

Attachment 1 Exchange Call Center Responder's Value Add Capabilities

RFP Section 4.4.11, page 24; Appendix B References #26 - 27

Our value-add capabilities are the natural consequence of our national leadership position in the Medicaid and CHIP arena as well as the time and resources we have invested as a company in thinking about how the Affordable Care Act can be implemented in the most cost-effective, transparent, efficient, and accessible way.

While the RFP and its Appendices limit the Exchange Call Center to a set of responsibilities that are focused on phone-based interactions, we believe that a more expansive view of the Call Center's communication responsibilities is worth considering. The value-add capabilities we describe in this section assume a hand-in-hand relationship with one or more Exchange vendors and sister agencies, facilitated and guided by the Exchange. In this model, our respective responsibilities would strategically blend to optimize the ways in which uninsured Connecticut residents and Exchange enrollees get information, make decisions, communicate with one another, and handle the basic Exchange tasks (applying, enrolling, and re-enrolling).

The credibility of our value-add capabilities arises from the high rate at which we win the re-procurements of our contracts and the validation of our approach by highly respected external entities.

Across our 30+ Health Services projects, more than 95 percent have been renewed through a competitive process. Our high renewal rate is partially based on our ability to do the sorts of things we describe in this section of our proposal. Our clients appreciate our flexibility and natural inclination toward data-driven innovation. We have the unique ability to expand and extend the reach of our services through a combination of technology, understanding of the populations we serve, and implementation protocols that anticipate and mitigate risk.

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1.1 Data-Driven Policymaking

The Exchange opens new doors for re-aligning how application and eligibility processes are carried out for the nearly 400,000 Connecticut residents who lack health insurance. While we understand the current and future design as articulated in the RFP and its Appendices, our value-add capabilities open up the possibility of other approaches as well, now or in the future.

The Affordable Care Act (ACA) is a blueprint for uninsured Americans to be covered through accessible and simplified processes built around the "no wrong door" concept. Behind the scenes, the coverage continuum is remarkably complex, with differing health plans and provider networks, variable premium assistance levels (depending on family income), eligibility guidelines for the various programs crisscrossing with one another, and diverging program rules that put enrollees at risk of a gap in coverage.

If the average uninsured Connecticut resident understood all of this, many or most of them would lose the fortitude and commitment necessary to pursue coverage through the Exchange or any other public program. Fortunately, through the Exchange's strategic vision, its partnerships with DSS and other public stakeholders, and engagement of a company with the strengths and track record of MAXIMUS, this complexity can be distilled down to operational simplicity and accessibility.

Almost from the day ACA became law, MAXIMUS has invested significant internal resources to study how the federal law can best be approached and implemented by dedicated public servants at the state level. We have developed white papers on a range of topics, conducted informational webinars, provided feedback to the National Association of Insurance Commissioners (NAIC), and visited with dozens of high-level state officials who bring their own ideas and perspectives to the growing national table of ACA implementers.

Through all of this, MAXIMUS has emerged as one of only a handful of private sector thought leaders on how to make ACA understandable, accessible, and attractive to the many millions of Americans it was designed to help. The following list includes some of the topics we have written and thought about:

- How to minimize "churn", in which people lose coverage because of a process-related failure or inability to understand why they are being moved from one program to another
- Effective communication of complex topics to individuals with low literacy levels
- Recruiting, training, and managing a culturally competent and trusted Navigator corps
- Integrating a Basic Health Plan into a cohesive coverage continuum (particularly for states with stand-alone CHIP programs)
- How to integrate Medicaid premium assistance into an Exchange model to maximize access to employer-sponsored health insurance market by low-income individuals and families
- Functional similarities of the various coverage programs (as a precursor to a strategic model that mitigates ACA's unavoidable complexity)

For the Connecticut Health Insurance Exchange, we see many potential opportunities for further streamlining and re-alignment of responsibilities, beginning with a greater role in MAGI-based eligibility determination and renewal. While we concur that DSS must retain full responsibility for non-MAGI eligibility for individuals who qualify for Medicaid based on their age or disability status, we believe it is possible that many MAGI duties could be shifted to the Exchange Call Center, given the way in which income-based eligibility crosses the various programs,

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We have the experience and people to initiate a productive discussion among the Exchange and DSS about how this might look. While DSS may retain final authority over Medicaid eligibility

determinations, other business process and customer support functions could be transferred to the Exchange Call Center. This would minimize the need for call transfers and simplify the system's complexity from the consumer standpoint.

