

Report of the Health Care Reform Readiness Taskforce

October 13, 2010

**Bi-State Primary Care Association
Vermont Assembly of Home Health Agencies
Vermont Association of Hospitals and Health Systems
Vermont Health Care Association
Vermont Medical Society**

Executive Summary

Over the past five years, Vermont has emerged as a national leader in health care reform and by a wide variety of national reports, has a health care system that currently serves Vermonters well. The efforts of public and private partners working together to expand health care coverage, transform the delivery of health care and connect all providers electronically have positioned practitioners, health care organizations and the state well for continued progress. The ongoing economic challenges and the passage of ground-breaking federal laws like the Affordable Care Act (ACA) have created a heightened urgency to accelerate this essential work.

In anticipation of this new environment, a group including hospital, physician, community health center, long term care and home health organizations and their Associations began meeting to better understand the many federal and state changes. The collective intention of this group is to leverage the opportunities and manage the risks contained in federal and state law.

The attached report is subdivided into 6 categories: (1) Coverage and Insurance Reform (2) Payment and Health Care Delivery Reform (3) Quality Improvement and Patient Safety (4) Health Information Technology (5) Workforce (6) Prevention/Wellness. Each outlines key changes in state and federal law and provides brief policy recommendations.

A few major themes emerge:

- 1) State initiatives, particularly Act 128 of 2010, need to be fully aligned with federal reform efforts.
- 2) Payment incentives designed to support a re-defined health care system need to promote quality and value.
- 3) The ability to deliver improved health care outcomes requires greater attention to and resources for health information technology, workforce education, recruitment and retention as well as expanded prevention/wellness programs. Keeping Vermonters healthy includes having an adequate supply of primary care clinicians to ensure access to preventive and primary care services.
- 4) Health care professionals and providers should be full partners with health plans and state government in planning for and implementing new payment methodologies, delivery system reforms and insurance reforms.
- 5) Most providers, particularly long term care and home health, face substantial net funding reductions under the ACA that must be considered by state policy makers.

The report that follows represents our recommendations thus far and we hope it will help inform policy makers as they consider the future. We look forward to our continued participation in this important policy discussion.

Access, Coverage and Insurance Reform

Principle: Vermont's coverage and insurance reform efforts should be fully aligned with federal reform as we work toward a system in which all Vermonters have affordable coverage and access to high quality health care services.

Federal Changes: The newly enacted Affordable Care Act (ACA) requires numerous changes that impact health coverage. Beginning in 2010 and continuing through 2014, the ACA begins to substitute national uniformity and administrative simplification for a myriad of state-based insurance rules. Some targeted changes will occur in 2010 and 2011, such as allowing children to stay on their parents' health plan until the age of 26. Beginning in 2014, reforms will transform the commercial insurance marketplace. All U.S. citizens and legal residents will be required to maintain "minimum essential coverage". Health Benefit Exchanges will be established to facilitate the purchase of qualified health plans in the individual and small group markets. These changes come with Medicaid program expansions and public subsidies up to 400% of the federal poverty level to help millions of Americans purchase and retain health coverage. The exchanges will only include those health plans that meet its standards. If a state chooses not to establish an exchange by January 1, 2013, the federal government must establish an exchange itself in that locale.¹

Perhaps the most important feature of the health insurance exchanges is that premium-assistance credits and cost-sharing subsidies will be accessible only to individuals enrolled in health plans through exchanges. Whether health insurance products outside the exchange will be allowed in Vermont will be a central policy question to answer.

Implications for State Policy:

- Many key Vermont agencies must undertake a thorough re-examination of current state policy and regulations with respect to new Federal requirements and opportunities. This effort will probably lead to revisions of state law, rules, and regulations related to health care access and coverage
- In consultation with health care providers and health plans, state insurance regulators will need to weigh the health insurance exchange options. These include whether to create a Vermont (or regional) exchange or rely on the Federal government, whether to combine the individual and small group markets into a single exchange and to determine the minimum criteria for inclusion of health insurance products in the exchange.
- The impact on Catamount Health may be significant. The program may lose a significant portion of young adults who-opt to remain on their parent's insurance plans until age 26. Given the relative health of this population, that could further increase premiums. In addition, it is not yet clear if Catamount Health will be eligible to participate in the health insurance exchange.

