

VERMONT LEGAL AID, INC.

OFFICE OF THE HEALTH CARE ADVOCATE

264 NORTH WINOOSKI AVE. - P.O. Box 1367

BURLINGTON, VERMONT 05402

(800) 917-7787 (VOICE AND TTY)

FAX (802) 863-7152

(802) 863-2316

OFFICES:

BURLINGTON

RUTLAND

ST. JOHNSBURY

OFFICES:

MONTPELIER

SPRINGFIELD

QUARTERLY REPORT

April 1, 2014 – June 30, 2014

to the

Agency of Administration

submitted by

Trinka Kerr, Chief Health Care Advocate

July 18, 2014

I. Introduction

The Office of the Health Care Advocate (HCA) provides consumer assistance to individual Vermonters on questions and problems related to health insurance and health care. The HCA also engages in consumer protection activities on behalf of the public before the Green Mountain Care Board, other state agencies and the state legislature.

The following information is contained in this quarterly report:

- This narrative which includes sections on **Individual Consumer Assistance**, **Consumer Protection Activities** and **Outreach and Education**
- Six data reports
 - **All calls/all coverages:** 1,022 calls
 - **DVHA beneficiaries:** 413 calls or **40%** of total calls
 - **Commercial plan beneficiaries:** 209 calls or **20%**
 - **Uninsured Vermonters:** 136 calls or **13%**
 - **Vermont Health Connect:** 419 calls or **41%** (this data report draws from the All Calls data set above)
 - **Reportable Activities (Summary & Detail):** 149 activities, 52 documents

II. Individual Consumer Assistance

The HCA provides assistance to consumers mainly through our statewide hotline (**1-800-917-7787**) and through our Online Help Request feature on our website, www.vtlawhelp.org/health.

We have a team of advocates located in Vermont Legal Aid's Burlington office which provides this help to any Vermonter free of charge.

The HCA received 1,022 calls 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 was as follows:

- **21.72%** (222) of our total calls were regarding **Access to Care**;
- **16.73%** (171) were regarding **Billing/Coverage**;
- **1.76%** (18) were questions regarding **Buying Insurance**;
- **8.51%** (87) primarily involved **Consumer Education**;
- **27.59%** (282) were regarding **Eligibility** for VHC programs and Medicare; and
- **23.68%** (242) were categorized as **Other**, which includes Medicare Part D, communication problems with providers or 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. This system allows us to track more than one issue per case, so that we can see the total number of calls that involved a particular issue. For example, although 282 cases had Eligibility for state health care programs as the primary issue, there were actually a total of 862 calls in which we spent a significant amount of time assisting consumers regarding eligibility for health insurance. 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. One call can involve multiple secondary issues. [See the breakouts 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.

See our recommendations to the state at the end of this section, beginning on page 10.

A. The HCA's call volume continued to set record high levels primarily due to problems with Vermont Health Connect.

The HCA's call volume was about 42% higher than in the same quarter last year, although calls decreased 13.6% from last quarter. The state launched its health benefit exchange, Vermont Health Connect (VHC), on October 1, 2013, as required by the federal Affordable Care Act (ACA). The rollout was rocky, and VHC continues to be plagued by operational problems. As a result, our call volume has hit record levels month after month since December 2013.

We received 1,022 calls this quarter, compared to 1,184 last quarter. This compares to 721 calls in the second quarter of calendar year 2013. Thus, our SFY 2014 Q 4 call volume was 41.7% higher than SFY 2013 Q 4. Because about 41% of our calls this quarter were related to VHC, it seems safe to assume that this big increase was directly attributable to problems with the exchange.

In each month this quarter we saw a record number of calls for that particular month. April's call volume was 354, compared to 253 last year; May's was 324 compared to 228; and June's was 344 compared to 240.

B. Vermont Health Connect still does not have Change of Circumstance functionality and the number of cases needing these changes has continued to grow.

