

State of Vermont
Agency of Administration

Overview of Vermont's Health Care Reform

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INTRODUCTION

On May 25, 2006, Vermont Governor James Douglas signed into law Acts 190 and 191 (Acts Relating to Health Care Affordability for Vermonters). These Acts, augmented by portions of Act 215 (the Fiscal Year 2007 State Appropriations Act), Act 142 (Establishing a SorryWorks! Program), and Act 153 (Safe Staffing and Quality Patient Care), provided the foundation for Vermont's Health Care Reform Plan.

Together, this comprehensive package of health care reform legislation was based on the following principles:¹

- (1) It is the policy of the state of Vermont to ensure universal access to and coverage for essential health care services for all Vermonters.
- (2) Health care coverage needs to be comprehensive and continuous.
- (3) Vermont's health delivery system must model continuous improvement of health care quality and safety.
- (4) The financing of health care in Vermont must be sufficient, equitable, fair, and sustainable.
- (5) Built-in accountability for quality, cost, access, and participation must be the hallmark of Vermont's health care system.
- (6) Vermonters must be engaged, to the best of their ability, to pursue healthy lifestyles, to focus on preventive care and wellness efforts, and to make informed use of all health care services throughout their lives.

Using these principles as a framework, Vermont's 2006 health care reform legislation contained over 35 separate initiatives designed to simultaneously achieve the following three goals:

- ❖ ***Increase access to affordable health insurance for all Vermonters***
- ❖ ***Improve quality of care across the lifespan***
- ❖ ***Contain health care costs***

It is significant that Vermont's 2006 Health Care Reform Plan was the product of extensive negotiation and collaboration by the Douglas Administration, legislative leaders of the Vermont General Assembly, and the private sector participants in Vermont's health care system. While there were multiple ideas and political agendas as part of the discussions, there is agreement that the final legislation was comprehensive in its breadth and significant in its potential impact on health care in Vermont. There also was a commitment to move forward with implementation in a collaborative, non-partisan manner to maximize its success.

This commitment was confirmed during the 2007 and 2008 legislative sessions when four additional bills were developed collaboratively between the Administration and the legislative health care committees, and signed into law by Governor Douglas. The first, Act 70 of 2007 (An Act Relating to Corrections and Clarifications to the Health Care Affordability Act of 2006 and Related Legislation) makes technical amendments and clarifications to several parts of the 2006 Health Care Affordability Act and related legislation. These included eligibility and operational clarifications for Catamount Health and existing Medicaid programs to ensure smooth implementation and beneficiary transition between these programs; clarifications regarding Catamount Health provider

¹ Act 191, Section 1.

reimbursement methodology and balanced billing; moving the contractual relationship for the state's health information exchange organization (VITL) from the Health Care Administration to the Department of Information and Innovation, and requiring that VITL establish a mechanism to help fund electronic medical records; and changing the treatment of part-time and seasonal employees within the employer contribution assessment.

The second 2007 health care bill, Act 71 (An Act Relating to Ensuring Success in Health Care Reform), focused on policy changes to enhance Acts 190 and 191 of 2006. Act 71 provided a framework for the state's outreach and enrollment efforts; established eligibility for VHAP to be effective the date the agency receives the application rather than at time of eligibility determination; limited premium assistance for Catamount Health plans to the amount of assistance for the lowest priced plan; refined the uses of the Catamount Fund; established a new Blueprint for Health Director exempt position in the Agency of Administration, created integrated medical home pilot projects within the Blueprint, required BISHCA to develop a regulatory approach for Blueprint carrier participation if necessary, and moved the Blueprint statewide implementation deadline from 2009 to 2011; required the secretary of administration to submit an annual legislative report that assesses the alignment between the state employees' health plan and the blueprint; established a work group to study and make recommendations on the advisability of eliminating the requirement that an advance practice nurse work in a collaborative practice with a physician; and required BISHCA to survey health insurers to determine reimbursement for primary care health services, mental health care providers and other non-physician health care providers.

Another comprehensive reform bill was enacted in 2008. Act 203— An Act relating to Health Care Reform - recognized that Act 191 of 2006 started significant new initiatives to transform our health care system but that they that will take years to complete; as such, we must continue to take next steps to focus on increasing access to coverage, to address cost drivers, and to focus on prevention and health care quality. Act 203 refined the new Catamount Health Plans, by allowing people with high deductible plans on the individual market to purchase Catamount Health, allowing people who lose insurance coverage due to reduced work hours to enroll in Catamount and Medicaid expansion plans without a 12 month waiting period, and alleviating some concerns regarding pre-existing conditions within the Catamount Plans by clarifying that pregnancy is not considered a pre-existing condition and providing an amnesty window for pre-existing conditions for people who enroll prior to November 1, 2008. The bill helps small businesses by changing the rule that required small businesses to enroll at least 75% of their employees in order to be able to offer an insurance plan by lowering these criteria to 50% for businesses with ten or fewer employees. Act 203 also gives BISHCA the authority to allow insurance carriers to offer products that are less costly to beneficiaries making healthy lifestyle choices, such as not smoking or participating in a smoking cessation program or exercising and maintaining a healthy weight or participating in a program to lose weight. The Bill also has a number of other provisions that will move our state towards healthier lifestyles and choices – which will benefit both our citizens and our health care costs in the long run. For example, the Health Department will be working with the Vermont Hospitality Council, the American Heart Association and the Food Services Industry to create proposed restaurant menu labeling to inform consumers of healthy nutrition choices, including the presence of trans fats. In addition, the Health Department will be making recommendations on how to make Vermont free of artificial trans fats in prepared foods by 2011. And it directs the commissioner of health to create a workgroup to develop priorities for sharing best practices in worksite wellness and employee health management.

The second bill signed into law in 2008 was Act 204 – An Act Relating to Managed Care Organizations, the Blueprint for Health, and Immunizations of Children Prior to Attending School and Child Care Facilities, and the Immunizations Registry. This Act requires enhances the linkages between insurance plans and the Blueprint for Health by requiring that all health insurance plans available in Vermont be offered, issued and administered consistent with the Blueprint; directing managed care organizations to establish chronic care programs consistent with the Blueprint; and firmly establishes the Blueprint Integrated Medical Home Pilot projects outlined in Act 71 of 2007 with the requirement of a multi-stakeholder Pilot Design and Evaluation Committee and BISHCA enforcement authority over carrier participation, to sunset in July, 2012. Act 204 of 2008 also enhances the state's immunization programs by requiring that all children enrolled in a child care facility have age-appropriate immunizations, and requiring that all immunization data be reported to the Department of Health Immunization Registry (although adult immunization data is note required until providers can submit it electronically).

Vermont Health Care Reform Legislation

■ 2006 Legislation

- Health Care Affordability Acts (Acts 190, 191)
- Common Sense Initiatives (Appropriations Bill)
- Sorry Works! (Act 142)
- Safe Staffing and Quality Patient Care (Act 153)

■ 2007 Legislation

- Corrections and Clarifications to the Health Care Affordability Acts of 2006 (Act 70)
- An Act relating to Ensuring Success in Health Care Reform (Act 71)

■ 2008 Legislation

- An Act Relating to Health Care Reform (Act 203)
- An Act Relating to Managed Care Organizations and the Blueprint for Health (Act 204)



In sum, since the first health care reform bills were signed into law in May 2006, Vermont has been working aggressively to implement and enhance a comprehensive and complex set of legislation to make health care affordable, accessible and of high quality for all Vermonters. In total, over 60 new initiatives are underway to achieve these goals.

BACKGROUND - HEALTH CARE IN VERMONT

Affordable, comprehensive and high quality health care is essential for the well-being of Vermont's citizens, its communities, its employers, and the state as a whole. It also is critical that the efficiency of the healthcare system be addressed so scarce resources can be used in the best manner to sustain, improve and expand health services.

Per capita health care costs are lower in Vermont when compared to the U.S., but the spending gap has been narrowing since 1999. Health care spending growth rates in Vermont have exceeded national averages for each of the last six years, and health care costs were 16.3% of Vermont's gross state product in 2006. ²

<i>Health Care Expenditures Vermont and U.S. (2006)</i>		
	<u>Vermont</u>	<u>U.S.</u>
Total (billions)	\$3.9	\$2,122.5
Per capita	\$6,321	\$7,092
Annual Change (2005-2006)	8.5%	6.8%
Average Annual Change (2003 -2006)	7.8%	7.0%
Share of Gross State/Domestic Product	16.3%	16.0%

While Vermont has been ranked as the 1st or 2nd healthiest state in the nation in 2005 through 2007 ³, access to affordable coverage and quality care continues to be a concern for our citizens. In 2003, the average family premium for health care coverage was \$9,483. In addition, chronic conditions are the leading cause of illness, disability and death, and consume more than three quarters of the \$3.3 billion Vermont spends on health care annually. However, national data indicate that only 55% of individuals with chronic illnesses receive the right care at the right time. In 2002, 84 percent of Vermonters said that a high priority for government should be to ensure that people get the health care they need. ⁴

Vermont has had significant experience using its Medicaid waiver authority to expand coverage for the uninsured. The Dr. Dynasaur program provides Medicaid coverage to all children with household income under 300% FPL, to pregnant women with household income under 200% FPL, and to parents and caretakers with household income under 185% FPL. The Vermont Health Access Plan (VHAP) provides coverage for uninsured adults with household income under 150% FPL and adults with children on Dr. Dynasaur with income under 185%, with no asset test. As a result, in 2005 Vermont had an uninsured rate of 9.8% (61,056) compared with a national rate of 15.7%, and an uninsured rate for children of 4.9%. ⁵

² The 2006 Vermont Health Care Expenditure Analysis can be found at http://www.bishca.state.vt.us/HcaDiv/Data_Reports/expenditure_analysis/2006EAReport.pdf

³ United Health Foundation, 2007


⁴ *Hard Choices in Health Care: What Vermonters Are Thinking. Commission on the Public's Health Care Values and Priorities, BISHCA., 2002.*

⁵ *Vermont Family Health Insurance Survey, 2005. The survey report can be found at http://www.bishca.state.vt.us/HcaDiv/Data_Reports/healthinsurmarket/2005_VHHIS_Final_080706.pdf*

Data from the 2005 Vermont Family Health Insurance Survey on the demographics of the uninsured in Vermont helped focus new policy development. According to the survey, fifty-one percent (51%) of the uninsured in Vermont were estimated to be eligible for a Medicaid program but not enrolled in the program; twenty-seven percent (27%) of the uninsured in Vermont had household income under 300% FPL but were not eligible for a Medicaid program; and twenty-two percent (22%) of the uninsured in Vermont had household income greater than 300% of FPL.

A major health care reform effort failed in Vermont in 1994 due in part to the inability of political leaders to reconcile the goal of covering the uninsured and the goal of containing costs for the insured.⁶ The recent successful health care reform efforts have succeeded in part from a realization by many policy makers that the fundamental goals of health care reform are inter-related: (1) Covering the uninsured will help to lower uncompensated care costs, which affect premiums paid by the insured; (2) Unless health care costs can be brought within a more manageable rate of growth, Vermont will not be able to afford to cover the uninsured; and (3) Public health initiatives and appropriate attention to healthy lifestyles and disease prevention are essential elements of an effective health care reform strategy.

