2014 Report of the Health Care Oversight Committee
December 2014

In Accordance with 2 V.S.A. § 852

Senator Ginny Lyons, Chair	*Representative Jill Krowinski, Vice Chair*
Senator Claire Ayer	*Representative Francis "Topper" McFaun*
Senator Kevin Mullin	*Representative Anne Theresa O'Brien*
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I. Statutory Authority and Responsibilities of the Health Care Oversight Committee

During the 1995 session of the Vermont General Assembly, the Legislature authorized the creation of the Vermont Health Access Plan (VHAP), taking one of the first steps in health care reform by offering health care coverage to uninsured low-income Vermonters (1995 Acts and Resolves No. 14). At the same time, the Health Access Oversight Committee was created to monitor the development, implementation, and ongoing operation of VHAP and to ensure improved access to health care. In 2006, the General Assembly broadened the Committee's jurisdiction to include the operation of the Medicaid program and all Medicaid waiver programs that may affect the administration and beneficiaries of these programs.

In 2011, the General Assembly again expanded the Committee's jurisdiction, this time to encompass all health care and human services programs in the State, including programs and initiatives related to mental health, substance abuse, and health care reform. The General Assembly also renamed the Committee the Health Care Oversight Committee (HCOC). The changes took effect on July 1, 2012. (See Appendix 1 to view the statutory authority for the HCOC.) In 2014 Acts and Resolves No. 179, the General Assembly repealed the statutory authority for the HCOC effective January 1, 2015. This will be the Committee's final report.

II. Summary of Committee Activities

The Committee met five times during the summer and fall of 2014, hearing from individuals and organizations representing a broad array of perspectives and interests. The Committee developed recommendations on the following topics as provided in this report:

- Vermont Health Benefit Exchange (Vermont Health Connect)
- Vermont Health Care Innovation Project care management inventory
- Choices for Care
- Adult Protective Services
- Medical malpractice reform
- Support and Services at Home (SASH)
- Wellness for Vermonters
- Protecting children from abuse and neglect
- Integrated family services
- Health care reform economic analysis

The Committee heard testimony regarding a number of other topics, including the State Auditor's findings of inadequate consumer information resulting from the Vermont Healthcare Claims Uniform Reporting System (VHCURES), the work of the Green Mountain Care Board, and agency error rates in 3SquaresVT, and urges the committees of jurisdiction to continue to monitor the efforts of State government and others to make progress in these areas as well.

2014 Acts and Resolves No. 179, Sec. E.306.6 directed the Committee, in consultation with the Mental Health Oversight Committee, to recommend whether a single oversight structure is needed to be the successor to the two committees, which are repealed effective January 1, 2015. The Committee's recommendations are included in this report.

(See Appendix 2 for the 2014 Witness List.)

III. Findings and Recommendations

A. Vermont Health Benefit Exchange (Vermont Health Connect)

The Committee received regular updates throughout the summer and fall from the Agency of Administration and the Agency of Human Services about the first year of enrollment and coverage through the Vermont Health Benefit Exchange, known as Vermont Health Connect (VHC). The Committee heard testimony regarding the continuing backlog in addressing enrollees' change of circumstances; the hiring of a new contractor, Optum, to implement improvements to the VHC website; and the Agency's decision to take the VHC web portal offline in the weeks leading up to the November 2014 open enrollment to address security functions and vulnerabilities. In addition, the Committee heard about organizational changes that moved VHC from the Department of Vermont Health Access to the Agency of Human Services and moved the Health Access Eligibility Unit functions related to VHC from the Department for Children and Families and to VHC.

Recommendations

The Committee recommends that the standing committees of jurisdiction continue to monitor VHC operations closely. The committees may also want to consider whether statutory changes are appropriate to align with the organizational changes to VHC within the Agency of Human Services.

B. Vermont Health Care Innovation Project Care Management Inventory

The Committee heard from the Project Director of the Vermont Health Care Innovation Project (VHCIP) (also known as the State Innovation Model (SIM) grant) about a care management inventory the Project developed. The inventory catalogues existing care management activities in Vermont and identifies redundancies, gaps, and opportunities for innovation and coordination in order to address unmet needs, minimize duplication, and improve alignment. The survey showed that the challenges experienced most frequently by care management organizations include difficulties in identifying individuals in need of care management, obstacles in recruiting qualified staff, technical barriers to sharing information between organizations, and challenges with engaging individuals in care management activities.