Our ability to suggest ways in which this could be done will also benefit from our award-winning Business Process Management (BPM) tools and capabilities. By applying data from similar projects, or by incorporating Exchange and/or DSS-data, we can model various scenarios to guide Exchange and DSS policymaking. We can create business process models, rich and multi-layered "what-if scenarios," technology assessments, and cost estimates.

Our analytical model for achieving greater efficiencies quantifies and deconstructs the type and intensity of the services provided and the frequency with which they happen in each general business process. In a non-optimized model, if a transaction takes twice as long, it will linearly cost twice as much. If a customer needs to access the service multiple times to achieve the same result, the unit cost of the service increases proportionately. For the Exchange and DSS, this means that common business and consumer assistance processes are at risk of avoidable redundancy that costs money and drives up consumer frustration and dissatisfaction.

The goal of our BPM approach is to leverage resources across all participating entities in a way that drives down the unit cost of a standardized and replicable transaction. We accomplish this by building a model with all of the relevant inputs necessary and then optimizing each component.

Through these BPM tools and methodologies, we can answer questions such as: What really happened in the past? Why did it happen? What is likely to happen in the future? By correlating and analyzing business events in the context of the processes in which they occur, we achieve accurate situational awareness that, in turn, helps us see opportunities, threats, or inefficiencies.

We look forward to making all of this analytical power available to the Exchange and DSS. Our goal in doing so is to give the Exchange and DSS an objective basis for considering possible incremental or large-scale modifications to its strategic design in service of the ultimate shared goal: reducing the number of Connecticut residents without health insurance.

1.1.1 New Media Tools

The Pew Internet and American Life Project studies and tracks how Americans are using technology in their personal lives. Their research shows that groups that have traditionally been on the unfavorable side of the digital divide in basic Internet and broadband access are increasingly using wireless connections to go online. Among smartphone owners, young adults, minorities, those with no college experience, and those with lower household income levels are more likely than other groups to say that their phone is their main source of internet access.

