
Vermont Legal Aid
Office of the Health Care Advocate

Quarterly Report
April 1, 2018-June 30, 2018
to the
Agency of Administration
submitted by
Michael Fisher, Chief Health Care Advocate
Office of the Health Care Advocate

July 15, 2018



TABLE OF CONTENTS

Introduction	3
Individual Consumer Assistance	4
Case Examples	4
Overview	6
Priorities	7
A. The HCA advocates participated in the COTS legal clinic with the goal of reaching vulnerable and underserved consumers.	7
B. The HCA organized a meeting with area healthcare providers to discuss improving access to transgender health care services.	7
C. HCA participated in the Adverse Childhood Experiences Pilot Project	8
D. The HCA participated in Rural Pride.	8
E. Overall call volume decreased somewhat, but is still higher than the call volume in the same quarter of 2017.	9
F. Calls concerning Vermont Health Connect decreased significantly.	9
G. Medicaid eligibility calls represented 25% of all our cases (240 calls/967 total calls). Consumers need assistance with all types of Medicaid.	10
H. The top issues generating calls.	10
Consumer Protection Activities	13
A. Rate Review	13
B. Hospital Budget Review	14
C. Oversight of Accountable Care Organizations	15
D. Other Green Mountain Care Board Activities	15
E. Other Activities	16
Outreach and Education	20
A. Increasing Reach and Education Through the Website	20
B. Other Outreach and Educational Activities	22
C. Promoting Plain Language in Health Communications	22

Introduction

The Office of the Health Care Advocate (HCA) advocates for all Vermonters through both individual consumer assistance and systemic advocacy on health care issues. We work to increase access to high quality, affordable health care for all Vermonters through individual advocacy and representing the public before the Green Mountain Care Board, state agencies, and the state legislature.

This quarter, the HCA saw an uptick in the number of calls from consumers with complaints about their providers (136 vs. 81). The HCA works to educate consumers about their rights with providers. It also works to support and strengthen Vermont's provider network, so consumers are able to find providers that meet their needs. We also saw an increase in consumers calling about transitions between providers and continuity of care issues (46 vs. 25). The HCA continues to be concerned about the wait times to see specialists and the lack of available primary care providers.

This quarter HCA outreach focused on particularly vulnerable and underserved Vermonters. We do direct work such as going to legal clinics and meeting directly with providers, as well as indirect work such as making notices more clear and understandable to all Vermonters.

The HCA is also working with other stakeholders to prepare for 2019 Open Enrollment. The HCA is committed to helping consumers understand how the changes to the premium pricing will impact their households.

The HCA is committed to helping Vermonters navigate the health care system during this confusing and anxious time. Our goal remains the same: to increase access to affordable, high-quality health care for all Vermonters. Today's uncertainty makes the role of the HCA even more essential.

The HCA supports Vermonters through individual advocacy as well as at the legislative and administrative policy levels. Our policy priorities are informed by our daily work with Vermonters struggling with a health care system that often does not meet their needs, such as Ava's experience described in the case narrative at right. We work to control unnecessary costs and make the health care system sustainable, and to ensure that Vermont consumers are heard by providers and policy-makers.

Ava's Story

Ava called because she needed to pick up a prescription, and when she went to the pharmacy she found out that her Medicaid had been closed. The HCA advocate investigated and found two problems. First Ava's Medicaid had been closed, and VHC had not sent the required closure notice telling her that Medicaid was closing and giving her appeal rights. When VHC closes a beneficiary's Medicaid, it is required to send a notice that explains the closure and appeal rights. The advocate was able to get VHC to reinstate the Medicaid immediately because of the failure to send the closure notice, and Ava picked up her prescriptions. Second, VHC had incorrectly found that Ava was over-income for Medicaid. When the advocate reviewed the income information, he found that some of the income being counted by VHC was non-taxable income that Ava earned as a caretaker. Since this income was non-taxable, it should not have been included in the income to screen for Medicaid eligibility. When the income was calculated correctly, Ava was found eligible for Medicaid once again.

Individual Consumer Assistance

Case Examples

These case summaries illustrate the types of problems we helped Vermonters resolve this quarter:

Eleanor's Story

Eleanor had lost her job and her health insurance. She called Vermont Health Connect (VHC) to find out about signing up for a plan. When she spoke to VHC, they told her that she qualified for a Special Enrollment Period (SEP) because she has lost her employer insurance, and that she had until the end of the next month to sign up for a plan. Eleanor later called back to sign up, and she was told she had missed her SEP and would need to wait until Open Enrollment to sign up. Eleanor was confused because she had called within the time frame that VHC had given her in the first call. When the HCA advocate investigated, she found that during the first call VHC had told Eleanor the wrong date. It had mistakenly told her that she had more time left in her SEP than she really did. Because Eleanor had relied on this incorrect advice, the advocate asked for a new SEP for Eleanor. VHC granted it, and Eleanor was able to sign up for a plan that suited her health care needs.

Arnold's Story

Arnold had surgery scheduled, and called the HCA because the prior authorization had not been approved, and the provider was threatening to cancel the surgery. Arnold was on Medicaid, and the surgery required a prior authorization under the Medicaid coverage rules. When the HCA advocate looked into the case, he found that although Arnold was on Medicaid, he was also an attributed member of OneCare. OneCare is a state-wide Accountable Care Organization (ACO). The ACO is supposed to improve efficiency, costs, and health outcomes for its members. OneCare members do not need prior authorization for certain medical procedures and services, including the surgery that Arnold had scheduled. This meant that Arnold could go forward with the surgery without getting approval from Medicaid. The HCA made sure Arnold's provider understood that he did not need a prior authorization, and the surgery went forward as scheduled.

Charlotte's Story

Charlotte was at the Kinney Drugs pharmacy to pick up a prescription that normally cost \$2. This time the pharmacist was telling her that the price was \$70. She had paid for it using her money for groceries and other bills, but could not afford it. The HCA has a partnership with Kinney Drugs to assist in cases just like Charlotte's, and the pharmacist made an emergency referral. The HCA advocate talked to Charlotte and the pharmacist and found out that Charlotte had VPharm coverage. VPharm helps pay the Part D premium, reduces out-of-pocket costs, and keeps co-payments between \$1 and \$2. The HCA advocate first made sure Charlotte's VPharm was active. It was, so this meant that the \$70 copayment had to be an error. He reached out to VHC and asked them to intervene to correct the co-payment problem. VHC was able to do this immediately. When

the pharmacist ran the prescription again, the copayment was now \$2. Charlotte was able to get a refund for the \$68.