Recommendations

The Committee found the care management inventory to be a step in the right direction toward improving care management but the Committee recommends that the standing committees of jurisdiction work with VHCIP and others to develop outcome measures in order to determine the number of Vermonters who are in need of care management and the number of Vermonters needing care management who are actually receiving it.

C. Choices for Care

Choices for Care, a Section 1115 Medicaid waiver program, provides patients with a choice between receiving long-term care services in a nursing home or through home- and community-based services. Under Choices for Care, an individual must first meet certain financial eligibility criteria; the person's needs are then evaluated through a clinical assessment and he or she is assigned to a risk group ranging from "Highest Needs" to "High Needs" to "Moderate Needs." The needs determination establishes priority for services, with those in the "Highest Needs" category enrolled as soon as Medicaid eligibility is established. Individuals assigned to the "High Needs" group are enrolled as soon as funds are available to pay for their treatment option. To the extent funds are available, "Moderate Needs" individuals then receive preventive services, such as adult day care, homemaker, and case management services.

While there is no wait for services in the Highest Needs and High Needs Groups, the Committee heard testimony, as it did in 2013, about the waiting lists in the Moderate Needs Group for adult day centers and for homemaker services provided by home health agencies. Concerns were again raised about the current allocation of funds across the State and whether there were a more accurate way to allocate the funds so that there would not be waiting lists for services in some geographic areas while surplus funds went unused in others. One of the reasons that waiting lists frequently exist is due to staff

shortages at the home health agencies, and the availability of services is often based more on staff availability than on client needs. Some of the problem may be ameliorated going forward by a new flexible funding option that allows a client to hire his or her own provider, but it also requires the client to be able to manage the employee or designate a surrogate to do so on the client's behalf. The Committee heard that there are delays in the eligibility determination process for Choices for Care as well, with some applicants waiting as long as six or eight months for a decision on their eligibility for services under the program.

The Committee also heard that a lack of housing and transportation were creating barriers to a robust home- and community-based care system. In particular, the Committee heard that it is difficult to find or retain home health care services or residential care home placements for individuals with mental health needs or challenging behaviors. Adult family care homes are a newer housing option that allows up to two individuals in the Highest and High Need groups to live in a private home owned or rented by a care provider and to receive 24-hour care and support from the provider according to a person-centered plan. While only 18 adult family care homes are currently active, the Department of Disabilities, Aging, and Independent Living (DAIL) is optimistic that they will provide a viable alternative for Choices for Care participants seeking to remain in a home- or community-based setting, and the availability of federal funds from the Money Follows the Person grant for eligible individuals may make adult family care homes a realistic option for more participants in the future.

Recommendations

The Committee recommends that the committees of jurisdiction:

1. Consult with DAIL to determine how to maximize the funding available through the federal Money Follows the Person grant to create an adult family care system that provides a meaningful alternative to nursing homes or residential care homes.
2. Explore establishing consistent training requirements and opportunities for direct care workers who provide services to individuals on Choices for Care, perhaps by establishing licensure or certification or other training requirements.
3. Clarify and simplify the Assistive Community Care Services process to encourage residential care homes to participate.
4. Establish a team from DAIL and the Department of Mental Health that is readily available to providers and advocates to assist them with treatment and placement issues that arise for individuals with challenging behaviors or mental health diagnoses.
5. Determine whether the Department for Children and Families has implemented new home- and community-based services eligibility and enrollment rules in a way that simplifies and expedites the eligibility determination and enrollment process.
6. Ensure that long-term care is included in health care reform, because it represents an important segment of the health care continuum. Direct appropriate

departments and agencies to undertake a demographic analysis to understand the needs of Vermont's aging population in order to build an appropriate system for the future in coordination with Vermont's Health Resource Allocation Plan.

7. Focus on addressing issues relating to housing and transportation for participants in the Choices for Care program.
8. Address the continued imbalance in distribution of funds in the Choices for Care program, in which some regions of the State experience wait lists for services in the Moderate Needs group while others retain unused funds. Both the redistribution of funds and the shortage of direct care workers need attention.

