



**State of Vermont
Agency of Administration
Health Care Reform**

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Reorganization of Government Health Care Related Functions

Act 48 of 2011, Section 11

Submitted to the

**Senate Committee on Health and Welfare
House Committee on Health Care**

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Introduction

In Act 48 of 2011, the general assembly charged the secretary of administration or designee with reporting to the House Health Care and Senate Health & Welfare committees on:

How to reorganize and consolidate health care-related functions in agencies and departments across state government in order to ensure integrated and efficient administration of all of Vermont's health care programs and initiatives.

Government health care-related functions are currently housed in several departments within the Agency of Administration, Agency of Human Services, the Department of Banking, Insurance and Health Care Administration, and the Green Mountain Care Board. The Agency of Administration is tasked with overseeing and coordinating health care reform across all state agencies and being a liaison with the Green Mountain Care Board. Within the Agency of Administration, the Department of Human Resources negotiates with the unions representing state employees to provide health coverage and administers health coverage for state employees. The Department of Labor administers the Workers Compensation program, which compensates injured workers for health-related costs, inspects workplaces to ensure the health and safety of employees, engages in workforce planning, and administers the existing employer assessment. Within the Agency of Human Services, six member departments and the central office are responsible for various aspects of health care provision, health oversight and health plan operations¹.

Government functions are split into the following broad categories or types of activities: health promotion and prevention, providing direct health care services, operations of a public health benefits plan (from rate setting and third party collections to chronic care management), regulating entities in the health care industry, and policy and planning related to health promotion, health care and health care reform.

The purpose of this report is to ensure efficient and coordinated functioning between different agencies of state government engaged in health-related functions. The remainder of this report describes the process used to determine the appropriate recommendations, a summary and discussion of the research in the area of government restructuring, and recommendations on how to ensure efficient and coordinated action in state government.

Process

An interagency team of state officials worked with the Center for State Innovation to look at different organizational structures found in other states to determine whether Vermont should reorganize the agency structure or pursue functional integration of services. The Center for State Innovation brought together several speakers to talk about reorganization in other states including: Stan Dorn, Urban Institute; Ron Levy, Missouri Department of Social Services; Claudia Page, Social Interest Solutions; Jeanne Smith, Oregon; and Deborah Bachrach, Manatt Health Solutions.

Research Summary & Discussion

A review of current literature and national activities yields two prevailing models taken by states interested in ensuring efficient and coordinated organization of state government health-related functions. These are: (1) reorganization of the hierarchy and structure of state agencies, staff relationships and missions, or (2) integration of functions and business processes across state agencies. Reorganization of state agencies involves

¹ Vermont Department of Health (VDH); Department of Mental Health (DMH); Department of Vermont Health Access (DVHA); Department of Children and Families (DCF); Department of Disabilities, Aging and Independent Living (DAIL); Department of Corrections (DOC)

legally redefining agencies to change the state government structure, including moving people and functions into different hierarchical configurations. The integration of functions across state agencies looks for ways to improve the efficiency and functioning of the existing agency structure. The presence of any distinct and separate agency structure inherently creates a silo, making coordination of functions across state agencies critical to the success of either model and vital for efficient operation of state government.

The following tables summarize the benefits and limitations of each approach, based on the research and discussions conducted by an interagency team. Many of the benefits and limitations are taken from the experiences of other states and Vermont’s Agency of Human Services, who have tackled large scale integration and/or reorganization.

Below is a summary of the benefits of each approach:

Restructuring of agencies	Functional Integration
Alignment of staff into one physical space more easily creates higher functioning relationships among staff	<p>Develops business processes to address integration of services, regardless of which agency is providing them;</p> <p>Creates an interagency team and awareness of all aspects of the issues, education & teamwork;</p> <p>Option to co-locate staff without disruption of staff reporting relationships</p>
May more easily consolidate purchasing of health services for agencies providing health coverage directly	Could consolidate purchasing across agencies through a process
Establishes single line of accountability from leadership to supervisors and team leaders	Establishes clear lines of authority & accountability as part of functional definitions, but also creates ways to minimize silos and to work across agencies
Creates unified ownership of challenges and solutions	Creates culture of teamwork across agencies
Tracks information more uniformly	Could track information more uniformly, but through a process
Creates less duplication of like functions across many units and departments	Creates less duplication of like functions once full integration is achieved
Aligns departments and functions under one agency secretary	Focuses on systems and process improvement for a function, instead of <i>who</i> is doing a function
	Little cost to the state
	Could result in cross-training of staff & the creation of stronger cross-agency relationships & operational structures
	Leverages the managed care entity structure created by Global Commitment to Health to ensure cross-agency processes and functional integration

The following table shows the limitations of each approach:

Restructuring of agencies	Functional Integration
Disruptive to staff; could result in staff moving locations or being reassigned to another job	
Without a strong and dedicated change management process it becomes about the boxes and not about better business processes; Creates new silos to work around	Maintains existing silos, which might not be optimal
Process for resolving disputes among leadership needed; just new process to adjust to new silos	Without clear leadership diffuse ownership of issues makes solution finding difficult; Multiple leaders in chain of command can slow decision making process; Process for resolving disputes among leadership needed
	Workers can get caught in the middle of different leadership styles, priorities and opinions.
Restructuring takes energy and focus away from the work to be done	
Not all health related functions need or benefit from consolidated purchasing features (e.g. regulatory functions)	
Costs to the state of moving staff, etc	
Major AHS reorganization in 2004-2006	

One notable artifact of state restructuring as reported by other states was the stress, time, energy, and distraction involved in reorganizing state agency structures. Such reorganization often involves moving staff and offices, renting new or different space, staff transfers, and business operation transfers of money, contracts, and other legal documents. For example, in Oregon, the state reorganized health related functions in mid-2000s in order to consolidate purchasing functions, but as of Fall 2011, the purchasing functions were not yet consolidated due to the disruption of the reorganization. For Vermont, this would be compounded by the stress and disruption of staff and organizational functioning caused by Hurricane Irene. With the closure of the state hospital, the unknown nature of Waterbury State Office Complex and the amount of work needed for Vermont to reach its health reform goals, it does not seem like an ideal time to propose more changes. Functional integration of services across state government appears to be a more efficient approach to ensure that different departments and agencies work together.

