LAWRENCE MILLER
Chief of Health Care Reform

State of Vermont
OFFICE OF THE GOVERNOR

TO: HCHC, SCHW, SCF, HROC, JFC
FROM: Lawrence Miller, Chief of Health Care Reform
Date: August 1, 2016
RE: Vermont Health Connect Report

I am submitting Vermont Health Connect's final report in conformance with Section C.106 of the budget bill passed in 2015. This update covers data through the end of the fiscal year, June 2016, and also touches upon more recent developments in July.

I am pleased to say that you will see a dramatic improvement in operational metrics across the board. These results can largely be attributed to system improvements made in an effort which we have dubbed the "Maintenance & Operations (M&O) Surge." As discussed in prior reports, we finished major system development in March, but still had a punchlist of defects to fix, errors to troubleshoot, and improvements to make. Our M&O partner Optum stepped up to the plate with a series of initiatives and deployments throughout the spring and early summer. Optum's dedication, along with that of state staff and other partners, is the reason we have seen this improvement. We are grateful that they have brought our system to a steady state and we will not rest until every customer gets the service they deserve.

Looking to the future, we are pleased to welcome an additional collaborator to the ranks of our team. Speridian is a firm that has experience both with Siebel systems similar to ours and with the OneGate customer-facing software. We are looking forward to working with Speridian in the coming months to implement a discreet set of steps that will further improve the customer experience.

Speaking of the customer experience, in addition to seeing improvement in our traditional operational categories, you will also see some new metrics. We have been asked to describe what success will look like for Vermont Health Connect and have outlined three focal areas in this report. One key area relates to operational structure and performance. Regarding structure, it's worth noting that the merger of all health care eligibility operations into the Department of Vermont Health Access was completed last month. This move is making administration more streamlined, efficient and effective.

Regarding performance, the Health Access Eligibility and Enrollment Unit (HAEEU) has set a goal of using the stabilized system to deliver timely service for customers. Specifically, the team is now aggregating the whole range of customer requests and tracking the time to resolution. By June 2017, they are aiming to complete 85 percent of customer requests within 10 business days of first request. This would be a significant accomplishment, both because it would be a steep increase from their 49 percent rate at the

start of 2016 and because it would put them on par, as a three-year old organization, with vaunted customer service levels of decades old insurance issuers.

As an interim goal, by October 2016, they are aiming to complete 75 percent of customer requests within 10 business days of first request. I am happy to report that they are well on their way to that goal, having averaged even better results (77 percent) over the ten weeks ending July 1!

Thank you for your continued interest in connecting Vermonters to quality health coverage and thank you for helping to make our shared goals a success.

VERMONT HEALTH CONNECT

AN UPDATE ON VERMONT'S INTEGRATED SYSTEM FOR MEDICAID AND QHP ENROLLMENT

PREPARED BY VERMONT HEALTH CONNECT AT THE DIRECTION OF 2015 ACT 58 SEC. C. 106.

AUGUST 1, 2016

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OVERVIEW OF KEY METRICS

Overview: Change in Key Metrics from May to July

Here are where key metrics stood in May and in July:

COC Inventory
Early May Count: 3,480

Integration – 2016 Transaction Inventory
Early May Error Rate: 3.5%

Open Escalated Cases
Early May Count: 234

Customer Requests Completed within 10 Days
Early May Rate: 66%

COC Inventory
Late July Count: 1,498 (down 54%)

Integration
Late July Error Rate: 1.6% (down 54%)

Open Escalated Cases
Late July Count: 30 (down 83%)

Customer Requests Completed within 10 Days
Early July Rate (most recent): 84% (up 27%)

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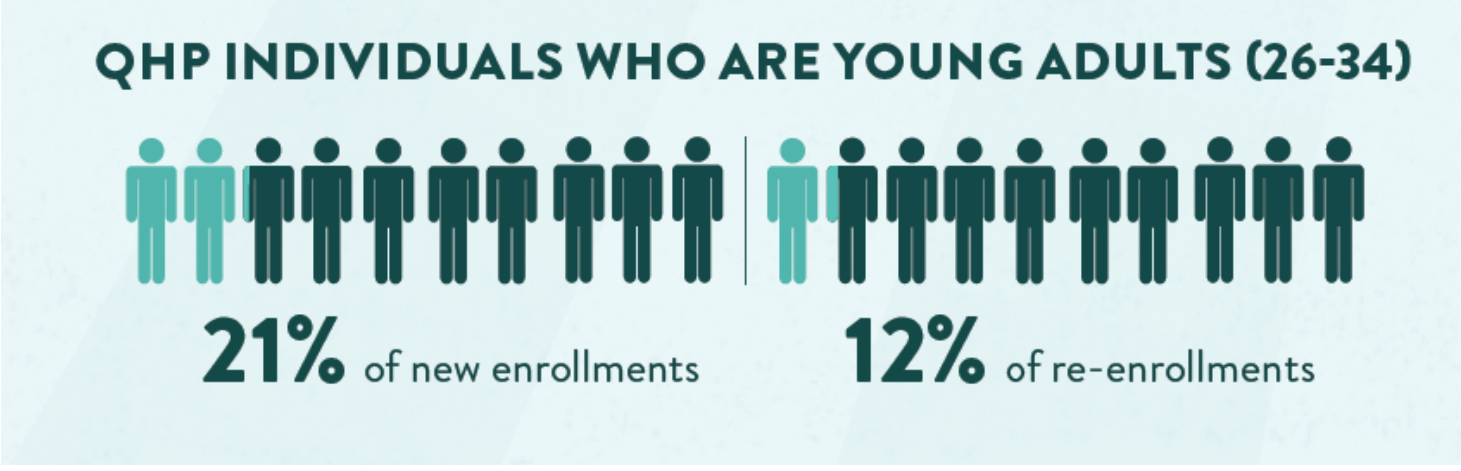
ENROLLMENT UPDATE

The Big Picture: Enrollment

- More than **one in three Vermonters is now covered** by a Vermont Health Connect health plan, either a qualified health plan (QHP) or Medicaid for Children and Adults (MCA).
- As of July 2016, approximately 220,000 Vermonters possessed such coverage.
  - QHP enrollment consisted of more than 78,000 Vermonters covered either as individuals through the exchange or direct-enrolled through a small business employer.
  - MCA enrollment included more than 77,000 adults and 63,000 children (including CHIP).
- DVHA's Health Access Eligibility and Enrollment Unit (HAEEU), which provides operational support to VHC customers, also manages enrollment for more than 30,000 Vermonters who receive Medicaid for the Aged, Blind, and Disabled (MABD).

The Big Picture: Enrollment and the Uninsured Rate

- National Center for Health Statistics estimates that Vermont's uninsured rate fell to 2.7% in 2015.
- Continuation of positive enrollment reports, such as those from Census Bureau showing that Vermont passed Hawaii and Washington, D.C. to attain one of the two lowest uninsured rates in the nation.
- 2016 VHC enrollment data shows that Vermont is:
  - continuing to chip away at the last 2.7% uninsured, and
  - reaching the challenging "young invincible" demographic.
- At time of 2014 Vermont Household Health Insurance Survey, 25-34 year olds were more than twice as likely as any other age group to be uninsured.
- They are now enrolling through VHC at a much higher rate.
- More than one in five (21%) new VHC QHP enrollees are in the 26-34 age group, compared to just 12% of the renewing population.



