

# VERMONT HEALTH CARE REFORM

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2007 ANNUAL UPDATE TO  
2006 FIVE - YEAR IMPLEMENTATION PLAN

Submitted to:

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# HEALTH CARE REFORM BACKGROUND

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## INTRODUCTION

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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 provided the foundation for Vermont's Health Care Reform Plan, 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).

Together, this comprehensive package of health care reform legislation was based on the following principles.<sup>1</sup>

- (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 health care reform 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 legislative session when two additional bills were developed collaboratively between the Administration and the legislative health care committees, and then signed into law by Governor Douglas in June, 2007. The first, Act 70 (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

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<sup>1</sup> Act 191, Section 1.

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 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.

In summary, since the first health care reform bills were signed into law in May 2006, Vermont has been aggressively working to implement and enhance a comprehensive and complex set of legislation to make health care affordable and accessible for all Vermonters. This work will continue into the 2008 legislative sessions and beyond.

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## BACKGROUND – HEALTH CARE IN VERMONT

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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 or 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. <sup>2</sup>

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<sup>2</sup> The 2006 Vermont Health Care Expenditure Analysis can be found at [http://www.bishca.state.vt.us/HcaDiv/Data\\_Reports/expenditure\\_analysis/2006EAREport.pdf](http://www.bishca.state.vt.us/HcaDiv/Data_Reports/expenditure_analysis/2006EAREport.pdf)

<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)	<b>8.5%</b>	<b>6.8%</b>
<b>Average Annual Change (2003 -2006)</b>	<b>7.8%</b>	<b>7.0%</b>
Share of Gross State/Domestic Product	16.3%	16.0%

While Vermont has been ranked as the 1<sup>st</sup> or 2<sup>nd</sup> healthiest state in the nation in 2005 through 2007<sup>3</sup>, access to affordable coverage and quality care continues to be a concern for our citizens. In 2005, the average annual family premium for health care coverage was \$11,420<sup>4</sup>. 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.<sup>5</sup>

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%.<sup>6</sup>

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.<sup>7</sup> The 2006 successful health care reform effort succeeded in part from a realization by many policy makers that the

<sup>3</sup> *United Health Foundation, 2007*

<sup>4</sup> [http://www.meps.abrq.gov/mepsweb/data\\_stats/summ\\_tables/insr/state/series\\_2/2005/tiid1.htm](http://www.meps.abrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2005/tiid1.htm)

<sup>5</sup> *Hard Choices in Health Care: What Vermonters Are Thinking. Commission on the Public's Health Care Values and Priorities, BISHCA., 2002.*

<sup>6</sup> *Vermont Family Health Insurance Survey, 2005. The survey report can be found at [http://www.bishca.state.vt.us/HeaDiv/Data\\_Reports/healthinsurmarket/2005\\_VHHIS\\_Final\\_080706.pdf](http://www.bishca.state.vt.us/HeaDiv/Data_Reports/healthinsurmarket/2005_VHHIS_Final_080706.pdf)*

<sup>7</sup> *Leichter, Health Policy Reform in America: Innovations from the States. 1997.*

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. (3) Public health initiatives and appropriate attention to healthy lifestyles and disease prevention are essential elements of an effective health care reform strategy.

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## OVERVIEW OF FIVE-YEAR IMPLEMENTATION PLAN

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Act 191 assigned responsibility to the Secretary of Administration for coordination of health care system reform among the executive branch agencies, departments, and offices in a manner that is timely, patient-centered, and seeks to improve the quality and affordability of patient care.<sup>8</sup>

As part of this responsibility, the Secretary was required to submit a five-year plan for implementing Vermont's health care system reform initiatives, together with any recommendations for administration or legislation, to the Governor and legislative committees<sup>9</sup> on or before December 1, 2006. The Secretary also was required to report annually to the General Assembly on the progress of the reform initiatives, beginning in January 2007.

There are more than thirty-five separate initiatives contained in the legislation that formed Vermont's 2006 Health Care Reform agenda. All initiatives are in some way related to all three of the health care reform goals: 1) increasing access to affordable health insurance for all Vermonters; 2) improving quality of care across the lifespan; and 3) containing health care costs. These three goals also are all related to each other. To provide a conceptual overlay of these relationships, the 2006 Strategic Plan was organized by the following framework:

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<sup>8</sup> *Sec. 3. 3 V.S.A. § 2222a*

<sup>9</sup> *To the Commission on Health Care Reform, the Health Access Oversight Committee, the House Committee on Health Care, and the Senate Committees on Health and Welfare and on Finance.*

## Goal: Increase Access to Affordable Health Care Coverage

**Assist with Affordability**

- Premium Assistance (ESI, Catamount)
- Reduction in VHAP Premiums

**Improve Outreach to Uninsured**

- Aggressive Marketing
- Dedicated Web-site, 1-800 #
- Application Simplification
- Measure Success and Adjust

**Enhance Private Insurance Coverage**

- Catamount Health Plan for the Uninsured
- Non-Group Market Reform
- Promotion of Employer-Sponsored Insurance
- Local Health Care Coverage Planning Grant

## Goal: Improve Quality of Care

**Increase Provider Availability**

- Loan Repayment Program
- Loan Forgiveness Program
- FQHC Look-alike Funding

**Increase Provider Access to Patient Information**

- Health Information Technology
- Electronic Medical Records
- Master Provider Index
- Multi-payer Database

**Chronic Care Management**

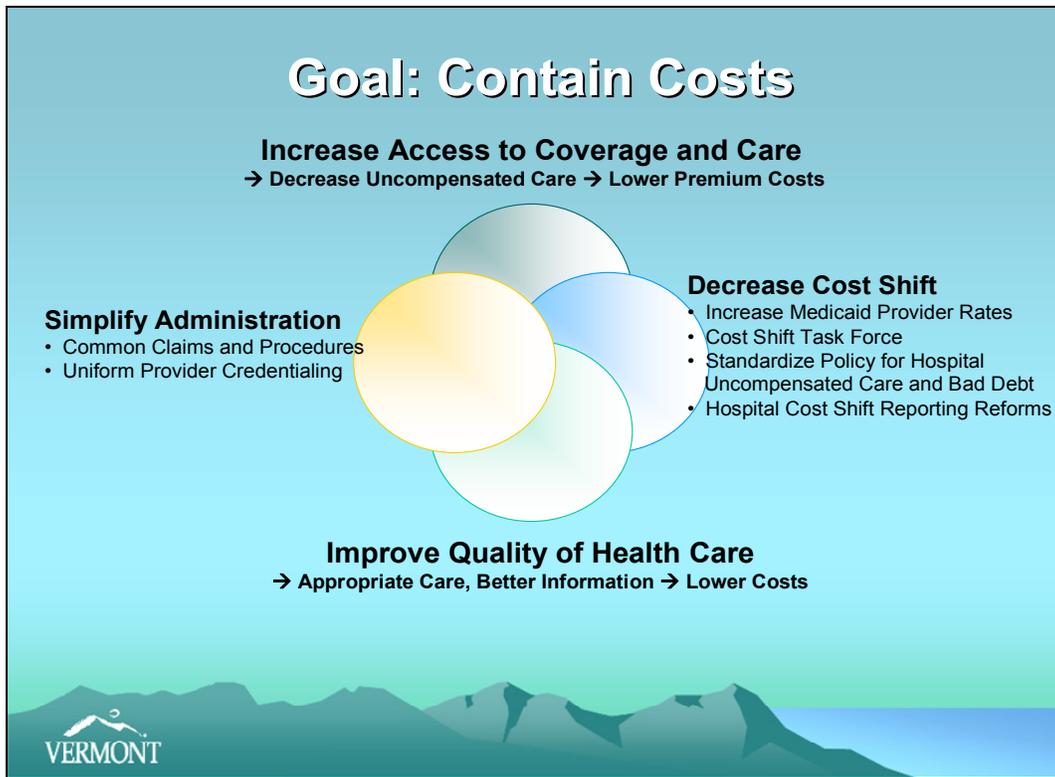
- Blueprint for Health
- OVHA Chronic Care Management Program
- State Employee Health Plan
- ESI Premium Assistance plan approval, cost-sharing
- Catamount Health coverage, cost-sharing
- Care Coordination
- Payment Reforms

**Promote Quality Improvement**

- Consumer Health Care Price & Quality System
- Adverse Events Monitoring System
- Hospital-acquired Infections Data
- Safe Staffing Reporting
- SorryWorks!
- Advanced Directives

**Promote Wellness**

- Immunizations
- CHAMPPS Grants
- Catamount Health Coverage, cost-sharing
- Healthy Lifestyles Insurance Discounts
- AHS Inventory of Health and Wellness Programs



Using this as a conceptual framework, the 2006 five-year plan presented a description of each of the individual health care reform initiatives; the 2011 strategic goal for that initiative; the known milestones associated with achieving the 2011 goal; the lead entity/entities within state government responsible for the milestone<sup>10</sup>, and any statutory changes that the administration believed were needed to assist in achieving the initiative's 2011 goal. It also contained sections on the mechanisms for Financing the Reforms and Health Care Reform Oversight.

