Vermont Health Connect

Update for Legislature

August 12, 2015

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Overview

- Project Development
  - Deliverables
  - Risks: Open and Recently Mitigated
- Enrollment Updates
- Operations Updates
  - Call Center and Customer Service
  - Change Processing Updates
  - Carrier Integration
  - Medication Redetermination
  - Federal Enhanced Match
  - Reconciliation for 2014, 2015
- SHOP Implementation Planning
- Contingency Planning
- Alternatives Evaluation

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Project Development

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Project Development

Status of Deliverables Related to Fall System Upgrades
Vermont's contract with Optum to deliver fall system upgrades, including renewals functionality, went into force on July 1.

On Schedule and In-Progress from Recent System Upgrades:

- Training Materials Development Complete
- Training of staff complete
- User Validation Test: On-going.
  - As types of change requests are validated and incorporated into business processes and training, they are verified by end users at Vermont Health Connect, Benaissance, and the insurance issuers

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Project Development

Status of Risks--Open and Recently Mitigated:

- Dentegra will not be participating in the marketplace as a carrier for 2016 open enrollment. Their addition as an issuer was identified as a potential risk due to a conflict with resource allocations related to fall systems upgrades.
- In preparation for fall upgrades, a schedule has been developed with Qualified Insurance Carriers to implement a systems enhancement to support business processes required for completion of the most complex change requests.
- Vermont Health Connect's hosting is transitioning from CGI to Optum.

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Enrollment Updates

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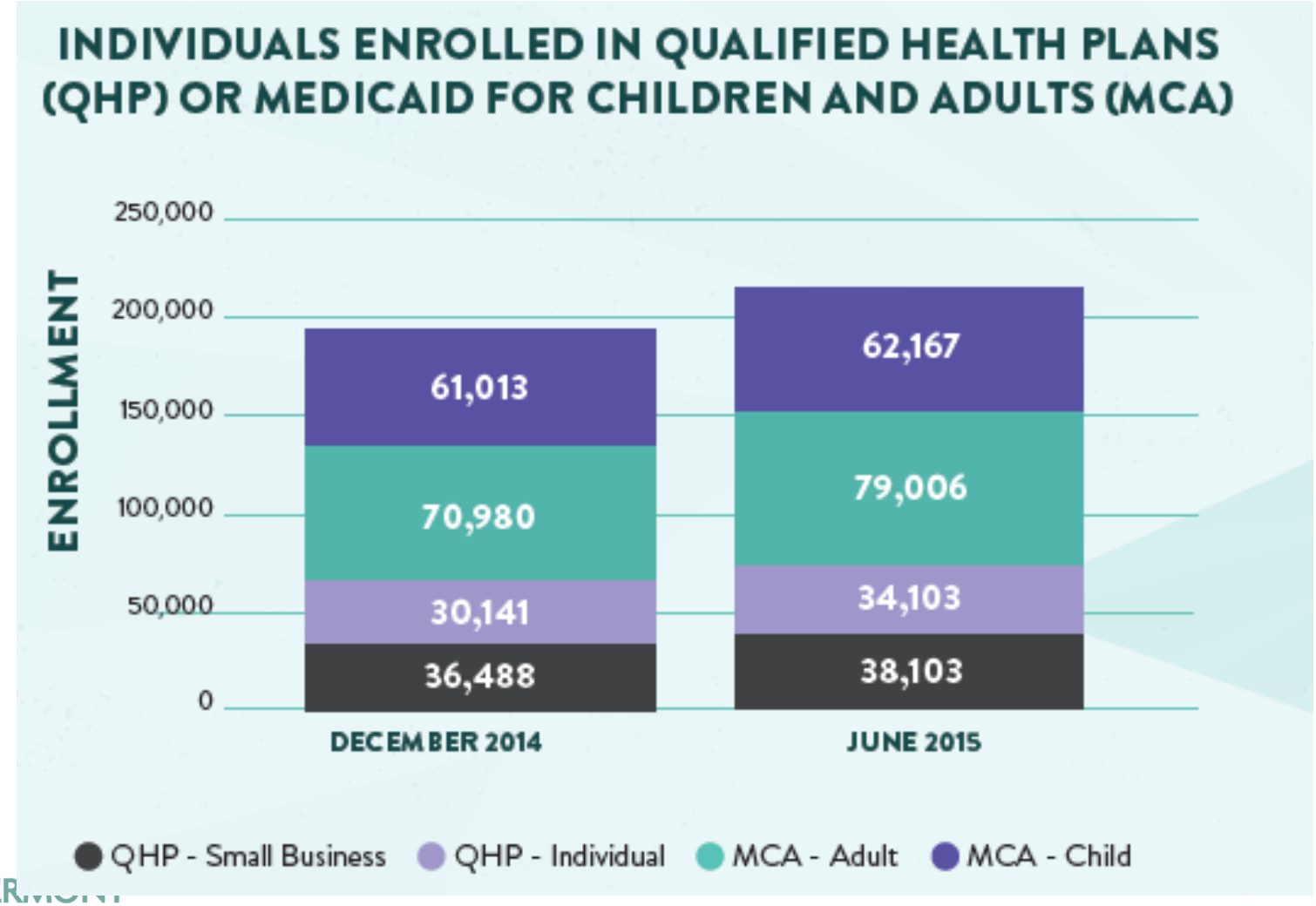
Lives Covered in Vermont



