

MEMORANDUM

TO: Martha Heath, Chair, House Appropriations Committee
Mark Larson, Chair, House Health Care Committee
Claire Ayer, Chair, Senate Health and Welfare Committee
Ann Cummings, Chair, Senate Finance Committee
Janet Ancel, Chair, House Ways and Means Committee

CC: Douglas A. Racine, Secretary, Agency of Human Services
Jim Giffin, Financial Director, Agency of Human Services
Jim Reardon, Commissioner, Department of Finance and Management
Susan Bartlett, Special Assistant, Governor's Office
Anya Rader Wallack, Special Assistant, Governor's Office
Robin Lunge, Department of Banking, Insurance, Securities and Health Care Administration
Lori Collins, Director, Department of Vermont Health Access
Vicky Loner, Director, Department of Vermont Health Access
Hunt Blair, Director, Department of Vermont Health Access
Lorraine Siciliano, Legislative Liaison, Department of Vermont Health Access
Betsy Forrest, Healthcare Affordability Director, Department of Vermont Health Access

FROM: Susan W. Besio, PhD, Commissioner, Department of Vermont Health Access

DATE: February 23, 2011

RE: Questions regarding SFY'12 Budget proposal for the Department of Vermont Health Access

Thank you for your time reviewing the SFY '12 budget proposal. We have captured a list of questions posed by various committees in the course our recent budget testimony, and have provided responses below.

1. Please provide more details on the HIV benefit: What is included in the pmpm? How are medical costs getting covered? VDH through their AMAP program pays the AIDS medication drug costs and dental care assistance. The pmpm benefit represents premium payment for the drug benefit. These are paid for with MCO investment dollars as they represent a benefit provided to beneficiaries who do not qualify for a Medicaid program. In the instance where these individuals qualify also for VHAP, DVHA pays for their traditional health coverage under that program.
2. Clarify the mandatory versus optional chart (e.g., eyeglasses are not covered). Please see Attachment 1.
3. How was the premium grace period calculation derived? This new provision requires States to grant individuals enrolled in separate a SCHIP program a 30-day grace period, from the beginning of a new coverage period, to pay any required premium before enrollment may be terminated. The new coverage period will begin the month following the last period for which a premium was paid.

States are required to inform CHIP enrollees that failure to pay any required premium within at least 30 days after the beginning of a new coverage period will result in termination of coverage.

There are three populations of children where the household pays a monthly premium for health care: SCHIP (225-300% FPL) \$60 per household per month; Medicaid Underinsured (225-300% FPL with other insurance) \$20 per household per month; and other Medicaid children (185 - 224% FPL) \$15 per household per month. While this change is required for SCHIP, the analysis included the two other populations in Dr Dynasaur that pay premiums because children move back and forth between Medicaid and SCHIP. The estimate was developed using the DCF Economic Services Division Medicaid Premium Coverage Group Closures monthly report. DCF reports monthly for each group who lost coverage for failure to pay the premium. The estimate is based on the number of children who lost coverage as of the 2nd business day of the following month. For example, the count for children who lost coverage in October is determined on the second business day in November. Each child who lost coverage is a member month. With implementation of this change, DVHA would incur the medicals cost (PMPM) for that child for that month.

Coverage Group	Member Months of Lost Coverage	PMPM	Estimated Medical Costs
SCHIP 225 - 300%	1,114	\$134.93	\$150,312
Underinsured 225 - 300%	276	\$49.12	\$ 13,557
Children 185 - 224%	1,437	\$167.25	\$240,338
Total	2,827		\$404,207

4. Is there a “penalty” for dropping off then coming back on programs due to lack of premium payment? Do people have to catch up on their missed payments, etc.? Our present health care premium payment system requires payment before health care coverage begins; however, there are no retroactive premium bill backs for beneficiaries who go off and on our programs due to lapse in premium payment. (Healthcare costs would not be covered during the timeframe in which that lapse occurs.) A premium grace period could allow an individual to maintain coverage and only pay premiums every other month. The intent of the premium grace period is to provide a family facing a short term financial challenge with a limited opportunity after their premium payment was due to retain health care coverage while arranging to make the payment. The intent of the premium grace period is not to allow individuals to receive coverage without paying the monthly premium. The premium payment for the grace period would be needed to maintain coverage. This will create challenges for some families that close due to falling behind in their premium payment. To re-open, the family will have a past month (grace period) premium and a new month payment due prior to receiving health care coverage. Most of our families pay premiums in a timely manner and will continue to do so.