This 2007 annual update to the 2006 Five Year Plan includes a status report on the 2006 initiatives, as well as new initiatives contained in Acts 70 and 71 of the 2007 legislative session. Some of the listed milestones and dates are statutorily mandated, while others are items identified by the administration as key to successful implementation. Similarly, this plan will need to be adapted in future years as implementation continues and future administrative and legislative priorities emerge.

<sup>10</sup> In a few instances, a non-state government entity is listed because of statutory authority for a milestone.

# HEALTH CARE REFORM INITIATIVES

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## REFORM GOAL: INCREASE ACCESS TO AFFORDABLE HEALTH INSURANCE FOR ALL VERMONTERS

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### 1. Enhance Private Insurance Capacity

#### 1.1. *Catamount Health Plan.*

Act 191 created a separate insurance pool for the purpose of offering a lower cost health insurance product for uninsured<sup>11</sup> Vermonters. The Catamount Health Plans offer a comprehensive benefit plan, modeled after a preferred provider organization plan with a \$250 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 were anticipated based on estimates concerning the claims costs of the uninsured relative to the claims costs of the general population, and based on reimbursement rates established in the law that are lower than commercial rates (but 10% higher than Medicare rates). Catamount Health policies began to be offered to the uninsured by Blue Cross Blue Shield of Vermont and MVP Healthcare on October 1, 2007, with benefit coverage available starting on November 1, 2007.

Acts 70 and 71 of 2007 included several minor clarifications regarding Catamount Health plan eligibility; codified employer sham provision in state rules to help ensure that employers do not drop insurance to enable employees to enroll in Catamount; disallows balance billing by Catamount participating providers; clarified that provider reimbursement methodology for non-facility health care providers should be equal to the least of contracted rates, billed charges, or the Medicare reimbursement rate plus 10%; and updated rate filing procedure so new carriers can offer Catamount in the future.

By stature (Act 190), 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.

**2011 Strategic Goal:** *Have available an affordable, high quality health care plan for uninsured Vermonters.*

#### **Milestone(s):**

- |   |        |                       |
|---|--------|-----------------------|
| <p>☐ File expedited rules for Catamount Health that include:</p> <ul style="list-style-type: none"> <li>▪ the process for insurance companies to follow re: individuals' dispute regarding Catamount eligibility</li> </ul> | BISHCA | 09/08/06<br>Completed |
|---|--------|-----------------------|

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<sup>11</sup> *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, got divorced, finished with 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; or 4) you had VHAP or Medicaid but became ineligible for those programs.*

	<ul style="list-style-type: none"> <li>▪ the ability for carriers to establish a pay-for performance demonstration project</li> <li>▪ rules for premium rate development</li> </ul>		
☞	Received letters of intent from three carriers (BCBSVT, MVP, CDPHP)	BISHCA	10/07/06 Completed
☞	Carrier Deadline for filing forms and rates (5 months after letter of intent)	BISHCA	03/07/07 Completed
☞	Coordinate with AHS on an aggressive enrollment strategy for Catamount Health and premium assistance	AHS/BISHCA	05/01/07
☞	Approval of Carrier premium rates	BISHCA	09/01/07 Completed
☞	Catamount offer date by BCBSVT and MVP	BISHCA/DCF	10/01/07 Completed
☞	Provide monthly progress reports on Catamount Health	AHS/BISHCA/AoA	Monthly after 01/15/08
☞	Evaluate affordability of Catamount Health Plan benefits and propose recommended changes if necessary	BISHCA/AoA	01/01/09
☞	Report # uninsured; Catamount Health costs & revenue trends, feasibility of opening Catamount at full premium cost, & # enrolled in chronic care management	BISHCA	01/15/09
☞	Evaluate Catamount Health Market re: cost effectiveness	HCR Commission	10/01/09
☞	If legislatively required, issue RFP for Catamount Health without assumption of risk, and with state purchase of stop-loss reinsurance	AoA	01/01/10

### **1.2. Non-group Market Reforms.**

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 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.

Act 191 also 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.

**2011 Strategic Goal:** *The non-group market will have comprehensive products that are affordable for Vermonters, as evidenced by an increased number of available carriers and affordable products in the non-group insurance market.*

**Milestone(s):**

☞ Applied for federal grant to assist with implementation	BISHCA	07/01/06 Completed
☞ Received federal grant to assist with implementation	BISHCA	10/06/06 Completed
☞ Provided recommendations to the Legislature regarding potential reforms for the non-group market	BISHCA	01/15/07 Completed
☞ Implement reforms approved during the 2007 legislative session	BISHCA	07/01/07 None approved during 2007 session
☞ Create Non-group Market Security Trust	BISHCA	07/01/07 Funds not approved during 2007 session
☞ Returned federal grant to assist with implementation	BISHCA	Summer, 2007 Completed
☞ Monitor non-group market performance, and continue to propose adjustments as necessary	BISHCA	On-going

**1.3. 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.

**2011 Strategic Goal:** *Locally based strategies to improve healthcare coverage and access will have been assessed and, if deemed successful, will be more broadly supported.*

**Milestone(s):**

<p>☞ Issued Community Planning Grant RFP to support a feasibility study for providing health coverage or insurance within a specified geographic region</p>	<p>Dept. of Health</p>	<p>09/20/06 Completed</p>
<p>☞ Provides \$100K planning grant to selected grantee</p>	<p>Dept. of Health</p>	<p>01/15/07 Completed</p>
<p>☞ Evaluate results of feasibility study to determine efficacy of local coverage initiative; if determined feasible, develop implementation recommendations for legislative consideration.</p>	<p>Dept. of Health/ Grantee</p>	<p>03/15/08 Final Study Report Available</p>

**2. Provide Assistance with Insurance Affordability**

**2.1. 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 plan<sup>12</sup> may apply for financial assistance to purchase a Catamount Health policy at the following rates:

Under 200% FPL:	\$60 per month
200-225% FPL:	\$90 per month
225-250% FPL:	\$110 per month
250-275% FPL:	\$125 per month
275-300% FPL:	\$135 per month
Over 300% FPL:	full cost of the Catamount Health policy (\$393 per month for individuals)

Act 70 of the 2007 session 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

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<sup>12</sup> *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 (covers physician, inpatient care, outpatient, prescription drugs, emergency room, ambulance, mental health, substance abuse, medical equipment/supplies, and maternity care ; and 2) a maximum individual in-network deductible of \$500.*

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 would be borne solely by the individual.

Acts 190 and 191 intended to create an integrated system of state assistance programs 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 eligibility requirements are met. However, not all of these possible transitions were sanctioned in Acts 190 and 191. Acts 70 and 71 of the 2007 session corrected these technicalities.

**2011 Strategic Goal:** *Uninsured Vermonters with low incomes will have access to Catamount health insurance offerings.*

**Milestone(s):**

<p>☞ Submitted waiver amendment request to CMS to implement Catamount premium assistance program</p>	AHS/OVHA	<p>09/11/06 Request Submitted</p> <p>10/30/07 Approval received for 200% FPL</p>
<p>☞ Established rules for Catamount premium assistance program to include:</p> <ul style="list-style-type: none"> <li>▪ Specific criteria for eligibility</li> <li>▪ Individual and family contribution amounts (adopt amounts specified in Title 33 §1984)</li> <li>▪ Grievance process</li> </ul>	DCF	<p>9/10/07 Rules approved.</p> <p>10/01/07 Rules effective</p>
<p>☞ Implemented Catamount Premium Assistance Program</p>	DCF/OVHA	<p>10/01/07 Completed</p>
<p>☞ Established individual and family contribution amounts; Act 71 of 2007 established premium assistance levels to be at lowest cost plan.</p>	DCF	<p>10/01/07 Rules effective</p>
<p>☞ Initiated aggressive outreach and enrollment strategy for Catamount Health and premium assistance (see 3.1)</p>	Administration	<p>11/01/07 and on-going</p>
<p>☞ Evaluate effectiveness of Catamount Health Plan premium assistance levels and propose recommended changes if necessary</p>	OVHA/BISHCA	<p>01/01/08 On-going None proposed at this time.</p>
<p>☞ Report to legislature on number enrolled and revenues</p>	DCF	<p>Monthly after 01/15/08</p>

<p>☞ Provide to E-board estimates of GC, HCR &amp; Catamount funds for past, current and future fiscal years &amp; estimated monthly caseloads &amp; PMPM for GC, LTC, VT Rx, Catamount Health &amp; premium assistance programs; Emergency Board review of cost compared to available resources; potential decision to suspend new enrollments.</p>	AHS/AoA/F&M	Semi-annually (Jan. & July) Reported at 01/07, 08/07 & 01/08 e-board meetings
<p>☞ E-board decision to support General Fund Appropriation to implement Premium Assistance Program to 300% FPL as planned although CMS approval granted only to 200%FPL.</p>	Emergency Board	08/23/07

## 2.2. *Employer Sponsored Insurance (ESI) Premium Assistance Program.*

If cost-effective for the state, adults currently enrolled in the Medicaid VHAP program and new VHAP applicants who have access to an approved employer-sponsored insurance (ESI) plan<sup>13</sup> are required to enroll in the employer-sponsored plan as a condition of continued 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 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 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 an 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.