¹ Health Insurance Exchanges and the Affordable Care Act, Key Policy Issues, T. Jost, The Commonwealth Fund, July 2010

Committee Recommendations:

- Develop a Vermont exchange (possibly in partnership with other states) rather than rely on the Federal government to do so.
- Develop a single exchange for the individual and group market, rather than separate exchanges for each one.
- Ensure that physicians and other provider groups play an integral part in the development of *criteria* for insurance products to be allowed into the Vermont exchange. The criteria should encourage the standardization of benefit design, payment methodologies, and performance measures to the greatest extent possible.
- The Department of Vermont Health Access should maximize enrollment in the programs for which Vermonters are eligible.
- The Department of Vermont Health Access should re-evaluate Vermont's previous Medicaid expansions. It may be that transitioning Vermonters covered under Medicaid expansions to commercial insurance purchased with Federal subsidies through an exchange is more cost-effective for the Medicaid budget.

Payment and Health Care Delivery Reform

Principle: A re-defined reimbursement and health care delivery system should align payment incentives with quality and value while also supporting the stability, availability and coordination of essential health care services.

Federal Changes: The recently enacted Affordable Care Act (ACA) contemplates payment reforms that will encourage the development and coordination of local, community systems of care to improve quality of care and reduce unnecessary costs. Toward this end, new structures such as accountable care organizations (ACOs), global payment systems and bundled payment mechanisms will fundamentally change how different clinicians and health care organizations are reimbursed and work together.

The law includes numerous funding incentives to test these mechanisms. Some of these opportunities support work in which Vermont is already engaged, such as the development of community-based, interdisciplinary health teams that support primary care and a health home program for eligible Medicaid enrollees.

CMS defines an ACO as an organization of health care providers that agrees to be accountable for the quality, cost and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it. To qualify for participation, an ACO must have a formal legal structure to receive and distribute shared savings; agree to participate in the program for not less than a three-year period; have defined processes to promote evidenced-based medicine, report data to evaluate quality and cost measures, coordinate care and demonstrate it meets patient-centeredness criteria. For each 12-month period, participating ACOs will be eligible to receive a percentage of any savings if the actual per capita expenditures of their Medicare beneficiaries are a sufficient percentage below their specified benchmark amount. CMS plans on establishing the program by January 1, 2012.

Trade groups such as the American Hospital Association have pointed out that there are some significant federal legal barriers to the clinical integration contemplated by ACA, which carry serious civil and criminal penalties for violations. These laws and regulations need to be clarified and/or modified to explicitly allow for the clinical integration and shared savings models embodied in Federal reform.²

Implications for State Policy: The ACA provides an opportunity to expand the Vermont Blueprint (Vermont's statewide partnership to improve health and the health care system) and to explore new payment methodologies and system designs which would encourage provider

² These include (1) antitrust laws that govern federal policies on competition (2) the Stark Law which limits the ability of hospitals to develop new reimbursement models with physicians (3) Civil Monetary Penalty Laws that prohibit hospitals from rewarding physicians for reducing or withholding services to Medicare or Medicaid patients (whether they are medically necessary or not) (4) the Anti-kickback Law aimed at financial incentives to influence referrals in programs including Medicare and Medicaid, with no safe harbor for clinical integration programs (5) IRS rules for not-for-profit hospitals (which includes all Vermont hospitals) prevent these tax-exempt organizations from using the organization's assets to benefit private individuals, *including physicians*.

collaborations across a continuum of care. These opportunities also carry risks to the stability of the delivery system. It will be essential for the Administration, Legislature and providers in Vermont to align their efforts to take advantage of the opportunities available through this new federal legislation and take steps to mitigate risks. Such collaborations are the cornerstone of Vermont's reform successes to date.

For example, Vermont's Act 128 of 2010 needs to be aligned with federal reform. The act includes provisions for payment reform pilot projects in Vermont and calls for the design of three universal coverage options. We appreciate the pragmatic approach taken by Dr. Hsiao (the Harvard economist hired by the Health Care Reform Commission to design the options) who said in a recent presentation that one of the plans will be "designed to be politically and practically viable for Vermont."³

ACA also places new financial pressures on some acute and long-term care providers at the same time it is looking to providers to re-design the delivery system. In ACA, provider reimbursement reductions adopted based on the assumption that the new law will significantly increase insurance coverage. Since Vermont has a very low uninsured rate, physicians, hospitals and the state may experience a net loss in revenue, since the coverage incentives will not appreciably change our current level of uncompensated care. Nursing homes and home health agencies will experience payment reductions due to ACA, and are generally left out of the waiver and grant opportunities created by the new law. In order for delivery system reform to evolve in a way which encourages collaboration along a continuum of care, nursing homes and home health agencies need to be adequately reimbursed for the services they will be expected to provide.

