



Toward Evidence-Based Health Care Reform

Vol. 3, No. 2

Status of Health Care Reform, Part II

Welcome to "Toward Evidence-Based Health Care Reform," a periodic e-memo providing facts, figures, examples and analysis of current issues in health care reform in Vermont. The memo is written by Jeanne Keller, Keller & Fuller, Inc., and sponsored by BRS, Inc., a member organization providing a range of services and support to Vermont's small businesses. For more about BRS, please visit our website: www.brsvt.com

To review past issues of Toward Evidence-Based Health Care Reform, www.vtreform.com.

To read and download the comprehensive health care reform proposal supported by BRS and several other Vermont business associations, <http://www.vtiha.org>.

First, an update from our last issue, which reported that Catamount Health could be running a deficit in the first year. Susan Besio, Director of Health Care Reform Implementation, sent us the new revenue and expenditure estimates for Catamount Health with this explanation:

In fact, almost all of the numbers on the Catamount Fund balance sheet have changed as we have refined our estimates for enrollees, cost of premium assistance, etc., so the bottom line is still in the positive. I have attached the relevant documents that were given to the E-board that shows that the expected revenue for the Catamount Fund on FY08 is greater than the expected expenditures for the Catamount Premium Assistance and Catamount-ESI programs. The Catamount Fund also is the source (by statute) for the immunizations Programs and the Non-Group Market Security Trust. The governor's proposed budget includes these and has a break-even fund balance for FY08.

The revenue for the Catamount Fund comes from tobacco taxes and tobacco settlement funds, and the new Employer Assessment. Expenditures for FY2007 will be \$0, because enrollment doesn't start until Oct 1. FY2008 expenditures are based on estimated enrollment of 2,653 in Catamount Health in the first year, and 102 in the Employer Sponsored Insurance (ESI) subsidy plan. Projections for 2009 enrollment and expenditures haven't been made yet.

	Revenues	Expenditures
FY2007	\$13.9 million	\$0
FY2008	\$19.8 million	\$11.6 million
FY2009	\$25.2 million	-

Now, to continue our status report on health care reform in Vermont.

Patient Safety and Adverse Event Reporting

- The Department of Health is charged with developing standards and a system for hospitals to report "adverse events" to the Department, along with an analysis of the causes of the event and a corrective action plan to prevent recurrences. The statute identified [the list of "serious reportable events"](#) developed by the [National Quality Forum](#) as the core set of events that must be reported. These are the so-called "never events," preventable errors that can cause serious injury or even death to a patient. Hospitals must demonstrate to the Department that they have internal processes and controls in place to ensure that adverse events are being internally reported, investigated, analyzed and corrected. The statute also requires the hospital to disclose adverse events to the affected patient and/or family.
- The Department convened a stakeholder group including hospital safety and quality staff, consumer representatives and legal advisors for input on the design of the system and to comment on drafts of the proposed regulations.
- The Department issued interim guidance to the hospitals on 12/11/06 alerting them to the upcoming requirements so that they could begin developing internal systems for identifying and reporting adverse events and errors.
- The Department must develop a data management system to receive the reports from hospitals, monitor and evaluate hospital corrective action, and perform statewide analyses of trends and events. In some form, not yet determined, data on adverse events will also be reported to the public.
- On deck for adverse event/patient safety reporting: the Department of Health will present draft rules to the legislative committee on administrative rules (LCAR) on 2/15/07. Once rules go through the comment period and are finalized, hospitals will begin reporting any adverse events to the Department, probably in 2008.

Cost and Quality Transparency / All-Payer Database

- BISHCA is working on regulations requiring insurers to provide information to their subscribers/members on comparative cost and quality of Vermont's health care providers "to empower individuals" to make "economically sound and medically appropriate decisions." A stakeholder group of consumers, insurers, employers and health care providers is providing feedback.
- Employers who pushed for this part of Act 191 are looking for the kind of information consumers need to comparatively price services such as uncomplicated surgeries, diagnostic tests and the like. Currently, consumers

can't access information that takes into account the "allowed charges" for their own insurer, and the providers' "retail price" that often has little connection to what shows up on an invoice. Also, while state and federal laws have already made hospital quality information available from [BISHCA](#), [HealthGrades](#) and other sources, little specific information is available about quality of care or consumer satisfaction with physicians and medical groups. Most insurers and states are waiting for the Medicare/Medicaid federal agency, CMS, to finalize [standards for measuring physician quality](#). It is expected that collecting some of this information will be costly; if not available from claims data, information will have to be abstracted from actual patient files. Eventually, Electronic Medical Records – EMRs – will automate data capture for tests process and outcome measures of quality (lab tests, etc).

