STATE OF VERMONT
AGENCY OF HUMAN SERVICES

GLOBAL COMMITMENT TO HEALTH
CONCEPT PAPER: SECTION 1115a WAIVER

February 2005

GLOBAL COMMITMENT TO HEALTH

Table of Contents

			Page
I.	**Introduction**		
	A.	Background	3
	B.	Problem Statement	3
II.	**Global Commitment to Health – Program Design**		
	A.	Key Concepts	7
	B.	Overview of Participating Departments and Programs	9
	C.	Office of Vermont Health Access	11
	D.	Division of Economic Services	15
	E.	Department of Health	16
	F.	Department of Corrections	21
	G.	Department of Education	22
	H.	Department of Aging and Independent Living	22
	I.	Department of Children and Families	23
	J.	Medicare	23
III.	**Waiver Implementation and Administration**		
	A.	Transition from VHAP	25
	B.	General Administration	25
	C.	Contingencies	25
IV.	**Budget Neutrality**		26

SECTION 1: INTRODUCTION

A. Background

The state of Vermont has been a national leader in making affordable health coverage available to low income children and adults. Vermont was among the first states to expand health coverage for children and pregnant women, through implementation of the state-funded Dr. Dynasaur program in 1989. The Dr. Dynasaur program became part of the state-federal Medicaid program in 1992.

When the federal government introduced the State Children's Health Insurance Program (SCHIP) in 1997, Vermont took full advantage by extending coverage to uninsured and underinsured children living in households with incomes below 300 percent of the Federal Poverty Level (FPL).

In 1995, Vermont implemented a section 1115a waiver program known as the Vermont Health Access Plan (VHAP). The program's primary goal was to expand access to comprehensive health coverage for uninsured adults with household incomes below 150 percent of the FPL (later raised to 185 percent) through enrollment in managed care. VHAP also included a prescription drug benefit for low income Medicare beneficiaries who did not otherwise qualify for Medicaid. Both waiver populations pay a modest premium based on household income.

Vermont has made enormous progress over the past fifteen years in reducing the number of uninsured in the state. Vermont's average uninsurance rate for the three year period of 2001 – 2003 was 9.9 percent, sixth lowest in the nation. (Many of the remaining uninsured are low income working adults with incomes between 185 and 300 percent of FPL.)

In State Fiscal Year 2004, there were approximately 36,000 persons enrolled in the VHAP managed care and prescription benefit programs and another 95,000 traditional Medicaid beneficiaries. The state today covers nearly one-in-four Vermonters through the Medicaid program.

B. Problem Statement

Vermont's achievements are now being jeopardized by the ever escalating cost and complexity of the Medicaid program. While the state has consistently kept Medicaid expenditures within VHAP waiver budget neutrality limits, the

Vermont Medicaid program today faces the prospect of large and deepening annual deficits[1]. Without program changes in fiscal year 2006, the Medicaid deficit will be approximately $78 million.

Figure 1.1 below presents current revenue and expenditure projections for Vermont through SFY2010. As it shows, the cumulative deficit over the upcoming five fiscal years, if unaddressed, will be $597 million.

Figure 1.1 – Projected Medicaid Deficit

	SFY06	SFY07	SFY08	SFY09	SFY10
Revenues	$ 592,427,900	$ 624,763,101	$ 661,943,534	$ 706,523,987	$ 750,624,192
Medicaid Cost	669,956,397	725,164,761	784,967,881	849,749,582	919,925,818
Net Revenue/(deficit)	(77,528,497)	(100,401,660)	(123,024,347)	(143,225,595)	(169,301,626)
Carry forward	16,307,127	(61,221,370)	(161,623,030)	(284,647,377)	(427,872,972)
Year-end balance	$ (61,221,370)	$ (161,623,030)	$ (284,647,377)	$ (427,872,972)	$ (597,174,598)

In his SFY 2005 budget adjustment, Governor Jim Douglas proposed that $39.1 million of surplus general fund revenue be allocated to shore up Medicaid. The Governor will recommend that an additional $10 million in base dollars be appropriated to the Health Access Trust Fund (HATF) for SFY 2006. Together, these will add one time and ongoing revenues of nearly $50 million dollars, and yet they will provide only temporary relief.

Vermont recognizes that it cannot spend its way out of the projected deficits. Taxes would have to be raised each year to keep pace with program growth. Figure 1.2 illustrates the impact of trying to fund this deficit by increasing either the sales or personal income tax.

1.2 – Scale of Medicaid Deficit Relative to Two Major Tax Sources (in millions)

Scale of Projected Medicaid Deficit Relative to Two Major Tax Sources					
	Fiscal Year				
	2006	**2007**	**2008**	**2009**	**2010**
Projected Annual Medicaid State Fund Deficit Unabated	$61.20	$100.40	$123.00	$143.20	$169.30
Increase in Tax Revenues Necessary to Meet Deficit					
Sales Tax: Cumulative Percentage Increase	21%	36%	44%	51%	60%
-OR-					
Income Tax: Cumulative Percentage Increase	12%	20%	23%	26%	29%

[1] Deficit as used here means a shortfall in state appropriations (and associated federal matching dollars) as compared to program needs, not a budget neutrality deficit.

Vermont's Medicaid program needs fundamental, systemic change. The factors driving growth, including restrictive use of resources and growing program complexity, must be brought under control. Everyone, including beneficiaries and providers, needs to share equitably in the solution.