By the end of this quarter, VHC did not yet have the ability to make changes to applications or accounts except through a difficult manual method. Many consumers have been waiting months to get their changes processed. The HCA had 62 VHC cases involving Change of Circumstance (COC) this quarter, or 16% of the total VHC calls. Many have put off health care while waiting in limbo for their insurance status to be fixed. At a certain point people cannot wait longer because they need care or prescriptions, and the situation becomes urgent. Thirteen of our VHC COC cases involved access to care issues. These cases are often complex and time-consuming for the HCA, difficult for the State to resolve, and extremely distressing for the consumers.

Even after the COC functionality is deployed, which we hope will be soon, it will only work prospectively. This means that all the COCs in the pipeline must be manually processed. Our understanding is that there were something like 12,000 COCs waiting to be processed at the end of the quarter. The State has hired a new vendor, Optum, to do this work. Meanwhile, new COC requests are added every day that the functionality is not in place.

C. Problems with the Vermont Health Connect invoice and payment system continue to exasperate consumers.

Many consumers who purchased Qualified Health Plans from VHC are having problems getting what they bought. The problems include non-receipt of invoices, delays in processing, and sometimes longer delays in actually getting coverage. Some people reported that they had made payments for months which did not seem to be recorded anywhere. Frequently these problems resulted in individuals not having coverage for months. Needless to say, by the time many of these callers got to the HCA, they were irate. In many cases they were deferring or going without care or medications because their insurance had not been activated.

D. Vermont Health Connect is still not sending out Notices of Decision.

Our call volume probably would have been even higher but for the fact that VHC has not yet started sending out written Notices of Decision (NODs) to applicants, which is a legal requirement. The HCA phone number is on DVHA NODs and is one of the main ways that consumers find out about our services. We started complaining about the lack of notices right after VHC launched. We know the State is working on this functionality, but at this point, eight months after the launch of VHC, it is unacceptable that NODs are still not going out.

E. The Medicaid renewal process has created difficulties for thousands of consumers.

VHC began processing previously deferred Medicaid renewals at the beginning of this quarter. For most Medicaid beneficiaries these reviews mean that they have to apply through VHC for the first time to have their eligibility determined under the new rules. This process has not gone well, and the reasons for that are not completely clear.

The Medicaid renewal process has generated calls to the HCA from consumers who thought they had completed the VHC application process to renew their Medicaid coverage, only to find out that their coverage was not active when they went to pick up medications at the pharmacy. Some consumers have not clearly understood that their Medicaid coverage would close if they did not proactively apply through VHC, and some were unsure how to actually apply through VHC. Furthermore, it is our understanding that thousands of Medicaid beneficiaries have not even started the VHC application process as required.

As of the writing of this report, VHC has told the HCA that it is acutely aware of the problems with Medicaid renewals and is working hard to resolve them. It is in the process of halting current and future reviews and reinstating individuals whose benefits were closed. It has been in close contact with the HCA on its efforts, which we greatly appreciate.

F. The HCA, Vermont Health Connect and the insurance carriers continue to work collaboratively to ensure consumers get the coverage they need.

Although there are many problems with VHC, there are also many people who are working extremely hard to help individuals and improve the system. We are grateful for everyone's efforts.

G. The top issues generating calls

This section includes both primary and secondary issues. The most common issues raised by callers were complaints about VHC, requests for information about VHC and applying for VHC and Medicaid programs, complaints about providers, access to prescription drugs, Medicaid eligibility, complaints about the VHC website, and premium billing problems.

All Calls (1,022, compared to 1,184 last quarter)

1. VHC complaints 190 (compared to 230 last quarter)
2. Information about VHC 138 (231)
3. Complaints about Providers 132 (118)
4. Access to Prescription Drugs 116 (112)
5. Information about DVHA programs 116 (139)
6. Medicaid (non-MAGI) eligibility 110 (104)
7. VHC website/technology problem 109 (108)
8. MAGI Medicaid eligibility 102 (131)
9. Premium Billing 70 (80)
10. Communication Problems with DCF/ESD/HAEU 67 (138)
11. Change of Circumstance 63 (41)
12. Affordability-access problem 60 (102)
13. Buying QHPs through VHC 54 (111)
14. VHC Invoice Problem 54 (38)
15. Premium Tax Credit Eligibility 53 (79)

DVHA Beneficiary Calls (413, compared to 469 last quarter)