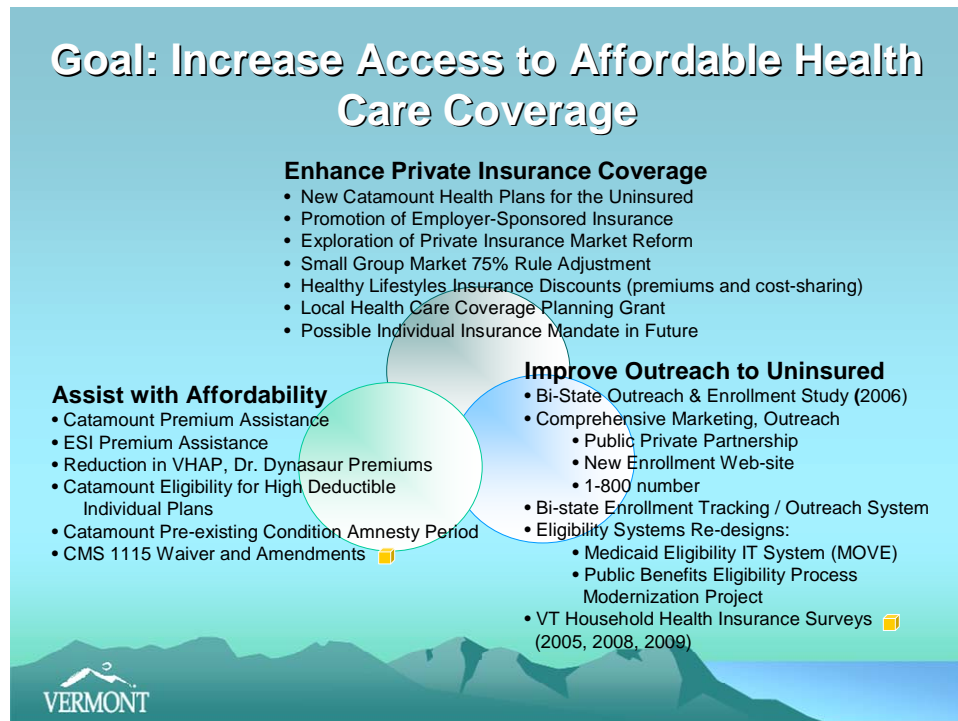


This document describes the goals, strategies, and specific initiatives of Vermont's health care reform. It also includes descriptions of several activities that were in place prior to 2006 that provided the building blocks for these reform efforts, many of which have been enhanced through the reform legislation over the past three years. These are noted by the following symbol: 

⁶ Leichter, *Health Policy Reform in America: Innovations from the States*. 1997.

VERMONT HEALTH CARE REFORM INITIATIVES

GOAL: INCREASE ACCESS TO AFFORDABLE HEALTH INSURANCE FOR ALL VERMONTERS



➤ Enhance Private Insurance Coverage

1. **Catamount Health Plan.** A separate insurance pool was created in the individual market for the purpose of offering a lower cost comprehensive health insurance product for uninsured⁷ Vermonters. The Catamount Health Plan is modeled after a preferred provider organization plan with a \$250 in-network deductible and \$800 out of pocket maximum for individual coverage. Cost sharing is prescribed in statute, and includes a waiver of all cost-sharing for chronic care management and services, and a zero deductible for prescription drug coverage. Lower premium costs as compared to equivalent benefit plans on the individual market were achieved due to estimates concerning the claims costs of the uninsured relative to the claims costs of the general population, and based on provider reimbursement rates established in the law that are lower than commercial rates (but 10%

⁷ *Uninsured means: 1) you have insurance which only covers hospital care OR doctor's visits (but not both); 2) you have not had private insurance for the past 12 months; 3) you had private insurance but lost it because you lost your job or your hours were reduced; got divorced; have or are finishing COBRA coverage; had insurance through someone else who died; are no longer a dependent on your parent's insurance; or graduated, took a leave of absence, or finished college or university and got your insurance through school; 4) you had VHAP or Medicaid but became ineligible for those programs; (5) you have been enrolled for at least six months in an individual health insurance plan with an annual deductible of \$10,000 or more for single coverage or \$20,000 or more for two-person or family coverage; or (6) you lost health insurance as a result of domestic violence.*

higher than Medicare rates). Catamount Health policies began being offered to the uninsured by Blue Cross Blue Shield of Vermont and MVP Health Care on October 1, 2007. The Health Care Reform Commission will review the Catamount Health insurance plans and the Catamount Health Assistance Programs by October 1, 2009 to determine the cost-effectiveness of the program, which may trigger discussions of an alternative approach to achieve the overarching goals of the health care reform.

2. **Promotion of Employer-Sponsored Insurance.** Vermont's health care reform is designed to support and build on our nation's current health care system that primarily relies on employer-based coverage. As such, the new Catamount Health Plan and the associated premium assistance programs were constructed to minimize "crowd-out" from employer coverage, and the funding of the reforms include an assessment on employers that do not offer insurance. For a full description of the premium assistance program, see the section on Assist with Affordability. For a full description of the employer assessment, see the section on Financing.
3. **Market Reform.** A viable non-group market (where premiums are perceived as affordable and where enrollment is stable for all demographic groups without access to employer-sponsored insurance) is an essential component of a well-functioning, all-lines health insurance market. Like many other states, the Vermont non-group market is characterized by declining enrollment, adverse selection, increasing prices, and limited carrier participation. Act 191 of 2006 directed BISHCA to establish a non-group market security trust to lower the cost of health care and thereby increase access to health care for Vermonters. The purpose of this trust was to reduce premiums in the non-group market by a minimum of 5% to make non-group products more affordable for individual Vermonters. In 2006, Vermont was awarded a federal grant from CMS for start-up expenses of a trust, but state funds were required as match. Unfortunately, state funds were not appropriated for this purpose during the 2007 legislative session. As such, the federal grant was returned and no progress was made to lower the costs for Vermonters enrolled in these products.

Act 191 of 2006 also directed the state to study the non-group market and make recommendations to the General Assembly to improve this option for Vermonters. BISHCA contracted with a national expert to conduct the required study and make recommendations for reforms to this market; the report was submitted to the legislature in January, 2007. While some testimony was scheduled on this issue, no legislative action was taken during the 2007 session. However, Act 203 of 2008 requires that the Legislative Health Care Reform Commission study the feasibility of a merger of the nongroup (including Catamount), small group, and association markets by calendar year 2011.

4. **Small Group Market 75% Rule Adjustment.** Act 203 of 2008 changed some aspects of the rule that required small businesses to enroll at least 75% of their employees in order to be able to offer an insurance plan. Now, businesses with ten or fewer employees only need to have 50% of their employees enrolled, and employees with state sponsored coverage do not count against the employer for meeting this rule. It also specifies that insurance carriers can not recertify employee participation more than annually and provides a 120 day grace period after the recertification, if needed, for employers to reach the required participation.

5. ***Healthy Lifestyles Insurance Discounts.*** Vermont is a community-rated state, and therefore costs variations within a specific insurance product are not generally allowed for different populations. However, Act 191 of 2006 authorized the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) to adopt regulations permitting health insurers to establish premium discounts (up to 15% of premiums) or other economic rewards for insured's in Vermont's community rated non-group and small group markets. Premium discounts can be made available for those who participate in programs of health promotion and disease prevention. Act 203 of 2008 expanded the prevue of these rules to include the option for carriers in the small and large group markets to offer split benefit design plans, which would allow a healthy lifestyles differential in cost sharing for the same premium cost. It is hoped that these new options will help make insurance more affordable for individuals and business, improve the health of Vermonters enrolled in these plans, and thereby affect the overall growth in our health care costs in the long run.
6. ***Local Health Care Coverage Pilot.*** Although the state is now engaged through broad health care reform to provide and improve healthcare access and services for all Vermonters, there may be potential for other more localized models to address these concerns. Communities can play a key role in the availability of structures, facilities and services that support healthy behaviors and provide access to care. Act 191 provided funds to support a planning grant of \$100,000 to one community organization or corporation to assist in establishing a local initiative to provide health care coverage or insurance to a community, region or geographic area of the state. This planning grant gave birth to a business plan to develop a technology- focused, community-based, consumer-driven health plan for Southern Vermont, for which capitalization is currently being sought.
7. ***Possible Individual Insurance Mandate.*** Act 191 of 2006 requires that if less than 96% of Vermont's population is insured by 2010, the legislature must "determine the needed analysis and criteria for implementing a health insurance requirement by January 1, 2011 ... including methods of enforcement, providing proof of insurance to individuals, and any other criteria necessary for the requirement to be effective in achieving universal health care coverage."

➤ **Provide Assistance with Insurance Affordability**

1. **Catamount Health Premium Assistance Program.** A Vermont resident who has been uninsured for at least 12 months, who is not eligible for a public insurance program such as Medicaid, and who does not have access to an approved employer-sponsored insurance plan⁸ may apply for financial assistance to purchase a Catamount Health policy at the following rates:⁹

	<u>Prior to July, 2008</u>	<u>As of July 1, 2008</u>
Up to 175% FPL:	\$60 per month	\$60 per month
175-200% FPL:	\$60 per month	\$65 per month
200-225% FPL:	\$90 per month	\$110 per month
225-250% FPL:	\$110 per month	\$135 per month
250-275% FPL:	\$125 per month	\$160 per month
275-300% FPL:	\$135 per month	\$185 per month
Over 300% FPL:	Full cost of the Catamount Health policy (\$393)	

Act 70 of 2007 established uniform state premium assistance for Catamount Health Plans, such that the state share of the Catamount Health premium would always be the difference between the individual's specified contribution and the premium for the lowest-cost Catamount Health plan. Any additional premium amount incurred because an individual chooses to enroll in a higher-cost Catamount Health plan will be borne by the individual.

The statutes and state regulations governing the premium assistance programs and the already existing Medicaid-related programs are designed to create an integrated system of state assistance to better assure the continuity of health care to covered beneficiaries, so that individuals who fall out of one assistance category may transition into another when financial eligibility requirements are met.

2. **Employer Sponsored Insurance (ESI) Premium Assistance Programs.** If cost-effective for the state, both adults currently enrolled in the Medicaid VHAP program and new VHAP applicants who have access to an approved employer-sponsored insurance (ESI) plan¹⁰ are required to enroll in their employer-sponsored plan as a condition of continued

⁸ At minimum, an approved employer-sponsored insurance plan for Catamount ESI Premium Assistance would be required to conform to the following standards: 1) the benefits covered by the plan must be substantially similar to the benefits covered under Catamount Health; 2) appropriate coverage of chronic conditions in a manner consistent with statewide participation by health insurers in the Vermont Blueprint for Health; and 3) after statewide participation is achieved, coverage of chronic conditions substantially similar to Catamount Health.

⁹ Premium assistance was increased to these amounts as of July 1, 2008 due to a downturn in the state's economic environment.