The nature of the problem was summarized by Governor Douglas in his inaugural address this past January. Governor Douglas also defined the principles which must guide the state's Medicaid reform efforts:

> *"Today, we face at least a seventy million dollar deficit in Medicaid. Left unrestrained, the very next legislature, in the very next biennium, will confront a deficit of almost two hundred seventy million dollars - over a quarter of a billion dollars. That's an amount equivalent to twenty-five percent of our entire general fund budget.*
>
> *"This deficit would be the largest in Vermont history. It threatens our fiscal stability, basic economic and health protections, and the already over-taxed Vermonter.*
>
> *"To eliminate a deficit of this magnitude, the legislature would have to impose draconian tax hikes on working people: raising personal income taxes by over fifty percent or nearly doubling the sales tax or almost quadrupling the gas tax.*
>
> *"These tax hikes would destroy the foundation of our economy. The fact is plain: we cannot, should not and must not tax our way out of this problem.*
>
> *"It falls on us - all of us - to find a solution that will save Medicaid for future generations before it collapses under the burden of its own weight. Getting spending under control will require leadership, and I am prepared to provide it. A solution will require a commitment as well from you, the legislature, to make those tough decisions required to put a responsible bill on my desk.*
>
> *"As you consider all of the other spending pressures you will surely face, including and especially additional health care spending, I ask you to tend to what we already have. I ask you to save Medicaid first…The plan that I (offer) is built around five fundamental principles to which any comprehensive plan must adhere.*
>
> - ✓ *Real health care reform must lower the cost of care for those Vermonters who are struggling to keep up.*
> - ✓ *Reform must be patient-centered and put decisions in the hands of patients and their doctors, not politicians and bureaucrats.*
> - ✓ *Reform must increase choices and options of care.*
> - ✓ *Reform must be affordable for Vermonters and sustainable for state government."*

Vermont is committed to preserving – and expanding – the affordable coverage gains made over the past ten years by developing and implementing creative reforms to the existing program. These reforms, which are described in the next section, will require more flexibility from traditional Medicaid rules than is

available under the current VHAP waiver. Vermont therefore proposes to replace VHAP with a new waiver that includes the tools necessary for the state, in partnership with the federal government, to address future needs in a holistic, global manner.

SECTION TWO: GLOBAL COMMITMENT TO HEALTH PROGRAM DESIGN

A. Key Concepts

The Vermont Medicaid program is the largest insurer in the state, representing approximately twenty percent of statewide health care spending. The Vermont Medicaid program serves a primary role as it relates to:

- Ensuring access to health services for individuals with disabilities
- Financing and administering the long-term care system
- Serving as a "safety net" for individuals unable to obtain private coverage

Vermont remains committed to meeting the health care needs of low-income individuals and individuals with specialized needs. However, program reform is necessary to permit Vermont to meet this commitment.

Vermont's budget deficit adds a new level of urgency to the problem, since the system's fragmentation also impedes efforts to deliver services more cost-effectively. The state has identified a number of cross-departmental initiatives that, together, would enable Vermont to obtain the greatest value from scarce health care dollars. However, Vermont has limited ability to act on many of these initiatives because of federal restrictions not addressed in the current VHAP waiver.

Additional flexibility will enable the state to more effectively manage public resources, provide the state with the tools necessary to make the program fiscally sustainable, and improve the Vermont health care system. The following initiatives have been identified as options to improve and sustain the Vermont program:

- ✓ Streamlining and standardizing eligibility processes across all coverage groups

- ✓ Implementing a statewide system of care that enables Vermonters with, and at risk of, chronic diseases to lead healthy lives

- ✓ Expanding health insurance options through introduction of market-based coverage alternatives, such as employer-sponsored insurance and health savings accounts

- ✓ Reducing the number of uninsured Vermonters through provision of premium subsidies for individuals with household incomes up to 300 percent of the Federal Poverty Level (FPL)

- ✓ Expanding the SCHIP program to extend coverage to low-income families

- ✓ Reducing administrative costs associated with health care delivery

- ✓ Adopting innovative approaches for reimbursing providers, including partial capitation and competitive contracting

- ✓ Developing initiatives to enhance the state's ability to manage pharmacy benefits

- ✓ Developing public-private partnerships to establish a system of care that ensures access for all Vermonters

- ✓ Expanding consumer choices and promoting early intervention for individuals with long-term care needs

- ✓ Enhancing access to services for individuals with developmental service needs

- ✓ Continuing coverage initiatives for working individuals with disabilities and exploring options to enhance benefits

- ✓ Improving access to services for children through integration of early childhood development and health services

- ✓ Strengthening the integration of community-based systems for mental health and substance abuse treatment

- ✓ Improving the continuum of care for individuals in correctional custody with mental health and substance abuse treatment needs

- ✓ Improving the coordination and integration of the Medicare and Medicaid programs

Vermont therefore proposes to replace the traditional Medicaid program, the VHAP waiver and existing 1915 waivers with a new, state-federal compact that provides greater operational flexibility to the state in exchange for budgetary certainty for the federal government. Operational flexibility will be granted at the outset, without the need for policy-specific negotiation and approval, thereby

enabling Vermont to quickly respond to changing health care market needs. Specifically (and subject to the approval of CMS):

- ✓ The state and federal governments will enter into a new 5-year agreement under the auspices of a section 1115a waiver.

