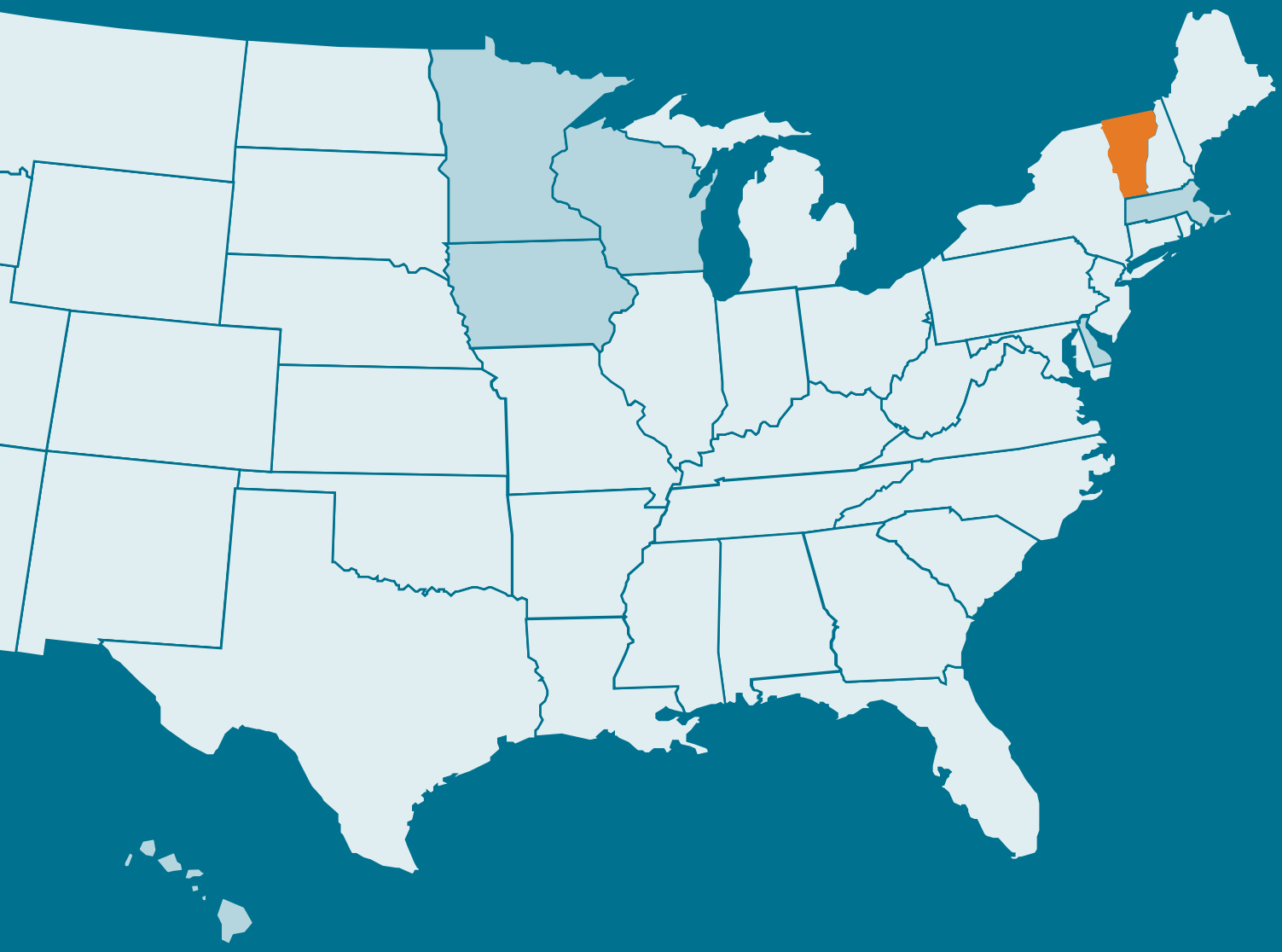
AIMING HIGHER FOR HEALTH SYSTEM PERFORMANCE

A Profile of Seven States That Perform Well on the Commonwealth Fund's 2009 State Scorecard: Vermont



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Aiming Higher for Health System Performance: *A Profile of Seven States That Perform Well on the Commonwealth Fund's 2009* State Scorecard: Vermont