Alice's Story

Alice called the HCA because her children's coverage on Dr. Dynasaur had closed. VHC had determined that the family was over-income for the program. Alice had also just lost her job and her insurance. She did not think that her family could afford a family plan on VHC. Dr. Dynasaur has a low monthly premium, and no deductible or cost-sharing, so a family plan would mean a higher premium and more out-of-pocket costs. When the HCA advocate studied Alice's income, he found that the family was right under the Dr. Dynasaur income limits. Alice's family had made some contributions to an IRA that should not have been counted in the taxable income for the Dr. Dynasaur eligibility calculation. Also, this took place in April, which was the month that VHC updated its income guidelines for Medicaid and started using the 2018 FPL (Federal Poverty Level) guidelines. The updated FPL guidelines changed the income limits slightly. When the contributions were properly calculated and the 2018 FPLs applied, the family was still eligible for Dr. Dynasaur. This meant that the children could stay enrolled on the \$60 per month Dr. Dynasaur coverage, and Alice and her partner were also able to enroll in a plan for couples.

Elijah's Story

Elijah called the HCA because VHC had told him that he had missed his Special Enrollment Period (SEP) and would need to wait until Open Enrollment to sign up for a VHC plan. Elijah had been on an employer sponsored insurance (ESI) plan, but he left that job for a new one that did not offer insurance coverage. He called VHC to apply, but did not pick a plan during that conversation. When he called back to enroll in a plan, VHC told him that he had missed his SEP. When the HCA advocate reviewed Elijah's case, he found that VHC had failed to send him an eligibility notice for his Medicaid, federal premium tax subsidies, or cost-sharing assistance. VHC is required to send eligibility notices when you apply for Medicaid or PTC. The notices also would have told Elijah of the 60 day limit for the SEP. The advocate asked for an SEP because of the failure to send the notice, and VHC granted it. Elijah was able to select a plan and enroll.

Gretel's Story

Gretel went to the pharmacy to pick up her prescription, and she was told by the pharmacist that she did not have a Part D plan. Medicare Part D covers prescriptions. She could not afford to pay for her prescriptions out of pocket. When the HCA advocate looked into the case, she found that Gretel had just enrolled in Medicare. She was also on Medicaid for Aged Blind and Disabled (MABD) and enrolled on a Medicare Savings Program (MSP) to help pay for her Medicare cost-sharing. The only piece that she was missing was a Part D plan to cover her prescriptions. The advocate found that she was, indeed, signed up for a Part D plan, but it was not starting until the first day of the following month. In the meantime, Gretel could not afford her prescriptions. In this situation, the advocate realized that Gretel would qualify for a program called LI NET. This program is designed to eliminate coverage gaps for low income individuals. Because Gretel was on MABD and on a Medicare Savings Program, she was be eligible for this program. The advocate spoke with the pharmacist and explained that LI NET program could be billed for Gretel's prescriptions until her Part

D plan started. The pharmacist was able to successful bill LI NET for Gretel’s medications, and so she was able to pick up her prescriptions that day.

Avery’s Story

Avery called the HCA because she needed some help getting to her medical appointments. She was on Medicaid which meant that she was eligible for Medicaid transportation to get to her appointments. When she requested a ride to the appointment, Medicaid told her would need to take the bus since she lived on the bus-line and that was the least-expensive mode of transportation. Medicaid transportation rules require beneficiaries to use the least-expensive mode of transportation available that suits the needs of the rider. Riding the bus, however, was very difficult for Avery. When she was a child, she had fallen from over 20 feet. The fall had left her with severe vertigo. Riding on buses aggravated her vertigo and also made her nauseated. She had tried using the bus to get to an appointment, and it had made her ill. The HCA advocate worked with Avery to get a letter from her doctor describing her medical condition. The advocate requested that Medicaid allow Avery to ride in a car to her appointments due to her medical condition. With the letter, Medicaid approved the request, and Avery was able to schedule a ride for her next appointment.

Overview

The HCA provides assistance to consumers through our statewide hotline (**1-800-917-7787**) and through the Online Help Request feature on our website, Vermont Law Help (www.vtlawhelp.org/health). We have a team of advocates located in Vermont Legal Aid’s Burlington office that provides this help to any Vermont resident free of charge, regardless of income.

The HCA received 967 calls¹ this quarter. We divided these calls into five issue categories. The figures below are based on the All Calls data. The percentage and number of calls in each issue category, based on the caller’s primary issue, were as follows:

- **27.09%** (262) about **Access to Care**
- **13.86%** (134) about **Billing/Coverage**
- **1.14%** (11) about **Buying Insurance**
- **10.55%** (102) about **Consumer Education**
- **26.06%** (252) about **Eligibility** for state and federal programs
- **21.30%** (206) were categorized as **Other**, which includes Medicare Part D, communication problems with providers or health benefit plans, access to medical records, changing providers or plans, confidentiality issues, and complaints about insurance premium rates, as well as other issues.

We have a customized case management system that allows us to track more than one issue per case. This enables us to see the total number of calls that involved a particular issue. For example, although 252 of our cases had eligibility for state and federal healthcare programs listed as the primary issue, a total of 542 cases had eligibility listed as a secondary concern.

¹ The term “call” includes cases we get through the intake system on our website.

In each section of this narrative, we indicate whether we are referring to data based on just primary issues, or primary and secondary issues combined. Determining which issue is the “primary” issue is sometimes difficult when there are multiple causes for a caller’s problem. This has proven to be particularly true for Vermont Health Connect (VHC) cases. See the breakdowns of the issue numbers in the individual data reports for a more detailed look at how many callers had questions about issues in addition to the “primary” reason for their call.

The most accurate information about eligibility for state programs is in the All Calls data report because callers who had questions about Vermont Health Connect and Medicaid programs fell into all three insurance status categories.