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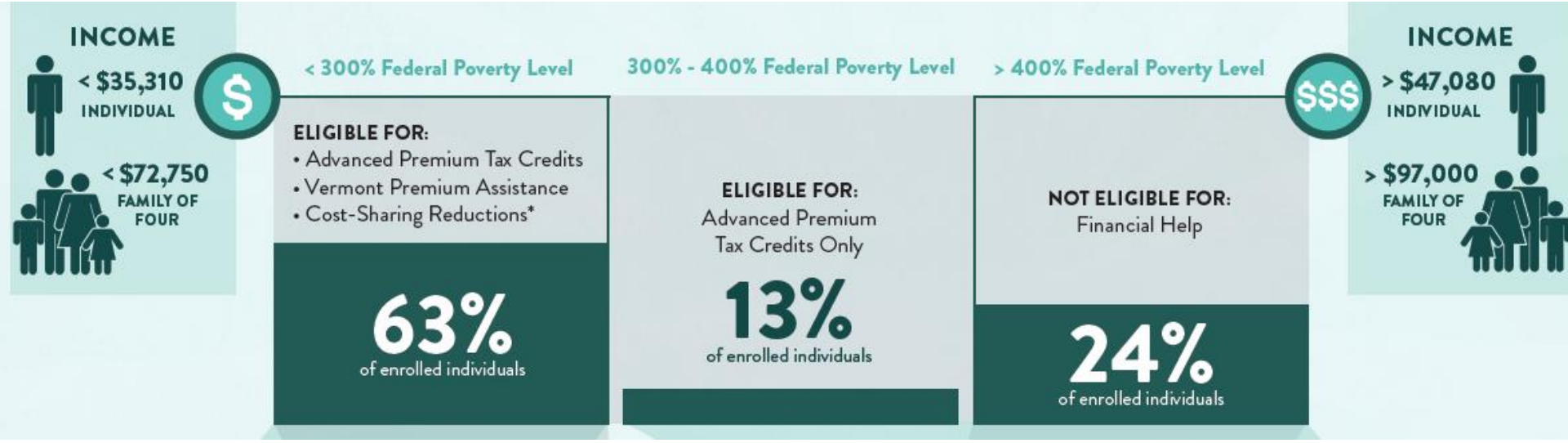
QHP Enrollment and Financial Help

- More than three-quarters (76%) of VHC-managed QHP enrollees receive financial help to make premiums and/or out-of-pocket costs more affordable.
- Up from approximately two-thirds last year.
- Proportion is even higher (87%) among newly enrolled QHP customers.



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THREE AREAS OF FOCUS

What does success look like?

Goal: To ensure that every Vermonter has access to high quality, affordable health care.

To achieve this goal, Vermont Health Connect must deliver in three areas.

1) Efficient, streamlined technology, which:
- promotes self-service,
- facilitates accurate and timely eligibility determination,
- ensures the integrity of data shared with partners.

2) A stable operating structure, which:
- enables accurate processing and service delivery,
- can withstand seasonal spikes in volume,
- provides quality customer service for Vermonters.

3) Educational resources and a network of partners, which ensure Vermonters:
- have quality health coverage options,
- are equipped to make the best decisions for their family's needs and budget,
- are supported in using their health coverage to get the best health outcomes.

TECHNOLOGY

Technology: “Maintenance & Operations Surge”

The successful March deployment of an upgrade to support VHC-system Medicaid renewals, the last in year-long series of system upgrades, allowed focus to shift to immediate priorities related to business operations and customer experience.

Dubbed the “Maintenance and Operations Surge,” a partnership between Optum and State of Vermont aligned work streams and resources to improve:

- **Medicaid Renewal:** optimize new functionality for enrollees already in system
- **Integration across all systems:** Carriers, Payment Processor (WEX), Legacy Medicaid system (ACCESS)
- **Reconciliation:** on-going monthly reconciliation

Goals

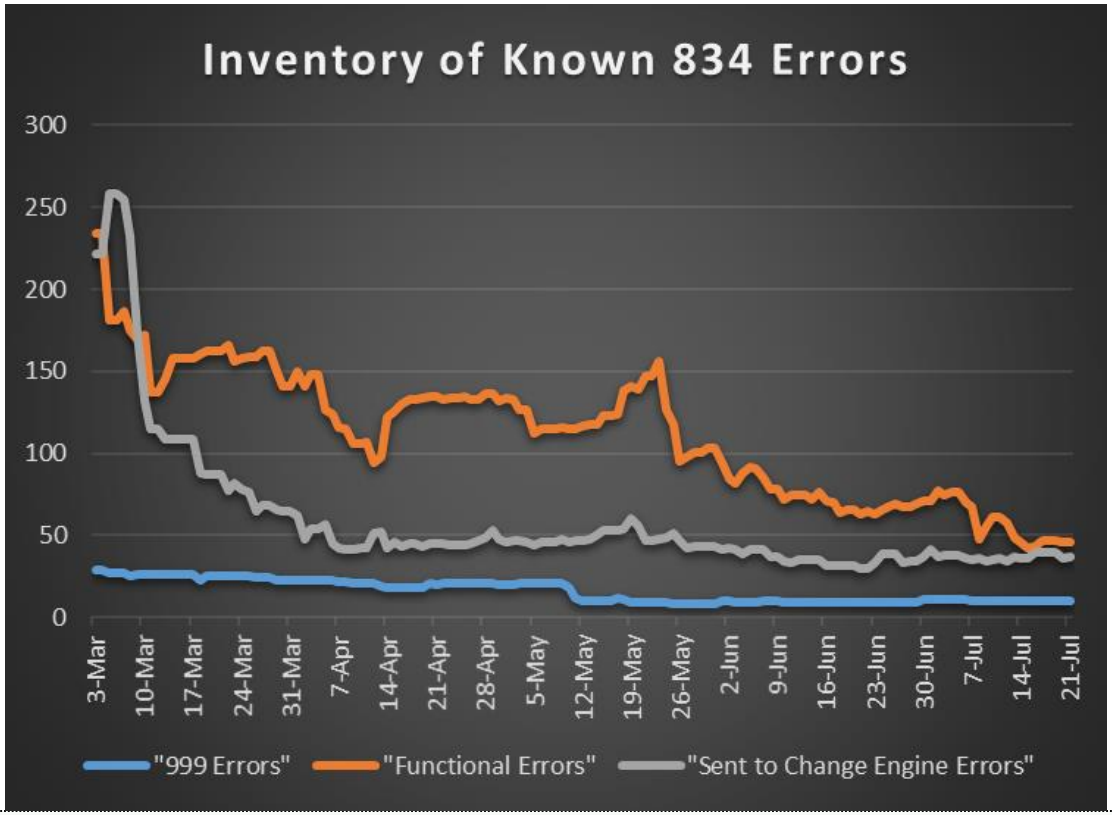
- For each stream, the focus included:
  - Root cause analysis
  - Remediation of existing issues
  - Prevention of future incidents

Results

- Significant deployments every three weeks to implement codes fixes, data clean-up, and process resolution.
- More than 200 defects addressed in first six deployments, including July 20.
- Dramatic improvement in key metrics across the board, from integration to COC to Access to Care.

Since March:

- Defect remediation and data clean-up from surge effort have reduced the number of new errors each month.
- Fixed 34 problem tickets and defects.
- Inventory of 834 errors down 83%.



In addition to working to resolve these known errors, VHC and carriers continue to work together to make sure transactions are being initiated and integrated across systems as expected.