Acts 70 and 71 clarified that the use of person’s medical history, medical condition or claims in the cost effectiveness test for VHAP/Catamount Premium Assistance versus ESI is prohibited; limited cost-sharing (or wrap) for Catamount Health eligible individuals receiving premium assistance for ESI coverage to services covered by VHAP that are related to evidence-based guidelines for ongoing prevention and clinical management of the chronic condition specified in the blueprint for health, instead of for all chronic care services; and required open enrollment in ESI plans for people who become eligible for ESI premium assistance.

<sup>13</sup> *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 Catamount Health (covers physician, inpatient care, outpatient, prescription drugs, emergency room, ambulance, mental health, substance abuse, medical equipment/ supplies, and maternity care); and 2) a maximum individual in-network deductible of \$500.*

**2011 Strategic Goal:** *Uninsured Vermonters with low incomes will have access to their employer's health plans.*

**Milestone(s):**

<p>☞ Submitted waiver amendment request to CMS to implement ESI premium assistance program</p>	AHS/OVHA	09/11/06 Request Submitted
		10/30/07 Approval received for 200% FPL
<p>☞ Conducted survey of people currently enrolled in VHAP to assess eligibility for ESI</p>	OVHA/DCF	11/01/06 Completed
<p>☞ Submitted ESI implementation/fiscal report to HAOC and JFC that contained estimated ESI premium, cost-sharing amounts, and wrap benefits, plan for kids, projected FY08 budget impact; enabled expenditures above initial \$250,000</p>	OVHA/DCF	11/22/06 Completed
<p>☞ HAOC/JFC joint meeting to approve expenditure of remaining \$750,000 for implementation of the ESI program</p>	HAOC/JFC	12/12/06 Completed
<p>☞ Initiated aggressive outreach and enrollment strategy for ESI premium assistance (see 3.1)</p>	Administration	11/01/07 and On-going
<p>☞ Group plans to define ESI premium assistance approval as a qualifying event that entitles enrollment within 30 days.</p>	BISHCA	07/01/07 Completed
<p>☞ Established rules for ESI premium assistance programs to include:</p> <ul style="list-style-type: none"> <li>▪ Specific criteria for eligibility</li> <li>▪ Criteria for approving ESI plans for Catamount eligibles– must be consistent with Catamount Health</li> <li>▪ Criteria for approving ESI plans for VHAP eligibles – must be consistent with typical plan of 4 largest small group &amp; association insurers</li> <li>▪ Criteria for assessing cost effectiveness of ESI premium assistance versus VHAP enrollment</li> <li>▪ Criteria for assessing cost effectiveness of ESI versus Catamount Health premium assistance</li> <li>▪ Process for over-payment recovery</li> <li>▪ Grievance process</li> </ul>	DCF/OVHA	09/10/07 Rules Approved  10/01/07 Rules Effective
<p>☞ Implemented ESI premium Assistance Program</p>	DCF/OVHA	10/01/07 Completed

☞ Cost-effective test: ESI with premium assistance versus Catamount w premium assistance	DCF/OVHA	10/01/07 Completed
☞ Cost-effective test: ESI with premium assistance versus VHAP enrollment; Act 70 of 2007 excluded medical history, conditions or claims history from cost effectiveness methodology.	DCF/OVHA	10/01/07 Completed
☞ Administration's decision to not include children in ESI Program.	OVHA	01/01/08 Completed
☞ Administration's decision to not extend ESI Premium assistance to other Medicaid enrollees at this time.	OVHA	01/01/08 Completed
☞ Evaluate effectiveness of ESI premium assistance levels and propose recommended changes if necessary	DCF/OVHA	On-going None proposed at this time
☞ Report to legislature on number enrolled, income levels, description of approved ESI plans, employer cost related to premium assistance program, and net savings of program. <sup>14</sup>	DCF/OVHA	Monthly after 01/15/08
☞ Report to Emergency Board projected ESI premium assistance enrollees and costs.	DCF/OVHA	Reported at 01/07, 08/07 & 01/08 e-board meetings
☞ Emergency Board review of cost compared to available resources; potential decision to suspend new enrollment	E-Board	Semi-annually (Jan. & July)

### 2.3. Eligibility and Premium Changes.

In an effort to make the premiums more affordable within existing Medicaid programs, premiums for children enrolled in the Medicaid Dr. Dynasaur program were decreased by 50% and premiums for adults in the Medicaid VHAP program were decreased by 35%, effective July 1, 2007.

**2011 Strategic Goal:** *All eligible Vermonters will be enrolled in VHAP and Dr. Dynasaur.*

#### Milestone(s):

☞ Report on dis-enrollment in each of the Medicaid programs subject to premiums, with # of beneficiaries terminated from coverage for non-payment <sup>15</sup>	DCF/OVHA	Quarterly Completed
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<sup>14</sup> Report must be submitted to the Health Access Oversight Committee, the Joint Fiscal Committee, and the Health Care Reform Commission.

<sup>15</sup> Report must be submitted to the House and Senate committees on Appropriations, the Senate Committee on Health and Welfare, the House Committee on Human Services, the Health Access Oversight Committee, and the Medicaid Advisory Board.

☞ Reduce premium payments for individuals enrolled in Dr. Dynasaur and SCHIP	DCF	07/01/07 Completed
☞ Reduce premium payments for individuals enrolled in VHAP	DCF	07/01/07 Completed
☞ Increase eligibility recertification or reapplication for Medicaid programs from every 6 months to every 12 months	DCF	05/01/07 Implemented
☞ Change VHAP to reimburse at time of application if the person is eventually found VHAP-eligible.	DCF	2008 Session Proposal to keep current reimbursement process in place.
☞ Report on the cost and benefits of providing coverage for state-funded pharmacy programs from the date of application if the person is eventually found eligible.	DCF	01/15/08 Report submitted

### 3. Improve Outreach to Uninsured

#### 3.1. *Comprehensive Outreach and Enrollment Strategy.*

Act 191 calls for 96% of Vermonters to have insurance coverage in 2010. The Administration and General Assembly recognize that the goals of the 2006 Health Care Reform will be successful only if outreach and enrollment is a priority. Act 191 authorized the Bi-State Primary Care Association to produce a report with recommendations regarding improved outreach and enrollment strategies for Medicaid; the purview of this report was expanded to include Catamount Health at the request of the Administration.

The Administration has worked with Bi-State and other Vermont stakeholders to develop a comprehensive marketing strategy across all the coverage and affordability initiatives. Through a contract with GMMB, a national marketing firm, an umbrella brand called Green Mountain Care was created to represent across all state-supported programs (Catamount Health Plans, premium assistance programs, Medicaid, VHAP and Dr. Dynasaur). The State also has implemented an aggressive outreach campaign, including television, radio, internet, and print advertising; developed a new Green Mountain Care website 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 2,000 participants. OVHA also has contracted with Bi-State to develop a tracking system to follow-up on individuals who have inquired about applying for the programs but have not completed enrollment, and OVHA is developing a proposal to the Centers for Medicaid and Medicare Services (CMS) to receive enhanced federal funding to develop a new enrollment and claims processing system. Act 71 of the 2007 session established principles for outreach and enrollment, and codified many of the system implementations described above that were already planned.

**2011 Strategic Goal:** *More than 96% of Vermonters will have health insurance coverage.*

**Milestone(s):**

☞ Bi-State Primary Care Association Report on outreach and enrollment strategies	Bi-State	11/15/06 Completed
☞ Convened multi-stakeholder steering committee to advise on outreach and enrollment efforts.	OVHA	01/08/07 Completed
☞ Established new web-site and enhanced existing toll-free help line re: enrollment and premium assistance	AHS	10/01/07 Completed
☞ Launched a comprehensive outreach and enrollment strategy across the continuum of solutions for the uninsured, using a unified marketing campaign.	Administration	11/01/07 and on-going
☞ Implement Applicant Inquiry Tracking System.	OVHA/Bi-State	03/15/08
☞ Complete Medicaid Information Technology Assessment (MITA) to submit to CMS for enhanced federal reimbursement for IT system changes	OVHA	05/01/08
☞ Report on insurance coverage to the General Assembly	BISHCA	01/01/10
☞ Using the 2009 survey as a guide, propose new initiatives to increase insurance coverage for Vermonters.	Administration	01/01/10
☞ Legislative decision about individual mandate	General Assembly	2010 Session

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**REFORM GOAL: IMPROVE QUALITY OF CARE  
ACROSS THE LIFESPAN**

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## 4. Improve Chronic Care Management

### 4.1. *Blueprint for Health – the State’s Chronic Care Plan.*

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.<sup>16</sup> 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.<sup>17</sup> The Blueprint model targets six change areas:

- *Individual Vermonters.* People will have the knowledge, skills and supports needed to actively manage and be responsible for his or her own care and make healthier choices.
- *Provider Practice Team.* Vermonters will receive care consistent with evidence-based standards, and their providers will have the training, tools and financial incentives to ensure treatment consistent with those standards.
- *Communities.* Communities will 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.* A Chronic Care Information System, coordinated with the Health Information Technology Plan (see 5.1), will be developed that supports statewide implementation of the Blueprint for both individual and population based care management.
- *Health System.* The Blueprint collaborative will 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.* Health promotion and public policy initiatives, modeled on the successful tobacco control programs, will 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 two Vermont communities, and expanded to four more in 2007. Act 191 required that the Blueprint be implemented statewide by 2009, and that other chronic care initiatives within the reform package (described below) align with the Blueprint priorities and projects.