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Vermont: A Blueprint to Control Costs and Expand Coverage

Vermont ranks at the top of The Commonwealth Fund's *State Scorecard on Health System Performance, 2009*. It is the only state that ranks in the top quartile of states across all five dimensions of performance measured by the *State Scorecard.* The state is a leader in integrating public health principles into the health care delivery system, and has one of the most innovative models of prevention and care coordination in the country. The goal of these activities is to shift the focus of health care from only treating illness to a system that prioritizes prevention, supports healthy environments and lifestyles, and improves access to preventive and primary care. The scorecard indicates the strategy is working—Vermont continues to improve its already-high rankings in prevention and treatment, and other measures of healthy lives, and to hold the line on cost (Table 3).

Since 2003, Vermont's health system performance has been driven by a "Blueprint for Health," initiated by Gov. Jim Douglas (R) and the health commissioner at the time, Paul Jarris, M.D., to cut costs and improve care by preventing chronic diseases and getting better treatment to people who have them. Vermont's majority-Democrat legislature endorsed and funded the Republican Governor's Blueprint in 2006, and created a new public–private insurance expansion called Catamount Health. In a remarkable burst of reform activity from 2006 to 2008, the legislature approved and the Governor signed 11 health reform bills with over 60 specific initiatives to increase access, improve quality, and contain the cost of health care in Vermont.[3]

Setting the Stage for High Performance

Vermont has a long history of political debate on the tension between health coverage and cost control. A major health reform effort in 1994 failed in part because of the inability of political leaders to reconcile the goal of covering the uninsured and the goal of containing costs for the insured.[4] A decade later, the debate again focused largely on how to finance coverage for the uninsured. In 2005, the General Assembly proposed a new payroll tax to support universal coverage, but some residents who already had health insurance (90 percent of the population was insured at the time) were convinced that they would pay even more for health care and receive less, and Gov. Douglas ultimately vetoed the bill.[5]

Although universal coverage did not pass in 2005, legislation was enacted to fund a new legislative Commission on Health Care Reform. The Commission was cochaired by Senate health chair Jim Leddy and his counterpart in the House, John Tracy. Both Democrats, Sen. Leddy and Rep. Tracy held hearings throughout the state, authored principles for reform with the Vermont Business Roundtable, and developed a new reform bill, which the Governor signed in January 2006. The final legislation struck a balance between controlling costs and expanding coverage. It funded the Governor's Blueprint priorities to modernize how care is delivered and create a statewide health information technology system—and it created a new public–private health plan called Catamount Health to cover uninsured Vermonters.

Coverage

Census data used in the State Scorecard *indicate that 86.5 percent of Vermont's nonelderly adults had health insurance in 2007–08 and 93.4 percent of children were insured. However, according to the Vermont Household Health Insurance Survey, since 2005 insurance rates for Vermont children have increased dramatically (2.0 percentage points) to 97.1 percent in 2008.*[6]

Since 1997, the Vermont Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA) has conducted periodic household health insurance surveys to monitor the health insurance coverage status of Vermont residents and related demographic, employment, and economic characteristics. Vermont's state-sponsored surveys include a more robust sampling approach than the federal Census Bureau's Current Population Survey and are tailored to specifically address health insurance issues. Early surveys supported efforts to target Medicaid outreach, and data from the 2005 survey provided data on the uninsured that was used to develop health care coverage reforms enacted in 2006. Three years into reform, the state reports 13,771 fewer Vermonters are uninsured, about 23 percent of the previously uninsured population (Table 4). More than half of the gain in insurance coverage since 2005 was achieved through the Medicaid program. There were also significant gains in military health insurance coverage and a modest gain in private coverage.[7]

Medicaid, Dr. Dynasaur, and the Vermont Health Access Plan

Vermont has significant experience using Medicaid waiver authority to expand coverage for the uninsured. The state was working to enact universal health insurance coverage early in the 1990s and, although the broader effort achieved less than universal coverage, Medicaid was expanded in an effort to cover most children. Today, the Dr. Dynasaur program provides Medicaid coverage to all children with household income under 300 percent of the federal poverty level, to pregnant women under 200 percent of poverty, and to parents and caretakers under 185 percent of poverty.[8] The Vermont Health Access Plan (VHAP) provides coverage for adults who have been uninsured for at least 12 months and are not otherwise eligible for Medicaid or Dr. Dynasaur, up to 150 percent of poverty. The 2006 health reform expanded Medicaid benefits to include a new Chronic Care Management Program (CCMP) and to create new Medicaid reimbursement incentives to improve care for people with chronic conditions.

