WISCONSIN LEGISLATIVE COUNCIL
STAFF MEMORANDUM

Memo No. 4

TO: MEMBERS OF THE SPECIAL COMMITTEE ON PERFORMANCE-BASED DISEASE MANAGEMENT PROGRAMS FOR LARGE POPULATIONS

FROM: Mary Matthias, Senior Staff Attorney

RE: Selected Provisions of 2005 Vermont Act 191, Relating to Health Care Affordability and the Blueprint for Health

DATE: October 9, 2008

This Memo, prepared at the request of Chairperson Wieckert, describes several elements of Vermont's 2005 Act 191, legislation relating to health care affordability for Vermonters, which established the Vermont "Blueprint for Health" program. Various provisions of the Act were discussed in several of the presentations to the Special Committee at its September 12, 2008 meeting.

The Memo describes provisions of the Act pertaining to: (a) the Vermont Blueprint for Health and, that strategic plan for its implementation; (b) the chronic care management program; (c) state employees health benefit plans; (d) the healthy lifestyle insurance discount and insurance regulation relating to disease prevention and health promotion; (e) common claims and procedures; and (f) uniform provider credentialing.

A. BLUEPRINT FOR HEALTH AND STRATEGIC PLAN

The Act states that the Blueprint for Health is the state's plan for chronic care infrastructure, prevention of chronic conditions, and chronic care management program, and includes an integrated approach to patient self-management, community development, health care system and professional practice change, and information technology initiatives.

The Act directs the State Commissioner of Health, in coordination with the Secretary of the state Department of Administration, to develop and implement the Blueprint for Health and a five-year strategic plan for its implementation.

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The Act states that it is the intent of the Vermont General Assembly that health insurers shall participate in the Blueprint for Health no later than January 1, 2009 and shall engage health care providers in the transition to full participation in the Blueprint.

Required Elements of the Blueprint for Health

The Blueprint for Health must be developed and implemented to further the following principles:

- The primary care provider should serve a central role in the coordination of care and shall be compensated appropriately for this effort.
- The use of information technology should be maximized.
- Local service providers should be used and supported, whenever possible.
- Transition plans should be developed by all involved parties to ensure a smooth and timely transition from the current model to the Blueprint model of health care delivery and payment.
- Implementation of the Blueprint in communities across the state should be accompanied by payment to providers sufficient to support care management activities consistent with the Blueprint, recognizing that interim or temporary payment measures may be necessary during early and transitional phases of implementation.
- Interventions designed to prevent chronic disease and improve outcomes for persons with chronic disease should be maximized, should target specific chronic disease risk factors, and should address changes in individual behavior, the physical and social environment, and health care policies and systems.

Executive Committee to Develop and Implement the Strategic Plan

The Secretary of Administration must establish an executive committee to advise the director of the Blueprint on creating and implementing a strategic plan for the development of the statewide system of chronic care and prevention. The executive committee must consist of at least 10 individuals, including the following:

- The commissioner of health.
- A representative from the Department of Banking, Insurance, Securities, and Health Care Administration.
- A representative from the office of Vermont Health Access.
- A representative from the Vermont Medical Society.
- A representative from a statewide quality assurance organization.
- A representative from the Vermont Association of Hospitals and Health Systems.

- Two representatives of private health insurers.
- A consumer.
- A representative of the complementary and alternative medicine profession.
- A primary care professional serving low income or uninsured Vermonters.
- A representative of the state employees' health plan, who shall be designated by the director of human resources and who may be an employee of the third-party administrator contracting to provide services to the state employees' health plan.
- The director of the commission on health care reform, as a nonvoting member.

The executive committee must engage a broad range of health care professionals, health insurance plans, professional organizations, community and nonprofit groups, consumers, businesses, school districts, and state and local government in developing and implementing the strategic plan.

Required Elements of the Strategic Plan

The strategic plan must include all of the following:

- A description of the Vermont Blueprint for Health model, which includes standard elements of the state chronic care management program (described in Section B, below), patient self-management, community initiatives, and health system and information technology reform, to be used uniformly statewide by private insurers, third-party administrators, and public programs.
- A description of prevention programs and how these programs are integrated into communities, with chronic care management, and the Blueprint for Health model.
- A plan to develop and implement reimbursement systems aligned with the goal of managing the care for individuals with or at risk for conditions in order to improve outcomes and the quality of care.
- The involvement of public and private groups, health care professionals, insurers, third-party administrators, associations, and firms to facilitate and assure the sustainability of a new system of care.
- The involvement of community and consumer groups to facilitate and assure the sustainability of health services supporting healthy behaviors and good patient self-management for the prevention and management of chronic conditions.
- Alignment of any information technology needs with other health care information technology initiatives.

- The use and development of outcome measures and reporting requirements, aligned with existing outcome measures within the agency of human services, to assess and evaluate the system of chronic care.

