authority to connect" to VHC on August 13, 2015.

security requirements, (2) oversee the implementation of information security controls, and (3) administer and monitor security contracts. DII contracts with a vendor (NuHarbor) to provide security testing, training, and consulting.

As of October 30, 2015, VHC had 121 open weaknesses, of which three were characterized as high-risk. At the request of DII, we are not identifying the control area associated with these high-risk weaknesses so as not to provide information that might be used to target an attack on the VHC system.

Table 2 summarizes the status of VHC's POAM as of October 30, 2015 (without the open high-risk weaknesses). The control weaknesses were identified during security reviews by independent organizations,[22] Optum, and the State's security staff and security vendor. A quarter of the moderate risk weaknesses were identified during a 2013 security risk assessment.

[22] For example, security assessments were conducted by Referentia and JANUS Associates, Inc. in late 2013 and mid- 2015, respectively. In 2015, the Internal Revenue Service and U.S. Government Accountability Office also conducted security reviews.

Table 2: Summary of the Number of Completed and Open VHC System Security Control Weaknesses by Class of Security Controls, as of October 30, 2015 (excluding three open high-risk weaknesses)

Name of Class of Control/Family of System Security Controls	Completed	Number of Open Weaknesses	
		Moderate Risk	Low Risk
Management Controls, which includes: Security assessment and authorization Planning Risk assessment System and services acquisition Program management	34	7	7
Operational Controls, which includes: Awareness and training Configuration management Contingency planning Incident response Maintenance Media protection Physical and environmental protection Personnel security System and information integrity	67	23	19
Technical Controls, which includes: Access control Audit and accountability Identification and authentication System and communications protection	67	32	29
Other	1	1	0
Total number of weaknesses	169	63	55

During 2015, a vendor (NuHarbor) conducted an information system risk assessment[23] in which it deemed the VHC platform in the scope of its review to be moderate risk.[24] In an August 2015 report, this contractor concluded the VHC environment is complex as it uses a shared responsibility model involving many parties.[25] The report cautioned that in a shared responsibility model it is easy to lose track of information governance tasks.

[23] NuHarbor followed the risk assessment methodology issued by the Federal National Institute of Standards and Technology (*Guide for Conducting Risk Assessments, Revision 1*). The purpose of a risk assessment is to inform decision makers and support risk responses by identifying: (1) relevant threats to organizations or threats directed through organizations against other organizations; (2) vulnerabilities both internal and external to organizations; (3) impact (i.e., harm) to organizations that may occur given the potential for threats exploiting vulnerabilities; and (4) likelihood that harm will occur.

[24] The scope of the review was the VHC application, supporting operating systems, and logging and monitoring controls.

[25] *Vermont Health Connect: Information Security Risk Assessment* (NuHarbor Security, August 24, 2015).

In a July 2015 security assessment report, the assessment contractor (JANUS Associates) noted a “dramatic” improvement in the quality of VHC’s system security plan and cited a transparent and productive working relationship between Optum and the State. Nevertheless, the report states that contingency plans must be finalized, system design documentation delivered, and incident response processes fully implemented with commensurate training. The contractor added that the State and Optum have project plans and corrective action plans to fully implement these controls and have demonstrated the capability and resources to do so effectively.

Other Matter

During the course of the audit, we found that the Department of Vermont Health Access (DVHA) authorized contractors to perform work using a document called an “authorization to proceed” letter, or ATP, that is not authorized by the State’s procurement policy. In other cases, contractors were performing work without benefit of any written agreements at all.

Under federal regulations (45 CFR 92.36), states procuring services under a grant (VHC has been largely funded by Federal grants) are to follow the procurement policies and procedures used for non-Federal funds. Bulletin 3.5 is the Vermont state government’s general policy and minimum standards for soliciting services and products and processing and overseeing contracts.[26]

In 2015, DVHA’s Commissioner signed agreements called ATPs that authorized Optum and Exeter Group to perform work in anticipation of a contract amendment. As of November 6, 2015, a contract amendment has not been signed with either Optum or Exeter Group pertaining to these ATPs.[27]

Table 3 summarizes three ATPs signed by DVHA and Optum for the remediation of the COC backlog.