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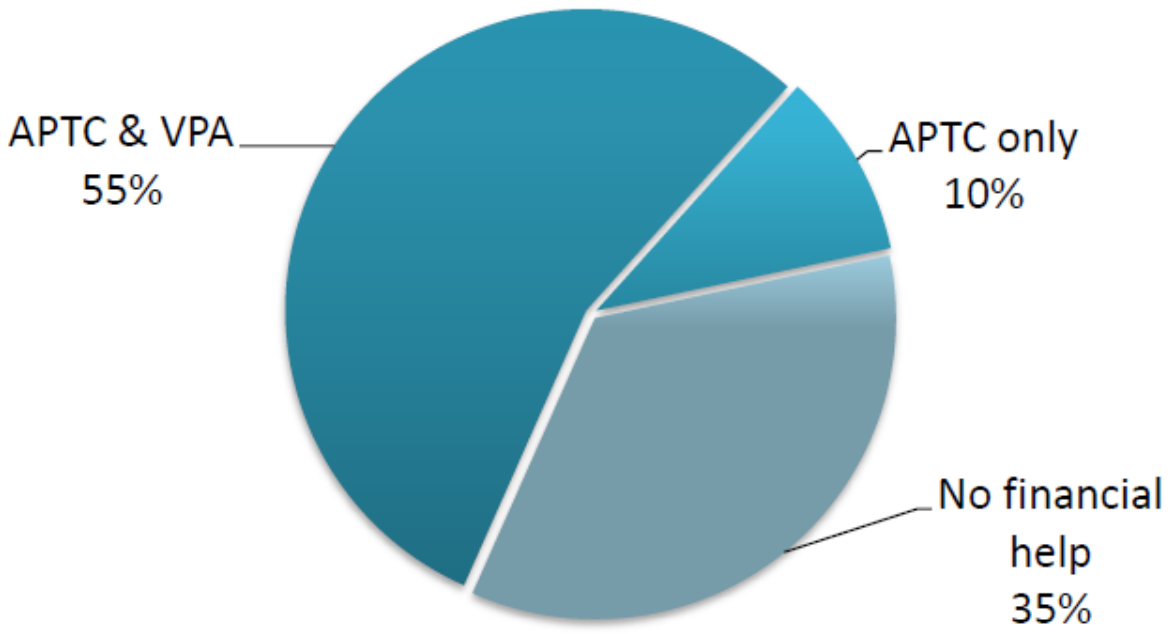
Lives Covered in Vermont

Customers in Qualified Health Plans (QHP) Receiving Financial Help to Make Health Coverage More Affordable



Between Medicaid/Dr. Dynasaur and premium assistance, nearly nine out of 10 individual customers receive financial help to make health coverage more affordable.

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Operations Updates

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Call Center Stats – July 2015

- Total Calls Offered: 26,635
- Average Time to Answer: 72 seconds
- Average Call Length: 10 minutes, 58 seconds
- Abandonment Rate: 4.1%
- % calls answered within 30 seconds: 77%

