Transcript of Virginia Health Benefit Exchange Meeting

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Case: Health Benefit Exchange Advisory Committee Meeting

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STATE CORPORATION COMMISSION

VIRGINIA HEALTH BENEFIT EXCHANGE

ADVISORY COMMITTEE MEETING

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A P P E A R A N C E S:

Voting Members:

Sabrina Corlette, Chair
Jane Norwood Kusiak, Vice Chair
Victoria Savoy, Director
Lee Biedrycki
Scott Castro
Doug Gray
Ikeita Cantu Hinojosa
Starla Kiser
Kenn Penn

Ex-officio Members:

Secretary Dr. Daniel Carey
Commissioner Duke Storen
Commissioner Dr. Norman Oliver
Commissioner Scott White

Also present:

Julie Blauvelt
Toni Janoski
Whitney Thomas

P R O C E E D I N G S

MS. SAVOY: I just want to welcome everyone to the July 2021 Virginia Health Benefit Exchange Advisory Committee meeting. The Exchange is one year old now, and we've had a very busy year. We have a slide a little later in the presentation to show you some of the things that we have been working on.

And at this time, I'm just going to turn the meeting over to Sabrina to welcome everyone, call the meeting to order, and then after that, Toni Janoski will call the roll. Thank you.

CHAIR CORLETTE: Thank you, Victoria. And I'm so pleased to welcome everybody back for our second full Advisory Committee meeting. There's been a lot happening since we last met in terms of both federal and state policy changes that have been some big implications that I know we'll talk about today.

I also just want to, on a more bittersweet note, acknowledge our departed colleague Chiquita Brooks-LaSure, who is not

with us today because she is running the Federal Center for Medicare and Medicaid Services. And we're very sad to lose her, but we have a fabulously talented and committed group of folks here on the Advisory Committee.

We're going to be hearing about work of two very active subcommittees on some essential Exchange functions, eligibility and enrollment and consumer assistance. So without further ado, I will turn it over to Toni to take the roll and call this meeting to order. Thank you.

MS. JANOSKI: This is Toni Janoski. I'm a member of the Health Benefit Exchange staff, the deputy director. So welcome, everyone. Thank you for being with us this afternoon.

I will reference information that Whitney has put up on the screen. There is a call-in number that you can share with others, should people have an interest in calling in. And also the live stream is available through the webcast page.

A couple of reminders for this

afternoon: If only the Committee members could have their cameras turned on, that's appreciated. And also, please stay mute until you're called on to speak. And the transcript will be made available online in a couple weeks.

So with that, I will call the roll. If you could just unmute yourself and let us know that you're here. Secretary Carey?

DR. CAREY: I'm here. Good afternoon.

MS. JANOSKI: Director Kimsey? Is anyone here on behalf of Director Karen Kimsey?

MS. ANNECCHINI: Good afternoon. This is Jessica Annecchini. I know that Ellen Montz will be joining us by 2 p.m., but I'm also here to represent DMAS.

MS. JANOSKI: Dr. Oliver? Is anyone here representing Dr. Oliver?

DR. CAREY: This is Dr. Carey. Dr. Oliver was here at the Patrick Henry Building a moment ago, and I think he's walking back to his office. So I anticipate he'll be on soon.

MR. JANOSKI: Wonderful. I'll look for him to join.

Commissioner Storen?

COMMISSIONER STOREN: Good afternoon, everybody.

MR. JANOSKI: Good afternoon. Commissioner White?

COMMISSIONER WHITE: I'm here.

MS. JANOSKI: Sabrina?

CHAIR CORLETTE: Hi. I'm here.

MS. JANOSKI: And Jane?

MS. KUSIAK: I'm here.

MS. JANOSKI: Lee?

MR. BIEDRYCKI: I am here.

MS. JANOSKI: Welcome, Lee. Scott Castro?

MR. CASTRO: I'm here.

MS. JANOSKI: Good afternoon, Scott. Liz Cunningham? Oh, that's right. We just referenced that.

Doug Gray?

MR. GRAY: Hello.

MS. JANOSKI: Ikeita?

MS. HINOJOSA: Good afternoon. I'm here.

MS. JANOSKI: Hi, Ikeita. Starla? Starla?

MS. KISER: I'm here.

MS. JANOSKI: And Kenn Penn? I believe I heard Kenn earlier. Kenn Penn?

MR. PENN: Yeah, good afternoon.

MS. JANOSKI: Hi, Kenn. Okay. Thank you so much.

MS. SAVOY: I think I am next for the update reports for all of the Exchange and state basic Exchange happenings.

So the first thing I'm actually going to do is I'm going to let you have a special guest appearance by Julie Blauvelt, the Deputy Commissioner of Life and Health from the Bureau of Insurance, and she's going to provide an update on the reinsurance program for us. Julie?

MS. BLAUVELT: Thank you, Victoria. Hello, everyone. As I'm pretty sure most of you know, the House Bill 2332 was passed last session and tasked the State Corporation Commission with applying for a state innovation waiver under Section 1332 of the ACA to administer a reinsurance program

that's expected to reduce premiums in the individual market in Virginia for plan year 2023 by up to 20 percent of what rates would have been without the reinsurance program.

So there are several steps to being able to submit that 1332 waiver reinsurance application. And we've completed the first one, which was Oliver Wyman, our consulting actuary performed a market scan of Virginia's individual market; that was completed with data as of March 31st of this year. So it just missed any information about pre ARPA, American Rescue Plan subsidies.

So the information that we're using, since we're looking at 2023, when, you know, currently it's expected that the ARPA subsidies will not be around in 2023, we can use that data we have up through March of this year to project and look at what might happen in 2023.

So from this market scan, we -- or Oliver Wyman, actually, has done a preliminary calibrated model that will -- that has -- that will provide us estimated costs of what a reinsurance program will look

like to the state. And they are looking at various premium reduction scenarios, anywhere from 5 percent reduction up to 20 percent reduction, and developing a model that's going to show us what the costs are for those various levels of premium reductions; they're doing them in increments of 5; so 5, 10, 15, and 20 percent, they're going to be able to show us what that looks like.

And at the stage that we're at right now, they've conducted that preliminary model, but now we have sent out a survey to the carriers who are participating or planning to participate in the individual market for next year, and we're seeking their feedback. And this is a really important step, because our actuaries have projected what they think is going to happen, but without getting the carriers' input on exactly how rates may change with the different factors, then they can't develop a good model without actually knowing what the carriers are going to do with that information.

So, you know, for example, Oliver

Wyman might predict that with the morbidity impact of the reinsurance program, a carrier may reduce its rates by a certain percent, but in actuality, there may be other factors that go into the carrier setting that rate. So the rate that actually happens may be very different.

So we're getting that carrier feedback so we can really get a good estimate of what the state costs are and also to be able to develop good parameters like co-insurance percentage for the reinsurance, and the cap, and the attachment points. So all of that is necessary to make sure we have the best estimate so that we, you know, don't get caught short with the funding or anything like that.

So once we get that carrier feedback -- hopefully by next week, we'll have that -- then we can finalize the model. And then, you know, decide on one of those premium reduction scenarios, the 5, 10, 15, or 20 percent. They'll give us a good estimate of what the funding will be. We'll make that decision based on, you know, what

we think the funding available will be. They'll do the required actuarial and economic reports. And we'll be able to develop the reinsurance parameters that will be used and make the final adjustments.

So as required by the statute, we have to have a draft application ready by October 1 of this year. We will have a public comment period on what's been developed as part of that application. And then once we get the comments and the feedback from that, we'll be able to submit the final application as also required by the statute by January 1 of next year.

So that is the basic layout of what's going on, and the next steps to happen. Are there any questions?

CHAIR CORLETTE: I don't have a question, Julie. That was a really helpful presentation and it's great to know that that's moving forward.

I do just want to flag, just from an Exchange perspective, it will be important to really think about how we message this to consumers in the fall of 2022, particularly

our subsidized consumers, just assuming that the Rescue Plan substitutes end at the end of 2022, because there are some real impacts on them if they don't actively shop for a new plan.

MS. BLAUVELT: That's great. Yeah, the benchmark where the subsidies are set, that plan will most likely be reduced by 5, 10, 15, or 20 percent, which makes people's subsidies decrease and they can be left with some sticker shock if they don't go back on and look to make sure the plan they're choosing, you know, they know what the premium is going to be for the next year.

MS. SAVOY: Does anyone else have any other questions or comments for Julie? Thank you, Julie. We appreciate that very much.

