

# VERMONT OFFICE OF HEALTH CARE OMBUDSMAN

## SFY 2012 ANNUAL REPORT

JULY 1, 2011 – JUNE 30, 2012

### STATE HEALTH CARE OMBUDSMAN

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## Table of Contents

BACKGROUND.....	1
EXECUTIVE SUMMARY.....	2
DESCRIPTION OF CASELOAD.....	4
Access to Care.....	5
Billing and Coverage.....	6
Eligibility.....	7
Types of Coverage.....	9
Geographic Distribution of Calls.....	10
Resolution of Calls.....	10
Outcomes .....	11
Case Examples.....	12
QUALITY ASSURANCE AND CONSUMER SATISFACTION.....	13
OTHER ACTIVITIES.....	177
COORDINATION.....	19
REPORTING .....	20
EXPENDITURES.....	21

## BACKGROUND

In 1998 the Vermont legislature created the Office of Health Care Ombudsman (HCO) to provide advice and advocacy for Vermonters with health care and health insurance problems. The HCO operates a statewide hotline in Burlington to help individuals navigate the complexities of the health care system. In addition, we act as a voice for consumers regarding health care policy with the state and federal government. We advise and assist Vermont residents, regardless of their income, resources or insurance status. Our services are free. As part of Vermont Legal Aid (VLA), we are able to refer cases to, and utilize the expertise of, the attorneys in the other VLA projects.

The HCO is funded by two state agencies: the Department of Financial Regulation<sup>1</sup> (DFR) and the Department of Vermont Health Access (DVHA), the state Medicaid agency. We now also receive several grants through the federal Affordable Care Act.

Individuals contact us through our hotline, the VLA website, or by walking into one of the five VLA offices located around the state. HCO advocates analyze their situation, provide information and advice, directly intervene or make a referral.

One of our main goals is to help individuals get access to care. We give the highest priority to individuals who are having difficulty getting immediate health care needs met or who are about to lose their insurance. We give information and advice about the health insurance options in Vermont and assist if there are problems with enrollment in public programs. We also educate consumers about their rights and responsibilities and provide information about and assistance with the appeal process.

Our cases involve all types of health insurance, including:

- Commercial insurance like BlueCross BlueShield, CIGNA, and MVP;
- State health care programs like Medicaid, Dr. Dynasaur and VHAP;
- Federal programs like Medicare and Tri-Care; and
- Hybrid government and private insurance programs like VPharm, Medicare Advantage, Medicare Part D, Catamount Health Premium Assistance (CHAP) and VHAP-ESIA.

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<sup>1</sup> On April 3, 2012, the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) changed its name to the Department of Financial Regulation.

## EXECUTIVE SUMMARY

### SFY 2012

#### **Introduction**

From July 1, 2011, through June 30, 2012, State Fiscal Year (SFY) 2012, the HCO consumer assistance hotline received 3,060 calls.<sup>2</sup> Of the 3,060 callers, about 43% were on state health care (DVHA) programs, 16% were on commercial health insurance plans, 25% were on Medicare<sup>3</sup>, and 9% were from uninsured individuals. In 18% of our cases the caller's insurance status was either unknown or not relevant.

#### **Overall HCO call volume decreased about 9%; calls related to eligibility for state programs decreased 22%.**

In SFY 2012 the HCO received 3,060 calls, which was a 9% decrease from SFY 2011, in which we received 3,348 calls. The drop in call volume was probably due to improvements in the Department for Children and Families' (DCF) eligibility determination system along with a slight improvement in the Vermont economy as the Great Recession slowly winds down. Calls related to eligibility for government health care programs decreased by 22%. Last year we saw an unusual spike in the number of eligible calls due to DCF's "Modernization" of the eligibility processing system. After a lot of effort, those problems seem to have abated, at least for the health care programs.

#### **Access to care calls dropped 9%.**

This year we received 869 calls from individuals having trouble getting medical care, compared to 952 in SFY 2011. It is not clear whether this is statistically significant. One possible reason for the decrease is that there was a slight increase in the number of individuals enrolled in state programs, which would improve access.

#### **The lack of affordability of health care is a growing problem.**

Affordability is a growing access problem. More and more individuals call the HCO and tell us they cannot afford their insurance premiums or their plan's cost-sharing. Sometimes plans exclude or limit medically necessary care. Many callers tell us they are foregoing care because they cannot afford it, even though they have insurance. This year we received more complaints about the lack of affordability than ever before: 399

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<sup>2</sup> The term "call" also includes individuals who come to us through our website or as walk-ins.

<sup>3</sup> Medicare beneficiaries may also be on DVHA programs, like Medicaid or VPharm.

calls, when both primary and secondary issues were counted.<sup>4</sup> This was a 26% increase over the previous year.

**Statewide flooding from Tropical Storm Irene caused a temporary spike in HCO calls.**

Tropical Storm Irene hit Vermont on August 28, 2011, causing massive flooding and destroying the state office complex in Waterbury. This wiped out much of the DCF's infrastructure for processing applications and reviews for DVHA health care programs. The HCO received 36 calls related to Irene. We coordinated with DCF's Health Care Operations unit and DVHA to quickly address many problems in the chaotic aftermath of the flood.

**The HCO advocated on behalf of consumers as Vermont's innovative health care reform efforts progressed.**

The HCO testified to legislative committees and worked with the Agency of Administration, DVHA, DFR and the Green Mountain Care Board (GMCB) on behalf of consumers. The Health Care Ombudsman provided state policy makers with feedback and data regarding the problems Vermonters were having with the current health care system. Pursuant to Act 48 of 2011 and Act 171 of 2012, the GMCB consults with the HCO about various health care reform issues. In addition, in March 2012 the HCO began representing the public in the revamped rate review process before the GMCB.