Committee Recommendation:

- Health care professionals and providers should be full partners with health plans and state government in planning for and implementing new payment methodologies and delivery system reforms.⁴
- The Administration should pursue initiatives that further the significant efforts already underway by organizations like Vermont Information Technology Leaders (VITL), Department of Vermont Health Access (DVHA) and those initiatives that are consistent

³ The Vermont Option: Achieving Affordable Universal Health Care, William C. Hsiao, PhD, FSA, August 5, 2010

⁴ From J. Hester, J. Lewis and A. McKethan, The Vermont Accountable Care Organization Pilot, The Commonwealth Fund, May 2010, p. 21:

"The full potential of the ACO can be realized only with the following prerequisites:

- Strong, committed leadership from physicians and other key stakeholders;
- Multi-payer participation of major commercial insurers and Medicare to achieve the necessary critical mass to support change;
- A strong patient-centered primary care model such as the medical home; and
- Robust IT support and reporting for clinical care coordination, process improvement, and financial management.

However, physician participation cannot be a casual commitment. The stress and challenges of system reform can only be met by a group of providers uniting for a common purpose. Though hard to measure, a shared vision is what will keep the provider group focused on its goals and sustain it through inevitable conflicts."

with the ACA. If new payment models are pursued Vermont should continue with the pilot approach that has been a successful component of other initiatives. It will be essential to encourage the development and coordination of local, community systems of care including vertical or horizontal networks of providers.

- Provider associations and the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) should review the federal legal barriers to care coordination and identify any opportunities for state assistance, such as anti-trust exemptions.
- The DVHA should quantify the potential financial impact (both positive and negative) of the ACA on Vermont providers.

Quality Improvement and Patient Safety

Principle: Vermont should continue to lead the nation in the delivery of high quality health care services based on nationally recognized performance standards.

Federal Changes: The recently enacted Affordable Care Act (ACA) includes many provisions aimed at improving quality and patient safety. Some are tied to reimbursement such as payment reductions for conditions acquired in hospitals and “value-based purchasing” (pay for performance) for nursing homes, home health agencies, hospitals and physicians. Others are related to the public reporting of quality information. Several are related to employing the evidence based interventions and developing strategies for bringing evidence-based standards into clinical practices. It also contains provisions to improve the delivery of health care services, particularly to low-income, underserved, uninsured minority and rural populations.

Implications for State Policy: Vermont’s state-wide initiatives to improve quality and patient safety, which have received national recognition, need to be evaluated to insure alignment with new federal initiatives. This includes Act 49 of 2009 which charged the Commissioner of the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) with analyzing geographic variation in utilization of health care services in Vermont and recommending a process to explore and potentially reduce variation. The Act 49 advisory group recommended the following three areas of utilization for further analysis: advanced imaging (including CT scans and MRIs); emergency department visits; and, inpatient hospitalization. It is anticipated that these three areas will be a focus of quality improvement activities in the future.

Committee Recommendations:

- The Act 53 Workgroup, a BISHCA-led multi-stakeholder committee focused on public reporting, should examine public reporting requirements to insure consistency with new federal initiatives.
- The Vermont Program for Quality in Health Care (VPQHC) and the Vermont Information Technology Leaders (VITL) should re-examine their workplans and strategic plans in relation to new federal initiatives as they develop and promote statewide adoption of best practices.
- Statewide organizations including provider associations, VPQHC, agencies of state government and payers should support, promote and align statewide quality improvement projects (including Act 49), particularly those that cut across multiple provider groups.
- Public and private performance incentives and “performance-based contracts” with providers should be aligned with each other and with statewide quality improvement priorities.
- Provider reporting requirements should be re-examined by appropriate state agencies and payers for redundancies with federal reporting requirements and streamlined to the greatest extent possible.
- Health plans should be required by BISHCA to use uniform nationally recognized and approved clinical measures to report physician quality information. The measures must be based on medical evidence and developed through a process in which health care

providers participate. In addition, the measures must include uniform definitions, measures, and forms for submission of data, and plans must seek to avoid increasing the administrative burden on health care providers.⁵

⁵ For an example, see <http://www.health.state.mn.us/healthreform/measurement/index.html>

Health Information Technology (HIT)

Principle: Health information technology is a cornerstone for improving health care quality, patient safety and the efficient delivery of care.