And continuing along, regarding federal activity, first thing I want to mention is -- it's actually not on this slide -- is to let you know about a CMS grant opportunity, which the Virginia Health Benefit Exchange took advantage of. And that is CMS had issued the notice of a

modernization grant under ARPA. It was announced June 21st and submissions had to be in by July 21st and award notices are expected September the 10th.

So this grant was to be used for the purpose of enabling Exchanges to modernize or update any system, program, or technology utilized by the Exchange to ensure it is compliant with all applicable requirements. There were two levels of awards. If you were a full state-based Exchange, you could receive up to a million three. And if you were a state-based Exchange on the federal platform, you could receive up to 800,000.

Virginia Health Benefit Exchange, we did apply for funds to support three different projects that are associated with the transition from being a state-based Exchange on the federal platform to a full state-based Exchange. So hopefully we will be successful and all of our projects will be approved.

So I just wanted to let you know that is something that came and went very quickly. We had a month to do everything.

And so with a lot of great help from the Bureau of Insurance and the Office of General Counsel within the State Corporation Commission, we were able to get that turned around in a month.

So continuing along now with the federal activity, the special enrollment period: As of June 30th, there have been over 40,000 new plan selections since the start of the special enrollment period in February. That is an increase of over 240 percent over the same time last year. So total plan selections in Virginia now sit at approximately 259,000 individuals.

So we're seeing -- I think Virginia's actually seeing a lot more activity than some other states, from what I've been hearing. So very pleased with that.

And right now, the special enrollment period is still scheduled to end August 15th. So we should get -- we get reports from CMS after the end of the month, so we'll receive July's reports in probably early August.

And then the last federal update I wanted to mention is the proposed payment parameters for a plan year 2022. This is actually the third notice for plan year 2022, and it was published on June 28th. And I know Sabrina has been following this very closely, and she may actually have more detailed information than I have. So Sabrina, please don't hesitate to speak up.

Some of the highlights are that -- now, again, this is proposed -- extension of open enrollment. So it would still start November 1st of 2022, but it would run an additional month and would end January 15th, 2023 rather than December 15th of 2022. And this would be a change for 2022 and going forward.

So every year, the open enrollment would be extended for about a month, and there would be an ongoing monthly special enrollment period for those enrollees with household income of no greater than 150 percent of the federal poverty level.

Also was mentioned, an increase in user assessment fees. And when they talk

about increase, it's an increase from one of the prior proposed payment parameter notices. So they're now anticipating 2.2 percent user fee for state-based Exchanges on the federal platform. Currently, states are paying 2.5 percent to the federal government.

But one of the earlier proposed payment parameters -- that's hard to say quickly -- actually had dropped that number down to 1.75 percent. It's now gone back up to 2.25 percent, and the rationale for that is the increased money that is being given out to Navigators associated with the full Exchanges, federal Exchanges.

Now Virginia has had a rate of one half of one percent, so .5 percent. And that is not anticipated to change. And there was a new rule put out by the Commission to set that at .5 percent for both plan year 2022 and plan year 2023.

Additional changes include a change in the separate billing requirements for premiums associated with abortion services. They're proposing to repeal the direct enrollment option. And there is a proposal

to modify -- or modifications to the Section 1332 state waiver policies.

So comments on these proposals are due July 28th. I'm not sure when any final notices will be actually issued by CMS.

So in addition to the federal grant that the Exchange applied for, we also are actually providing grant funds to our Navigators. Last year, if you recall, was the first year for Navigator grant funds distributed by the State Corporation Commission to two Navigator groups.

And so those for were a one-year period. We have put out a request for funding applications for plan year 2022; that was issued in June. And the responses were actually due last week. The review will occur and selection notification is expected to be announced around August the 16th and the awards will be actually issued expected to start September the 1st, 2021 for the sort of 2021 to 2022 year.

Regarding requests for proposals, there are a few, and they're in different stages right now. Probably the one that most

people have heard a lot about is a software platform and consumer assistance center RFP. There are final tweaks that are occurring right now, and we are awaiting additional input, as necessary, regarding Medicaid coordination. The expected issue date for that RFP is October the 1st.

The consultation or consultant RFP, that was an RFP that was issued in late May, and responses have been received on that. The evaluation committee is in the process of reviewing responses at this time. And it is my understanding that the expected award date for that will be early August, and that is for sort of subject matter expert consultation from someone who has state basic Exchange experience to assist the Virginia Exchange.

The third RFP that we are working on is for advertising and branding. Again, we had a small RFP for the last open enrollment period and this would be for not only this upcoming enrollment period, but actually to get us through the transition to be a full state-based Exchange. That we are expecting

to be issued soon. It's in the final review stages right now. And like I said, it will be in place for open enrollment for plan year 2022, which begins November the 1st, 2021.

We are still continuing our Medicaid coordination with the Department of Medical Assistance Services and Department of Social Services. We've been conducting research and talking to other state Exchanges to determine how their coordination works. And that is definitely running the gamut of tight coordination to not very well coordinated. So that's provided a lot of information for us. We've had a lot of meetings with Department of Medical Assistance Services and Department of Social Services.

The Exchange consultant that I just mentioned will be providing input on that also. And we plan to have some option to be discussed with Department of Medical Assistance Services and Department of Social Services prior to the issuance of the software platform RFP. So we are working on -- we're continuing to work on that.

And as was mentioned, Chiquita

Brooks-LaSure, one of the Virginia Exchange Advisory Committee members, has been appointed to a lead CMS. And she did step down from her position on the Exchange Advisory Committee. The Governor's office is in the process of working on a replacement appointment, and it has not been announced, but I believe that the announcement -- or an announcement will be made shortly, perhaps in a couple of weeks.

If some of you may recall, the Advisory Committee, some members are appointed by the State Corporation Commission and other members are appointed by the Governor. And Chiquita was appointed by the Governor, so the Governor will be appointing her replacement.

And then for the Exchange staffing update, just to let you-all know, that the State Corporation Commission Office of General Counsel provides legal support to every division in the Commission, including the Exchange Division. Up to this point, there have been several Office of General Counsel attorneys have been supporting the

Exchange in addition to their regular assignments, though they've been very good about supporting us.

But I'm very happy to announce that Ms. Mary McLaurin is a new attorney in the Office of General Counsel who has been assigned to support the Exchange as her primary assignment. And Mary is with us today; if you would like to say hi, Mary.

MS. McLAURIN: Good afternoon. As Victoria said, I'm Mary McLaurin. I joined the Office of Consumer Counsel about two weeks ago. And I'm delighted to be working on this project and supporting the Exchange.

MS. SAVOY: Thank you, Mary. So you'll probably see Mary's name on a lot of correspondence or as part of meetings. We've already given her a lot to start with, so we appreciate that she hasn't run away screaming.

And then one more update that I was asked to mention: Some of you, I know, were participating in the Virginia Association of Health Plans annual meeting. And when I gave my little update at that meeting, I mentioned

that there would be stakeholder meetings with the health carriers coming up shortly.

And I just wanted to give a little update that we are still working on those. And it kind of threw our timing off when the CMS grant came in and we kind of had to put everything we were doing aside to work on that grant. But we are still working to create a stakeholder meeting for the health carriers, and we are requesting contacts for small group discussions with the carriers and seek carrier input on the software platform, the consumer assistance center, as well as marketing aspects. So I just wanted to mention we haven't forgotten about that. That's still on our to-do list.

And last but certainly not least, Whitney, if you would like to go forward. Whitney put this together. Happy first birthday to the Exchange. And as you can see, a lot has happened in a year. We went from zero employees to four employees. Even when I started in September, there was no official space allocated to the Exchange, and we now occupy about 1600 square feet on the

fifth floor of the Tyler Building.

So thank you, Scott White, for letting us have some of the space on the Bureau of Insurance floors. And part of what we've done is we've built a shared conference room that can be used by all of the divisions of the Bureau, plus the Exchange.

As you can see, we have increased the new plan selections in Virginia by about 7.6 percent in a year. And we went from zero certified application counselor designated organizations, the CDOs; we went from 0 to 34. And we also started at zero for the certified application counselors, and we are now at 195. So those are overseen by Virginia.

We went from 22 Navigators registered in Virginia to 35. And as I mentioned a little while ago, we had zero funded Navigator organizations; those original grants were issued in September of 2020, so in July we had nothing. And we now have two funded Navigator organizations.

And as you all know, we did not have an Advisory Committee back in July. And we

worked on that. That was one of the first things we did. And I'm really pleased to say we have 15 great and active people. We've had two meetings. This is our third meeting. And I look forward to more quarterly meetings.