5. What kind of fines are charged when Program Integrity issues are discovered?
 There are no fines collected when Program Integrity issues are identified. Costs, however, are recouped.

6. Can we require beneficiaries to sign an advanced directive? Preliminary research would indicate that there isn't a specific prohibition against requiring Advance Directives in Medicaid. However, the DVHA would need more information about the proposal to confer with CMS about its implications for eligibility and access to services.
7. What is the cost of the six Program Integrity staff added as a result of 2010 Act 156. If you had more staff, could you save more money? The six additional Program Integrity staff cost \$480,000. Presently, four (4) Federal/State programs already exist to address Medicaid program integrity: (1) Medicaid Integrity Contractors (MIC); (2) Payment Error Rate Measurement (PERM); (3) the Attorney General's Office, Medicaid Fraud and Residential Abuse Unit (MFRAU), and; (4) Medicaid Program Integrity (PI). In addition, in 2011, Medicaid is required under the Affordable Care Act to fully implement its *Recovery Audit Contractor (RAC) Program*. At that time, a total of five (5) programs related to detecting Medicaid fraud will be operating in Vermont. Therefore we do not recommend adding any addition staff at this time; rather we would recommend giving the existing programs and the RAC program being implemented this year time to improve their processes and work through existing caseloads.
8. Have we considered limiting unnecessary C-sections? Should we bring this to the Clinical Utilization Review Board for consideration? What about case managing children with asthma? Or case managing high-risk pregnancy? We are currently analyzing its C-Section rate, and will bring this topic to the CURB if the data suggests there is a problem in this area. DVHA participates in the AHRQ project discussing strategies for states to reduce C-Sections and to encourage vaginal delivery in patients who has a previous C-Section. The AHRQ, the Agency for Healthcare Research and Quality, is an agency within the federal Department of the Health and Human Services supporting research that helps people make more informed decisions and improves the quality of health care services.

Through its Vermont Chronic Care Initiative (VCCI), the Department of Vermont Health Access (DVHA) partners with APS Healthcare to offer disease and case management services for both children and adults with specific chronic conditions, including asthma. The VCCI state-employed care coordination staff consists of registered nurses and medical social workers. They use a holistic approach and emphasize evidence-based, planned, integrated and collaborative care for beneficiaries who exhibit high-prevalence chronic diseases, high-expense utilization, high medication utilization, and/or high emergency room and inpatient utilization.

Several methods are used to identify children with a diagnosis of asthma, including APS' predictive modeling software, direct referral from providers and community partners, and self-referral. The VCCI uses a tiered approach, with high risk beneficiaries receiving face-face case management from one of the DVHA care coordinators, while beneficiaries at lower risk receive health education and coaching from registered nurses employed by APS. DVHA currently is piloting an alternative approach in Franklin and Rutland counties, the new *Challenges for Change Blueprint Integrated Care Coordination* model. In this model, DVHA care coordinators provide the full range of services, including short-term interventions for children and adults at low and moderate risk, as well as the intensive support they traditionally have provided to those at higher risk. The care coordinators also are collocated in high volume primary care offices, specialty practices, and hospitals, and may work with any beneficiaries referred to them, not just those with specific chronic conditions.

Lastly, the VCCI will be performing a focused quality improvement project (QIP) this spring to identify the highest risk children with asthma and work with their physicians to provide case management services. Preliminary analysis suggests approximately 535 children could be eligible. "High risk" for this project is defined as any child up to the age of 18 years who has filled four or more rescue inhaler prescriptions in the past 12 months *or* has filled at least one rescue inhaler and has had either an asthma-specific emergency room or inpatient admission within the past 12 months.