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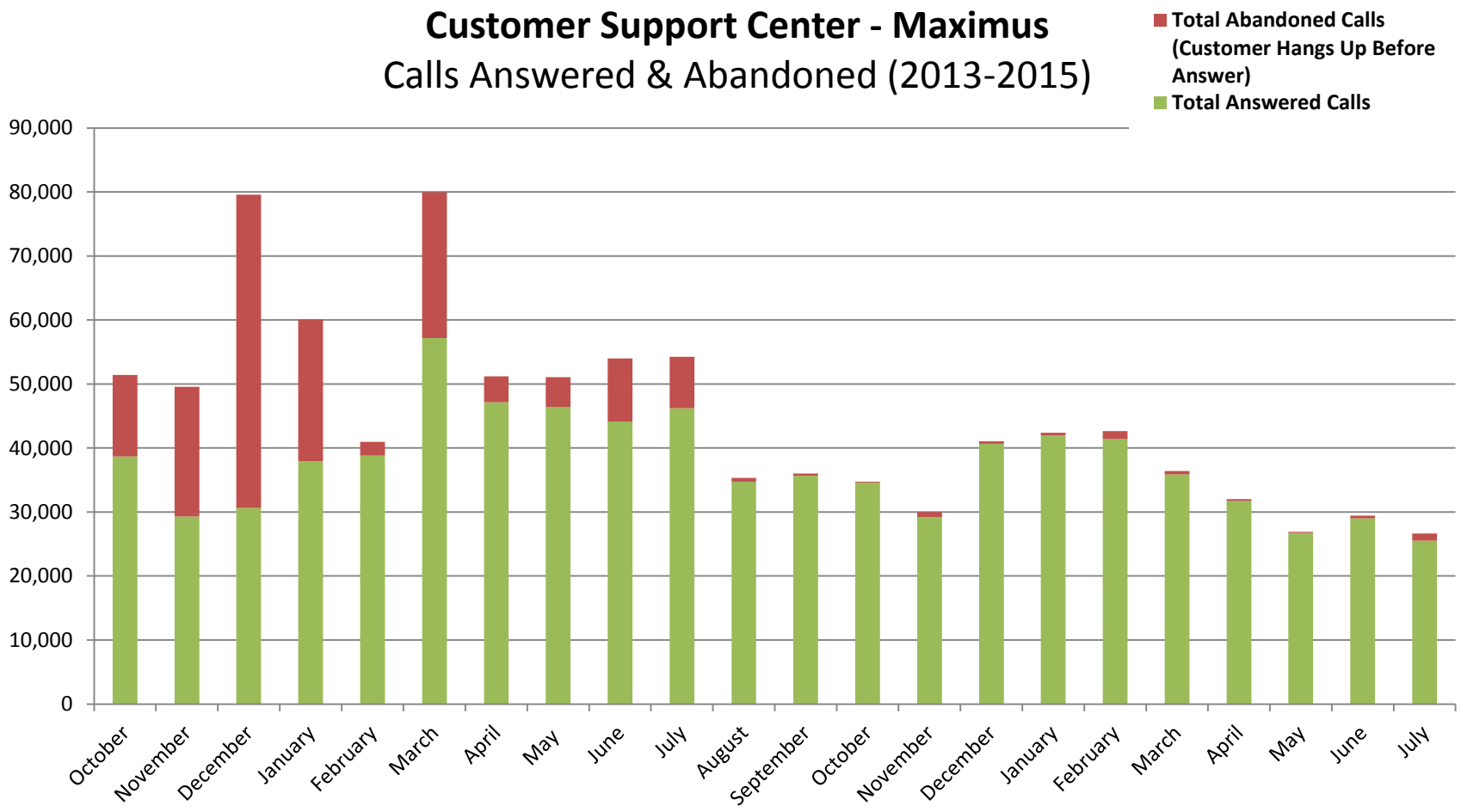
Call Center Stats