And with that, I'm going to turn it back over to the Chair, Sabrina Corlette.

CHAIR CORLETTE: Thank you, Victoria. Before we launch into the reports and other business, I guess I should just ask, does anybody have any questions for Victoria? That was a lot of information, a lot of activity. So if there are questions, now's a good time.

DR. CAREY: This is Secretary Carey. One of the -- first of all, congratulations on that great progress in our first year and signing up for our partners. How on those -- whether it's the counselors and the different customer service folks -- how have we been on the geographic distribution? As we know, Virginia is two or three states if not more. And how are we doing in southwest versus Northern Virginia, the Valley; how are we

doing on that?

MS. SAVOY: Well, I must admit, off the top of my head, I don't know that. But I will certainly find out and let you know. I believe -- I know our Navigator organizations have multiple locations across the state, but I don't know about the other types of assisters, but I'll certainly find that out and bring that back.

DR. CAREY: Thanks so much. Appreciate it.

CHAIR CORLETTE: You're welcome. Any other questions for Victoria?

MR. CASTRO: Hey, Victoria. This is Scott Castro. Two brief questions: One, regarding the ARPA funds, did SCC or BOI submit any requests for the use of ARPA funds for anything benefiting the Health Benefit Exchange for this upcoming special session?

MS. SAVOY: I don't think so. We were not asked to provide any information to the General Assembly with that regard, no.

MR. CASTRO: Thanks. And also, any progress on -- I know you guys were looking for a director, a deputy director of

legislative affairs and consumer outreach. Any progress on that?

MS. SAVOY: Yes. We have had progress. We're in the process of that. Right now, as you can imagine, since it's one of the leadership positions in the division, the judges have been more involved than they are with the lower level. So because there's more individuals, it's taken awhile to coordinate with the Commissioners' schedules.

So it's still in the process, but that's probably all I can say right now.

MR. CASTRO: I appreciate that. Thank you.

MS. SAVOY: Sure.

MR. GRAY: This is Doug. I have a question. I'm interested in a timeline for the RFP. Do we have a general sketch yet or is it a little too early for that?

MS. SAVOY: No, I do. I have that over here. Yes. The timeline that I've worked on with the State Corporation Commission procurement project management office -- and as you can imagine, this is tentative because it goes out aways -- but

we're anticipating that the software platform RFP will be posted in October.

And then we're anticipating that we will begin to receive proposals in November. And we'll start working on the scoring and negotiations in December and work through that final contract and negotiations phase.

And actually, our plan right now is to award the contract by end of April of 2022, which would give us over a year for implementation purposes.

MR. GRAY: Thank you.

MS. SAVOY: Sure. And I think someone else -- yes?

MS. HINOJOSA: Hi. This is Ikeita Cantu Hinojosa. My question was regarding the notice of benefit and payment parameters. You know, there's some really important things that are happening with regard to those, especially just in terms of reversing some of the last administrations's rather dangerous trends and kind of putting us back in the right direction of expanding access, especially in terms of advancing equity for people of color and for historically

underserved communities.

I know you mentioned, I believe, at the end of this month was a deadline to submit proposed comments for the proposed rules. So I was just wondering, are we going to submit comments for that?

MS. SAVOY: The Exchange itself -- we as a single Exchange do not plan to submit comments. But I know that the National Association of Insurance Commissioners has, I believe -- either has submitted comments or plans to. And the Affinity Group of the state-based exchanges under NASHP, they plan to provide comments to the proposed payment.

So we'll get our comments in that way in a little more indirect route rather than just as single comments.

MS. HINOJOSA: Thanks.

MS. SAVOY: Any other questions? Go ahead Sabrina. Thank you.

CHAIR CORLETTE: Okay. Great. Well, before we turn to the reports from our subcommittees, I had raised an issue a few weeks ago with our Exchange team about the

end of the federal public health emergency. As folks may know, because of COVID-19 at the beginning of the pandemic, the federal government announced a public health emergency and, under federal legislation, passed, in 2020, part of that under the -- until the PHE is over, states that enrolled people in Medicaid have what's called a maintenance of effort requirement, where they're not allowed to disenroll those folks until the end of the PHE.

With the waning of the pandemic, the end of the PHE is on the horizon. We don't know exactly when that will be; it could be the end of this year -- sorry? I guess if you're not speaking, if you could put yourself on mute, that would be great.

So the public health emergency could end at the end of this year or stretch into 2022, but the reason I brought it up to Victoria and her team is because DMAS will have to process a bunch of eligibility redeterminations for Medicaid. And a number of those folks, we don't know quite yet how many, are likely to be eligible for fairly

generous subsidies for a Marketplace plan.

And I know a number of states are starting to think through the kind of coordination and activities that might be needed to ensure a smooth transition for these folks into Marketplace or private coverage.

And so I invited -- at Victoria's suggestion, which I thought was an excellent suggestion, we have invited Jessica Annecchini from DMAS; hopefully, Jessica, I got your name pronounced correctly. But we are just delighted to have you here with us today to talk a little bit about how DMAS is thinking about the end of the public health emergency and this transition period and also just any ideas you may have about how we as the Exchange Advisory Committee or how the Exchange can help keep people in comprehensive coverage after the PHE ends.

With that, I will turn it over to Jessica.

MS. ANNECCHINI: Good afternoon, everybody. I am the senior policy advisor for administration. So I report to Deputy

Sarah Hatton. So what I'm going to be doing is giving you guys an overview of where Virginia is in our beginning stages of planning far and wide. Go ahead to the next slide.

So, of course, before we start talking about unwinding, we need to talk about how did we get to where we are today. So just a quick snapshot here on what Virginia has done. So as previously mentioned, for eligibility and enrollment, all closures and reductions have been suspended in order to meet those maintenance of effort requirements.

Now, of, course with any rule, there is exceptions. And some of those exceptions are things like cases of death, permanently leaving Virginia, a customer's request to end their benefits, and member incarceration.

Also for our FAMIS, which is our CHIP population, pregnant women and individuals that turn 19, as well as our pregnant individuals that have a CHIP or 214 immigration status, they are not eligible under maintenance of effort. So when they no

longer meet their requirements due to age or postpartum, then we do have to reevaluate them for any ongoing coverage or close them out if they're not eligible.

So we also introduced verbal authorization from incapacitated individuals to assister groups. So this is really important, especially in cases early on, where individuals could not be in the same physical location as the applicant. So this really helped our assister groups in maintaining their safety.

We've also extended reasonable opportunity periods, and that is mostly for non-financial information. And then we also extended temporary out-of-state absences.

So we also made sure while we have current policy today that asks a processing entity to work with an applicant if they're having difficulty getting verifications, because of the multiple delays that have occurred with the PHE, we've definitely heightened that to say, if there's any circumstances outside of a customer's control or even delays due to mail, to work with

those applicants in processing their information.

So we did pause our manual renewal processing. This is where a worker would actually take a paper renewal form and run it through our eligibility system. But we did continue our automated ex parte or no-touch process.

We're not sending administrative renewal forms at this time. That is due to the uncertainty of the end of the PHE and, of course, subsequent changes that may happen once that form is returned.

We did resume renewal processing in July of 2020, but when we entered 2021, we did pause that processing again. So there has been a little back-and-forth based on the dates, but at this point, we are not processing any of those renewals manually.

And then a couple other areas outside of eligibility and enrollment: So for appeals, we have the automatic retention of benefits during the appeal. And that's a change from normal processes. So normally, a customer, when they appeal, they do have to

request that they maintain their benefits during the appeal because there's usually a financial association to that, where we can recover if we're found in favor of the agency.

So with that, not only is a customer allowed to automatically maintain their benefits, but there will be no financial recovery for continuing that coverage during an appeal. Also with appeals, we extended the time frame to request a fair hearing as well as verbal authorization, again, for representation during the appeal.

And then lastly on our services and benefits side, we did eliminate member co-pays and increased telehealth and electronic signatures, increased prescription allotments and delivery methods, and decreased barriers to our long-term services and supports, especially in the screening side.

And one thing I want to say that DMAS has done since putting these in place, some of the flexibilities for telehealth have been extended permanently, and we are looking

to seek permanent authority to remove those co-pays.

So what we've seen, since coming into the PHE, we now cover over 1.8 million members. And as of July 14th, we've enrolled 325,000 members since the beginning of the federal PHE. And currently, we're gaining about 4,000 members weekly.