As noted above, DVHA's Vermont Chronic Care Initiative already provides registered nurses and medical social workers to help beneficiaries manage their chronic conditions. In addition, DVHA currently is piloting a model in Franklin and Rutland counties in which DVHA care coordinators work with any beneficiary referred to them by the providers with whom they are colocated. The registered nurses in these pilot areas do work with high risk pregnant women and also help coordinate appropriate referrals for them to other community partners and agencies specializing in high risk maternal care. However, DVHA does not have a program dedicated to managing women with high risk pregnancies. A comprehensive program serving the special needs of this group of women and their newborns would require special expertise in maternal-fetal medicine and neonatology, which is not part of the current program.

9. Springfield Hospital has an urgent care not referenced in the report on Hospital-sited Primary Care Clinics Challenges for Change Initiative. Why? Excellent point made more interesting because of Springfield's FQHC status. The focus of the Challenge initiative was on *hospital-sited clinics*, so while DVHA is aware of the urgent care clinic being located at the site of the former Rockingham Hospital being operated by the Springfield Hospital, it was excluded based on that definition.
10. Where are we with the radiology prior authorization project? As part of Act 156 (SFY 2011), the legislature authorized the Department of Vermont Health Access (DVHA) to institute a prior authorization (PA) process for high-tech imaging. The imaging PA process applies to outpatient, non-emergency scans such as computed tomography (CT), computed tomographic angiography (CTA), magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positron emission tomography (PET), and positron emission tomography/computed tomography (PET/CT).

Through its contract with HP Enterprise Services (HP), the DVHA has partnered with MedSolutions to provide the high-tech imaging PA service for Medicaid recipients. After selecting the vendor and fulfilling the legislative requirement to provide participating providers a sixty (60) day notice period, MedSolutions began accepting PA requests on August 23, 2010, for program implementation on September 1. The program originally had been projected to save \$2 million dollars (net) in SFY 2011. However, since this projection was based on the program being fully operational the entire year, projected savings were reduced by \$333,333 during SFY '11 Budget Adjustment, resulting in expected total net savings of \$1,666,667 during SFY 2011.

The DVHA, HP and MedSolutions undertook several activities to provide clear guidance and transparency, and to mitigate any operational start-up complications. Specifically, HP and the DVHA's Member and Provider Services Unit worked closely with the Vermont Medical Society (VMS) and its membership to obtain provider input (e.g., reviewing codes selected for PA, reviewing the provider manual, etc.). Additionally, MedSolutions offered pre-implementation training to providers in the form of written materials, web-based seminars, and in-person presentations. Information remains available through MedSolutions' 24/7 web portal, toll-free

number, and by fax. MedSolutions' clinical guidelines also are available through its website at no cost to providers; these guidelines are based on the *American College of Radiology Appropriateness Criteria*, as well as criteria endorsed by other specialty societies (e.g., American Academy of Neurology, American College of Cardiology, National Comprehensive Care network).

The DVHA's Clinical Operations and its Member and Provider Services Units work with HP to monitor MedSolutions' performance against both service and savings requirements. MedSolutions reports monthly on service performance measures, including but not limited to the following: decision turn-around timeframes for urgent and routine requests; average speed to answer the telephone; call abandonment rate; number of cases reviewed; number and percentage of cases denied and approved; cases pended for insufficient information or for peer-peer case review; number and percentage of retrospective requests; denial and approval rates for the twenty highest requesting providers; number and type of complaints. All reports and other monitoring activities indicate the program is meeting contractual service expectations and with savings close to those projected. Only four (4) complaints have been received since implementation. Based on the first trimester, annualized net savings of \$1.5 million are projected (compared with the approximately \$1.7 million that was budgeted). However, it is difficult to accurately project annual savings after only four months of operation and MedSolutions has noted in writing they remain confident the program is on track to meet the entire net savings originally projected for SFY 2011.