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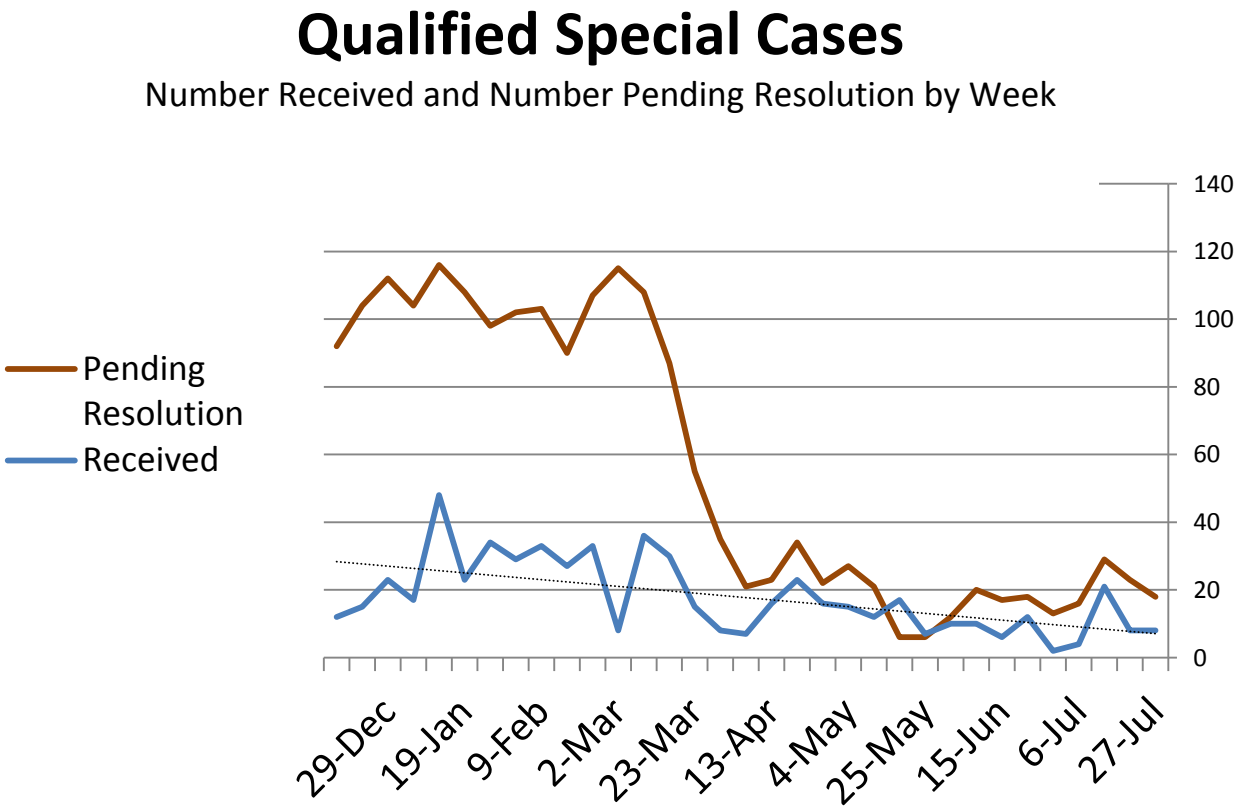
Qualified Special Cases



Qualified Special Cases are cases that are escalated to a dedicated customer service team due to their complexity, medical or financial urgency, or inability to be resolved through normal channels.

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System Performance

Month	Unscheduled Downtime (minutes)	Availability	Avg Page Load Time (seconds)	Max Peak User	Visits
April 2015	40	99.99%	2.2	86	42,284
May 2015	0	100.00%	2.0	82	30,926
June 2015	0	100.00%	0.5	69	34,837
July 2015	400	99.87%	0.6	93	37,116

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Change Processing Updates

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Change Requests

Households Awaiting Changes				
	26-May	**10-Aug**	**change**	**% change**
Total	10,272	4,476	-5,796	-56%

Households Awaiting Changes (households not mutually exclusive)				
	26-May	**10-Aug**	**change**	**% change**
Households with a QHP	5,141	2,532	-2,609	-51%
Households with Medicaid	5,963	2,292	-3,671	-62%