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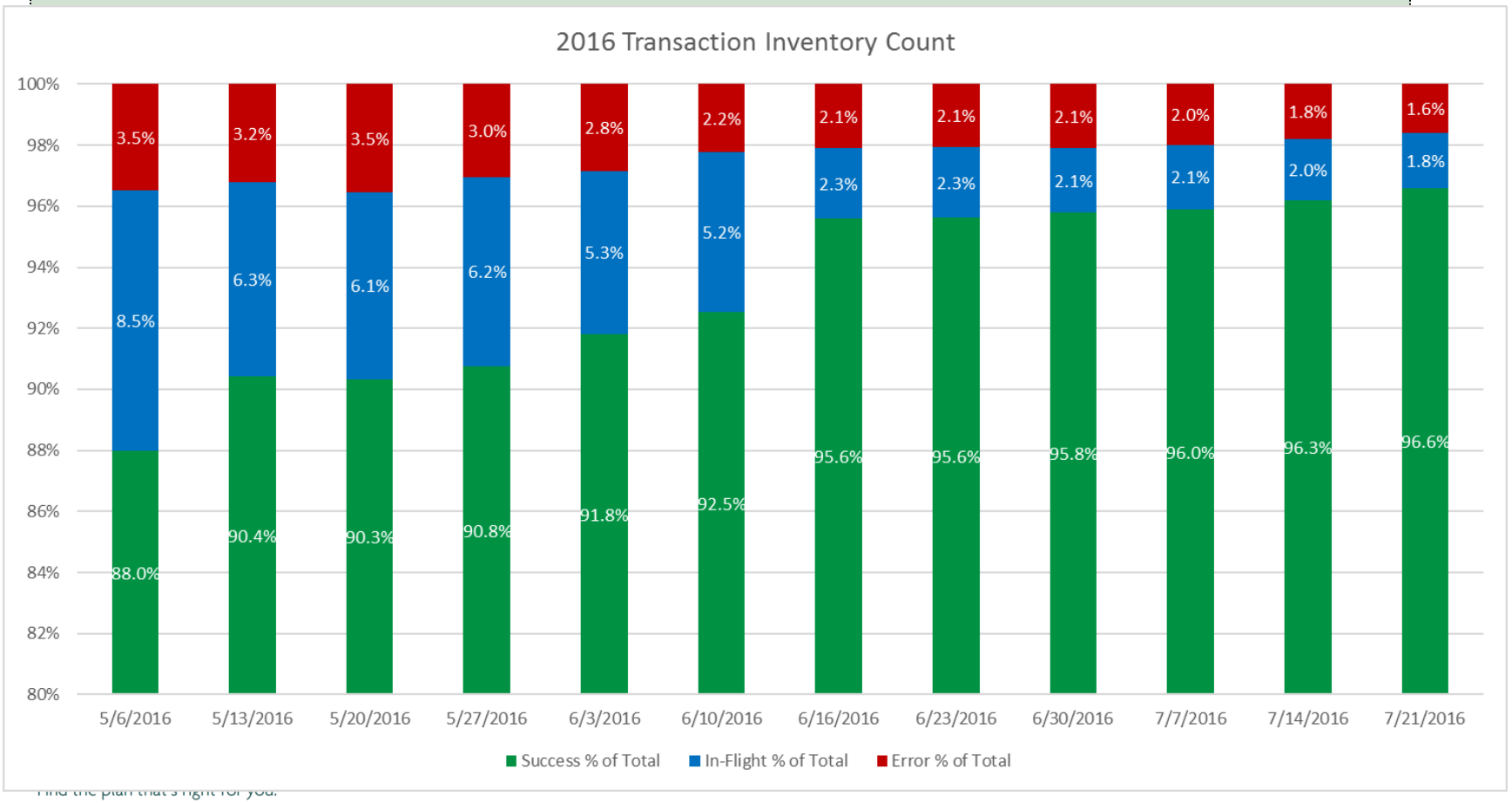
Integration

- "In-Flight" refers to transactions that have been sent from one system, but have yet to receive either a confirmation or an error from the other system.
- In addition to reducing the error rate, Optum and VHC have focused on reducing the number of transactions – and the time – that are in-flight.

Since May:

- Inventory of in-flight transactions cut by more than three-quarters (76%).
- Error rate cut by more than half (54%), from 3.5% to 1.6%.



Reconciliation

With system developed and stable, defects remediated through the Maintenance & Operations Surge, and performance metrics improved, data reconciliation across systems is key to improving the customer experience for those Vermonters with lingering issues.

Key steps:

- VHC now receives monthly reconciliation reports and actively works priority discrepancies with WEX and carrier partners.
- Reconciliation team can now fix 95% of discrepancies by using the system and not resorting to workarounds such as spreadsheets.
- VHC's integration team and reconciliation team have been combined to ensure maximum collaboration and efficient resolution of errors.

OPERATIONS

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Key Developments:

- Maintenance & Operations Surge allowing for greater efficiency and reduced errors.
- Merger of DCF-Health Care and DVHA providing streamline operations.
- Maximus processing more types of requests over the phone, providing faster customer service and reducing the work passed to HAEEU.
- Introduction of Tier 3 Call Center providing faster resolution to most complex customer issues.

Next Step:

- Commitment to sustained progress in delivering efficient customer service, and new benchmarks to measure that progress.

Goal:

- By October 2016, complete 75% of customer requests within 10 business days of first request.
- By June 2017, complete 85% of customer requests within 10 business days of first request.

Achieving benchmarks will benefit:

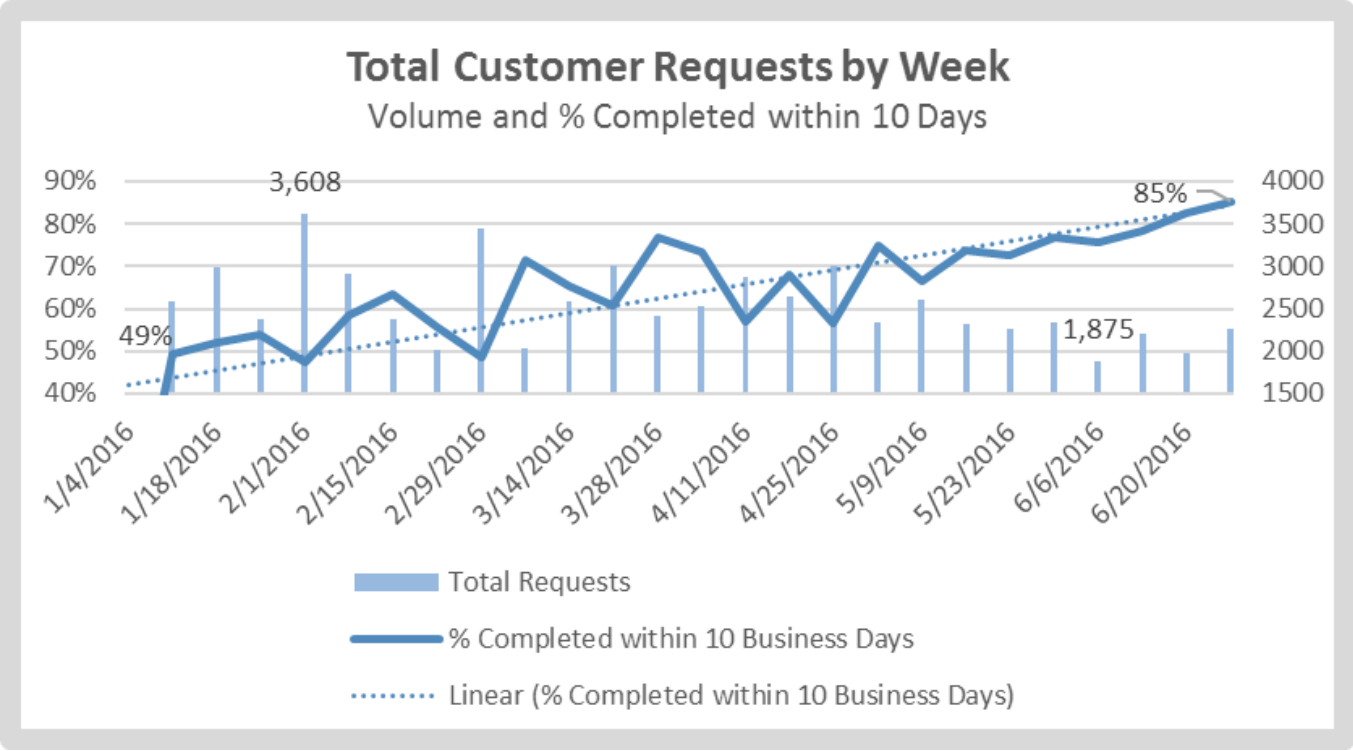
- *Customers* – confidence that request will be completed with one call; no need for multiple follow-ups.
- *Carrier partners* – minimize system discrepancies that can occur when work is delayed.
- *Staff* – ability to set realistic expectations and meet them; pride in knowing that they will have a achieved a level of service delivery within three years of launch that is on par with decades-old organizations.