- ✓ To allow for greater budget certainty on the part of both the state and CMS, the federal government will commit to an aggregate annual allotment, to be trended forward at a mutually agreed upon rate. The trend rate will cover both medical inflation and anticipated caseload growth.

- ✓ Under the new waiver, Medicaid expenditures from multiple state agencies and departments will be reported in aggregate, demonstrating Vermont's continued commitment. (The affected agencies/departments will continue to manage discrete accounts, within the overall budget, as determined by the legislature.) Reported expenditures would include programs and services not recognized for match today.

- ✓ Vermont will commit to controlling the cost of the Medicaid program, while preserving and expanding the gains achieved over the past fifteen years, by undertaking innovative reforms that stress private-public sector partnerships, streamlined operations and personal responsibility.

- ✓ Vermont will continue to serve core Medicaid groups (low-income individuals and individuals with specialized needs) and ensure coverage for a broad set of benefits.

- ✓ Vermont will continue to ensure access to medically necessary treatment for children, as required by EPSDT.

Through adoption of these key concepts, total federal expenditures will be locked-in and will grow at a slower pace than would have occurred absent the adoption of structural reforms. Vermont's Medicaid program will be restored to long term fiscal solvency, allowing the state to undertake new initiatives to improve accessibility and quality of care.

B. Overview of Participating Departments & Programs

The *Global Commitment to Health* waiver will encompass a variety of existing programs across multiple departments that today receive federal Medicaid matching dollars. These departments and their major areas of focus are identified in Figure 2.1 below.

2.1 – Global Commitment to Health Departments and Programs

The individual departments, and their respective initiatives within the *Global Commitment to Health*, are described in greater detail below. Some proposed initiatives may be implemented at the start of the waiver, while others may be deferred or phased-in over time. New initiatives may be identified after the waiver takes effect.

It is important to note that Vermont is seeking the freedom to modify program components during the life of the waiver without undergoing a lengthy federal review process each time. This desire is consistent with the President's goal of providing greater flexibility to states through such vehicles as the HIFA (Health Insurance Flexibility and Accountability) waiver, and is essential for the ultimate success of the *Global Commitment to Health*. Since Vermont will be subject to a pre-determined federal allotment, the state must have the flexibility to make program changes swiftly, when circumstances warrant. Consistent with this

philosophy, the proposed initiatives should be viewed as concepts, rather than fixed plans.

C. Office of Vermont Health Access (OVHA)

The Office of Vermont Health Access oversees the Dr. Dynasaur and VHAP waiver programs today, under which all beneficiaries are enrolled into a state-managed product. Under the *Global Commitment to Health*, the state intends to reform the premium and benefit components of the state-managed product to more closely align it with private health insurance.

Vermont also plans to introduce market-based coverage alternatives such as subsidies for employer-sponsored insurance and health savings accounts. Finally, the state intends to expand waiver coverage for adults from 185 percent of FPL to 300 percent, through implementation of a premium assistance program for this "notch group".

Revised Premiums for Waiver Enrollees

Vermont has relied on a modest schedule of enrollee premiums to offset program costs for several years. In State Fiscal Year 2004, the Legislature increased monthly premiums in conjunction with elimination of point-of-service cost sharing obligations.

Under the *Global Commitment to Health* waiver, Vermont may elect to introduce premiums for children living in households with incomes between 100 and 185 percent of FPL who are enrolled in Dr. Dynasaur. The state likewise may increase premiums for higher income Dr. Dynasaur enrollees and for the adult waiver population.

The revised premium structure has been designed to equitably distribute enrollees' financial obligations as a percentage of total household income. Children in households with incomes below 100 percent of the FPL will continue to be eligible without a monthly premium obligation. Uninsured adults with incomes below 50 percent of the FPL likewise will have no monthly premium obligation. (Uninsured adults with incomes below 50 percent of the FPL account for 37 percent of total VHAP waiver enrollment.)

Figure 2.2 below presents the current monthly premium amounts, the percentage of income the current premiums represent, the proposed premium amounts and the percentage of income the revised premiums represent. The new premium levels would not be locked in for the life of the waiver, but could be adjusted as deemed appropriate by the state to meet budgetary and enrollment targets. Any

changes from existing premium levels would receive legislative review and approval before implementation.

2.2 – Enrollee Premiums: Current and Proposed

Eligibility Group/Income	Current		Proposed	
	Premium	As Pct of HH Income	Premium	As Pct of HH Income
Children (Dr. Dynasaur)				
Dr. Dynasaur 100 - 185% FPL	$ -	0.0%	$ 20.00	1.0%
Dr. Dynasaur 186 - 225% FPL	$ 25.00	1.1%	$ 35.00	1.5%
Underinsured Children 226 - 300% FPL	$ 35.00	1.1%	$ 50.00	1.6%
Uninsured Children 226 - 300% FPL	$ 70.00	2.2%	$ 90.00	2.8%
Adults (VHAP Waiver)				
VHAP 50 - 75% FPL	$ 10.00	1.3%	$ 25.00	3.1%
VHAP 76 - 100% FPL	$ 35.00	3.3%	$ 40.00	3.8%
VHAP 101 - 150% FPL	$ 45.00	2.8%	$ 60.00	3.8%
Weighted Average Based on Enrollment	$ 20.47	1.0%	$ 30.84	1.5%

Employer-Sponsored Insurance

Under VHAP and Dr. Dynasaur today, the state directly administers health benefits through the Medicaid program. Vermont proposes to launch an employer-sponsored insurance (ESI) initiative to make coverage more affordable for individuals with access to employer-sponsored coverage. This initiative would facilitate the use of commercial, market-based coverage, representing an important step toward meeting the state's goal of offering more choice to program beneficiaries.