The full quarterly report for April 1 - June 30, 2018 includes:

- This narrative, which contains sections on **Individual Consumer Assistance, Consumer Protection Activities** and **Outreach and Education**
- Seven data reports, including three based on the caller’s insurance status:
 - **All calls/all coverages:** 967calls (compared to 1047 last quarter)
 - **Department of Vermont Health Access (DVHA) beneficiaries:** 355 calls (319 calls last quarter)
 - **Commercial plan beneficiaries:** 165 calls (222 calls last quarter)
 - **Uninsured Vermonters:** 92 calls (100 calls last quarter)
 - **Vermont Health Connect (VHC):** 242calls (325 calls last quarter)
 - **Reportable Activities (Summary & Detail):** 94 activities and 14 documents (121 activities, 11 documents)

Priorities

A. The HCA advocates participated in the COTS legal clinic with the goal of reaching vulnerable and underserved consumers.

The advocates educated consumers about both state and federal health care programs and about how the HCA could help them. They also talked to specific consumers about their eligibility for health care programs. Specifically, they advised multiple consumers how to apply for Medicaid and advised them on their eligibility for the program. The HCA also handed out brochures and cards, and plans on participating in clinics in the future.

B. The HCA organized a meeting with area healthcare providers to discuss improving access to transgender health care services.

The HCA, along with Vermont Legal Aid attorneys and nine providers, met to discuss current Medicaid coverage criteria, and the barriers presented by the criteria. This group plans on meeting with AHS to discuss how the current coverage criteria could be changed to expand access of medically-necessary coverage. The group discussed consumer and provider experiences with commercial insurance coverage for these services, and plans on working to increase access to these health care services for all Vermont consumers.

C. The HCA participated in the Adverse Childhood Experiences Pilot Project.

HCA advocates and attorneys met with a local pediatrician who has teamed with the Family Center of Washington County for a pilot project to address adverse childhood experiences (ACEs). ACEs are traumatic childhood experiences. Children who experience an increased number of ACEs have been shown to suffer from chronic health conditions and other health problems at a greater rate. The project funds two social workers in the pediatrician's office. The pediatrician uses a questionnaire to identify patients who may be at risk for ACEs. The social workers then coordinates help for the families to try to reduce the ACE risk factors. The pilot project is seeing encouraging results but needs additional funding to continue. The HCA discussed some potential funding mechanisms and helped connect the project with some local organizations that may be able to further facilitate funding.

**D. The HCA participated in Rural Pride.**

This event was organized by the National Center for Lesbian Rights and Green Mountain Crossroads. The HCA advocate presented information on rural LGBTQ health care concerns for an audience of

30. The advocate also outlined the services that the HCA offers—and how it can help Vermonters with healthcare problems and questions.

E. Overall call volume decreased somewhat, but is still higher than the call volume in the same quarter of 2017.

The total call volume decreased by 7.6%. (967 this quarter vs. 1047 last quarter). In 2017, the HCA had 861 calls in the second quarter compared to 967 in 2018. About 12% of those calls involved getting consumers onto new coverage, preventing the loss of coverage, or obtaining coverage for services. We saved consumers \$45,408.64 this quarter.

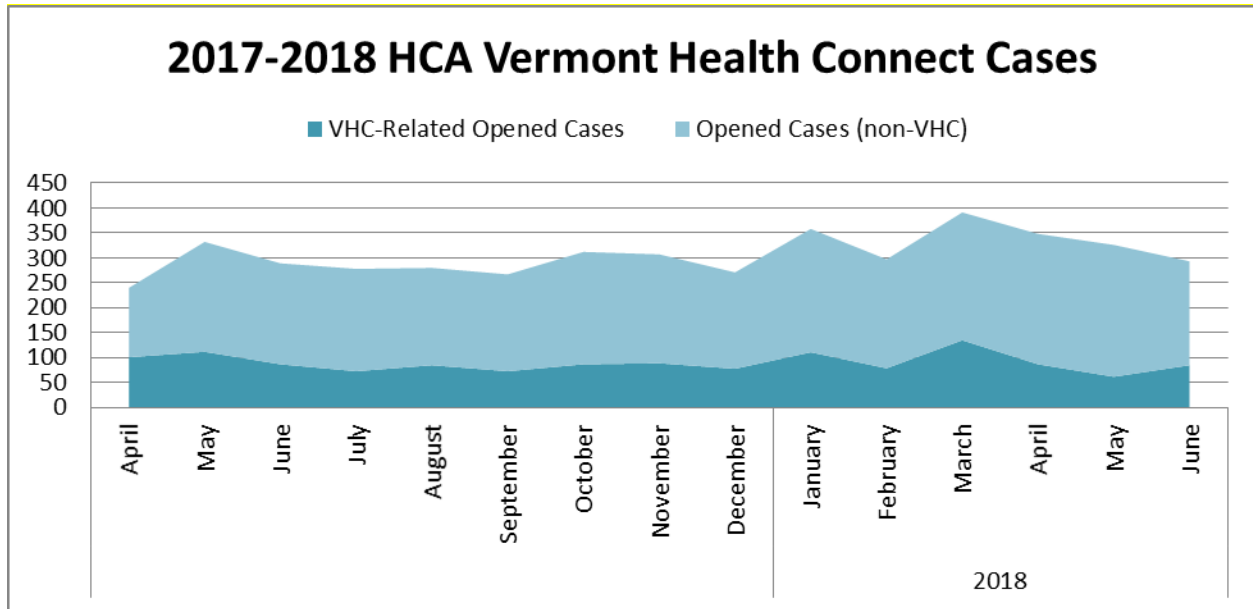
	All Calls (2008-2018)										
	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
January	309	240	218	329	282	289	428	470	411	340	358
February	232	255	228	246	233	283	304	388	511	330	297
March	229	256	250	281	262	263	451	509	416	308	391
April	235	213	222	249	252	253	354	378	333	240	348
May	207	213	205	253	242	228	324	327	325	332	326
June	245	276	250	286	223	240	344	303	339	289	294
July	205	225	271	239	255	271	381	362	304	278	-
August	152	173	234	276	263	224	342	346	343	280	-
September	147	218	310	323	251	256	374	307	372	267	-
October	237	216	300	254	341	327	335	311	312	312	-
November	192	170	300	251	274	283	306	353	287	307	-
December	214	161	289	222	227	340	583	369	284	271	-
Total	2604	2616	3077	3209	3105	3257	4526	4423	4237	3554	2014

F. Calls concerning Vermont Health Connect decreased significantly.

The volume of calls concerning Vermont Health Connect decreased by 26%, compared to the previous quarter (242 v. 325). With the ending of tax season, we saw an expected decrease in our tax-related calls (ACA Tax issues, 30 vs. 43 calls; and 1095-A & B issues, 17 vs. 46 calls). Consumers, however, continue to call in significant numbers about eligibility for Special Enrollment Periods and Termination of insurance (40 vs. 37 for SEPS; and 41 vs. 48 for Termination). The HCA will continue to focus our consumer education and outreach efforts on making sure that consumers enroll in QHPs that they can afford and that best meet their medical needs. This quarter, 96 VHC cases required complex interventions that took more than two hours of an advocate's time to resolve, and 60 required a direct intervention to resolve the case.