So as I mentioned on the previous slide, we're not disenrolling members; however, we are continuing to run our ex parte, that no-touch renewal process. An ex parte process is only successful if we're able to maintain the current coverage or increase coverage for our members.

And so out of those cases that are eligible for ex parte review, Virginia has seen an 80 percent success rate in that. We definitely thank our partners at DSS, at Department of Social Services; they own the eligibility system where we run all these cases through. So we've worked with them to make sure we have robust data matching services in order to serve our members without having to send those administrative

renewal forms.

So we have been tracking, even before unwinding was even being thought of, we were tracking groups and members to prepare for unwinding. And so there's three main groups. We have those that have an overdue renewal. Then we have members that no longer meet non-financial requirements but cannot be reevaluated due to maintenance of effort.

Some examples would be other individuals that may have aged out of coverage or some of our pregnant women that would not be otherwise eligible other than what I talked about previously with FAMIS. And then time-limited benefits that have been extended to meet maintenance of effort, and those are our medically-needy individuals, individuals who are typically over income for Medicaid; however, they have had medical expenses that have allowed them to meet a temporary period of coverage.

So the main question is are we ready for unwinding? Our current guidance indicates that the federal PHE may be

extended through 2021. Of course, we know that that still is up in the air. We know constantly we're hearing about variants and the number of cases that we're receiving, so of course, that can change daily.

But based on this guidance, which has been a letter that was sent out to governors at the beginning of the year, we are working with DSS to plan our action steps in January of 2022.

So we have begun bucketing our populations to rank and determine a course of action to reevaluate. So again, there's the three -- the list of the three groups that we talked about on the previous page; however, within that, Virginia has a multitude of covered groups, depending on what type of benefits you may be eligible for.

Now with that, I just want to add, CMS, last week, there was a learning initiative webinar on risk assessment. And CMS has provided a little bit of guidance on some documents that states can use to track their risk assessment.

We've actually already been working

on that. It doesn't give the timeline, which is really one of the most important things that we'll talk about in a little bit here; however, the risk assessment helps to show what groups should you be looking at in what order, what are our potential populations.

So for Virginia, what we've looked at is our overdue renewals. This is going to be the primary mode to reevaluate our individuals, followed by those changes in circumstances, and of course, those are both things that may have been reported by a customer and those that are automatically determined during the course of their enrollment.

And then, of course, we need to align our systems, our eligibility and enrollment systems. And we'll get into a little bit more of each of those buckets in a little bit.

So as the maintenance of effort would continue through the end of the month in which the PHE expires, we would begin actions in February to reevaluate and then reduce and terminate coverage if the PHE were

to end in January. So the maintenance of effort requirements in order to maintain the increased federal matches, those would end in the month in which the PHE ends, but I do want to point out here, as well, the match rates themselves, they do not end until the end of the quarter in which the PHE ends. So there's a lot of different guidance on eligibility and enrollment versus services versus payment records.

So current guidance is six months to fully unwind from the end of the PHE. New guidance is forthcoming. We don't have a timeline for that, and I know multiple states ask in multiple meetings, you know, when is that guidance coming out. So we're all waiting for that; you know, as soon as we can get it from CMS, then we can begin putting a better timeline on our unwinding.

Now, of course, we would like to implement in a phased approach, when possible, but we must balance the budget considerations, which is what I just talked about; while we may have six months to unwind while we may only receive that enhanced match

for two months. So making sure that you're getting, you know, the best bang for your buck as well as serving your customers in the best way possible.

All right. So we actually were making some preparations that we were planning on using within our eligibility system even prior to the PHE. So I know this may be a little bit tiny for you guys. So in our eligibility system, VACMS, an update was made to an existing automated redetermination. Automation is key in making sure we can get through as many customers as possible using our existing information. So we actually expanded this process to include additional populations.

So we did not turn this on because this automated process does reduce and terminate. However, what this will help us do is it will automate the redeterminations for all of our pregnant women once they reach the end of their postpartum period, individuals that age out of coverage at 1, 19, 26, and 65. Those ages are important in terms of covered groups; certain individuals

can -- you know, our children's group are mainly under 19; 26 are for our former foster care individuals; and 65 is when most individuals would move from expansion coverage to one of our age, blind, and disabled coverages.

We also will have some automated processes if we determine that someone is now eligible for Medicare. You cannot have Medicare while you're in expansion coverage in normal times. And so what this will do is this will actually automate sending out information to gain information from our customers that we would need to evaluate them for those age, blind, and disabled groups.

So we will utilize our current ex parte process as well. Right now, the ex parte process works prospectively, and so what we would like to do is actually use that and rerun individuals that may have failed in the past, but we can successfully ex parte renew them now. A lot of times, automated renewals may fail due to data sources, and so rechecking those data sources may lead to increases in success.

And of course, we're going to resume the administrative renewal form process. That is actually built in to our automated process and that if someone does not successfully ex parte renew, no touch, then we send the administrative renewal form through that process.

Now, of course, automation being as great as it can be, there are some gaps that we have to address with manual work. And just a few notes on this: We do have other automated processes that we will be bringing back and resuming. Our transitional Medicaid, also known as extended Medicaid, that's a monthly process we'll be bringing back. And our foster care process does already run; however, we'll be expanding that to reevaluate individuals that are no longer eligible.

And then, of course, manual work, you know, that's going to come with anything that hasn't been reported or recorded within our eligibility systems, which we'll go into on the next slide.

All right. So like I said, there's

a number of processes that will need planning to implement; however, customer reported changes is going to be one of our biggest hurdles to jump over when it comes to manual processing. So we do have a self-directed, again, a no-touch process, when someone submits an application or a renewal but changes must be renewed manually.

Now this includes changes that may have been reported directly to an eligibility worker and may not be unloaded into the system; or changes that have been reported, however, it was determined that those changes couldn't be acted upon because they would cause the reduction or closure not allowed with maintenance of effort.

And then our manual renewal processing, so we've gone over the ex parte process. So those individuals that cannot go through ex parte, it may be because we need to get additional information for them or their covered group is not eligible for ex parte renewal. Currently, in Virginia, any of our covered groups that have a resource test are not eligible for ex parte review.

We do have some electronic sources that can help match liquid resources, which is an asset verification system; however, there are some sources of income or some of those other non-liquid resources that do need to be verified with the additional help from the customers.

And then another thing I had noted on the last slide was aligning our systems. So aligning our systems includes making sure that our eligibility system, VACMS, says the same thing as our enrollment system, MMIS. And sometimes those systems can become out of sync; it could be in terms of enrollment, it could be in terms of renewals. And so that is another process that we have to work on manually to make sure that everything aligns.

So then the Marketplace role. So, of course, we know that most individuals are referred to the Marketplace when they're not eligible for full coverage through Medicaid or FAMIS. Now, some of the big exceptions to that are if someone is closed due to a report of death or if someone is enrolled in

Medicare, we do not refer those individuals to the Marketplace.

So currently, Virginia sends a file to the federal Marketplace with details regarding the applicant's eligibility, including the reasons for ineligibility for Medicaid or FAMIS. So when that happens today, the individual receives a fact sheet in with their notice of action. This is called the Marketplace referral. And it advises them of next steps. So this is not something that is automatic currently.

So the customer has two options. They have 60 days once we have sent the information to the Marketplace to complete their application. And they can either wait for a letter from the Marketplace to give them next steps or they can go ahead and go into the Marketplace and start their application.

There's actually a question on the application that asks if someone has recently been denied from Medicaid or CHIP coverage, as that's what it's known as federally, and so if they answer yes to that question, which

the letter directs them to do, that will end upon linking the information.

So we do think that there will be an increase of referrals likely at the beginning of unwinding; however, that will probably -- that will probably level off over time.

So there are temporary increases for individuals who report changes that have made them ineligible and haven't had any subsequent changes that would allow them to remain enrolled. I will say with this, and for the referral process, we have already been in conversations with CMS, however. We are on technical calls with them monthly and we want to make sure we have clear guidance on all referral rules, that we make sure our eligibility system is up to date to make sure we've incorporated all of those rules.

So all of that being said and everything that we were planning for unwinding, a lot of the information and timeline is still up in the air. This is still very early planning stages. We do have at lot of members that we need to touch. So just some considerations here that we are

going through as we're planning for unwinding.

So the length of time that we will have to unwind and the level of outreach are key. And we are waiting for updated guidance from CMS to be able to do this. We've already talked about the length of time of renewals and we've talked about it from the financial side of our match rates. However, one thing to consider when you're renewing your population is if you're trying to unwind and renew your entire population within six months, you're setting up yourself for year after year having increased renewals due on one half of the year.