**Federal health care reform provided additional HCO funding.**

As a result of the federal Affordable Care Act of 2010 (ACA), the HCO received some new funding which allowed us to provide greater service to Vermonters. We received an ACA Consumer Assistance Program (CAP) grant through DFR. This grant allowed us to increase direct assistance to consumers through the hotline. That grant expired in January 2012. However, we also received funding from three additional ACA grants: one through DFR to represent the public in rate review proceedings and to advise the Green Mountain Care Board, one to expand our website capabilities and outreach, and a third to provide analysis of our consumer complaint data to DVHA for the implementation of Vermont's Health Benefit Exchange. As of this writing we are waiting to hear about another ACA CAP grant to again expand our consumer assistance capacity.

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<sup>4</sup> The HCO assigns every case a primary issue. If more than one issue is raised in the call, we code the ones that are not the primary focus of the call as secondary. There can be multiple secondary issues in one call and thus the data on secondary issues can overlap.

The HCO looks forward to playing an important role as health care reform proceeds at the state and national levels. We hope to have the resources to assist individuals, to represent the public before regulators and policy makers and to help make the reforms a real improvement for all Vermonters.

Trinka Kerr  
State Health Care Ombudsman  
August 2012

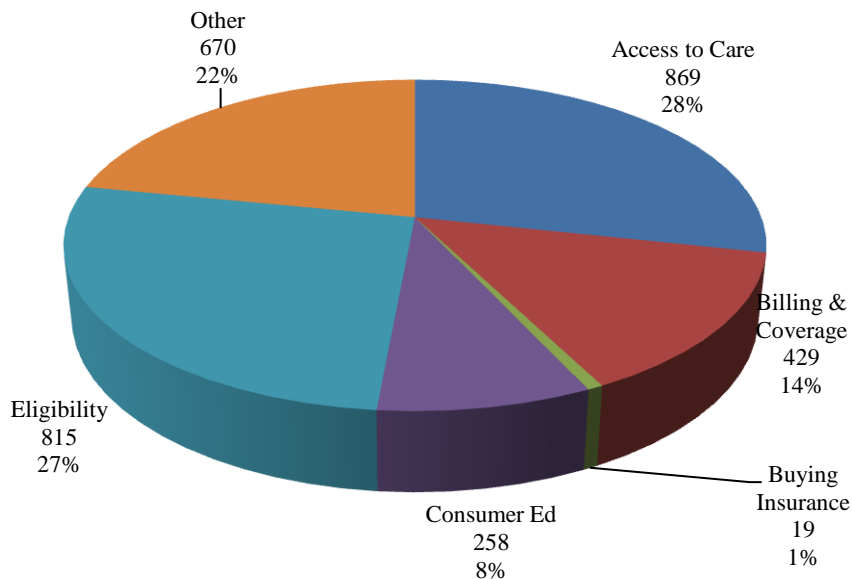
### DESCRIPTION OF CASELOAD

In State Fiscal Year (SFY) 2012 we received 3,060 calls to our statewide hotline, compared to 3,348 in SFY 2011 and 2,536 in SFY 2010. We closed 3,086 cases during this period, and had 82 cases pending at the end of June 2012. The HCO keeps various data on the issues raised by callers. We subdivide the issues into six categories: *Access to Care, Billing and Coverage, Buying Insurance, Consumer Education, Eligibility, and Other*. Every case is assigned to one of these categories.

- *Access to Care* (caller has not received needed care): 28%, 869 calls, compared to 28%, 952 calls in SFY 2011;
- *Billing and Coverage* (care received, but claim denied or other billing issues): 14%, 429 calls, compared to 14%, 480 calls;
- *Buying Insurance*: 1%, 19 calls, compared to 1%, 26 calls;
- *Consumer Education* (education about a particular issue, but not in relation to a specific denial of care or inability to access care): 8%, 258 calls, compared to 5%, 162 calls;
- *Eligibility* (for government health care programs, including Catamount Health and premium assistance): 27%, 815 calls, compared to 31%, 1,041 calls; and
- *Other* (includes complaints about providers, confidentiality or HIPAA problems, Medicare Part D, terminations of commercial insurance, access to medical records, health insurance marketing, etc): 22%, 670 calls, compared to 21%, 687 calls.

The following pie chart illustrates the comparative volume of calls for each category.

### Description of Caseload



### Access to Care

*Access to Care* cases are those in which individuals are seeking care. Access calls decreased 9%. The HCO received 869 *Access* calls in SFY 2012, compared to 952 in 2011. These types of calls constituted 28% of our call volume this year, the same as last year. An additional 994 callers cited access issues as secondary to their primary problem.

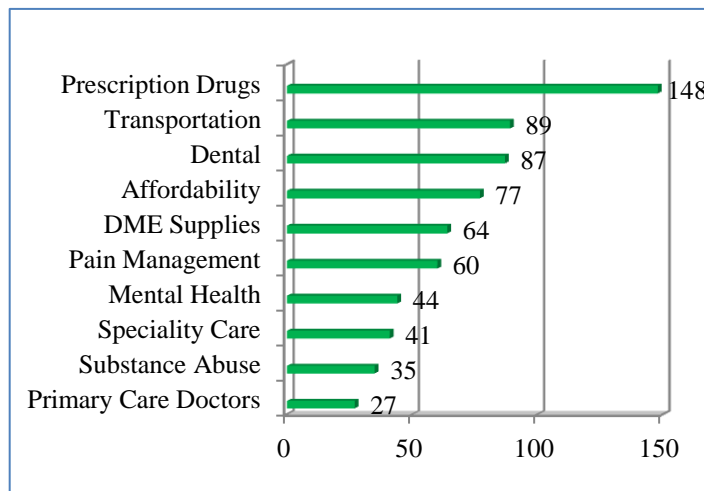
We have over 40 subcategories in *Access to Care*. The top volume subcategories in *Access to Care* this year were almost the same as last year. As has been the case for years, the largest access issue was Prescription Drugs. This year we received calls from 148 Vermonters unable to promptly get necessary medications, compared to 179 last year. This number is even higher when the 14 Medicare Part D calls are added, totaling 162. However, Medicare Part D calls dropped from 60 to 14, a dramatic 77% decrease. Medicare Part D calls have steadily been decreasing over the years.