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[26] *Bulletin No. 3.5, Contracting Procedures* (July 15, 2008).

[27] On November 9, 2015, DVHA reported that no payments have been made to Optum or Exeter Group for services performed under the ATPs.

Table 3: Authority to Proceed Letters with Optum to Perform COC Remediation

<table>
<tr><th>Date</th><th>Work to be Performed</th><th>Period of Performance</th><th>“Not to Exceed” Amount</th><th>Comment</th></tr>
<tr><td>7/20/15</td><td>Remediation of backlog of COC cases</td><td>7/23/15 to 8/31/15</td><td>$319,120</td><td rowspan="3">These ATPs are not cumulative (i.e., $485,840 is the total “not to exceed” amount covering the time period of all three letters). Each of the ATPs state that (1) the parties agree to abide by the terms of contract #26801[a] until a new contract is executed and (2) should the parties fail to reach a contract agreement; Optum is authorized to invoice the State for the services performed in accordance with the ATP pursuant to the terms of contract #26801.</td></tr>
<tr><td>9/2/15</td><td>Remediation of backlog of COC cases</td><td>7/20/15 to 9/11/15</td><td>$321,360</td></tr>
<tr><td>10/13/15</td><td>Remediation of backlog of COC cases</td><td>7/20/15 to 10/2/15</td><td>$485,840</td></tr>
</table>

[a] Contract #26801 is the original VHC contract signed with Optum in June 2014.

On September 18, 2015 the DVHA commissioner also signed an ATP with Exeter Group to provide business process support services to the VHC operations group until November 30, 2015. Until a contract amendment was signed, the parties agreed to abide by the terms of contract #28117 (whose period of performance ended on November 15, 2014). The maximum dollar amount authorized by this ATP is $305,131. This ATP states that the State “will pay the Contractor for Services delivered under this Statement of Work” and includes specific amounts for the months of September-November 2015.

Bulletin 3.5 does not authorize or even mention ATPs and there is no evidence that DVHA sought approval to use such arrangements to procure services. Bulletin 3.5 includes two provisions under which such approval could have been sought. First, should an agency determine that it has a class of contract exhibiting characteristics that cannot be reasonably accommodated within the requirements of Bulletin 3.5, the Secretary of Administration can approve a written contracting plan that provides an acceptable alternative to requirements of the bulletin. Second, Bulletin 3.5 includes a waiver process that can be used on a case-by-case process to obtain pre-approval for a deviation from the state’s contracting processes.

Neither DVHA nor its parent agency, the Agency of Human Services, has submitted a contracting plan to the Agency of Administration requesting its approval of ATPs. Moreover, the Secretary of Administration did not approve a waiver of Bulletin 3.5 provisions for the Optum and Exeter Group ATPs.

In a meeting on November 6, 2015, DVHA's general counsel asserted that ATPs are not contracts and are not binding on the State. The general counsel added that the contractors know that they can only be paid for their services if a contract amendment is signed. This assertion is not consistent with either Bulletin 3.5 or the Agency of Human Service's contracting policy. Bulletin 3.5 defines a contract as any legally enforceable agreement between an agency and another legal entity to provide services and/or products. Bulletin 3.5 goes on to state that this includes all such agreements whether or not characterized as a "contract," "agreement," "miscellaneous agreement," "letter of agreement," "purchase order," "license agreement," or other similar terms. The Agency of Human Services' contracting policy[28] defines a contract as a written agreement between an authorized agent of the state (which the policy states includes a department commissioner) and a potential service provider that covers the delivery of products or services to agency clients, employees, or programs as described in Bulletin 3.5. In the case of each of the ATPs, an authorized agent of the State (DVHA commissioner) signed an agreement with either the contractor's vice-president (Optum) or president (Exeter Group) authorizing their companies to provide services within a specific timeframe to be billed at a specific amount or rate.

The use of these ATPs has the effect of circumventing the approval requirements in Bulletin 3.5. This bulletin requires that the Attorney General and Secretary of Administration approve contract amendments in advance if it is the third or more amendment to the contract or is for more than 15 percent of the contract's original amount. In the case of Optum, there have been eight amendments to contract #26801. In the case of Exeter Group, the maximum amount of the ATP is 61 percent of contract #28117.