1. Complaints about Providers 67 (73 last quarter)
2. Access to Prescription Drugs 63 (60)
3. Information about DVHA programs 59 (60)
4. Medicaid (non-MAGI) eligibility 54 (46)
5. MAGI Medicaid eligibility 42 (50)
6. VHC complaints 41 (37)
7. Medicaid Billing 36 (24)
8. VHC website/technology problem 31 (17)
9. Affordability-access problem 31 (40)
10. Information about VHC 28 (54)

Commercial Plan Beneficiary Calls (209, compared to 271 last quarter)

1. VHC complaints 80 (152 last quarter)
2. Information about VHC 54 (87)
3. Premium billing 37 (43)
4. VHC invoice problem 32 (29)
5. VHC website/technology problem 29 (53)
6. Change of Circumstance 25 (25)
7. Access to Prescription Drugs 21 (15)
8. Copayments-access problem 19 (11)
9. MAGI Medicaid 18 (19)
10. Buying QHPs through VHC 18 (53)
11. Affordability-access problem 15 (27)

Vermont Health Connect Calls (419, compared to 541 last quarter)

1. VHC complaints 190 (230 last quarter)
2. Information about VHC 138 (228)
3. VHC website/technology problem 109 (108)
4. MAGI Medicaid eligibility 97 (127)
5. Medicaid eligibility 63 (63)
6. Change of Circumstance 62 (41)
7. Information about applying for DVHA programs 55 (72)
8. Premium billing problem 55 (60)
9. Buying QHPs through VHC 54 (110)
10. VHC Invoice problem 54 (38)
11. Premium Tax Credit eligibility 53 (79)
12. Access to Prescription Drugs 52 (48)

H. Hotline call volume by type of insurance:

The HCA received 1,022 total calls this quarter. Callers had the following insurance status:

- **DVHA programs** (Medicaid, VHAP¹, VPharm, or both Medicaid and Medicare aka “dual eligibles”) insured **40%** (413 calls), compared to 40% (472) last quarter;
- **Medicare**² (Medicare only, Medicare Advantage Plans, Medicare and a Medicare Supplemental Plan aka Medigap, Medicare and Medicaid aka “dual eligibles,” Medicare and Medicare Savings Program aka Buy-In program, Medicare and Part D, or Medicare and VPharm) insured **21%** (210), compared to 23% (269) last quarter;
- **Commercial plans** (employer sponsored insurance, individual or small group plans, and Catamount Health³ plans) insured **20%** (209), compared to 23% (270) last quarter; and
- **Uninsured** callers made up **13%** (136) of the calls, compared to 14% (165) last quarter.
- In the remainder of calls the insurance status was either unknown or not relevant.

I. Dispositions of closed cases

All Calls

We closed 1,021 cases this quarter, compared to 1,114 last quarter.

- 27% (276 cases) were resolved by brief analysis and advice;
- 25% (259) were resolved by brief analysis and referral;

¹ Although the VHAP program ended on March 31, 2014, three cases were coded as VHAP because their problems related to VHAP billing issues.

² Since Medicare beneficiaries can also have commercial or DVHA coverage, these Medicare numbers overlap with those figures.

³ Although the Catamount Health program ended on March 31, 2014, one case was coded as Catamount because the consumer’s problem involved a Catamount billing issue.

- 23% (234) of the cases were complex interventions involving complex analysis, usually direct intervention, and more than two hours of an advocate's time;
- 20% (208) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc.;
- <1% (4) of the cases were resolved in the initial call.
- In the remaining cases, clients withdrew, resolved the issue on their own, or had some other outcome.
- Appeals: 18 cases involved help with appeals: 4 commercial plan appeals, 11 Fair Hearings, 2 DVHA internal MCO appeals and 1 Medicare appeal. With all the problems VHC was having, we expected a sharp increase in appeals. However, because VHC was aware of the high number of problems in processing eligibility, it resolved most of our clients' complaints outside of the appeal system.

DVHA Beneficiary Calls

We closed 401 DVHA cases this quarter, compared to 455 last quarter.