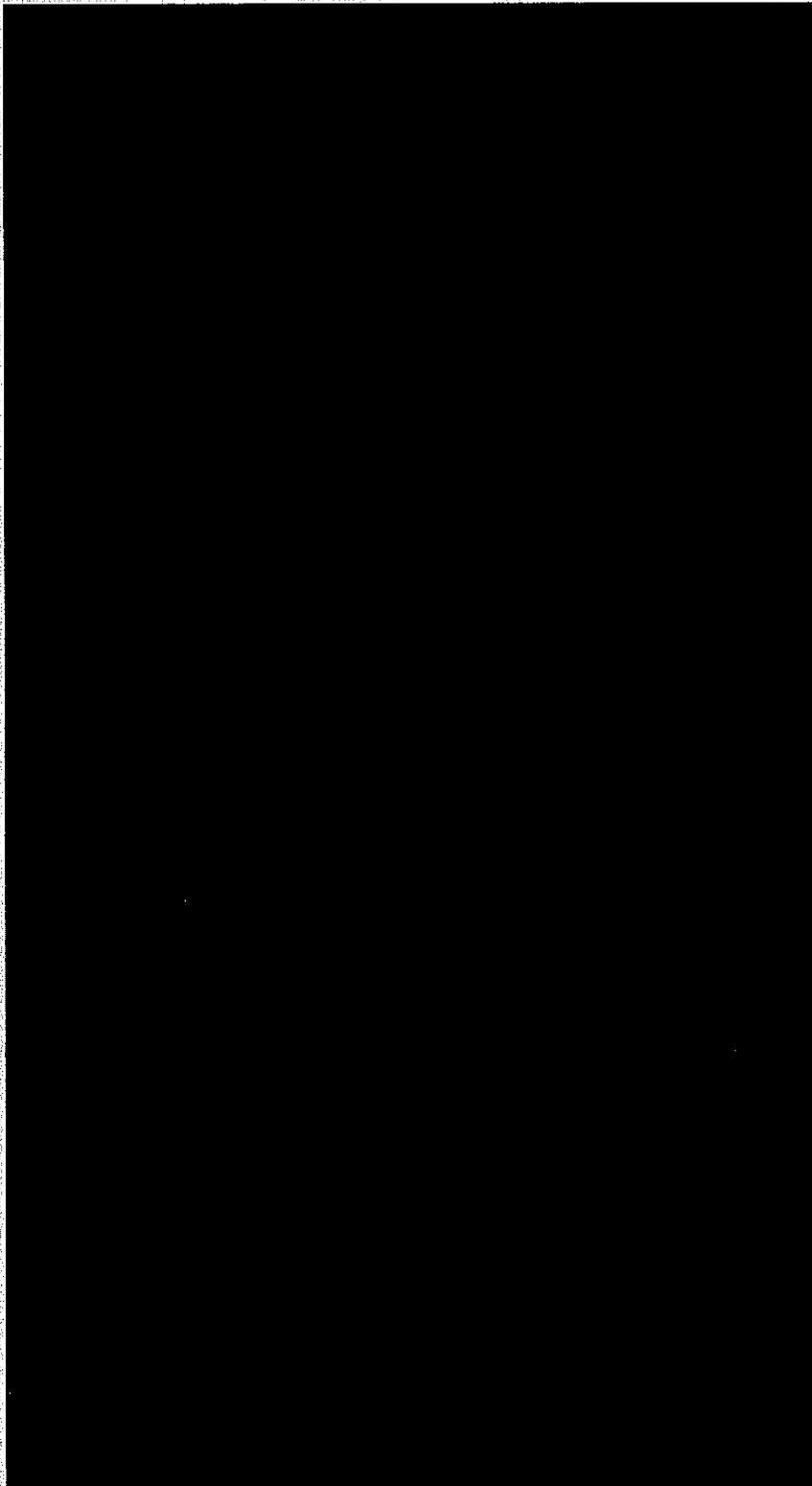
African Americans and English-speaking Hispanics are as likely as whites to own a mobile phone, and are more likely to use their phones for a wider range of activities.

Social media is penetrating all demographic cohorts of American society. For health-related programs and initiatives, it is an increasingly important and relevant forum for people from all walks of life to share ideas, concerns, frustrations, and positive feelings about their health. People will be discussing the Exchange through the most common social media tools, and it is essential for the Exchange to at least observe these conversations and, ideally, help guide and support them.

Our ideas for mobile technology and social media are presented as capabilities we could implement through new and expanded Call Center responsibilities. Alternatively, the Exchange could draw on our experience and knowledge to inform its strategic thinking in this area, particularly in connection with marketing and outreach.

Our mobile and social media ideas are intended to be an extension of the Exchange's overall marketing and outreach strategy. By having a presence where consumers turn for personal information and a virtual community of like-minded people, the marketing and outreach efforts are supported and magnified.

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Approval, Security, and Reporting

As with all other materials, the Exchange retains full approval authority over all new media content, as well as the ability to monitor and edit content as necessary. MAXIMUS will also work with designated Exchange staff to make sure any new media security settings align with Exchange outreach and social marketing goals. [REDACTED]

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1.1.2 Back-Up Capacity for the DSS Benefits Center

As we note throughout our proposal, the Exchange shares the "no wrong door" objective with the Department of Social Services (DSS). When fully implemented, this approach will empower Connecticut residents to learn about, and apply for, affordable health insurance programs without needing to understand the different programs or eligibility rules. All they will need is a desire to be covered and a phone number or website URL.