In responding to a draft of our report, the Secretary of the Agency of Human Services stated that while DVHA had a different understanding at the time, the department is now clear that it should seek the Secretary of Administration's approval for ATPs, consistent with Bulletin 3.5, and would seek such approval going forward.

In other cases, VHC contractors, Optum and Archetype, have performed services for the state without either a contract or an ATP in place.

- The most recent Optum ATP for working on the COC backlog was dated October 13, 2015, but covered a three-week period that ended October 2, 2015. Optum continued to work on the COC backlog until October 30, 2015. Accordingly, between October 2, 2015 and October

[28] *Contracts for Services* (Agency of Human Services policy 1.08, October 7, 2009).

30, 2015, Optum worked on the COC backlog without either a contract amendment or ATP authorizing this work. As of November 6, 2015, a contract amendment with Optum has not been signed for this work.

- In mid-October 2015, a DVHA deputy commissioner authorized Archetype to proceed with work related to IRS forms and Medicaid reconciliation. The deputy commissioner authorized Archetype to perform additional work on October 26, 2015. As of November 6, 2015, a contract amendment with Archetype had not been signed.

Conclusions

The addition of automated change of circumstances and QHP renewals are significant improvements to the VHC system's functionality that should help alleviate customer dissatisfaction with the system. However, other significant improvements to be implemented remain in order to fully comply with the Patient Protection and Affordable Care Act and Medicaid requirements, such as Medicaid renewals, SHOP, and Medicaid billing. The ability of the State to make changes to the VHC system has been made more difficult by Exeter Group's decision not to support OneGate™ or provide the State with professional services to support the VHC system. In addition, while improvements have been made to VHC security, there continues to be high and moderate risk weaknesses to be remediated. As decisions are made about the future of VHC, it is important to consider both the current state of the system and its planned future state and the time and money it will take to achieve the final end result.

During the course of our audit we found that DVHA had authorized contractors to perform work in a manner that circumvented the State's contracting policy. In particular, the State's procurement policy, Bulletin 3.5, does not authorize or even mention the use of authorization to proceed letters. Bulletin 3.5 has mechanisms for state organizations to seek approval for exceptions to its requirements, but such approval was not obtained.

Recommendations

Because the objectives of this report were to provide a status update for information purposes, we are not making recommendations pertaining to our three objectives.

Because we found non-compliance with the State's procurement policy, we are making the recommendations in Table 4 to the Commissioner of the Department of Vermont Health Access.

Table 4: Recommendations and Related Issues

Recommendation	Report pages	Issue
1. Immediately negotiate and sign contracts or contract amendments with Optum, Exeter Group, and Archetype for the work currently being performed without benefit of such documents.	20-23	DVHA authorized Optum and Exeter Group to perform work using a document called an "authorization to proceed" letter that was not authorized by the State's procurement policy (Bulletin 3.5) and had not been otherwise approved. In other cases, Optum and Archetype were performing work without benefit of any written agreements at all.
2. Immediately stop the use of ATPs until such time as the Secretary of Administration has approved their use either through an approved contracting plan or waiver as called for in Bulletin 3.5.		

Managements' Comments

The Secretary of the Agency of Human Services provided written comments on a draft of this report on November 17, 2015, which is reprinted in Appendix IV. We also provided a copy of the report to the Commissioner of the Department of Information and Innovation who replied via email that the department had no comments.

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In accordance with 32 V.S.A. §163, we are also providing copies of this report to the commissioner of the Department of Finance and Management and the Department of Libraries. In addition, the report will be made available at no charge on the state auditor's website, http://auditor.vermont.gov/

Appendix I
Scope and Methodology

To address our first objective, we reviewed Act 58 (2015) and the Optum contract amendments 6 and 8 and compared the requirements and milestones in these documents to a variety of VHC documentation. This documentation included: (1) VHC scope statements for R1 and R2, (2) Optum requirements documents, (3) Optum test plans, (4) Optum test results, (5) a list of outstanding defects, and (6) change requests. We also considered weekly VHC summaries of the project status by Optum and VHC project managers, and monthly reports submitted to the legislature. We interviewed various VHC information technology officials, including the program manager, implementation manager, test manager, and project managers, and sought the viewpoints of representatives from Blue Cross Blue Shield and MVP Health Care.