The top ten *Access to Care* issues only changed slightly from last year. They were:

- prescription drugs (148, compared to 179 in SFY 2011);
- transportation (89, compared to 56);
- dental care, dentures, orthodontia (87, compared to 81);

- affordability (77, compared to 101);
- durable medical equipment, supplies and wheelchairs (64, compared to 56);
- pain management treatment (60, compared to 77);
- mental health treatment (44, compared to 59);
- specialty care (41, compared to 50);
- substance abuse treatment (35, compared to 36); and
- primary care doctors (27, compared to 29)<sup>5</sup>.

### Top Ten Access to Care Problems



### Billing and Coverage

Calls in this category are from Vermonters who received the care they needed, but subsequently experienced problems getting their insurance to pay for that care or had other problems with the billing process. We received 429 calls in this category, compared to 480 last year. *Billing and Coverage* cases constituted about 14% of our calls, the same as SFY 2011. As a general rule, individuals who call about billing problems no longer get direct intervention from us. Instead, we provide advice on ways to handle the situation. This is consistent with the higher priority that we give to *Access to Care* and *Eligibility* calls.

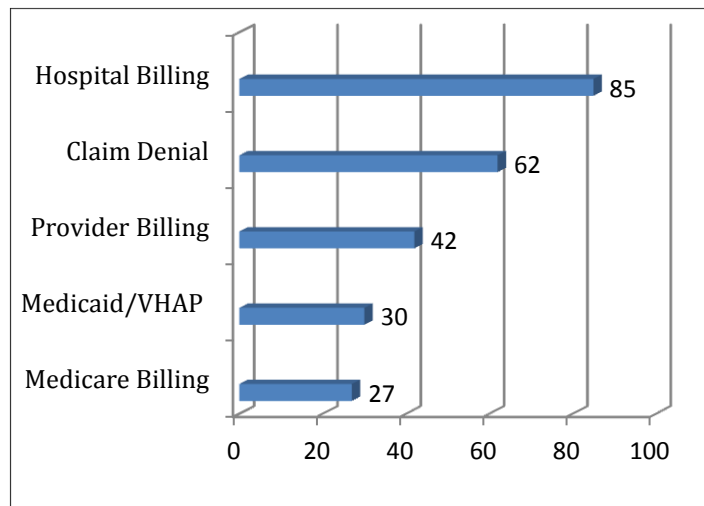
<sup>5</sup> Last year lack of access to a primary care doctor did not make the top ten access problems. Medicare Part D drugs did, at 60 calls. This year we only received 14 Part D calls.



*Billing and Coverage* calls are broken down into more than 35 subcategories. The top five most common types of billing calls were the same as last year, just in slightly different order. They were:

- hospital billing (85, compared to 76 in SFY 2011);
- claim denials (62, compared to 53);
- provider billing (42, compared to 38);
- Medicaid/VHAP billing (30, compared to 79); and
- Medicare billing (27, compared to 39).

**Top Five Billing and Coverage Problems**



**Eligibility**

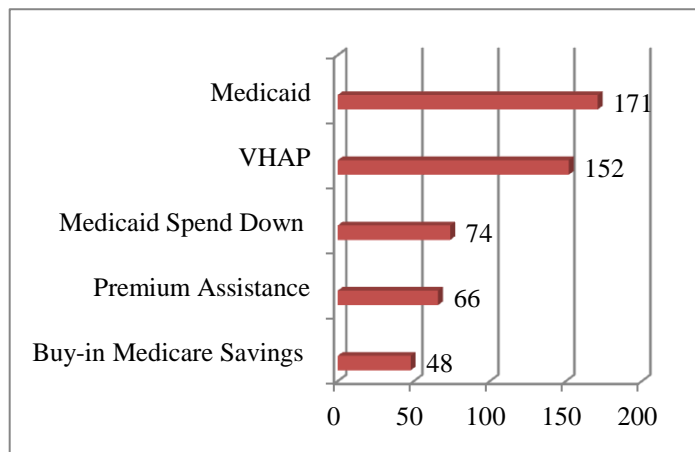
*Eligibility* calls decreased 22% in SFY 2012. We received 815 calls about eligibility for state health care (DVHA) programs in SFY 2012, compared to 1,041 in SFY 2011 and just 751 in SFY 2010. Calls regarding *Eligibility* made up 27% of our calls this year, compared to 31% last year. Notably, we also had an additional 800 calls in which *Eligibility* issues raised as a secondary issue, for a total of 1,615 calls in which *Eligibility* was an issue.

*Eligibility* calls came from individuals who were uninsured, who had commercial insurance they couldn't afford, or who were on state programs but facing termination

of that coverage or other barriers to enrollment. The top five subcategories, out of more than 28, were:

- Medicaid (171 calls, compared to 255 last year);
- VHAP (152, compared to 252);
- Medicaid Spend Down Program (74, compared to 37);
- Premium Assistance (66, compared to 88); and
- Buy In or Medicare Savings Programs, in which the state pays for Medicare premiums (48 calls, compared to 55).