The HCA continues to resolve its cases by working directly with Tier 3 Health Access Eligibility Unit (HAEU) workers, who are trained to resolve all aspects of complex cases. In addition, the HCA meets with VHC as needed to discuss cases and has regular email contact with Tier 3. This quarter we had 69 escalated cases (69 vs. 83 last quarter). Of the 69 escalated cases, 62 were resolved within the quarter.

Tier 3 also now works on resolving Green Mountain Care cases (VPharm, Medicaid for Aged Blind and Disabled (MABD), Medicare Saving Programs, and Medicaid Spenddowns). This quarter we continued to get significant numbers of consumers calling with questions about Medicare Savings Programs (61 vs. 65), MABD (73 vs. 68), and VPharm eligibility (56 vs. 40).



G. Medicaid eligibility calls represented 25% of all our cases (240 calls/967 total calls). Consumers need assistance with all types of Medicaid.

Medicaid eligibility was again the top issue generating calls. We had 102 calls about eligibility for MAGI (expanded) Medicaid, 73 about eligibility for Medicaid for the Aged Blind and Disabled (MABD), 25 about Medicaid Spenddowns, and 17 about Medicaid for Working Disabled. We also had 23 calls specifically about the Medicaid renewal process. MAGI Medicaid and MABD Medicaid have different eligibility and income rules, and HCA advocates assess and advise on eligibility for both programs. Consumers frequently have questions about what counts as income, who should be counted in their household, what expenses can be used to meet a Spenddown, how to complete renewal paperwork, and whether their eligibility decision is correct.

H. The top issues generating calls

The listed issues in this section include both primary and secondary issues, so some of these may overlap.

All Calls 967 (compared to 1047 last quarter)

1. Complaints about providers 136 (81)
2. MAGI Medicaid eligibility 102 (115)
3. Information/applying for DVHA programs 81 (77)
4. Premium Tax Credit eligibility 79 (63)
5. Medicaid eligibility (non-MAGI) 73 (68)
6. Information about VHC 64 (58)

7. Buy-in programs/Medicare Savings Programs 61 (65)
8. Access to Prescription Drugs/Pharmacy 60 (44)
9. Special Enrollment Periods eligibility 59 (54)
10. Information about Medicare 58 (52)
11. Termination of insurance 56 (58)
12. VPharm eligibility 56 (40)
13. DME, Supplies 53 (15)
14. Transition/Continuity of Care 46 (25)
15. Fair hearing appeals 43 (50)

Vermont Health Connect Calls 242 (compared to 325 last quarter)

1. MAGI Medicaid eligibility 90 (97)
2. Premium Tax Credit eligibility 78 (57)
3. Information about VHC 58 (53)
4. Termination of insurance 41 (48)
5. Special Enrollment Periods 40 (37)
6. Grace Periods – VHC 39 (40)
7. IRS Reconciliation 31 (25)
8. ACA Tax issues 30 (43)
9. Fair hearing appeals 30 (39)
10. Change of Circumstance 27 (32)

DVHA Beneficiary Calls 355 (compared to 319 last quarter)

1. Complaints about providers 68 (24)
2. DME, Supplies 47 (11)
3. MAGI Medicaid eligibility 44 (44)
4. Medicaid eligibility (non-MAGI) 41 (29)
5. Transition/Continuity of Care 38 (2)
6. Information/applying for DVHA programs 32 (23)
7. Provider Directory Problems 29 (not counted as separate issue previously)
8. Network Adequacy 27 (2)
9. Choosing/Changing Providers 24 (11)
10. Access to prescription drugs/pharmacy 19 (28)

Commercial Plan Beneficiary Calls 165 (compared to 222 last quarter)

1. Premium Tax Credit eligibility 39 (35)
2. Information about VHC 20 (17)
3. Eligibility for Special Enrollment Periods 17 (14)
4. Insurance Coverage/Contract Questions 18 (13)
5. ACA Tax issues 17 (23)
6. Eligibility for VHC grace periods 16 (18)
7. IRS Reconciliation 17 (17)
8. 1095-A & 1095-B problems 15 (25)
9. MAGI Medicaid eligibility 13 (27)
10. Change of Circumstance 13 (13)

The HCA received 967 total calls this quarter. Callers had the following insurance status:

- **DVHA program beneficiaries** (Medicaid, Medicare Savings Program also called Buy-In program, VPharm, or both Medicaid and Medicare also known as “dual eligible”): 36.7% (355 calls), compared to 30.5 % (319 calls) last quarter
- **Medicare² beneficiaries** (Medicare only, Medicare Advantage Plans, Medicare and a Medicare Supplemental Plan aka Medigap, Medicare and Medicaid also known as “dual eligible,” Medicare and Medicare Savings Program also called Buy-In program, Medicare and Part D, or Medicare and VPharm): 28.7% (278 calls), compared to 28.01% (293 calls), last quarter
- **Commercial plan beneficiaries** (employer-sponsored insurance, small group plans, or individual plans 17.1% (165 calls) , compared to 21.1% (222 calls) last quarter
- **Uninsured:** 9.51% (92 calls), compared to 9.56% (100 calls last quarter)

Case Results

A. Dispositions of Closed Cases

All Calls

We closed 1029 cases this quarter, compared to 981 last quarter:

- 32% (327 cases) were resolved by brief analysis and advice
- 32% (327) were resolved by brief analysis and referral
- 22% (228) of the cases were complex interventions involving complex analysis, usually direct intervention, and more than two hours of an advocate’s time
- 9% (97) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc.
- In the remaining cases (50), clients withdrew, resolved the issue on their own, or had some other outcome.