¹⁰ At minimum, an approved employer-sponsored insurance plan for VHAP-ESI Premium Assistance would be required to conform to the following standards: 1) the benefits covered by the plan must be substantially similar to the benefits covered under the certificates of coverage offered by the typical benefit plans issued by the four health insurers with the greatest number of covered lives in the small group and association market in the State, and 2) the plan must include appropriate coverage of chronic conditions in a manner consistent with statewide participation by health insurers in the Vermont Blueprint for Health.

premium assistance or coverage under VHAP. The premium assistance program provides a subsidy of premiums or cost-sharing amounts based on the household income of the eligible individual to ensure that the individual's out-of-pocket obligations for premiums and cost-sharing amounts are substantially equivalent to or less than the annual premium and cost-sharing obligations under VHAP. In addition, supplemental benefits or "wrap-around" coverage is offered to ensure VHAP-eligible enrollees continue to receive the full scope of benefits available under VHAP.

The ESI Premium Assistance Program also makes health coverage more affordable for uninsured low-income Vermonters who are not eligible for Medicaid or VHAP, have incomes under 300 percent FPL, and who have access to approved employer-sponsored coverage. The ESI Premium Assistance Program provides a subsidy of premiums or cost-sharing amounts based on the household income of the eligible individual, with greater amounts of financial assistance provided to eligible individuals with lower household income and lesser amounts of assistance provided to eligible individuals with higher household income. However, if providing the individual with assistance to purchase Catamount Health is more cost-effective to the State than providing the individual with premium assistance to purchase the individual's approved employer-sponsored plan, the State enrolls the individual in the Catamount Health Assistance Program.

3. ***Decreases in VHAP and Dr. Dinosaur Premiums.*** As a result of Act 191, premiums for children enrolled in the Medicaid Dr. Dinosaur program were decreased by 50%; premiums for adults in the Medicaid VHAP program were decreased by 35%. Consideration was given during the 2008 legislative session to increasing these premium amounts due to state economic conditions; however changes were made to the Catamount Health premium assistance amounts instead.

➤ **Improve Outreach to the Uninsured**

1. ***Outreach and Enrollment Study.*** According to a 2005 statewide survey, an estimated fifty-one percent (51%) of the uninsured in Vermont are eligible for but not enrolled in a Medicaid-related program. Act 191 of 2006 tasked the Bi-State Primary Care Association to study and provide recommendations by the end of 2006 on how to improve outreach activities for these individuals. Expanded to also include outreach for the new Catamount Plans, Bi-state formed a broad and inclusive work group to develop the report. The work group's core recommendation was to approach the continuum of uninsured individuals with a continuum of coverage solutions that are comprehensive, consumer friendly, and include both a broad public education campaign and highly targeted assistance aimed at reaching individuals "where they live, work and play." This report provided the framework for our statewide outreach and enrollment efforts.
2. ***Comprehensive, Integrated Marketing and Outreach.*** Act 191 of 2006 called for 96% of Vermonters to have insurance coverage in 2010. The Administration and General Assembly recognize that the goals of Vermont's health care reform will be successful only if marketing and outreach is a priority. The Administration has worked with Bi-State, the private carriers offering Catamount Health Plans, and other Vermont stakeholders to develop a comprehensive marketing strategy across all the coverage and affordability

initiatives. An umbrella brand called Green Mountain Care was created to represent all state-supported programs (Catamount Health Plans, premium assistance programs, Medicaid, VHAP and Dr. Dynasaur). Through a contract with GMMB, a national marketing firm, the State also has implemented an aggressive outreach campaign, including television, radio, internet, and print advertising; developed a new Green Mountain Care web-site with a high level screening tool; augmented an existing toll-free help-line to inform people about and assist them to enroll in Green Mountain Care programs; and conducted trainings around the state with over 2,500 participants. The state also is working with the Department of Labor to conduct outreach to employers and is implementing targeted outreach to 18-34 year olds where they live, work and play.

3. ***Bi-State Enrollment Tracking / Outreach System.*** The Office of Vermont Health Access (OVHA), the state's Medicaid agency, has contracted with Bi-State Primary Care Association to develop a tracking system and deploy staff to follow-up with individuals who have inquired about applying for the programs but have not completed enrollment. Closely integrated with the 800 number, this effort began in August 2008 to assist people who have had difficulty completing the application process. It also will provide the State with crucial information about why interested people decide not to enroll.
4. ***Eligibility Systems Re-designs.*** The Office of Vermont Health Access (OVHA), the state's Medicaid agency, is in the process of implementing a new eligibility determination system and claims processing/payment system. Called the MOVE Project (Modernization of Vermont's Enterprise), the goal is to increase efficiency and provide better support to Medicaid beneficiaries through information technology (IT) systems that are modern, interactive, flexible, responsive and interoperable with other IT systems. It is anticipated that the new eligibility system will be available by mid 2011, and the new claims system will be completed by the end of 2012.

In addition, the Vermont Department for Children and Families (DCF) determines and reviews benefits eligibility for more than 150,000 Vermonters (e.g., state subsidized health care programs, child care and adoption subsidies, food stamps, home heating fuel assistance, reach-up, Lifeline). The way these services are provided has not changed in several decades. In a time when most people have access to a computer, clients must still complete lengthy and often confusing paper applications; then, they must repeat this process (at least annually) when eligibility is reviewed. For these and other reasons, DCF is modernizing the administration of its public benefits programs. The objectives include enhancing client satisfaction and access to services; easing the burden on staff; improving eligibility and payment accuracy; and making the most efficient use of taxpayer dollars. This modernization strategy has two basic components: 1) business-process modifications, which includes replacing a geographically-bound, generalist caseworker model with a function-based, just-in-time production model; streamlining client intake; creating self service options; and a telephone-based client service center; and instituting a performance-centered management culture; and 2) technology investments, aimed at enhancing productivity, expanding access, and multiplying the channels of communication between workers, community partners, and the department (i.e., creating community-based technology centers, online applications and benefits-management tools, and a telephone-based client service center). This modernization project is expected to be completed by early 2010.

5. ***Vermont Household Health Insurance Surveys.*** Since 1997, the Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) has been managing periodic household surveys to monitor the health insurance coverage status of Vermont residents and related demographic, employment and economic characteristics. The data and reporting from these surveys support the efforts of Vermont policy makers, state agencies, providers, payers, planners, researchers and advocates to design and improve programs for covering uninsured Vermonters and for improving access to care. The earlier surveys supported efforts to target outreach for the Vermont Health Access Plan (VHAP) and Dr. Dynasaur. The data from the most recent 2005 Vermont Household Health Insurance Survey provided data on the uninsured in Vermont that were used to develop the recent health care reform policies, and later to marketing and outreach efforts for Catamount Health and state-sponsored programs such as VHAP and Dr. Dynasaur. The survey data also are used in combination with BISHCA's administrative data to monitor trends in the private health insurance market related to employer-sponsored insurance (ESI) and perceptions about out-of-pockets costs and access to care. In the fall of both 2008 and 2009, BISHCA will conduct the survey again to measure the percentage of uninsured Vermonters and to understand the demographics and dynamics underneath insurance coverage categories to help inform our health care reform efforts into the future.

GOAL: IMPROVE QUALITY OF CARE ACROSS THE LIFESPAN

Goal: Improve Quality of Care

Promote Wellness

- Immunizations Programs and Registry
- Healthy Lifestyles Insurance Discounts
- Community Wellness & Healthy Living Plans
- Community Health & Wellness (CHAMPPS) Grants
- Healthy Community Environmental & Policy Strategies
- Healthy Worksite Best Practices Promotion
- Nutrition Guidelines for Schools
- Healthy Choices & Trans Fats Labeling in Restaurants
- Elimination of Artificial Trans Fats in Prepared Foods by 2011
- Healthy Weight thru Primary Care (Pilots & Best Practices)
- Blueprint for Health Prevention Activities
- Catamount Health Plans (no cost-sharing)

Enhance Care for Chronic Conditions

- Blueprint for Health Statewide Chronic Care Initiatives
- Blueprint Multi-payer Integrated Medical Home Pilot Programs
- OVHA Chronic Care Management / Care Coordination Programs
- Mental Health Parity
- Vermont Integrated Services Initiative (VISI) for Co-occurring Disorders
- State Employee Health Plan Alignment, Provider Satisfaction
- Catamount Health Plans (no cost-sharing)

Goal: Improve Quality of Care, cont.

Focus on Transparency / Quality Improvement

- Hospital Report Cards:
 - Quality of Care
 - Infection Rates
 - Nurse Staffing
 - Price and Financial Reports
- Nurse Safe Staffing Data
- Consumer Health Care Price & Quality System
- Patient Safety Surveillance & Improvement System
- Never Events Non-Payment Policy
- Advanced Directives
- Multi-payer Database (VCHURES)
- Academic Detailing Program

Increase Provider Availability

- Loan Repayment Program
- Loan Forgiveness Program
- FQHC / VT Rural Health Alliance Funding
- Dental Dozen Initiative
- Tele-psychiatry Pilot
- Insurer Claims Payment and Prior Authorization Standards
- Studies on Fair Contracting, Restrictive Covenants, and Workers' Compensation Claim Processing
- Provider Reimbursement Surveys
- Nurse Authority Study

Promote Health Information Technology

- VT Information Technology Leaders (VITL)
 - statewide RHIO & Health IT Plan
- Health IT Reinvestment Fund
- Electronic Medical Record Projects
- Blueprint Clinical Tracking Tool
- Medication History Exchange
- E-Prescribing Study
- Master Provider Index

➤ Promote Wellness

1. ***Immunizations Program and Registry.*** Immunizations are one of our nation's most successful and cost-effective public health tools, preventing serious disease in the children and adults who receive immunizations. Act 191 required the Department of Health to begin to implement a process to enable clinically recommended immunizations to be provided to all Vermonters across the lifespan at no cost when not otherwise reimbursed. It also called for the Health Department to identify strategies for improving immunization rates, enhancing access in medical and public health settings, equitable cost sharing between public and private resources, expanding the use of the Adult Immunization Registry, and ensuring the quality of services. The initial stages of this program were implemented in October, 2007. Act 204 of 2008 enhanced the state's immunization programs by requiring that all children enrolled in a child care facility have age-appropriate immunizations, and requiring that all immunization data be reported to the Department of Health Immunization Registry (although adult immunization data is not required until providers can submit it electronically).
2. ***Healthy Lifestyles Insurance Discounts.*** For a description of the initiatives on healthy lifestyles insurance discounts, see the previous section on Enhance Private Insurance Coverage.
3. ***Community Wellness and Healthy Living Plans.*** Act 203 of 2008 significantly enhanced the focus on statewide prevention efforts. For example, this Act directs the department of health to work with communities to develop comprehensive public plans to identify and prioritize community needs relating to wellness and healthy living, including an inventory of existing and needed policy and environmental supports.
4. ***CHAMPPS (Coordinated Healthy Activity, Motivation and Prevention Program).*** Vermont has recognized that public health concerns such as those relating to overweight and poor nutrition are major drivers in the incidence of chronic disease, related morbidity, and health care costs. CHAMPPS provides competitive multi-year grants to communities to assist them in promoting healthy behavior and disease prevention across the lifespan of the individual, consistent with the Blueprint and community goals. Examples include the promotion of good nutrition and exercise for children, community recreation programs, elderly wellness, lead poisoning abatement, obesity prevention, maternal and child health, immunization, and tobacco prevention and cessation programs. Act 203 of 2008 added the requirement that successful grant applications include a plan for ensuring that all food vending machines located in public buildings contain foods and portion sizes consistent with the Vermont nutrition and fitness policy guidelines, and address socioeconomic or other barriers that stand in the way of fit and healthy lifestyles.
5. ***Healthy Community Environmental and Policy Strategies.*** Act 203 of 2008 directs the commissioner of health to work with her state government counterparts in Agriculture, Transportation, Education, Housing and Community Affairs, Forest Parks and Recreation, and the Regional Planning Association to make recommendations on how to strengthen strategies for environmental and policy change within Vermont communities, and how to enhance coordination among exciting programs and funding. The recommended strategies are to focus on promoting physical activity; increasing access to healthy foods; and

promoting physical activity, nutrition and healthy living in planning processes that involve zoning and land use, growth centers, and downtown revitalization. A legislative report on the recommendations is due by January 15, 2009.

