



Vermont Health Policy Perspectives

June 2006

Vermont Association of Hospitals and Health Systems • 148 Main Street • Montpelier, Vermont 05602 • 802-223-3461

President's Message: Every Journey Begins with the First Step

Legislators adjourned earlier this month after passing health reform legislation that promises to dramatically change the delivery of health care in Vermont. The centerpiece of these legislative initiatives is Catamount Health, a new health plan which will begin providing publicly subsidized, but privately offered health insurance to currently uninsured Vermonters in October 2007.

Getting to “yes” on Catamount Health entailed considerable political wrangling between legislative leaders and the Administration. Details aside however, all parties had long agreed on the overall approach: create aligned reform proposals that will slow the rate of growth and provide the currently uninsured with affordable, comprehensive health insurance. H.861, the Health Care Affordability Act, is the core piece of legislation that embodies this strategy, although important reform pieces are also contained in H.881, the budget bill and S.198 (Safe Apology and Sorry Works!). The question is, can all of these reform initiatives, such as the chronic care implementation plan and the Vermont Blueprint for Health slow the growth of health care fast enough to help pay for the increased demand for health services created by Catamount Health? That question of course can only be answered in time, but it's clear that between the layers of rule-making and future funding, there is little room for error.

The Catamount Health program has certainly been scaled back from earlier legislative versions, but we will still learn valuable lessons as this health plan is constructed over the next year. Catamount Health will be offered to currently uninsured Vermonters who have not had insurance coverage within the preceding twelve months. The benefit package developed by the health plans must offer primary, preventive, hospital, acute episodic and chronic care services, with specific limits on co-pays, deductibles and premiums defined in statute. Eligible individuals above 300% of the federal poverty level (FPL) will be able to purchase Catamount Health at cost, with state-funded subsidies available for those at lower income levels.

In some ways, Catamount Health will operate like a statewide pilot project. Private health plans will offer Catamount Health initially, but if no health plans offered Catamount Health within a reasonable time, the Commissioner of Banking Insurance

Securities and Health Care Administration (BISHCA) could mandate that they offer Catamount Health on the non-group market. Two years after the Catamount Health program begins, the Health Care Commission will evaluate the program to determine its' cost-effectiveness. At that time, the legislature could decide that the state should bear the risk for Catamount Health, similar to the state's Medicaid program.

Another pilot-like aspect of Catamount Health is the focus on cost containment. Legislators project that growth in the Catamount Health program would remain at least 30% less than other privately offered health insurance products for three reasons: lower-than-commercial payments to providers, an anticipated healthier population and a mandatory enrollment cap that will automatically go into effect should utilization exceed projections.

There are other factors in this legislation however, that could drive up costs. Co-payments and deductibles must be waived for chronic care management and preventive care. While this provision makes perfect sense from a patient perspective, it could drive up utilization – and costs – in the short term. The bill also allows for “any willing provider” to receive payment for covered services or conditions. Since Catamount Health is to be structured as a Preferred Provider Organization (PPO), this provision will likely dilute the plans' ability to manage costs by creating a defined provider network. In contrast, Massachusetts eliminated their “any willing provider” law as part of their recently passed health reform in an effort to contain costs. Finally, limited pre-existing condition provisions apply, except for chronic conditions if the patient is participating in a chronic care management program. Again, this makes policy sense, but may drive up costs in the short-term.

(continued as President's Message on inside right)

ALSO IN THIS ISSUE:

- Adverse Events Reporting
- S.198, Safe Apology and “Sorry Works”
- FY07 Appropriations Bill



Adverse Events Reporting Included in Healthcare Reform Bills

The healthcare reform bills, H.861 and H.895 include a provision for the creation of a “comprehensive patient safety surveillance and improvement system” under the auspices of the Vermont Department of Health. It represents the work of a small group of stakeholders with diverse perspective, including hospitals, physicians, consumers and state regulators. Thanks to the leadership of Senator James Leddy, this group worked quickly to develop a consensus package for legislative consideration. Hospitals and physicians were very concerned with maintaining the gains made in recent years to promote a culture of safety. This culture means that reporting on events is safe and without “shame and blame.” Without such a culture, too many system problems go unreported. Consumers and the Vermont Department of Health understood those concerns, but also placed a high value on public accountability. The provisions of the bill attempt to balance all of those needs.

The bill would require four different levels of internal and external reporting by hospitals of adverse events.

