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QUARTERLY REPORT
July 1, 2013 – September 30, 2013
to the
DEPARTMENT OF FINANCIAL REGULATION
and the
DEPARTMENT OF VERMONT HEALTH ACCESS
submitted by
Trinka Kerr, Vermont Health Care Ombudsman
October 21, 2013

I. Introduction

This is the Office of Health Care Ombudsman's (HCO) report to the Department of Financial Regulation (DFR) and the Department of Vermont Health Access (DVHA) for the quarter July 1, 2013, through September 30, 2013. In addition to operating a hotline to provide individual consumer assistance, the HCO also engages in consumer protection activities such as representing the public in Green Mountain Care Board rate reviews.

The following information is contained in this quarterly report:

- This narrative section which includes **Individual Consumer Assistance, Consumer Protection Activities** and a **Website update**
- Five data reports
    - **All calls/all coverages**: 751 calls
    - **DVHA beneficiaries**: 367 calls or **49%** of total calls
    - **Commercial plan beneficiaries**: 103 calls or **14%**
    - **Uninsured Vermonters**: 85 calls or **11%**
    - **Health Website Usage Report**

II. Individual Consumer Assistance

The HCO provides assistance to consumers through our statewide hotline. In preparation for the launching of Vermont Health Connect in October, this quarter we hired two new advocates. This means we now have a total of seven advocates to provide help to individuals through our hotline and our website. We also leased new space at the back of our current building which is being renovated to accommodate this increase in staffing.

With regard to services we provide to individuals, note that our case management 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 202 cases had Eligibility for DVHA programs as the primary issue, there were actually a total of 399 calls in which we spent a significant amount of time assisting consumers regarding access to health insurance. In each section of this narrative we record whether we are referring to data based on just primary issues, or both primary and secondary issues. 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 other than the primary reason for their call.]

Also, the most accurate information about eligibility for state programs is in the All Calls data report because callers who had questions about the DVHA programs fell into all three insurance status categories.

A. Total call volume increased 4% from last quarter.

The HCO received 751 calls this quarter, compared to 721 last quarter. We received 769 calls in the third quarter of 2012. July's call volume was 270, higher than last year's July total of 255. August's was 224, significantly lower than last year's August total of 263. And September's call volume of 256 was close to last September's 251. There was no identifiable reason for the decrease in August.

The HCO divides calls into five issue categories. The breakout by issue category in this quarter based on the caller's primary issue was as follows. [See the DVHA data report for a similar breakdown for the DVHA beneficiaries who called us.]

- **25.83%** (194) of our total calls were regarding **Access to Care**;
- **15.31%** (115) were regarding **Billing/Coverage**;
- **1.73%** (13) were questions regarding **Buying Insurance;**
- **9.05%** (68) were **Consumer Education**;
- **26.90%** (202) were regarding **Eligibility** for state programs, Medicare and Catamount Health plans; and
- **21.17%** (159) were categorized as **Other**, which includes Medicare Part D, communication problems with providers or plans, access to medical records, changing providers or plans, enrollment problems, confidentiality issues, and complaints about insurance premium rates.

B. The top issues generating calls

This section includes **both** primary and secondary issues. The affordability of health care, information about applying for state programs and complaints about providers continue to be the most common reasons for calls

All Calls (751, compared to 721 last quarter)