6. ***Healthy Worksite Best Practices Promotion.*** The Department of Health has an established worksite wellness workgroup that has developed resources and a web-site ¹¹for employers and business groups statewide; working in partnership with the Governor's Council on Physical Fitness and sports, annually awards worksite wellness awards for model practices and share these practices via the web-site and presentations; and has held a statewide worksite wellness conference to highlight best practice and share wellness program materials, tools and resources. In addition, these activities dovetail with Vermont Department of Labor initiatives such as project WorkSAFE. Act 203 of 2008 augments this work by codifying in statute this workgroup and its activities, and requests that the workgroup specifically explore best practices regarding the use of financial incentives for employers and their employees to focus on wellness, and provide a legislative report on recommendations by January 15, 2009.
7. ***Nutrition Guidelines for Competitive Food and Beverage Sales in Schools.*** A work group that includes the Department of Health, Department of Education, American Heart Association, School Food Service, Vermont Dairy Council and Agency of Agriculture is updating the school nutrition policy guidelines for competitive foods in schools, based on the Alliance for a Healthier Generation and the Institute of Medicine school nutrition standards. Act 203 of 2008 directs the commissioner of education to report on the number of schools complying with the guidelines, and to make recommendations on how to make the guidelines adopted statewide by 2011.
8. ***Healthy Choices and Trans fat Labeling in Restaurants.*** Act 203 of 2008 directs the Department of Health to work with stakeholders to create a proposed restaurant menu labeling to inform consumers of healthy nutrition choices, including the presence of trans fats.
9. ***Elimination of Artificial Trans Fats in Prepared Foods by 2011.*** Act 203 of 2008 also directs the Department of Health to provide recommendations by January 15, 2009 on how to make Vermont free of artificial trans fats in prepared foods by 2011.
10. ***Healthy Weight.*** Focusing on obesity and healthy weight has been a policy and funding priority in Vermont for several years. The Governor unveiled a Fit and Healthy Kids initiative in 2005, and in 2006 the Department of Health issued *Preventing Obesity in Vermont: A Statewide Plan Engaging Individuals, Organizations, Communities, Government and Industry*. This was followed by a toolkit for Promoting Healthier Weight in Primary Care developed by the Department of Health and the Area Health Education centers (AHEC) and the development of the CHAMPPS grants discussed above. Act 203 of 2008 enhanced this focus by directing the department of health to convene a work group to 1) review recommended best practices for treating patient with unhealthy weight in primary care settings, 2) develop a plan for promoting and tracking body mass index in primary care settings, 3) recommend ways that payment policies can encourage stronger relationships between primary care practices and

¹¹ See

public policy regarding the treatment of unhealthy weight, and 4) submit a report on the above by January 15, 2009. It also recognizes the necessary coordination with the Blueprint pilot projects (see Chronic Care Management section below) regarding the treatment of unhealthy weight in primary care settings.

11. ***Blueprint for Health Prevention Focus.*** In 2003, Vermont established the Blueprint for Health, a comprehensive and statewide process of transformation designed to reduce the health and economic impact of the most common chronic conditions. (See the Chronic Care Management section below for a full description of the Blueprint for Health). Recognizing that ultimately, the best “management” of chronic disease comes through prevention, Act 191 of 2006 codified the Blueprint as the state’s plan for addressing chronic care in Vermont, and also added prevention of chronic disease as a primary Blueprint goal. Since that time, the Blueprint has supported the development of community prevention programs in both Blueprint and non-Blueprint communities that reflect local resources and needs. Examples include exercise and walking programs, community walking maps, structured information for patients and providers oriented towards healthy lifestyles, enhanced smoking cessation efforts and others.

Prevention also is an integral component of the new Blueprint Medical Home pilot program (see the Chronic Care Management section below). These pilots are establishing an infrastructure in local communities to integrate care delivery and public health based approaches to prevention. Each Community Care Team (CCT) associated with the Medical Home Pilot program includes a dedicated Prevention Specialist that works out of the local health department office (using pre-existing infrastructure). A Prevention Specialist also is part of new Community Prevention Teams in each of 12 regions of the State, comprised of the Prevention Specialist and existing positions (Health Department District Director and Substance Abuse Prevention Consultant). The Community Prevention Team, working with community members, will: assess the community’s prevention needs based on epidemiological data; assist to identify other resources, including private funding & volunteer contributions; identify community readiness to address prevention needs and service gaps; develop a strategic prevention plan with community specific priorities; implement effective community prevention programs, policies and practices; oversee implementation of CHAMPPS Grants to communities; and, evaluate the efforts for improved wellness outcomes. The Prevention Specialist also will work closely with the CCT members to identify key needs in the community based on patient experiences, and use this information to help design evidence based approaches to prevention.

12. ***Catamount Health Plan Preventative Care.*** The new Catamount Health Plans are required to include coverage, and carriers are required to waive cost-sharing, for preventive care. Preventive care includes immunizations, screening, counseling, treatment and medication determined by scientific evidence to be effective in preventing or detecting a condition.

➤ Enhance Care for Chronic Conditions

1. ***Blueprint for Health - the State's Plan for Chronic Care and Prevention.*** Chronic conditions are the leading cause of illness, disability, and death in Vermont. More than half of all Vermont adults have one or more chronic conditions (e.g., diabetes, hypertension, cardiovascular disease, asthma, arthritis, cancer, respiratory diseases, depression and other mental health disorders, substance dependence and many others). Caring for Vermonters with chronic conditions consumes more than three-quarters of the funds spent in the state each year on health care.¹² As such, Vermont has decided to invest significant public funds in the redesign of our state's health system to improve the quality and cost-effectiveness of preventing chronic conditions and providing care for those with chronic conditions.

Launched in 2003 by Governor James Douglas as a public-private partnership, the Blueprint for Health was fully endorsed in Act 191 of 2006 as Vermont's plan to have a systemic statewide system of care that improves the lives of individuals with, and at risk for, chronic conditions.¹³ The Blueprint model targets six change areas:

- *Individual Vermonters.* Provide structured approaches (e.g., self management workshops) to provide patients with the knowledge, skills and supports needed to actively manage and be responsible for their own care and make healthier choices.
- *Provider Practice Team.* Give providers the training, tools and financial incentives to ensure treatment consistent with evidence-based standards of care.
- *Communities.* Support communities to become engaged in public health at the local level to address physical activity, nutrition, and other behaviors to prevent or control chronic diseases.
- *Information Technology.* Assist providers to have information technology tools to support individual care and population based care management.
- *Health System.* Develop common performance measures and clinical guidelines for chronic conditions, improve systems coordination, and link financing mechanisms and insurance reimbursement with the attainment of chronic care treatment goals.
- *Public Health Systems.* Address the environmental changes essential to supporting individuals, providers, communities and the health system make and sustain the needed changes.

The Blueprint initially focused on diabetes only in two of Vermont's 13 Hospital Service Areas, and expanded to four more in 2007. To enhance the delivery of diabetes care in these areas, the Blueprint provides primary care offices with process improvement and Clinical Microsystems training, expanded use of information technology, and some provider financial incentives for evidenced based care. In addition, the Blueprint has implemented self management workshops and support for community activation and prevention programs statewide (see CHAMMPS above).

A major focus of Act 71 of 2007 was to enhance implementation of the Blueprint. It established a new Blueprint Director exempt position in the Agency of Administration; re-

¹² *It is estimated that in excess of \$2.3 billion was spent on chronic conditions in Vermont in 2002, including approximately \$407 million in Medicaid spending. Vermont Health Care Expenditure Analysis 2002. Vermont Dept. of Banking, Insurance, Securities, and Health Care Administration.*

defined the membership of the Blueprint Advisory Committee; established additional principles for development and implementation of the Blueprint focused on the integral role of primary care providers, information technology, and payment reform; set benchmarks for the Blueprint Director concerning progress in adopting and implementing clinical quality and performance measures, coordination of chronic care management, and sustainable payment mechanisms to achieve Blueprint goals; and established the intent that health insurers participate in the blueprint for health no later than January 1, 2009, that insurers engage health care providers in that transition, and required BISHCA to develop regulations to insure this participation if necessary.

While Act 191 of 2006 required that the Blueprint be implemented statewide by 2009, Act 71 of 2007 changed the deadline for statewide participation to January 1, 2011, but added the requirement that all communities implement at least one component of the Blueprint by January 1, 2009.

2. ***Blueprint Multi-payer Integrated Medical Home Pilot Program.*** Act 71 of 2007 also directed the Blueprint Director to develop three medical home integrated pilot projects that include community-based coordination, chronic care payment reform, and health IT, using shared financial resources and a consistent approach across all major payers. These pilots are being implemented in three hospital service areas between July 2008 and January 2009, with the ultimate goal of systems-level transformation statewide by 2011. The Blueprint medical home model is based on shared and consistent approaches across the state's primary payers (Medicaid, CIGNA, BCBS-VT, and MVP Healthcare) to help primary care providers operate their practices as patient-centered medical homes for all their patients and commonly occurring chronic conditions. Although a detailed discussion of the model is beyond the scope of this document, key components of the pilots include: a) Community Care Teams (CCTs) that provide local multidisciplinary coordinated care support for provider practices and patients, incorporating strategies to enhance patient self management and community prevention efforts; b) financial reform that includes shared costs across payers for the CCTs, and alignment across payers for provider financial incentives linked to agreed-upon patient healthcare goals; c) an advanced web-based clinical information system that supports health maintenance for all patients as well as guideline-based care for patients with the most common chronic health conditions, offers electronic medication prescribing, and interfaces with the state's health information exchange network and existing provider EMRs, if available; d) clinical work flow transformation through provider training and incentives to systematically and consistently support guideline-based care as well as evidence-based improvement; e) nationally peer-reviewed evidence-based process evaluation and improvement; e) integration with broader community prevention efforts, including grants to support community activation and prevention programs; and f) a systematic approach across payers for program evaluation, utilizing claims data to examine health and economic outcomes for patients receiving care in pilot practices (intervention) as compared to demographically and clinically matched patients receiving routine care.
3. ***OVHA Care Coordination Program (CCP) and Chronic Care Management Program (CCMP).*** The Office of Vermont Health Access (OVHA), the state's Medicaid agency, has two programs to help improve the quality of care and quality of life of Medicaid beneficiaries with chronic conditions. OVHA initiated a Care Coordination Program (CCP) in 2006 that

hired state staff to assist primary care providers to address the medical and social needs of Medicaid beneficiaries with the most complex needs (top 2% of enrollees). The CCP team supports providers by offering intensive case management services to the beneficiary and assistance in achieving self-management goals.