D. Adult Protective Services

DAIL presented two quarterly reports on its Adult Protective Services (APS) program during the summer and fall of 2014. DAIL reported that it had met seven of the eight benchmarks required as the result of a settlement agreement reached last year. The one benchmark not met related to closing financial exploitation cases within 90 days of assignment. DAIL identified financial exploitation as the most common type of exploitation of vulnerable adults, and noted that a family member was typically the perpetrator.

Introduced in the last biennium, S.23, An act relating to access to records in adult protective services investigations, would have provided APS workers and law enforcement with access to financial and medical records when investigating a report of alleged abuse, neglect, or exploitation. The bill passed the Senate in 2014 but was not considered in the House.

Recommendations

The Committee recommends that the committees of jurisdiction review DAIL's quarterly reports on APS in order to monitor DAIL's timely response to reports of abuse, neglect, and exploitation, particularly regarding financial exploitation. In addition, the Committee recommends that the committees of jurisdiction consider legislation similar to S.23, An act relating to access to records in adult protective services investigations, in order to streamline the process for law enforcement and APS workers to obtain relevant medical and financial records for alleged victims of abuse, neglect, or exploitation.

E. Medical Malpractice Reform

The Committee heard testimony regarding implementation of the medical malpractice reforms enacted by 2012 Acts and Resolves No. 171. These measures, applicable to claims based on injuries occurring on or after February 1, 2013, require submission of a certificate of merit prior to filing a medical malpractice lawsuit and the use of

confidential pre-suit mediation. The act directed the Secretary of Administration or designee to report on the impact of the reforms by September 1, 2014. The Administration reported to the Committee that it was too soon to assess the impact of the reforms on the state of medical malpractice in Vermont, both because of the small number of cases that may have been affected by the reforms in the 18 months since the provisions took effect and the lack of data tracking the number of certificates of merit and use of pre-suit mediation. The Administration recommended following up with a retrospective analysis on or after February 1, 2017, which would be one year following the date after which the statute of limitations will have run out for many of the relevant cases. It also suggested measuring rates of cases going to pre-suit mediation and tracking the number of patients unable to access the courts as the result of their inability to obtain a certificate of merit in order to provide quantifiable data to assess the impact of the two reforms.

Recommendations

The Committee recommends that the standing committees of jurisdiction request a retrospective analysis of the certificate of merit and pre-suit mediation reforms on or after February 1, 2017, as recommended in the Administration's report. The Committee also recommends that the standing committees look at other states that have successfully reduced their medical malpractice costs and continue to pursue the cost savings that may be available as the result of medical malpractice reform.

F. Support and Services at Home (SASH)

Support and Services at Home (SASH) is a program for individuals in independent senior living with or at risk for high levels of health care consumption. It links housing and health care for older Vermonters and Vermonters with disabilities with services by connecting nonprofit affordable housing with 65 organizations throughout Vermont, including hospitals, patient-centered medical homes, area agencies on aging, home health agencies, and mental health agencies, and it is affiliated with the Blueprint for Health. SASH acts as a Blueprint "extender" by bringing care coordination into patients' homes. Funding for SASH is through a Medicare demonstration project. As of September 2014, Vermont's SASH program had 3,861 participants, 80 percent of whom were on Medicare. The program receives $70,000 per "panel," each of which can accommodate up to 100 participants. Vermont has the capacity for 54 panels, or 5,400 participants.

SASH has a "no discharge" policy, which means that once a participant is in SASH, he or she will always be in SASH, and if the individual has an acute episode, SASH will help put together a plan to transition that person from the hospital back to his or her home. SASH is tracking the success of its prevention efforts over time, including looking at the number of SASH participants with a primary care physician, having an annual physical exam, and getting a flu shot. These rates appear to have improved over time, while the number of falls experienced by older SASH participants has been reduced. An

independent evaluation commissioned by the U.S. Department of Health and Human Services determined that SASH in Vermont resulted in $1,756 per year in savings on total Medicare expenditures, including $542 per year in savings on acute care expenditures and $1,092 per year in savings on post-acute care expenditures. As the result of its impressive results in Vermont and other states, the Centers for Medicare and Medicaid Services announced in September that it would extend the SASH Medicare demonstration program for an additional two years, through December 31, 2016.

Recommendations

The Committee recommends that the standing committees of jurisdiction support the good work and continued growth of the SASH program as an excellent example of the Blueprint philosophy in action in Vermont. The Committee recommends that the standing committees rely on results-based accountability to ensure that SASH continues to work as intended.