1. Affordability 137 (compared to 116 last quarter)
2. Information about applying for DVHA programs 127 (113 last quarter)
3. Complaints about Providers 105 (104 last quarter)
4. Eligibility for VHAP 79 (69 last quarter)
5. Eligibility for Medicaid 64 (57 last quarter)
6. Communication Problems with ESD 56 (69 last quarter)
7. Access to Prescription Drugs 51 (73 last quarter)
8. Eligibility for Premium Assistance 39 (30 last quarter)
9. Consumer Education about Fair Hearings 37 (31 last quarter)
10. Medicaid Buy In programs 36 (20 last quarter
11. Consumer Education about Medicare 33 (28 last quarter)
12. Medicaid Spend Down program 31 (27 last quarter)
    Hospital Billing 31 (19 last quarter)
13. Consumer Education about the ACA 30 (24 last quarter)
    Access to Specialty Care 30 (29 last quarter)
14. Transportation to medical care 25 (30 last quarter)
    Billing-Premiums 25 (10 last quarter)
15. Marketplace inquiries-general 24 (not tracked last quarter)
16. ESD Eligibility Mistake 23 (17 last quarter)
17. Access to Mental Health treatment 22 (38 last quarter)
    Medicare Billing 22 (18 last quarter)
18. Hospital Financial Assistance 21 (11 last quarter)
19. Communication Problems with insurer 20 (16 last quarter)
20. Consumer Education about health care reform 19 (9 last quarter)
    Access to Pain Management treatment 19 (16 last quarter)

Three issues that fell off the list this quarter were:

- Access to Substance Abuse treatment 10 (22 last quarter)
- Access to Durable Medical Equipment & Supplies 16 (19 last quarter)
- Access to Dental Care 16 (18 last quarter)

DVHA Beneficiary Calls (367, compared to 364 last quarter)

1. Complaints about Providers 66 (56 last quarter)
2. Information about applying for DVHA programs 56 (43 last quarter)
3. Affordability 43 (49 last quarter)
4. Eligibility for VHAP 34 (34 last quarter)
5. Communication Problems with ESD 27 (37 last quarter)
6. Consumer Education about Fair Hearings 25 (28 last quarter)
7. Transportation to medical care 24 (27 last quarter)
   Eligibility for Medicaid 24 (25 last quarter)
8. Access to Prescription Drugs 23 (43 last quarter)
9. Access to Specialty Care 21 (16 last quarter)
10. Access to Primary Care Doctor 16 (9 last quarter)

11. Eligibility for Medicaid Spend Down 15 (13 last quarter)
    Hospital Billing 15 (7 last quarter)
    ESD Eligibility Mistake 15 (7 last quarter)
12. Medicaid Billing 14 (13 last quarter)
13. Access to Durable Medical Equipment & Supplies 13 (11 last quarter)
    Buy In Programs 13 (9 last quarter)
14. Access to Pain Management Treatment 12 (11 last quarter)
15. Consumer Education about HIPAA 12 (1 last quarter)
16. Consumer Education about the ACA 11 (5 last quarter)
    Eligibility for Premium Assistance 11 (9 last quarter)
17. Access to Mental Health treatment 10 (20 last quarter)
    Access to Dental Care 10 (8 last quarter)
    Billing Problems with providers 10 (11 last quarter)
    Consumer Education about Health Care Reform 10 (3 last quarter)
    Consumer Education about VHC 10 (not tracked last quarter)

One issue fell off the list from last quarter:

- Access to Substance Abuse treatment 4 (15 last quarter)

C. The HCO did not see a big increase in calls leading up to the October launch of Vermont Health Connect, but more consumers did ask questions about the marketplace .

Our calls about the exchange or marketplace did not increase as much as we expected this quarter. This may be because people are going to Vermont Health Connect's website, calling the expanded VHC Customer Support line and going to Navigators for information as the State's education and outreach effort has recommended.

However, the HCO is continuing to get more callers asking about what the changes will mean for them. We coded these cases as "Info re the ACA". This quarter we received 30 such inquiries. Last quarter we received 24, and just 10 the quarter before that. See the next section about how we are coding calls about health care reform.

We expect to get more calls and questions as the roll out of VHC continues.