To augment this program, Act 191 of 2006 required OVHA to develop a chronic care management program, consistent with the policies and standards established by the Blueprint for Health, through a contract with a private company for the 25% of Vermonters with chronic conditions enrolled in Medicaid, Dr. Dynasaur and VHAP. This new program started on July 1, 2007. The CCMP supports a patient-focused model of care committed to enhanced patient self-management skills and appropriate utilization of healthcare services. The CCMP involves two contracts: (1) the Center for Health Policy and Research (CHPR) at the University of Massachusetts Medical School to provide population selection and program monitoring services, and (2) APS Healthcare Services, Inc., to provide Health Risk Assessments (HRA) and Intervention Services (IVS) to eligible beneficiaries. Disease management services include quarterly newsletters, educational tools and self-management strategies, telephonic access to disease management specialists, and, for those beneficiaries assessed as relatively higher risk, one-on-one support provided by an APS nurse health coach or social worker. Health coaches assist beneficiaries and their health care providers in developing a Plan of Care with individualized health goals. As goals are reached and outcomes achieved, beneficiaries move to a less intense level of services.

4. ***Mental Health Parity.*** The inter-connectedness between mental health and physical health is well documented, and clearly mental health treatment should be an integral part of Vermont's health care reform. This was codified in statute in 2008. While Vermont's mental health parity law, which was passed and signed into law in 1997, continues to be one of the most progressive in the country, legislation was passed in 2008 to enhance the 1997 law, and included the statement that: "It is the goal of the general assembly that treatment for mental health conditions be recognized as an integral component of health care, that health insurance plans cover all necessary and appropriate medical services without imposing practices that create barriers to receiving appropriate care, and that integration of health care be recognized as the standard for care in this state."

Vermont's parity law (including the new provisions) prohibits a health insurance plan from establishing any rate, term, or condition that places a greater burden on an insured person for access to treatment for a mental health condition than for access to treatment for other health conditions. It also requires mental health carve-outs and insurers to comply with expanded rules to be developed by the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA), which must assure that:

- Utilization review does not deter timely and appropriate care, including emergency hospital admissions;
- The portion of an insurer's rate attributable to mental health and substance abuse treatment is reviewed under insurance law to determine whether it is excessive, inadequate, unfair, misleading or contrary to Vermont law;
- The insurer's plan is consistent with the Blueprint for Health with respect to mental health conditions;

- A quality improvement project is completed annually to implement policies and incentives that increase collaboration among providers and facilitate clinical integration of services for medical and mental health conditions; and
- An up-to-date list of active mental health care providers in the plan's network who are available to the general membership is available.

New 2008 provisions require the health insurance plan's revenue loss and expense ratio for mental health and substance abuse treatment to continue to be included in the annual report card filed with BISHCA.

5. ***Vermont Integrated Services Initiative (VISI) for Co-occurring Mental Health and Substance Use Disorders.*** The Vermont Integrated Services Initiative (VISI) is working to 1) increase the integration of the state health, mental health and substance use systems; 2) develop peer led, community based supports for people with co-occurring mental health and substance abuse conditions; and 3) build capacity among service providers to deliver quality integrated services for people with co-occurring conditions. As a framework, the Agency of Human Services (AHS) has developed a policy statement on co-occurring capability within systems of care, and the Department of Mental Health (DMH) and the Division of Alcohol and Drug Abuse Programs (ADAP) have developed a Joint Policy Expectation on screening that is accompanied by a screening User's Guide for Co-occurring screening. To support the implementation of these policies, DMH and ADAP have developed: a two day Training of Trainers event on co-occurring conditions for the first 25 member training cohort that will provide trainings throughout the state; a joint training agenda with dozens of co-occurring trainings held throughout the year; an online E-learning Co-occurring 101 course is available to all AHS staff and contracted providers; a sixty member VISI Forum or "learning community" that helps guide practice change; and a consortium with seven mental health and substance use providers that includes "coaching" from national experts. The VISI also uses a fidelity assessment tool administered annually to establish a baseline and to measure and track practice improvement in serving people with co-occurring mental health and substance use conditions.


Integration with physical health also is a key component of this effort. Three primary care practices are part of the VISI Initiative and two are systematically screening and providing brief interventions and brief therapy for both mental health and substance use conditions. The three Blueprint integrated medical home pilots also are developing a systematic process within these primary care practices to provide screening, brief interventions and brief treatment on co-occurring mental health and substance use issues, and the Community Care Teams are developing relationships with local community mental health and substance use providers to refer patients more seamlessly for long term treatment.

6. ***State Employee Health Benefits Program Alignment with Blueprint.*** The state's self-insured health care plan for employees was required to include alignment with the Blueprint as a component of the contract re-bid process in 2006. To ensure this alignment, Act 71 of 2007 required the secretary of administration to submit an annual report to the legislature that assesses the alignment between the state employees' health plan and the Blueprint; reports on the results of a provider satisfaction survey (designed in consultation with health care professional and trade associations, VDH and Blueprint Director) to assess whether the state employees' health plan vendor has an adequate network and compensation

agreements to align with the Blueprint goals; and, if the secretary determines that provider satisfaction levels are creating a barrier to successful implementation of the Blueprint, includes an action plan for improving provider satisfaction. It also authorized health care professional and trade associations to obtain a list of bidders for the state employees' health care plan, to submit information about the business practices of the bidders for the secretary to consider, and to request meetings with the secretary to discuss the information. In addition, the Secretary of Administration is required to hold annual discussions with health care professional and trade associations regarding provider regulation, reimbursement and quality of care.

7. ***Catamount Health Plan Chronic Care Programs.*** The Catamount Health Plans are required to have a chronic care management programs, and to waive cost-sharing for chronic care for individuals participating in chronic care management. The BCBS-VT Catamount Health Plan has chronic care management programs for anxiety disorder, asthma, bipolar disorder, chronic obstructive pulmonary disease, diabetes, heart disease, major depression, post-traumatic stress disorder, schizophrenia, and substance abuse. The MVP Catamount Health Plan has chronic care management programs for asthma, cardiac care, depression, diabetes, and low back pain.

➤ Focus on Transparency / Quality Improvement

1. ***Hospital Report Cards.***  In 2003, the Vermont Legislature passed Act 53, "An Act Relating to Hospital and Health Care System Accountability, Capital Spending, and Annual Budgets." One of the requirements of Act 53 is that Vermont hospitals publish annual hospital community reports containing information about quality, hospital infection rates, patient safety, nurse staffing levels (see below), financial health, costs for services, and other hospital characteristics. The law also required the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) to publish some of that same information in a comparative format on its website¹⁴.

The comparative hospital data regarding quality of care on the BISHCA web site includes heart attack care, heart failure care, pneumonia care, infection reporting (surgical complication prevention, surgical site infection rates, prevention and control of drug-resistant infections, prevention of central line associated blood stream infections and central line associated bloodstream infection rates), nurse staffing,¹⁵ and volume and mortality for selected procedures (Esophageal Resection, Pancreatic Resection, Abdominal Aortic Aneurysm Repair, Coronary Artery Bypass Graft, Percutaneous Transluminal Coronary Angioplasty, Pediatric Heart Surgery, and Carotid Endarterectomy). The BISHCA website also contains comparative hospital data on patient satisfaction, and pricing and financial reports, including pricing (gross charges) of top inpatient admissions, outpatient surgical cases, and outpatient diagnostic procedures; hospital budget and financial information, hospital financial investments, cost shift related to hospital budgets, and hospital financial health benchmarks and indicators.

¹⁴ See

www.bishca.state.vt.us/HcaDiv/HRAP_Act53/HRC_BISHCAcomparison_2007/index_BISHCA_HRC_compar_me nu_2007.htm

¹⁵ The nurse staffing and infection rate data were added as a requirement of Act 191 of 2006.

2. ***Nurse Staffing Data.*** Act 153 of 2006 specifically mandated that hospital information about nurse staffing levels be included in the Hospital Report Cards available on the BISHCA web-site (see above). As such, data on nursing care hours per patient day are now included for each hospital. In addition, Act 153 required that direct care nurse to patient ratios per shift in each unit be made available to patients and the public. This information is now posted on hospital units and is available to the public.
3. ***Consumer Health Care Price and Quality Information System.*** Consumer knowledge about the price and quality of health care products and services is directly related to improving quality of care and hopefully controlling health care costs. It is also especially important as more benefit plans require higher levels of out of pocket spending. As mandated by Act 191 of 2006, BISHCA has adopted rules effective October 2008 that require health insurers to file Consumer Information Plans that describe how they will provide transparent price and quality information so that their members are empowered to make economically sound and medically appropriate decisions. The Consumer Information Plans required by this rule will describe how the insurers will provide their members with information about quality of care; prices for common procedures, medications, equipment, and supplies; as well a free care and discount policies. For hospital quality and price information, insurers must provide a link to or information about the BISHCA Hospital Report Card web-site by October, 2008 (see above). Using a phased-in approach, by January 2013, insurers must describe in their Consumer Information Plans how they will provide members with price information on selected procedures and services provided by individual physicians or physician practices and other health care providers (e.g., chiropractors, mental health, dental, physical therapy), prescription drugs, durable medical equipment, and medical supplies. By January 2011, insurers must describe in their the Consumer Information Plans how they will provide quality information on physicians , using NCQA recognition and other nationally recognized or Commissioner-approved quality measures. By January 2013, insurers must describe in their Consumer Information Plans how they will provide quality information on other health care providers in addition to physicians, and how they will report price and quality information jointly in a way that provides information on relative value of procedures and services.
4. ***Patient Safety Surveillance and Improvement System (Adverse Event Reporting).*** Act 191 of 2006 authorized the Vermont Department of Health (VDH) to develop a Patient Safety Surveillance and Improvement System, designed to be used within Vermont hospitals to improve patient safety, eliminate adverse events, and support quality improvement efforts. Hospitals must track adverse events and analyze the causes, with protections for patient confidentiality and peer review, and they must report to patients or family when an adverse event causes death or serious bodily injury. Currently, all Vermont hospitals are reporting the national 28 National Quality Forum (NQF) events (also called “Never Events”) to the VDH Patient Safety Program via a secure electronic reporting system, and are also submitting Root Cause Analysis (RCA’s) and Action Plans following each reportable event to the VDH Patient Safety Program. Patient Safety Program staffs also are conducting routine and periodic monitoring and focused compliance reviews at Hospitals. Information on hospital adverse events eventually may be reported to the public on an annual basis through the Hospital Community Report Cards (see above).