G. Wellness for Vermonters

The Committee heard about the Department of Health's continued efforts to focus on prevention and promote wellness for Vermonters, including its interest in implementing a Health in All Policies approach and undertaking health impact assessments for Vermont.

Health in All Policies is a framework that seeks to improve the health of all Vermonters while advancing the goals of improving air and water quality, protecting natural resources and agricultural lands, increasing availability of affordable housing, improving infrastructure systems, planning economically vibrant and sustainable communities, and meeting the State's climate goals. It means looking at health beyond medical care and integrating health criteria into decisionmaking across multiple sectors. Existing examples in Vermont include the Support and Services at Home (SASH) Program, Community Supported Agriculture (CSA) prescriptions for health, Complete Streets and Safe Speeds legislation, and Healthy Community Design.

In the context of the Public Service Board's investigative docket concerning sound, the Department reports that it has filed a proposed framework for evaluating the potential impact of energy projects on public health. The Department is also monitoring the effect of including health and safety into transportation planning as a result of the Complete Streets and Safe Speeds legislation. Going forward, the Department recommends that agencies and departments of State government use their existing authority to include health in their regulatory, programmatic, and budgetary decisions. In addition, the Department is exploring establishment of a multi-agency Health in All Policies Task Force that would:

1. identify potential opportunities to include health criteria in regulatory, programmatic, and budgetary decisions;
2. develop annual work plans for the agencies and departments represented on the Task Force that would include implementing the opportunities identified;

3. develop analytic tools to support all branches of government in identifying the health impacts of policies and decisions, including ways to enhance positive impacts and mitigate negative impacts; and
4. review promising practices from other jurisdictions to identify opportunities for innovation and coordination across sectors.

A health impact assessment is a tool for implementing Health in All Policies. 2011 Acts and Resolves No. 48 charged the Department of Health with "recommending a plan to institute a public health impact assessment process to ensure appropriate consideration of the impacts on public health resulting from major policy or planning decisions made by municipalities, local entities and State agencies." A health impact assessment is initiated to inform a decision making process in advance. It uses a systematic analytic process and requires input from stakeholders in order to ascertain and respect community values. Then it identifies appropriate recommendations, mitigations, and design alternatives, as appropriate, which generally leads to better decisions. In order to assess the impact of a proposed course of action on public health, the Department says it must determine whether the proposed change will have a positive or a negative impact on health, whether the potential health benefits and risks are distributed equitably, and whether there are ways in which the proposal can be modified to maximize beneficial impacts and minimize harmful ones. The Department hopes to begin a health impact assessment this year and to build the capacity for assessments in State government.

Recommendations

The Committee recommends that the standing committees of jurisdiction continue to monitor the Department of Health's work on wellness programs, including the development of Health in All Policies and health impact assessments. The Committee urges the standing committees to look for demonstrated savings as a result of the Department's initiatives.

H. Protecting Children from Abuse and Neglect

The Committee received updates from the Committee on Child Protection and endorses the work of that committee. In addition, the Health Care Oversight Committee heard from Joe Hagan, M.D., Chair of the Vermont Citizens Advisory Board for the Department for Children and Families (DCF), about the work of his group in the wake of the deaths of two Vermont toddlers whose families were receiving services from DCF. Dr. Hagan also talked about the need for a physician in Vermont hospitals who specializes in child abuse pediatrics. He said his group was looking at the system as a whole and how it can help families. The Board was expecting to deliver a draft report analyzing the fatalities to the Agency of Human Services by October.

Newly appointed DCF Commissioner Ken Schatz told the Committee that in order to protect children from abuse and neglect, the State needs to address other issues related to

poverty, including homelessness, safety net programs, and substance abuse prevention and treatment. The Commissioner said that going forward, particularly serious child abuse cases would be reviewed in consultation with the DCF central office, instead of being addressed solely at the local level. He also told the Committee that Casey Family Programs will be assessing Vermont's child protection system and was expecting to provide DCF with recommendations by the middle of November, particularly with respect to children under three years of age and families in which substance abuse is an issue. In addition, the National Center on Substance Abuse and Child Welfare will be providing technical assistance to DCF on an ongoing basis to help DCF employees with accepting cases, safety planning, monitoring and drug testing, and training staff.