- 29% (115 cases) were resolved by brief analysis and advice;
- 25% (99) were resolved by brief analysis and referral;
- 23% (91) were considered complex intervention, which involves complex analysis, usually direct intervention, and more than two hours of an advocate's time;
- 21% (86) were resolved by direct intervention on the caller's behalf, including advocacy with DVHA and providers, writing letters, and gathering medical information;
- Just 3 DVHA beneficiary calls were resolved in the initial call.
- In the remaining cases, clients withdrew, resolved the issue on their own, or had some other outcome.
- Appeals: 13 cases involved appeals: 11 Fair Hearings and 2 internal MCO appeals.

Commercial Plan Beneficiary Calls

We closed 222 cases involving individuals on commercial plans,, compared to 239 last quarter.

- 31% (68 cases) were resolved by brief analysis and advice;
- 15% (34) were resolved by brief analysis and referral;
- 28% (63) were considered complex intervention, which involves complex analysis, usually direct intervention, and more than two hours of an advocate's time (this measure increased by 20% over last quarter);
- 23% (52) were resolved by direct intervention on the caller's behalf, including advocacy with the carrier and providers, writing letters, and gathering medical information;
- Just 1 call from a commercial plan beneficiary was resolved in the initial call.
- In the remaining cases clients withdrew, resolved the issue on their own, or had some other outcome.
- Appeals: 4 cases involved appeals.

J. Case outcomes

All Calls

The HCA helped 137 people get enrolled in insurance plans and prevented 17 insurance terminations or reductions. We obtained coverage for services for 52 people. We got 36 claims paid, written off or reimbursed. We assisted 11 people with completing applications and estimated VHC insurance program eligibility for 34 more. We provided other billing assistance to 31 individuals. We obtained hospital patient assistance for 3 people. We provided 491 individuals with advice and education. We obtained other access or eligibility outcomes for 64 more people, many of whom we expected to be approved for medical services and state insurance.

We encourage clients to call us back if they are subsequently denied insurance or a medical service after our assessment and advice.

In total, this quarter the **HCA saved individual consumers \$127,348.41** in cases opened this quarter. The amount of individual savings for State Fiscal Year 2014 was **\$313,265.50**.

K. Case examples

Here are a few examples of how we helped Vermonters this quarter:

1. Lack of Change of Circumstance functionality delayed Medicaid coverage for Ms. A. Ms. A lost her job and could no longer afford her health insurance premiums for her Qualified Health Plan (QHP). She reported the job loss and the resulting decrease in income to VHC at the end of March. Her income had dropped so low that she became eligible for Medicaid. However, because VHC's Change of Circumstance (COC) functionality was still not working, VHC could not easily transfer Ms. A from her QHP to Medicaid. Ms. A was stuck on the QHP and required to pay premiums to maintain coverage. She stopped paying those premiums because she did not have the money. When she was about to run out of her diabetes medications, she called the HCA for help. In the two and a half months since she reported her change in income, VHC had not moved her to Medicaid. Ms. A's HCA advocate contacted VHC and requested that her COC be rushed because of the high medical need for her medications. Within two days, Ms. A was put on Medicaid so she could pick up her medications.
2. VHC's failure to promptly apply Ms. B's payment to her account caused her to delay medical treatments.

Ms. B signed up on VHC to start her health care coverage on May 1, 2014. She paid the first payment on time with her debit card in the third week of April. The money was taken from her bank account that same day. By mid-May, however, VHC still had not applied the payment to her account. This meant that Ms. B's QHP coverage was not activated. Ms. B called VHC during the first week of May and was told that the issue would be investigated and someone would call her back. No one called her back. Ms. B finally called the HCA because she had been delaying medical appointments due to lack of insurance coverage. The HCA advocate asked VHC to apply the payment to her account immediately. VHC confirmed that Ms. B had made the payment, and explained that a computer glitch had prevented the application of the payment to her account. More than three weeks after the initial payment, and several weeks after the promised start date for her QHP, Ms. B's coverage was made active.