Individuals currently enrolled in VHAP (with the exception of uninsured parents and caretakers, 150-185 percent of FPL) and Dr. Dynasaur programs would be permitted to continue to receive services through the state-operated programs, as long as such eligibility continues. New program participants who do not have access to employer sponsored insurance would receive the current VHAP or Dr. Dynasaur coverage (with increased premiums, as described previously).

Newly eligible Dr. Dynasaur participants in households below 100 percent of the FPL and VHAP eligibles in households below 50 percent of the FPL also would continue to access benefits through the current programs.

Other, newly eligible program participants who have access to employer-sponsored coverage would no longer be eligible for coverage under the current VHAP program, but instead would be offered program subsidies to make such

coverage more affordable. The proposed subsidy would represent approximately one-half the cost of coverage under the VHAP program and sixty percent of the cost of coverage under the current Dr. Dynasaur program.

Because the ESI program does not apply to individuals currently enrolled, the transition to ESI would be gradual. Figure 2.3 below presents estimated enrollment in the current program and the ESI subsidy program, as well as the estimated number of individuals who choose not to participate. The table also presents the estimated state savings resulting from the transition to an ESI subsidy program.

2.3 – ESI Projected Enrollment and Savings

	Persons Enrolled					
SFY2006	Existing Program	ESI Subsidy Program	Total	ESI Percent of Total	Individuals with Access to ESI who do not Participate	Program Savings: State Share
Dr.Dynasaur	19,017	1,627	20,644	7.9%	361	$ 365,402
VHAP	19,622	2,074	21,696	9.6%	1,037	$ 1,961,314
SFY2006 Total	38,639	3,701	42,340	8.7%	1,398	$ 2,326,716
SFY2007						
Dr.Dynasaur	18,025	3,498	21,523	16.3%	777	$ 886,029
VHAP	17,906	3,732	21,638	17.2%	1,866	$ 3,893,960
SFY2007 Total	35,931	7,230	43,161	16.8%	2,643	$ 4,779,989
SFY2008						
Dr.Dynasaur	17,931	4,701	22,632	20.8%	1,045	$ 1,285,861
VHAP	17,625	4,493	22,118	20.3%	2,247	$ 5,598,436
SFY2008 Total	35,556	9,194	44,750	20.5%	3,292	$ 6,884,297

In addition to offering the ESI option to existing eligible groups, the state may offer premium assistance to uninsured adults in households with incomes between 150 and 300 percent of FPL who have access to health coverage through an employer[2]. The subsidy amount would vary by income and would apply to both the employee share of premiums and deductibles (same subsidy percent for each):

- ✓ Households from 150 – 200 percent FPL - 60 percent subsidy
- ✓ Households from 200 – 250 percent FPL - 40 percent subsidy
- ✓ Households from 250 – 300 percent FPL – 20 percent subsidy

The state estimates that approximately 14,000 Vermonters would be eligible for the premium subsidy and about two-thirds, or 9,500, would enroll. Even allowing for some drop off in participation among current eligibles, as shown in

[2] These persons will be eligible only for premium assistance and not for the state-managed benefit.

Figure 2.3, the net result of the ESI initiative would be an increase in the total number of insured.

SCHIP Funding for ESI

Under the *Global Commitment to Health* waiver, the State intends to use SCHIP funding to provide family coverage under the ESI option when children eligible for SCHIP reside in the household. The state believes that this approach is a cost-effective approach to making coverage more accessible.

Programs Designed to Encourage Employer Participation

Incentives to encourage employers to offer coverage is key to improving the uninsured rate and to reducing Medicaid program costs. Vermont intends to explore a number of cost-effective options to encourage employer-sponsored coverage, including tax credits and group purchasing options.

Health Savings Accounts

Vermont believes that market-based approaches to health coverage will, over time, offer the greatest number of options to beneficiaries and the wisest use of scarce health care dollars. In addition to the ESI initiative, the state may offer the option of Health Savings Accounts (HSAs) in the hope that this particular model will appeal to persons who are eligible for coverage, but have elected not to enroll in the face of premium obligations for employer coverage. The HSA option may be offered to all children and adults eligible for enrollment in either the SCHIP or VHAP programs who have a premium payment liability.

Families electing to enroll their children in the HSA would continue to pay an amount equivalent to the premium under the state-offered benefit, which will be used to fund their HSA account. There would be a single account for each family. The "account balance" at the beginning of the year will be set at an amount equal to the value of the annual premium.

Pharmacy

OVHA manages the pharmacy benefit for both the traditional Medicaid/VHAP waiver programs as well as the VHAP-Pharmacy, VScript and VScript-Expanded programs for low income Medicare beneficiaries. (VScript-Expanded currently is funded with state dollars, only.)