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-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.

In addition, Act 71 required the Blueprint Director to set up three medical home integrated pilot projects that include community-based coordination, chronic care payment reform, and health IT. These pilots were required to be designed by October 1, 2007, implemented in the first community by January 1,

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<sup>16</sup> 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.

2008, and implemented in one additional community by July 1, 2008. Given this change in direction for the Blueprint, the Act also changed the deadline for statewide participation in the Blueprint from January 1, 2009 to January 1, 2011, but added the requirement that all communities implement at least one component of the Blueprint by January 1, 2009.

Statutes require that the Blueprint have its own Strategic Plan and Annual Report; therefore this Health Care Reform Implementation Plan provides only provides highlights of the proposed Blueprint implementation. More detailed information on implementation of the Blueprint can be found at <http://healthvermont.gov/blueprint.aspx>.

**2011 Strategic Goal:** *Vermont has a systemic statewide system of care that improves the lives of individuals with, and at risk for, chronic conditions, as evidenced by better management of chronic conditions, reduction in the risk factors associated with developing chronic diseases and/or their complications, and reduced growth in health care costs.*

**Milestone(s):**

☞ Established executive advisory committee for five-year plan	Dept. of Health	05/25/06 Completed
☞ Submitted preliminary report on Blueprint organizational structure	Dept. of Health	06/15/06 Completed
☞ Provided incentive grants & stipends to physician practices participating in Blueprint pilots	Dept. of Health	07/01/06 Completed and on-going
☞ Presented interim revised Blueprint strategic plan that included 1/1/07 target for full IT model design	Dept. of Health	10/01/06 Completed
☞ Presented final Blueprint 5-year strategic plan, with a report on implementation status, amendments, and alignment of IT needs with other health care IT initiatives.	Dept. of Health	01/01/07 Completed
☞ Developed AHS implementation plan for prevention and management of chronic conditions	AHS	01/01/07 Completed
☞ Established measures for each of the chronic conditions covered by the Medicaid Chronic Care Management Program; and review for consistency with Medicare.	AoA/Health	07/01/07 Completed and on-going
☞ Established a new exempt position for Executive Director within Agency of Administration	AoA	08/20/07 Completed
☞ Developed an implementation plan to regulate insurers, if necessary, to ensure their implementation of the Blueprint by 01/01/09.	BISHCA	01/01/08 Report Submitted; Permissive Legislation Proposed
☞ Establish risk stratification strategies to identify individuals with or at risk of chronic diseases and stratify care accordingly.	AoA/Health	01/01/08 Under Development

☞ Tie Medicaid reimbursement for hospitals & health care professionals to Blueprint standards and performance standards	OVHA	02/01/08 OVHA participating in integrated pilots
☞ Implementation of first Integrated Project that includes medical homes, community-based care coordination, payment reform, self-management, decision support tools, and development of community resources.	AoA/Health	03/15/08
☞ Provide clinical health information and registry systems for Blueprint providers.	AoA/Health/VITL	03/15/08 In Process
☞ Grant funds to Vermont Rural Health Alliance to participate in the Integrated Projects, upon Alliance receipt of \$185,000 federal grant.	VDH	04/01/08 Funds in budget
☞ Implementation of second Integrated Project site.	AoA/ Health	07/01/08
☞ Expand Blueprint communities and diseases as resources allow	Dept. of Health	07/01/08 and on-going
☞ Develop guidelines for promoting commonality, consistency, and coordination across health insurers in care management programs, in consultation with employers, consumers, health insurers, and health care providers.	AoA/Health	01/01/09
☞ Health insurers report to Secretary of Administration on progress towards alignment of their chronic care management program with the Blueprint.	Health Insurers	01/01/09
☞ Health insurers to report to Blueprint Director on satisfaction levels of providers participating in Blueprint care management programs.	Health Insurers	01/01/09
☞ All communities statewide to have implemented at least one component of the Blueprint.	AoA/Health	01/01/09
☞ Blueprint Director to report to Health Care Reform Commission on recommendations for sustainable payment mechanisms and other needed changes to support achievement of Blueprint goals.	Aoa/Health	01/01/09
☞ Blueprint Director to add at least one measure each year and have measures for all Blueprint chronic conditions by 01/01/2010, and review for consistency with Medicare.	AoA/Health	07/01/10
☞ Statewide Blueprint participation deadline – recommend changes if not achieved	AoA/Health	01/01/11 Changed to 2011 from 01/01/09 – Act 71 of 2007

<p>☞ Provide Annual report to legislature that includes number of participating insurers, professionals and patients; progress toward achieving statewide participation; expenditures and savings; satisfaction results, risk stratification and sustainable payment mechanisms, evaluation of Integrated Pilot implementation.</p>	AoA/Health	Annually 01/04/08 2008 Annual Report Submitted
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#### 4.2. *OVHA Chronic Care Management Program (CCMP).*

Act 191 required that the Office of Vermont Health Access (OVHA), the state's Medicaid agency, develop a Chronic Care Management Program for Vermonters enrolled in Medicaid, Dr. Dynasaur and VHAP, through a contract with a private company and consistent with the policies and standards established by the Blueprint for Health.

**2011 Strategic Goal:** *All Medicaid, Dr. Dynasaur, and VHAP beneficiaries living with a chronic condition will receive health care services that are based on nationally recognized clinical best-practice guidelines for health treatments and self care.*

##### Milestone(s):

☞ HCR Commission approval of RFP before it was issued.	OVHA	10/06/06 Completed
☞ Determination that Medicaid waiver not needed for Chronic Care Management Program.	OVHA/AHS	01/01/07 Completed
☞ Fill 3 new positions for Chronic Care Management Program contract management	OVHA	06/01/07 2 positions filled
☞ Vendor began implementation of Chronic Care Management Program	OVHA	07/01/07 Selected and On-going
☞ Modify program as needed to align with Blueprint	OVHA	01/01/08 and On-going

#### 4.3. *Medicaid Reimbursement Incentives for Participating in CCMP.*

OVHA also was mandated to determine how to restructure payment to health care professionals for chronic care to pay doctors to provide the right care at the right time. They also will provide incentive payments to health care professionals participating in the Medicaid care coordination program; and reimbursement increases in the future will be tied to performance measures established by the Blueprint for Health - the Chronic Care Initiative.

**2011 Strategic Goal:** *Provider reimbursements will facilitate providers' efforts to meet the Blueprint and Chronic Care Management program standards.*

**Milestone(s):**

☒ Develop incentives & payment restructuring for health care professionals participating in care coordination management program	OVHA	07/01/07 <sup>18</sup> Completed
☒ Develop proposals to tie Medicaid reimbursement for hospitals & health care professionals to Blueprint standards and performance standards	OVHA	01/01/09 <sup>19</sup>

**4.4. 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 assessment of 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 authorizes 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.

**2011 Strategic Goal:** *All state employees living with or at risk of developing a chronic condition will receive health care services that are based on nationally recognized clinical best-practice guidelines for health treatments and self care.*

**Milestone(s):**

☒ Ensured that the State Employee Health Benefits Program that began in January 2007 included a Chronic Care Management Program and alignment with the Blueprint principles	DHR	01/01/07 Completed
☒ Ensure that the selected carrier engages in Blueprint leadership committees.	DHR	01/01/07 and On-going

<sup>18</sup> The statutory timeframe for this milestone is 01/01/07; however, the OVHA chronic care management program is not projected to begin until 07/01/07.

<sup>19</sup> The statutory timeframe for this milestone is 07/01/07; however, the Blueprint is not expected to be statewide until 01/01/09. As such, proposals for tying Medicaid provider payments to Blueprint standards should be considered after the Blueprint is statewide.

☐ Conducted survey of providers regarding contractor's adequacy of network and compensation to allow Blueprint alignment.	DHR	01/01/08 Survey completed
☐ Health Care Professional and Trade Associations may request to meet with Administration Secretary to review and discuss provider satisfaction surveys before the Secretary's determination about alignment.	AoA/DHR/Health Care Associations	03/07/08
☐ Report on assessment of alignment between contractor's chronic care management program and Blueprint Strategic Plan, including results of a provider satisfaction survey.	AoA/DHR	03/21/08
☐ Action Plan by the contractor if assessment determines provider satisfaction is creating barriers to alignment.	AoA/DHR/Contractor	04/30/08
☐ Evaluate effectiveness of State Employee Health Benefits program's chronic care management services	DHR	01/01/09
☐ Ensure that the State Employee Health Benefits Program that begins in January 2010 includes a Chronic Care Management Program and alignment with the Blueprint principles	DHR	01/01/10

#### 4.5. *Employer-Sponsored Insurance (ESI) Premium Assistance Chronic Care Coverage.*

Acts 190 and 191 required that ESI plans approved by the state for the premium assistance programs must include chronic care coverage consistent with Blueprint. In addition, the state's premium assistance program will cover all chronic care cost-sharing amounts for beneficiaries enrolled in a Chronic Care Management Program.

Act 71 of 2007 clarified that cost-sharing (or wrap) for Catamount Health eligible individuals receiving premium assistance for employer-sponsored health coverage are limited to services covered by VHAP that are related to evidence-based guidelines for ongoing prevention and clinical management of the chronic condition specified in the Blueprint for health, instead of for all chronic care services.