Recommendations

The administration recommends focusing on functional integration of health-related tasks in state government to ensure coordinated and consolidated efforts among and across agencies. The scope of work for implementing functional integration is substantial and will be a multi-phased effort, requiring cultural change.

Over the last year, each agency and department created a strategic plan to guide its work moving forward¹. In addition, there is a consolidated health care reform strategic plan, which provides a three-year roadmap for state government agencies, including which agencies will work together to achieve certain goals using particular strategies. See **Appendix A** for a copy of the Health Care Reform Strategic Plan. Together, these strategic plans articulate the critical goals and implementation strategies across those parts of state government touching health and health reform policy, programs, and operations.

Second, the Director of Health Care Reform in the Agency of Administration has formed interagency teams around the four health care reform goals: 1) Reduce health care costs and cost growth; 2) Assure that all Vermonters have access to and coverage for high-quality health care; 3) Support improvements in the health of Vermont's population; and 4) Assure greater fairness and equity in how we pay for health care. Each team is lead by a team leader and has representation of all state agencies involved in the effort. The interagency teams are tasked with achieving the goals and strategies in the strategic plan. The goal of this structure is to create functional integration across multiple departments and to create a culture of inter-agency teamwork.

In addition, to ensure coordination on a broader scale, the Director of Health Care reform is re-forming the Governor's health care cabinet, which has broad representation from any agency in state government with any health care function or role. The purpose of the health care cabinet is to ensure that agency leaders are informed about health care reform efforts and to ensure that there is coordination among agencies on these efforts. The cabinet will meet quarterly, or more frequently as needed, and may form task forces when there are particular efforts that need more intensive work.

Third, the Division of Health Reform at the Department of Vermont Health Access (DVHA) is charged with ensuring that the health data and information infrastructure – the Health Services Enterprise portfolio of health reform and health IT systems – will be designed and implemented to support the broad availability of real-time and close-to-real time information to guide a functionally integrated state organizational structure. In addition, DVHA is leading cross-cutting, inter-agency/inter-departmental cultural change initiatives to support the technological and organizational changes necessary to ensure state government is internally aligned and prepared to implement health reform as a whole.

Fourth, there are several targeted efforts within state government to integrate services and functions among agencies more efficiently. Within the Agency of Human Services there are several related efforts: 1) Integrated Family Services initiative; 2) Integrated Treatment Continuum for Substance Abuse Dependence (aka the Hub and Spoke model); 3) Blueprint for Health; 4) Alignment of Global Commitment to Health, Choices for Care, Medicare/Medicaid Dual Eligible planning and Information Technology Modernization and Integration; 5) Integration of housing and stable community based treatment and support for our most vulnerable citizens; and 6) Integration of substance abuse, mental and physical health treatment. Other State government restructuring efforts underway include the Department of Banking, Insurance, Securities and Health Care Administration to ensure coordination, but not duplication, of efforts with the Green Mountain Care Board.

AHS: Integrated Family Services

Currently AHS children's services exist in every AHS department and are administered by eleven divisions of the agency. Divisions and departments historically developed separate and distinct Medicaid waivers and Medicaid procedures for managing sub-specialty populations within various departments. While these were the best approaches available at the time, the artifacts of this history are multiple and fragmented funding streams, policies, and guidelines about our work with children and families. With the inception of the Global Commitment waiver, these siloed Medicaid funding structures no longer exist. The Integrated Family Services Initiative seeks to bring all agency children, youth and family services together in an integrated and consistent continuum of services for families. The premise being that giving families early support, education and

interventions will produce more favorable outcomes at a lower cost than the current practice of *waiting until circumstances are bad enough* to access *high end* funding streams which often result in out of home or out of state placement. Efforts across the agency over the past several years have moved in the direction that this initiative champions.

The basic elements of this model will also be integrated with the Blueprint Community Health Teams and the expanded DVHA Chronic Care initiative. The integrated family services effort will support and over time expand on wellness coaching and ensure a connection with the developing health information exchange network and modernized information technology efforts to maximize their applicability to the child and family services efforts.

The goals of the functional integration and alignment of programs and services within the AHS include:

- Unified leadership with a single focused plan and intent for children and families that would allow for specialized responses and at the same time ultimately achieve the overall goals and outcomes established through the Agency of Human Services
- More efficient service delivery with clearer outcomes and expectations, including tracking capabilities
- Condensed budgets that can be managed more effectively to outcomes
- More consistent goals for providers and service delivery
- Further streamlining of documentation and reporting
- Condensed budget, contracting, licensing and IT structures and advocacy for these needed resources
- Better oversight of the provider system and response to quality management issues
- Clear consistent roles and use of AHS staff for full implementation of the single focused plan for AHS support, treatment and intervention services.