And of course, our ex parte rates, like I said, they're 80 percent successful, which does take care of a lot of our MAGI populations. There's a large number of population that we do need to touch manually. And so that's something to consider.

So when we're talking about outreach, this is also important because there's still outstanding guidance from CMS on, if someone has reported a change, at what

point do you need to reach out to the customer and say, "Has anything else changed since this point?" You know, customers sometimes, you know, when they report a change, they may know that they're over income, but they may not understand that, while still enrolled, they can report subsequent changes.

So this will be key as well for the Marketplace and referrals. Because once we receive that guidance on how long, you know, those changes stand versus when we have to reach out again, may affect how many individuals we automatically refer versus having to go through another change reporting requirement with them.

So avoiding unnecessary churn. Churn is a huge issue for a lot of states. And churn is, of course, someone coming on and off of those Medicaid rolls. And we want to be able to do that not only to keep them where they should be but to keep those referrals bouncing back and forth between us and the Marketplace.

So what Virginia is doing is

utilizing all data sources possible, making sure our data sources are correct, and including our data from other programs.

Virginia has an Enterprise eligibility system, which means our SNAP or food stamp benefits and our TANF benefits were all within one system. And that allows us to actually use data from other programs in order to make those redeterminations. So not only helpful for keeping individuals that should be on Medicaid stay on Medicaid, but if we do need to refer them to the Marketplace, making sure that the information we send is up to date.

So with that, we need to bring in stakeholders and community partners to understand this timeline. You know, the correspondence is meaning those checklists that we send out for information and notices of action so we can educate both members and the community.

So lastly, we have the staffing for member support. So of course, it's not guaranteed, but increases in reductions and termination could lead to increases in

appeals, and of course, calls to our statewide call centers.

So we are considering training across multiple divisions to ensure everyone is aware of the changes; we want to make sure whether or not -- you know, of course the PHE has touched all of us in DMAS, but when it comes to eligibility and enrollment, everyone can take a role to educate customers and assisters. And so we just want to make sure everyone is aware of those changes and to be able to answer the increased call to support our members.

That is the last slide that I have. I know that, you know, we wanted to talk about the role for the Marketplace, so I just wanted to open it up for any questions anybody has and just to say thank you for letting me come and present.

CHAIR CORLETTE: Jessica, thank you so much. That was very, very helpful information. And it looks like you guys have, you know, very wisely started early on the planning for all of this. This seems like it's a lot to do. It seems like it's

far away, but it's actually not.

I just have a question, and then I'll open it up. So I know there is just a lot of unknowns, but do you have any sense at all, of the populations that you are tracking, how many might be eligible for Marketplace subsidies, like kind of what sort of volume of people might the Exchange be preparing for? And I know we don't know in advance how quickly all of this will happen, but do you have any sense at all of the numbers of people we might be talking about here?

MS. ANNECCHINI: So there's definitely some different numbers that we can provide and maybe for the next meeting we can give some of those in a breakdown. I would say, unfortunately, when it comes to those changes, like I said, a lot of times you're not sure whether or not those changes, I would say, have stuck. If you had someone that has reported an increase in income eight months ago, that income may not be the same anymore.

And so that's one of those things

that we'll have to reach out to customers again and say, "Have you had any other changes?" One thing with our eligibility system is, once you start processing something, unfortunately, you can't roll it back. And so I know that some agencies, some local departments of social services are keeping track of their lists, but until you actually go in and determine the eligibility, you don't know whether or not they're going to either reduce coverage or terminate.

And so I think you can probably give some light numbers of the populations that we're tracking; however, the numbers that may be ineligible are a little harder to basically determine at this time, because we have to see has there been anything that's happened since the last time they've given us information.

So I'm sorry; I know I kind of said yes but no. But unfortunately, it is a big number up in the air.

CHAIR CORLETTE: Yeah. Well, if you've gotten 325,000 people just in the last, what, 15 months, that's just a lot

of -- that's more than -- that would be more than double the size of the Exchange. Not that all of them would be eligible for the Marketplace, but it's just a lot of people.

MS. ANNECCHINI: And I would say that, you know, some of these individuals may have been eligible before the PHE. Anytime that there's large policy changes and, you know, Medicaid comes into the news, you do end up gaining enrollment for people that were eligible before.

And so I think that that's another thing to think of, too, is that we may see some individuals that stay on coverage, post PHE. I think that, you know, we'll eventually come back to those PHE numbers, but I think it may be a slower process than, you know, a sharp increase.

CHAIR CORLETTE: Well, I'd love to open it up to anybody on the Advisory Committee who has any questions for Jessica or Exchange staff.

MS. HINOJOSA: Thank you so much for your presentation, Jessica. You made a really important point about how sometimes

the automated renewals fail due to data sources, and of course, we know that just, you know, one of the realities of low-income and underserved communities is that, you know, addresses and phone numbers and life circumstances are just frequently changing. And so, of course, that kicks your team into doing the manual review for a lot of those data sources.

But you mentioned that Virginia has the Enterprise eligibility system, where you're able to get information from SNAP and TANF and other programs. So I just wanted to ask you, if you do get updated data from Medicaid, somebody's address, for example, is that data input into the Enterprise eligibility program and shared across all those other programs?

MS. ANNECCHINI: It is. So depending on how the case is built in the system, a lot of times all of the benefits are actually on the same case. And while you run eligibility based on your program, a lot of that data is shared among the clients, and then case level data is shared among the

case. And so that information does automatically update.

So for example, if they report the new address on their Medicaid renewal, if their Medicaid and SNAP benefits are all on the same case, when you update it for one, it updates it for all.

MS. HINOJOSA: Great. Thank you.

CHAIR CORLETTE: Anybody else have questions for Jessica? I guess -- and I know there's just so many uncertainties, but I guess I would have a question for Victoria and your team: I mean, if conceivably we can start to get an increase in these transfers as early as February, is there going to be a need to sort of rethink Navigator staffing, customer service staffing? Because I think a lot of these folks may have questions about what they're eligible for, how to apply, those kinds of things, making sure that there's resources to support people through the transition. I know, typically, after open enrollment, it's kind of a quiet period.

MS. SAVOY: Not this year. But no, you're very correct. We would, I think, have

to anticipate. Even though enrollment would be through the federal Exchange still, because we're still operating on the federal platform, you're right, the Virginia Navigators should expect to get probably a lot more questions and calls.

So I'm thinking that our two agencies, we need to keep in touch so that we can work together and make sure that we have some common communications or at least an understanding of the timing so we can work on this.

And perhaps at that point in time, there will be -- we will have our marketing RFP complete and we can actually maybe have some targeted marketing, things like that.

So you're right, even though we won't be able to help out in the actual enrollment, we can certainly do some of the ancillary activities, like the Navigators and the assisters and the marketing and anything customer outreach that could help in Virginia. Good point.

CHAIR CORLETTE: And then I guess I have a question: I don't know if Julie is

still with us, or maybe Doug. You know, I'm thinking about the carriers, the Marketplace QHP carriers. And again, I know often insurance companies do not like uncertainty, and I don't know how much is known about the population that might be making this transition, so I'm just curious if this is on the radar screen for the Bureau or for the health plans that participate in the Marketplace and if there are any consideration in terms of rates or networks or otherwise to make a picture of it that it's a stable market.

MR. GRAY: Yeah, it's actually an issue for us. We've been asking a lot of questions about what, when, where. I mean, part of the challenge here is whether we can transition people back over a year, over six months, over three months. I mean, what's the policy decision? And that's what we're all waiting on.

I think it would be intelligent from a policy perspective and an operational perspective to give people a year so that we're not having large groups of people

getting dumped off all at once. Because that would completely exacerbate your previous question of needing help.

But I would share the observation with you that we had the opposite problem as we were transitioning to an Exchange. And the problem we had was that we had people who were on the Exchange that were now eligible for Medicaid. And we wanted them to seamlessly move off of the Exchange and into Medicaid plans.

And we were not permitted to, for example, have a list of folks that we could, you know, help them transition, even though we knew they were going to be coming off. The position of CMS was, well, they're entitled to enroll in an Exchange and Medicaid, even though they will get dinged on their taxes for taking the subsidy at the end of the year.

But they basically said the law would not permit them to just refuse them admission to the Exchange and put them in Medicare. Now I think a state Exchange could have done that.