In summary, the high-tech imaging PA program has been successfully implemented, all service performance indicators are positive, and the contracted vendor is confident the entire projected net savings will be achieved. The DVHA will continue to monitor the program closely. In addition, the DVHA plans to work with MedSolutions and the Vermont Medical Society to implement a *Gold Card* system, which will exempt providers with exceptional approval histories from the Medicaid imaging PA process.

11. Is there an assumption that H.202 has even faster implementation of the Blueprint? No, the Blueprint will continue on the current track outlined in Act 128 of 2010: there will be a minimum of two primary care practices (defined as primary care internal medicine, family medicine, pediatrics, obstetrics and gynecology) in each of the state's 13 Hospital Service Areas by July 2011, and the opportunity for all willing primary care providers to participate by October 2013.
12. Provide the palliative care report to the committees. The 2011 Annual Report from the Palliative Care and Pain Management Task Force is available online here: <http://www.leg.state.vt.us/reports/2011ExternalReports/263668.pdf>
The 2009 Report on Palliative Care for Children submitted by DVHA is Attachment #2.
13. Could we save any more money due to the 340B initiative? We expect to see savings from 340B grow substantially over time, but because of the operational challenges and uncertainties related to start-up of the program at the newly eligible Covered Entities, both DVHA and the Commissioner of Finance and Management do not recommend booking larger savings for SFY '12.
14. What is the Dental Dozen? Please see Attachment #3.
15. What happens if nursing home or MCO goes out of business? Or anyone else taxed? Would they still owe the tax? No. Assessments are set on a state fiscal year basis. If a provider goes out of business during that state fiscal year, there is no basis for which to justify the assessment.

16. What is 5 year history of provider rate changes for assessed businesses?

	2008	2009	2010	2011	2012
Hospital	2,000,000	16,925,000	-	20,000,000	10,000,000
Hospital - One Time	-	-	-	3,075,031	-
Nursing Home	-	1,650,000	1,800,000	-	3,275,209
ICF/MR	-	-	-	-	4,959
Home Health	810,000	750,000	(170,747)	-	237,304
Pharmacy	-	-	(2,464,828)	(3,389,429)	-
Dental	787,862	1,412,441	-	-	5,975,000