We looked at the effect of R1 changes on customers by reviewing the most recent quarterly report by the Vermont Health Care Advocate. To consider the effect of R1 and R2AB on VHC operations, we made inquiries of the director of operations, reviewed VHC job aids, and obtained statistics regarding the inventory of COC changes and 834 errors (we did not assess the reliability of these numbers). We also obtained statistics on the number and type of maintenance and operations tickets from Optum reports (we did not assess the reliability of these numbers).

To address our second objective, we sought updates on functions that had not been implemented as of our April 2015 report, such as SHOP and Medicaid billing. We also identified unimplemented requirements by reviewing Optum R1 and R2AB requirements and testing documents, which identified requirements that were out of scope or planned for future releases, and reviewed VHC's risk registers.

The State's POAM submitted on October 30, 2015 was our primary source of evidence for objective 3. We summarized the information from this document and reviewed and discussed with a DII security official the security reviews conducted in 2015, including a July 2015 security assessment report, an August 2015 security risk assessment, and a September 2015 audit report by the U.S. Government Accountability Office.

We performed our work between August 2015 and early November 2015, primarily at VHC headquarters in Winooski. We conducted this performance audit in accordance with generally accepted government auditing standards, which require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix II
Abbreviations

ATP	Authority to proceed
CMS	Centers for Medicare and Medicaid Services
COC	Change of circumstances
DII	Department of Information and Innovation
DVHA	Department of Vermont Health Access
POAM	Plan of Action and Milestones
QHP	Qualified Health Plan
R1	Release 1
R2AB	Release 2AB
R2C	Release 2C
SHOP	Small Business Health Options Program
VHC	Vermont Health Connect

Appendix III
Summary of Status of Change of Circumstances

VHC operations unit identified 34 types of COCs. Table 5 shows the automation status of each COC type as of the end of October 2015.

Table 5: Automation Status of Types of Changes of Circumstances as of October 2015

Type of COC	Fully Automated	Needs Intervention by VHC Staff to Process Correctly	Customer Self-Service on VHC Website
Change in residential address	X		X
Change in mailing address	X		X
Change in name	X		X
Change in date of birth	X		X
Change of social security number	X		X
Change of email	X		X
Change of phone	X		X
Change of secondary phone	X		X
Change of responsible person name and address (for child subscriber plan)	X		
Change of marital status	X		X
Addition of a household member	X		X
Removal of a household member from application		VHC staff enter change because file may have to be resent due to software defect.	
Applying for coverage	X		X
Change of citizenship/immigration status	X		X
Change of disability status	X		X
Change of health coverage information	X		X
Change in help paying for coverage	X		X
Change of incarceration status	X		X
Change of pregnancy status		VHC staff enter change because file may have to be resent due to software defect.	
Change of tax filing status	X		X
Member disenrollment from a plan (not all policy members)	X		
Plan change within carrier	X		X
Income change	X		Added 11/1/15
Qualified Health Plan newborn/birth/ adoption		Manual workaround because not supported by VHC software. Sent to carriers via spreadsheet instead of 834 enrollment file.	
Medicaid newborn		Manual workaround to fix member effective date and post-partum dates because of software defect.	

Appendix III
Summary of Status of Change of Circumstances

Type of COC	Fully Automated	Needs Intervention by VHC Staff to Process Correctly	Customer Self-Service on VHC Website
Policy disenrollment, all policy members	X		X
Subscriber[a] removal due to death or at member request		VHC staff enter change because file may have to be resent due to software defect.	
Reinstatement of coverage		VHC staff enter change because it requires VHC to grant an exception to standard business process.	
Change in effective date of enrollment or disenrollment (also known as a date flip)		VHC staff enter change because it requires VHC to grant an exception to standard business process.	
Change of information along with a single approved COC	X		X
Multiple COCs	X	If complex change causes an error with the carrier, manually corrected by VHC staff.	X
Multiple coverage level changes in one transaction	X	If complex change causes an error with the carrier, manually corrected by VHC staff.	X
Multiple subsidy changes in one transaction	X	If complex change causes an error with the carrier, manually corrected by VHC staff.	X
Re-do of a Qualified Health Plan renewal (i.e., correction of COC error)		VHC staff members enter corrections to ensure processed correctly.	