Steps:

- Identify the types of customer requests that VHC receives: 1095-A Reviews, 1095-B Reviews, Access to Care – Medicaid, Access to Care – QHP, Change of Circumstance, General Inquiries, Money Moves, Reinstatements, Termination.
- Track these nine types of requests by date of request and date of completion.
- Use data to celebrate success with staff and to identify opportunity for improvement.

How are we doing?

- Average completed within 10 days for:
  - First 10 weeks of the year: 56%
  - Last 10 weeks (through week of 6/27): 77%
- Great accomplishment; fast progress.
- Challenge will be sustaining service level when request volumes increase after the summer.
- Team is confident that improved system performance and operational structure will help it rise to the challenge.



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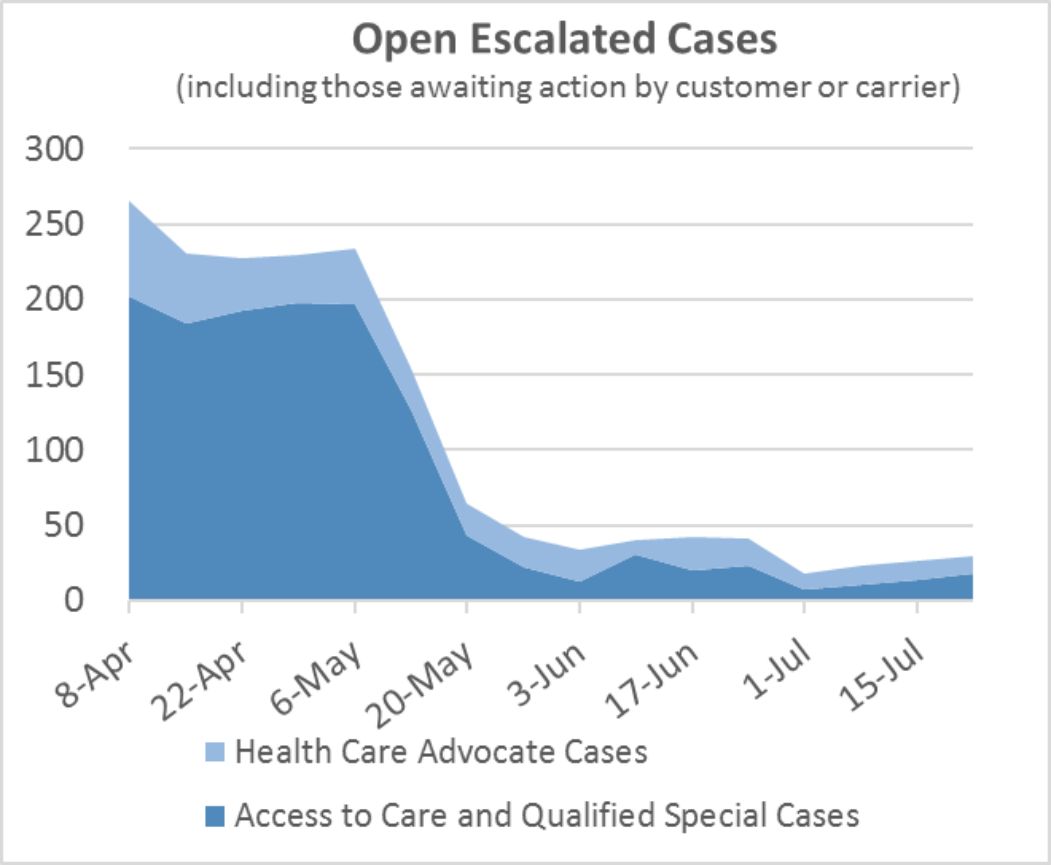
Customer Service: Access to Care and other Escalated Cases

- Integration teams have performed root cause and remediation as part of the escalated case process.
- Number of open escalated cases down 85% since early April.
- Of the 10 open Access to Care cases on 7/22, six were being worked by VHC and four were waiting on a response with information from customer.

Escalated Cases include cases from Vermont Legal Aid, Access to Care, and Qualified Special Cases (cases that are escalated due to their complexity, urgency, or inability to be resolved through normal channels.)