### Top Five Eligibility Problems



Last year there were an unprecedented number of cases related to problems with DCF, mostly related to “Modernization.” Most of those problems decreased significantly in SFY 2012. Looking at both primary and secondary issues:

- DCF mistakes decreased from 119 to 53;
- Application delays decreased from 43 to 22;
- Lost paperwork decreased from 43 to 25; and
- Member Services errors decreased from 13 to 9.
- Only problems with the mail increased from 19 to 22.

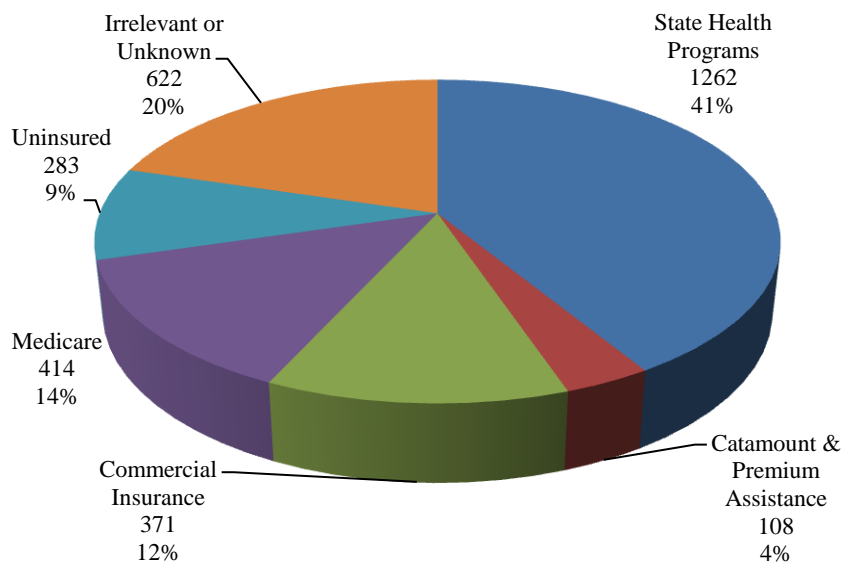
### Types of Coverage

The HCO receives calls from Vermonters with all types of health insurance, and from the uninsured. The chart below breaks down our calls by type of coverage of the caller. State health care programs include Medicaid, Dr. Dynasaur, VHAP, VHAP-ESIA, VHAP Pharmacy, VScript, VPharm, and combinations of Medicaid and Medicare. Commercial insurance includes both individuals with small and large group coverage, and those with individual coverage. In some cases the caller’s insurance status is not relevant to the problem or is unknown, and the HCO does not get the information. The breakdown this year, as compared to the previous two years is:

	<u>2012</u>	<u>2011</u>	<u>2010</u>
State Programs	1,262 (41%)	1,345 (40%)	924 (36%)
Catamount & Premium Assistance	108 (4%)	204 (6%)	122 (5%)
Commercial Insurance	371 (12%)	398 (12%)	485 (19%)
Medicare	414 (14%)	364 (11%)	300 (12%)
Uninsured	283 (9%)	345 (10%)	255 (10%)
Irrelevant or Unknown	622 (20%)	692 (21%)	451 (18%)

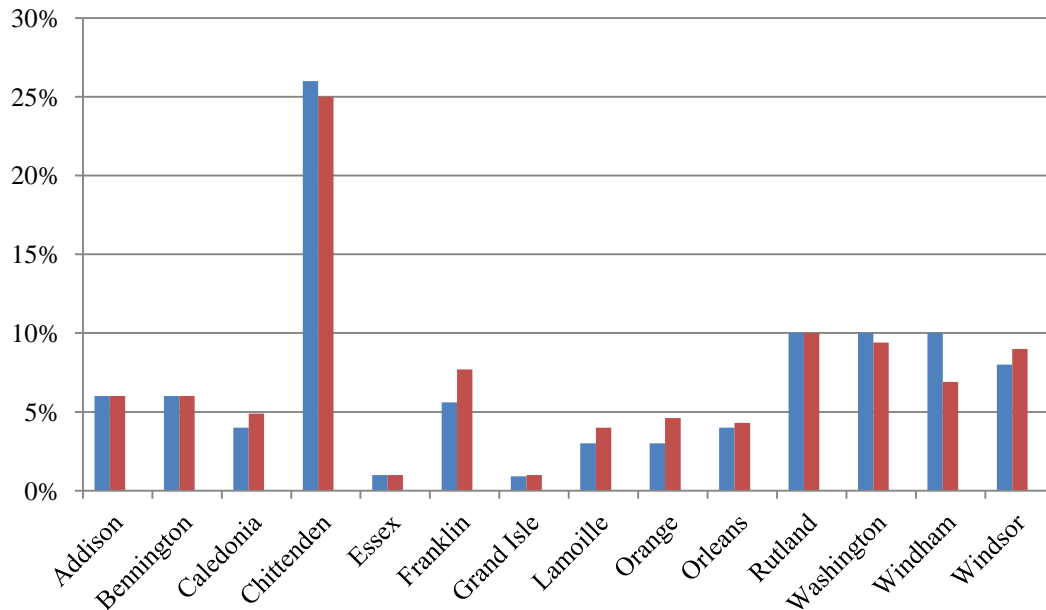
It is notable that when beneficiaries who are on Medicare plus Medicaid or VPharm are added into the Medicare total, **25% of the calls were from Medicare beneficiaries**. The number of Medicare beneficiaries calling us has steadily been increasing. This is probably due to the aging of the population.

### Types of Coverage



### Geographic Distribution of Calls

The HCO provides services statewide. While there was some variation by county, our calls are spread across the state in almost direct proportion to the population of the state. The chart below shows a comparison of the calls received (first column, in blue) to the general population by county (second column, in red).