[a] A subscriber is an entity or individual who enters into the contract for health insurance with the health insurance issuer.

Appendix IV
Comments from the Secretary of the Agency of Human Services

State of Vermont
Agency of Human Services
Office of the Secretary
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[phone] 802-871-3009
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Hal Cohen, Secretary

November 17, 2015

Mr. Douglas R. Hoffer
State Auditor
Office of the State Auditor
132 State Street
Montpelier, VT 05602

Dear Mr. Hoffer:

Thank you for the opportunity to review and provide responses to the findings and recommendations contained in the draft report *Vermont Health Connect: Status of Planned Enhancements*. As you will note in our responses, the Agency is in agreement with the findings and recommendations contained in this report, and we are actively working to address any issues raised.

As your report accurately notes, Vermont Health Connect (VHC) has made significant improvements in several key areas that were called for in Act 58. While we acknowledge that certain enhancements remain to be completed, and additional work is needed in order to further improve the functionality of the VHC system, I am confident that our dedicated VHC team will be successful in its efforts to complete those tasks.

With VHC operational and open enrollment for the 2016 plan year going smoothly, it's important to recognize and appreciate the efforts of the staff in helping to get us to this point. Developing and launching VHC on such a short timeline presented a number of challenges, but this team's expertise and hard work allowed us to move beyond those challenges and meet recent milestones. The VHC team's commitment to creating a system that serves the needs of Vermont health care consumers has been impressive and, as their work continues, I look forward to sharing more milestones with you.

Again, thank you for the opportunity to review and respond to the findings and recommendations contained in this report.

Regards,

Hal Cohen
Secretary
Agency of Human Services

Appendix IV
Comments from the Secretary of the Agency of Human Services

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Official Management Comments related to Findings and Recommendations

Objective 1 Findings:

A. VHC software change releases in May 2015 (R1) and October 2015 (R2AB) implemented some critical requirements as expected, but other functionality was not implemented. As called for in Act 58, as of October 2015, VHC implemented automated change of circumstances (COC) and qualified health plan renewals functionality, although manual intervention is needed to process some types of changes. In particular, five COC types require manual intervention because of a software defect or because they are not supported by the VHC software. In other cases, however, the manual intervention is for business reasons because the COC type is complicated or requires VHC to grant an exception to a standard business process. VHC's operations director estimated that 90-95 percent of changes can be made using the automated COC process. Other requirements contained in amendments 6 and 8 of the system integrator's contract (Optum) that were to be included in R1 and R2AB, respectively, were not fully implemented. For example, according to amendment 8, R2AB was to include a renewals process for Medicaid, but this change was not made. The State and Optum mutually agreed to the reductions in the R1 and R2AB scopes from those contained in amendments 6 and 8.

VHC Response: We agree with this finding. The primary objective of the December, 2015 release is to deliver Medicaid Renewal functionality.

B. Overall, the result of R1 and R2AB deployment appears positive, although the true test will come during the open enrollment period (November 1, 2015 to January 31, 2016), and problem areas remain. For example, in October 2015 Vermont's Office of the Health Care Advocate, which provides consumer assistance, reported that its COC cases have been reduced, but VHC billing issues have increased. Operationally, VHC has seen significant improvements. For example, in April we reported that (1) it took an average of 2.5 hours of VHC staff time to process a COC and (2) the backlog of unprocessed COCs was 7,256 as of March 9, 2015. Now, most types of changes can be entered by customers or be processed with limited VHC staff member intervention and the inventory and backlog of changes has been greatly reduced. While it is too early to tell the extent to which the State will achieve operational improvements from Release 2AB, it is likely to be significant since the onerous manual processes utilized during the last renewal period will not be used.

VHC Response: We agree with this finding.