The VHAP-Pharmacy, VScript, and VScript Expanded programs are likely to be converted into a wraparound benefit to offset the impact of the Medicare Modernization Act by offering coverage beyond what is available through Medicare Part D. With respect to the general pharmacy benefit, OVHA plans a number of steps to more effectively manage utilization and costs. These include:

- ✓ Gaining more rapid compliance with the Preferred Drug List (PDL) by bringing major classes of drugs under the PDL that have been exempt;
- ✓ Providing financial incentives to beneficiaries who switch from brand to generic drugs;
- ✓ Increasing the number of days of medication a patient with a maintenance drug need can obtain;
- ✓ Using mail order to pay for certain categories of drugs and supplies; and
- ✓ Offering a maintenance drug benefit that is more consistent with the accepted practices of other health insurers.

Other Reimbursement Reforms

OVHA intends to evaluate innovative reimbursement approaches that may serve to equitably fund covered services, encourage appropriate utilization of services and reduce program administrative costs. Examples of approaches to be examined include performance-based payments, competitive contracting, revised fee-for-service reimbursement methodologies (e.g., Diagnosis-Related Groups [DRGs] for inpatient hospital services and Resource-Based Relative Value Scale [RBRVS] for physician services), establishment of partial capitation approaches and global targets, and consolidation of claims processing functions across entire provider groups.

D. Economic Services Division (ESD) – Standardized Eligibility

The Economic Services Division within the Department for Children and Families has responsibility for processing applications for Medicaid, Dr Dynasaur and VHAP, and making financial eligibility determinations. Under the current system, DES manages over 200 discrete "coverage groups", each with its own set of eligibility criteria. The complexity of the system forces inordinate resources to be devoted to identifying the right "slot" for each applicant – resources that could be better used elsewhere. The current system also creates confusion on the part of program applicants.

Vermont plans to explore making major reforms to the eligibility determination process, ultimately collapsing the 200 existing categories into as few as ten. Concurrent with this change, the state may adopt a common financial screen for

all applicants, possibly based on gross income, to further simplify and rationalize the process.

Vermont also intends to evaluate a standardized, clinical assessment process as part of its eligibility reform initiative. Through standardized clinical assessment based on functional need, the state could more effectively identify individuals with unserved needs and allocate needed health care resources.

E. Department of Health (DOH)

The Vermont Department of Health has broad responsibility for public health initiatives in the state, as well as specific responsibility for management of mental health and substance abuse treatment programs for the Medicaid and VHAP populations.

The Department of Health, along with OVHA, will play a leading role in reforming this portion of the program through implementation of several key initiatives. While OVHA focuses on the pharmacy benefit, DOH will target chronic care and mental health/substance abuse services.

Chronic Care Initiative

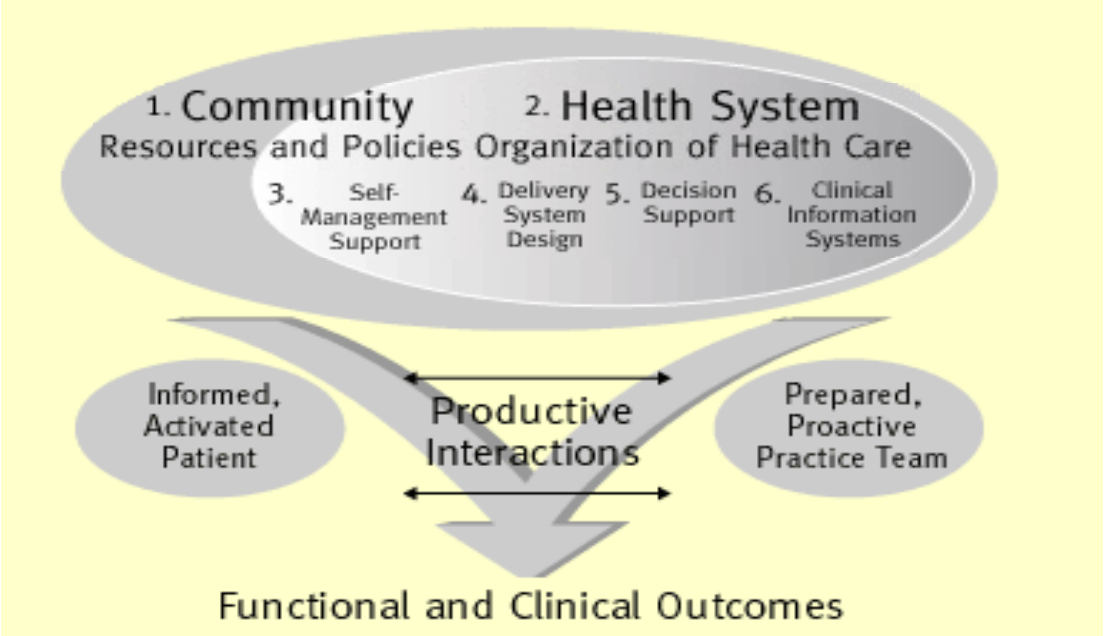
Vermont is poised to become the first state in the country to unveil multiple projects aimed at implementing its statewide Chronic Care Model. Staff at the MacColl Institute for Healthcare Innovation in Washington State developed the model, drawing on available literature about promising strategies for chronic illness management, and organizing that literature in a new more accessible way.

The model was further refined during a nine-month planning project supported by The Robert Wood Johnson Foundation, and revised based on input from a large panel of national experts. It was then used to collect data and analyze innovative programs recommended by experts. RWJF then funded the MacColl Institute to test the model nationally across varied health care settings: the national program being "Improving Chronic Illness Care" (ICIC).