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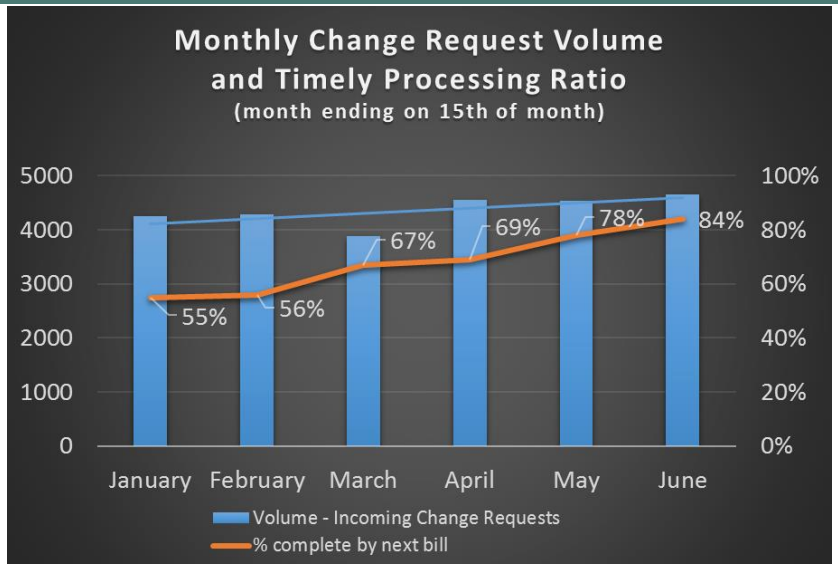
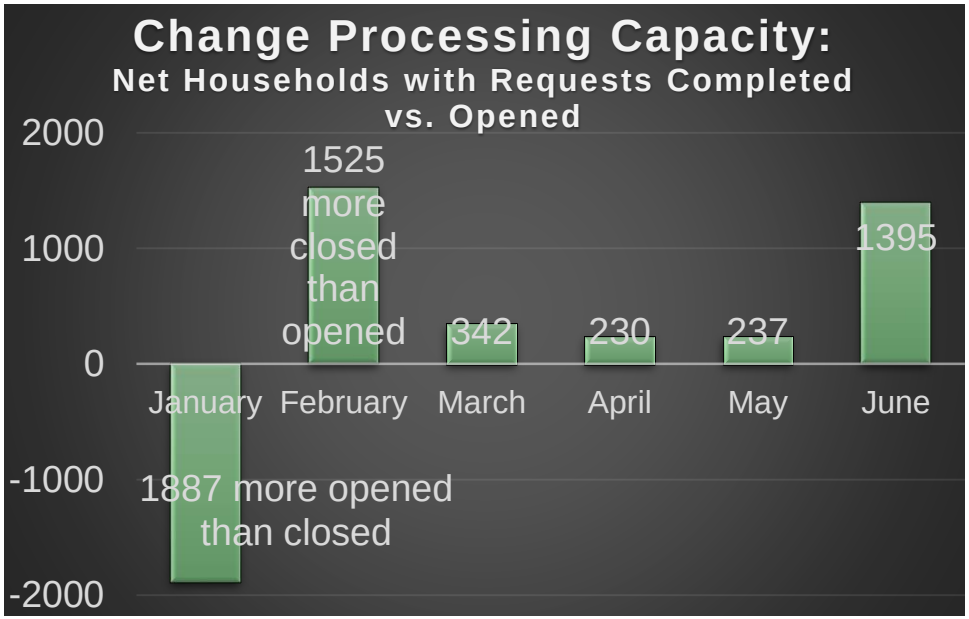
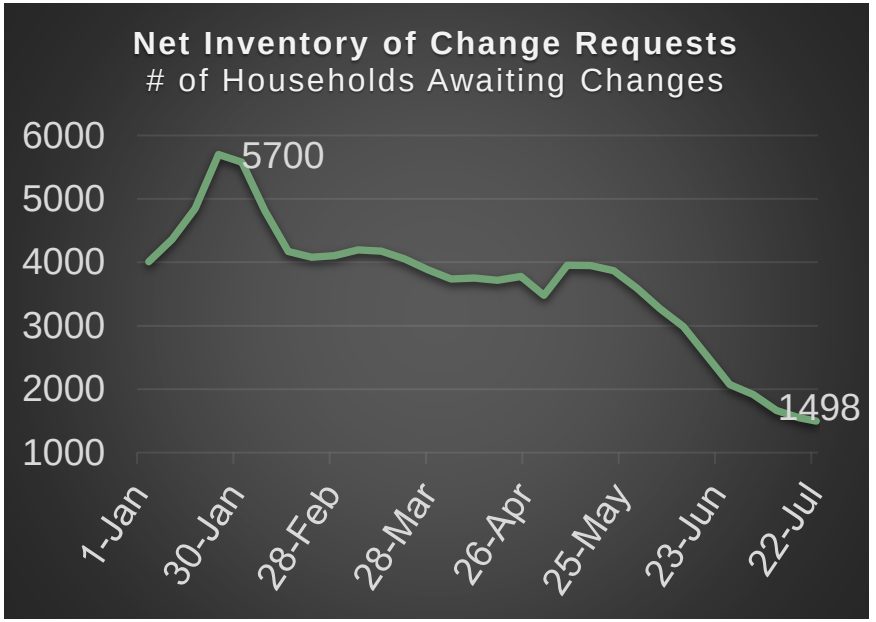
Target: *Provide Access to Care within three business days.*

Customer Service: Change Requests

- Inventory of open requests (1,498 households) is the lowest of the year – about one in four (380) involve a QHP household.
- Four out of five (83%) requests made 6/16-7/15 were completed by 7/22, two weeks ahead of the next bill.
- In each of the last five months, VHC has processed more changes than it received.







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Target: *Changes requested by 15th day of month should be completed by the next bill (mailed on or around 5th day of next month).*

EDUCATIONAL RESOURCES AND PARTNERS

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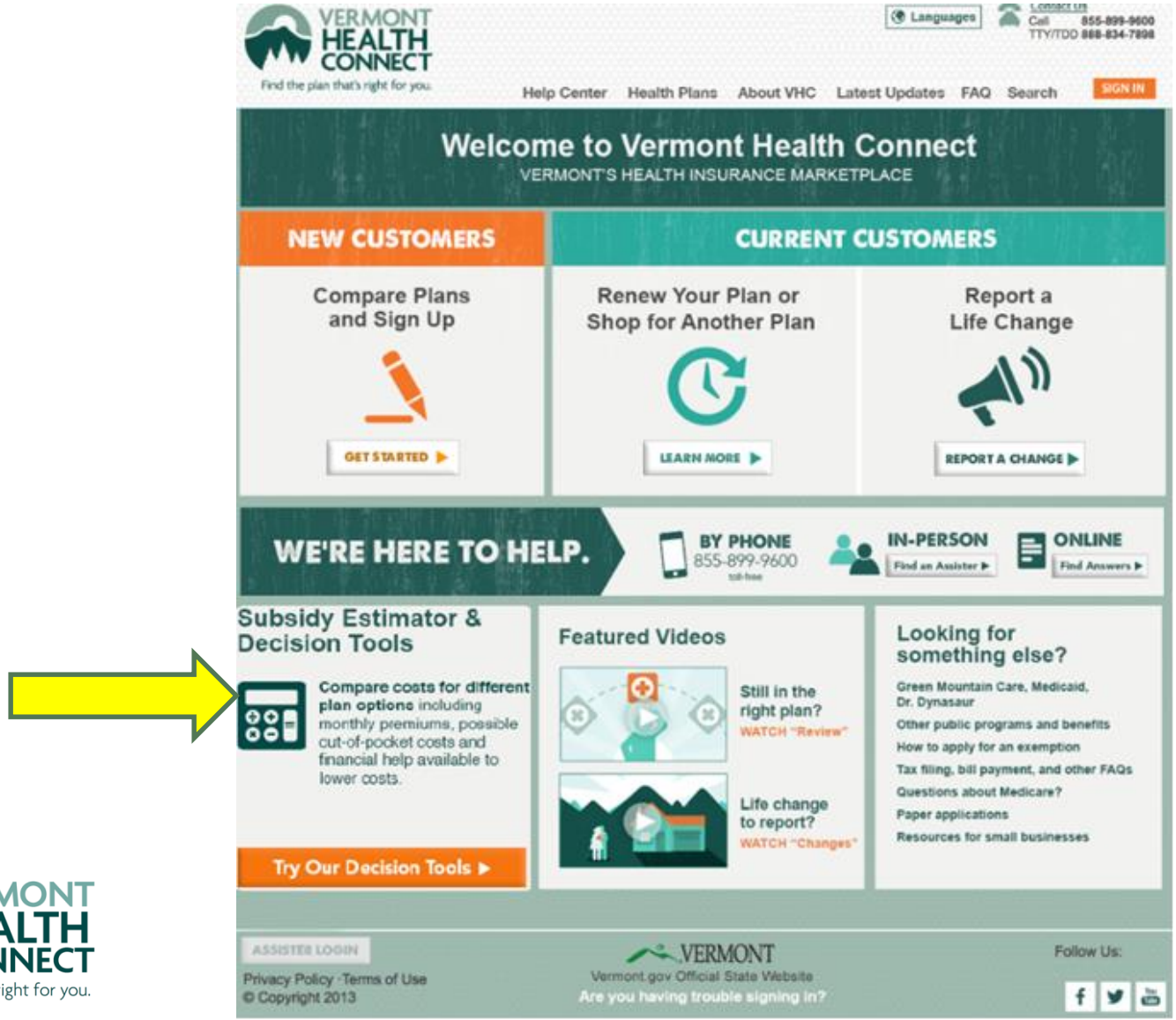
Plan Comparison Tool

- Online tool helps customers understand and compare the total costs – premium and out-of-pocket costs minus subsidies – of various plans.