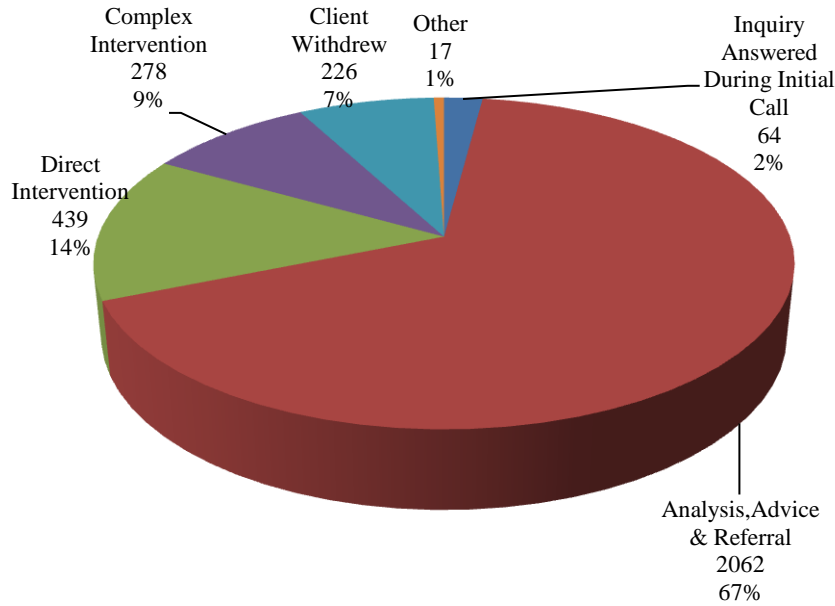


### Resolution of Calls

In SFY 2012, the HCO closed 3,086 cases, compared to 3,324 last year. When each case is closed, we document how we resolved the case, where we referred the individual, and what materials we sent. We use the following categories to track how we resolve calls:

- *Inquiry Answered During Initial Call*: 64 calls, 2%, compared to 120, 4 % in SFY 2011;
- *Analysis, Advice and Referral* (advice and/or referral after analysis for cases that are slightly more complex): 2,062 calls, 67 %, compared to 1,947, 59 %;
- *Direct Intervention* (made calls or took other action on behalf of the client, up to two hours work per case): 439 calls, 14 %, compared to 495, 15%;
- *Complex Intervention* (direct intervention that took more than two hours to resolve case): 278 calls, 9%, compared to 205 calls, 6 %;
- *Client withdrew*: 226 calls, 7%, compared to 502, 15 %; and
- *Other*: 17 calls, 17%, compared to 55 calls, 1 %.

### Resolution of Calls



### Outcomes

The HCO records outcomes whenever we know them. Frequently when we give advice, we do not know the ultimate result of that advice. However, we do track our outcomes to as high a degree as possible.

### Outcome Summary

	SFY 2012	SFY 2011
Advice or Education	2,017	1,030
Assisted with application for insurance	31	47
Bill Written Off	26	14
Claim Paid as a result of HCO Intervention	42	27
Client Not Eligible for Benefit	23	48
Client Responsible For Bill	13	30
Estimated Eligibility for Insurance	98	245
Got Client onto Insurance	114	146
Obtained Coverage for Services	55	63
Other Access/Eligibility Outcome	209	602

Other Billing Assistance	28	150
Other Outcome	332	752
Patient Assistance Provided	11	31
Prevented Termination or Reduction in Coverage	66	98
Reimbursement Obtained	11	26
Service Excluded Under Contract	7	11
Service Not Medically Necessary	2	2
<b>Grand Total:</b>	<b>3,085</b>	<b>3,322</b>

### Case Examples

Here are three case examples which demonstrate the kind of work we do:

- A family of four was stuck in another state after Tropical Storm Irene because their Vermont home had become inaccessible due to road damage. The mother tried to get her medications but was told by the pharmacist that she and her family no longer had Vermont Medicaid. It was urgent that she get her medications and she could not wait up to 30 days to get a new application processed. She called Senator Bernie Sanders' office for help. His office referred her to the HCO. The HCO determined that her review paperwork had been lost as a result of the storm. By working with Health Care AOPS the HCO was able to get the entire family back on Medicaid immediately. The mother was able to pick up her prescriptions within hours.
- The Area Agency on Aging referred a client who was living on Social Security Disability Income (SSDI). He had received multiple claim denials from a Catamount Health plan, a private individual plan for which he received state premium assistance. The denial was due to a pre-existing condition that had disabled the individual the previous year. On his limited income, he was unable to pay the medical bills resulting from the pre-existing condition exclusion. The HCO advocate determined that, through two earlier employer-sponsored health insurance plans, the individual had in fact had sufficient continuous creditable coverage to avoid the pre-existing condition exclusion. The advocate filed a first level appeal with the requisite certificates of coverage. Within days the plan overturned the denials and paid more than \$2,200 in claims.

- A client's chronic care manager had recommended a peak flow meter to help monitor the client's asthma. The individual's commercial plan was requiring her to pay co-insurance for the device, even though preventive services recommended by the plan's chronic care management program were not supposed to have cost-sharing. At first the plan insisted that devices like this were not preventive. The HCO advocate pressed the carrier, going up the chain of command. Eventually the carrier agreed the device should be completely covered for this client without cost-sharing. More importantly, the carrier agreed to eliminate this cost-sharing for all other plan members in the chronic care management program as well.

### **QUALITY ASSURANCE AND CONSUMER SATISFACTION**

The satisfaction of our clients is extremely important to us. To monitor how consumers feel about the way we provide our services, we send a Client Satisfaction Questionnaire (CSQ) with a list of questions to every client on whose behalf we intervene directly. We try to follow up with every client who requests follow up via returned CSQ in order to resolve complaints or outstanding issues, but sometimes that is not possible.

