



Hotline

February 2003 PRESIDENT'S MESSAGE



As I put pen to paper, we are finishing the second month of the legislative session. Not surprisingly, the Association has been focused on the State House. For hospitals, we have been most recently focused on governance and the Certificate of Need (CON) issues. During the month of February, the House Health and Welfare Committee has been considering

legislation that proposes sweeping changes in both of these areas. In response to that legislation, the Vermont Association of Hospital and Health Systems has submitted a four part proposal. This proposal reflects our rock solid commitment to make positive change. It also reflects our determination to maintain health care systems that are responsive and efficient – systems that will continue to deliver the highest quality of care to Vermonters. The proposals include:

Public Reporting of Quality Measures: All Vermont hospitals have agreed to report publicly on three conditions – acute myocardial infarction, congestive heart failure, and community-acquired pneumonia – as part of a national initiative led by the American Hospital Association (AHA). Additional measures, based on twenty priorities outlined by the Institute of Medicine, are under development.

Financial and Efficiency Benchmarks: Building on the work of the VAHHS benchmark committee, this section of our proposal would require the Public Oversight Commission to increase their use of financial and efficiency benchmarks when reviewing hospital budgets. The Association strongly believes that the increased use of benchmarks will bring consistency and predictability to the hospital budget review process.

Community Needs Assessment and Accountability Act: The Association has proposed legislation that would require each Vermont hospital to work with other providers and community groups to develop an

assessment of the health care needs of its service area. This assessment would be done every three years under uniform guidelines, and in turn, each community's assessment would become part of an overall state plan. In addition, hospitals would be required to report annually to their communities on financial, strategic, and operational matters.

CON Law Improvements: The Association has proposed legislation to make the Certificate of Need process more streamlined, predictable, and efficient.

We are in the midst of a major evolution in health care. Patients are demanding greater involvement in decisions being made about health care delivery, both in their personal care and at the community level. This is good, because an educated and involved consumer population will ultimately play an important role in addressing tough issues like utilization and resource allocation. As we enter a new world in health care decision-making, it matters that we forge a path of collaboration between health care providers and members of the community we serve.

So what should be the proper steps to moving this evolution forward? In our view, it begins with community assessment. Conceptually, it is a process of engagement in which many people and constituencies come together to understand the health care needs of their community and, together, prioritize the services that they need.

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A community assessment should include a community profile based on objective data that can be compared to other communities. The objective data includes information such as how many people smoke, how many people are overweight, and how many exercise regularly. The profile should identify the existing services in a community as well as barriers to health care access. The profile would also depend on subjective data and participant involvement. Community members should have the opportunity to express their concerns about the level and type of services they would like to have. Once the profile is complete, community members, hospitals, and other health care providers can use it to set future health care priorities.

This is not easy work. In many ways, developing the profile is the easy part. The hard part will be agreeing on priorities and changing behavior in order to conserve resources. Under the legislation we have proposed, each assessment would be updated every three years and filed with the Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA). Both creation of the needs assessment and preparation of the annual report would involve extensive opportunity for public participation and input.

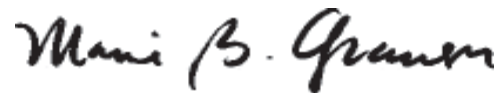
Community assessments are not "hospital report cards." Hospital report cards focus on the performance of the hospital and may be used by consumers and policy makers to compare institutions to one another. They may also be used by hospital leadership to help determine the priorities for the institution's performance improvement program. The public

reporting initiative being led by the AHA and implemented by VAHHS (the first part of our proposal that I mentioned earlier in this article) is an attempt to provide a common framework for such public reporting.

Community assessments provide information about the needs of the community served by the hospital and, if done well, will be the catalyst for community-based initiatives in which the hospital will be one of many partners. They will provide an opportunity for community members to describe all of their health needs, including those needs that are not traditionally met by hospitals.

VAHHS has proposed a formal community assessment process because we know that community assessment is the best way to engage our consumers in effective decision making. We also believe that hospitals are in a unique position to lead this kind of community planning process. By spearheading assessments throughout Vermont, the hospital community will be able to work with the state to develop a statewide health plan that marries resources to needed services.

The health care evolution we are experiencing is real, and it isn't going to go away. We hope you will join us in forging a path toward collaboration between service providers and community members that will lead to better health care for all of us.



CMS ISSUES LONG-AWAITED HIPAA SECURITY RULE

On February 20, 2003 the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* the final HIPAA security regulations.

Some highlights include:

- The rule has been changed to provide consistency with the privacy rule (for example, the "chain of trust" agreement has been replaced with additional security requirements in business associates contracts)
- The final security rule applies to protected health information (PHI) in electronic form only
- The rule provides more generic guidance and less detail, focusing more on principles, less on check-lists
- The security rule becomes effective April 20, 2003, following a 60-day comment period. Covered entities have two years – until April 20, 2005 – to comply.

For more information, including a link to the entire security regulation, please visit the NHVSHIP website (www.nhvship.org) or contact Greg Farnum (223-3461).

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VAHHS CONVENES NURSING SYMPOSIUM

On February 12th, VAHHS convened a one-day nursing symposium to address Vermont's nursing shortage. More than 50 hospital CEOs, nursing leaders, nursing educators and others participated. The purpose of the symposium was to generate ideas for continued collective and individual efforts to recruit and retain nurses into the profession.