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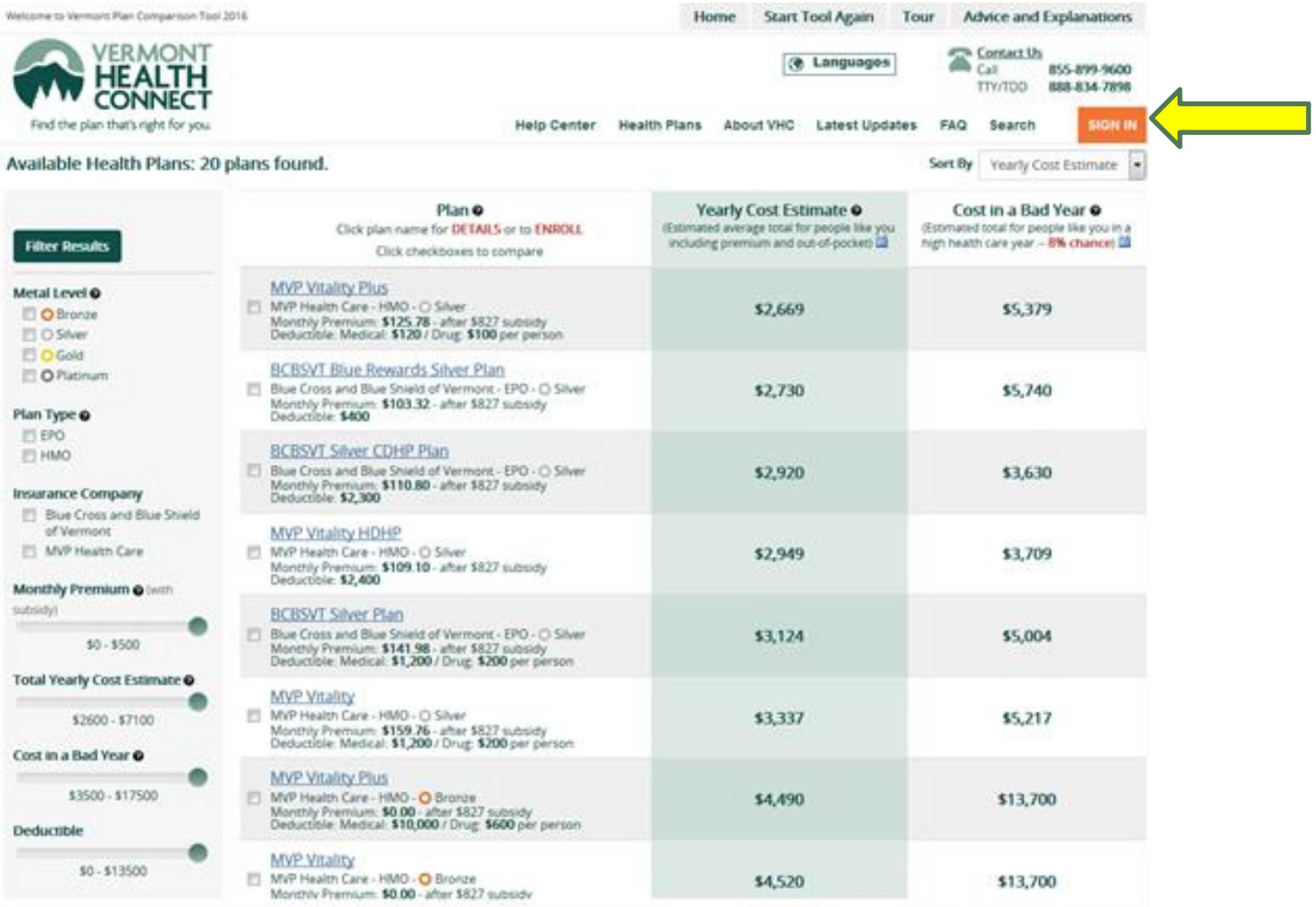
Plan Comparison Tool

- Individual QHP enrollees and small business employees can all use the tool to help decide which health plan is best for their family's needs and budget.
- Tool has had more than 30,000 sessions since December.



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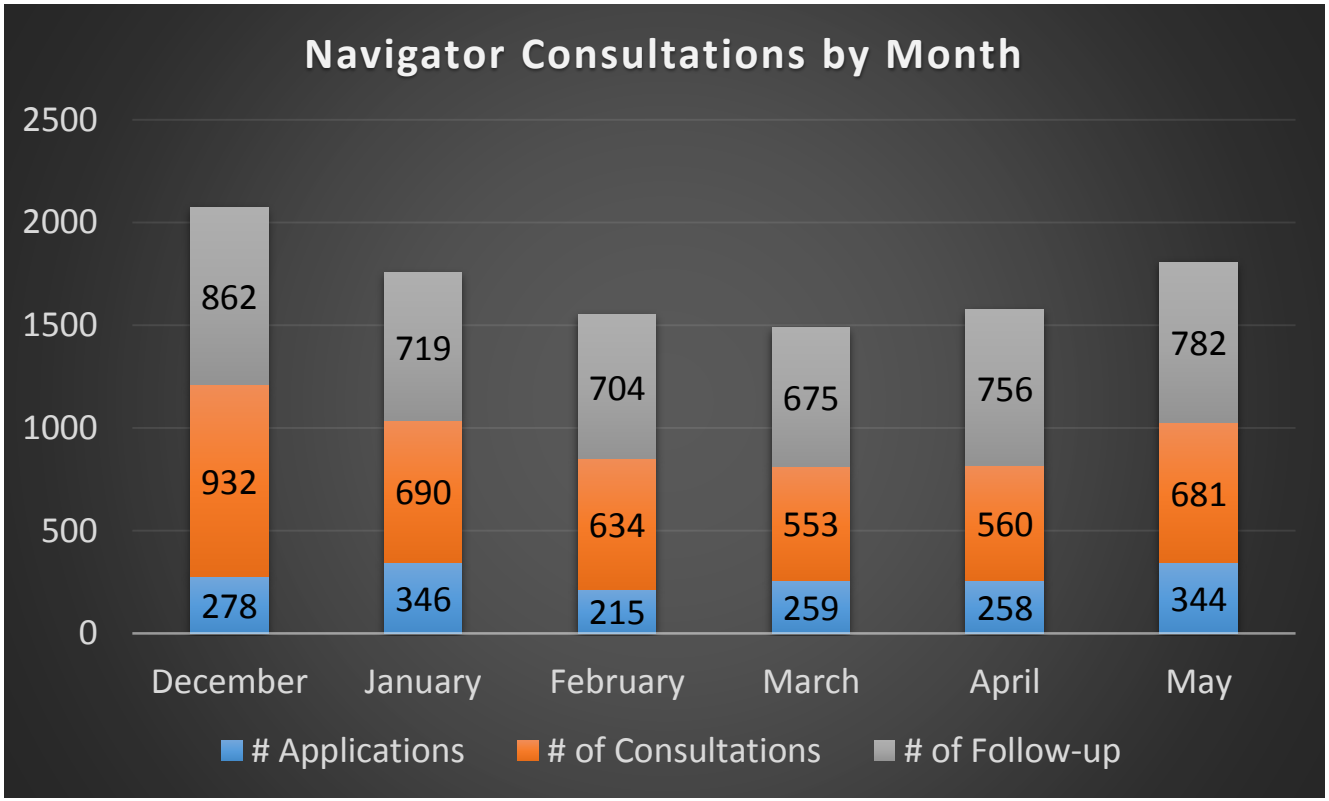
Assisters

- Number of Assisters up 15% in last three months, largely due to the training and certification of 29 new Certified Application Counselors (CACs).
  - 17 staff at Centurion have become CACs and are helping recently incarcerated Vermonters apply for coverage, which will save the State money by reducing more expensive health care spending.
- Since Open Enrollment, Navigators and CACs have focused largely on Medicaid renewal support, especially for New Vermonters and other vulnerable populations with accessibility challenges.