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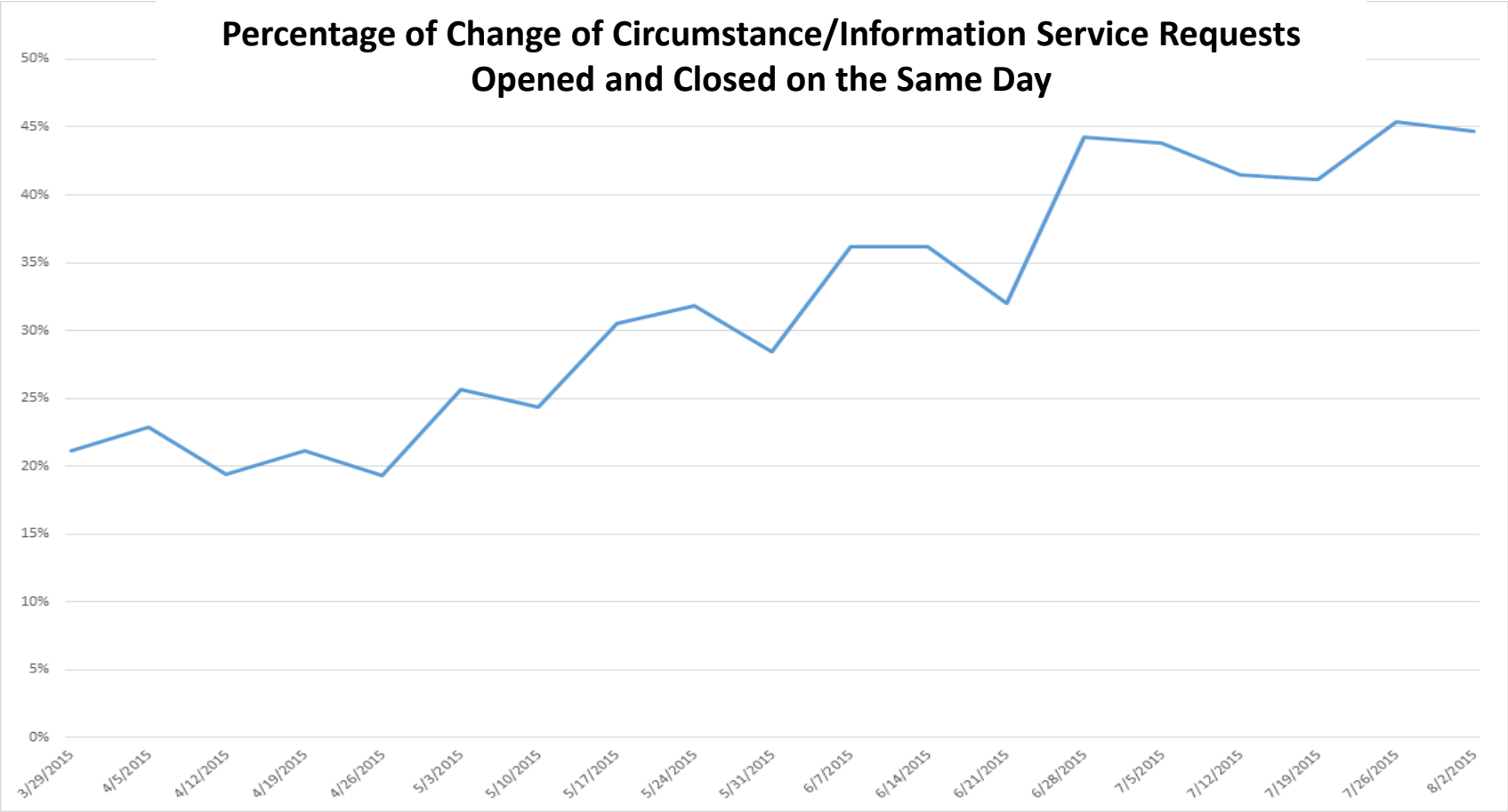
Change Requests

- As of August 10, just under 4,500 households had change requests waiting to be processed.
  - June marked the first month this year VHC processed more change requests than received; July was the second month.
  - Even with roughly 100 new requests per day, approximately 5,800 fewer households were awaiting changes on August 10 than at the time of system upgrades.
  - Nearly half of new service requests are now closed on the same day they are opened – oftentimes while the customer is on the phone.