This integration has led to the establishment of more coordinated senior management processes. Within AHS, Integrated Family Services includes all child and family focused services provided either directly by state employees or through contracted providers. The cross departmental groups that have come together to manage internal change under the direction of a Director of Integrated Family Services in the Secretary's Office include:

- A Senior Management team consisting of a Deputy Commissioner or Division Director from each Department, the AHS Director of Healthcare Operations, the AHS Director of Integrated Family Services and the AHS Central Office Business Manager
- An Implementation/Operations team consisting of a Director or Operations Manager from each Department, an AHS IT representative and the AHS Director of Integrated Family Services
- A leadership team consisting of the AHS Secretary, Deputy Secretary, Commissioners, AHS Director of Healthcare Operations, the AHS Director of Integrated Family Services and the AHS Central Office Business Manager
- A newly expanded Act 264 Advisory Board
- Various workgroups that include state employees, providers, the Department of Education, families and youth.

All departments within AHS participate in IFS and assure that their daily work is connected to the overall plan of integrating services and eliminating silos. The optimal organizational structure to support this model is under consideration.

Integrated Treatment Continuum for Substance Abuse Dependence

The Agency of Human Services (AHS) is collaborating with community providers to create a coordinated, systemic response to the complex issues of opiate and other addictions in Vermont. Medication assisted

treatment (MAT) is the use of medications, in combination with counseling and behavioral therapies, to provide a whole patient approach to the treatment of substance use disorders. Research shows that when treating substance use disorders, a combination of medication and behavioral therapies is most successful. Although this initiative initially focuses on medication assisted treatment for individuals with opiate addictions, it creates a framework for integrating treatment services for other substance abuse issues and co-occurring mental health disorders into the medical home through a managed approach to care. In addition, this treatment approach will help reduce recidivism in corrections and enhance outcomes for families where addiction is an identified problem for child welfare.

To develop a state of the art model for dealing with opiate, and eventually all, addictions the DVHA and VDH – Division of Alcohol and Drug Abuse Programs have proposed a highly integrated AHS response. This response, in order to be successful, will integrate clinical best practices from DVHA, ADAP and Integrated Family Services Initiatives with Blueprint Advanced Practice Medical Homes, FQHC’s physicians, mental health and addictions treatment specialists, to create a therapeutic partnership at the local level. This will include medication assisted treatment, recovery supports, contingency management, and case management services.

The agency is working to create an evaluation methodology that will track medical costs as well as social impacts and savings anticipated in areas such as corrections, employment, and children in custody

Information Technology Modernization

AHS has embarked on an enterprise wide transformation and modernization of all its information technology systems using advances in health information technology as the foundation. These efforts include:

State Technical Infrastructure: AHS (and DII) implementation of the Service Oriented Architecture (SOA) core components, state Master Provider Directory and Master Persons Index, and IT systems to support a fully integrated approach to meeting the health related business needs of AHS Departments and programs.

Eligibility / Enrollment / Exchange: VIEWS (the Vermont Integrated Enrollment Workflow System) procurement and implementation, which will include both the new public health benefits eligibility and enrollment system and the Health Insurance Exchange (HIX) functions. Opportunities related to the New England HIX Innovations Grant project.

Financial Records / Transactions: The Medicaid Enterprise Solution (MES) procurement and implementation, which includes both Medicaid claims processing and information management to support Medicaid Operations and Program Management, Program Integrity, Provider Management and Member Management. A Claims Normalization Gateway (the “single pipe” platform), its relationship to existing and future-state insurance plans, claims clearinghouses, and the risks / opportunities associated with disintermediation and / or redesign of the claims “supply chain.” IT systems to support planning, analytics, payment mechanisms for transition to and operation under Global Budgeting are included here as well, but have substantial overlap with the Reporting / Evaluation category below.

Clinical Records: Health Information Technology – existing (and potentially expanded) resources, time lines, dependencies, risk factors relating to Electronic Health Record adoption and implementation; Health Information Exchange connectivity; expansion and adoption of the Blueprint clinical data repository and registry; expansion/modernization/integration of Public Health IT registries; and broadly available, integrated Personal Health Record and patient-driven Health IT applications and services. What are the critical interdependencies relating to the adoption and implementation of these systems,

given that most of them are outside the direct control of the State and subject to multiple market and environmental factors.

Reporting / Evaluation: this is a cross-cutting category that supports all of the three above, including the opportunity for leveraging information resources across clinical and claims records domains. Opportunities for enhancement of the VHCURES (Vermont Healthcare Claims Uniform Reporting & Evaluation System) multi-payer claims data base, further alignment with and development of the IRIS (Integrated Research Evaluation System) health informatics data platform at UVM, and enhanced integration of the reporting and clinical quality measurement capacities of the Blueprint IT systems, state HIE, and Meaningful Use reporting by providers.

BISHCA and the Green Mountain Care Board

Act 48 requires a transition of staff and responsibilities from the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) to the Green Mountain Care Board (GMCB). As part of this transition the GMCB and BISHCA have worked closely over the past six months to determine what, if any, additional transitions of responsibility and/or staff should be made between the two agencies so that both can complete their statutory obligations. The initial review and preferences expressed by the House Committee on Health Care resulted in the transition of specific tasks and responsibilities from BISHCA to the GMCB in H.559 As Passed the House. These include: hospital budgets, the expenditure analysis, the unified health care budget and certificates of need.