17. Can you provide how much Medicaid money is spent for each taxed provider to your chart? Please see Attachment #4.

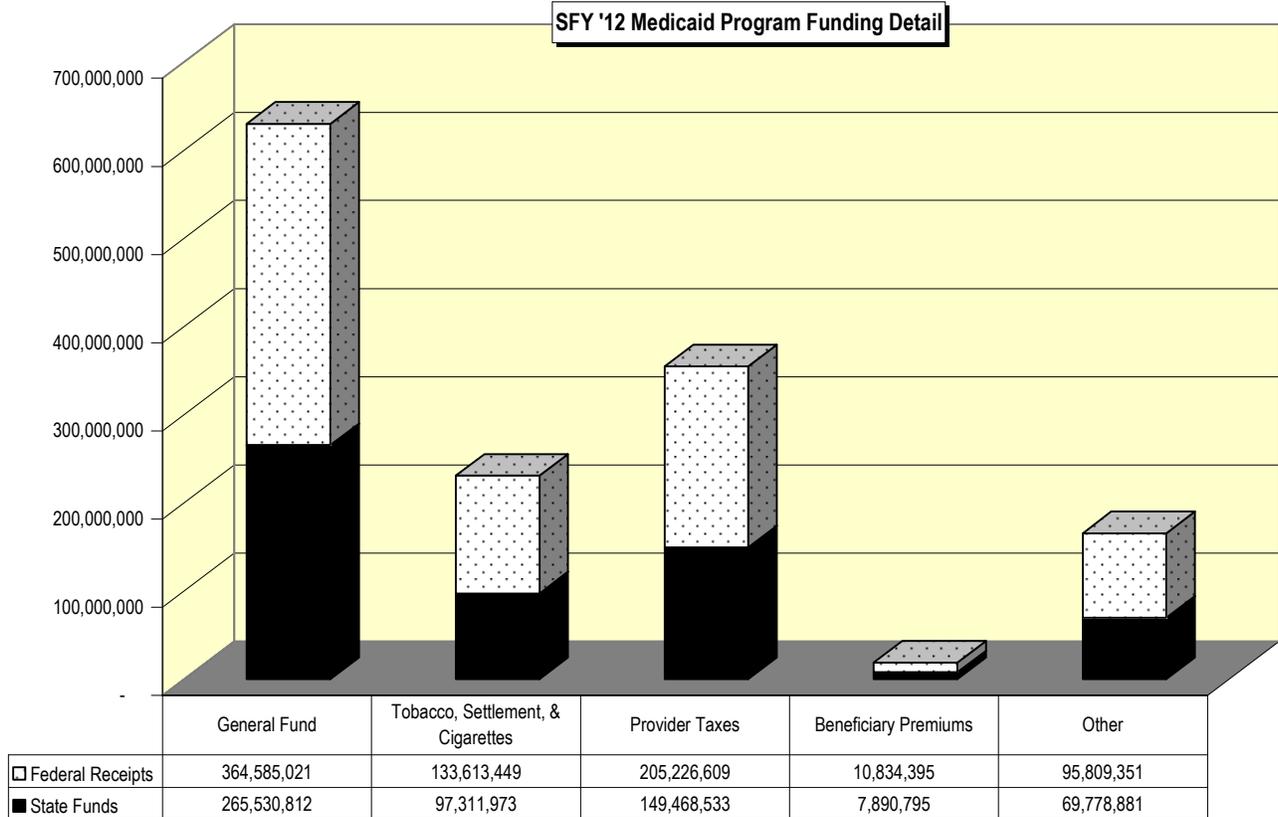
18. Please provide an “apples to apples” comparison of the \$138 million inpatient / outpatient figure on the hospital Medicaid revenue and assessment chart (in the SFY '10 column) to the SFY '12 budget value referenced in Attachment #4. The provider assessment handout referenced an SFY '12 figure of \$280 million for hospital inpatient and outpatient expenditures. This number, however, included out-of-state hospital costs. In order to provide a like comparison to the \$138 million also displayed in the provider assessment handout (representing SFY '10 actual inpatient and outpatient costs), the \$280 million would need to be reduced by 17% associated with out-of-state expenditures bringing the like figure for SFY '12 to \$233 million.

19. Can you provide a year-over-year comparison of matching revenues for the Medicaid program?

	2007	2008	2009	2010	2011	2012
General Fund	235,665,944	253,962,503	192,748,332	159,856,997	190,619,471	265,530,812
Tobacco, Settlement, & Cigarettes	77,615,985	80,140,227	93,912,287	95,372,988	97,818,873	97,311,973
Provider Taxes	83,361,511	82,214,247	85,442,805	91,473,176	113,013,448	149,468,533
Beneficiary Premiums	5,881,738	5,779,281	6,811,547	6,036,560	6,715,503	7,890,795
Other	49,609,467	55,925,142	62,129,460	67,951,200	61,836,795	69,778,881
Total State Funds	452,134,645	478,021,400	441,044,431	420,690,921	470,004,090	589,980,994

20. Please amend the state chart funding detail to include federal receipts associated with each funding source.

State Fund Match Source	State Funds	Federal Receipts	Total
General Fund	265,530,812	364,585,021	630,115,833
Tobacco, Settlement, & Cigarettes	97,311,973	133,613,449	230,925,422
Provider Taxes	149,468,533	205,226,609	354,695,142
Beneficiary Premiums	7,890,795	10,834,395	18,725,190
Other	69,778,881	95,809,351	165,588,232
Total State Funds	589,980,994	810,068,826	1,400,049,820



21. Can you chart the provider impact of moving from Catamount to VHAP Expanded? This is a very complex request that will require a bit of additional time to complete. We are working collaboratively with JFO on this analysis and will provide the answer to this question under separate cover as soon as feasible.