Active Assisters

CACs	99
Brokers	80
Navigators	54
Total	233



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MEDICAID RENEWALS

Key Takeaways on Medicaid Reviews

1) MABD reviews are on schedule. By October 2016, all enrollees will have undergone a review within the year, and the following year's review will immediately begin.
2) MABD enrollees typically respond promptly, often after the first notice.
3) MAGI reviews are on schedule. Over 65,000 households representing 100,000 individuals have been noticed. The remainder will receive notices by October.
4) MAGI enrollees do not typically respond promptly. Only about half respond prior to their closure notice. Applications continue to trickle in over the course of the following months – likely as the former enrollees attempt to go to a provider or pharmacy – although coverage can then be made retroactive for up to three months.
5) The vast majority of respondents are still eligible for Medicaid. Nearly nine out of ten (89%) households processed to date have been determined to still be eligible for MAGI Medicaid. Of the rest, most (79%) have experienced a modest income increase that now qualifies them for state and federal subsidies to purchase a qualified health plan.
6) An analysis of claims data from non-responders shows that customers who used services the least over the past year are the slowest to re-apply. If this trend continues, Medicaid could experience a dip in enrollment but a corresponding increase in the cost per enrollee.
7) The donut group will be in a better position to discuss projected impacts on the budget in the fall once a) the three-month retroactive window is passed and

MABD reviews are on schedule

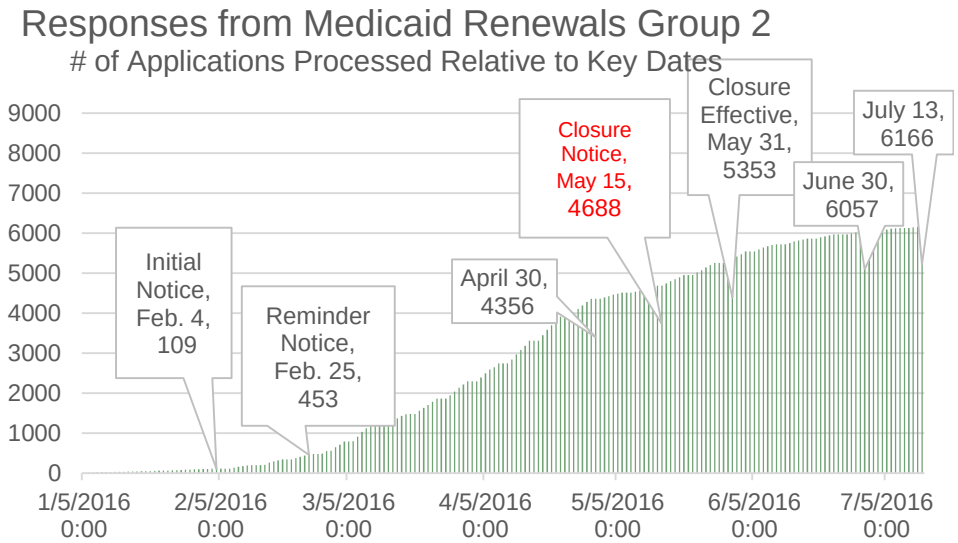
- MABD reviews were re-started in October 2015, a little over a year after they were paused (July 2014). By October 2016, all enrollees will have undergone a review within the year, and the following year's review will immediately begin.
- Review dates are based on when enrollees first received coverage and are conducted on an annual basis.
- Reviews average roughly 1,000 households per month, but there is considerable variance – ranging from just over 600 to more than 1,900 in any given month.
- MABD enrollees typically respond promptly, often after the first notice.

Reduction in MABD enrollment is due to changed coverage classification, not loss of coverage

- An analysis of nearly 3,000 closed MABD enrollees shows that nearly nine out of ten (86%) transitioned from MABD to VHC.
- This transition was appropriate because enrollees had an ANFC (old Medicaid) category code that had been included in MABD reporting rather than in an MCA category.
- Their reviews are properly based on MAGI rules.

MCA (MAGI) Medicaid Renewals

- VHC has initiated the renewal process for 65,000 MAGI households (9,000 per month); more than 100,000 individuals.
- Verifying all Medicaid households at initial application and redetermination for income, SSN, citizenship, & immigration status.
- Approved mitigation plan with CMCS which brings us into compliance with CMCS priorities in 2017.
- Unlike MABD enrollees, MCA enrollees tend to wait longer to respond.
  - Only about half respond by closure notice.
  - Many don't apply until they need medical services.
  - DVHA has mailed promotional posters and handouts to Medicaid providers and asked them to communicate the importance of prompt renewal to patients.



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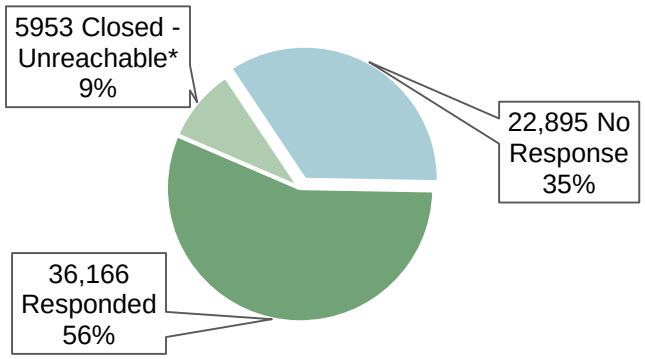
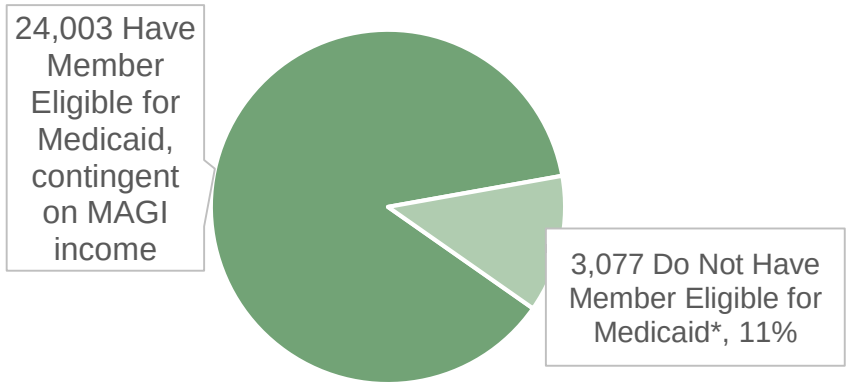
MAGI Medicaid Renewals

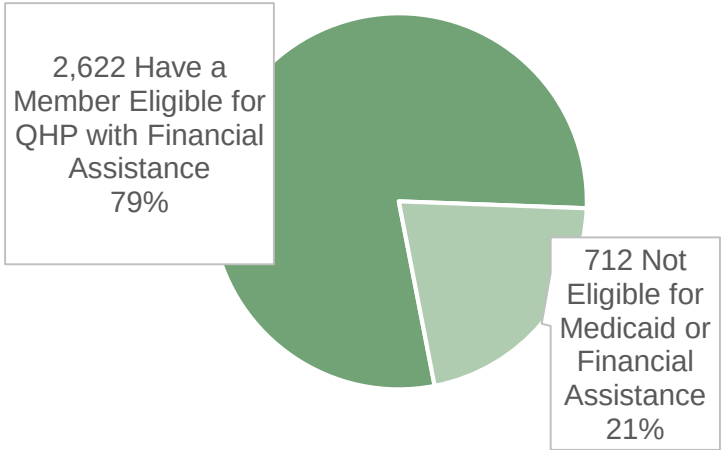
Of the first 65,000+ MAGI Medicaid households engaged in the renewal process, roughly half received a reminder and then had their coverage closed. After the closure, the response rate climbs.