D. The HCO needs to improve its coding related to health care reform and the launch of Vermont Health Connect.

The above analysis brings out some issues with our data collection right now. Because it is relatively easy for us to add new issue fields to our case management system, we have added several related to health care reform in the last few months. Here are the codes we had this quarter to track Affordable Care Act related issues, along with the number of times we received calls about the issue and coded it as the primary reason for the call:

Billing/Coverage

- Lifetime caps – 0 calls

Buying Insurance

- Buying QHPs through VHC - 1
- Marketplace Inquiries – 6
- Individual/Small group – 2
- Tax advisor problem - 0

Consumer Education

- Health Care Reform - 3
- Info re ACA – 10
- Info re VHC – 7

Eligibility

- College student/young adult – 4
- MAGI Medicaid – 0
- Premium Tax Credit – 0
- Seasonal Employment -0
- Small business owner – 1
- Young adults & parental plans – 0

Other

- Exchange – 0
- Family Law interface with health insurance – 5
- Pre-existing condition – 0
- VHC complaints - 0

We will spend some time in the next few weeks clarifying what each of these codes means and when they should be used, as well as determining what new codes we should create. We are open to suggestions about what issues we should track.

E. Lack of affordability remains the largest barrier to consumer access to health care, even for the insured, and especially for DVHA beneficiaries.

The high cost of health care continued to be the most-identified barrier to access to health care. The HCO had 137 calls, 18% of all calls, in which the consumer said that cost was making it difficult for them to get care. This is slightly higher than the percentage of such calls last quarter. Of these 137 calls, 43 or 31 % were from DVHA beneficiaries. The inability to access care due to the cost of a service, or the cost of insurance, is an issue for consumers across all groups, those insured by state programs, federal programs, private companies, and the uninsured.

F. Desire for more information about DVHA programs remains high.

The HCO continues to provide consumer education about DVHA programs to a high percentage of callers, which is related to the affordability problem. It was once again the second most common issue overall, with 127 calls. Interest in DVHA's programs is due to a number of factors: the cost of commercial plans and health care generally, the high degree of complexity of the programs which results in questions about the rules and navigating the requirements for eligibility, confusing notices from the Economic Services Division (ESD), and insufficient education provided by ESD eligibility staff or Member Services.

G. Complaints about providers continue, especially from DVHA beneficiaries.

Call volume about problems with providers was about the same as last quarter, 105 versus 104, or about 14% of all calls. Of those, 66 calls or 63% were from DVHA beneficiaries, compared to 56 last quarter. The reasons for these calls are varied. They range from claims of rude treatment to medical malpractice.

H. Hotline call volume by type of insurance:

The HCO received 751 total calls this quarter. Callers had the following insurance status:

- **DVHA programs** (Medicaid, VHAP, VHAP Pharmacy, Premium Assistance, VScript, VPharm, or both Medicaid and Medicare aka dual eligibles) insured **49%** (367 calls), compared to 50% (363) last quarter;
- **Medicare** (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 **31%** (236), compared to 30% (209) last quarter;
- **Commercial carriers** (employer sponsored insurance, individual or small group plans, and Catamount Health plans) insured **14%** (103), compared to 15% (111) last quarter; and
- **Uninsured** callers made up **11%** (85) of the calls, compared to 9% (67) last quarter.
- In the remainder of calls the insurance status was either unknown or not relevant.

I. Dispositions of closed cases

<u>All Calls</u>

We closed 746 cases this quarter, compared to 745 last quarter.

- 29% (217 cases) were resolved by brief analysis and advice;
- 32% (236) were resolved by brief analysis and referral;
- 17% (125) of the cases were complex interventions, which involves complex analysis, usually direct intervention, and more than two hours of an advocate's time;

- 14% (108) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc.;
- Less than 1% (7) 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: 26 cases involved direct help with appeals, and 43 involved consumer education about appeals.

DVHA Beneficiary Calls

We closed 353 DVHA cases this quarter, compared to 301 last quarter.