Table 3. State Scorecard on Health System Performance: Vermont

	Overall and Dimension Rankings		Number of 2009 Indicators in:		Number of Indicators That Improved by 5% or More
	Revised 2007 Scorecard	2009 Scorecard	Top Quartile of States	Top 5 States	
OVERALL	2	1	22	8	14
Access	12	13	1	0	0
Prevention & Treatment	6	3	10	3	9
Avoidable Hospital Use & Costs of Care	9	11	7	3	1
Equity	2	2	*	*	*
Healthy Lives	10	8	4	2	4

Note: Data were available to rank Vermont on all 38 *State Scorecard* indicators in 2009. Trend data were available for 35 indicators.
* The equity dimension was ranked based on gaps between the most vulnerable group and the U.S. national average for selected indicators; thus, it is not included in indicator counts.
Source: The Commonwealth Fund, Oct. 2009.

Employer Sponsored Insurance Premium Assistance

Adults currently enrolled in the Medicaid VHAP program and new VHAP applicants who have adequate access to employer-sponsored insurance (ESI) are required to enroll in their ESI plan, if it meets state minimum requirements. The state provides subsidies to ensure that that the individual's out-of-pocket obligations are no more than premiums and cost-sharing under VHAP. The state also offers supplemental benefits or "wraparound" coverage to ensure VHAP-eligible 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 residents who are not eligible for Medicaid or VHAP. For uninsured people with incomes under 300 percent of poverty who have access to ESI coverage, the state provides a subsidy of premiums or cost-sharing amounts based on the household income of the eligible individual. 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 ESI plan, then the state enrolls the individual in the Catamount Health Assistance Program.

Catamount Health

Catamount Health is a public–private health insurance program that offers a lower-cost comprehensive health insurance product to uninsured residents.[9] Catamount Health is modeled after a preferred provider organization plan with a $250 in-network deductible and $800 out-of-pocket maximum for individual coverage. Plans are required to include coverage and waive cost-sharing for chronic care management programs and preventive care, including immunizations, screening, counseling, treatment, and medication. Mental health coverage is subject to the state's mental health parity law, which has been in place since 1997 and continues to be one of the most progressive in the country. Catamount Health provider rates are established in law and are lower than commercial rates but 10 percent higher than Medicare rates. Blue Cross Blue Shield of Vermont and MVP Health Care began offering Catamount Health policies in October 2007.

Catamount Health includes a premium assistance program. The state pays the difference between an

Table 4. Vermont's Insured Population Since the Implementation of Health Reform

Type of Insurance	2005	2008	Change 2005–2008	Percent Change 2005–2008
Private*	369,348	371,870	+2,522	+0.7%
Medicaid	91,126	99,159	+8,033	+8.8%
Medicare	90,110	88,027	–2,083	–2.3%
Military	9,754	14,910	+5,156	+52.9%
Uninsured	61,057	47,286	–13,771	–22.6%
Total Members	**621,395**	**621,252**	**–143**	**+ 0.0%**
Est. Percentage Insured	90.2%	92.4%		

* Private health insurance coverage includes 9,326 covered through Catamount Health as of November 2008.
Source: Vermont BISHCA, "2008 Household Insurance Survey: Refresher and Updates," July 2009.

individual's specified contribution—ranging from $60 per month for residents with income up to 175 percent of poverty to the full cost of the Catamount Health policy for those over 300 percent of poverty—and the premium for the lowest-cost Catamount Health Plan, which was $393 per month as of August 2009. Any additional premium amount incurred because an individual chooses to enroll in a higher-cost Catamount Health plan is paid by the individual. Approximately 73 percent of Catamount Health enrollment consists of previously insured residents who switched to a Catamount plan, and 27 percent are residents who were previously uninsured.