3. Ms. C called the HCA because her COBRA coverage had ended and she was unable to get new coverage through VHC.

When Ms. C called VHC to apply for new coverage, she was told that because she was outside the open enrollment period she would have to wait until the next open enrollment period to apply for coverage, which could not start until January 2015. Furthermore, she was told that she did not qualify for a "special enrollment period" (SEP). Desperate, she called the HCA. Her HCA advocate knew that CMS had recently authorized a temporary SEP specifically for loss of COBRA coverage, and that Ms. C qualified for that SEP. The advocate contacted the State, and argued that it had incorrectly denied the SEP for Ms. C. VHC agreed and reversed its decision. Ms. C was able to select and enroll in a QHP and now has coverage.

4. Mr. D called the HCA because Medicaid had denied coverage of a life-changing medication.

Mr. D had a life threatening illness. His doctor prescribed a very expensive new medication for him, which has the potential to cure rather than simply treat the disease. Mr. D's provider submitted two prior authorizations to Medicaid which were each denied. Mr. D requested an internal appeal and asked the HCA to help him prepare for the hearing. His HCA advocate reviewed the reasons for the denial and the criteria for coverage, talked to the provider, researched background on the new medication, and helped develop Mr. D's argument and strategy for the hearing. Mr. D prevailed at the hearing and DVHA reversed its decision. He was thus able to pick up the medication and begin his course of treatment.

L. Table of all calls by month and year

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
January	252	178	313	280	309	240	218	329	282	289	428
February	188	160	209	172	232	255	228	246	233	283	304
March	257	188	192	219	229	256	250	281	262	263	451
April	203	173	192	190	235	213	222	249	252	253	354
May	210	200	235	195	207	213	205	253	242	228	324
June	176	191	236	254	245	276	250	286	223	240	344
July	208	190	183	211	205	225	271	239	255	271	
August	236	214	216	250	152	173	234	276	263	224	
September	191	172	181	167	147	218	310	323	251	256	
October	172	191	225	229	237	216	300	254	341	327	
November	146	168	216	195	192	170	300	251	274	283	
December	170	175	185	198	214	161	289	222	227	340	
Total	2409	2200	2583	2560	2604	2616	3077	3209	3105	3257	2205

M. Recommendations

1. *The Change of Circumstance functionality must be made operational as soon as possible.*

This is still the biggest problem we see. We know VHC is well aware of this issue and working on it, but it remains a huge problem affecting thousands of people. No firm date has been given for the deployment of the COC functionality.

2. *The backlog of Change of Circumstances must be eliminated before open enrollment begins.*

The State's new vendor, Optum, has just begun to work through the backlog of thousands of COCs. This is a big undertaking but we are hopeful that by the end of the summer the backlog will be gone, although that could be overly optimistic considering the complexity of the problems. All 2014 COCs need to be processed before open enrollment begins on November 15th. If they are not, there will be massive confusion and problems with renewals.

3. *The invoice and payment system must be fixed or redesigned.*

We continue to hear from consumers who say they are not getting invoices, are not getting correct invoices, or whose premium payments are not being processed in a timely manner or sometimes even recorded. It is very difficult for the HCA to pinpoint what the exact problems are, because these problems are not happening to everyone. It might make more sense to have consumers pay the carriers directly, rather than send their payments to VHC. There are too many steps in the payment process which result in opportunities at each step for something to go wrong.

- 4. The functionality to send Notices of Decision to all VHC applicants must be fixed before open enrollment.*

The 2014 coverage NODs must go out before the 2015 NODs. With the next open enrollment only about four months away, VHC needs to address how it is going to handle the NODs for 2014 coverage if they haven't gone out well before November 15th. It will be very confusing to consumers when open enrollment starts if they still haven't gotten notices regarding eligibility for their 2014 coverage. Sending NODs for both 2014 and 2015 coverage around the same time will be a recipe for disaster. If the 2014 NODs can't go out before Vermonters start hearing about open enrollment for 2015, they probably shouldn't go out at all. The State is legally required to send these notices, so this functionality must be fixed.

- 5. Maximus and the Health Access Eligibility Unit staff need to continue to work on training, resource materials and supervision.*

We continued to hear incorrect information from some Maximus customer service representatives and HAEU staff. We also heard the same thing from consumers and navigators. These errors cause confusion and serious problems for consumers. We report these errors in individual cases to VHC and AOPS frequently, and we assume that they report the types of problems we see to each other and to HAEU. We appreciate the difficulties in running large call centers which must handle complex information, but because the mistakes can be so harmful, there should be an ongoing effort to improve training, resource materials and quality control. This quarter we encountered 30 instances of HAEU errors and 9 instances of Maximus errors.