1) Hospitals are required to implement internal procedures that identify and analyze adverse events and “near misses” in order to develop corrective action plans. All Vermont hospitals already have such programs in place. The bill would give the health department the authority to set standards for those programs as well as the authority to audit hospitals to insure they have been implemented. Perhaps of greatest concern to hospitals is that the bill allows for health department representatives to examine peer-review protected materials, under the auspices of a peer-review protected process. Hospitals will work closely with the Department of Health to insure that this provision of the bill does not have a chilling effect on the internal reporting systems already in place.

2) Hospitals are required to disclose to patients or their survivors, at a minimum, adverse events that cause death or serious bodily injury. This provision seeks to foster more open discussions with patients without creating the unintended consequences of increasing the number of civil cases or burdening providers with increased paper work. Vermont hospitals already have such policies in place and have worked hard to reverse a long-standing trend in health care to disclose as little as possible. In recent years, more open disclosure has become industry practice and is required by the Joint Commission on Accreditation of Health Care Organizations. If it passes, the new safe apology language found in S.198 (see opposite page) will provide an important new protection and help promote more open communications between patients and providers.

3) Hospitals are also required to report to the Department of Health those adverse events that include the 27 “serious reportable events” published by the National Quality Forum. The list is diverse – it includes such things as criminal acts and wrong-site surgery. Hospitals are also required to provide the department with copies of its causal analysis and corrective action plan in connection with each reportable adverse event. With the passage of H.861/H.895, Vermont will become the fifth state in the country to require the reporting of these ‘never events’. This provision of the bill represents the most significant new expectation. While all hospitals have internal reporting systems and some hospitals participate in the voluntary JCAHO sentinel event reporting program, most hospitals have no mechanism in place for external reporting. In addition, those states that have implemented “never event reporting” have found that some events are not adequately defined by the NQF and have had to be further explained on the state level.

4) Finally, hospitals shall notify the Department of Health if it believes that an intentional unsafe act as it pertains to patients has occurred. An intentional unsafe act is defined as an adverse event or “near miss” that results from: a criminal act; a purposefully unsafe act; alcohol or substance abuse; or patient abuse. These intentional unsafe acts are not the result of system problems but, rather they result from the actions of an individual. If appropriate, the individual would be referred by the Commissioner of Health to law enforcement or a licensing board for further action. Essentially, this provision is aimed at preventing the patient safety program from shielding those rare providers who cause adverse events themselves, not as part of a failing system. VAHHS will work to insure that the implementation of this section of the bill does not have a chilling effect on internal reporting programs.

VAHHS staff look forward to continuing the collaboration begun through the process of developing legislation into the implementation process. VAHHS expects there will be a collaborative and extensive rule making process to fully implement the bill. We are optimistic that the program can be implemented in a way that is harmonious with similar requirements already laid out by JCAHO and federal regulations. Our focus will be to insure that the implementation of the program does not create unnecessary administrative burdens on hospitals and maintains a focus on improving safety.





FY 2007 APPROPRIATIONS

The FY 2007 Appropriations bill (H.881) passed on May 10, 2006. Despite a pending Medicaid deficit of \$212 million over five years, the Conference Committee did not recommend any significant changes for the budget. The bill appropriates \$1 million in state and federal dollars for hospital inpatient and outpatient services and \$2.5 million to primary care physicians. H.881 does fully fund the chronic care initiative, funds dental programs in schools, increases funding for community clinics, funds the Area Health Education Centers and gives a 5.2% increase to tobacco prevention and cessation programs.

Effective July 1, 2006, only the division of rate setting will be able to amend the rules for establishing Medicaid rates for nursing home services. There is no increase to the bed tax, and the inflation factor is still intact. The bill creates a task force to look at the future sustainability of nursing homes and to develop a long-range plan. A needs assessment regarding the present and future workforce issues of direct care workers in Vermont was also funded. The bill attempts to prepare for long term fiscal challenges by allocating \$20 million through the health care bill for FY 2008 deficit.

The Vermont State Hospital received full funding, including \$1 million for planning and implementation of the VSH Futures Project. The core of the Futures proposal is a 32-bed intensive and specialized care facility; 24 long-term, sub-acute or secure beds for residential care; 10 crisis beds for stabilization and subsequent transfer. Another key component is care management, which would include development of common admission, transfer utilization and communication protocols. The overarching philosophy behind the plan is to continue the trend for community-based care and decrease reliance on institutional care.