- 29% (102 cases) were resolved by brief analysis and advice;
- 31% (111) were resolved by brief analysis and referral;
- 15% (54) were considered complex intervention, which involves complex analysis, usually direct intervention, and more than two hours of an advocate's time;
- 20% (72) were resolved by direct intervention on the caller's behalf, including advocacy with DVHA and providers, writing letters, and gathering medical information;
- Less than 1% of calls (3) from DVHA beneficiaries were resolved in the initial call.
- In the remaining cases, clients withdrew, resolved the issue on their own, or had some other outcome.
- Appeals: 12 cases involved help with DVHA program appeals, of which 1 was an internal MCO appeal and 11 were Fair Hearings.

J. Case outcomes

All Calls

The HCO helped 36 people get insurance and prevented 20 insurance terminations or reductions. We obtained coverage for services for 20 people. We got 27 claims paid, written off or reimbursed. We assisted 10 people complete applications for DVHA programs and estimated program eligibility for 37 more. We provided other billing assistance to 16 individuals. We obtained hospital patient assistance for 7 people. We provided 398 individuals with advice and education. We obtained other access or eligibility outcomes for 56 more people, many who will 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. In total, this quarter the **HCO saved individual consumers $75,234.96.**

DVHA Beneficiary Calls

The HCO prevented 18 terminations or reductions in coverage for DVHA beneficiaries, and got 4 more people onto different DVHA programs. We estimated the eligibility for other programs for 11 DVHA beneficiaries. We obtained coverage for services for 16 individuals. We got 15 claims paid, written off or reimbursed. We got other billing assistance for 9 people and hospital

patient assistance for 1 individual. We provided 203 DVHA beneficiaries with advice or education, and obtained other access or eligibility outcomes for 31 more people.

K. Case examples

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

The HCO successfully appealed a commercial carrier's denial of coverage for a specialized rehabilitation device.
Mr. A suffered a Traumatic Brain Injury that left him with multiple disabilities, including difficulty walking. His doctor and physical therapist had prescribed a device to help him improve his ability to walk. Mr. A's insurer denied coverage for the device, claiming it was experimental. The HCO advocate helped the client appeal this decision by compiling research and working with his providers to show that the device was not experimental, and that it was actually the only device that met Mr. A's particular needs. After submitting our research, medical information and arguments and while we were waiting for the external review to be scheduled, the insurance company reversed its decision and agreed to cover the device, which cost about $8,000.

The HCO worked with ESD to get immediate insurance coverage so that an extremely low income individual could have imminent surgery covered.
Ms. B called the HCO in a panic on the day before she was to have knee surgery. She was unable to work because of her knee problems and was living on a small disability benefit from her employer. Because she had less income, she was unable to afford her employer sponsored insurance. Because she had not paid the last premium for the ESI, her insurance had been cancelled. Without insurance, she was not going to be able to afford the surgery. Without the surgery, she was not going to be able to go back to work. She had applied for VHAP but was denied because she had not been uninsured for twelve months. Her HCO advocate realized that because her income had fallen below 75% of the federal poverty level, she met an exception to the twelve month rule. The advocate communicated this to ESD, which immediately enrolled her in VHAP. This enabled Ms. B to have her surgery the next day.

L. Recommendations to DVHA

Maximus should increase its training for customer service representatives. The biggest issue we had this quarter related to DVHA was problems with Maximus due to the switchover from DVHA's Member Services to VHC's Customer Support Center. This was a huge expansion for the call center which meant that starting in September they had a high proportion of very new customer service representatives who had only a few weeks of training. As a result, every time we called Maximus for information, the calls took longer because the new CSRs often had to check with supervisors before they gave out information. We have heard that there is also a fairly high rate of turnover with the Maximus CSRs, so we have some concerns about how soon Maximus will be able to get back to its previous high level of service. We have just recently begun biweekly meetings with Maximus to improve communication and discuss issues.

ESD should assign designated HAEU workers to assist individuals with Medicaid Spenddowns. This is a repeat request. We continue to get calls from Vermonters who have difficulty navigating the eligibility requirements for this program. This quarter we received 20 calls in which the primary reason for the call was Medicaid Spenddown eligibility, and 11 more in which it was a secondary reason for the call. In each of the previous two quarters we had 13 such calls.