- 6. VHC needs to continue to work on its process for resolving consumer issues and providing improved customer service.*

We continue to hear from consumers who have spent many hours on the phone with VHC trying to resolve problems. By the time they reach the HCA for assistance, they have talked to multiple people and frequently heard multiple explanations of the problem, and have been given multiple assurances that the situation was being worked on. Problems cannot be fixed quickly in many cases and consumers understandably get extremely frustrated. VHC needs to work on providing consistent customer service, focusing particularly on timeliness and accuracy. Consumers should not be told that they will get a return call when no one actually makes those call backs. Consumers should also be given accurate and realistic estimates of how long it will take to resolve an issue.

III. Consumer protection activities

A. Rate review work

Insurance carriers filed four new rate cases with the Green Mountain Care Board (GMCB) in this calendar quarter. The HCA filed Notices of Appearance in all of these new filings. We also filed

memoranda in eight rate cases filed in this quarter and the prior quarter. No contested hearings were held during this quarter.

The most significant new filings were the two filings for Vermont Health Connect filed by Blue Cross Blue Shield of Vermont and MVP on June 2, 2014. The HCA has worked with its independent actuary to review these filings and prepare suggested questions for the Board to pose to the carriers. Four pre-hearing conferences for these filings were held during the quarter.

The HCA participated in a panel at a forum about rate review held by the Green Mountain Care Board in Burlington in May.

The HCA continued to work to amend the GMCB's policy regarding the treatment of confidential materials in rate review cases. We have requested that we be allowed to keep a record of some hearing materials which contain confidential information after the time for appeal has ended. The negotiation regarding this request continued during the quarter.

A summer intern from the George Washington University Law School worked with HCA staff on policy issues before the Green Mountain Care Board during the quarter. He has helped to review and analyze the VHC rate filings and is researching topics including the effect of cost sharing in plan benefit design on different populations.

B. Other Green Mountain Care Board activities

Pursuant to Act 48 of 2011 and Act 171 of 2012, the GMCB is required to consult with the HCA about various health care reform issues. The HCA is directed in Act 79 of 2013 to "suggest policies, procedures, or rules to the GMCB in order to protect patients' and consumers' interests." This quarter we:

- Attended 11 GMCB public meetings
- Attended one meeting of the GMCB Advisory Committee
- Met twice with GMCB staff
- Met once with the Chair of the GMCB
- Continued to monitor new and pending Certificate of Need (CON) letters of intent, requests for jurisdictional determination and applications.
- Filed a Notice of Intervention as an Interested Party in one CON, the Fletcher Allen Health Care, Burlington Property Acquisition, GMCB-015-14con in June.

C. Vermont Health Care Innovation Project

We continue to participate in the State's Vermont Health Care Innovation Project (VHCIP) aka the SIM grant. This quarter we:

- Participated in two meetings as a member of the VHCIP Steering Committee
- Participated, along with representatives from other projects of Vermont Legal Aid, as “active members” in six of the seven VHCIP work groups: the Payment Models Work Group, the Quality and Performance Measures Work Group, the Disability and Long Term Services and Supports Work Group (formerly the Duals Demonstration Work Group), the Population Health Work Group, the Care Models and Care Management Work Group, and the Health Information Exchange/Health Information Technology Work Group
- Attended three meetings of the Core Team
- Submitted comments to the Quality and Performance Measures Work Group recommending changes to the criteria to be used to select measures for the second year of the Accountable Care Organization (ACO) Medicaid and Commercial Shared Savings Programs
- Submitted six sets of comments to DVHA and the Medicaid Shared Savings Program ACOs on their patient notices, opt out forms, change of preference forms, call center scripts, and consumer advisory group recruitment materials.

D. Other Activities

Plain Language Materials

One of the HCA’s priorities this quarter has been to advocate for the use of plain language in materials written for health care consumers.