Subsequent review has shown that the GMCB has a significant need for access to data and data analysis related to implementation of its health care cost containment charge. BISHCA is the responsible party for two data sets that are critical to the GMCB's work: the VHCURES multi-payer claims data set and the Hospital Discharge Data Set. As the GMCB delves into its work in this area, the Board has found the need to work regularly with the BISHCA staff who manage the VHCURES data set and the Hospital Discharge Data Set. Additionally, the GMCB has taken the lead with CMS in obtaining Medicare claims data for inclusion in VHCURES, which requires significant use of GMCB resources. Currently, BISHCA and the GMCB hold multiple meetings and engage in extensive communication to ensure that all parties are aware of any issues related to these data sets. While BISHCA and the GMCB work collaboratively, it would be more efficient and effective if the GMCB were the responsible party for these two data sets and the staff associated with managing them.

It is important to note, however, that GMCB is not the only entity using the data, especially VHCURES. Moving VHCURES to the GMCB will increase the Board's responsibilities in managing data requests from other agencies and outside entities who request access to the data.

The administration and GMCB will propose a policy on the transition of these responsibilities in the 2013 legislative session.

Integration of Mental Health, Substance Abuse, and Physical Health

Integrating mental health, substance abuse, and physical health has been a long-standing goal of the state of Vermont. For example, Vermont has a long-standing mental health parity law, which was as one important step toward this goal. Vermont's renewed commitment to health care reform exemplified by Act 48 of 2011 provides a new opportunity to continue these efforts and strive to achieve true integration among these services.

There are a number of opportunities to further integrate physical and mental health. First, the creation of a benefits package for Green Mountain Care, the universal single-payer system of the future, will allow Vermont to take a unique approach to benefit design. This provides an opportunity to study best practices in integration of these services and try new approaches. Unfortunately, the approach taken by the U.S. Department of Health and Human Services may not initially provide an opportunity to re-define benefits in this area. The

federal essential benefits package in 2014 and 2015 will be based on an existing plan in the state's market, which institutionalizes coverage for these services and does not allow for great flexibility. HHS will revisit this approach for 2016.

Second, payment and delivery system reform provides an opportunity to look at the way that mental health services are delivered in Vermont and to promote greater integration. For example, the Blueprint for Health and the Department of Mental Health are collaborating to promote more connections among mental health providers and community health teams to ensure that care is coordinated and integrated at the patient level.

Third, the Department of Banking, Insurance, Securities and Health Care Administration is looking at ways to strengthen Vermont's mental health parity law by ensuring that financial co-payments for services are aligned between physical and mental health. This is a complicated process, because mental health services are a mix of primary and secondary care and have not historically be classified into the same types of categories as physical health services.

Integration of Services for Individuals Eligible for Medicaid and Medicare

Vermont was one of 15 states awarded a \$1 million CMS Demonstration Grant to develop a proposal on how to integrate and streamline services for Vermonters receiving both Medicare and Medicaid services ("dually eligible beneficiaries"). The focus of the Dual Eligible Integration Project is to develop a seamless integrated system of care across state departments and community providers for Vermont's 22,000 dually eligible individuals. Many of these individuals have chronic illnesses and concurrent disabilities which span medical, behavioral, developmental, and long term care domains. As a result, dual eligible beneficiaries are served by multiple departments (Disabilities, Aging, and Independent Living; Mental Health; Vermont Health Access, and the Division of Rate Setting) and a variety of providers. Failure to coordinate and integrate services for this population drives unnecessary hospitalizations, nursing facility placements, and other needless health care expenditures.

The Dual Eligible Project will develop a new integrated approach of service delivery for this high utilization population which can function as a template for Vermont's state agencies. Payment reform incentives will be employed to help community providers link the long term care service system with primary care physician practices via the Blueprint for Health. In addition, performance measures for community providers will require collaboration among agencies and state departments to develop a more coordinated system of care.

Vermont will submit its Dual Eligible proposal to CMS in May 2012. If CMS funds Vermont's Dual Demonstration proposal, implementation would begin in early 2014, dovetailing with Vermont's Global Commitment Waiver renewal as well as changes required by the Affordable Care Act.

Appendix A: Strategic Plan for Health Care Reform 2012-2014

ⁱ For links to the strategic plans for the six departments of the Agency of Human Services please visit <http://humanservices.vermont.gov/strategic-plan>



Strategic Plan For Vermont Health Reform 2012-2014

**Released January, 2012 by Robin J. Lunge, J.D.,
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State of Vermont**

Developed with input from the following state agencies and departments:

**Governor Peter Shumlin's Office
The Green Mountain Care Board
The Department of Banking, Insurance, Securities and Health Care
Administration
The Agency of Human Services, Office of the Secretary
The Department of Vermont Health Access
The Department of Health
The Department of Mental Health
The Department of Labor
The Agency of Administration, Secretary's Office
The Department of Taxes**

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I. Introduction: why health care reform?

It is essential that we undertake reform of our health care system for both moral and economic reasons. The U.S. spends about \$2.5 trillion or 17.6% of GDP on health care, and that amount grew from \$75 billion or 7.5% of GDP in 1971. A recent study in *Health Affairs* found that Americans, on average, essentially forfeited wage increases for the past ten years in favor of increased spending on health care coverage.

On a per capita basis the U.S. spends more than twice the amount of the average OECD country on health care and we do not get better outcomes, in terms of health care quality or population health, for our additional spending.

All that is bad enough, but we don't provide insurance coverage or adequate access to services for many Vermonters. Almost 50,000 Vermonters are estimated to be uninsured. Another 150,000 Vermonters are underinsured: they have insurance coverage, but their insurance coverage is so limited that their potential out-of-pocket exposure for health care costs is not considered affordable. In addition, while most Vermonters have insurance coverage, many experience barriers to needed services, particularly primary care and mental health services.