The bill includes a number of studies. The Health Access Oversight Committee will explore options for and develop a plan to eliminate the Medicaid deficit. This committee will study the reimbursement rates paid by Medicaid, VHAP and Dr. Dynasaur and the effects of the rates on Vermont's health care system. The Committee will look for: opportunities in the Global Commitment waiver; methods to streamline Medicaid, VHAP, and Dr. Dynasaur administration and regulation; and other strategies for reducing the deficit. The Committee's report and plan will be due to the legislature by January 15, 2007.

The bill also updates the required health care study sections of last year's budget bill. The Commission on Health Care Reform, in consultation with BISHCA, is directed to complete an economic impact study by January 15, 2007. The study

will review alternative ways of financing universal health care coverage based on either private insurance or a single payer. It will consider employer assessments, payroll taxes, income taxes, premiums (either employment-based or independent of employment) or other revenue options.

The Commission will also monitor state health information technology (HIT) activities, including reviewing State government HIT systems, continued review of HIT systems used by health care providers and activities by the Blueprint for Health and by Vermont Information Technology Leaders (VITL).

President's Message

(continued from front)

Revenues for Catamount Health will come from increased cigarette taxes, individual premiums, and federal funds available through the Global Commitment and a new assessment on employers with uninsured employees. Funding as ever, comes from a patch-work of sources. Payments to physicians and other individual providers are to be made at Medicare rates plus 10%, with hospital payments set initially at cost plus 10%. Insurance contracts will be renegotiated as necessary to include these lower than commercial rates.

Another wild card is the new employer assessment. This annual assessment will be \$365 per FTE in the first year, and is targeted at employers who do not offer insurance, who have employees who are ineligible for their insurance (for example, work too few hours to qualify), or whose employees are eligible for but decline insurance, and are not insured through other means. The first 8 FTEs per employer are initially exempted from this assessment. It remains to be seen how much revenue this provision will generate and how much of a regulatory head-ache this will cause for employers.

With draft rules due in just three months, the Secretary of Administration, Banking Insurance Security and Health Care Administration (BISHCA) will have to work quickly with all interested stakeholders (and there are many) to get Catamount Health off to a solid start. This framework conceptually holds together, but it's a beginning, not an end. It will only add strength to our health care delivery system if the new regulations help to eliminate waste and if the funding provides the right incentives for rapid, positive change. Taking this step is a risk, but without these first steps, others will not be possible.





S.198, SAFE APOLOGY AND “SORRY WORKS”

S. 198 is a bill with two distinct components. The first is a so-called “safe apology.” This provision is designed to create more open communication between providers and patients both for its own sake and in the hope that it will reduce litigation. The bill encourages providers to apologize and explain unexpected outcomes of care by prohibiting the introduction of such communications as evidence in malpractice proceedings. It does provide new legal protection for evidence which is otherwise discoverable, such as the medical record. About half the states in the country have adopted such provisions. Unlike Vermont, most states do not limit the timeframe for the disclosure to 30 days. VAHHS did not support including a timeframe for fear that there would be much debate in court about when providers knew or “should have known” that an event took place. Conversely, Vermont is also nearly unique in extending protection to both apologies *and* explanations. VAHHS very much supported that additional protection.

The second component of S. 198 is known as the “Sorry Works” program. This voluntary pilot program seeks to reduce malpractice litigation by encouraging providers to quickly disclose medical errors to patients and offer “fair compensation.” Similar legislation recently passed in Illinois, although no provider has taken advantage of it. There is also similar legislation that has been introduced in the United States Senate. We expect that implementation of the program will be impeded by concerns raised by medical malpractice carriers who may not cover claims if hospitals “jeopardize their defense” by negotiating settlements too early. The bill contains no provisions to reduce the financial risk a participating provider can expect to incur if their malpractice carriers will not cover claims handled through this program. VAHHS remains interested in finding ways to reduce litigation and malpractice insurance costs, but it is not clear that is possible without more fundamental changes to the litigation system. S. 198 was signed into law as Act 142 on May 15, 2006.

Please address comments to: M. Beatrice Grause, President and CEO / VAHHS / 148 Main Street / Montpelier, Vermont 05602 / Email: Bea@VAHHS.org / Tel: (802) 223-3461 / Fax: (802) 223-0364



**Vermont Association of
Hospitals and Health Systems**
148 Main Street, Montpelier, Vermont 05602

Bulk Rate
U.S. Postage
PAID
Permit #118
Montpelier, VT
05602