5. ***Never Events Non-payment Policy.*** Although not in legislation, Governor Douglas and the Vermont Association of Hospitals and Health Systems (VAHHS) announced in January 2008 that all Vermont hospitals will adopt a uniform policy to not seek payment from patients or insurers for hospital care resulting in eight certain rare but serious adverse events as defined by the National Quality Forum (NQF). The eight events include: surgery on wrong body part, surgery on wrong patient, wrong surgical procedure, air embolism-associated injury, medication error injury, artificial insemination/wrong donor, retention of foreign object, and incompatible blood-associated injury. Vermont was the third state in the nation to take this voluntary step. Hospitals are working to implement the policy and expect that it will be in place by late fall of 2008.
6. ***Advanced Directives.*** Act 191 of 1 2006 enhanced Vermont's Advanced Directives statutes by requiring health care providers to notify the registry and submit a copy of any amendments, suspensions, and revocations about which it knows. It also clarified that an advance directive can specify who can and cannot bring probate court action and the probate court must honor this. The law is also applied to "procurement organizations" as appropriate.
7. ***Multi-payer Data Collection Project - VCHURES.*** Health care providers, hospitals, insurers and the state need a comprehensive health information system in order to improve the quality and cost-effectiveness of the health care system. Modeled after programs in Maine and New Hampshire, Act 191 of 2006 authorized BISHCA to design the data collection program and to begin program implementation for a multi-payer claims database that will provide integrated claims and eligibility data collection and reporting across payers and providers. This database is expected to be fully populated with an initial data set for all commercial payers, by January 2009. VHCURES will include claims for Vermont Medicaid and Medicare enrollees pending approval of the Centers for Medicare and Medicaid Services.
8. ***Academic Detailing.*** Studies show that physicians are often unable to readily obtain unbiased information about cost effective prescription drugs. Counter-detailing is intended to provide unbiased information regarding lower cost alternatives to expensive new therapies. Such efforts, if successful, could reduce the dramatic rate of increase in spending on pharmaceuticals. Passed in 2007, Act 80 limits the use of certain doctor-identifiable prescription information for the marketing and promotion of prescription drugs. Several private plaintiffs filed a lawsuit against the Attorney General challenging the constitutionality of portions of Act 80; this pending lawsuit has caused some portions of the bill to be delayed, including the fee that would pay for counter detailing. Act 203 of 2008 provides the University of Vermont Office of Primary Care (which includes the Area Health Education Center- AHEC) the authority and funding to start operating a counter-detailing project to provide information on generic prescription drugs to physicians, pharmacists, and others while the law is proceeding thorough the legal process. It also requires the Department of health and the office of Vermont Health Access (OVHA) to collaborate with AHEC to notify prescribers about expiration dates for brand-named drugs.

➤ Statewide Health Information Technology

1. ***Vermont Information Technology Leaders.*** Vermont, like many other states, municipalities, businesses and organizations, recognizes the many benefits of health information technology, and we have taken significant steps to increase its utilization across the state. As a public-private partnership, the state's health care reform efforts financially support the Vermont Information Technology Leaders (VITL), a private non-profit organization, as the entity to develop the statewide, integrated, electronic health information infrastructure for the sharing of health information among health care facilities, health care professional, public and private payers, and patients.¹⁶ Act 191 of 2006 also required that VITL develop a State Health Care Information Technology Plan to address issues related to data ownership, governance, and confidentiality and security of patient information.¹⁷
2. ***Health Information Technology Reinvestment Fund.***¹⁸ Vermont, like other states, has struggled to find a way to fund health IT efforts and ensure its sustainability in future years. During the 2008 Legislative session, a new Health Information Technology Fund was established in the state treasury to be used for health care information technology programs and initiatives such as those outlined in our Vermont Health Information Technology Plan. The Fund is financed through an assessment of 0.199 of one percent of all health insurance claims for Vermont members, beginning with quarterly payments in November, 2008. The Fund, which is administered by the Agency of Administration, must be used for the development of programs and initiatives designed to promote and improve health care information technology, including:
 - A program to provide electronic health information systems and practice management systems for primary care practitioners in Vermont, such as the Electronic Health Record Pilot Program currently offered by Vermont Information Technology Leaders (VITL);¹⁹
 - Financial support for VITL to build and operate the health information exchange network;²⁰
 - Implementation of the Vermont Blueprint for Health information technology initiatives and the advanced medical home project;²¹ and
 - Consulting services for installation, integration, and clinical process re-engineering relating to the utilization of healthcare information technology such as electronic medical records.

Entities seeking funds must submit an annual expenditure plan and quarterly expenditure reports that are reviewed by the Joint Legislative Commission on Health Care Reform and approved by the Secretary of Administration. In addition, the Secretary of Administration is required to submit an annual report on the receipts, expenditures, and balances in the health IT-fund to the Joint Legislative Fiscal Committee and the Joint Legislative Commission on

¹⁶ For more information about VITL, go to: www.vitl.net

¹⁷ The plan can be found at www.vitl.net/interior.php/pid/7

¹⁸ For more information, go to www.hcr.vermont.gov/improve_quality/healthcare_IT_fund

¹⁹ See <http://www.vitl.net/right.php/pid/6/sid/50>

²⁰ See <http://www.vitl.net/>

²¹ See <http://healthvermont.gov/blueprint.aspx> and <http://www.vitl.net/interior.php/pid/6/sid/29>

Health Care Reform by October 1 of each year. Grants for the first year of projects will be awarded in October, 2008.

Vermont takes very seriously the fact that a new fee assessment creates an additional burden on our health care resources. This fund was created with the expectation that the use of the funds will produce benefits that outweigh this burden in terms of increased quality of care and a reduction in the overall costs within our health care system. To be good stewards of these funds, it is imperative that we routinely assess the value of this investment. As such, the October 1 report from the Secretary of Administration also must include information on the results of an annual independent study of the effectiveness of programs and initiatives funded through the health IT-fund, with reference to a baseline, benchmarks, and other measures for monitoring progress and including data on return on investments made. An RFP for an Independent Study vendor was issued in June 2008, and a contract is expected to be signed in November 2008. The State intends to use the results of the Independent Study to inform its future policy decisions with respect to the allocation of Health IT Funds, and the need for continuation of the fund in future years.

3. ***Electronic Medical Record Pilot Project.*** Act 71 of 2007 required VITL to develop a pilot program to assist provider practices to employ Electronic Health Records. The pilot project was funded by \$1 million in voluntary contributions from Blue Cross Blue Shield of Vermont, CIGNA, MVP Health Care, the Office of Vermont Health Access (OVHA), and the Community Grant Foundation of the Vermont Association of Hospitals and Health Systems. Under the pilot project, grants to cover 75% of the cost to employ an HER system (up to \$45,000 per provider FTE) were made to five practices (with a total of 18 full-time equivalent clinicians). Since it is difficult for physician practices to evaluate the large number of EHR systems on the market, VITL reviewed information from 27 vendors of electronic health records systems and produced a list of six pre-screened products that met VITL's criteria in functionality, service and support, technology, the vendor's vision for the future, and the company's ability to execute that vision. The VITL Pre-Screened EHR Product List served as a source of basic research and helps practices with the selection process. VITL is also assisting physician practices with evaluating systems to determine which one best meets their needs. Once a system is chosen, VITL provides assistance with negotiating contracts with vendors.

To increase the likelihood of successful EHR system adoption, VITL also is using a clinical transformation process to support the adoption and use of electronic information. Specifically, this process is designed to build the foundation of more efficient practice by analyzing and improving processes and workflows, understanding the patients served, maximizing the potential of the staff, and unifying the organization under the common purpose of improving care delivery through the use of technology. Once the basics of clinical process improvement are mastered, the technology is layered on to achieve the end goal.

4. ***Blueprint Clinical Tracking Tool.*** Even with the efforts of the Electronic Medical record (EMR) Projects, the expense and complexity of an EMR installation means that it is likely that many physicians may not be ready to embrace them. To address this gap, beginning in 2008, the Blueprint for Health will offer primary care providers a web-based clinical information system that has many but not all of the functions of a complete EMR. It

supports high quality health maintenance as well as guide-line based care for patients with the most common chronic health conditions helping to avoid the medical expense that is associated when these conditions are not well controlled. This system also supports electronic medication prescribing, which is nationally recognized as a priority to improve healthcare and reduce the chance of medical errors. In addition, the system includes a flexible reporting tool that supports population management. It also will serve as a bridge that helps providers to transition from a paper-based practice and prepare to use a complete EMR. During 2008 and 2009, this web-based clinical information system will be offered to between 170 and 200 primary care providers in a broad range of practice settings, including solo and small practices and Federally Qualified Health Centers that deliver care to lower socioeconomic populations. The Blueprint will work with providers to help them transition their clinical work flow to the use of advanced health information technology. The Blueprint and VITL will work together to optimize use of the system as part of VITL's health information exchange network.

5. ***Medication History Exchange.*** VITL has developed a Medication History Service to provide comprehensive medication histories for patients who consent at three Vermont hospital emergency departments. If a patient gives consent (and over 90% have), physicians and other clinicians in Emergency Rooms are able to electronically access a list of all the medications a patient has taken in the past 12 months. With the medication history report, clinicians have a more complete medication history than relying on patients to accurately recall all the medications they are taking. This gives clinicians better information to base treatment decisions on, reduces duplicate medications, and lowers the number of adverse drug events. It also assists hospitals in completing medication reconciliation, a key quality improvement step. The goal is to eventually expand it to all emergency departments in the state, as well as integrate it into health information exchange within other health care settings.
6. ***E-Prescribing Study.*** E-prescribing is an efficient tool that can save the health care system time and resources and decrease errors. However, there also are a number of complexities involved in implementing such a system statewide. Act 203 of 2008 directs the staff of the legislative commission on health care reform and VITL to study the feasibility of statewide implementation of e-prescribing and provide a report by January 15, 2009.
7. ***Master Provider Index for Vermont Health Care Professionals.*** Act a 191 of 2006 charged a work group of the Area Health Education Centers (AHEC) Program of the University of Vermont College of Medicine was charged with developing recommendations about how to create a master provider index for information technology referencing purposes. Such and index is now being deployed as part of VITL's health information exchange network.

➤ Increase Provider Availability

1. ***Loan Repayment Program.*** Recognizing the need to attract and retain providers in underserved specialties and geographic areas, a new program was established in 2006 (and has been increased each year) to fund loan repayments for Vermont health care providers and educators who have outstanding loans, with the agreement that they will serve patients enrolled in Medicare, Medicaid, or other state health benefit plans. The program, administered by the Area Health Education Centers (AHEC) Program of the University of Vermont College of Medicine, targets Vermont's most rural and underserved regions and is available to primary care practitioners, dentists, nurses, and nurse educators/faculty. In 2008, awards under this program totaled \$1,420,000 to 249 healthcare professionals.
2. ***Loan Forgiveness Program.*** Funds also have been appropriated for an existing loan forgiveness program administered by the Vermont Student Assistance Corporation (VSAC) for dental hygienists and nurses, specialties that hard to recruit and retain in Vermont.
3. ***FQHC / Vermont Rural Health Alliance Funding.*** Located in high-need areas, Federally Qualified Health Centers (FQHCs) are not-for-profit health care practices that have a mission to provide primary care regardless of their patients' ability to pay or insurance status. FQHCs provide care to people of all ages with services including comprehensive primary and preventive care, 24-hour coverage, obstetrical and gynecological care, dental care, mental health and substance abuse services, pharmacy, laboratory and other ancillary services, and enabling services such as case management, translation services, and transportation. FQHCs are governed by a Board composed of at least 51 percent consumer/patient Directors who reflect the demographic and socioeconomic mix of the health center's patient panel. FQHCs are supported by patient fees and private insurance, Medicaid and Medicare reimbursement, federal grants, and private philanthropy. Vermont's six federally-funded FQHCs provide care to over 64,000 Vermonters (1 in 10) with 28 sites in eight of Vermont's fourteen counties; however there are many more medically disenfranchised Vermonters living in counties without FQHC access. Act 71 of 2005 included the goal "to ensure there are FQHCs in each county in Vermont." Act 191 of 2006 included funds to assist with this effort.