Bob Clarke, Chancellor of Vermont State Colleges kicked off the event. Chancellor Clarke served as Chair of the Blue Ribbon Commission on Nursing. This commission studied the nursing shortage in 1999 and 2000 and made several key recommendations on how to address the shortage. Mary Val Palumbo, Director of the Office of Nursing Workforce, presented enlightening information about our nursing workforce and discussed the "gaps" still remaining in the Blue Ribbon Commission's recommendations. Harvey Yorke, CEO of Southwestern Vermont Health Care followed with an inspiring presentation on the economic and cultural benefits of achieving magnet status at their hospital. (Magnet status is an accreditation by the AACN that recognizes hospitals as being exemplary places for nurses to practice). The last speaker was Betty Rambur, Dean of UVM's School of Nursing and Allied Health. Betty discussed the challenges of increasing the numbers of students entering nursing school and illustrated several promising ideas for retaining nurses.

The last hour of the symposium was devoted to a brainstorming session. Some of the ideas generated included:

- An exportable distance learning program
- A partnership to fund marketing efforts
- A statewide Magnet Initiative
- Statewide diversity recruitment:
"Are you man enough to be a nurse in Vermont?"
- More public forums to talk about issues
- A Vermont Nurses Trail
- Continued research

These ideas will be discussed and prioritized in several forums, including the Workforce Development Partners - a public/private workgroup that includes members from UVM, the Department of Employment and Training, the Department of Education, Area Health Education Centers, VAHHS and others.

MONTHLY CMS OPEN DOOR CONFERENCE CALLS

The Center for Medicare and Medicaid Services (CMS) has scheduled a series of open door conference calls on various health topics.

Schedules can be found at the CMS web site:
<http://www.cms.gov/opendoor/schedule.asp>

Newsletters from past events can be found at:
<http://www.cms.gov/opendoor/newsletter/>

THE COST OF HEALTH INSURANCE VS. THE COST OF PROVIDING CARE

So often we hear that the cost of health care in Vermont is high. It is important to understand, however, that the cost of providing health care services and the cost of providing health care insurance coverage are two very different things.

The 2000 Vermont Health Care Expenditure Analysis, October 2002, published by the Department of Banking, Insurance, Securities and Health Care Administration reports that Vermont hospitals' average cost to deliver health care is lower than both the national average and other New England states.

While the cost to purchase health insurance and the cost to deliver care are related, they are very different issues. When we attempt to make changes to our health care system it is critical to be much more precise in our discussion of cost to ensure we solve the right problem.

So why is the cost to deliver care low on average while the cost to provide insurance coverage is high? One reason is the cost shift. In Vermont, Government payers – Medicare and Medicaid – do not pay the actual cost to care for their beneficiaries. The difference between the Medicare and Medicaid reimbursement and the actual cost for the care is paid by (or shifted to) commercial insurers. Commercial insurers actually pay more than cost to cover the government underpayments. As such, the cost shift increases the cost of health insurance coverage.

Federal law states that Medicaid cannot pay more for the same services than Medicare. The legislature passed a law in 2000 to gradually increase Medicaid payments to Medicare levels. To reach parity with Medicare, Medicaid reimbursement would need to increase by approximately \$24 million. It is important to remember that even if Medicaid were to increase payments to Medicare's rates, it still would not be paying cost. VAHHS estimates that Medicare will underpay Vermont hospitals \$33 million in FY 2003.

VAHHS is working closely with the American Hospital Association and members of our congressional delegation to improve the Medicare reimbursement for Vermont hospitals.

VAHHS also continues to talk with legislators and other state representatives to address the issue of the Medicaid underpayments.

For more information, contact Erica McNamara.

FEDERAL BUDGET OFFERS LIMITED HELP

Despite intense lobbying by the health care community, the federal fiscal year (FFY) 2003 omnibus appropriations bill passed by Congress does not roll back the Medicare cuts to hospitals, nursing homes, and home care agencies that were implemented last October. However, the bill does contain limited Medicare relief for rural small community, and small urban hospitals and permanent relief for physicians. President Bush is expected to sign the legislation into law.

VAHHS and the American Hospital Association (AHA) are fighting to keep provider payment relief on the short-term congressional agenda. However, President Bush's willingness to accept additional provider payment cuts is likely to place health care providers in the position of fighting new cuts.

Politics overshadowed the debate over inclusion of hospital and health system relief. The White House had threatened to veto any package that spent more than the President favored. With the President opposed to rolling back the new Medicare provider and Graduate Medical Education cuts, the Republican-controlled Congress put off the hospital and health system agenda and set final spending levels in accordance with White House stipulations.

Medicare provider provisions in the appropriations bill include:

- A temporary and limited payment increase to rural, small community and small urban hospitals would increase the Medicare standardized base payment amount for inpatient services by 1.6% to match the large urban standardized amount for the second half of the current federal fiscal year, without building these funds into the permanent payment base. The provision would raise Medicare payments by about \$2.4 million overall to most Vermont hospitals.
- A change in the physician fee schedule update formula would cost \$54 billion over ten years and result in a 1.6% increase in Medicare payments to physicians this year, as opposed to the 4.4% reduction that was slated to take effect on March 1.
- Another provision would give hospitals nationwide \$518 million in bioterrorism funds that were promised last year as part of the Public Health and Bioterrorism Response Act. The bill also includes \$15 million to begin implementation of the Nurse Reinvestment Act, which was signed into law last year.