- [Aetna](#) and a few national insurers are providing fairly detailed cost and quality information to their subscribers voluntarily. BCBSVT internally measures provider performance as part of their NCQA accreditation, but uses the results for quality improvement, and not consumer reports. All cost information available to consumers is 'average' charges, not the actual approved charges based on their own insurance plan.
- The Vermont law is, we believe, the first attempt by a state to require [all insurers](#) in the state to provide meaningful cost and quality information to aid consumers in making informed health care decisions.
- The workgroup is now discussing aligning the Transparency effort with the Act 191 requirement to establish an "all-payer database." This would allow for hospital and physician cost/quality reporting using claims data from all payers, rather than each insurer producing a report based on its own subset of the data. The value of this effort would be in measuring performance across a much larger pool of patients, thus allowing profiles to be more statistically valid, and adding Medicaid results to the cost and quality reports. Aligning the Transparency initiative with the All-Payer Database initiative would mean that cost/quality information would be available to all Vermonters based on the experience of the 90% of residents who are insured. No other state has nearly that robust a dataset, and no individual carrier could accomplish this. The All-Payer Database can also be used to map the incidence of chronic disease and compare efficiency and effectiveness across the state at managing the disease --- for example, by tracking the rate of ER use by *all insured* asthmatics or diabetics in each part of the state. This would get at the heart of quality: how well is the whole health system dealing with chronic illness, and how does each region stack up to other parts of the state? Discussion at the 2/13 meeting of the workgroup indicated that a pilot of the all-payer database could be put together "over the weekend" by GE, the contractor for the statewide IT initiative.
- On deck for Transparency: a draft of the requirements is being circulated for comment. The stakeholder group is meeting monthly. Insurers are expressing concern over the high cost and long-term planning required for revising their websites to incorporate these requirements. BISHCA's draft plan would have insurers starting to post information for subscribers by mid-2008.

Hospital Infection Reporting

- Another little-known element of Act 191 requires hospitals to begin reporting on [Hospital-Acquired Infections \(HAIs\)](#) starting in June 2007. The [HAI measures](#) will be added to the current [Hospital Report Cards](#) required by BISHCA. Currently, [hospitals report their surgical site infection](#) prevention practices, and there is a wide variation from hospital to hospital on compliance with these nationally recognized prevention standards.
- Central Line Infections will be the first measure publicly reported (June 2007). Vermont has been working with the Center for Disease Control to train hospital personnel on developing standards and definitions for accurate reporting.
- The most robust statewide HAI reporting program currently is Pennsylvania's. Their [second annual report](#) disclosed that hospital stays in which an HAI developed, on average, are 16 days longer and cost \$150,000 more than stays without an infection. They estimate the excess cost at more than \$3.5 billion a year. Savings in Vermont can't be estimated until the reporting starts.
- On deck for HAI reporting: defining and setting timelines for hospitals' public reporting of specific surgical site infections (e.g. knee and hip replacements, hysterectomies, etc), ventilator-associated pneumonia and other HAIs.

Common Claims and Administrative Simplification

- Unlike other advisory groups developing implementation plans for Act 191, [this group](#) is not managed by a division of state government, but rather is self-directed by provider and insurer organizations, with input from consumers and employers. The group is charged with recommending steps to simplify the claims administration process for consumers and providers so that the process is more understandable, less time consuming and reduces administrative costs.
- To date, the group has identified the processes affected, established sub-committees to work on specific tasks and produced a detailed work plan. They submitted an [interim report](#) to the legislature, but to date, there are no specific recommendations for how to simplify administration, or what the common claims form or common EOB should be.
- The advisory group heard a presentation from the Utah Health Information Network that is already doing what the VT law envisions, and that VT could simply link to. The group is now exploring the few similar models in other states and regions. (A PowerPoint on the Utah network starts on p. 23 of the [interim report](#).)
- On deck for common claims: agreeing upon the common claim, common EOB and standards for simplifying claims administration. BISHCA is expected to issue regulations for health care providers and insurers based on the group's recommendations.

This periodic newsletter will continue to provide updates on reform activities. The best single site for monitoring and downloading information on reform is maintained by the Administration at <http://hcr.vermont.gov/>. To view task force reports, click on "documents" in the left column on the home page.