**2011 Strategic Goal:** *All participants in ESI premium assistance will have access to chronic care treatment.*

#### **Milestone(s):**

☐ Established the criteria to be used to evaluate whether ESI plans have appropriate chronic care coverage	OVHA	09/10/07 Rules Approved
		10/01/07 Rules Effective
☐ Implemented the administrative processes to pay chronic care cost-sharing for beneficiaries enrolled in a Chronic Care Management Program.	OVHA	10/01/07 Completed

#### 4.6. *Catamount Health Plan Chronic Care.*

Carriers offering Catamount Health Plans are required to have a Chronic Care Management Program available to their Catamount health beneficiaries, and must waive cost-sharing for beneficiaries that are actively participating in those Chronic Care Management Programs.

**2011 Strategic Goal:** *All Catamount Health Plans will include Chronic Care Management Programs and those programs will waive cost-sharing for beneficiaries that actively participate.*

**Milestone(s):**

☐ Included requirement in Catamount Health rules	BISHCA	09/08/06 Completed
☐ Catamount Health Chronic Care Management Programs filed with the State (5 months after letter of intent)	BISHCA	03/07/07 Completed

#### 4.7. *Chronic Fatigue Syndrome Informational Packets.*

The Vermont Department of Health was required to prepare and distribute an informational packet to health care providers, and make such information available to the public, to broaden understanding and awareness of this debilitating condition.

**2011 Strategic Goal:** *Vermont health care providers and the general public will have easy and ready access to current information on the diagnosis, treatment, and available resources for Chronic Fatigue Syndrome to improve the quality of life for those affected by this serious and debilitating condition.*

**Milestone(s):**

☐ Put Chronic Fatigue Syndrome information on Department of Health web-site	Dept. of Health	11/01/06 Completed
☐ Informed health care providers of the information available on the web-site through publication of an article in the Disease Control Bulletin.	Dept. of Health	12/30/06 Completed
☐ Used the Vermont Health Alert Network to inform family practice, internal medicine, pediatric and OB/GYN providers of the information available on the web-site.	Dept. of Health	12/30/06 Completed

## 5. Increase Provider Access to Patient Medical Information

### 5.1. *Statewide Health Information Exchange.*

The Health Care Reform financially supports the Vermont Information Technology Leaders (VITL), a public-private partnership, 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. As a first step, the Medication History Pilot Project has been implemented in two pilot areas to reduce the risk of adverse drug events; improve the quality of health care for many Vermonters, and save health care costs. VITL also is the conduit for the Chronic Care Management Information System to support the Blueprint for Health. The 2006 legislation 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.

Act 70 of 2007 moved the contractual relationship for VITL/health information technology from BISHCA to Department of Information and Innovation to better reflect the integration of VITL's work with the broader goal of creating connectivity across all Vermont by the end of 2010.

**2011 Strategic Goal:** *All Vermont providers will be able to share real-time clinical information with other providers across the state to improve patient outcomes, reduce service duplication, and decrease the growth of health care costs, while ensuring patient confidentiality.*

#### Milestone(s):

☞ Secretary of Administration approval of VITL plan to coordinate with Blueprint and delivery of sustainable business plan to Secretary of Administration and Legislature	VITL/AoA	07/01/06 Completed
☞ VITL submission of preliminary Health Information Technology Plan	VITL/BISHCA	01/01/07 Completed
☞ Medication History Project implemented at first two sites - Regional Medical Center and Northeastern Vermont Regional Hospital	VITL	03/01/07 Completed
☞ VITL Contract and reporting relationship changed from BISHCA to Dept. of Information and Innovation	VITL/DII	07/01/07 Completed
☞ VITL submission of final Health Information Technology Plan	VITL/BISHCA	07/01/07 Completed
☞ VITL progress report on health care information technology (HC IT) and EHR Interim Fund and Pilot Program	VITL/BISHCA	Annually 01/10/08 completed
☞ Implementation of first community site - Mt. Ascutney - for the Blueprint Chronic Care Information System (CCIS)	VITL /Dept. of Health	02/08 In Process

☞ Support implementation of simple clinical health information systems for Blueprint and other small providers	VITL	On-going
☞ Assure IT components of Blueprint, OVHA Global Clinical Record, and other HC IT projects are incorporated into and comply with Statewide Health Information Technology Plan (VITL) & DII Initiatives	AHS	On-going
☞ Assure IT components of VPQHC quality assurance system are incorporated into and comply with Statewide Health IT Plan (VITL) and DII Initiatives	VITL	On-going
☞ Continue to expand VITL capacity to develop statewide infrastructure	VITL	On-going

### 5.2. *Physician Electronic Health Information.*

The legislation required that VITL develop a loan and grant program for electronic medical records at primary care practices, and that implementation be a component of the VITL State Health Care Information Technology Plan.

**2011 Strategic Goal:** *All Vermont Health Care providers, hospitals, insurers and the state have access to a comprehensive health information system in order to improve the quality and cost-effectiveness of the state's health care.*

#### Milestone(s):

☞ Establish a loan & grant program for electronic medical records at primary care practices.	VITL	07/01/07 Not yet established
☞ Explore availability of low interest loans through federal or private organizations as complementary or alternative to state funding.	VDH/VITL	07/01/07 Under development
☞ RFI issued to provide computer software or systems or both in connection with a system to enable electronic health records use by pilot sites, and for implementation consulting.	VITL	10/16/07 Completed
☞ VAHHS, OVHA, MVP, BCBS & CIGNA Commitment on Health Information Technology Interim Fund	VITL/AoA	12/01/07 Completed
☞ Announce pre-screened list of EHRs and selected practice for initial pilot sites Electronic Health Record deployment.	VITL	01/31/08
☞ Announce winning vendors for implementing EHRs for selected practices.	VITL	04/28/08

### 5.3. *Master Provider Index for Vermont Health Care Professionals.*

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 to ensure uniform and consistent identification and cross reference of all Vermont health care professionals for information technology purposes.

**2011 Strategic Goal:** *Vermont will have a health technology infrastructure that enables provider cross-referencing to facilitate better health care services and cost effectiveness.*

**Milestone(s):**

☞ Work group convened to make Master Provider Index recommendations	AHEC	09/01/06 Completed
☞ Report to Legislature regarding creation of Master Provider Index	AHEC	01/15/07 Completed

## 6. Promote Wellness

### 6.1. *Free 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, starting October 1, 2007.

Act 70 of 2007 clarified that VDH will not pay for vaccinations for individuals enrolled in Medicaid, VHP, Dr. Dynasaur, or any federal health insurance program covering immunizations.

**2011 Strategic Goal:** *All Vermonters will have access to all ACIP\*-Recommended Immunizations. (Advisory Committee on Immunization Practices of the Centers for Disease Control)*

**Milestone(s):**

☞ Submitted report with recommendations re: methods to ensure universal access to immunizations	Dept. of Health	01/25/07 Completed
☞ Established Immunization Advisory Committee	Dept. of Health	05/01/07 Completed
☞ Implemented two pilots for universal access	Dept. of Health	10/01/07
☞ Submit plan to expand program.	Dept. of Health	02/15/08

### 6.2. *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 incidence and in increased medical inflation. CHAMPPS will provide 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, mental health promotion and substance abuse prevention, maternal and child health and immunization, and tobacco prevention and cessation programs.

**2011 Strategic Goal:** *Comprehensive community prevention grants will support a holistic approach to promoting community health and the prevention of leading causes of disease.*

**Milestone(s):**

☞ Established community grants committee	Dept. of Health	09/01/06 Completed
☞ Submitted report to Legislature on inventory of state wellness initiatives and funding	Dept. of Health /AHS	12/15/06 Completed
☞ Report to Legislature on status of community grants program	Dept. of Health	01/15/07 Completed and Annually
☞ Grants awarded to nine communities.	Dept. of Health	07/01/07 Completed
☞ Expand program as resources allow	Dept. of Health	07/01/08

### 6.3. *Catamount Health Plan Preventative Care.*

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

**2011 Strategic Goal:** *All Catamount Health Plans will include coverage for preventative care and waive cost-sharing related to preventative care.*

**Milestone(s):**

☞ Included requirement in Catamount Health rules	BISHCA	09/08/06 Completed
☞ Ensured that preventative care is incorporated into carrier coverage forms.	BISHCA	03/07/07 Completed

#### 6.4. *Healthy Choices Insurance Discount.*

The Catamount Health legislation 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.

**2011 Strategic Goal:** *Facilitate the implementation of pricing structures in the private health insurance market which will encourage Vermonters to make healthy lifestyle choices and improve overall health quality.*

**Milestone(s):**

☞ Establish draft rules to permit carriers, et. al. to establish wellness rewards for enrollees	BISHCA	03/30/08 Under development
☞ Finalize Rules	BISHCA	09/01/08

## 7. Increase Provider Availability

#### 7.1. *Educational Loan Repayment Program.*

Recognizing the need to attract and retain providers working in underserved areas (specialties or geographic) or with underserved populations, the legislation authorized awards to Vermont health care providers and faculty educators that meet these criteria who have outstanding educational loans, with the agreement that they will serve patients with Medicare, Medicaid, or state health benefit coverage, if applicable.