In addition, a new organization, the Vermont Rural Health Alliance (VRHA), was developed in 2007 by Bi-State Primary Care Organization in partnership with the Vermont Department of Health (VDH) state Office of Rural Health & Primary Care and the federal Office of Rural Health Policy (ORHP). VRHA provides a vehicle to allow Vermont's rural health centers, clinics, and small hospitals to work collaboratively to be involved in Vermont's health care reform efforts. The initial membership of VRHA consists of Bi-State, six Federally Qualified Health Centers, one Federally Qualified Health Center Look-Alike, one Critical Access Hospital and its affiliated Rural Health Clinics, the 11 sites of the Vermont Coalition of Clinics for the Uninsured, the 16 Vermont sites of Planned Parenthood of Northern New England, Vermont's Area Health Education Center (AHEC) network, the Vermont Program for Quality in Health Care (VPQHC), and Vermont Information Technology Leaders (VITL).

VRHA has identified four goal to support its members:

- support participation in the Vermont Blueprint for Health and other quality improvement initiatives;
- optimize Health Information Technology (HIT) and Health Information Exchange (HIE) utilization and effectiveness in accordance with the objectives of the *Vermont HIT Plan*;
- support and enhance outreach and enrollment activities for the Green Mountain Care programs; and
- develop a statewide infrastructure for a health center-owned 340B prescription drug program and tele-pharmacy.

In 2007, Bi-State received federal network planning grant funding top develop VHRA.. Vermont appropriated dollar-for-dollar match funding in FY08 for a federal network implementation grant awarded in 2008, and funding was included in the Blueprint budget for FY09 to assist with health IT efforts within the VHRA network.

4. ***Dental Dozen Initiative.*** Oral health has a direct effect of physical health. Many Vermonters face challenges in receiving appropriate oral health care due to the limited number of practicing professionals, the affordability of services, and a lack of emphasis on the importance of oral health care. Challenges frequently are more acute for low-income Vermonters. Initiated in 2007, the Office of Vermont Health Access (Medicaid) and the Vermont Department of Health have partnered with other stakeholders to develop and implement the following 12 targeted initiatives to improve access to oral health for all Vermonters: 1) ensure oral health exams for school-age children; 2) increase dental Medicaid reimbursement rates; 3) Medicaid reimbursement for primary care physicians for oral health risk assessments; 4) place dental hygienists in all 12 district health offices; 5) selection/assignment of a dental home for children enrolled in Dr. Dynasaur; 6) enhance outreach; 7) Medicaid codes to report missed appointments / late cancellations; 8) automation of Medicaid cap information for adult benefits; 9) loan repayment program for dentist serving low income Vermonters; 10) scholarships for new dentists; 11) incentive grants to expand access to Medicaid beneficiaries; and 12) supplemental payments to dentists serving high volumes of Medicaid beneficiaries.
5. ***Tele-Psychiatry Pilot.*** The use of tele-medicine is a cost-effective way to fill the state's gap in available child psychiatrists. Act 203 of 2008 provided one-time funds to support the launch of a pediatric tele-psychiatry fellowship program that will both bring much needed services to isolated rural communities and will allow Vermont's psychiatrist workforce to grow by 1-2 child and adolescent psychiatrist fellows each year. The program will be conducted through a partnership between the University of Vermont College of Medicine and Vermont's FQHCs.
6. ***Insurer Claims Payment and Prior Authorization Standards.*** Act 203 of 2008 included several provisions addressing the relationship of health care practitioners and insurers regarding payment and processing of claims. The Act limits retrospective denial of paid claims (overpayment recovery) to a period of 12 months after payment of the claim, and insurers must provide 30 days notice to practitioners including an explanation of the reason for the proposed adjustment. It also requires health insurers to pay claims for health care

services if a health care practitioner has received prior authorization from a health insurer, and to provide practitioners with a current list of services and supplies requiring prior authorization and post that list on their websites. In addition, Act 203 establishes standards for payment and processing of claims. Health insurers are required to accept and process claims consistent with the current version of the American Medical Association's (AMA) Current Procedural Terminology (CPT) codes, the Centers for Medicare and Medicaid Services Health Care Common Procedure Coding System (HCPCS), and the National Correct Coding Initiative (NCCI). Any other appropriate guidelines or standards for claim payment require approval by the Commissioner of the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA). This section also prohibits insurers from automatically reassigning or reducing the code level of evaluation and management codes billed for covered services (downcoding) and requires health insurers to publish the name of any commercially available claims-editing software that they use and any custom edits the insurer has added to the software product.

Act 203 also strengthens the authority of BISHCA to enforce the timely payment, claims processing and credentialing laws by allowing the Department to impose administrative penalties on health plans that violate these provisions, and to issue orders requiring the health plan to cease and desist from further violations, and remediate the violation.

7. ***Studies on Fair Contracting, Restrictive Covenants, and Workers' Compensation Claim Processing.*** Act 203 of 2008 also includes three studies to be conducted through workgroups convened by the Vermont Medical Society: fair contracting standards, restrictive covenants, and workers' compensation claims processing. A report on each study is to be presented to the legislature in January, 2009.
8. ***Provider Reimbursement Surveys.*** Act 71 also contained provisions to examine the adequacy of reimbursement rates within specific areas of health care practice in order to understand the impact of reimbursement on access to providers, the cost shift, workforce shortages and recruitment and retention of health care professionals. It required BISHCA to annually survey providers to determine the reimbursement for the 10 most common billing codes for primary care health services, using 90-day-old aggregated data that does not identify provider-specific or facility-specific reimbursement information. It also required BISHCA to conduct a one-time survey of health insurers to determine the reimbursement paid for the 10 most common billing codes for mental health services, and the same for other non-physician health care providers.²²
9. ***Nurse Authority Study.*** Act 71 of 2007 emphasized the essential role of primary care providers within our health delivery system. As one way to enhance this workforce, it required the commissioner of health, the director of the office of professional regulation, and the board of nursing to establish a work group to study and make recommendations on the advisability of eliminating the requirement that an advance practice nurse work in a collaborative practice with a physician. A report on the study was submitted to the legislature in January 2008.

²² The survey reports can be found at: www.bishca.state.vt.us/HcaDiv/Data_Reports/a_data_reports_index.htm


GOAL: CONTAIN HEALTH CARE COSTS



➤ Increasing Access to Insurance and Improving Quality of Care


1. All of the initiatives described above that increase insurance coverage and improve quality of care are expected to have a direct effect on containing Vermont's health care costs. For example, reducing the number of uninsured and underinsured people, increasing the rates paid by public health insurance programs, and assisting enrollment in employer-sponsored insurance programs will reduce the cost shift, which in turn will reduce increases in health care premiums. In addition, the Blueprint and the multiple other efforts related to prevention and chronic care are built on the premise that preventing disease and improving the quality of care for people with chronic illness are effective ways to reduce the overall demand for high-cost treatment services and reduce the growth rate in health care costs throughout the system. Improved quality of care and cost savings also are anticipated from implementation of many other initiatives, including the provision of transparent price and quality information, the adverse events system, and SorryWorks! In addition, there are specific initiatives described below that are aimed at directly decreasing the cost shift and improving administrative efficiencies to control escalating costs.

➤ Health Resource Planning / Oversight

1. **Health Resources Allocation Plan (HRAP).**  In 2003, the Vermont Legislature passed Act 53, "An Act Relating to Hospital and Health Care System Accountability, Capital Spending, and Annual Budgets," which amended the laws concerning the regulation of hospitals and other health care facilities. Among other things, it required the Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA), in consultation with the Agency of Human Services, an Advisory Committee and public hearings, to prepare a four year Health Resource Allocation Plan (HRAP) that identifies Vermont's needs in health care services, programs and facilities; the resources available to meet those needs; and the priorities for addressing those needs on a statewide basis. Act 53 specified that the HRAP must include hospital, nursing home and other inpatient services; home health and mental health services; treatment and prevention services for alcohol and other drug abuse; emergency care; ambulatory care services, including primary care resources, federally qualified health centers, and free clinics; major medical equipment; and health screening and early intervention services. The primary purpose of the HRAP is to serve as a resource document for state policymakers and for those involved in the CON process (see below). However, the purpose of the HRAP also is to provide source material for the public, health care providers and others interested in Vermont's health care system.

The 2005 HRAP²³ is a seven-chapter 433 page document divided into Inpatient, Emergency, and Hospital-based Services; Ambulatory Services; Community-based Services; Other Medical Services; Workforce; Health Care Information Technology; and Certificate of Need Standards. Because they are service-based, the first four chapters all include: a description of the services, facilities and resources; an assessment of current supply and demand; an assessment of needs and priorities; special considerations and findings; recommendations; and, where relevant, a discussion of state policy implications, challenges and opportunities. Each chapter begins with an executive summary of the service and a number of quick facts or data highlights taken from the chapter material. Most chapters have one or several appendices that provide another level of data, reference materials, and/or background on relevant health care initiatives in states other than Vermont. To put the HRAP in context, the chapters are prefaced by a statement of principles built on the Institute of Medicine's six aims, recommended Certificate of Need standards applicable to all services, and brief summaries of the State Health Plan and statewide Community Needs Assessments.

The HRAP must be updated every four years, and BISHCA is in the process of revising the 2005 Plan for 2009. In this process, the plan will be updated with more current data and information, and the goal also is to make it more user-friendly.

2. **Certificate of Need (CON).**²⁴  The Division of Health Care Administration of the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) administers the annual binding budget program for all Vermont hospitals in an effort to monitor and control increases in hospital costs. As part of this process, the Certificate of

²³ The 2005 HRAP can be found at: www.bishca.state.vt.us/HcaDiv/HRAP_Act53/HRAP_index.htm


²⁴ More CON information can be found at: www.bishca.state.vt.us/HcaDiv/CON_main/CON_Main_Index.htm

Need (CON) Program was created in 1979, and amended from time to time by the Legislature, to ensure that health care facilities and services are necessary, non-duplicative, help contain or reduce health care costs, and are distributed fairly throughout the state. Via the CON process, the need, cost, type, level, quality, and feasibility of projects are reviewed and assessed prior to the development of high cost projects, defined as a capital threshold of \$3 million for hospitals and \$1.5 million for non-hospital facilities and services, and by an equipment threshold of \$1 million for hospitals and for non-hospital facilities and services, and by \$500,000 in operating costs for new services not previously offered by the health care facility. However, projects in excess of \$30 million must go through a two-phase CON process: phase one requires applicants first secure a conceptual development phase certificate of need which permits the applicant to make expenditures for architectural services, engineering design services, and any other planning services; phase two requires applicants to secure a certificate of need which permits construction and implementation of programs and services.

Applicants must prove their projects meet seven statutory CON Criteria:

1. The application is consistent with the Health Resource Allocation Plan (HRAP);
2. The cost of the project is reasonable (meaning that the facility can afford the project, the health care system can afford the project, and the project will not result in an undue increase in the cost of health care and that less expensive alternatives do not exist, would be unsatisfactory or are not feasible or appropriate);
3. there is an identifiable, existing, or reasonably anticipated need for the proposed project which is appropriate for the applicant to provide;
4. The project will improve the quality of health care in the state or provide greater access to health care for Vermont's residents, or both;
5. The project will not have an undue adverse impact on any other existing services provided by the applicant;
6. The project will serve the public good; and
7. If the application is for the purchase or lease of new health care information technology, it conforms with the VITL health information technology plan.