The Committee also heard from Voices for Vermont's Children, which said that the outside advocacy community wants an Office of the Child Advocate for Vermont that would look into cases of child abuse and neglect and monitor the child protection system.

Recommendations

The Committee recommends that the standing committees of jurisdiction review the findings and recommendations of the Committee on Child Protection and the results of the Casey Family Programs assessment. The Committee urges the standing committees to consider how best to recruit a child abuse pediatrician to Vermont, establish an Office of the Child Advocate, identify which entities inside and outside State government are best situated to lead prevention efforts, and determine the appropriate role of the General Assembly in providing oversight. The Committee also recommends that the standing committees consider whether the current emphasis on family reunification is appropriate and whether alternative strategies should be explored in certain circumstances.

I. Integrated Family Services

Interim Secretary of Human Services, Harry Chen, told the Committee that the staff for the Integrated Family Services (IFS) program would be moved so that they all share the same physical space and would also work with staff focused on payment reform in order to accomplish the bundled rates envisioned as part of the IFS model. The first IFS pilot is under way in Addison County, with a second getting started in Franklin County. Carol Maloney, formerly of DCF, has taken over the IFS effort at the Agency of Human Services, and the State's Race to the Top grant from the federal government includes funds to monitor the success of IFS initiatives.

Recommendations

The Committee recommends that the standing committees of jurisdiction continue to monitor IFS implementation, including accessing any available reports on its progress to date.

J. Health Care Reform Economic Analysis

Vermont's Legislative Joint Fiscal Office has contracted with the RAND Corporation for incidence work related to who pays for health care in Vermont. The project will establish a baseline from which further analysis of proposals for health care reform from the Administration and the General Assembly can be evaluated. The RAND Corporation is expected to deliver a draft report in November and a final report in December. Separately, the Agency of Administration has contracted with the Wakely Consulting Group, the Center for Health Law and Economics at the University of Massachusetts Medical School, and Jonathan Gruber, Ph.D., Professor of Economics at the Massachusetts Institute of Technology, to provide actuarial, economic, and related analyses regarding the Administration's financing plan for Green Mountain Care.

Recommendations

The Committee urges the standing committees of jurisdiction to learn from the failures of the Vermont Health Connect contract with CGI in their evaluation of the outcome of the contracts with the RAND Corporation and Dr. Gruber. The Committee recommends that the General Assembly consider establishing specific terms and conditions and procurement standards for State contracts going forward to ensure transparency and improved health outcomes are the standard in all health-related State contracts.

K. Legislative Oversight

The Committee discussed the appropriate role of interim and standing committees in providing oversight of health care and human services issues when the General Assembly is not in session. The Committee recommends that the standing committees of jurisdiction consider:

1. In order to reduce unnecessary duplication, not permitting the standing committees of jurisdiction to meet during the summer and fall and not permitting oversight committees to meet when the General Assembly is in session.
2. Extending the tenure of the Mental Health Oversight Committee until the mental health system of care envisioned by 2012 Acts and Resolves No. 79 is fully implemented in this State.
3. Continuing the Health Reform Oversight Committee through implementation of Green Mountain Care, as established by 2011 Acts and Resolves No. 48.
4. Establishing a Health and Welfare Oversight Committee charged with the oversight of human services and related health care issues, to meet annually during the legislative interim.

2014 Report of the Health Care Oversight Committee to the Vermont General Assembly and the Governor of the State of Vermont

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Senator Ginny Lyons, Chair	*Representative Jill Krowinski, Vice Chair*
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Senator Claire Ayer	*Representative Francis McFaun*
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Senator Kevin Mullin	*Representative Anne O'Brien*
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Senator Michael Sirotkin	*Representative Christopher Pearson*
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Senator Richard Westman	*Representative George Till*

Appendix 1.
Health Care Oversight Committee Charge
2 V.S.A. §§ 851–853

§ 851. CREATION OF COMMITTEE

(a) A Legislative Health Care Oversight Committee is created. The Committee shall be appointed biennially and consist of ten members: five members of the House appointed by the Speaker, not all from the same political party, and five members of the Senate appointed by the Senate Committee on Committees, not all from the same political party. The House appointees shall include one member from the House Committee on Human Services, one member from the House Committee on Health Care, one member from the House Committee on Appropriations, and two at-large members. The Senate appointees shall include one member from the Senate Committee on Health and Welfare, one member from the Senate Committee on Finance, one member from the Senate Committee on Appropriations, and two at-large members.