Federal Changes: The Health Information Technology for Economic and Clinical Health Act (HITECH Act) established programs under Medicare and Medicaid to provide incentive payments to physicians and hospitals for the "meaningful use" of certified Electronic Health Record (EHR) technology. The programs begin in 2011. The HITECH Act also established a number of grants to organizations willing to assist physicians with the adoption of EHRs and to help build Health Information Exchanges for the secure sharing of electronic health information between practices. Federal HIT policy has largely excluded significant components of the delivery system, notably nursing homes and home health agencies. In addition, hospitals and physicians will have to make significant investments beyond the incentive payments. They will also need to pay for many improvements up front which will present a cash-flow barrier.

Implications for State Policy: HITECH's grant opportunities are already partially funding significant efforts to build Vermont's HIT infrastructure. Several organizations in Vermont have secured funding under HITECH in order to create a health information exchange network and to help physicians and hospitals qualify for the Medicare/Medicaid incentive programs by achieving "meaningful use"⁶ of certified Electronic Health Records. These include the Vermont Information Technology Leaders, Inc. (VITL) designation as a Health Information Technology Regional Extension Center, a Vermont Agency of Human Services health information exchange program grant and a grant to Bi-State Primary Care Association.

HITECH created incentive payments for physicians and hospitals who achieve meaningful use of certified electronic health record (EHR) systems within a certain timeframe although policy makers acknowledge that these incentives do not include the full cost of the investments hospitals and physicians will need to make.

However, HIT is an area where Federal policy is inconsistent. HITECH does not include incentives for all players in the delivery system. It excludes nursing homes and home health agencies. Yet the ACA is attempting to move the delivery system to one that better integrates care (and payments) across the care continuum.

⁶ The final "meaningful use" rule for electronic medical record adoption was issued by Centers for Medicare and Medicaid Services (CMS) on July 13, 2010 and it provides meeting certain objectives to qualify for the federal Medicare or Medicaid incentives. CMS also issued Vermont physicians and hospitals some flexibility in a final rule the same day outlining the standards and criteria EHR vendors need to follow for their products to become certified for meaningful use.

Committee Recommendations:

- Grant funds should be used by VITL to operate and expand the statewide health information exchange network for Vermont using the standards endorsed by the national Health Information Technology Standards Panel (HITSP) and IHE Profiles.
- Grant funds should be used by VITL to assist all primary care practices to be "meaningful users" of certified EHR technology by 2012 in order to fully qualify for Medicare and Medicaid incentive payments.
- Federal and state policy makers need to continue to explore ways to create financial incentives to expand HIT to home care, nursing homes and other providers. Due to information technology's high capital costs and the fundamental changes it brings to the day-to-day practice of clinicians, financial incentives to expand health information technology and train providers in the use of this new technology are an essential ingredient of health care reform.

Workforce

Principle: The transformation of Vermont’s health care system depends on an adequate supply of trained health professionals being available to ensure appropriate access to health care services throughout Vermont. Access to primary and specialty health care services is critical to ensuring a high performing health system and healthy Vermonters.

Federal Changes: Current national projections indicate a shortage of 125,000 physicians by 2025 (this does not account for increased access under the new reform law, which will exacerbate the shortage). The recently enacted Affordable Care Act (ACA) provides temporary increased Medicaid and Medicare reimbursement to primary care health professionals and other specialties and financial support to local, regional and state groups attempting to educate, recruit and retain health care professionals. The Act also increases funding for educational institutions, loans and scholarships designed to increase the overall size of the health care workforce in order to meet the increased demand for services due to expanded insurance coverage and improved access to comprehensive disease prevention and health promotion services.

State Implications: As the demand for services increases under the ACA, Vermont will face a growing shortage of physicians and other health professionals, just as the need for health care services for an aging population with an increased prevalence of chronic disease is growing. Further, the success of the patient-centered medical home initiative that is a central component of Vermont’s health care reform activities depends upon adequate access to primary care professionals whose attraction and retention is made particularly challenging by poor reimbursement and a difficult practice environment.