22. What will the out-of-state benefits be for VHAP Expanded beneficiaries? When out of state, if beneficiaries have an emergency they should seek treatment from the closest qualified provider regardless of whether or not the provider is enrolled in Vermont Medicaid (FYI – dialysis is considered an emergency service). We will then work with the beneficiary and the provider to get the information, enroll and pay the provider. “Emergencies” are described on page 9 of the DVHA Beneficiary Handbook: <http://dvha.vermont.gov/for-consumers/handbook-mco-082410.pdf>

For non-emergency care, we are in the process of more clearly defining our “in-state network” to include not only all enrolled Vermont-based providers, but also any border provider that is willing to enroll in the Vermont Medicaid program and accept our rates.

If an enrollee wants to see a provider that is ‘out-of-network (e.g., not in Vermont or a border community), beneficiaries and/or provider can request a prior authorization for these services, with a justification for needing them from an out-of-network provider; DVHA will then work with the provider to get them enrolled in our program. Our goal is to enable beneficiaries who are out of state to get the medical services that they need, but to also make sure that we are prohibiting abuse of this system for unjustified reasons. However, it should be noted that we are prohibited by federal law from reimbursing providers that are out of the United States with federal funds.

23. Can we reimburse VHAP Expanded at a higher rate? Yes, we can have different reimbursement rates for this new eligibility group. Though please be advised that the Governor's recommended budget relies on the savings associated with these lower reimbursement rates.
24. Are we prohibited from paying more than Medicare? Federal law prohibits DVHA from paying above Medicare costs for either Inpatient or Outpatient services in the aggregate across all privately-owned hospitals. (This is the Federal Upper Limit – FUL.)

- Attachments:
1. Health Care Program Coverage Grid – Optional Services
 2. DVHA's 2009 Report on Palliative Care for Children
 3. Dental Dozen Initiative
 4. Provider Assessment Overview

Attachment 1 - Health Care Program Coverage Grid – Optional Services

OPTIONAL SERVICES*	MEDICAID/ DR. DYNASAUR FFS	MEDICAID/ DR. DYNASAUR PC PLUS	VHAP LIMITED	VHAP PC PLUS
Podiatrists	Y	Y	Y	Y
Optometrists	Y	Y	Y	Y
Psychologists	Y	Y	Y	Y
Physician Directed Clinic Services	Y	Y	Y	Y
Home Health Audiology Therapy	Y	Y	Y	Y
Dental (Adult)	Y	Y	N	N
Dental (Children)	Y	Y	n/a	n/a
Physical Therapy	Y	Y	Y	Y
Occupational Therapy	Y	Y	Y	Y
Speech & Language Therapy	Y	Y	Y	Y
Prescribed Drugs	Y	Y	Y	Y
Prosthetic Devices	Y	Y	N	Y
Screening Services	Y	Y	Y	Y
Preventive Services	Y	Y	Y	Y
Mental Health Stabilization Rehab	Y	Y	Y	Y
Mental Health Other	Y	Y	Y	Y
Inpatient Hospital, NH, ICF/MR	Y	Y	Y,N,N	Y,Y,N
Inpatient Psych. For Under 21	Y	Y	Y	Y
Personal Care Services	Y	Y	N	N
Targeted Case Management`	Y	Y	N	N
Primary Care Case Management	N	Y	N	Y
Hospice Care	Y	Y	Y	Y
Respiratory Care for Ventilator Dependent	Y	Y	N	Y
PACE	Y	Y	N	N
Transportation	Y	Y	N	N
Nursing Facility for Under 21	Y	Y	N	Y
Emergency Hospital for Non- MCAre Particip.	Y	Y	Y	Y
Eyeglasses (Adults)	N	N	N	N
Eyeglasses (Children)	Y	Y	n/a	n/a
Orthotics	Y	Y	N	Y
ADAP	Y	Y	Y	Y
Dialysis	Y	Y	Y	Y
Ambulance	Y	Y	Y	Y
HCBS (Children's Waiver ?? DS Waiver??)	Y	N	N	N

*Reference Medicaid Rule and VHAP Procedure for service definition, clarifications, restrictions, and limitations.