(b) The Committee may adopt rules of procedure to carry out its duties.

§ 852. FUNCTIONS AND DUTIES

(a) The Health Care Oversight Committee shall monitor, oversee, and provide a continuing review of health care and human services programs in Vermont when the General Assembly is not in session, including programs and initiatives related to mental health, substance abuse treatment, and health care reform.

(b) In conducting its oversight and in order to fulfill its duties, the Committee may consult with consumers, providers, advocates, administrative agencies and departments, and other interested parties.

(c) The Committee shall work with, assist, and advise other committees of the General Assembly, members of the Executive Branch, and the public on matters relating to health care and human services programs. Annually, no later than January 15, the committee shall report its recommendations to the governor and the committees of jurisdiction.

§ 853. MEETINGS AND STAFF SUPPORT

(a) The Committee may meet during a session of the General Assembly at the call of the Chair or by a majority of the members of the Committee. The Committee may meet during adjournment subject to the approval of the Speaker of the House and the President Pro Tempore of the Senate.

(b) For attendance at meetings which are held when the General Assembly is not in session, the members of the Committee shall be entitled to the same per diem compensation and reimbursement for necessary expenses as those provided to members of standing committees under section 406 of this title.

(c) The staff of the Legislative Council and the Joint Fiscal Office shall provide professional and administrative support to the Committee. The Department of Financial Regulation, the Agency of Human Services, and other agencies of the State shall provide information, assistance, and support upon request of the Committee.

Appendix 2.
2014 Witness List

- Senator Claire Ayer, Vice Chair, Mental Health Oversight Committee
- Catherine Benham, Associate Fiscal Officer, Joint Fiscal Office
- Sean Brown, Deputy Commissioner, Department for Children and Families
- Jennifer Carbee, Legislative Counsel, Office of Legislative Council
- Harry Chen, Acting Secretary, Agency of Human Services
- Molly Dugan, Director, Support and Services at Home (SASH)
- Erin Flynn, Senior Policy Advisor, Vermont Health Care Innovation Project
- Andrew Garland, Vice President, MVP Healthcare
- Al Gobeille, Chair, Green Mountain Care Board
- Joe Hagan, M.D., Clinical Professor in Pediatrics, University of Vermont College of Medicine and the Vermont Children's Hospital
- Paul Harrington, Executive Vice-President, Vermont Medical Society
- Dixie Henry, Deputy Secretary, Agency of Human Services
- Doug Hoffer, State Auditor, State Auditor's Office
- Trinka Kerr, Chief Health Care Advocate, Office of the Health Care Advocate
- Stephen Klein, Chief Legislative Fiscal Officer, Joint Fiscal Office
- Andy Lange, Fraud Unit Chief, Department for Children and Families
- Nolan Langweil, Senior Fiscal Analyst, Joint Fiscal Office
- Robin Lunge, Director of Health Care Reform, Agency of Administration
- Erin Maguire, Executive Director of Student Support Services, Chittenden Central Supervisory Union
- Georgia Maheras, Project Director, Vermont Health Care Innovation Project
- Jackie Majoros, Long Term Care Ombudsman, Vermont Legal Aid
- Joyce Manchester, Senior Economist, Joint Fiscal Office
- Katie McLinn, Legislative Counsel, Office of Legislative Council
- David Mickenberg, Lobbyist, COVE
- Lawrence Miller, Senior Advisor to the Governor, Chief of Health Care Reform
- Jill Olson, Vice President of Policy & Legislative Affairs, Vermont Association of Hospitals and Health Systems
- Sheila Reed, Associate Director, Voices for Vermont's Children
- Kenneth Schatz, Commissioner, Department for Children and Families

- Karen Shea, Child Protection & Field Operations Director, Department for Children and Families
- Senator Michael Sirotkin
- Andrew Stein, Special Investigator, State Auditor's Office
- Lindsey Tucker, Deputy Commissioner for the Exchange, Department of Vermont Health Access (DVHA)
- Susan Wehry, Commissioner, Department of Disabilities, Aging & Independent Living
- David Yacovone, (former) Commissioner, Department for Children and Families