The Chronic Care Model identifies the essential elements of a health care system that encourage high-quality chronic disease care. These elements are the community, the health system, self-management support, delivery system design, decision support and clinical information systems. Evidence-based change concepts under each element, in combination, foster productive interactions between informed patients who take an active part in their care and providers with resources and expertise. The model can be applied to a variety of chronic illnesses, health care settings and target populations. The bottom line is healthier patients, more satisfied providers, and cost savings.

Figure 2.4 below summarizes the major components of the model[3].

Figure 2.4 – Chronic Care Model



In Vermont, the Chronic Care Model would be implemented under the auspices of the *Global Commitment to Health* waiver. The model will have three objectives that support, and complement, the state's overall waiver goals:

1. Implement a statewide system of care that enables Vermonters with, and at risk for, chronic disease to lead healthier lives.

2. Develop a system of care that is financially sustainable.

3. Forge a public-private partnership to develop and sustain the new system of care.

In furtherance of these above goals, the Global Commitment, as conceptualized by the state, would provide the necessary flexibility to allow all of Vermont's current Medicaid recipients to be involved in evidence-based best practices as implemented utilizing the Chronic Care Model, without regard to their eligibility category.

The effect of chronic conditions on the health of Americans and health care costs is staggering. Individuals with chronic conditions account for 72 percent of all visits to physicians, 76 percent of hospital admissions, and overall, 84 percent of

[3] Source: MacColl Institute

all health care expenditures. In Vermont, 51 percent of all adults have one or more chronic conditions. In the population from 45 to 64 years old, 68 percent of individuals have chronic conditions, and in the population 65 years and over, the rate is 88 percent, with 20 percent of this population having at least four chronic conditions. Thirty percent of the population with a chronic condition has their daily activity limited by the condition, which impacts productivity in the workplace.

Just one common chronic condition – cardiovascular disease – accounts for 20 percent of all hospital admissions, or more than 47,000 patient days, at an expense of over $47 million. It is a leading cause of permanent, premature disability, and drives up disability premiums. It is the leading cause of death in Vermont, accounting for 27 percent of all deaths. Cardiovascular disease is largely preventable, and once obtained, is largely controllable. It is one of the chronic conditions that would be addressed through the Blueprint for Health.

The prevalence of chronic conditions has increased in our society due to unhealthy behaviors, including excessive caloric intake, lack of physical activity and smoking. However, our system of care has not changed, and the system, designed for acute care problems, is ill equipped to deal with chronic conditions.

According to the Institute of Medicine, more than 50 percent of individuals with chronic conditions such as diabetes, cardiovascular disease, and asthma are inadequately managed. In other words, they do not get appropriate care to minimize the impact of their condition on their health, quality of life and ability to be productive members of our community. This results in the exacerbation of their condition, the development of related medical problems and increased use of health care resources.

"The Vermont Blueprint for Health: The Chronic Care Initiative" is a public-private partnership formed to address the increasing burden of chronic care on individuals, the health care system, businesses and government programs such as Medicaid. The initiative envisions a future in Vermont where informed, activated patients interact with prepared, proactive practice teams, with the results being effective encounters with the health care system, improved health outcomes and decreased utilization of the health care system.

The Blueprint includes active roles for individuals, communities and providers. This would be assisted by information systems, such as a patient registry, that will facilitate proactive care management by providers and patients by furnishing them with the information they need when they need it. It would allow us to move from a system of reactive care to one of planned care, which will slow disease progression, reduce the number of hospitalizations for

complications associated with chronic conditions (e.g., amputations due to diabetes) and decrease the number of premature deaths, while allowing Vermonters to lead productive lives.

Targeted Public Health Initiatives

In conjunction with the overall chronic care initiative, Vermont may implement or expand targeted initiatives meant to address specific public health concerns. One area that may be expanded is Vermont's Tobacco Control Program, which includes telephone and face-to-face counseling services and nicotine replacement therapies. Tobacco is a leading cause of preventable death in Vermont, causing about 800 deaths each year and costing $182 million in health care dollars, nearly a third of which are Medicaid.

Another is "Fit and Healthy Kids". Fit and Healthy Kids is a coordinated comprehensive approach to reduce the prevalence of obesity among children and youth. There are a growing number of youth who are at an increased risk for chronic diseases such as diabetes, cardiovascular disease and hypertension due to poor nutrition and being overweight. The direct medical costs attributable to obesity in adults are estimated to be as high as $92 billion nationally in 2002 dollars, with approximately half financed by Medicaid and Medicare.

Projects developed under the Fit and Healthy Kids initiative provide a direct service to children, families and communities with the objective of reducing the disease risk associated with overweight and obesity. Based on lessons learned from the tobacco program, strategies to improve nutrition and increase physical fitness include individual behavior changes (e.g., increasing physical activity to at least 20 min per day); community wide response (e.g. increasing opportunities for physical activity, limiting access to soft drinks in schools); and public policy (e.g., promote implementation of school nutrition policies).

Substance Abuse- Screening and Brief Intervention

Alcohol abuse and dependence are major public health problems, resulting in 100,000 deaths per year in the United States and costing the healthcare system billions of dollars annually. Excessive alcohol use is a major cause of injuries, violent crime, lost productivity at work and school, family and social problems, and disease.