This year we sent out 717 CSQ's and 228 were returned, which is a response rate of 32%. Of those that were returned, 96% said they were Satisfied or Very Satisfied with the service they received from our office. About 83% reported they were Very Satisfied.

Eight people said they were not satisfied with the overall service. Four of those were from Medicare beneficiaries who lost their eligibility for a Medicare Savings Program due to the Social Security cost of living increase this year, which meant they had to start paying their Medicare Part B premium. One was unhappy that Medicaid would not pay for a specific type of transportation, which Medicaid does not cover. One client had a medical malpractice claim she was seeking representation for.<sup>6</sup> One CSQ was from an individual seeking opioids for pain management. And one was a legitimate complaint from a client who did not get a call for almost three weeks due to an HCO mistake. A protocol has been put into place to make sure that doesn't happen again.

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<sup>6</sup> The HCO refers medical malpractice cases to the private bar through the Lawyer Referral Service.

Here is a sampling of the comments on this year's CSQ's:

- *[My advocate] understood my problem, took action, followed up, solved the problem, and called to let me know what was happening. Problem solved in quick order! Help was critical as my husband and I were transitioning from private insurance to state programs. My husband is severely disabled and dependent upon prescription medications. State computers were down, our town was flooded, our pharmacy flooded, too. We needed an advocate to resolve "glitches" in processing our applications. [My advocate] saved us a lot of additional stress.*
- *Words cannot express my appreciation and gratitude for the kind and compassionate way you dealt with my issue. Being diagnosed with breast cancer is frightening enough, but then having to deal with the anxiety following Hurricane Irene and not being able to continue with my diagnosis and treatment was horrible. Because of your speedy actions I have received my MRI and I am awaiting surgery. Thank you from the bottom of my heart for helping me with this deeply personal matter.*
- *I have a very severe mental illness and was just recently put on VPharm and Medicaid Spend Down. I'm ashamed because complicated programs with many requirements confuse and terrify me. Unfortunately my case manager's sketchy understandings and explanations terrified me even more so. I am extremely thankful to [my advocate] who patiently walked me through both programs and sent complete follow up written instructions, which will crucially educate my case manager to help me going forward. Your organization and your advocates are a healthcare lifeline to all vulnerable Vermonters like me!*
- *My experience was overwhelming due to the fact that I had just gone through major surgery. [My advocate] did an excellent job correcting the wrong and being polite and professional during the whole process. [My advocate] never promised me the outcome but the results were excellent. Thank you many times over! Promote [my advocate]!*
- *We have had to use the HCO a couple of other times in the past, and it has never failed. They are always very helpful; they explain things thoroughly and are very, very kind. Everything is done in a timely manner. For once, it seems so nice to know and comforting to know that there is an organization out there in the community to help people with a low income in need.*
- *The whole situation was extremely complicated to understand. [My advocate] went to great lengths to help me understand it. [My advocate] was lovely... totally efficient and effective, worked quickly to solve my problem.*



- *[My advocate] was awesome! [My advocate] did in one day what I was trying to do over five months!*
- *[My advocate] is an angel on earth! I hope [my advocate] comprehends the magnitude of the HCO's help.... My husband lost so much...yet your employee gave him hope that people out there really do care and I will be forever thankful for that.*
- *Even when I realized HCO could not help, I was able to discuss my case like an adult. This survey is also a first since I moved to Vermont in 2007.*
- *Never having had to ask for help before, it was wonderful to have a warm, informed and non-judgmental person to help me. I am thankful there are people like [my advocate] to help with the maze of paperwork. Thank you for the services you provide.*
- *I feel good to live in a state that has people like you.*
- *We were not making any headway on our own, we felt almost victimized not to mention disregarded--it was depressing. We could not have done it on our own, we tried. Thank you so very much!*
- *[My advocate] was very nice and understanding, as I was in pain and very rude. I have to say [my advocate] went way above and beyond to help me.*
- *[My advocate] is a credit to your organization. [My advocate] was thorough and made sure I understood the information and never lost patience when I didn't understand right away. [My advocate] was: kind, considerate, very conscientious... Even though things didn't turn out as I had hoped, I have nothing but the highest praise for [my advocate's] professionalism and courtesy.*
- *I'm so glad you guys are there. The insurance company would not listen to me. I had taken the same approach as [my advocate] but apparently because I was the client I did not get the respect that [my advocate] did because [my advocate] was calling from the HCO. [My advocate] was great, but I should not have had to call the HCO on this.*
- *No question, great service. Health care system can be complex with much fine print. The HCO was there for me and was understanding and above all, got things done!*
- *Some people like me don't understand what most of this is about or how to fix it. Thank you.*

- *What a huge relief! [My advocate] cleared up in one day the issues I'd been working to clear up for a month.*
- *If [my advocate] was not involved the case would not have been resolved so quickly. My [insurance company] did not want to pay for the meds I needed without me trying another first. Their letters were not very clear. [My advocate] got them to waive one of the step therapy meds.*
- *The HCO has been the nicest, most empathetic and gets quick resolutions. If only more of the hurdles I have to jump through to survive chronic pain and mental impairments were as easy as dealing with your office, my pain levels would be down due to less stress and anxiety.*
- *I wouldn't have been able to get health insurance without the help from your office.*
- *I called 211. They gave me the number of the HCO. [My advocate] not only got my insurance reinstated but I am now on Medicaid and have no premiums. What [my advocate] did in four hours would have taken me a lifetime.*
- *[My advocate] was very helpful and took care of the problem within 48 hours. I had been trying to get answers for over two months.*
- *I love the HCO! Everyone I've connected with there has been intelligent, respectful, resourceful and responsive. Thanks for all your help! Now if only we could fix the health care system!*
- *I am really happy to talk to you people. God could not be everywhere that's why he created people like you to help people like us. Thank you.*
- *It is nice to know there is someone to turn to when you need help when you get old.*
- *I am thankful for [my advocate] and the HCO. I had been in the hospital three times and had no money to buy meds. I am a diabetic and only had five days left of insulin when I got my insurance back. Thanks to you all I am still alive.*

## OTHER ACTIVITIES

In addition to providing services to individuals, the HCO works for systemic change. Because we talk to consumers every day and track data, we can serve as a sort of sentinel function to policy makers. We see trends in problem areas and try to get them fixed. We inform public agencies and the legislature about the concerns of consumers related to health care. We monitor, analyze and comment on federal and state laws and regulations. We collaborate with federal and state advocacy organizations in order to increase the voice of consumers in the public debate. We strive to promote the development of consumer organizations and to educate citizens about their rights and responsibilities.