In addition, we waste an inordinate amount of money, both nationally and in Vermont, on administration, on pushing paper at every level of the system. The cost of interacting with insurers costs an estimated \$83,000 per year per physician in the U.S. – four times as much as in Canada. Overall administrative costs are close to ten percent of total health care costs – a staggering amount, given the complexity and frustration that spending breeds for health care providers, patients and their families.

We can do better, and we must do better. The plan that follows provides a roadmap for reducing health care cost growth, assuring coverage for all, reducing administrative cost and complexity and assuring greater fairness in health care financing in Vermont. This plan outlines state government's role in this effort. We aim to engage all Vermonters in making this a reality, as we all have something to gain from a reformed health care system.

II. Purpose of this Plan and Summary of Health Reform Goals for 2011-14

Governor Shumlin has defined a bold agenda for health reform in Vermont. This includes implementing a single payer system of health insurance coverage for Vermonters and controlling the rate of growth in health care costs. This strategic plan is intended to guide state government in implementing the Governor's agenda and following the further guidance provided by the legislature in Act 48 of the 2011 session, over the next three years. The state's current health reform agenda builds on progress already made over more than two decades to expand and improve health insurance coverage in Vermont, improve fairness in our insurance market and fundamentally redesign and improve our primary care system.

In the next phase of health reform, our goals are to:

1. Reduce health care costs and cost growth;
2. Assure that all Vermonters have access to and coverage for high-quality health care (health care includes mental and physical health and substance abuse treatment);
3. Support improvements in the health of Vermont's population; and
4. Assure greater fairness and equity in how we pay for health care.

Health Reform Goals



This plan connects our broad reform goals with specific strategies we believe will best accomplish those goals. Our intent is to establish a framework of coherent and state

policy, coordinated with federal policy, which creates incentives for health care providers, communities and individuals to also work toward our goals.

Advancing and sustaining this agenda will require intense and well-coordinated work among numerous parties. Given the scope and complexity of reform efforts, it is imperative to have a common understanding across agencies and departments of the goals we are pursuing, the strategies we have identified to achieve those goals and the responsible parties. It also is essential that we identify measures and corresponding data sources to gauge our success in meeting our goals.

This plan is not meant to provide an exhaustive inventory of activities aimed at improving health and health care in Vermont. Rather, it is meant to provide a focused guide for the core reform activities of state government to assure their successful completion and coordination. It also is intended to articulate clearly, for audiences outside state government, our intended path and milestones that can be used to gauge our progress.

This strategic plan addresses state government's role in health reform during the next three years. The Agency of Administration will continue to have overall responsibility for coordinating health care reform efforts within the executive branch, with the Director of Health Care Reform within the Agency taking the lead role in that regard. Additional efforts will be necessary on the part of the private sector, most notably health care practitioners and health care organizations responsible for changing health care delivery and health information technology. We will not be able to reduce health care cost growth without work by multiple parties to better prevent illness and disease, avoid preventable use of health care resources and manage the care of those who have chronic illnesses. Engagement from the public is essential, too, to ensure that efforts to improve our health care system are understood, reflect the values of Vermonters, encourage Vermonters to be and stay healthy and support strong relationships between Vermonters and their health care practitioners.

Our efforts to achieve these goals will encompass numerous activities throughout state government. The next section of this plan describes 16 specific strategies we will pursue to achieve our goals. Most of those strategies are encompassed by one of several major initiatives already underway:

- A broad-scale effort to implement a sustainable global budget for Vermont and to change the way health care providers are paid by all payers, moving away from volume incentives and toward incentives for value;
- An effort to build and operate a health benefits exchange and other technological infrastructure that will simplify health insurance purchasing, reduce administrative waste and complexity, and maximize new federal funding for coverage of Vermonters;

- An effort to increase access to high quality primary care through an integrated model that expands on the Blueprint for Health and includes prevention, wellness and physical and mental health;
- An effort to develop operational and financial plans to cover all Vermonters through a unified system, not linked to employment, with equitable financing that reduces complexity in the system; and
- An effort to expand the state's health care data and analytic capacity to better understand and evaluate health care costs, quality and access and support policy-making and quality improvement.

Other important related efforts outside of state government will be necessary to achieve our goals, including development of statewide health information technology through Vermont Information Technology Leaders (VITL) and efforts by health care providers to improve the efficiency and effectiveness of their operations. In addition, adherence to federal policy, and permission from the federal government to deviate from their policy in specific instances, will be central to our success.

The remainder of this document is organized into four sections. Section II restates our health reform goals for the next three years and identifies the specific strategies we will employ to achieve our core goals. Section III assigns primary responsibility for each of those strategies to a specific agency or department, identifies tasks to be completed, and attaches a deadline for completion, where appropriate. Section IV defines the measures we will employ to gauge our success in advancing this plan. The final section of the plan provides a department-by-department list of assigned responsibilities under the plan.

III. Specific Strategies to Achieve Our Goals

We have identified 16 key strategies for best achieving our four goals, given our timeline and current state and federal resources and constraints. These are summarized below. A later section of this plan identifies the specific agency or department responsible for pursuing each of these strategies, and tasks involved in their completion.