Appeals: The HCA assisted 27 individuals with appeals: 14 Fair Hearings, 3 Commercial Insurance – Internal 1stLevel appeals, 2 Commercial Insurance – Internal 2nd Level appeals, 1 Commercial External Appeal, 1 Medicare Part A, B, or C appeal, 2 Medicare Part D appeals, and 4 Medicaid MCO Internal appeals.

DVHA Beneficiary Calls

We closed 363 DVHA cases this quarter, compared to 301 last quarter:

- 32% (117 cases) were resolved by brief analysis and/or referral
- 31% (113) were resolved by brief analysis and/or advice
- 19% (70) were considered complex intervention, which involves complicated analysis, usually direct intervention, and more than two hours of an advocate’s time
- 13% (46) were resolved by direct intervention on the caller’s behalf, including advocacy with the carrier and providers, writing letters, and gathering medical information
- In the remaining cases (17) clients withdrew, resolved the issue on their own, or had some other outcome.

Appeals: The HCA assisted 7 DVHA beneficiaries with appeals: 1 Fair Hearing, 2 Medicare Part D appeals, and 4 Medicaid MCO Internal appeals.

² Because Medicare beneficiaries can also have commercial or DVHA coverage, these Medicare numbers overlap with the figures for those categories.

Commercial Plan Beneficiary Calls

We closed 201 cases involving individuals on commercial plans, compared to 214 last quarter:

- 32% (64 cases) were considered complex intervention, which involves complicated analysis, usually direct intervention, and more than two hours of an advocate's time
- 30% (61) were resolved by brief analysis and/or advice
- 22% (44) were resolved by brief analysis and/or referral
- 13% (26) were resolved by direct intervention on the caller's behalf, including advocacy with the carrier and providers, writing letters, and gathering medical information
- In the remaining cases (6) clients withdrew, resolved the issue on their own, or had some other outcome.

Appeals: The HCA assisted 23 commercial plan beneficiaries with appeals: 14 Fair Hearings, 3 Commercial Insurance – Internal 1st Level appeals, 2 Commercial Insurance – Internal 2nd Level appeals, 1 Commercial External Appeal, 1 Medicare Part A, B, or C appeal, and 2 Medicare Part D appeals.

B. All Calls Case Outcomes

The HCA helped 87 people with applications for or enrollment in insurance plans and prevented 21 insurance terminations or reductions. We obtained coverage for services for 20 people. We got 24 claims paid, written off, or reimbursed. We estimated VHC insurance program eligibility for 56 more. We provided other billing assistance to 20 individuals. We provided 593 individuals with advice and education. Fourteen people were not eligible for the benefit they sought, and nineteen were responsible for the bill they disputed. We obtained other access or eligibility outcomes for 170 more people.

Consumer Protection Activities

A. Rate Review

The HCA monitors all commercial insurance carrier requests to the Green Mountain Care Board (Board) for changes to premium prices. These requests are typically requests to increase the premiums that Vermonters must pay for commercial health insurance.

Five filings related to premium price increases were decided during the quarter covering April 1 through June 30, 2018. Additionally, there are two proposed premium price increases pending at the end of the quarter.

Two decided filings were submitted by Blue Cross Blue Shield of Vermont (BCBSVT) and The Vermont Health Plan (TVHP), a subsidiary of BCBSVT: the BCBSVT Large Group Filing and the TVHP Large Group Filing. BCBSVT and TVHP proposed an average premium price increase of 11.2 percent. Approximately 14,200 Vermonters who obtain coverage through their employers were impacted by the proposed premium price increases. The HCA appeared on behalf of Vermonters in these matters and filed questions to the carriers, post-hearing memoranda, and various motions. The Board reduced BCBSVT's and TVHP's proposed price increases by 12.5 percent to an average increase of 9.8 percent. These premium price reductions translate into approximately \$1M of savings for Vermonters.

The other three proposed premium price increases were filed by MVP Health Care, Inc. (MVP). Two of these proposed premium price increases were dealt with jointly, namely, the MVP Large Group HMO 3Q/4Q 2018 and the MVP Large Group Point of Service Rider. This premium price increase affected approximately 2,200 Vermonters who obtain health insurance coverage through their employer. The HCA appeared on behalf of Vermonters in this matter and filed questions to the carrier, and a post-hearing memorandum. The Board reduced MVP's proposed premium price increase to 2.32 percent. This premium price reduction translates into approximately \$162,000 of savings for Vermonters.

The final decided filing was related to MVP's small group grand 3Q/4Q 2018 book of business. This premium price increase affected approximately 1,300 Vermonters. The HCA appeared on behalf of Vermonters in this matter and filed questions to the carrier, and a post-hearing memorandum. The Board reduced MVP's premium price increase to 0.8 percent. This premium price reduction translates into approximately \$103,000 of savings for Vermonters.

There are two pending filings related to premium price increases for individual and small group health insurance plans. These two proposed premium price increases were filed by BCBSVT and MVP and represent approximately \$41M in additional premiums that Vermonters may have to pay. These two proposed price increases will impact approximately 77,700 Vermont members. The HCA appeared on behalf of Vermonters in these matters and has filed questions to the carriers and various motions. We intend to file all appropriate memoranda and other documents to represent the interests of Vermonters in these matters. Additionally, we intend to represent Vermonters at the public hearings related to these two premium price increases.

Lastly, as we noted last quarter, the HCA devoted substantial effort to modify the rate review process to allow the HCA to better represent the interests of Vermonters. In response to HCA advocacy, the Board has, for the first time, required health insurers to answer questions related to affordability, access to care, quality of care, and other relevant public policy questions related to how proposed premium price increases impact Vermonters. The HCA is hopeful that its efforts will continue to result in meaningful changes to the rate review process although we have laid the groundwork for a possible statutory solution next legislative session should that be necessary.

B. Hospital Budget Review

The HCA participates in the Board's annual hospital budget review process. This quarter, the Chief Health Care Advocate and HCA staff met with executives at three Vermont hospitals to open channels of communication, share information about the role of the HCA outside the hospital budget review process, and learn about the hospitals' successes and challenges. These first three meetings were with Porter Medical Center, Northeastern Vermont Regional Hospital, and Northwestern Medical Center. Additionally, this quarter the HCA met with leadership at the Vermont Association of Hospitals and Health Systems to discuss the hospital budget review process.