### State Legislature

The HCO staff frequently speak to state legislators, submit reports on the trends and cases we are seeing, and provide written and oral testimony to standing committees. When the legislature is not in session, we report regularly to the Health Access Oversight Committee.<sup>7</sup> Some of the legislative areas we worked on this year were:

- Health care reform proposals and changes to Act 48 of 2011, an act relating to a universal and unified health system. This year we monitored and testified on the bill which became Act 171 of 2012, an act relating to health care reform implementation. Act 48 and Act 171 include an increased role for the HCO as health care reform progresses in Vermont.
- DVHA budget changes.
- Health insurer reporting requirements to DFR.
- Creation of a mental health ombudsman, as part of Act 79 which reforms Vermont's mental health system.
- Expansion of Medicaid for Working Persons with Disabilities.
- Reduction in cost-sharing for prescription drug coverage for individuals on Vermont's premium assistance for employer sponsored insurance program.
- Increased access to substance abuse treatment.
- Health care exemptions in the Public Records Act.
- Worked with COVE to try to find a legislative fix to the problem of the 2012 Social Security cost of living increase exceeding the Federal Poverty Levels which caused some Vermonters to lose eligibility for the Medicare Savings Programs.

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<sup>7</sup> Now called the Health Care Oversight Committee.

**State Agencies**

**Agency of Human Services**

- Participated in the stakeholder working group for a demonstration project to integrate and improve the care for individuals who are dually eligible for Medicaid and Medicare.

**Department of Financial Regulation (DFR) and the Green Mountain Care Board**

- Began representing the public in the health insurance rate review process before the GMCB pursuant to Act 48 in March 2012.
- Commented on two versions of proposed regulations about the rate review process used by the GMCB.
- Worked with DFR and the GMCB to upgrade their websites to improve consumer access to the rate review process.
- Provided feedback to DFR on materials describing insurance options for people retiring early.
- Worked with DFR to clarify the issue of which plans are qualified for the health coverage tax credit under the Federal Trade Act.
- Testified and commented on the Green Mountain Care benefits (Vermont's single payer package for 2017).
- Monitored Certificate of Need applications, including Fletcher Allen Health Care's proposed sale of its dialysis units to Fresenius, which was denied.

**Department for Children and Families (DCF)**

- Worked with other projects within Vermont Legal Aid to improve health care eligibility processing times.

**Department of Health (VDH)**

- Commented on regulations proposed by the Alcohol and Drug Abuse Program (ADAP) regarding the State's substance abuse treatment program.
- Participated in the stakeholder group working on surrogate decision-making rules, specifically regarding Clinician Orders for Life Sustaining Treatment (COLST) and Do Not Resuscitate orders.

**Department of Vermont Health Access (DVHA)**

- Participated in the Exchange Advisory Board and the Medicaid Advisory Board. Now the Health Care Ombudsman is a member of the newly created Medicaid Exchange Advisory Board.
- Monitored, reviewed, and commented on proposed Medicaid program regulations, including limitations on physical therapy, occupational therapy, and speech therapy visits and prior authorization requirements for out of state care.

- Communicated regularly with DVHA regarding policy issues.

### **Other Efforts**

- Participated in the legislatively created Palliative Care and Pain Management Task Force to improve access to such care.
- Provided Vermont's Congressional delegation with information regarding the health care and health insurance concerns of Vermonters.
- Collaborated with other health care consumer programs around the country and commented on proposed federal rules related to federal health care reform.
- Did a presentation on state health care reform and the State Exchange on public television with the Campaign for Health Care Security.
- Provided consumer education to University of Vermont students.
- Wrote about issues related to health care reform in VLA's Justice Quarterly newsletter.
- Provided community education to the Vermont Association for the Blind and Visually Impaired about health insurance.

## **COORDINATION**

HCO coordinates its efforts with other advocacy groups and agencies on many issues and projects to expand access to health care. These collaborations include these organizations:

- AARP
- Area Agencies on Aging
- Bi-State Primary Care Association
- Center on Budget and Policy Priorities
- Community Catalyst
- Community of Vermont Elders (COVE)
- Department of Financial Regulation (formerly BISHCA)
- Department of Health
- Department of Vermont Health Access
- Disability Rights Vermont
- Families, USA
- Spectrum Youth and Family Services
- State Health Insurance Counseling and assistance Program (SHIP)
- Vermont 2-1-1
- Vermont Association of Mental Health
- Vermont Businesses for Social Responsibility
- Vermont Campaign for Health Care Security

- Vermont Cancer Society
- Vermont Council of Developmental and Mental Health Services
- Vermont Dental Society
- Vermont Ethics Network
- Vermont Family Network
- Vermont Heart Association
- Vermont Interfaith Action
- Vermont Low Income Advocacy Council (VLIAC)
- Vermont Medical Society
- Vermont Ombudsman Project, Disability Law Project, Senior Citizens Law Project, and all projects of Vermont Legal Aid
- Vermont Program for Quality in Health Care (VPQHC)
- Vermont Public Interest Research Group (VPIRG)
- Vermont Voices for Children
- Vermont Workers' Center

## **REPORTING**

The HCO provides quarterly reports to the Vermont Department of Financial Regulation (DFR), the Vermont Department of Vermont Health Access (DVHA), and the Center for Consumer Information and Insurance Oversight (CCIIO) at the Centers for Medicare and Medicaid Services (CMS). We submit an annual report to the Vermont General Assembly, the Governor, DFR and DVHA. Reports are also given to the Vermont Health Access Oversight Committee, and the State Health Care Ombudsman testifies before the Committee on a regular basis. The HCO communicates frequently with DFR, DCF, DVHA, and CCIIO staff.