To reduce health care costs and cost growth:

1. Develop and operationalize (through hospital budget, certificate of need and insurer rate review processes) a health care budget for Vermont that reflects the principles embodied in Act 48 and is economically sustainable over time
2. Implement simplifications that reduce administrative costs
3. Implement innovations in payment and benefit design that will encourage individuals and health care providers to reduce costs of care
4. Implement specific efforts to better manage care for Vermonters with one or more chronic conditions
5. Maximize federal funding to support coverage and health care services in Vermont

To assure that all Vermonters have access to and coverage for high-quality health care:

6. Cover uninsured Vermonters
7. Increase enrollment and retention in coverage for insured Vermonters
8. Assess the adequacy of Vermont's health care workforce and service availability and recommend specific steps to enhance and improve it as needed
9. Define a minimum standard of benefits for all Vermonters that includes coverage of services with proven cost effectiveness in preventing illness and enhancing health status, provides incentives for individuals and their health care practitioners to attain and maintain good health and manage disease appropriately, and coordinates with public health services

To improve the health of Vermont's population:

10. Assure that all Vermonters have access to high quality, well-coordinated preventive health services by building on and continuously improving the Blueprint integrated health services model and expanding the scope of services coordinated through the Blueprint
11. Evaluate and continuously improve health care delivery by expanding the "learning health system" encompassed by the Blueprint for Health

12. Assure access for all working Vermonters to healthy worksites, Employee Assistance Programs, and other community supports that can serve as a gateway to health management
13. Improve the health of school aged children by promoting and implementing the Coordinated School Health Model recommended by the Centers for Disease Control
14. Support Vermont communities to respond to specific public health challenges

To assure greater fairness and equity in how we pay for health care:

15. Gain passage of legislation and approval of a federal waiver for public financing that is divorced from employment and sensitive to the ability of individuals and businesses to pay for coverage and is more sustainable
16. Reduce cost shifting between public and private sectors and between segments of the private sector

IV. Primary Responsibility for Pursuit of the Strategies, Specific Tasks and Deadlines

This section identifies the agencies or departments that have primary responsibility for specific tasks described in the previous section. Specific tasks and deadlines associated with the strategies also are identified, as well as necessary inter-agency coordination.

Key to Agency and Department Abbreviations:

AHS = Agency of Human Services

AOA = Agency of Administration

BISHCA = Department of Banking, Insurance, Securities and Health Care Administration

DCF = Department for Children and Families

DOE = Department of Education

DVHA = Department of Vermont Health Access

DOL = Department of Labor

GMCB = Green Mountain Care Board

TAX = Tax Department

VDH = Department of Health

1. Develop and operationalize (through regulatory, planning and budgeting processes) a health care budget for Vermont that reflects the principles embodied in Act 48 and is economically sustainable over time

Primary Responsibility:

GMCB

Specific Tasks:

- Work with BISHCA, DVHA and the federal government (through CMS) to complete development of the VHCURES all-payer data set
- Develop enhanced analytic capacity to use the all-payer data set to support system planning and evaluation and target cost reduction efforts
- Refine modeling of baseline health care costs, necessary investments and potential/actual savings from reforms
- Translate overall modeling into specific growth targets and metrics to be applied in the hospital budget, insurer rate and certificate of need processes

Deadline:

Ongoing – 2012 for VHCURES completion

Other Involved Agencies/Departments:

DVHA, BISHCA

2. *Implement simplifications that reduce administrative costs*

Primary Responsibility: DVHA

Specific Tasks:

- Plan for and operate a health benefit exchange as authorized by the federal Affordable Care Act
- Maximize administrative simplification within the exchange
- Develop/update eligibility, enrollment and other information systems within AHS and DVHA to maximize their efficiency and effectiveness
- Update and accelerate implementation of the state's health information technology plan
- Develop and implement new payment methodologies for providers that result in administrative simplification and reduced transaction costs

Deadline:

2014

Other Involved Agencies/Departments:

BISHCA/AHS/GMCB

3. *Implement innovations in payment and benefit design that will encourage individuals and health care providers to reduce costs of care*

Primary Responsibility:

GMCB

Specific Tasks:

- Approve all-payer payment reform pilots that test alternatives to fee-for-service payment on a broad scale
- Evaluate payment reform pilots and implement all-payer payment policies consistent with pilots that successfully improve quality and reduce cost growth
- Implement payment reform through other processes such as hospital budgets, payer and provider policy
- Approve benefits for the health benefit exchange that include coverage of services with proven cost effectiveness in preventing illness and enhancing health status and provide incentives for individuals and their health care practitioners to attain and maintain good health and manage disease appropriately

- Approve benefits for Green Mountain Care that include coverage of services with proven cost effectiveness in preventing illness and enhancing health status and provide incentives for individuals and their health care practitioners to attain and maintain good health and manage disease appropriately

Deadline:

Ongoing – 2012 for initial payment reform pilots and benefits approvals

Other Involved Agencies/Departments:

DVHA and BISHCA (payment reform)
AHS, AOA, DVHA, DMH and VDH (benefits)

4. *Implement specific efforts to better manage care for Vermonters with one or more chronic conditions*

Primary Responsibility:

DVHA/GMCHB/AHS

Specific Tasks:

- Expand payment reform pilots to include specialists who care for individuals with chronic conditions
- Develop and implement state-level management of payments and care models for individuals who are dually-eligible for Medicare and Medicaid (see also strategy #5 below)

Deadline:

- Payment reform pilots – implement in 2012
- Duals proposal – 2012 (implementation to follow if approved by federal government)

Other Involved Agencies/Departments: AOA

5. *Maximize federal funding to support coverage and health care services in Vermont*

Primary Responsibility:

AHS/DVHA

Specific Tasks:

- Maximize tax credits available under the Affordable Care Act
- Renew the state’s Global Commitment Waiver on favorable terms (AHS)
- Pursue state-level management of care for individuals who are dually-eligible for Medicare and Medicaid

- Include Medicare and Medicaid in payment reform pilots and demonstrations

Deadline:

- ACA tax credits – 2014
- Renew Global Commitment Waiver – 2014
- Duals proposal – 2012 (implementation to follow if approved by federal government)
- Payment reform pilots and demos – ongoing

Other Involved Agencies/Departments: GMCB, AOA, TAX

6. Cover uninsured Vermonters

Primary Responsibility:

DVHA

Specific Tasks:

- Design and operate a health benefits exchange
- Maximize tax credits for small businesses and individuals
- Maximize coverage through Medicaid, VHAP and CHIP of individuals who are eligible for but not enrolled in those programs
- Maximize ease of enrollment for all types of insurance through a common eligibility portal
- Identify any remaining coverage gaps and costs associated with filling those gaps (AOA)

Deadline:

2014

Other Involved Agencies/Departments:

AOA, TAX, DCF

7. Increase enrollment and retention in coverage for insured Vermonters

Primary Responsibility:

DVHA

Specific Tasks:

- Implement new eligibility and enrollment systems
- Coordinate eligibility and enrollment with private sector to minimize complexity and gaps in coverage

- Develop recommendations for other interventions to reduce or eliminate gaps in coverage

Deadline:

Ongoing

Other Involved Agencies/Departments:

AHS, DCF

8. *Assess the adequacy of Vermont's health care workforce and recommend specific steps to enhance and improve it as needed*

Primary Responsibility:

DOL and DVHA (AOA designees)

Specific Tasks:

- Develop workforce plan through coordinating the various public and private workforce initiatives underway
- Develop specific recommendations for interventions to enhance and improve workforce to meet VT's needs

Deadline:

2013

Other Involved Agencies/Departments:

GMCB (responsible for approval of workforce plan)

9. *Define a minimum standard of benefits for all Vermonters that includes coverage of services with proven cost effectiveness in preventing illness and enhancing health status, provides incentives for individuals and their health care practitioners to attain and maintain good health and manage disease appropriately, and coordinates with public health services*

Primary Responsibility:

DVHA/GMCB (coordinated through AOA)

Specific Tasks:

- Develop draft benefits for Exchange (DVHA)
- Develop draft benefits for Green Mountain Care (DVHA)
- Approve both benefit packages (GMCB)

Deadline:

2012

Other Involved Agencies/Departments:

DMH, VDH, BISHCA

10. *Assure that all Vermonters have access to high quality, well-coordinated preventive health services by building on and continuously improving the Blueprint integrated health services model and expanding the scope of services coordinated through the Blueprint*

Primary Responsibility:

DVHA

Specific Tasks:

- Expand Blueprint model to statewide availability, including patient-centered medical homes, multi-disciplinary community health teams, supportive all-payer payments and information technology infrastructure
- Support regional planning and implementation groups, as necessary, to establish Blueprint availability in unserved areas of the state
- Expand services encompassed by the Blueprint to assure access to and coordination of the full spectrum of primary and preventive care, including mental health

Deadline:

All willing providers by October 2013

Other Involved Agencies/Departments:

GMCB, VDH

11. *Evaluate and continuously improve our efforts by expanding the “learning health system” encompassed by the Blueprint for Health*

Primary Responsibility:

DVHA

Specific Tasks:

- Expand the learning health system to serve all Blueprint practices statewide with: practice facilitators; shared learning collaboratives; data analysis and feedback, and; evaluation
- Expand the number of practice facilitators available to Blueprint practices
- Expand data analysis to include Medicaid and Medicare data
- Begin collection of patient experience (survey) data from Blueprint patients
- Enhance reporting to Blueprint practices
- Expand evaluation to include additional services integrated in Blueprint

Deadline:

Ongoing

Other Involved Agencies/Departments:

GMCB/BISHCA (for expansion of data analysis and coordination of evaluation criteria/methodologies)

12. Assure access for all working Vermonters to healthy worksites, Employee Assistance Programs, and other community supports that can serve as a gateway to health management

Primary Responsibility:

VDH

Specific Tasks:

- Develop and promote best practice guidelines for healthy worksites

Deadline: 2013

Other Involved Agencies/Departments:

DOL, GMCB, DMH

13. Improve the health of school aged children by promoting and implementing the Coordinated School Health Model recommended by the Centers for Disease Control

Primary Responsibility:

VDH

Specific Tasks:

- Monitor and evaluate critical health-related behaviors among young people, and assess the effectiveness of school health policies and programs in promoting healthy behaviors and reducing risky ones
- Build partnerships among state-level government agencies and nongovernmental organizations with authority to coordinate efforts and maximize use of resources (Vermont Coordinating Council)
- Establish policies (nutrition, physical activity, health education) to help schools implement and coordinate their school health efforts

Deadline:

2013

Other Involved Agencies/Departments:

DOE

14. Support Vermont communities to respond to specific public health challenges

Primary Responsibility:

VDH

Specific Tasks:

- Provide technical support and resources to community organizations to complete community health assessments
- Work with communities to develop and implement community health improvement plans
- Strengthen the role of public health in Blueprint Community Health Teams to reduce risk factors and encourage primary prevention
- Develop capacity for easily-accessible and understandable reports for communities on health indicators and challenges

Deadline:

2012

Other Involved Agencies/Departments:

AHS, DVHA

15. Gain passage of legislation and approval of a federal waiver for public financing that is divorced from employment and sensitive to the ability of individuals and businesses to pay for coverage and is more sustainable