While the Exchange Call Center is a major element in this laudable strategy, another major component is the DSS Benefit Center. The centralized Benefit Center is part of the ConneCT project that aims to modernize client service delivery for Medicaid around standardized consumer assistance processes and the latest IVR and call distribution technology.

This is a very good concept, but one that will require a fundamentally different way of thinking and operating at DSS. Given the demands on the agency from other high-profile initiatives—especially Integrated Eligibility—we believe there are risks in the aggressive timeline. We offer ourselves as a back-up strategy for whatever additional time DSS needs to implement the Benefit Center in the best possible way.

There are several ways in which we can add Benefit Center capacity and infrastructure in the short term, depending on DSS needs and Exchange direction. Our ability to do this is driven by the scalability of our solution and the fact that we have successfully done this in other projects. For example, for our Medicaid client in Massachusetts, we expanded our call center capacity to take information-only calls that were previously being handled by overburdened state staff—through IVR self-service and our call center representatives. By off-loading these relatively simple but often time-consuming calls to us, the commonwealth was able to target its limited state resources to the tasks that only state workers could perform. With our help, we handle approximately two-thirds of the calls, half by self-service and half by our CCRs. The benefits of this shared responsibility are clear—reduced backlogs, increased customer satisfaction, and rising morale of state staff.

Because we are experienced and flexible with the ability to scale up and down with ease, we will be able to take on these additional, short-term duties on relatively short notice, based on the progress of the Benefit Center implementation. If that happens, we look forward to implementing the changes through the following steps:

- Document in writing the scope of work, schedule, and anticipated quantitative workload to confirm and validate our mutual assumptions
- Establish communication protocols and mutual expectations among DSS, the Exchange, and MAXIMUS
- Assess the impact of the changes on current Exchange Call Center operations, resources, training, quality assurance, and technology
- Assess and formulate any necessary adjustments to Call Center hiring, physical space, training, and re-deployment of existing staff
- Develop a timeline and risk assessment in relation to ongoing operations while the changes are developed and put in place
- Modify training materials and quality assurance methods
- Temporarily reorganize one or more functional units to align resources with the changes in operations
- Add or amend performance measures
- Modify systems and reports
- Develop a turnover plan in which our temporary duties are carefully and systematically returned to DSS

1.1.3 In-Person Assistance

In-person assistance is an essential Exchange communication channel to reach consumers who prefer to get help from individuals or organizations they trust. While a highly performing call center can gain this level of trust over time, the Exchange will benefit from a group of Navigators and licensed Brokers who

understand the new coverage continuum and are motivated to help others learn about, apply for, and enroll in coverage offered through the Exchange and the other programs.

Even as more and more people depend on the Exchange Call Center as a trusted resource, some consumers will continue to turn to in-person assistance for cultural, linguistic, or personal reasons. This means that while Navigators and Brokers will be particularly important during the initial enrollment period, the need for their services will never completely go away.

The Navigator concept has its roots in several programs, but perhaps the most prominent and successful of those is a California model built around Enrollment Entities (EEs) and Certified Application Assistants (CAAs). An enrollment entity is an organization that is credentialed to offer application assistance through the individual efforts of its CAAs. A person who wishes to be a CAA must be affiliated with an EE. Similarly, an organization that aspires to be an EE must take the necessary steps to make its employees knowledgeable and motivated CAAs.

When this model is applied to the Navigator concept, a Navigator organization would most likely be the equivalent of an Enrollment Entity and individual Navigators would be the equivalent of the CAA. Just as a Call Center Representative helps a consumer apply and enroll over the phone, we envision Navigators having role-based access to the Exchange portal to take in-person actions on behalf of a consumer who has authorized that kind of assistance on his or her behalf.

MAXIMUS has been responsible for administering the California EE/CAA program for almost a decade. Because of our work in California, MAXIMUS is uniquely qualified to recruit, train, and oversee a diverse group of Navigators. While our responsibilities would be more limited in relation to licensed Brokers—given their professional credentialing and regulatory environment—we believe we can still be a training resource for them regarding the functional aspects of the Exchange that are different from the purely commercial health insurance world.

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