**2011 Strategic Goal:** *Vermont will have a sufficient number of health professionals in all communities to meet the healthcare access needs of all Vermonters.*

**Milestone(s):**

☞ New fund established to help recruit and retain health care providers and educators in underserved geographic and specialty areas	Dept. of Health AHEC	01/01/07 Completed
☞ Awarded funds to 2007 selected providers	AHEC	01/01/07 Completed
☞ Award funds to 2008 selected providers	AHEC	01/01/08 Completed

### 7.2. *Educational Loan Forgiveness Program.*

The legislation augmented an existing educational loan forgiveness program for dental hygienists and nurses, two specialties that are hard to recruit and retain in Vermont.

**2011 Strategic Goal:** *Vermont will have an adequate supply of dental hygienists and nurses to meet the needs of our population.*

**Milestone(s):**

<input type="checkbox"/> Augment funding for existing educational loan forgiveness program for dental hygienists and nurses	Dept. of Health VSAC	09/15/06 Completed
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### 7.3. *Funds for FQHC Look-alikes.*

Uncompensated care pool funds were designated for an income-sensitized sliding scale fee schedule for patients at FQHC look-alikes to provide equal geographic distribution of funds.

**2011 Strategic Goal:** *Vermont will have a FQHC look-alike or FQHC in every county.*

**Milestone(s):**

<input type="checkbox"/> Funded FQHCs look-alikes to develop income-sensitive sliding scale fees	Dept. of Health	03/09/07 Grants completed
<input type="checkbox"/> Fund FQHCs look-alike (CHSLV) to develop income-sensitive sliding scale fees	Dept. of Health	02/01/08

### 7.4. *Provider Reimbursement*

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, with a report due to the committees on health and welfare and on health care and commission on January 15, 2008.

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.

**2011 Strategic Goal: Provider reimbursement rates will be sufficient to recruit and maintain the necessary health care workforce in Vermont.**

**Milestone(s):**

<p>☞ Established a work group to make recommendations on the advisability of eliminating the requirement for an advanced practice nurse to work in a collaborative practice with a licensed physician.</p>	Health	09/01/07 Workgroup Formed
<p>☞ Submitted report on advanced nurse practitioner workgroup recommendations</p>	Health	01/15/08 Completed
<p>☞ Conduct annual survey of health insurers re: average reimbursement rate for ten most common billing codes for primary care health services</p>	BISHCA	01/31/08 and annually  04/01/08 report available
<p>☞ Conduct one-time survey of health insurers re: average reimbursement rate for ten most common billing codes for mental health services, including differences due to provider education or licensure.</p>	BISHCA	04/01/08 report available
<p>☞ Conduct one-time survey of health insurers re: average reimbursement rate for the most common billing codes for non-physician health care services, including differences due to provider education or licensure; survey limited to 20 billing codes as long as it includes at least 2 common billing codes for each major class of provider.</p>	BISHCA	04/01/08 report available
<p>☞ Secretary of Administration to meet annually with established health care professional and trade associations re: provider regulation, provider reimbursement, or quality of care.</p>	AoA/DHR	07/01/08 and annually

## 8. Promote Quality Improvement

### 8.1. *Consumer Price and Quality Information System.*

A major factor in the success of consumer driven health care plans is consumer access to good price and quality information. This is especially important as more benefit plans require higher levels of out of pocket spending. The Health Care Reform legislation directed the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) to adopt rules for health insurers to provide transparent price and quality information so that consumers are empowered to make economically sound and medically appropriate decisions.

**2011 Strategic Goal:** *Vermont insurers, providers, consumers and state regulators will work together to ensure that health care consumers have access to accurate, understandable and reliable health care price and quality information.*

**Milestone(s):**

☞ Established advisory Consumer Price and Quality Transparency Work Group	BISHCA	10/31/06 Completed
☞ Initiated rulemaking to require insurers and other participants in the health care system to make price and quality information available to consumers	BISHCA	04/30/07 Completed
☞ Completed rulemaking to require insurers and other participants in the health care system to make price and quality information available to consumers	BISHCA	07/01/08
☞ Provide public reports on price and quality information.	BISHCA	12/01/08
☞ Continue to expand price and quality system as new data become available.	BISHCA	On-going

## 8.2. *Multi-payer Data Collection Project.*

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 directed BISHCA to design the health insurance claims data collection program and to begin program implementation.

Act 71 of 2007 gave BISHCA the authority to limit access to the multi-payer database once it is developed in order to comply with federal requirements, and also required BISHCA to provide a report by January 15, 2008 on how to financially sustain the multi-payer database.

**2011 Strategic Goal:** *All Vermont health care providers, hospitals, insurers and the state have access to a comprehensive health information system in order to improve the quality and cost-effectiveness of the state's health care.*

**Milestone(s):**

☞ Implemented pilot initial registration of TPAs and PBMs to test the registration process and proposed draft registration form.	BISHCA	01/31/07 Completed
☞ Issued an RFP for the development and management of the health insurance claims data collection, data base, and reporting system	BISHCA	07/01/07 Completed

<p>☞ Established rules for the collection, management and reporting of health insurance claims data including required participation and enforcement, data submission standards, security, privacy protections, and policy and procedures addressing permissible data release and reporting.</p>	BISHCA	08/15/07 Draft Rules  08/01/08 Rules to LCAR
<p>☞ Selected a vendor for development and management of the health insurance claims data collection, database, and reporting system.</p>	BISHCA	09/01/07 Completed
<p>☞ Vendor began work to develop system.</p>	BISHCA	01/01/08 Completed
<p>☞ Recommendations Report for annual financial support for VUCURS</p>	BISHCA	01/15/08 Report submitted
<p>☞ Collect an initial test set of claims data from required participants</p>	BISHCA	03/31/08
<p>☞ Collect 2007 claims and eligibility data set from commercial reporters, TPAs and PBMs.</p>	BISHCQ	07/31/08
<p>☞ Report out on compliance, technical barriers, data quality, and responsiveness of required participant to corrective action plans in preparation for full implementation of data collections</p>	BISHCA	07/31/08
<p>☞ First test series of standard reports; start processing first 2 quarter of 2008 data.</p>	BISHCA	10/31/08
<p>☞ Implement full data collection, processing, data base development and reporting capabilities</p>	BISHCA	12/31/08
<p>☞ VITL and VPQHC access to the BISHCA healthcare database subject to such terms and conditions as the commissioner may prescribe by regulation.</p>	BISHCA	01/31/09

### **8.3. Patient Safety Surveillance and Improvement System Implementation (Adverse Event Reporting.)**

The Vermont Department of Health was required to develop a Patient Safety Surveillance and Improvement System to improve patient safety, eliminate adverse events, and support quality improvement efforts. Hospitals must develop internal policies to track medical 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. Hospitals must provide information to the Health Department relating to certain reportable adverse events. Information on hospital medical events and hospital infection rates will be reported to the public on an annual basis through hospital community reports.

**2011 Strategic Goal:** *Vermont Hospitals and the Department of Health work as partners on a comprehensive statewide patient safety surveillance and improvement system that is continuously improving patient safety, reducing adverse events in Vermont Hospitals and supporting and facilitating quality improvement by hospitals.*

**Milestone(s):**

☞ Established system to collect and analyze data.	Dept. of Health	06/30/07 Completed
☞ Verify hospital compliance, provide technical assistance.	Dept. of Health	06/30/07 on-going
☞ Adverse event rulemaking for hospital organizations	Dept. of Health	01/01/08 Rule Effective Date
☞ Interim report on status and effectiveness of adverse event system	Dept. of Health	01/15/08 Completed
☞ Final report and recommendations on expansion of adverse event system	Dept. of Health	01/15/09
☞ Recommend to BISHCA which adverse event data to include in Hospital Community Reports (18 months after data available)	Dept. of Health BISHCA	03/01/09
☞ Adverse event reporting system is fully functional and used routinely by all hospitals.	Dept. of Health	12/31/11

#### 8.4. *Safe Staffing.*

Hospital nurse staffing measures must be made available to patients and the public in Hospital Community Reports and through daily public posting in hospitals.

**2011 Strategic Goal:** *All Vermont consumers will have access to information on nurse staffing in hospitals through annual reporting in Hospital Community Reports and through daily public posting in hospital units.*

**Milestone(s):**

☞ Began daily posting of nurse staffing in hospital units	Hospitals	07/01/06 Completed
☞ Research nurse staffing measures that are appropriate for public reporting in Hospital Community Reports	BISHCA	11/15/06 Completed
☞ Determined reporting mechanisms for selected measure(s)	BISHCA	12/15/06 Completed
☞ Prescribed data collection time period.	BISHCA	12/15/06 Completed

☞ Added nurse staffing measures to Hospital Community Reports	BISHCA	06/01/07 Completed
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### 8.5. *SorryWorks!*

Another component of the health care reform legislation was a voluntary, pilot SorryWorks! program in which physicians and hospitals promptly acknowledge and apologize for mistakes in patient care that result in harm and promptly offer fair settlements. Such an oral apology or explanation of how the medical error occurred, made within 30 days, may not be used to prove liability, is not admissible, and cannot serve as the subject of questioning in administrative or civil proceedings. Negotiations under SorryWorks! are confidential, and the statute of limitations is tolled during negotiations. A settlement resulting from participation in the SorryWorks! program bars further litigation; if settlement is not reached, the patient may bring a civil action.