Primary Responsibility:

AOA

Specific Tasks:

- Develop financing plans required by Act 48 and report to legislature
- Assess impact on individuals and businesses within Vermont
- Seek federal waiver from Affordable Care Act

Deadline:

2013 (for financing plan), waivers as soon as is permissible under federal law

Other Involved Agencies/Departments:

DVHA, TAX, GMCB (for benefits)

16. Reduce cost shifting between public and private sectors and between segments of the private sector

Primary Responsibility:

GMCB and DVHA

Specific Tasks:

- Develop enhanced methodology for quantifying and making more transparent cost shift
- Develop recommendations for reducing cost shifting through payment reforms and state budgeting process
- Incorporate consideration of effect on cost shifting in insurer rate review and hospital budget processes, state budgeting and provider rate-setting

Deadline:

Ongoing

Other Involved Agencies/Departments:

BISHCA

V. Measures of Our Success

To demonstrate success in implementing this plan, we must measure our progress toward our goals using specific metrics and available data sources. Measurement of our progress should be transparent and readily accessible to the public and decision-makers, and should compare Vermont to other state, national and international benchmarks wherever possible. We recommend the following specific measures. **These are measures on which we might reasonably expect to evaluate our impact within the next three years, and do not necessarily represent the ideal data set for evaluation of health reforms over a longer time horizon.** Further work is planned to develop a regular reporting format for these measures and corresponding benchmark data, and to develop measures that reform should affect long-term.

Goal 1 (control costs):	Data source
Rate of growth in Vermont health care expenditures	GMCB: expenditure analysis
Rate of growth in per capita expenditures relative to economic growth	GMCB: expenditure analysis and dashboard
Savings relative to predicted spending	AOA/BISHCA/GMCB forecast/expenditure model
Goal 2 (assure access to services and coverage):	
Percentage of Vermonters covered/insured (full year and point-in-time)	BISHCA: 2013 Household survey
Percentage of Vermonters who are underinsured	BISHCA: 2013 Household survey
Percentage of Vermonters with a medical home	DVHA: Blueprint data
Provider supply relative to benchmarks of adequate supply	Vermont AHEC and Department of Health surveys
Goal 3 (improve health):	
Blueprint enrollment	DVHA: Blueprint data
Blueprint outcomes measures	DVHA: Blueprint data
Number of communities with community health assessments	Department of Health
Goal 4 (greater fairness and equity in financing of care):	
Percentage of income spent on health care and out of pocket costs by Vermonters on average, range of variation	BISHCA: 2013 Household survey
Rate of increase in costs by payer type	GMCB: expenditure analysis
Magnitude of cost shifting	GMCB: cost shift analysis
Passage of legislation authorizing more	Director of Health Care Reform

equitable financing	
Receipt of a waiver from the federal government authorizing more equitable financing	Director of Health Care Reform

VI. Responsibilities Organized by Lead Agency/Department

AGENCY OF ADMINISTRATION/DIRECTOR OF HEALTH CARE REFORM

1. Gain passage of legislation and approval of a federal waiver for public financing that is divorced from employment and sensitive to the ability of individuals and businesses to pay for coverage and is more sustainable

DEPARTMENT OF VERMONT HEALTH ACCESS

1. Implement simplifications that reduce administrative costs
2. Implement specific efforts to better manage care for Vermonters with one or more chronic conditions (shared with AHS and GMCB)
3. Maximize federal funding to support coverage and health care services in Vermont (shared with AHS)
4. Cover uninsured Vermonters
5. Assess the adequacy of Vermont's health care workforce and recommend specific steps to enhance and improve it as needed (AOA designee, working with DOL)
6. Define minimum standard of benefits (shared with GMCB)
7. Increase enrollment and retention in coverage for insured Vermonters
8. Assure that all Vermonters have access to high quality, well-coordinated preventive health services by building on and continuously improving the Blueprint integrated health services model and expanding the scope of services coordinated through the Blueprint
9. Evaluate and continuously improve health care delivery by further developing a "learning health system" as embodied in the Blueprint for Health
10. Reduce cost shifting between public and private sectors and between segments of the private sector (shared with GMCB)

GREEN MOUNTAIN CARE BOARD

1. Develop and operationalize (through hospital budget, certificate of need and insurer rate review processes) a health care budget for Vermont that reflects the principles embodied in Act 48 and is economically sustainable over time
2. Implement innovations in payment and benefit design that will encourage individuals and health care providers to reduce costs of care
3. Implement specific efforts to better manage care for Vermonters with one or more chronic conditions (shared with AHS and DVHA)
4. Define a minimum standard of benefits for all Vermonters (shared with DVHA and AHS)
5. Reduce cost shifting between public and private sectors and between segments of the private sector (shared with DVHA)

AGENCY OF HUMAN SERVICES

1. Maximize federal funding to support coverage and health care services in Vermont (shared with DVHA)
2. Implement specific efforts to better manage care for Vermonters with one or more chronic conditions (shared with DVHA and GMCB)

DEPARTMENT OF HEALTH

1. Support Vermont communities to address specific public health challenges
2. Improve the health of school aged children by promoting and implementing the Coordinated School Health Model recommended by the Centers for Disease Control
3. Assure access for all working Vermonters to healthy worksites, Employee Assistance Programs, and other community supports that can serve as a gateway to health management

DEPARTMENT OF LABOR

1. Assess the adequacy of Vermont's health care workforce and recommend specific steps to enhance and improve it as needed (AOA designee, working with DVHA)