We will begin our review of the hospitals' proposed 2019 budgets and their answers to our first set of written questions (submitted with the Board's budget guidance in March) when the proposed hospital budgets are submitted to the Board in July.

C. Oversight of Accountable Care Organizations

This quarter, the HCA worked with the Board and OneCare Vermont to develop a proposed measure set for the 2019 Medicare ACO program. HCA staff met with the Board and OneCare twice to review measures proposals and develop a recommendation. The group developed a consensus set of 15 measures which were submitted to the Centers for Medicare and Medicaid Services (CMS) by Board staff. CMS accepted 13 of the 15 measures and these are expected to form the core Medicare measure set for 2019. At the Board meeting where the measure set was discussed, the HCA gave an oral comment supporting the consensus measure set and asking the Board and OneCare to implement a point-of-care measure of the patient experience of shared decision-making. Additionally, this quarter the HCA submitted formal comments to the Board outlining concerns about affordability and how patient cost-sharing will interact with ACO goals. In these comments we reiterated our suggestion that the Board and the ACO monitor the patient experience of shared decision-making, including affordability of recommended care, via a point-of-care measure. The HCA continues to have concerns that the ACO quality measures will not be sufficient to assess the model and how it is affecting patients' care experiences.

D. Other Green Mountain Care Board Activities

The HCA continues to participate in several stakeholder groups organized by the Green Mountain Care Board in addition to attending weekly Green Mountain Care Board meetings and periodic Green Mountain Care Board Advisory Board meetings. The Federal Issues Work Group was organized to discuss state issues that could arise as a result of changes made by the federal government. The group is looking at a variety of issues including loss of federal cost sharing funds and changes in federal rules related to short term and association health insurance plans. All of these issues have the potential to increase the cost of health insurance for Vermonters. The HCA actively participates in this group, representing consumers' interests.

In the last quarter, the HCA provided the Board with a report examining demographic change in Vermont by health service area, motivated by a desire to assist the Board with its efforts towards data-driven, responsive policy making. Unlike past demographic data presented to the Board by third parties, the HCA highlighted the complexity of demographic change on health care system function including the potential of demographic change to indicate increased health risks and how the geography of demographic change leads to the need for context-sensitive regulation.

In the last quarter, the HCA also monitored the Board's upcoming Hospital Budget review and Accountable Care Organization Budget review. As a part of this, the HCA asked the Board and OneCare to implement a point-of-care patient experience measure assessing shared decision-making. The HCA also met with Board staff members to discuss ways the Board can better integrate its regulatory processes for rate review, hospital budget review, certificate of need, and accountable care organization budget review.

E. Other Activities

Administrative Advocacy

✦ Access to Screening Mammography

This quarter the HCA continued to advocate for the implementation of Act 25 of 2013, which requires first-dollar coverage of screening mammography including additional views. The law has now been amended, and starting in 2019, ultrasound screening will also be covered with no cost-sharing. The HCA will continue to follow this issue to ensure that law is fully implemented.

✦ Access to Treatment for Hepatitis C Virus

This quarter, the HCA continued to advocate for increased access to hepatitis C virus (HCV) treatment. In the previous quarter we had submitted a request to the Vermont Department of Corrections (VTDOC) for basic information about treatment for patients with HCV in the correctional system in 2017 and early 2018. We received a response to this request in April with some limited data and VTDOC's health care contractor (Centurion)'s treatment protocol. We were told that in 2017, 258 people with HCV spent time in custody of VTDOC, that the total cost of treatment was just over \$330,000, and that information about the number of people treated did not exist. We were later told that this information was inaccurate.

In early June we received more information from VTDOC. In this communication they told us that the information provided to us in April was not correct. They informed us that 1 person was treated for HCV in 2017 and that rather than the over \$330,000 figure that was previously cited, Centurion spent \$47,250 on antiviral medication during that year. Of particular note, we were informed that in 2017 Centurion was paid \$2,719,719 for pharmaceuticals. In that same year Centurion spent only \$1,785,926 on pharmaceuticals. Similarly, the state paid Centurion \$2,113,726 for off-site services for 2017, of which Centurion spent only \$883,203.

We submitted an additional request for information to VTDOC and AHS in June asking for explanations as to why only one person was treated for HCV, and where the remaining dollars paid by the state to Centurion for pharmaceuticals and off-site services went. As of quarter-end, we are still awaiting a response.

Additionally, the HCA continues to actively participate in the Vermont Department of Health Hepatitis C Task Force, and our Policy Analyst is a member of the Task Force Steering Committee. We attended one meeting of the Task Force this quarter.

✦ University of Vermont Medical Center Mental Health Program Quality Committee

This quarter the HCA began attending the UVMHC Mental Health Program Quality Committee (PQC). The PQC meets monthly and discusses mental health quality, programs, infrastructure, and planning. This quarter we attended two meetings of the PQC.

✦ Vermont Health Connect Escalation Path

The HCA and VHC continue to collaborate to resolve complex VHC issues. The VHC escalation path now also works to resolve issues regarding Medicaid for Aged, Blind and Disabled (MABD), Medicare Savings Programs, Medicaid Spenddowns and V-Pharm. We communicate with VHC multiple times a day and meet as needed to discuss the most difficult cases.

✧ **Comments on Vermont Health Connect Notices**

At VHC's request, the HCA commented on 4 notices, in an effort to make them more readable and consumer-friendly. See **Promoting Plain Language in Health Communications** below.

✧ **Medicaid and Exchange Advisory Board**

This quarter, the Chief Health Care Advocate continued to co-chair and actively participate in Vermont's Medicaid and Exchange Advisory Board (MEAB).

Legislative Activities

The 2018 Legislative session finally came to a close during this quarter. The HCA put considerable time and effort into legislative advocacy during this session. With the close of the session, a review of the legislative year is in order here. A significant theme of this work has been in response to actions or potential actions from the Federal Government that would have a negative impact on the stability of Vermont's health insurance marketplace.