Change Requests



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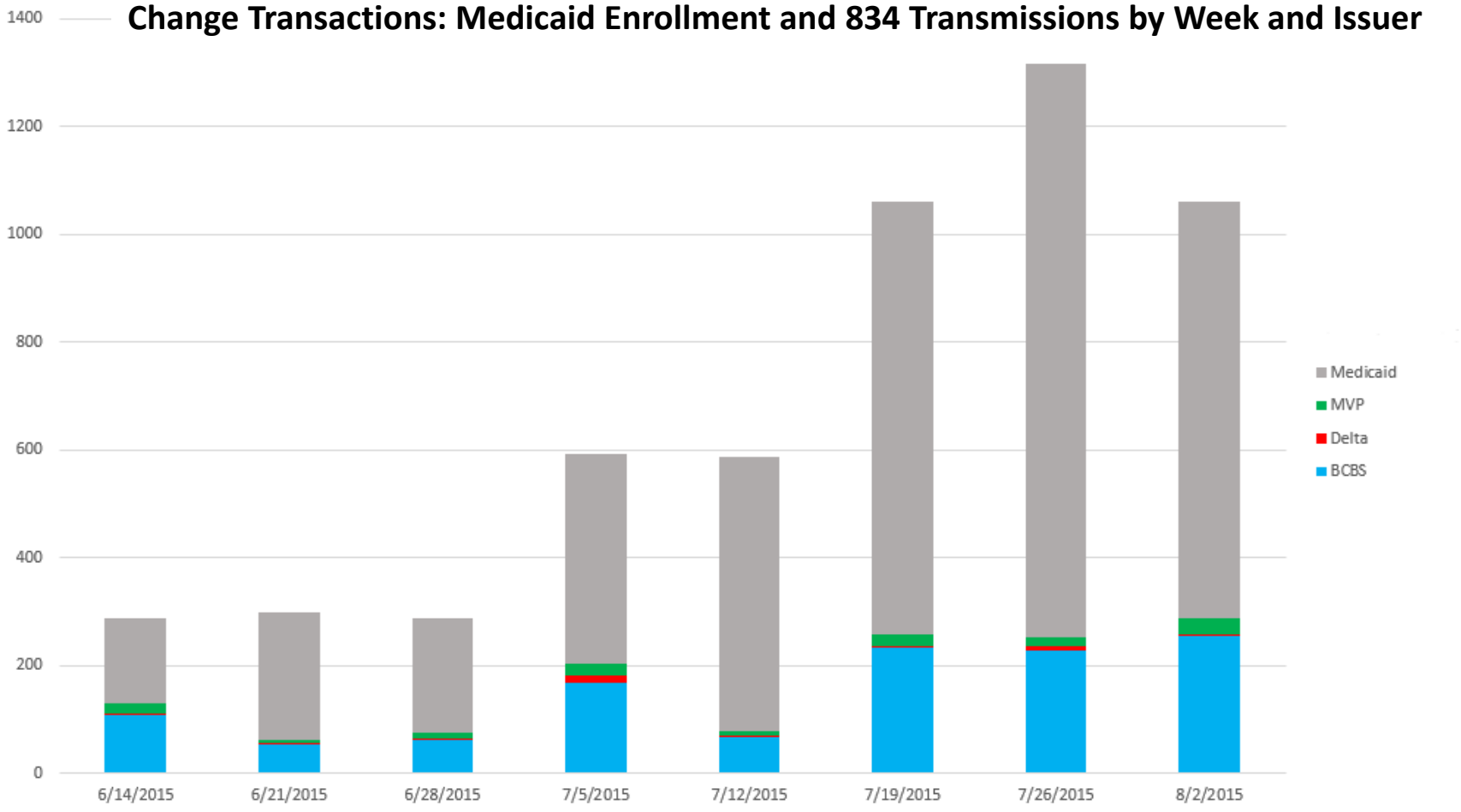
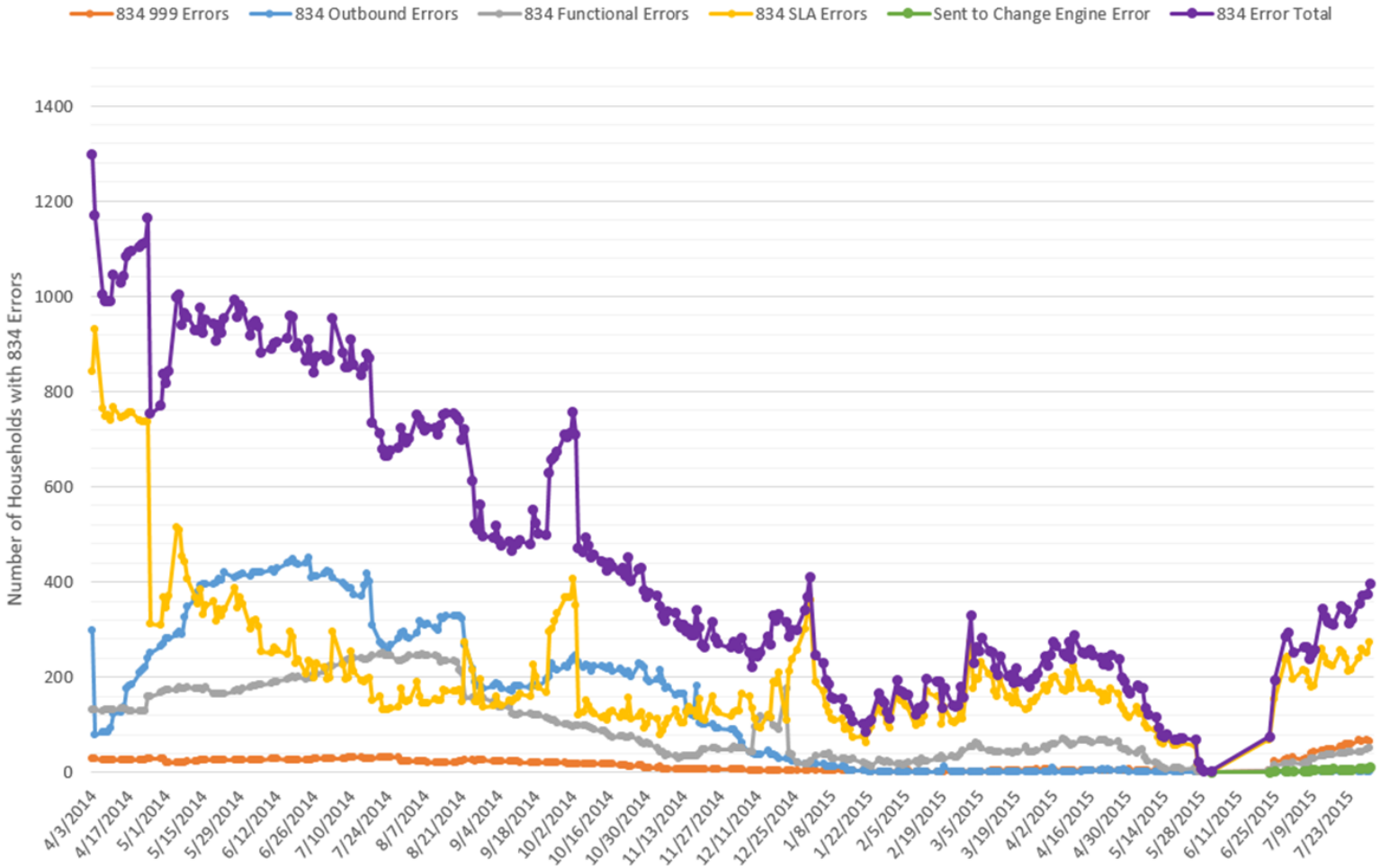
Carrier Integration