Unfortunately, no hospitals were able to work with their insurers in 2007 to enable them to implement this program as designed in statute. However, some hospitals are considering implementation of a similar program in 2008.

**2011 Strategic Goal:** *Vermont has a medical malpractice system which improves patient safety, enhances the doctor patient relationship and lowers the overall costs of medical malpractice for providers and patients.*

#### Milestone(s):

☞ Southern Vermont Medical Center currently exploring options that do not require legislation. Let statute sunset.	BISHCA	10/01/07
☞ Continue to work with hospitals and their insurance agents to facilitate their participation in the voluntary program	BISHCA VAHHS	01/01/08 On-going
☞ Allow statutory Pilot program to sunsets	BISHCA	06/01/09

### 8.6. *Advance Directives.*

The health care reform legislation 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 also applied to "procurement organizations" as appropriate.

**2011 Strategic Goal:** *Vermonters will prepare advance directives and file them in the Registry, and providers will be able to retrieve them from the Registry quickly and easily to ensure that patients' health care and end of life wishes are honored.*

#### Milestone(s):

☞ Initiated rule-making process for Advanced Directive Forms	Dept. of Health	08/30/06 Completed
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☞ As existing licenses & ID cards are depleted, issue new cards allowing Advanced Directive indication	DMV	09/01/06 Completed and on-going
☞ Established rules for Advanced Directive registry	Dept. of Health	01/08/07 Rules Effective
☞ Established Advanced Directive registry	Dept. of Health	01/08/07 Registry Available
☞ Provided Advanced Directive information on the web-site	Dept. of Health	01/08/07 Completed
☞ Provided stickers for people in registry	Dept. of Health	01/01/07 On-going

### 8.7. *Infection Reporting in Hospital Community Reports.*

Hospitals are required to report valid, reliable and useful measures of hospital-acquired infections in their annual Hospital Community Reports.

**2011 Strategic Goal:** *Vermont consumers and others will have access to accurate, reliable and understandable information on hospital-acquired infections, resulting in informed consumers and reductions in infections.*

#### Milestone(s):

☞ Convened Infection Reporting Advisory Subcommittee of Act 53 Hospital Community Reports Work Group	BISHCA	09/30/05 Completed
☞ Identified potential infection measures for public reporting.	BISHCA	01/12/06 Completed
☞ Determined reporting mechanisms (CDC's National Healthcare Safety Network) for selected measures and coordinating body (VPQHC) for inquiries and data analysis	BISHCA /VPQHC	08/20/06 Completed
☞ Established training schedule for hospitals to and enroll in CDC system	BISHCA /VPQHC	11/10/06 Completed
☞ Collected data for 2007 public reporting of central line infection rates	BISHCA	11/01/06- 04/30/07 Completed
☞ Published data in 2007 Hospital Community Reports and repeat process	BISHCA /VPQHC /Hospitals	06/01/07 On-going

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## REFORM GOAL: CONTAIN HEALTH CARE COSTS

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### Increasing Access to Insurance and Improving Quality of Care

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 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.

## 9. Decrease Cost Shift

### 9.1. *Medicaid Provider Reimbursement Increases.*

Medicaid provider underpayments result in a cost shift to commercial plans that must be paid by commercial health insurance premiums. To begin to address this, the 2006 Health Care Reform legislation increased Medicaid provider reimbursements in the following manner: (i) evaluation and management services will be paid at Medicare rates in order to support primary care physician practices; (ii) supplemental payments will be provided to dentists with high Medicaid patient counts; and (iii) hospital rates will be increased annually until the federal upper limit is reached.

**2011 Strategic Goal:** *The cost shift resulting from insufficient Medicaid reimbursement rates will be reduced.*

#### Milestone(s):

☑ Submitted preliminary findings re: impact of federal Deficit Reduction Act generic drug provision on pharmacists and patients	OVHA	09/01/06 Completed
☑ Provided supplemental payments to dentists with high Medicaid patient counts; Provide report to HAOC on program parameters	OVHA	10/01/06 Completed
☑ Reported to HAOC plan for allocation of FY '07 appropriations for provider and hospital rate changes	OVHA	10/31/06 Completed
☑ Submitted Medicare Part D cost projections report to HAOC	OVHA	12/01/06 Completed
☑ Submitted final report on impact of Federal Deficit Reduction Act generic drug provision on pharmacists and patients	OVHA	01/30/07

☞ Increased Medicaid dental rates: First restore 02/06 cuts, then split remainder in half to increase dental rates and adult dental cap	OVHA	01/01/07 Increases implemented
☞ Increased OVHA base rates for evaluation management and procedure codes to 2006 Medicare rates	OVHA	01/01/07 implemented
☞ Increase hospital rates annually until federal upper limit is reached, within available resources	OVHA	01/01/07 and Beyond Increases implemented for Inpatient care
☞ Continue to increase Medicaid provider rates, within available resources	OVHA	07/01/08 and Beyond

### 9.2. 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 charged the Department of Banking, Insurance, Securities and Health Care Administration to undertake several cost shift initiatives, including:

- Requiring hospitals to account for Medicaid reimbursement increases in their annual budgets established by the department.
- Standardizing hospital bad debt and free care policies.
- Developing procedures to account for changes in uncompensated care and Medicaid reimbursement when the department approves health insurance rates.

**2011 Strategic Goal:** *Enhanced provider and payer reporting systems will be in place to enable the State to monitor and evaluate changes in the cost shift and to measure the effect of cost shift changes on hospital and commercial insurance rates.*

#### Milestone(s):

☞ Convened Task Force to make recommendations re: statutory/admin changes to reduce cost shift (via slower growth rate in hospital charges & insurance premiums)	BISHCA	10/30/06 Completed
☞ Task Force report on recommendations re: statutory/admin changes to reduce cost shift	BISHCA	12/01/06 Report submitted 12/1/06
☞ Submitted report on a recommended standard statewide uniform policy for hospital uncompensated care and bad debt	BISHCA	01/17/07 Report submitted
☞ Changed hospital reporting requirement to reflect any increase in federal reimbursements, increase in # insured, decrease in bad debt/charity	BISHCA	04/30/07 Completed and On-going
☞ Update on recommendations from 2006 Cost Shift Report.	BISHCA	02/01/08 Annually

## 10. Simplify Health Care Administration

### 10.1. *Common Claims and Procedures.*

The Vermont Association of Hospitals and Health Systems (VAHHS) was charged with adopting regulations designed to simplify the claims administration process, and to lower administrative costs in the health care financing system.

**2011 Strategic Goal:** *Vermont insurers and providers will implement coordinated, improved and simplified claims administration and other procedures to lower administrative costs and provide more understandable and less time-consuming processes for consumers, health care providers, insurers and others.*

#### Milestone(s):

☞ Established common claims and procedures work group	VAHHS	07/01/06 Completed
☞ Presented two-year work plan and budget to House Committee on Health Care and the Senate Committee on Health and Welfare	VAHHS	09/01/06 Completed
☞ Presented interim report on progress and interim steps	VAHHS	01/15/07 Completed
☞ Submitted final report with findings and estimated cost savings achieved and expected future savings	VAHHS	01/15/08
☞ Amend rules adopted pursuant to 18 VSA §9408 to reflect agreed-upon recommendations in common claims report	BISHCA	07/01/08
☞ Oversee implementation of new administrative procedures.	BISHCA	07/01/08 and Beyond

### 10.2. *Uniform Provider Credentialing.*

BISHCA was also charged with prescribing a standard credentialing application form to be used by insurers and hospitals for credentialing their providers by January, 2007. Insurers and hospitals were required to inform providers of deficiencies in their applications, according to statutory timeframes.

Act 70 of 2007 allowed the 2007 deadline to be extended to January, 2008 for hospital implementation.

**2011 Strategic Goal:** *All insurers and hospitals will use the Council for Affordable Quality Healthcare (CAQH) credentialing application form, resulting in reduced administrative costs and increased time savings for providers, insurers and hospitals.*

**Milestone(s):**

☞ Convened meeting to obtain input from insurers, hospitals providers and CAQH.	BISHCA	09/21/06 Completed
☞ Developed and distributed draft bulletin to interested parties	BISHCA	11/05/06 Completed
☞ Received comments from interested parties.	BISHCA	11/17/06 Completed
☞ Drafted and distributed final bulletin	BISHCA	12/01/06 Completed
☞ Provided training opportunities and educational resources for insurers, hospitals and providers	BISHCA/CAQH	12/15/06 Completed
☞ Ensure that new uniform credentialing application form is used by insurers and hospitals	BISHCA/Insurers /Hospitals	01/01/07 and Beyond

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## FINANCING VERMONT'S HEALTH CARE REFORM

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**2011 Strategic Goal:** *There are viable financing mechanisms in place to sustain Vermont's health care reform initiatives.*

### 11. Catamount Health Fund

Acts 191 and (budget 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 transfers approved by the General Assembly. Sources of revenue include 17.5 % of the new cigarette taxes (see 12 below), the Employers' Health Care Premium Contribution (see 13 below), Catamount Health premium assistance amounts paid by individuals to the State (see 2.1), and other revenues established 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.