Vermont is one of only a few states that requires guaranteed issue and community rating.[10] The state does not currently have an individual mandate to purchase insurance, but the 2006 health reform requires that if less than 96 percent of Vermont's population is insured by 2010, then the legislature must "determine the needed analysis and criteria for implementing a health insurance requirement by January 1, 2011." Also, 2008 reforms require that the Commission on Health Reform study the feasibility of merging the nongroup (including Catamount), small group, and association health insurance markets by 2011.

Prevention and Treatment

Vermont ranks very high—third among all states—in terms of the quality of preventive care and treatment. The state improved its performance on most State Scorecard *quality indicators from 2007 to 2009, with substantial gains on several key measures, including the rates of adults (age 50 and older) receiving appropriate screening and preventive care (which increased nearly 5 percentage points, representing an 11 percent relative improvement from baseline), and of diabetic patients getting recommended services to prevent disease complications (which increased nearly 10 percentage points, for a 22 percent relative improvement).*

Vermont is investing significant public funds to redesign the state's health system to improve quality and cost-effectiveness by preventing chronic diseases and getting better treatment to people who have them. Seventy percent of Vermont's health care costs can be attributed to care for a chronic condition.[11] This urgent fact led the Governor to initiate and the legislature ultimately to fund Vermont's Blueprint for Health.

Blueprint for Health

Vermont's Blueprint for Health is a public–private plan to create a statewide system of care to improve the lives of individuals with, and at risk for, chronic conditions. It is designed to provide patients with the knowledge, skills, and supports needed to manage their own care and make healthier choices; give providers the training, tools, and financial incentives to ensure treatment consistent with evidence-based standards of care; support communities to address physical activity, nutrition, and other behaviors to prevent or control chronic diseases; assist providers to have information technology tools to support individual care and population-based care management; and 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.

Blueprint activities are designed to meet the specific needs of individual communities, and can be scaled to fit the population and intensity of need. "Even in a small state like Vermont, the real action is at the community level," says Jim Hester, Ph.D., director of the legislative Health Care Reform Commission. "That's where the pieces of health

reform come together." Every community in Vermont has implemented at least one component of the Blueprint, and full implementation is set for January 2011.

The Blueprint initially focused on chronic care management for people with diabetes in six of Vermont's 13 hospital districts.[12] These projects started to change how health care providers and policymakers thought about *systems* of care, and illustrated the power of *integrated* systems of care. The state leveraged the lessons learned in these early sites into broader reform, and created pilot programs in three counties to test new ways of paying for care to help practices establish integrated systems. These pilots require commercial insurers, Vermont Medicaid, and Medicare (with Blueprint subsidies) to provide 1) enhanced reimbursement on top of negotiated rates to providers that meet certain medical home standards, and 2) direct financial support for local multidisciplinary Community Care Teams to support system integration and planning. Each Community Care Team includes clinical staff who are selected for the team based on specific community needs, and a public health prevention specialist who is based in the local health department district office. The Community Care Team provides support and expertise to participating medical practices through direct services and care coordination, population management, and quality improvement activities.

"Payment reform is the key to system change," says Craig Jones, M.D., director of Blueprint for Health. "We have to make quality primary care economically attractive," he says, "and provide the basic infrastructure—Community Care Teams in Vermont—to address risk factors across a community."

Statewide Health Information Technology

Vermont's health care reform also includes a plan to improve Vermont's health information technology (HIT), which mirrors the Community Care Team model in its effort to bridge public health and health care delivery. The state established a Health Technology Fund in 2008, financed through an assessment of 0.199 percent of all health insurance claims, to support the development of a health information exchange with Vermont Information Technology Leaders (VITL), the state's private, nonprofit Regional Health Information Organization. VITL operates the exchange, provides grants to assist practices in adopting electronic health records (EHRs), and offers clinical transformation consultation to help providers adopt and use electronic health information technology.

In 2008, Vermont selected DocSite to provide a Web-based clinical tracking system, populated with health information from the VITL exchange. The DocSite tracking system is a critical component of the Blueprint pilots. It has many but not all of the features of an EHR, and gives health care providers free access to treatment guidance at the point of care, electronic prescribing and a flexible reporting tool that supports population management. VITL intends DocSite to serve as a bridge to help providers transition from a paper-based practice and prepare to use a complete EHR.