M. Table of all calls by month and year

All Cases

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
January	241	252	178	313	280	309	240	218	329	282	289
February	187	188	160	209	172	232	255	228	246	233	283
March	177	257	188	192	219	229	256	250	281	262	263
April	161	203	173	192	190	235	213	222	249	252	253
May	234	210	200	235	195	207	213	205	253	242	228
June	252	176	191	236	254	245	276	250	286	223	240
July	221	208	190	183	211	205	225	271	239	255	270
August	189	236	214	216	250	152	173	234	276	263	224
September	222	191	172	181	167	147	218	310	323	251	256
October	241	172	191	225	229	237	216	300	254	341	
November	227	146	168	216	195	192	170	300	251	274	
December	226	170	175	185	198	214	161	289	222	227	
Total	2578	2409	2200	2583	2560	2604	2616	3077	3209	3105	2306

III. Consumer protection activities

A. Rate Reviews

There were relatively few rate filings which were ready for review by the Green Mountain Care Board (GMCB) in this calendar quarter. The HCO filed notices of appearance and legal memoranda in six new rate cases. No contested hearings were held during the quarter.

One rate review proceeding that generated some publicity involved a significant premium increase proposed by Blue Cross Blue Shield of Vermont for its Catamount Health plan. The state is ending the Catamount program as of December 31, 2013, so the proposed increase was for a six month period. The GMCB issued its decision on this filing, which had been pending at the end of last quarter, on July 16, 2013. BCBSVT had proposed a rate increase of 24.4%. The Commissioner of DFR recommended modifications to the rates which would have reduced the rate increase to 13.9%, and we recommended further reductions. Ultimately the GMCB adopted some but not all of the modifications supported by the HCO. It approved an increase of 11.9%. This increase would have affected 15,351 people, except that 11,902 of them had state premium subsidies. For them, the state absorbed the increase. The remaining 3,449 are paying the increased rates until the program ends.

In five other cases the HCO supported modifications recommended by the Commissioner of DFR and suggested additional reductions in rates. The GMCB accepted the DFR recommendations but did not adopt the HCO's additional suggested modifications.

The HCO worked on the new GMCB proposed rate review regulations which are being promulgated pursuant to changes in statute made in Act 79 of 2013. These rules will take effect in January 2014. The HCO met with the GMCB General Counsel and attended a public hearing with the GMCB and the carriers about these new rules. We also submitted written comments which largely focused on maximizing opportunities for consumers to obtain information and offer input in the rate review cases. The GMCB adopted many of the HCO's suggested changes in the version of the proposed regulations it filed with the Secretary of State in September. The changes clarified the process by which an individual or group can request interested part status, added to the information that will be made available to the public on the GMCB's website, ensured that the parties in the rate review filings will have timely access to the answers to questions posed by the GMCB actuary to the carrier and made changes to the procedures followed by the GMCB during its 30 day review period.

As part of our efforts to encourage public involvement in rate review proceedings, we worked with the HCO's outreach specialist to develop consumer education materials about the rate review process for our new website. See Section III below, Website Update. We also attended a presentation about the new DFR/GMCB website materials explaining rate review.

The HCO continued to work with its law school intern, Kroopa Desai, through August 2, 2013. Kroopa assisted with research, writing memoranda and hearing preparation for rate review cases, helped to draft comments on the proposed GMCB rate review regulations and assisted with developing materials describing the rate review process for the Vermont Law Help web site.

The HCO hired a new independent actuary during the quarter, NovaRest, a firm based in Sahuarita, AZ.