Screening and brief intervention are two separate skills that can be used together to reduce risky substance use. "Screening" involves asking questions about alcohol or drug use. A "brief intervention" is a negotiated conversation between professional and patient designed to reduce alcohol and drug use. In his 2006

budget, President Bush reaffirmed his funding support for programs built around this concept.

Vermont's ability to operate screening and brief intervention programs is limited by the current eligibility process. Many times an uninsured person is brought to a hospital emergency room, treated and discharged before the eligibility determination process can even begin. Under the *Global Commitment to Health*, Vermont may explore establishing a diagnosis/service-specific presumptive funding process to facilitate access to treatment. If it proves successful, this concept may be expanded to other, carefully selected diagnoses/services as needs are identified.

Mental Health – Meeting Community Needs

Vermont is a rural state with a shortage of mental health professionals, particularly child psychiatrists. In many cases, children with mental health conditions are treated by primary care providers who may lack the expertise to properly diagnose and treat without the assistance of a mental health professional.

Physician-to-physician consults offer one method for stretching scarce mental health resources in a cost-effective manner. Psychiatrists often can provide valuable assistance to primary care providers by telephone in lieu of seeing a patient themselves, but are reluctant to do so without compensation. Under the *Global Commitment to Health*, Vermont will explore reimbursing psychiatrists for this service.

The Vermont community mental health system serves a vital role in meeting community needs. Vermont is a national leader in providing community-based care for individuals with mental health, substance abuse treatment and developmental service needs. In recent years, community providers have faced increasing fiscal challenges as demand has exceeded public resources.

Vermont will further rely on the community system as part of its comprehensive plan to close the Vermont State Hospital. Consistent with the state's general philosophy to treat individuals in the community, the state intends to develop community resources to help serve individuals previously admitted to the State Hospital. While initial expenditures for development of alternatives to the State Hospital will be more costly, the state anticipates that the revised system will produce better treatment outcomes and prove cost effective over the long term.

Another challenge facing the community system is balancing the enhanced need for emergency services with available funding streams. Community providers

are responsible for providing emergency mental health services in their geographic areas, on a 24-hour/7 days per week basis, for both individuals in crisis and in response to community-wide crises (e.g., violent community events). However, the nature of the service makes it difficult to receive adequate reimbursement on a fee-for-service basis. Under the *Global Commitment to Health*, the state intends to evaluate a service-specific, presumptive funding process for financing community-based emergency services.

The state currently operates its Community Rehabilitation and Treatment (CRT) program for individuals with serious mental health needs under the VHAP 1115 waiver. The state intends to continue to administer the CRT program under the *Global Commitment to Health* as it currently operates. The state also intends to explore initiatives to identify at-risk individuals to facilitate early treatment.

Similarly, the state intends to continue the administration of the children's mental health waiver and develop strategies to efficiently manage the benefits of those enrolled.

F. Department of Corrections – Integration of Community-Based Health Services

The link between criminal activity and substance abuse has been well-established. The Vermont correctional system currently faces a financial crisis as the need for additional prison beds continues to grow. Nearly seventy-five percent of individuals entering the Vermont correctional system are in need of substance abuse treatment.

Individuals entering the correctional system also possess a disproportionate need for mental health treatment. The Department of Corrections recently developed a Comprehensive Mental Health Plan to address the growing need for mental health services.

Vermont intends to develop strategies to enhance the continuum of care for mental health and substance abuse services provided to individuals under correctional custody. Through improved coordination, the State expects to improve treatment outcomes to reduce the incarceration recidivism rate and improve overall health.

G. Department of Education

The State of Vermont currently operates a program for Medicaid reimbursement of school-based health services. The need for specialized health services continues to grow for a number of reasons, including more effective methods to identifying children with needs. While the Medicaid program provides some funding for these programs, the amount of paperwork necessary to collect Medicaid monies requires professional staff time that could be better spent serving children. Under the Global Commitment Waiver, Vermont intends to streamline the funding process for this program. The streamlined funding process will reduce administrative costs while continuing to equitably reimburse schools for health services.

Many children who would benefit from Individualized Education Plans (IEPs) and special education services fail to meet one of the qualifying criteria and instead are served in accordance with alternate, "504 plans". Those with 504 plans also include children moving off of IEPs who still need some level of assistance to prevent a relapse. Under the Global Commitment approach, Vermont would remove artificial barriers that hinder appropriate funding of health services for low-income children.

H. Department of Aging and Independent Living (DAIL)

The Department of Aging and Independent Living is responsible for the elderly, physically disabled and developmentally disabled populations in Vermont.

Elderly and Physically Disabled

DAIL is implementing major reforms of the Vermont long term care system under the aegis of a Section 1115a waiver currently being negotiated with CMS. These reforms would continue under the *Global Commitment to Health.* The long-term care waiver seeks to restructure the long-term care system for individuals receiving nursing facility services, individuals enrolled in the two 1915 waivers (Home and Community-Based Services [HCBS] and Enhanced Residential Care [ERC] waivers), and individuals in need of other long-term care services. The waiver is designed to give the state the tools it needs to more effectively manage resources as it faces the increased demand on the system due to the aging of the population.

DAIL is responsible for administration of the 1915 waiver for individuals with traumatic brain injuries (TBI). The state would continue to administer this waiver program under the *Global Commitment to Health* as it does today.