Potentially Avoidable Use of Hospitals and Costs of Care

Vermont ranks in the top quartile of states on all but one of the State Scorecard's *eight indicators of potentially avoidable hospital use, and in the top five states on three of these indicators. Costs present a mixed picture: Vermont is among the most expensive states for employer-sponsored health insurance premiums, which*

were 12 percent higher than the national average for individuals in 2008. Conversely, Medicare spending per capita was 12 percent lower in Vermont than the national average in 2006.

The Blueprint for Health's focus on prevention and chronic care management is expected to reduce the overall demand for high-cost treatment services over time, and reduce the growth rate in health care costs throughout the system. In addition, the state has several programs that are specifically designed to improve health system efficiency. Since 2003, Vermont hospitals have been required to publish annual hospital community reports containing information about quality, hospital infection rates, patient safety, nurse staffing levels, financial health, cost for services, and other hospital characteristics. BISHCA publishes much of this information on its Web site.[13] Also, all Vermont hospitals report medical errors to the state's Patient Safety Program, including a Root Cause Analysis and Action Plans following each reportable event. Although not in legislation, Gov. Douglas and the Vermont Association of Hospitals and Health Systems announced in January 2008 that all hospitals in Vermont will not seek payment from patients or insurers for hospital care resulting in eight rare but serious adverse events.[14]

The state also is pursing administrative reforms to improve health system efficiency. All of Vermont's state-supported coverage programs—Medicaid, premium assistance programs, and Catamount Health Plans—are currently marketed under an umbrella brand called "Green Mountain Health." The Department of Children and Families is currently working to implement an eligibility modernization project across these programs to replace outdated systems (e.g., clients must still complete lengthy paper applications, and repeat the process at least annually when eligibility is reviewed). The state is also creating a new Vermont Healthcare Claims Uniform Reporting System (VHCURES), a multipayer database that contains claims data from all private and public insurance plans to help the state better understand the effectiveness and efficiency of the health care delivery system.

Since 2006, Vermont's health reform investments include Medicaid coverage expansions, some provider rate adjustments, premium assistance programs for employer sponsored insurance and Catamount Health Plans, and other Blueprint programs. The financing of Vermont's health reform is based on the principle that everybody is covered and everybody pays. Individuals pay sliding-scale premiums based on income. Employers pay a health care contribution based on the number of their employees (measured as full-time equivalents) who are uninsured ($91.25 per uninsured FTE per quarter, or $365 per year). Other revenues come from an 80-cent increase in the cigarette tax, Medicaid programs savings due to employer-sponsored insurance enrollment, and through matching federal dollars under a federal Medicaid 1115 demonstration waiver called Global Commitment to Health. The Medicaid waiver is particularly important to sustaining reform. It consolidated funding for most of the state's Medicaid programs and converted the Office of Vermont Health Access (the state's Medicaid agency) into a public managed care organization (MCO). Under the waiver, the MCO can invest in health services that typically would not be covered by Medicaid, and has more flexibility to implement creative programs and payment mechanisms to curb health care costs.

Healthy Lives

Vermont has the third-lowest rate of mortality amenable to health care among the states, with a nearly 16 percent reduction over three years—from 81 deaths per

100,000 population in 2001–02 to 68 deaths per 100,000 in 2004–05. Adult smoking has also declined substantially. However, some measures, such as infant mortality and childhood obesity, are moving in the wrong direction.

From the beginning, Vermont approached health reform with an emphasis on public health. Public health and clinical medicine have common roots but over time have grown apart—the Blueprint is attempting to bring them back together. Clinical professionals and public health prevention specialists work together on the Blueprint's Community Care Teams. The state's health information exchange collects and shares information that is relevant for individuals at the point of care and that is used to track risk factors across populations. Catamount Health includes coverage and waives cost-sharing for chronic care management and preventive care, and Medicaid includes new benefits and reimbursement incentives to improve chronic care management.

The Blueprint also has reinvigorated traditional public health activities. The state sponsors Healthier Living Workshops that target people with arthritis, asthma, heart disease, chronic pain, and other chronic conditions. The Fit & Healthy Vermonters Initiative focuses on preventing obesity by encouraging physical activity and healthier eating in schools, worksites, early childcare sites, and other settings. And the Department of Health is implementing a process to enable the provision of clinically recommended immunizations to all residents across the lifespan at no cost when not otherwise reimbursed.