And so what's interesting about this is now we have the opposite problem. And so we're all figuring out, all right, how do we make this smooth? So we obviously would love to figure out how to do it. But I mean, there are a number of rules that I'm sure will create barriers to making the seamless easy sort of transition.

CHAIR CORLETTE: And Jessica --

MR. GRAY: And let's say you are a plan that has both Medicaid and an Exchange plan, you would like to be able to keep them, right? You'd be able to reach out and transition them. But of course, they have a right to choose and a whole bunch of other criteria have to be met. So it's not simple. And there are plans that don't offer on the Exchange who do offer on Medicaid. So that's also...

CHAIR CORLETTE: Thank you, Doug.

And Jessica, are there any limits at all on the automatic transfer of data to the Marketplace to the FFM to ease the transition into coverage if somebody's getting off of Medicaid? Or what about getting those names

and contact information to Navigators? Are there limits on that?

MS. ANNECCHINI: I'm sure there would have to be data exchange agreements and things like that that would need to be set up, considering the PHI and that. I know that we have a lot of Navigator groups that do reach out to us. And even talking about the health plans, some of our health plans even reach out to us because they want to make sure that they're also, you know, communicating with their customers; this is what may happen; you know, they'll focus more on the renewals, of course, than other things.

But I mean, anything is possible. I don't want to limit us to that. And like I said, I mean, the big thing is, you know, until you actually pick up those cases and redetermine the possibility of whether or not those individuals, you know, stay where they are, maybe move within coverage within Virginia, or would be transitioned to Marketplace, one, that would be very hard to prepare for, because of course, we need to

get that guidance on how long can you take the information that's on file and use it versus reaching out to those customers again.

But it's definitely something we can look into, because I think all the help we can get, the better. We also have an outreach chain. And like I mentioned, we want to make sure that we're giving resources to any of our advocates and stakeholders so they can help individuals; when you get this letter that says, "You've been transitioned to the Marketplace," that you don't stop; you have to go in and get that application started so you don't have a gap.

CHAIR CORLETTE: Right. Right. Well, and Doug, you know, I hear you. Especially for the plans that have both products in the Medicaid market and in the Exchange market, you know, perhaps there's a way to sort of temporarily sort of seamlessly move people over; and I totally agree, people should have a right to opt out or choose, but if there's some way to just sort of transfer them, even on a temporary basis, just so they don't have a gap in coverage. I don't know

if that's possible, but it's something to think about.

MR. GRAY: Well, the key way to avoid is to spread things out over a significant period of time --

CHAIR CORLETTE: Yes.

MR. GRAY: -- six months or longer. That will certainly reduce the number. But even if we did that, you may have a month where we have an extraordinarily large number that is more than we can process in a month. That's not an appropriate thing for us to make happen at any level.

CHAIR CORLETTE: Right.

MR. GRAY: So we need to try to avoid that if we can.

CHAIR CORLETTE: Yeah. Okay. Any other questions on this topic or observations, recommendations?

MS. KISER: I have a question. This is Starla. Just for my own knowledge, how does DMAS -- where do you get the -- what data allows you to do the automatic enrollment? Because I'm almost thinking of a different issue as well, just thinking about

a future where not just filling the gap and people going between but making enrollment in those eligible for the Exchange that don't have to pay anything out of pocket, making that automatic in the future somehow.

So I'm just wondering, you know, like when an individual fills out their state income taxes, there could be a question, "Would you like to be automatically enrolled, yes or no," or something. But I'm wondering, how does Medicaid -- what automatic touchpoints does Medicaid have? So if you think about all the automatic touchpoints, people that are signing up for vehicle registration or getting a driver's license or doing their income taxes, where does Medicaid get the automatic information to enroll?

MS. ANNECCHINI: Sure. So from the non-financial side, a lot of our sources come from DHS, actually. There is no requirement to match an address. An address is an attestation as well as Virginia residency for Medicaid. So we don't have to verify that information. Our non-financial verifications are more for your SSN or your citizenship or

immigration status. So a lot of those go through data sources with DHS.

On the income side, we have matches with VEC as well as The Work Number or TALX. We do have -- I'm trying to think of what else. We do also match with the IRS.

And there's a hierarchy for that. It depends on -- of course, some of those data sources more recent. VEC, we use for both earned and unearned income, so unemployment income. Then for resources, like I said, we do have asset verification, which only works for our applicant. So if others in the household, if those resources are needed, we do have to ask for that manually. But our asset verification system will ping for disclosed and undisclosed liquid assets, so mainly those bank accounts.

MS. KISER: Thank you.

CHAIR CORLETTE: Any other questions for Jessica, recommendations, suggestion?

MS. HINOJOSA: Jessica just mentioned VEC. And so Victoria, my question is actually for you. As the Exchange, are we coordinating with the Virginia Employment

Commission that, as people experience these various life transitions, to make sure to educate recipients on the availability of low-cost private health insurance coverage as they're signing up for unemployment insurance and making sure that VEC is also, as they're communicating their information, also including information on health insurance enrollment and providing the appropriate links on their website and outreach materials?

MS. SAVOY: At this time, we are not. It's a very good idea, but right now, we just don't have the staffing to handle that at this time.

MS. HINOJOSA: Okay. We may want to flag that for the future, though.

MS. SAVOY: Sure. Yes. I agree.

CHAIR CORLETTE: I would also say that's a really great point to make. And we've noticed that, in this pandemic period, a number of the state-based Marketplaces have been really, I think, forging great connections and partnerships with their unemployment agencies. So there is, you

know, more coordination, more information getting into the hands of people who are applying for unemployment benefits.

I guess it's making lemonade out of lemons with the pandemic, but we've seen some of the SBMs really forging great cross-agency partnerships that I think will have long-standing impact. So lots of lessons to learn from others.

COMMISSIONER STOREN: This is Duke Storen, Commissioner of Health. I mean, on the VEC website and the UI portal, there is a link to cover Virginia and encouragement for people to apply for health benefits in that manner.

And the VEC also has a really great technology where they're able to sort of parse out their participants and former participants in target messaging. I know they've put out messages for us on the expanded child care eligibility recently. And it seems to be a really doable strategy without a lot of labor intensity.

So I do think that there is some good things happening in that partnership,

and that there certainly can be, without too much difficulty, more to be done there. Thanks.

MS. SAVOY: Thank you. That's good information to know. Appreciate that.

CHAIR CORLETTE: Great. Lots of work to do.

MS. SAVOY: I'm just taking notes here, yes.

CHAIR CORLETTE: Well, we can maybe move on to the reports. Jessica, a thousand thanks for joining us. And no good deed ever goes unpunished, so we hope to be able to be in touch with you again in the future to figure out how we can better deport your current customers in any transition that they have ahead.

MS. ANNECCHINI: Absolutely. Thank you so much for having me.

CHAIR CORLETTE: All right. So we're moving on to the reports from our subcommittees. The Advisory Committee had two active subcommittees this year. And we're first going to hear from our eligibility and enrollment subcommittee.

Doug Gray was kind enough to step forward early this year to serve as the chair of that subcommittee. Doug, would you be able to just kind of recap that work and some of the recommendations that are now final and have, I believe, been posted to the Advisory Committee's website. Are you still with us, Doug?

MR. GRAY: Helps if you unmute. This subcommittee had a series of meetings where we kind of ended our work, our efforts to create the report around in February. So it's been a little bit. We had six sort of categories of issues that we were interested in around the RFP in particular.

Enrollment was a big issue, particularly the accuracy of the data, how it's collected, what the eligibility verification documentation process is, how it's collected.

The administrative capacity of Medicaid to determine eligibility and to coordinate that communication to others, whether it's the no-wrong-door approach or interoperability with DMAS. So that's really

a summary of the enrollment provisions, the use and sharing of data, having access to realtime data, in particular, and the integration.

The third category was really the timeline of the RFP, which we've had some discussion about. There were some recommendations to have a backwards timeline, definitely concerns about prelaunch testing and making sure there's enough time for it, which it appears there will be.

And also, just to have a -- at the time, we said it would be important to be able to keep our state status, and as a state Exchange using the federal Exchange, if it needed to take longer. After we made that recommendation, there was a decision made to go a year later. So the good news is we've got another year; the bad news is, if something goes wrong, we don't have another year. So the good news is we're going to use our time wisely.

The call center, definitely some questions about whether it should be separate and whether it could be a separate platform

vendor, what its role is, whether it can provide enrollment support and technical support; can it accommodate language needs; can it elevate a call so that a complex case can be handled at a different level, so there would be multiple levels; obviously, how it's called, it would be measured.