DAIL may seek to undertake additional reforms designed to ensure the cost-effective use of dollars for institutional care, such as introducing selective contracting, or competitive bidding, for nursing facility bed days. At the same time, DAIL will seek to maintain and reinforce the greatest possible array of community-based service options, including attendant services, adult day health, respite care, homemaker services, supportive housing arrangements and mobility training and other services for the elderly visually impaired.

Developmental Services

Vermont has been successful in offering home- and community-based service options for its developmentally disabled population; as a result, the states only institution for people with developmental disabilities closed over a decade ago.

However, the program is facing long term challenges resulting from the lengthening life spans of the developmentally disabled and the growing number of aging caregivers (usually parents). To strengthen the system in the face of this demographic trend, Vermont will explore opportunities for enhancing existing caregiver respite programs.

I. Department for Children and Families – Children's Services

The Department of Children and Families (DCF) is responsible for the social, emotional, physical and economic well being and the safety of Vermont's children and families. This is done through the provision of protective, developmental, therapeutic, probation, economic, and other support services for children and families in partnership with schools, businesses, community leaders, service providers, families, and youths statewide. Medicaid funds currently support a number of programs and services administered by DCF, including respite care, treatment services and targeted case management. Currently, eligibility and program funding requirements vary. The State intends to evaluate these programs in order to identify strategies to steer individuals to appropriate care systems and streamline the eligibility/assessment process.

J. Medicare

Vermont is interested in exploring with the federal government a new partnership to better serve persons dually eligible for Medicare and Medicaid. The state is prepared to enter into negotiations aimed at placing all health care dollars for dually-eligible Vermonters into a single budget, to be managed by the state under an integrated care model. This could occur through enrollment of

dual eligibles into a Medicare Special Needs Plan to be operated by the state, or through some other negotiated mechanism.

Vermont recognizes that this proposal could take longer than other waiver components to negotiate and therefore presents it only as a concept at this time. Vermont will seek to open discussions on this topic after the *Global Commitment to Health* waiver has been approved and implemented. Any waiver initiative then would be authorized under a separate waiver amendment.

III WAIVER IMPLEMENTATION & ADMINISTRATION

A. Transition from VHAP

The *Global Commitment to Health* would take effect on July 1, 2005; the VHAP waiver would be terminated at the same time. Persons enrolled under the current Medicaid/VHAP program, including traditional Medicaid, Dr Dynasaur, 1915 waiver enrollees, VHAP waiver beneficiaries and VHAP-Pharmacy beneficiaries, would be transitioned to the new program. From a beneficiary perspective, there would be no immediate impact on benefits as a result of the transition.

B. General Administration

The *Global Commitment to Health* will be a collaborative, cross-departmental effort involving major portions of the Vermont state government, as well as private insurers, employers and other stakeholder groups. Ultimate responsibility for administration of the waiver will reside with the Office of Vermont Health Access within the Agency of Human Services, Vermont's Single State Agency. OVHA will be responsible for day-to-day management of the waiver and for meeting all CMS reporting requirements.

C. Contingencies

Under the proposed waiver, Vermont will assume risk for caseload growth and medical inflation during the next five years. The state is confident it will be able to manage the program within negotiated limits using the additional flexibility being sought. However, in the event of a national emergency – either economic or medical (such as an epidemic), Vermont will seek authority to suspend the waiver in consultation with CMS until the emergency has passed. This suspension would be limited to events beyond Vermont's control that, left unaddressed, would endanger the health of the state's citizens.

Vermont anticipates that the *Global Commitment to Health* will meet the needs of Vermont citizens and the federal government so that it is mutually beneficial to continue the waiver for an indefinite period. In the event that the *Global Commitment to Health* no longer defines the state – federal agreement, Vermont will seek assurances to have federal authority and sufficient federal funding to sustain the programs it has developed over the past decade.

IV BUDGET NEUTRALITY

Vermont believes that the innovative strategies described in this document will enable the state to effectively manage public resources while preserving and enhancing access to health care services in the state. The state is seeking federal authority to reform its program to control overall program expenditures in exchange for a continued, predictable commitment of federal funding. The state believes its strategies will result in program spending below levels that would be necessary absent program reform.

The state will seek federal funding at levels consistent with historical program growth. Figure 4.1 presents historical program funding and caseload for State Fiscal Years 1999 through 2004.

Figure 4.1 – Historical Expenditures and Caseload Growth, SFY1999-2004

	State Fiscal Year						Average Annual Trend
	1999	2000	2001	2002	2003	2004	
Aggregate Expenditures							
Federal Funds	292,529,992	352,959,482	385,730,041	438,213,405	477,075,205	538,354,561	12.97%
State Funds	180,621,644	216,251,909	233,072,474	259,148,872	275,269,583	289,056,448	9.86%
Total, State and Federal	*473,151,636*	*569,211,391*	*618,802,515*	*697,362,277*	*752,344,788*	*827,411,009*	*11.83%*
Program Caseload	111,263	118,179	122,784	127,338	130,224	131,280	3.36%
Average Cost per Enrollee	$ 4,253	$ 4,817	$ 5,040	$ 5,476	$ 5,777	$ 6,303	8.19%

Under the *Global Commitment to Health,* Vermont will seek federal funding that will be fixed at an established annual allotment. The federal obligation would be inflated annually by a pre-determined trend rate.

The state will continue to collaborate with CMS to develop a funding agreement that meets the objectives and needs of both the federal government and the Vermont program.