Committee Recommendations:

- Support recruitment and marketing activities that highlight Vermont as an attractive, innovative health care practice environment, and increase state educational loan repayment and student grant/scholarship programs to complement the newly enhanced federal workforce programs like the National Health Service Corps.
- Address state policies to provide appropriate compensation for physicians and other health professionals under the Medicaid program and provide reimbursement for electronic communications, such as telemedicine services, telephone services, remote patient visits and exchanging secure e-mails with patients.
- Address stresses in the practice environment by reducing the administrative burdens on health care professionals, including those relating to claims payment processes, prior authorization processes, pharmacy management and enacting medical liability reform.
- Improve health care workforce data collection and analysis activities.
- Coordinate the health care delivery system needs in Vermont with our education system to ensure that training and education programs reflect state needs and markets for health workers. This would include options for primary care residency training programs state-wide.
- Apply for federal planning and job training grants that will be available for workforce planning and expansion of the state apprenticeship program and other training programs for many health care occupations, including direct care.

- Create job opportunities for Vermonters by using health care career marketing strategies that will encourage the use of new training programs and other health career resources.
- Public and private health care organizations in Vermont should work together to influence Federal policy that impacts patient access to health care professionals. For example:
 - Congress should lift the cap on Medicare-supported residency positions so that future physicians can finish their training.
 - Congress should repeal the sustainable growth rate Medicare physician pay formula. Absent Congressional action, in December the Medicare physician payment cut will be 23% and the payment cut will increase to nearly 30% in January of 2011. Reimbursement cuts of this magnitude will threaten physicians' ability to treat Medicare beneficiaries.

Prevention/Wellness

Principle: The U.S. population and by extension Vermont's, should be the healthiest in the world. A new and sustained focus on disease prevention and promotion of wellness must be developed that includes individuals, employers and communities.

Federal Changes: The recently enacted Affordable Care Act (ACA) and recent state changes support the goal of continued investment in public health and preventive care as a long-term strategy to “bend the cost curve.” Some of these changes include:

- Improve prevention by covering only proven preventive services and eliminating cost-sharing for preventive services in Medicare; increase Medicare payments for certain preventive services to 100% of actual charges or fee schedule rates. (January 1, 2011)
- Provide Medicare beneficiaries access to a comprehensive health risk assessment and creation of a personalized prevention plan and provide incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs. (January 1, 2011)
- Provide grants for up to five years to small employers that establish wellness programs. (January 1, 2011)
- Permit employers to offer employees rewards of up to 30%, increasing to 50% if appropriate, of the cost of participating in a wellness program and meeting certain health-related standards. (January 1, 2014)

Implications for State Policy: Reducing the prevalence of disease (by lowering risk factors and supporting healthy behaviors) is essential to lowering the cost of health care coverage. A population-based approach to chronic disease prevention requires resources outside of the traditional delivery system. These might include school-based initiatives, public health resources, local community development to support healthier lifestyles and employer-based wellness initiatives. The Blueprint for Health works to help Vermonters who have chronic conditions stay as healthy as possible – improving their quality and enjoyment of life and avoiding the need for complex care later when illness is harder to treat. Hundreds of Vermonters have attended [Healthier Living Workshops](#) sponsored by the Blueprint. These self-help workshops teach individuals to manage their chronic conditions and improve their health. Effective chronic disease management is best achieved when the patient actively manages his or her own care in collaboration with his primary care physician and other members of a health care team.

Committee Recommendation:

- State Government should provide assistance for small employers to apply for wellness program grants. In addition, employers should promote employee engagement in healthy behaviors and the appropriate use of the health care system. Incentives may include premium discounts of up to 15% off employee health insurance costs in return for adherence to health promotion and disease prevention programs and the use of advance directives.

- Prevention and management of chronic disease requires a supportive environment with the active involvement of the individual, families, providers and the community. The Vermont Department of Health should identify funding and develop collaborative regional and statewide planning and grant applications tied to state population health needs.
- Federal and state policy makers should continue to encourage individuals to take greater responsibility for their personal behaviors and choices to the extent they are able.
- Fully maximize the opportunities in Vermont for the utilization of ACA funds available for preventive services and community prevention programs.