And then the oversight of the vendor, there are certainly concerns about just making sure that the vendor is accountable of sharing information in a transparent way and make sure that that oversight is robust.

And then there was definitely a serious conversation about website customer support and making it consumer friendly, easy to use, appropriately written for the user, and as useful as possible in terms of accessibility and systems, live chat functions and language access and usability for people with disabilities. So those are really the big issues.

I would say a number of the issues have been addressed. I think one question that is -- that we didn't ask or really

haven't talked about today was whether there was going to be one RFP or not. And it sounded to me like, when you gave us the timeline, that there's one RFP. And obviously, in my mind, there wouldn't be enough time to do more than one, under the timeline that's been suggested. But I thought I would just try to confirm that.

And just to say what I thought I've heard previously from our previous conversations in these different venues is that there may be the ability to have a one unified RFP or to apply for part of the RFP -- it could be both or it could be separate -- was the general description I've heard previously. I don't know if that still stands or if that's the right interpretation.

So it's kind of a two-part question: You know, is there one RFP? Which I think the answer is yes. And the second one is are people able to apply for parts of it or is it just for the whole thing?

MS. SAVOY: Doug, you are correct, there will be one RFP that is issued. Just

as you said, given the time, it was felt that, one, we would need to run everything through as one RFP.

And what we're doing is we did tweak it a little bit. And we will look for complete responses; however, a company can work with another company, so that if someone -- as an example, if a company says, "Well, I can do the software, but I don't have the customer assistance center," and this other company says, "Well, I have a customer assistance center," those two companies can come together and respond as one RFP. Or you could have a company that says, "Well, I do everything from soup to nuts." But that's how we've decided to do it in the interest of time and to get through the process.

But you can have multiple organizations or companies get together as part of an RFP response. Does that answer your question?

MR. GRAY: It does. You know, my natural thought is that there would be one responsible party if folks came together. In

other words, one would kind of sub to the other. And that's just because I'm assuming that managing it otherwise would be just, you know, awful.

MS. SAVOY: And I'm going to, of course, defer to the procurement experts and the legal experts on how those types of things would be structured.

MR. GRAY: Okay.

MS. SAVOY: So I don't have an answer for you right now on that.

MR. GRAY: Okay. And I'm happy to answer any questions folks may have. I'm sorry; I should have offered to do that sooner.

MS. HINOJOSA: Yeah, that would also be my question, Victoria, is the idea that there would be one lead and one subcontractor in that scenario or is the idea that there would be, you know, two co-applicants in a scenario like that? So I understand if you're not the one to answer, but that would be my question.

MS. SAVOY: Okay. I can certainly get that answer and bring it back to the

group, yes. I'll make another note on that. Thank you.

CHAIR CORLETTE: Anybody else have questions for Doug?

DR. STOREN: This is one question maybe for the SCC folks. Are you-all under the authority of VITA for your technology or are you outside of VITA? I think it just makes a difference if it's in the -- the approval of the timeline for IT procurement. Thank you.

MS. SAVOY: The State Corporation Commission as an independent agency, it's my understanding that we are outside of VITA for project approvals, but that's my understanding. But I have not heard otherwise.

COMMISSIONER STOREN: Thank you.

CHAIR CORLETTE: Any other questions for Doug? Or for Victoria?

MR. GRAY: Thank you.

CHAIR CORLETTE: Well, I believe -- Whitney can maybe confirm this -- but I believe the eligibility/enrollment subcommittee recommendations have been

posted. They are approved by the Advisory Committee, so they should be available on the website.

And we'll just move on to the second subcommittee that we formed for consumer assistance. But of course, people are welcome to ask more questions on the eligibility/enrollment piece, since the two are linked.

This subcommittee was actually chaired by Liz Cunningham. And unfortunately, she is ill today and not able to join us. So she did ask me if I could stand in for her in this presentation, which I'm happy to do. I'm just sad that she can't be with us, because she did a lot of great work chairing this subcommittee.

But this subcommittee met back in April, at the end of April. And prior to this subcommittee meeting, the group reviewed an evaluation of the Exchange's Navigator program that was conducted by a consulting firm, Health Management Associates.

And that report, coupled with a very robust discussion among the group, generated

a set of recommendations about how to enhance the consumer assistance function as required under the ACA for the Exchange. And so the recommendations that this group developed touched on a range of areas, including information sharing, making sure that, as we consider enhancing or improving the Navigator program, we're getting input from consumers themselves and the Navigators, of course. But from actual clients about what is working and where there is area for improvement.

Working to aggregate data from anybody who is working with consumers, whether it's Navigators, agents, or CACs, to try to get that into a single repository to encourage information sharing among everybody who's working in this space. There were recommendations on outreach and education, focusing not just on eligibility and enrollment functions but also on health literacy, the nature of health coverage and how to use it.

And then considering looking at a more boots on the ground presence, particularly as we emerge from the pandemic,

to really make sure people can get in-person help. Also, really trying to tailor outreach efforts to different segments of the population so that it's really focused on particular populations and what their needs are; a number of recommendations around accessibility and making sure that people, no matter what their abilities, are able to access these services.

We also had a set of recommendations around measuring impact of the Navigator program, looking at and making sure that they're meeting certain goals and oversight of the program to ensure that we had a constant improvement -- assessment and improvement type role.

These Committee recommendations were developed at the subcommittee level and then put forward to the full Committee earlier this month. We did have a couple of amendments suggested to these Committee recommendations. The first one is a suggestion from Secretary Carey. We had, as one of our recommendations, using the Virginia Medical Reserve Corps to supplement

the Navigator or consumer assistance infrastructure. And Secretary Carey had a note about the work of the Medical Reserve Corps and where they might be best optimized.

Secretary Carey, I don't know if you'd like to say anything about that. We have -- oh, thank you, Whitney. Whitney is about to share the screen that would show your suggested modifications of that language.

DR. CAREY: Sure thing. The background is that we are so appreciative of many, of both those that had medical professional certifications and licenses, as well as the lay public that have volunteered for the Medical Reserve Corps. And we saw that in great -- demonstration of great success with our community testing events and in collaboration with localities and the Department of Health and VDEM, etc.

So those were scheduled events where someone could sign up for two days or one day or a weekend. And those episodic ones were dramatically effective. Where we had

challenges with our Medical Reserve Corps -- and we did that with contact tracing, canvassing a neighborhood for a testing event or for an information session. We've seen that with, again, it's short-term, limited, not Corps staff.

So when I read the proposal, I just wanted to make sure that we didn't presume Medical Reserve Corps could suddenly be tapped for base staffing, core staffing, as opposed to episodic supplemental staffing and help do call-in lines, information; there's no doubt that we could train them as we have with a number of other areas. But it seemed to me I wanted to make distinction.

We saw with the nursing home crisis early in the pandemic, just -- it was very, very challenging to get them in an environment in which there was -- it was indefinite, they didn't have core staffing, and it wasn't like a field hospital from the National Guard that other states have or that we have in limited supply that could just parachute in and take over.

So I just wanted to be very clear as

to what they can do successfully and what we can expect of them. That's all.

CHAIR CORLETTE: Yeah, I thought it was a very helpful clarification of the potential for this workforce. Does anybody have any response to Secretary Carey's suggested addition to our recommendations?

MS. KUSIAK: I do. As someone who is on the MRC, I just want to emphasize also that the reason that it's been effective is the Department of Health has done an outstanding job of reaching out, giving very good information to the volunteers, and following up and giving a lot of flexibility.

So if we use them, we have to make sure that there's an infrastructure in place to really harness their talent in a way that optimizes both their flexibility and the needs of the project.

DR. CAREY: Jane, I couldn't agree more. You've added better concepts than I have. I couldn't agree more.

MR. CASTRO: I think our members at the medical side of Virginia would echo those

sentiments as well.

CHAIR CORLETTE: All right. Great. So it sounds like the suggested language from Secretary Carey is acceptable; but also, that this is an area that probably requires a little bit further, deeper thought and work before it actually turns into an actual program. But certainly, a great idea. And we'll move forward with this segment.

Whitney, if you don't mind scrolling down to the second page. We had another suggestion from Doug Gray on the measuring impact set of recommendations.

Doug, would you mind just saying a little bit about this suggestion?

MR. GRAY: Sure. This was suggested by one of my members, which was -- I think they were interested in metrics being reported on a regular basis by the Navigator grantee organizations and CDOs so we really have a measured understanding of what's happening in terms of calls and appointments and face-to-face encounters and advertising as well.