- **S.19** – An act relating to allowing silver-level nonqualified health benefit plans to be offered outside the Vermont Health benefit Exchange. The HCA joined with other advocates to successfully change the organization of Vermont's marketplace to allow the costs of the Federal Cost Sharing Reduction subsidies to be loaded on to the silver-level premiums inside the exchange. This change will draw down significantly more Federal Premium Tax credits for low income Vermonters to more than offset the loss of the Federal CSR monies.
- **H.696** – An act relating to establishing a State individual mandate. This bill creates a state Individual mandate that will be implemented for the 2020 plan year. The bill also includes intent language that the individual mandate will be enforced by a financial penalty or other enforcement mechanism that will be enacted during the 2019 legislative session. An individual mandate working group is established that includes the HCA and is tasked with developing a proposal for legislative action by November 1, 2018. The HCA as well as the Department of Health Access are also directed to engage in outreach efforts for the 2019 open enrollment period.
- **H.892** – An act relating to regulation of short-term, limited-duration health insurance coverage and association health plans. This bill clarified that short-term, limited-duration health insurance coverage plans cannot be longer than 3 months and cannot be renewed in Vermont. It also requires the Department of Financial Regulation to engage in rulemaking to regulate Association Health Plans.
- **H.912** - An act relating to the health care regulatory duties of the Green Mountain Care Board. This was passed by the House and has not been acted upon by Senate Health and Welfare as of the close of the quarter. The HCA engaged significantly and successfully on the CON portion of this bill as well as other incidental sections including the creation of a workgroup to focus on the regulation of freestanding health care facilities. H.912 was also the context in which we engaged in an important conversation about the HCA's ability to ask relevant questions in the Rate Review process. While this advocacy did not result in an update of the statutes, it did result in a memorandum from the Chair of Senate Health and Welfare calling on the GMCB and the HCA to

improve the process to assure that the HCA is able to access the information it requests of carriers while not unjustifiably increasing the administrative burdens of the insurers.

- **S.262** - An act relating to miscellaneous changes to the Medicaid program and the Department of Vermont Health Access. S.262 passed the Senate and has not seen final action in the House Health Care committee as of the close of the quarter. The HCA and VLA advocated for some important changes to this bill with a focus on appropriate notice to applicants that DVHA is using electronic asset verification to review Medicaid eligibility, developing a system to give beneficiaries appropriate assistance asking for a fair hearing after an internal appeal, as well as a minor update to the factors that can lead to a secretary reversal of a HSB decision.
- **H.404** - An act relating to Medicaid reimbursement for long-acting reversible contraceptives. This bill requires Medicaid to reimburse health care providers for the full cost of long acting reversible contraception devices. The HCA supported this bill in each stage of action.
- **H.639** - An act relating to banning cost-sharing for all breast imaging services. This act requires health insurance coverage for screening by ultrasound without cost-sharing requirements for patients whose screening mammograms were inconclusive or who have dense breast tissue, or both. It also directed the Department of Financial Regulation to issue a bulletin by October 1, 2018, providing clarification to health insurers regarding the coding structure for screening mammograms and ultrasounds and for call-back screenings, including clarifying that call-back mammograms and ultrasounds for patients whose screening mammograms were inconclusive or who have dense breast tissue, or both, must be covered without cost-sharing. The HCA worked on this issue for many months from both an individual advocacy perspective as well as advocating for correcting this problem with insurers and providers and ultimately in the legislative context.
- **H.914** - An act relating to reporting requirements for the second year of the Vermont Medicaid Next Generation ACO Pilot Project. This act requires the Department of Vermont Health Access to provide written updates to the legislative committees of jurisdiction, the Green Mountain Care Board, the Medicaid and Exchange Advisory Committee, and the Office of the Health Care Advocate. The HCA generally supported this bill. We testified about specific areas of concern.
- **S.53** - An act relating to a universal, publicly-financed primary care system. S.53 has passed the Senate and was voted out of the House Health Care Committee. It did not make it out of the House Appropriations committee before the end of the session. The HCA testified in favor of this bill in both the Senate and the House.
- **S.175** - An act relating to the wholesale importation of prescription drugs into Vermont. This act directs the Agency of Human Services, in consultation with interested stakeholders and appropriate federal officials, to design a program for wholesale importation of prescription drugs into Vermont from Canada that complies with federal requirements. The HCA supported this bill and tracked it through the process.

- **S.1 (Special Session)** - An act relating to co-payment limits for chiropractic care and physical therapy. This act establishes limits on the amount of the co-payment requirement that certain health benefit plans can impose for chiropractic care and physical therapy services. For plan year 2019 only, the act limits the amount of the co-payment requirement that silver- and bronze-level plans offered through the Vermont Health Benefit Exchange (Exchange), and reflective silver plans offered outside the Exchange, may impose for chiropractic services to the amount of the copayment requirement for primary care services under the plan. Beginning in plan year 2020, the act limits the amount of the co-payment requirement that silver and bronze-level Exchange plans and reflective silver plans may impose for chiropractic care and physical therapy services to between 125 and 150 percent of the co-payment requirement for primary care services under the plan. The HCA did not support this bill.

Collaboration with Other Organizations

The HCA regularly collaborates with other organizations to advance consumer-oriented policy objectives and to conduct outreach and education. We worked with the following organizations this quarter:

- American Civil Liberties Union of Vermont
- Bi-State Primary Care
- Blue Cross Blue Shield of Vermont
- Community Catalyst
- Families USA
- IRS Taxpayer Advocate Service
- Ladies First
- MVP Health Care
- OneCare Vermont
- Planned Parenthood of Northern New England
- University of Vermont Medical Center
- Vermont Association of Hospitals and Health Systems
- Vermont Care Partners
- Vermont CARES
- Vermont Coalition of Clinics for the Uninsured
- Vermont Department of Health
- Vermont Department of Taxes
- Vermont Health Connect
- Vermont Medical Society
- Vermont Program for Quality in Health Care
- VNAs of Vermont
- Voices for Vermont's Children

Outreach and Education

A. Increasing Reach and Education through the Website

Vermont Law Help is a statewide website maintained by Vermont Legal Aid and Law Line of Vermont. The site includes a substantial Health section (<https://vtlawhelp.org/health>) with more than 250 pages of consumer-focused health information maintained by the HCA.

HCA advocates work diligently to keep the site updated in order to provide the latest and most accurate information to Vermont consumers.