Carrier Integration



Major systems upgrading created an expected temporary rise in 834 errors. An 834 is an electronic file sent from VHC to an insurance carrier with information about a household's enrollment information. An 834 error indicates that this electronic file has not yet been successfully processed for some reason. The vast majority of the 834 errors are reflections that the coverage confirmation has not been accepted nor rejected by the insurance carrier.

Carrier Integration

- Major systems upgrading created an expected temporary rise in 834 errors
  - An 834 is an electronic file sent from Vermont Health Connect to an insurance carrier about a household's enrollment information
- 834 errors indicate that an electronic file has not yet been successfully processed
  - The vast majority of the current 834 errors reflect that coverage effectuation was not confirmed nor rejected by the carrier
  - These customers are still effectuated as their coverage change has taken effect
  - VHC's enrollment team continues to work with Optum and the issuers semi-weekly to improve the process of 834 resolution.

Medicaid Redetermination

- 2015 Federal Poverty Levels (FPL) were implemented for Medicaid eligibility determination in June.
- Following federal guidelines, 2015 FPLs do not impact APTC (or VPA) until January 2016.
- Vermont Health Connect has identified customers who potentially became newly Medicaid eligible and is developing its strategy to reach out to them.

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Reconciliation

2014:

- Efforts for Reconciliation picked up after systems upgrades:
- Data collected from Benaissance, BCBSVT, MVP & VHC
- Analysis & solutioning underway
- Developing business rules to systematically correct discrepancies (for example, mismatched end dates)
- Determining adjustments to ensure VHC, Benaissance and carriers systems all reflect correct information

2015:

- Data analyzed to identify discrepancies,
- Fix mismatches, investigate causes, fix problems
- Reconcile VHC, Benaissance and carriers

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Optum Contract and Federal Funding

- Under Contract Amendment 6, Optum delivered back-end functionality for processing change requests more quickly.
- Federal partners agreed to pay 55% of certain costs incurred between Feb. 22 and June 30, and 90% of other costs.
- If the State had waited for a full federal review of contract before beginning work, federal partners would have likely paid more. But negative impacts would have included:
    - 1-2 month delay in the timing and delivery of the system upgrade, with additional reliance on labor-intensive manual processes with high operating expenses.
    - Increases in the number of customers waiting for changes to be processed (as opposed to the progress we've seen in lowering the inventory from 10,200 to 4,500).
    - A likely inability to deliver fall upgrades in time for November's Open Enrollment period, resulting in costly contingencies.