We have found that many agencies draft materials in language too complex or high-level for the average consumer to read and understand. This quarter, we worked extensively with DVHA and the two Medicaid Shared Savings Program ACOs (OneCare Vermont and Community Health Accountable Care) to improve the readability of their consumer materials. These materials included patient notices, opt out and change of preference forms, phone scripts for call center staff who will be answering consumer questions, and consumer advisory group recruitment materials. We also continued to work with Vermont Information Technology Leaders, Inc. (VITL) on their patient consent materials, which we discuss further below. Additionally, we brought the issue of plain language materials to the Green Mountain Care Board at one of our monthly meetings with board staff, and subsequently created a summary of widely used guidelines for writing in plain language. We have shared the summary with GMCB and DVHA staff.

In February 2014 and at the HCA’s request, the Green Mountain Care Board ordered VITL to work with the HCA to develop a plain language consent form, revocation form, and informational brochure for the Vermont Health Information Exchange (HIE). The HCA collaborated with VITL on this project for several months and agreed on the final drafts in June 2014. While VITL’s materials began at a grade level of 18, which is equivalent to two years of

graduate-level education, the HCA negotiated the language for the brochure, consent form, and revocation form down to 7th, 8th, and 9th grade reading levels, respectively. Our understanding is that all providers participating in the Vermont Health Information Exchange will use these materials. The HCA's work with VITL will help Vermont patients to understand the Vermont Health Information Exchange and what it will mean if the individual gives or withholds consent for his or her information to be accessed on the HIE.

Policy Paper on Emerging Privacy Issues

The HCA receives a significant number of phone calls regarding consumer concerns about health information privacy. In addition, there are emerging privacy issues related to electronic health records and electronic health exchanges. In order to keep abreast of these issues, the HCA developed a white paper on federal and state privacy rules related to health records.

The paper was posted to the HCA's website in June:

[Protected Health Information: What Vermonters Should Know](#)

This document concentrates on HIPAA (Health Information Portability and Accountability Act) rules, including recent changes to the Act that address electronic health records and health information exchanges, as well as Vermont laws that provide patients with additional rights and protections. Specific topics include information on how patients can obtain a copy of their health records, when providers must obtain consent before sharing a patient's protected health information, and what patients can do if they would like a provider to amend their health information.

Health Benefit Eligibility and Enrollment regulations

For more than a year the Agency of Human Services has been working on its regulations for implementing the new health insurance programs required by the Affordable Care Act. These proposed and emergency rules not only set out the requirements for Vermont's expanded Medicaid program and the purchase of commercial plans through VHC, but also integrated some of the previous Medicaid program rules into one set of rules.

The HCA, in collaboration with other projects at Vermont Legal Aid, has been extensively involved in this process. In this past quarter we submitted 40 pages of formal comments on the HBEE final proposed regulations. We also had numerous conversations with AHS staff about the rules.

On June 26, 2014, we testified before the Legislative Committee on Administrative Rules (LCAR) about the HBEE regulations. Although we had resolved many of our concerns with AHS, we opposed portions of the rules at that LCAR meeting. We believed certain provisions changed the Choices for Care program and might harm a small group of Vermonters. As a result, LCAR delayed its decision on the rules until its next scheduled meeting, on July 10, 2014. By that time the HCA and VLA had reached a resolution with AHS. We withdrew our opposition to the rules

and AHS agreed to continue to work with us to improve the regulations, including the provision related to the Choices for Care program. LCAR approved the rules with a number of amendments that AHS had negotiated with various stakeholders, including the HCA.

Other Activities

In addition, the HCA engaged in the following systemic activities:

- Participated in:
 - Three Medicaid and Exchange Advisory Board (MEAB) meetings
 - Two Governor’s Consumer Advisory Council meetings
 - Two Improving Access Work Group meetings (a subgroup of the MEAB to improve access to Medicaid services, which the Chief Health Care Advocate chairs)
 - Two VHC Consumer Experience Work Group meetings
 - Two VHC Customer Support meetings with Maximus, VHC, DVHA and HAEU
- Commented on VHC notices at least 12 times.
- Participated in at least 34 legislative activities, testified two times, and submitted one document
- Participated with other stakeholders in a work group to improve the VHC application
- Submitted at least two sets of complaints and suggestions to VHC
- Participated in two national e-mail forums organized by Consumers Union, The Health Cost Forum and a Rate Review Group
- Participated in the following staff training activities:
 - One webinar on Designing Silver Health Insurance Plans with Affordable Out-of-Pocket Costs for lower and moderate income individuals
 - Two webinars on rate review hosted by Consumers Union
 - One webinar on meaningful Consumer Engagement, hosted by CMS in collaboration with The Lewin Group and Community Catalyst
 - One webinar on Community Health Needs Assessments and Health Equity, hosted by the Association of State and Territorial Health Officials (ASTHO)

E. Collaboration with other organizations

The HCA worked with the following organizations this quarter:

- American Civil Liberties Union (ACLU)
- Bi-State Primary Care
- Families USA
- Community of Vermont Elders (COVE)
- Disability Rights Vermont
- Planned Parenthood of Northern New England
- Vermont Campaign for Health Care Security
- Vermont CARES
- Vermont Family Network

- Vermont Public Interest Research Group (VPIRG)
- Voices for Vermont's Children

IV. Outreach and education

A. Website

Vermont Law Help is a statewide website that is maintained by Vermont Legal Aid and Law Line of Vermont. The site includes a substantial Health section, www.vtlawhelp.org/health, with more than 150 pages of consumer-focused information that is maintained by the HCA. Since the launch of Vermont Health Connect, we have worked diligently to keep the site updated in order to provide the latest and most accurate information to Vermont consumers.

The end of this quarter marks a year and a half since we began to expand and enhance the presentation of the health contents on the Vermont Law Help website. While we regularly update, add to and otherwise improve the site, it is unrealistic to continue to expect the dramatic double- and triple-digit increases in site performance statistics we have experienced over the past year.

When comparing this quarter's statistics with the same quarter last year, however, the number of pages visited by Vermonters seeking information about and assistance with health care is still increasing:

- Pageviews of the Health Home Page **increased by 75.93%** (519 vs. 295)
- Pageviews of All Health Pages **increased slightly** (1,109 vs. 1,101)

The bounce rate (percentage of people who left the site from the page they entered on without interacting with the page) **decreased by 38.76%** (51.44% vs. 84%). A decrease in the bounce rate is a positive sign that users are finding information they're looking for and are clicking links to get even more information.

Vermonters Continue to Seek Information Related to Vermont Health Connect and Health Care Reform

More than half (29) of the 50 most-visited pages in the Health section provide information related to **health insurance topics**:

- 24 of these 29 pages explain aspects of Vermont Health Connect, health care reform (including rate reviews), and Vermont's sunseting health care programs
 - Four of the top-visited pages within this category were:
 - How to Be Involved in Vermont Health Care Reform (policy) (58 visits)
 - Health Insurance Rate Reviews (55 visits)
 - How the Public Can Participate (rate reviews) (44 visits)
 - News: Public Invited to Comment on 2015 Vermont Health Connect Plan Rates (21 visits)
- The other five pages provide general information about insurance, employer-sponsored health insurance and regulation.

Health Care Policy Page

The new Health Care Policy section that was launched last quarter continues to gain traction. We post policy papers, comments and other work the HCA Policy Team produces to represent consumers before the Green Mountain Care Board; the legislature; and state agencies, committees, boards and task forces as well as white papers on important and emerging health care issues.

How to Be Involved in Vermont Health Care Reform was the most visited page in the Health section after the home page. Visitors spent an average of four minutes, nearly three times the Health site average, interacting with this page.

Privacy

Consumers also sought out information about the privacy of their health information. Eight different web pages in the Health section that relate information about personal health records, privacy and HIPAA, including the recently added policy paper **Protected Health Information: What Vermonters Should Know**, were among the 50 most-visited pages in the Health section.

B. Education

In April the HCA presented a workshop on Vermont Health Connect at Vermont Family Network's annual meeting. The presentation was an overview of eligibility requirements for Vermont's Medicaid expansion, the income rules for this new adult program, and premium tax credits and cost sharing reduction subsidies for Qualified Health Plans.