- Target timelines for inclusion of specific chronic conditions in the chronic care infrastructure and for statewide implementation of the Blueprint for Health.

- Identification of resource needs for implementing and sustaining the Blueprint for Health and strategies to meet the needs.

- A strategy for ensuring statewide participation no later than January 1, 2011 by health insurers, third-party administrators, health care professionals, hospitals and other professionals, and consumers in the chronic care management plan, including common outcome measures, best practices and protocols, data reporting requirements, payment methodologies, and other standards. In addition, the strategy should ensure that all communities statewide will have implemented at least one component of the Blueprint by January 1, 2009.

Strategic Plan Review and Modifications

The strategic plan must be reviewed biennially and amended as necessary to reflect changes in priorities

Implementation Benchmarks

The Act establishes the following benchmarks for implementation of certain elements of the Strategic Plan:

Clinical Quality and Performance Measures

By July 1, 2007, clinical quality and performance measures must be adopted for each of the chronic conditions included in the Medicaid Chronic Care Management Program (described in Section B, below). These conditions include, but are not limited to, asthma, chronic obstructive pulmonary disease, congestive heart failure, diabetes, and coronary artery disease.

At least one set of clinical quality and performance measures must be added each year and a uniform set of clinical quality and performance measures for all chronic conditions to be addressed by the Blueprint must be available for use by health insurers and health care providers by January 1, 2010.

Coordination of Chronic Care Management

By October 1, 2007, risk stratification strategies must be used to identify individuals with or at risk for chronic disease and to assist in the determination of the severity of the chronic disease or risk thereof, as well as the appropriate type and level of care management services needed to manage those chronic conditions.

By January 1, 2009, guidelines for promoting greater commonality, consistency, and coordination across health insurers in care management programs and systems must be developed in consultation with employers, consumers, health insurers, and health care providers.

Requirements for Studies and Reports on Payment Mechanisms and Implementation of the Blueprint

The Act requires several studies to be conducted, and requires the development of recommendations for payment mechanisms, and the submission of several reports on progress in implementing the Blueprint, as described below:

- By January 1, 2009, the director of the Blueprint, in consultation with employers, consumers, health insurers, and health care providers, must complete a comprehensive analysis of sustainable payment mechanisms.

- By January 1, 2009, the director must report his or her recommendations for sustainable payment mechanisms and related changes needed to support achievement of Blueprint goals for health care improvement, including the essential elements of high quality chronic care, such as care coordination, effective use of health care information by physicians and other health care providers and patients, and patient self-management education and skill development.

- By January 1, 2009, and each year thereafter, health insurers must participate in a coordinated effort to determine satisfaction levels of physicians and other health care providers participating in the Blueprint care management initiatives, and report on these satisfaction levels to the Blueprint director.

- Beginning July 1, 2009, and each year thereafter, health insurers, in collaboration with health care providers, must report to the secretary of administration on evaluation of their disease management programs and the progress made toward aligning their care management program initiatives with the blueprint guidelines.

- Annually, no later than January 1, the Blueprint director shall report on the status of implementation of the Blueprint for the prior calendar year. The report shall be provided to the House Committee on Health Care, the Senate Committee on Health and Welfare, the Health Access Oversight Committee, and the commission on Health Care Reform.

B. CHRONIC CARE MANAGEMENT PROGRAM

The Act directs the secretary of administration to create a chronic care management program to be administered or provided by a private entity for individuals with one or more chronic conditions who are enrolled in Medicaid, the Vermont health access plan (a health insurance program for low-income adults age 18 and older who have been uninsured for 12 months or more), or Dr. Dynasaur (a health insurance program for low-income children, teenagers under age 18, and pregnant women).

The secretary must include a broad range of chronic conditions in the chronic care management program.

The chronic care management program must be designed to include all of the following:

- A method involving the health care professional in identifying eligible patients, an enrollment process which provides incentives and strategies for maximum patient participation, and a standard statewide health risk assessment for each individual.

- The process for coordinating care among health care professionals.

- The methods of increasing communications among health care professionals and patients, including patient education, self-management, and follow-up plans.

- The educational, wellness, and clinical management protocols and tools to be used by the care management organization, including management guideline materials for health care professionals to assist in patient-specific recommendations.

- Process and outcome measures to provide performance feedback for health care professionals and information on the quality of care, including patient satisfaction and health status outcomes.

- Payment methodologies to align reimbursements and create financial incentives and rewards for health care professionals to establish management systems for chronic conditions, to improve health outcomes, and to improve the quality of care, including case management fees, pay for performance, payment for technical support and data entry associated with patient registries, the cost of staff coordination within a medical practice, and any reduction in a health care professional's productivity.

- Payment to the care management organization which would put the care management organization's fee at risk if the management is not successful in reducing costs to the state.

- A requirement that the data on enrollees be shared, to the extent allowable under federal law, with the secretary in order to inform the health care reform initiatives.