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SHOP Implementation

Two components to current SHOP efforts:

- **2016**
- **2017**

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2016 SHOP

- CMS requested the following before allowing State-Based Exchange (VHC) to continue SHOP through direct enrollment with carriers for plan year 2016:
  - Describe carrier processes for direct enrollment of employers and employees
  - Describe how State handles appeals of employer eligibility determinations
  - Identify sources of technical assistance for small employers, employees, agents & brokers, and other assisters
  - Describe how SHOP IRS enrollment reporting will be produced in a timely manner as required by federal law
  - Provide a plan for an online SHOP exchange in 2017
    - VHC's 2016 proposal submitted to CMS/CCIIO on July 30

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2017 SHOP

- Options for SHOP 2017 being assessed include:
  - Additional work by our current partners, primarily Optum and Exeter
  - Purchase of SHOP capability from a vendor who has successfully implemented SHOP in another state(s)
  - Efficiencies available through multi-state or regional arrangements
  - Federally supported or federally run alternatives
- Data collection has been initiated. Successful vendors and other state-based marketplaces have been contacted.
- First draft recommendations expected by August 28th.
- If decision is made to consider vendors with prior success in other states, a bid process will be initiated.
- With focus on SHOP implementation efforts for 2017, other VHC functions are being considered, including the individual Exchange and Medicaid.

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Contingency Planning

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Primary VHC Renewals Strategy

- Legislature asked Vermont Health Connect to prepare a "Contingency Plan" as back-up to the anticipated automatic renewal process for Open Enrollment, starting November 1
- This plan was submitted; but VHC expects to rely on its main plan:
  - by October 1, VHC launches automated renewals functionality
  - All customers automatically renewed in 2016 equivalent of their 2015 plan, with updated eligibility determination
  - When Open Enrollment starts on Nov. 1st, customers able to use portal self-service features to easily make changes for 2016 plans
  - Customers not required to take any action to be covered in 2016
- While risks have been noted; normal renewal process is expected

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Contingency Planning Overview

- In the event no further deployments were to occur, VHC would input new applications for all current customers
- Plan is achievable using existing technology and augmented staff
- Customers still able to submit 2016 renewals change requests

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Contingency Plan Costs

- Projected costs of full contingency plan are $3.5 million, or $140 per household.
  - This represents 1.75% of the $200 million premium base
  - To compare: broker fees are $20/month per enrolled employee, or $240/year
- Customers could view renewal data by browsing on-line or calling, but could not access their information on the portal
  - Customers can access it via online account after renewal processed
- Unpaid amounts due in 2015 would not show on 2016 bills, so billing, payments and grace period tracking of 2015 bills will be separated and manually followed
- This was how renewals occurred for 2014-2015

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Contingency Planning

- In the unlikely scenario that VHC needs to trigger the contingency plan, the technology and resources are available
- VHC and carriers have developed an aggressive but manageable schedule for readying the system for R1 and deploying for Open Enrollment, with no anticipated risks identified
- After R1, change requests will be automated, eliminating the additional resources and wait time previously associated with those
  - Once renewals are processed, life changes will be processed within one billing cycle

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Alternatives Evaluation

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Alternatives Evaluation

- Currently researching & interviewing states who moved from SBM to either FFM or SSBM, including Nevada, Oregon, Hawaii and Maryland
  - Surveys have been distributed to both types of respondents and results are being gathered now
  - Follow up phone calls planned for more information and clarification
- Each state has a unique path and different information technology situation

Alternatives Evaluation

- Developing cost estimates – both cost of transition and on-going operations costs
- Examples of transition costs include:
  - Consulting costs to complete federally required gap analysis and reports,
  - Medicaid IT development for connection to the federal technology
  - Individual and SHOP exchange information technology requirements
  - Outreach and education to consumers
- Example of on-going costs include increased Medicaid call center costs

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Alternatives Evaluation:

Other Considerations:

- Reviewing statutory and rule changes needed
  - For example, rate review process &/or timeframe would need to be revised to meet federal deadlines for plan submission
- CT example – Maryland changed their Medicaid program to be the same as CT
- Reviewing CT technology lease arrangements
- Also researching options for completing business exchange (SHOP)
  - ➢ Initial recommendation expected by the end of August

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