**Milestone(s):**

☞ Report to Joint Fiscal Committee on receipts, expenditures and balances of the Catamount Fund	F&M	08/23/07 and annually at Sept. Meeting
☞ Administration's proposal to restore revenue due to changes in the Employer Contribution created by Act 70 of 2007.	AoA	12/01/07 Letter submitted
☞ Provide monthly progress reports on Catamount Health	AHS/BISHCA/AoA	Monthly after 01/15/08
☞ Evaluate affordability of Catamount Health Plan benefits and propose recommended changes if necessary	BISHCA/AoA	01/01/09
☞ Report # uninsured; Catamount Health costs & revenue trends, feasibility of opening Catamount at full premium cost, & # enrolled in chronic care management	BISHCA	01/15/09

**12. Increases in Tobacco Product Taxes****Milestone(s):**

☞ Increased cigarette tax by \$.60 per pack (institute a new tax on "little cigars" and roll-your-own tobacco as cigarettes)	Dept. of Taxes	07/01/06 Completed
☞ Increase cigarette tax by \$.20 per pack increase	Dept. of Taxes	07/01/08
☞ Change the method of taxing moist snuff to a per-ounce basis and increases tax by \$.17	Dept. of Taxes	07/01/08

**13. Employers' Health Care Premium Contribution**

Act 191 of 2006 established an Employer Health Care Contribution Fund to contribute to the Catamount Fund. Employers pay an assessment based on their number of "uncovered" employees, based on 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, and on workers who refuse the employer's health care coverage and do not have coverage from some other source. (However, see changes due to Act 71 below.)

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 the Catamount Health Plan premium growth.

Based on the workgroup report that examined options to address issues related to seasonal employees, Act 70 of 2007 created an exemption for seasonal or part-time employees of employers who offer health

coverage to full-time employees, if the seasonal or part-time employee has coverage elsewhere (excluding Medicaid or VHAP).

**Milestone(s):**

☞ Established rules for employer assessment (administration and premium collection)	Dept. of Labor	01/01/07 Completed
☞ Reported to General Assembly on options to address seasonal employees in employer assessment	Dept. of Labor	01/15/07 Completed
☞ Implemented employer assessment (first payment due July 30, 2007)	Dept. of Labor	04/01/07 Implemented
☞ Amended rules to reflect changes related to part-time and seasonal employees	Dept. of Labor	01/15/08 Rules finalized
☞ Change employer contribution amount based on Catamount health plans premium increases.	Dept. of Labor	07/01/08 and Annually

## 14. Medicaid Global Commitment to Health Program

In 2005 Vermont entered into a new five year comprehensive 1115 federal Medicaid demonstration waiver named Global Commitment to Health (GC). This waiver is 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 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 has requested an amendment from CMS to include Catamount Health and the employer-sponsored insurance premium assistance programs under the financial umbrella of this waiver.

**Milestone(s):**

☞ Submitted GC waiver amendment request to CMS to establish (& include in MCO premium rate) the ESI and Catamount premium assistance program for VHAP & uninsured up to 300% FPL.	AHS/OVHA	09/11/06 Request Submitted
☞ Communication from CMS that approval would only be granted up to 200% FPL		08/07 Completed
☞ Health Access Oversight Committee (HAOC) Report regarding recommendations to eliminate Medicaid deficit	HAOC	01/25/07 Completed

## 15. Medicaid VHAP program savings due to employer-sponsored insurance enrollment

### Milestone(s):

- |  |                 |                                   |
|--|-----------------|-----------------------------------|
| <p>☞ Report on number enrolled, income levels, description of approved ESI plans, employer cost related to premium assistance program, and net savings of program. <sup>20</sup></p> | <p>DCF/OVHA</p> | <p>Monthly after<br/>01/15/08</p> |
|--|-----------------|-----------------------------------|

## 16. State General Fund Appropriations

### Milestone(s):

- |  |                                      |                 |
|--|--------------------------------------|-----------------|
| <p>☞ Ensure that annual appropriations enable successful implementation of the health care reform initiatives.</p> | <p>Governor<br/>General Assembly</p> | <p>Annually</p> |
|--|--------------------------------------|-----------------|

## 17. State Fiscal Obligations Protected

The health care reform legislation enables the state Emergency Board (E-Board) to establish caps on enrollment in the Premium Assistance Programs if sufficient funds are not available to sustain them.

### Milestone(s):

- |   |                        |  |
|---|------------------------|--|
| <p>☞ Provide to E-Board revenue estimates of Global Commitment, state health care resources &amp; Catamount funds for immediately succeeding, current and 2 future FYs, &amp; estimated monthly caseloads &amp; PMPM for GC, LTC, VT Rx, Catamount Health &amp; premium assistance programs; Emergency Board review of cost compared to available resources; potential decision to suspend new enrollments.</p> | <p>AHS/AoA/F&amp;M</p> | <p>Semi-annually<br/>(Jan. &amp; July)<br/>Reported at<br/>01/07, 08/07 &amp;<br/>01/08 e-board<br/>meetings</p> |
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<sup>20</sup> Report must be submitted to the Health Access Oversight Committee, the Joint Fiscal Committee, and the Health Care Reform Commission.

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## HEALTH CARE REFORM OVERSIGHT

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**2011 Strategic Goal:** *Vermont will have achieved the goals of the 2006 Health Care Reform legislation and other initiatives enacted into law in subsequent years..*

**Milestone(s):**

☞ Created Legislative Commission on Health Care Reform access; provided funds for consultation for IT & other implementation	General Assembly	07/01/06 Completed
☞ Submission of five-year implementation plan for reforms, including recommendations for administration/legislation	AoA	12/01/06 Completed
☞ Developed web-site for health care reform implementation	AoA	12/31/06 Completed
☞ Report on progress of reform initiatives	AoA	01/08 Annual Report and Monthly Testimony
☞ Work collaboratively with the legislature to identify new initiatives to help achieve health care reform goals.	Governor and Administration	On-going
☞ Determine needed analysis and criteria for changing health care financing and delivery system if less than 96% of Vermonters have insurance in 2010	HCR Commission	01/01/11

## **APPENDIX A--GLOSSARY OF ACRONYMS AND TERMS**

<b>Term</b>	<b>Description/Definition</b>
Administration	The Administrative arm of state government; used in this document to refer to situations when multiple agencies and departments across state government are involved
AHEC	Area Health Education Centers
AHS	Vermont Agency of Human Services
AoA	Vermont Agency of Administration
BISHCA	Vermont Department of Banking, Insurance, Securities and Health Care Administration
Blueprint for Health	The state's plan for chronic care infrastructure, prevention of chronic conditions, and Chronic Care Management Program, and includes an integrated approach to patient self management, community development, health care system and professional practice change, and information technology initiatives.
Care coordination	A component of Chronic Care Management that includes intensive intervention and support for people with advanced disease, multiple complications. May also be referred to as case management
CCIS	Chronic Care Information System: The electronic database developed under the Blueprint for Health that shall include information on all cases of a particular disease or health condition in a defined population of individuals.
Chronic Care	Health services provided by a health care professional for an established clinical condition that is expected to last a year or more and that requires ongoing clinical management attempting to restore the individual to highest function, minimize the negative effects of the condition, and prevent complications related to chronic conditions.
Chronic Care Management	A system of coordinated health care interventions and communications for individuals with chronic conditions, including significant patient self-care efforts, systemic supports for the physician and patient relationship, and a plan of care emphasizing prevention of complications utilizing evidence-based practice guidelines, patient empowerment strategies, and evaluation of clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.
Chronic Care Model	A national model for collaborative care and quality improvement that illustrates the components necessary to improve care for people with chronic conditions within a health care setting.
Chronic condition	Chronic illnesses and impairments that are expected to last a year or more, limit what the individual is able to do, and/or require ongoing medical care.
CMS	Centers for Medicare and Medicaid Services
DCF	Vermont Department for Children and Families
DHR	Vermont Department of Human Resources
DII	Vermont Department of Information and Innovation
DMV	Vermont Department for Motor Vehicles

Term	Description/Definition
E-Board	The Board is established in Vermont Statute to have the authority to make any expenditure necessitated by unforeseen emergencies and may borrow on the credit of the state for the same. Members of the Emergency Board are the Governor, the chairman of the Senate finance committee, the chairman of the Senate appropriation committee, the chairman of the House ways and means committee and the chairman of the House appropriation committee.
F&M	Vermont Department of Finance and Management
HAOC	Health Access Oversight Committee of the Vermont Legislature
Healthcare Providers	The physicians, nurse practitioners, physician assistants, nurses, counselors, and other health and public health professionals who work with individuals to guide, support and assist them to be healthy, and who deliver treatment and care when needed.
HCR	Health Care Reform
JFC	Joint Fiscal Committee of the Vermont Legislature
OVHA	Office of Vermont Health Access (Medicaid)
VHAP	Vermont Health Access Plan (public health insurance program for uninsured adults who are not eligible for Medicaid).
VDH	Vermont Department of Health
VDOL	Vermont Department of Labor
VITL	Vermont Information Technology Leaders
VPQHC	Vermont Program for Quality in Health Care