<b>Vermont Legal Aid, Inc.</b>	
SFY 2012	
<b>Office of Health Care Ombudsman - ACA</b>	
HCO Annual Report 2012	
(July 1, 2011 to November 28, 2011)	
<b><u>Salaries</u></b>	
Project Director	\$ 7,178.81
Attorneys	\$ 5,736.83
Lay Advocates and Para Professional Staff	\$ 13,964.45
Management Professional Staff	\$ -
Clerical Support	\$ 2,863.24
<i>Total Salaries</i>	<b>\$ 29,743.33</b>
<b>Fringe Benefits</b>	
	<b>\$ 12,323.60</b>
<b>Total Personnel</b>	<b>\$ 42,066.93</b>
<b><u>Operating Costs</u></b>	
Occupancy	\$ 5,281.59
Office Supplies and Other Office Overhead	\$ 546.94
Telephone Service	\$ 189.83
Equipment Rental, Repair and Maintenance	\$ 411.66
Computer Programming, Services and Support	\$ 2,767.74
<b>Total Operating</b>	<b>\$ 9,197.77</b>
<b><u>Grant or Contract Specific Expenses</u></b>	
Travel	\$ 209.69
Training	\$ 510.18
Law Library	\$ 439.70
Other Specific Costs (Interns, Translation Service/Reports)	\$ 172.22
<b>Total Specific Expenses</b>	<b>\$ 1,331.78</b>
<b><u>Administrative Overhead</u></b>	
Administrative Support Expenses	\$ -
Depreciation	\$ 1,153.36
<b>Total Administrative Overhead</b>	<b>\$ 1,153.36</b>
<b>Direct Costs</b>	
	<b>\$ 53,749.83</b>
<b>Indirect Expenses</b>	
	<b>\$ 6,858.48</b>
<b>TOTAL COSTS</b>	<b>\$ 60,608.31</b>

<b>Vermont Legal Aid, Inc.</b>			
<b>SFY 2012</b>			
Health Care Ombudsman Project - DVHA and DFR			
<b>HCO ANNUAL REPORT 2012</b>			
<b>EXPENDITURES</b>			
	<b>DVHA Grant SFY 2012</b>	<b>Financial Regulation Grant SFY 2012</b>	<b>TOTAL</b>
<b>Salaries</b>			
Project Director	\$ 30,825.74	\$ 22,721.94	\$ 53,547.68
Attorneys	\$ 31,095.77	\$ 20,547.53	\$ 51,643.30
Lay Advocates and Para Professional Staff	\$ 72,938.98	\$ 50,625.00	\$ 123,563.98
Management Professional Staff	\$ 23,880.16	\$ 16,524.12	\$ 40,404.28
Clerical Support	\$ 12,339.36	\$ 9,552.93	\$ 21,892.29
<b>Total Salaries</b>	<b>\$ 171,080.00</b>	<b>\$ 119,971.52</b>	<b>\$ 291,051.52</b>
<b>Fringe Benefits</b>			
	<b>\$ 74,957.52</b>	<b>\$ 53,450.49</b>	<b>\$ 128,408.02</b>
<b>Total Personnel</b>	<b>\$ 246,037.53</b>	<b>\$ 173,422.01</b>	<b>\$ 419,459.54</b>
<b>Operating Costs</b>			
Occupancy	\$ 28,143.76	\$ 19,490.56	\$ 47,634.32
Office Supplies and Other Office Overhead	\$ 2,713.42	\$ 1,643.14	\$ 4,356.56
Telephone Service	\$ 967.85	\$ 656.77	\$ 1,624.62
Equipment Rental, Repair and Maintenance	\$ 2,442.95	\$ 1,715.05	\$ 4,158.00
Computer Services and Support	\$ 9,588.35	\$ 5,920.58	\$ 15,508.94
<b>Total Operating</b>	<b>\$ 43,856.33</b>	<b>\$ 29,426.10</b>	<b>\$ 73,282.43</b>
<b>Grant or Contract Specific Expenses</b>			
Travel	\$ 887.22	\$ 773.67	\$ 1,660.89
Training	\$ 4,350.67	\$ 2,935.75	\$ 7,286.41
Law Library	\$ 2,071.31	\$ 1,329.49	\$ 3,400.79
Other Specific Costs	\$ 1,978.02	\$ 1,341.45	\$ 3,319.47
<b>Total Specific Expenses</b>	<b>\$ 9,287.22</b>	<b>\$ 6,380.35</b>	<b>\$ 15,667.57</b>
<b>Overhead</b>			
Administrative Support Expenses	\$ 4,135.35	\$ 3,023.62	\$ 7,158.97
Depreciation	\$ 3,929.58	\$ 2,747.92	\$ 6,677.49
<b>Total Overhead</b>	<b>\$ 8,064.92</b>	<b>\$ 5,771.53</b>	<b>\$ 13,836.46</b>
<b>TOTAL COSTS</b>	<b>\$ 307,246.00</b>	<b>\$ 215,000.00</b>	<b>\$ 522,246.00</b>