Applications are reviewed by BISHCA and supplemented as necessary by applicants through a question and answer process until the application is deemed complete (or certain time periods have passed) and ready for a hearing before the Public Oversight Commission (POC). External persons and organizations may request interested party, amicus curiae, or competing applicant status. The POC hears the matter and issues its recommendations to the Commissioner of BISHCA, who then issues a decision. Decisions may be appealed to the Vermont Supreme Court.

3. **Public Oversight Commission (POC).**  The Public Oversight Commission (POC) was created by the Vermont legislature as part of Act 180 of 1996, which was designed to coordinate the oversight and regulation of health insurers and health care systems. The POC's duties were revised as part of Act 53 of 2003. The purpose of the POC is to represent the interest of the public as it:
 - Review Certificate of Need (CON) applications and make recommendations to the Commissioner;

- Review Hospital Capital Expenditures (one-year plans and four-year projections) and engage in a dialogue with hospitals regarding the Health Resource Allocation Plan (HRAP) and health policy needs of the state;
- Consult with the Commissioner in the periodic updating of the HRAP; and
- Consult with the Commissioner on developing and updating hospital quality and financial measures.

Following their review of each hospital budget and Certificate of Need application, the Commission makes a recommendation on whether to approve them to the Commissioner of BISHCA. The thirteen members of the Public Oversight Commission are appointed by the Governor, with the advice and consent of the Senate. Members are chosen to reflect the broadest sense the various health care needs and the demographic and geographic diversity of the State of Vermont. The Governor appoints one member of the Commission to serve as Chair.

➤ **Change Provider Financial Incentives**

1. ***Blueprint for Health Financial Reform.*** Changing the way that providers are paid for their services is a key component of health care reform. The Blueprint is piloting a shared public - private approach to financial reform that is designed to help practices operate as patient centered medical homes with local care support services. The components of this financial reform include; a) enhanced provider payment based on a how a practice scores against NCQA patient centered medical home (PCMH) standards that is the same for patients insured by a commercial carrier, Vermont Medicaid, and Medicare (subsidized by Blueprint), and, b) financial support for local multidisciplinary care support teams (Community Care Teams) that is shared by commercial carriers, Vermont Medicaid and the Blueprint (subsidizing Medicare).
2. ***Accountable Care Organization Study.*** Building from the Blueprint payment reform for primary care providers, Act 203 of 2008 charged the staff of the Legislative Commission on Health Care Reform to conduct a feasibility study for community-based payment reform and integration of care at the regional level, including a design based on the accountable care organization model (ACO) as described by Elliot Fisher of The Dartmouth Institute for Health Policy and Clinical Practice. The ACO would be a vehicle for enabling a regional health care delivery system composed of key providers of primary and secondary care within a community (including specialist physicians, the local acute care hospital, and other key providers) to foster a shared accountability for both the costs and quality of care of the population they serve. The ACO would have financial incentives to recapture part of the savings realized by operating more effectively, e.g. reducing the volume of questionable surgical procedures, and to avoid future capacity driven growth. The product from the feasibility study will be an assessment of whether there are implementation or policy issues which would make it unlikely that the pilot could be implemented. The product will include an overall recommendation of whether or not to proceed with a pilot at this time, the scope of the pilot, an estimate of the resources required to design and implement the pilot, and options for funding. The feasibility study report is due in January, 2009.

➤ Simplify Health Care Administration

1. ***Vermont Claims Administration Collaborative. Common Claims and Procedures.*** Act 191 of 2006 charged the Vermont Association of Hospitals and Health Systems (VAHHS) to convene a workgroup to identify strategies to simplify the claims administration process, and to lower administrative costs in the health care financing system. The Common Claims workgroup developed strategies in the following five areas:
 - Maximization of electronic claims process
 - Simplification of explanation of benefits and patient bills
 - Pre-Authorization
 - Improving the efficiency of claims adjudication
 - Simplification of workers compensation claims processingAct 191 also required that the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) adopt regulations to implement the work group strategies. Draft regulations were issued in summer 2008 that establish the Vermont Claims Administration Collaborative, an inclusive work group consisting of hospitals, health care professionals, payers, consumers, public health programs and regulators, charged with making recommendations to the Commissioner for the adoption of uniform standards for health insurance claims administration. Specifically, the workgroup is charged with developing standards relating to patient invoices and explanation of benefits forms, member identification cards, claims forms, the use of payment codes, claims submission and processing procedures (including electronic claims processing), and the prior authorization process, to be implemented on or before March, 2010.
2. ***Uniform Provider Credentialing.*** BISHCA was charged with setting a standard form and process to be used by insurers and hospitals for credentialing their providers. The Council for Affordable Quality Healthcare credentialing application form is now being used by health insurers and hospitals that perform credentialing of providers beginning in January, 2007. To better support providers in the process, Act 203 of 2008 reduced the time that health insurers have to complete credentialing of participating physicians to no more than 60 days, once their applications are complete.

➤ Decrease Cost Shift

1. ***Medicaid Provider Reimbursement Increases.*** Medicaid provider underpayments can threaten access to care, and underpayments result in a cost shift to commercial plans that must be paid by commercial health insurance premiums. To begin to address this, appropriations in both 2006 and 2007 increased Medicaid provider reimbursements in the following manner: (i) evaluation and management services were paid at Medicare rates in order to support primary care physician practices; (ii) supplemental payments were provided to dentists with high Medicaid patient counts; and (iii) hospital rates were to be increased annually until the federal upper limit is reached. While increases were provided to hospitals in SFY07 and SFY08, subsequent budgetary constraints have impeded the achievement of the latter goal at this point in time.

2. ***Other Cost Shift Initiatives.*** Individuals and businesses who pay commercial health insurance premiums pay additional premium because of the shifting of costs attributable to the uncompensated care of the uninsured, and attributable to Medicaid and Medicare underpayments. Act 191 of 2006 required the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) to convene a Cost Shift Task Force to make recommendations to the legislature about any changes needed to “ensure that reductions in the cost shift are reflected in a reduction or slower rate of growth both in hospital and provider charges and in private insurance premiums.” As a result of the Task Force recommendations, BISHCA has undertaken several cost shift initiatives, including:
 - Standardizing hospital bad debt and free care policies.
 - Requiring hospitals to account for Medicaid reimbursement increases in their annual budgets established by the Department.
 - Developing procedures to account for changes in uncompensated care and Medicaid reimbursement when the Department approves health insurance rates.
 - Submitting an annual *Vermont Health Care Cost Shift Analysis Report* to the legislature (the first report was submitted in March 2008) ²⁵

3. ***Employer Health Care Contribution Fund.*** The creation of the Employer Health Care Contribution Fund (see below in Financing) to help support the 2006 health reform initiatives was specifically developed based on the principle that employers who do not offer health insurance should help pay for their employees who use health care resources without coverage, thereby contributing to the cost shift.

²⁵ *The report can be found at:*
www.bishca.state.vt.us/HcaDiv/Data_Reports/legislative_reports/2008CostShiftAnalysis.pdf

FINANCING VERMONT'S HEALTH CARE REFORM

Funding for the programs within Vermont's Health Care Reform is based on the principle that everybody is covered and everybody pays.

- ***Catamount Health Fund:*** Acts 191 and the State Appropriations Bill of 2006 established this new fund in Fiscal Year 2007 as a source of funding for the Catamount Health and ESI premium assistance programs, the Immunization Initiative, the Non-Group Market Security Trust, and other uses approved by the General Assembly. Act 71 of 2007 revised the uses of this fund to limit it to the Catamount Health and ESI premium assistance programs, the Immunization Initiative, and the Blueprint for Health, and deleted the previous uses in Act 191 for the non-group health insurance market assistance and transfers to the Medicaid fund.

Sources of revenue include 17.5 % of the new cigarette taxes (see below), the Employers' Health Care Premium Contribution (see below), Catamount Health premium assistance amounts paid by individuals to the State, and other revenues established by the General Assembly.

- ***Increases in Tobacco Product Taxes:***

- A \$.60 per pack increase in the cigarette tax beginning July 1, 2006 and an additional \$.20 per pack increase beginning July 1, 2008.
- A new tax on "little cigars" and roll-your-own tobacco as cigarettes.
- Changes the method of taxing moist snuff to a per-ounce basis and increases tax on July 1, 2008 by 17 cents.

- ***Employers' Health Care Contribution Fund.*** Act 191 of 2006 established an Employer Health Care Contribution Fund to contribute to the Catamount Fund.²⁶ Employers pay an assessment based on their number of "uncovered" employees, using the following guidelines:

- Employers without a plan that pays some part of the cost of health insurance of its workers must pay the health care assessment on all their employees.
- Employers who offer health insurance coverage must pay the assessment on workers who are ineligible to participate in the health care plan (unless the plan is offered to all full-time employees, and the employee is a seasonal or part time worker with coverage elsewhere), and on workers who refuse the employer's health care coverage and do not have coverage from some other source.

The assessment is based on full-time equivalents at the rate of \$91.25 per quarter (\$365 per year), exempting eight FTEs in fiscal years 2007 and 2008, six FTEs in 2009, and four FTEs in and after 2010. The assessment rate will increase annually indexed to Catamount Health Plan premium growth.

- ***Medicaid Global Commitment to Health Waiver.*** In 2005 Vermont entered into a new five year comprehensive 1115 federal Medicaid demonstration waiver designed to: 1) provide the state with financial and programmatic flexibility to help Vermont maintain its broad public health care coverage and provide more effective services; 2) continue to lead the nation in

²⁶ More information can be found at: www.labor.vermont.gov/Default.aspx?tabid=1164

exploring new ways to reduce the number of uninsured citizens; and 3) foster innovation in health care by focusing on health care outcomes. The Waiver program consolidates funding for all of the state's Medicaid programs, except for the new Choices for Care (long-term care) waiver and several small programs (SCHIP and DSH payments for hospitals). It also converts the Office of Vermont Health Access (OVHA), the state's Medicaid organization, to a public Managed Care Organization (MCO). Under this new waiver, the MCO can invest in health services that typically would not be covered in our Medicaid program, and Vermont's Medicaid program has programmatic flexibility to implement creative programs and reimbursement mechanisms to help curb our health care costs.

The State requested an amendment from CMS to include Catamount Health and the employer-sponsored insurance premium assistance programs under the financial umbrella of this waiver. However, CMS only approved use of Medicaid funds up to 200% of FPL. The Governor and the Legislature agreed to use state General Fund to subsidize the premium assistance for individual within the 200% to 300% FPL range, recognizing that many of these individuals cannot afford to purchase full cost insurance on their own.

- ***Savings in the Medicaid VHAP program due to employer-sponsored insurance enrollment.***
- ***State fiscal obligations protected.*** The legislation enables the state Emergency Board to establish caps on enrollment in the Premium Assistance Programs if sufficient funds are not available to sustain the programs. This has not been employed to date.

CONTACTS FOR FURTHER INFORMATION:

Vermont Health Care Reform web-site: www.hcr.vermont.gov

Green Mountain Care web-site: www.greenmountiancare.org

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