- A method for the care management organization to participate closely in the Blueprint for Health and other health care reform initiatives.

- Participation in the state pharmacy best practices and cost-control program, including the multi-state purchasing pool and the statewide preferred drug list.

The secretary of administration must issue a request for proposals for the program and review the request for proposals with the commission on health care reform prior to issuance. The issuance of the request for proposals is conditioned on the approval of the commission. Any contract under the program may allow the contractor to subcontract some services to other entities if it is cost-effective, efficient, or in the best interest of the individuals enrolled in the program.

The secretary of administration must ensure that the chronic care management program is modified over time to comply with the Blueprint and the strategic plan and to the extent feasible, collaborate in its initiatives.

C. STATE EMPLOYEES HEALTH BENEFIT PLANS

The Act requires the commissioner of human resources to include in any request for proposals for the administration of the health benefit plans for state employees a request for a description of any chronic care management program provided by the entity and a description of how the program aligns with the Blueprint for Health strategic plan. The commissioner must also work with the secretary of administration and the Vermont state employees' association to determine how and when to align the state employees' health benefit plan with the goals and statewide standards developed by the Vermont blueprint for health.

D. HEALTHY LIFESTYLE INSURANCE DISCOUNTS AND INSURANCE REGULATIONS RELATING TO DISEASE PREVENTION AND HEALTH PROMOTION

The Act authorizes health insurers to establish rewards, premium discounts, rebates, or otherwise waive or modify applicable co-payments, deductibles, or other cost-sharing amounts in return for adherence by a member or subscriber to programs of health promotion and disease prevention.

The Act directs the commissioner of insurance to consult with the commissioner of health and the director of the office of Vermont health access in the development of health promotion and disease prevention regulations. Such regulations must do all of the following:

- Limit any reward, discount, rebate, or waiver or modification of cost-sharing amounts to not more than a total of 15% of the cost of the premium.

- Be designed to promote good health or prevent disease for individuals in the program and not be used as a subterfuge for imposing higher costs on an individual based on a health factor.

- Provide that the reward under the program is available to all similarly situated individuals.

- Provide a reasonable alternative standard to obtain the reward to any individual for whom it is unreasonably difficult due to a medical condition or other reasonable mitigating circumstance to satisfy the otherwise applicable standard for the discount and disclose in all plan materials that describe the discount program the availability of a reasonable alternative standard.

The insurance health promotion and disease prevention regulations must include all of the following:

- Standards and procedures for health promotion and disease prevention programs based on the best scientific, evidence-based medical practices as recommended by the commissioner of health.

- Standards and procedures for evaluating an individual's adherence to programs of health promotion and disease prevention.

- Provisions that exempt certain health insurers under certain conditions.

E. COMMON CLAIMS AND PROCEDURES

The Act requires establishment of a common claims and procedures work group composed of:

- Two representatives selected by the Vermont Association of Hospitals and Health Systems.
- Two representatives selected by the Vermont Medical Society.
- One representative of each of the three largest health care insurers.
- The director of the Office of Health Access or designee.
- Two representatives from business groups appointed by the governor.
- The health care ombudsman or designee,
- One representative of consumers appointed by the governor.
- The commissioner of the Department of Banking, Insurance, Securities and Health Care Administration or designee.

The group must design, recommend, and implement steps to achieve the following goals:

- Simplifying the claims administration process for consumers, health care providers, and others so that the process is more understandable and less time-consuming.
- Lowering administrative costs in the health care financing system.

The Act directs the work group to present a two-year work plan and budget to the House Committee on Health Care and the Senate Committee on Health and Welfare on or before September 1, 2006.

The work plan may include the elements of the claims administration process, including claims forms, patient invoices, and explanation of benefits forms, payment codes, claims submission and processing procedures, including electronic claims processing, issues relating to the prior authorization process and reimbursement for services provided prior to being credentialed.

The work group must make an interim report to the Governor and the General Assembly on or before January 15, 2007, describing the progress of the group and any interim steps taken to achieve the goals of the work plan.

The work group must make a final report to the Governor and the General Assembly on or before January 15, 2008, with findings that illustrate the outcomes of implementations derived from the work group actions along with a list of future actions and goals, which shall specify cost savings achieved and expected future savings.

F. UNIFORM PROVIDER CREDENTIALING

The Act defines "credentialing" as a process through which an insurer or hospital makes a determination, based on criteria established by the insurer or hospital, concerning whether a provider is eligible to provide health care services to an insured or hospital patients and receive reimbursement for the health care services.

The Act requires the Department of Banking, Insurance, Securities, and Health Care Administration to prescribe the credentialing application form used by the Council for Affordable Quality Healthcare, or a similar, nationally recognized form prescribed by the commissioner, in electronic or paper format, which must be used beginning January 1, 2007 by any insurer or a hospital that performs credentialing.

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