C. There are two operational areas that have had at least a temporary degradation after R1 deployment—enrollment file transmissions to the carriers (called the 834 file) and system maintenance and operations. VHC transmits an 834 enrollment file to insurance carriers with data about a household's enrollment information. The average number of 834 errors (i.e., customer records not successfully processed) more than doubled after R1 deployment, although in early October the number of errors began to decline. The number of open maintenance and operations

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tickets began to increase in early June 2015 and has remained at much higher levels than the four months prior to the deployment. In many cases, open tickets were the result of software releases deployed with uncorrected system defects.

VHC Response: We agree with this finding.

Objective 2

There are several major efforts planned to improve system functions related to exchange requirements, although significant uncertainties regarding these efforts remain. For example:

A. The State decided to deploy other major software change releases in December 2015 and, tentatively, February 2016. As of November 6, 2015, the State and Optum had not signed a contract amendment consistent with this decision. Moreover, the ability of the State and Optum to implement R2C has been made more difficult by an Optum subcontractor's decision to stop supporting the OneGate™ product—a core component of the VHC system—on October 30, 2015. This subcontractor will also no longer provide professional services to support VHC's implementation of OneGate™. The State and its contractors have taken, or are in the process of taking, actions to mitigate this decision by the Optum subcontractor.

   VHC Response: We agree with this finding. As of 11/10, the State has initiated contracting activities with Optum and Archetype to secure needed resources to fill the gap left by the lack of Exeter services and product support.

B. The VHC system is not in compliance with Medicaid's billing requirements, and delinquent Medicaid accounts in the VHC system have not been terminated. The State requested that its VHC premium processor, Benaissance, provide a quote to implement a Medicaid billing solution. As of November 6, 2015, no decision on whether to implement the Benaissance proposal had been made.

   VHC Response: We agree with this finding, and we intend to comply with applicable Medicaid billing requirements. We are actively exploring our options to implement a technical solution and resolve delinquent cases.

   The VHC system's functionality to implement the federally required Small Business Health Options Program (SHOP) did not work, so the State opted to have small employers enroll directly with the VHC carriers for the 2014, 2015, and 2016 plan years. The State decided to contract for a SHOP solution to handle plan year 2017 and intends to seek bids from vendors who have successfully implemented SHOP in other states. As of October 26, 2015, the State was working on SHOP bid documentation and requirements. Concurrently, the State is considering seeking a waiver from the Centers for Medicare and Medicaid Services (CMS) to exempt the State from implementing this system functionality.

   VHC Response: We agree with this finding.

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Objective 3

A. Vermont submitted its latest VHC system security POAM to CMS on October 30, 2015, listing 121 remaining outstanding security weaknesses, of which three were high risk and 63 were moderate risk. CMS defines high risk as a threat event that could be expected to have a severe or catastrophic adverse effect on organizational operations, organizational assets, individuals, other organizations, or the nation. Moderate risk is defined as a threat event that could be expected to have a serious adverse effect on organizational operations, organizational assets, individuals, other organizations, or the nation.

   VHC Response: We agree with this finding.

Other Matter

During the course of the audit, we became aware that the Department of Vermont Health Access (DVHA) was not complying with the State' procurement policy, Bulletin 3.5. In particular, between July and October 2015, DVHA's Commissioner signed agreements that authorized two contractors (including Optum) to perform work in anticipation of a contract amendment. As of November 6, 2015, DHVA had not signed contract amendments pertaining to these agreements. Bulletin 3.5 does not authorize or even mention these types of arrangements, and there is no evidence that DVHA sought approval from the Secretary of Administration to use such documents to procure services.

Recommendations:

1. Immediately negotiate and sign contracts or contract amendments with Optum, Exeter Group, and Archetype for the work currently being performed without benefit of such documents.

2. Immediately stop the use of ATPs until such time as the Secretary of Administration has approved their use either through an approved contracting plan or waiver as called for in Bulletin 3.5.

VHC Response: Although DVHA had a different understanding at the time, the Department is now clear that it should seek Secretary of Administration approval for ATPs, consistent with Bulletin 3.5, and will seek such approvals going forward.