Conclusion

Vermont persevered through several health reform setbacks until its political leadership was able to strike a sustainable balance between expanding coverage and controlling costs. Vermont's approach is not simple—it involves nine reform bills and more than 60 initiatives, including payment reform, new models for delivering care, a statewide information technology system, and a new public–private health coverage program. But it is the comprehensiveness of the reform that many of Vermont's policy leaders credit as its success. The complexity of health care and its many dysfunctions, they say, require multiple, integrated solutions to expand access, improve quality, and control costs. The *State Scorecard* indicates Vermont's robust combination of strategies is working—the state continues to improve its already-high scorecard rankings—and is a useful model to inform other state efforts.

Notes

[1] The 13 states in the top quartile of overall health system performance on the *State Scorecard* are Vermont, Hawaii, Iowa, Minnesota, Maine, New Hampshire, Massachusetts, Connecticut, North Dakota, Wisconsin, Rhode Island, South Dakota, and Nebraska.

[2] Examples of statewide, multi-stakeholder organizations that collect and report health information include the Iowa Healthcare Collaborative, Massachusetts' Quality and Cost Council, Minnesota's Institute for Clinical Improvement, Vermont's Blueprint for Health, and the Wisconsin Collaborative for Healthcare Quality.

[3] 2006 Health Care Affordability Acts (Acts 190, 191), Appropriations Bill, Sorry Works! (Act 142), Safe Staffing and Quality Patient Care (Act 153); 2007 Corrections and Clarifications to the Health Care Affordability Acts of 2006 (Act 70), An Act Relating to Ensuring Success in Health Care Reform (Act 71); 2008 An Act Relating to Health Care Reform (Act 203), and An Act Relating to Managed Care Organizations and the Blueprint for Health (Act 204; and An Act Relating to Health Care Reform (Act 61), and An Act Relating to Containing Health Care Costs (Act 49).

[4] H. M. Leichter, ed., *Health Policy Reform in America: Innovations from the States* (Armonk, N.Y.: M. E. Sharpe, 1997).

[5] K. E. Thorpe, "Vermont's Catamount Health: A Roadmap for Health Care Reform?" *Health Affairs* Web Exclusive, Oct. 16, 2007, w703–w705.

[6] Vermont Household Health Insurance Survey: http://www.bishca.state.vt.us/HcaDiv/Data_Reports/healthinsurmarket/2008VHHIS_Comprehens.pdf.

[7] Vermont state officials believe the increase in the military as primary source of coverage can be attributed to continued deployment of Vermont residents to Iraq through the National Guard.

[8] State of Vermont Agency of Administration, "Overview of Vermont's Health Care Reform" (Oct. 2008), p.6.

[9] 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 or your hours were reduced, you got divorced, you have or are finishing COBRA coverage, you had insurance through someone else who died, you are no longer a dependent on your parent's insurance, or you graduated, took a leave of absence, or finished college or university and got your insurance through school; 4) you had VHAP or Medicaid but became ineligible for those programs; 5) you have been enrolled for at least six months in an individual health insurance plan with an annual deductible of $10,000 or more for single coverage or $20,000 or more for two-person or family coverage; or 6) you lost health insurance as a result of domestic violence.

[10] Thirteen states guarantee issue in the small-group health insurance market. Among the states profiled in this paper, those in the Upper Midwest (Iowa, Minnesota, Wisconsin) do not require guaranteed issue, but the rest do (Delaware, Hawaii, Massachusetts, Vermont). Twelve states require community rating, which means health insurance premiums cannot vary based on health status, including two of the states profiled in this paper, Massachusetts and Vermont (Source: http://www.statehealthfacts.org).

[11] Thorpe, "Vermont's Catamount Health," 2007.

[12] The original care management model for diabetes was based on the Chronic Care Model developed by Ed Wagner at the MacColl Institute for Healthcare Innovation.

[13] BISHCA Division of Health Care Administration Hospital report cards: http://www.bishca.state.vt.us/HcaDiv/hcadefault.htm.

[14] Vermont hospitals now will not bill for air embolism-associated injury, artificial insemination/wrong donor, incompatible blood-associated injury, medical error injury, retention of foreign objects within a patient, wrong-patient and wrong-site surgery and wrong surgical procedure.

Sources

Vermont

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State of Vermont Agency of Administration, "Overview of Vermont's Health Care Reform," Oct. 2008.