Of 27,000+ Households Entered and Determined:



Of 3,000+ Households Applying for Assistance but Not Eligible for Medicaid:



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Budget Implications

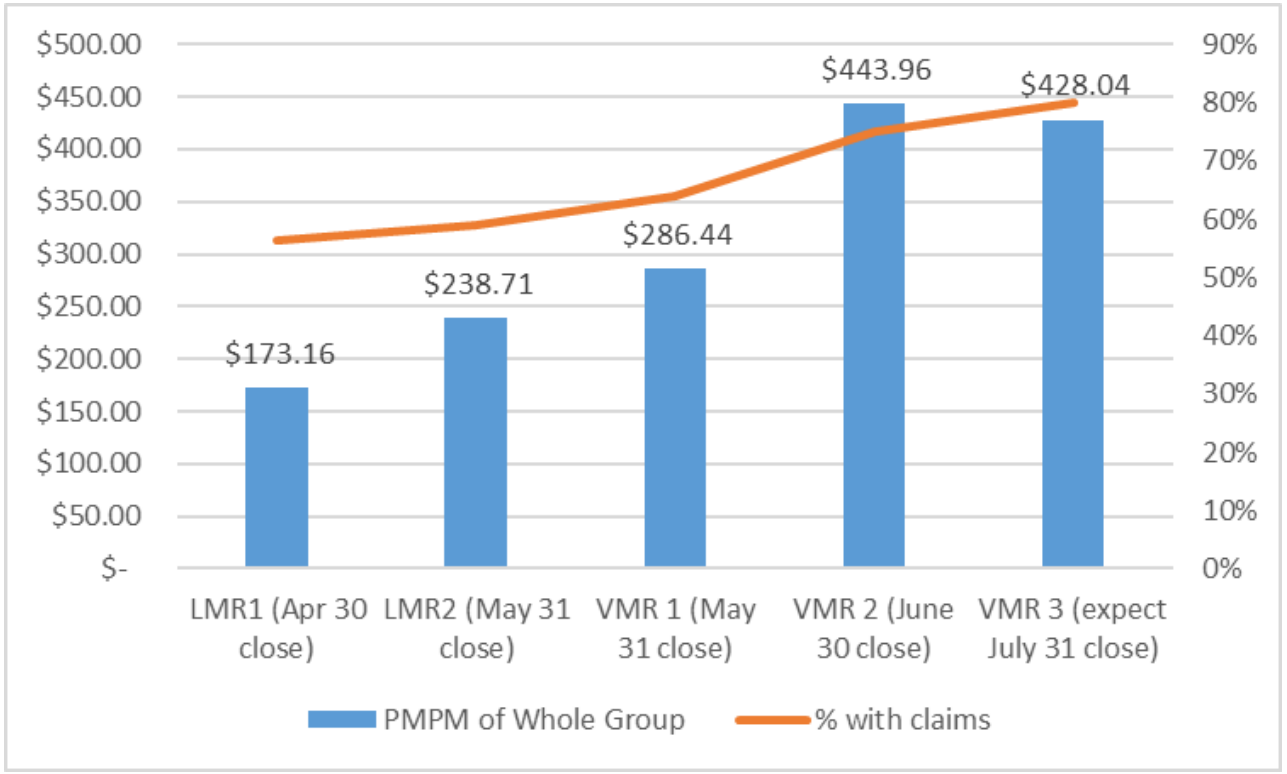
- It's still early to be certain, but trends are starting to emerge.
- Better projections will be able to be made once:
  1) The three-month retroactive window is passed and policymakers learn how many enrollees signed up retroactively to avoid a gap in coverage.
  2) There is adequate data to assume an average post-closure reenrollment rate.

Important to underscore that we are seeing two types of churn:

- Normal changes in income for households (both on and off of Medicaid).
- The lag of MAGI re-enrollment will likely cause a decrease in caseload but a corresponding increase in PMPM.

- For example, in the case of the New Adult population, enrollees who still hadn't responded six weeks after their closure date had a much lower PMPM – and were most likely to have zero claims in the last 12 months – than either average enrollees or those who renew earlier in the process.
- In fact, Vermonters who closed on April 30 and still hadn't responded by July 11 had a previous year PMPM half that of the '16 BAA PMPM.
- If this trend continues, Medicaid could experience a dip in enrollment but a corresponding increase in the cost per enrollee.

PMPM of New Adult Non-Responders by Renewal Group



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OPEN ENROLLMENT 2017

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November 1, 2016 through January 31, 2017

- Held first OE planning meeting with carrier partners in June.
- Internal working groups meeting weekly to finalize business process, data clean up strategy, training plan, and testing approach.
- First notices for individuals who did not give the State authorization to ping the Federal Hub will mail in September.
- Standard renewal notices will mail in October.
- Goal is to passively renew 95% of all QHP customers and to complete all initial renewals by December 15th.

ADDITIONAL UPDATES AND METRICS

QHP Verification Notices

- Mailed to approximately 320 households the week of 6/20.
- Similar to last year, the District Offices coordinating with DVHA to accept documentation from customers who want to drop it off in person, not by mail.

Age-off Notices

- Mailing to 415 Vermonters who are turning 65.
- Customers can choose to terminate their qualified health plan, or they can keep it and pay full price (no subsidies after eligible for Medicaid).

Customer Support Center

- Medicaid renewals driving high call volume.
- Customer Support Center received more calls in June than any month since early 2014.
- Transfer rate is down to 9% as Level 1 Customer Support Representatives (CSRs) can process most applications on initial call.

Month	Calls Offered	Answer Rate	Calls Answered	Calls Answered <24 Sec	Transfer Rate
January 2016	42,769	83%	35,352	32%	10%
February 2016	45,043	81%	36,514	46%	9%
March 2016	41,661	93%	38,678	75%	11%
April 2016	36,774	96%	35,354	79%	11%
May 2016	43,940	90%	39,683	55%	9%
June 2016	49,132	80%	39,450	32%	9%

Service Level Agreement (SLA): answer 60% of calls within 25 seconds.

- Met SLA in March and April after missing first two months of the year.
- Met SLA nine out of 12 months in 2015.

Comparison: Average wait time over the three months of 2016 Open Enrollment (Nov-Jan):

- Vermont: 5min 3sec; Federal: 10min 30sec

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System Performance

- System continues to operate as expected.
- Average page load times faster than two second target for five months in a row.
- 99.95% availability across all systems in June.

Month	Total Availability	Average Page Load (sec)	Max Peak User	Visits
January 2016	99.86%	2.02	136	67,911
February 2016	99.91%	1.72	168	52,952
March 2016	99.90%	1.45	106	62,509
April 2016	99.91%	1.36	113	59,458
May 2016	99.95%	1.09	107	58,174
June 2016	99.95%	1.67	109	58,715

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Service Level Agreement (SLA): Optum-Liable Availability not <99.9%; Load Time not > 2 seconds.

- Have met Load Time SLA in 11 of 12 months since May 2015 system upgrades.
- Have met Availability SLA every month since May 2015 system upgrades.
- Total Availability met same goal in 10 of 12 months.