Popular Web Pages

- The total number of **health pageviews increased by 6%** in the reporting quarter ending June 30, 2018 (11,080 pageviews), compared with the same quarter in 2017 (10,406 pageviews).
- The **top-20 health pages** on our website this quarter with change over last year:
 - [Income Limits – Medicaid](#) – 2,936 pageviews (7% ↑)
 - [Health](#) – section home page – 1,422 (24% ↑)
 - [Services Covered by Medicaid](#) – 457 (84% ↑)
 - [Resource Limits – Medicaid](#) – 450 (23% ↑)
 - [Dental Services](#) – 442 (2% ↑)
 - [Vermont Choices for Care](#) – 379 (38% ↓)
 - [Buying Prescription Drugs](#) – 296 (317% ↑)
 - [HCA Online Help Request Form](#) – 229 (12% ↑)
 - [Medicaid](#) – 205 (125% ↑)
 - [Advance Directive Forms](#) – 178 (249% ↑)
 - [Federally Qualified Health Centers](#) – 175 (11% ↑)
 - [Long-term Care](#) – 171 (20% ↑)
 - [Medical Decisions – Advance Directives](#) – 159 (29% ↑)
 - [Medicare Savings / Buy-In Programs](#) – 159 (1% ↑)
 - [Choices for Care Resource Limits](#) – 148 (33% ↓)
 - [Choices for Care Income Limits](#) – 142 (28% ↓)
 - [Choices for Care Requirements](#) (new page)– 123 (100% ↑)
 - [Medicaid and Medicare dual eligible](#) – 120 (3% ↓)
 - [Health Insurance, Taxes and You](#) – 120 (48% ↓)
 - [Medicaid Transportation](#) – 112 (38% ↑)
- Besides the pages listed above, other **spikes in interest** in our pages included:
 - [Health home page](#) – 1,422 (24% ↑)
 - [Long-Term Care Help](#) (new page) – 89 (100% ↑)
 - [Green Mountain Care](#) – 93 (86% ↑)
 - [ACA Assisters](#) – 59 (211% ↑)
 - [Moving from VHC to Medicare](#) – 57 (73% ↑)
- And we saw a 56% **decrease** in pageviews of our medical marijuana registry pages.

Popular PDF Downloads

21 out of 70, or 30% of the unique PDFs downloaded from the Vermont Law Help website were on health care topics. Of those unique health-related PDF titles:

- 14 PDFs were created for consumers. The top five consumer-focused PDF downloads were:
 - [*Advance Directive, short form*](#) (122 downloads)
 - [*Advance Directive, long form*](#) (106 downloads)
 - [*Vermont Dental Clinics Chart*](#) (95 downloads)
 - [*Vermont Medicaid Coverage Exception Request Form*](#) (25 downloads)
 - [*BCBSVT 2016 Annual Report*](#) (19 downloads)
 - The advance directive forms were accessed much more often this year as compared to the same period last year (228 downloads versus 131 last year).
- 5 PDFs were prepared for lawyers, advocates and assisters who help consumers with tax issues related to the Affordable Care Act. The top advocate-focused download was:
 - [*PTC Rule Allocation Summary*](#) (23 downloads)
- 2 PDFs covered topics related to health policy. The top policy-focused download was:
 - [*VT ACO Shared Savings Program Quality Measures*](#) (5 downloads)

The [*Advance Directive Short Form*](#) is the **fifth most downloaded of all PDFs** downloaded from the entire Vermont Law Help website. The *Long Form* is the **sixth most downloaded**.

The [*Vermont Dental Clinics Chart*](#) is the **ninth most downloaded of all PDFs** downloaded from the entire Vermont Law Help website.

New Online Help Tool Adds to Our Reach

Last year we added a new Health section to the online help tool on our website. It is found at https://vtlawhelp.org/triage/vt_triage and it can be accessed from most pages of our website. The website visitor answers a few questions to find specific health care information they need. The new feature addresses some of the most popular questions that are posed to the HCA. In addition to our deep collection of health-related web pages, the online help tool adds a new way to access helpful information — at all hours of the day and night. The website user can also call us or fill in our online form to get personal help from an advocate.

Website visitors used this new tool to access health care information **145 times** during this quarter. That's a **10% decrease** over the previous quarter (January – March).

Of the **36** health care topics that were accessed using this tool, the top topics were:

- Dental Services - I need help finding a low-cost dentist and paying for dental care.
- Dental Services - I need help with dentures.
- Long-Term Care - I want to go over my long-term care options (nursing homes, in-home care and more).
- Long-Term Care - How do I know if I can get Choices for Care Long-Term Care Medicaid?

B. Other Outreach and Educational Activities

Are You Leaving Money on the table? (April 9, 2018)

Mike Fisher, the Chief Health Care Advocate, appeared on WDEV Radio to educate Vermonters about the opportunities for tax credits and promote the HCA's Tax Time PTC Reminder fact sheet.

Meeting with Health Care Providers (April 9, 2018)

HCA advocates and attorneys met with health care providers to discuss Medicaid coverage rules for transgender patients.

Rural Pride (April 27, 2018)

An HCA advocate did a presentation on rural LGBTQ health concerns to an audience of 30.

Meeting with the Pride Center (June 11, 2018)

HCA advocates met with the Pride Center to explain how cases can be referred to the HCA, and how the HCA can help Vermonters with their health care questions and problems.

Training on the revised Medicaid rules regarding internal appeals, grievances, notices and State fair hearings. (June 19, 2018)

HCA presented a training on the revised Medicaid rules for Vermont Legal Aid attorneys.

COTS Legal Clinic (June 19, 2018)

HCA advocates participated in the Legal Clinic and advised Vermonters on state and federal health care programs.

C. Promoting Plain Language in Health Communications

During this quarter, the HCA provided feedback and revisions to promote the use of plain language and increase consumers' accessibility to and understanding of important communications from the state and other health organizations regulated by the state. The HCA made plain language edits and edits/comments to improve comprehension of message and ability to resolve the problem being addressed in the following notices/letters:

- Authorization form for spouse of MABD/LTC applicant
- Asset Verification on 202 Med application
- OneCare Patient Fact sheet
- OneCare Notice for Medicare beneficiaries

Office of the Health Care Advocate

Vermont Legal Aid
264 North Winooski Avenue
Burlington, Vermont 05401
800.917.7787

<http://www.vtlegalaid.org/health>