B. Hospital Budget Reviews

This quarter the GMCB performed its second annual hospital budget review. In preparation, we reviewed the hospitals' budget materials and Community Needs Assessments, researched related issues, and submitted suggested questions for the GMCB to pose to the hospitals. We attended the fourteen hearings and submitted comments on the budgets to the GMCB. Our general comments focused largely on increasing consumer input on hospital planning and budgeting and on hospitals' treatment of individuals with mental illness. In addition, we commented on each hospital's specific budget.

C. Other Activities

Pursuant to Act 48 of 2011 and Act 171 of 2012, the GMCB is required to consult with the HCO about various health care reform issues. This quarter we:

- Attended nine GMCB meetings including six meetings related to hospital budget review;
- Met monthly with General Counsel for the GMCB;
- Participated in four meetings of the Accountable Care Organization (ACO) Measures Work Group convened by the GMCB's Director of Payment Reform and one meeting of the Patient Experience Survey Subgroup. We also submitted written comments. This ACO work group is one of three groups working to support the GMCB's initiative to establish population-based payment pilots with ACO's. The group has been working to identify standardized measures that will be used for commercial plans and Medicaid to evaluate the performance of Vermont's ACO's, qualify and modify shared savings payments and guide improvements in health care delivery;
- Participated in three meetings of the ACO Standards Work Group as it began to review the measures developed by the Measures Work group and to develop ACO governance standards; and
- Worked with the GMCB on new proposed rate review regulations based on legislative revisions of the rate review process;
- The Health Care Ombudsman attended three State Innovation Model (SIM) steering committee meetings and three Medicaid and Exchange Advisory Board meetings as a member. She also now chairs the new Improving Access MEAB workgroup which is working with stakeholders and DVHA to improve prompt consumer access to Medicaid services.
- The HCO, working with other attorneys at Vermont Legal Aid, submitted extensive comments on the Vermont Health Connect regulations and engaged in further discussions with VHC attorneys to try to improve this mammoth set of rules. We will continue to do this over the next few months as the Agency of Human Services promulgates more emergency rules.

Finally, this quarter we hired a health care policy analyst who will start working with us on November 4th. We expect that this new staff member will help with analysis of hospital budgets, certificates of need, payment reform and other policy issues.

IV. Website update

Vermont Legal Aid and Law Line of Vermont maintain a statewide website called Vermont Law Help. The site includes a Health section, which is maintained by the HCO. With funding from the federal government through the Affordable Care Act, the HCO developed an all new website which went live in early September. The site can be seen at www.vtlawhelp.org/health.

We reviewed, revised or deleted all of the health contents from the old site and developed text for a large number of new topics including health care reform in Vermont. We made significant

efforts to enhance the consumer experience with the site, including adding advanced search functionality and greatly improved navigation. We added Google translate buttons that enable users to translate the site into seven languages that are common in Vermont, and we added a tool to help those with vision problems easily re-size the text. We provide links to Vermont Health Connect, the state's online insurance marketplace. Finally, the HCO added an **online intake button** to all health-related pages to make it easier for Vermonters to request HCO assistance 24/7.

The new site platform and underlying structure will help us to obtain more accurate and specific information about website usage via Google Analytics. The new platform is also device-responsive, which means that the 23.84% of visitors who access our site from mobile devices will find a site that is both readable and navigable on those devices.

The number of visits to the entire Vermont Law Help website increased modestly during this reporting period – from 27,494 in 2012 to 30,833 in 2013, or 12.14%. However, the number of pageviews increased dramatically from 60,487 to 80,648, or 33.33%. While the numbers for the health-related page views are small by comparison, the increases are substantial. There were 2,065 health-related views this quarter, compared to 209 for the same period last year, an increase of 888%. Unique page views also increased significantly, from 167 last year to 979 during this reporting period – an increase of 486%.

The average time viewers spent on a health page decreased this year by 69%, and the bounce rate improved by 22.56%. These changes demonstrate our successful efforts to create shorter, more focused pages and to assist the user in finding specific information quickly and easily. [See the attached report called Health Website Usage Report for more detail.]

We will continue to improve the site and add additional content over the next few months.