So I thought it was just a good way

to kind of square up what we hoped to already know. But as you know, what's measured gets done; what doesn't get measured, doesn't.

MS. SAVOY: And I would like to add to that. As part of the Navigator grant awards, there were reporting requirements -- or there are reporting requirements. And a lot of the details that are included in this suggestion, we are gathering information on.

And we are -- we get them on a routine basis from those two Navigator groups. So we can certainly bring those to the Advisory Committee meetings on a routine basis, if that's what the group would like to see.

CHAIR CORLETTE: I think that would be great, Victoria. I do have one thought though. And that is that I think it's absolutely right that the Navigators should be reporting on the metrics that Doug has suggested here.

But I also want to caution a little bit about measuring Navigators solely around the quantity of customers that they're servicing or calls that they're receiving. I

think Navigators are often working with extremely complex family situations, income situations. And part of the goal of the program is for Navigators to really spend a lot of time with individual families and people who have, you know, in addition to complex situations, may have language barriers, may have cultural barriers.

So I would encourage metrics that don't just look at volume or quantity but also the level of consumer satisfaction or sort of other metrics that would get at that; they're really, really critical, their high-touch goal that we need our Navigators to play.

MR. GRAY: That's a really good point. I mean, the outcome is what matters. I mean, we want them to get enrolled, right? And if they can't get enrolled, we need to know why. There may be a really good reason why they can't. Maybe they're not eligible. Maybe there's another issue. Or maybe they got other coverage. But knowing the outcome really matters.

MS. HINOJOSA: Yeah, I would echo

the importance of the qualitative information. Enrollment stories are really important just in terms of communicating impact. And so I don't know, in terms of the information that we're collecting already, just making sure that there is an opportunity for folks to be able to share some of those, oftentimes, success stories; you know, of course, there are the lessons learned of why people are unable to enroll.

But there are some really good inspirational things happening on the ground that we need to hear about as well and that are really helpful as we communicate with decisionmakers and donors and those kinds of other stakeholders as we share the impact of what our programs are doing.

CHAIR CORLETTE: Good points. Any other comments or suggestions with respect to the monitoring or measuring impact recommendations?

So I think we may as well -- I mean, we can do this now or we can do this over e-mail, but I think we have achieved sufficient consensus with maybe a minor tweak

to address the qualitative measurement. I'm wondering if it's worth soliciting a motion to adopt these recommendations, if people want to do that here in this meeting. What do folks think?

MS. KUSIAK: I so move.

MS. BIEDRYCKI: I noticed that the outreach and education bullet that Liz and I worked through doesn't appear to be modified.

CHAIR CORLETTE: Oh. Uh-oh. That's a conversion control problem. Thank you, Lee. I have so many versions of this document, I may have lifted the wrong one. My apologies.

Well, let's hold off on adopting this.

MS. KUSIAK: I take back my motion.

CHAIR CORLETTE: Lee, thank you, to the rescue. We will do this over e-mail, guys; my apologies.

All right. Well, that concludes the subcommittee reports then. Unless anybody else either from those subcommittees or other members of the Advisory Committee would like to make any comment.

Okay. Hearing none, I think we are ready for the next item on the agenda, which is, I think, just general -- is it other business, Victoria?

MS. SAVOY: Actually, it's -- I think it would be more along the lines of if you had voted on this and you specifically asked us to look into something and bring back a response to the Committee, that's what's normally in the next section, but we don't really have anything to that.

So really, I think the next section is the other business. And that really is just an announcement of the next Advisory Committee meeting. And that is October 28th. It's already been scheduled for 1 to 4 p.m. We are trying to schedule these meetings at least a little in advance so that people can plan for them better.

And I'm not sure we have the December meeting scheduled yet, but we do have this October meeting scheduled. And I believe you may even have an invitation that's already come out on that. And if anyone has any questions about the next

meeting, I'm happy to answer those if I can.

I guess I will say that -- this might be a good place to mention -- originally, the State Corporation Commission's extended telework policy was ending in September, and therefore, the October meeting may or may not have been in person. Earlier this week, the State Corporation Commission has chosen to extend the telework period through the end of the calendar year. So we will have this October meeting as a virtual meeting only. So no coffee or cookies for the October meeting.

Also, the next slide, we did not receive any requests from the public to ask for public -- time for public comments. So we have no -- I know we always schedule time for that, but we did not receive any for this meeting time.

So really, I think other than if someone has any questions, comments, or thoughts, I mean, I have some takeaways from this meeting, definitely some areas that you -- I will look into or get information

and bring that back to the group. And Sabrina, I'll talk to you and you can let me know whether you want me to do so in an e-mail or wait till the next meeting, but we can talk about that afterwards.

But if there's questions or comments or just other business, maybe someone has something else they'd like to bring up.

MR. GRAY: One item that I'm just going to write a note about that we haven't really talked about, not that I expected to talk about it, was the approach on the SHOP Exchange, or the SHOP concept. As you remember, there's been a lot of discussion about, you know, whether having -- what approach to take around that general topic.

And people really haven't done much in the way of SHOPs that have been successful. The cost of creating, you know, a full SHOP is pretty eye-popping versus the number of people who can use it and are eligible to use it.

And so I think recent guidance from CMS over the last week or two has discouraged going with the full SHOP approach and going

towards a contracted entity approach or something like that. I didn't know if there's any information you could share about an approach on that. So I just thought I would ask.

MS. SAVOY: Doug, to be honest, we've been focusing on the software platform and all of these changes that the federal government keeps giving to us. And so we have not focused a lot of attention right now on the SHOP and different ways that we could set that up.

I mean, we do have -- it's my understanding we have a very small SHOP aspect that runs through the federal Exchange right now. I know there are some states that don't have any SHOP period. I think we will plan to at least keep some form, but I can't tell you right now what that form will look like.

MR. GRAY: Okay.

CHAIR CORLETTE: Do we know, Doug, do we know for the states that have recently undergone a transition, Nevada, New Jersey, Pennsylvania, does anybody know what they did

with their SHOPs?

MR. GRAY: I don't know off the top of my head. I suspect they have it. They had shorter timelines, too, so I think it would have been unlikely. But I'm not sure if there's an option to just leave it where it is with the feds or whether -- maybe that's one of the options, but I know some states have gone with kind of just picked a vendor, which you know, of course, relieves them of having to build a huge, bulky tech solution for something that's not used very often. Thank you.

MR. BIEDRYCKI: I would just like to piggyback with Doug in saying that from our lens, the initial number of employers that were able to qualify for the SHOP were very few. The ones that did qualify ultimately permed because all of the employee ads and terms had to go through VFFM. And keeping track of that ended up being more trouble than it was worth to the employer to get the benefits of the SHOP.

So I think that, with things being equal, it would probably be best to leave it

where it is, if that's possible.

MS. SAVOY: And that is a good example of the benefit of stakeholder meetings that we are planning to have, so we can hear more of this information firsthand from all of you. So I appreciate this.

Well, Sabrina, I turn this over to you. What would you like to do at this point?

CHAIR CORLETTE: Well, I think we can give people an hour back in their day, don't you?

MS. SAVOY: I'm sure no one would complain about that.

CHAIR CORLETTE: All right. Well, do I hear any objections to adjournment?

DR. CAREY: I appreciate the efficient managing of business and presentations; it was excellent. Thank you.

MR. LEE: Thanks to the whole team.

CHAIR CORLETTE: Yeah, thank you Victoria and Toni and Whitney. You guys are doing great work. And thank you to the Committee. Thank you all.

MS. SAVOY: Yes, thank you all.

Appreciate everyone's time and efforts today.

And in the past.

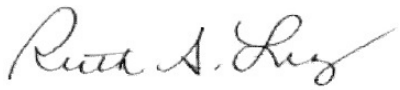
CHAIR CORLETTE: Thank you. Bye.

(Meeting adjourned at 3:00 p.m.)

CERTIFICATE OF REPORTER

I, Ruth A. Levy, RPR, do hereby certify that the proceedings were heard remotely before me in the State Corporation Commission hearing herein; further that the foregoing is a true and accurate record of the testimony and other incidents of the hearing herein; and that I am neither counsel for, related to, nor employed by any of the parties to this case and have no interest, financial or otherwise, in its outcome.

Given under my hand, this 3rd day of August, 2021.



Ruth A. Levy, RPR

Notary Public, Commonwealth of Virginia
My Commission Expires August 31, 2022
Notary Registration No. 224511

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