PALLIATIVE CARE FOR CHILDREN

Report to:

**Senate Appropriations Committee
Senate Health and Welfare Committee
House Appropriations Committee
House Human Services Committee**

**Office of Vermont Health Access
Agency of Human Services**

November 16, 2009

Executive Summary

Act 25 (H.435), passed by the Vermont legislature in 2009, requires the Agency of Human Services to submit a report to the House Appropriations and Human Services Committees and the Senate Appropriations and Health and Welfare Committees on the programmatic and cost implications of a Medicaid and State Children's Health Insurance Program (SCHIP) waiver amendment allowing Vermont to provide concurrent palliative and curative care to Medicaid- and SCHIP-eligible children who have life-limiting illnesses. The full text of Section 7 of Act 25 is included as Attachment 1.

The Office of Vermont Health Access (OVHA), which is submitting this report on behalf of the Agency, estimates that Vermont could provide additional palliative care services to 29 to 170 Medicaid children with life-limiting illnesses for a cost of between \$160,000 and \$1 million per year in state funds. Based on the number of children served in other states' palliative care programs, the cost would likely be closer to \$160,000 than to \$1 million.

Introduction

Over the last decade there has been growing concern that children with life-limiting illnesses do not always receive the care they need to alleviate physical and psychosocial pain. Under Centers for Medicare and Medicaid (CMS) rules, hospice services, which were originally designed for adults, are available to children only if they have a life expectancy of six months or less and their parents agree to forego any potentially curative treatments. Children and their families often need hospice-like services at an earlier stage of their illness, and many parents are reluctant to terminate curative treatments. Nationally, child health organizations, providers, and advocates are attempting to define a pediatric palliative care model that will enhance the quality of life for both the terminally ill child and the family.

Palliative vs. Curative Care

Hospice is a model of care that focuses on relieving symptoms and supporting patients with a life expectancy of six months or less. Medicare and Medicaid pay for hospice services for children, but federal regulations allow hospice services to be reimbursed only when there is an expectation that the patient will die within the next six months, and only if the child's parents have signed a statement agreeing to forego further curative treatment. Typically adults with a terminal illness experience a precipitous decline just before the end of life, whereas many children with life-limiting illnesses experience a gradual but inevitable decline, thus making it very difficult, if not impossible, to determine whether they are within six months of death.

Palliative care is patient- and family-centered care that seeks to enhance quality of life by providing treatments that focus on the relief of symptoms, such as pain, and conditions, such as loneliness or fear, that cause distress and detract from the child's quality of life. It also seeks to ensure that bereaved families are able to remain functional and intact.

Curative care is intended to eliminate the disease and promote recovery or prolong the life of the patient. However, the term "curative care" is not accurate for many children with severe malignancies or developmental or genetic diseases where survival to adulthood is often unlikely. The continuation of disease-modifying efforts for children with life-limiting diseases is usually life-prolonging rather than curative and may, in fact, provide palliative care rather than curative treatment. In adults, the election of hospice accompanies the medical decision that further disease-treating efforts will not substantially alter the natural course of the disease. In children, the continuation of disease-treating efforts may be seen as providing the child and family with additional improved quality of life.

Services currently available to Medicaid and SCHIP children in Vermont

"Dr. Dynasaur" is the name that most Vermonters recognize as Vermont's Medicaid and SCHIP program. Dr. Dynasaur children currently have access to many types of curative and palliative care services, such as

- physician visits
- inpatient and outpatient care
- medications for pain and symptom control
- medical equipment and supplies
- rehabilitative therapies (PT, OT, speech, inhalation)
- counseling and group therapy
- nurse practitioner services
- home health services, and
- personal care services.

Children also have access to hospice services. However, federal Medicare and Medicaid regulations require that children's life expectancy be six months or less in order to qualify for hospice services. The parents of the child must sign a statement that waives all other Medicaid services, except the services of a designated family physician, ambulance service, and services unrelated to the terminal illness. Hospice services are reimbursed on a per diem basis and are available for a maximum of 210 days.

Additional services under a waiver amendment

If Vermont requested an amendment to its Global Commitment waiver, and the amendment was approved by the Centers for Medicare and Medicaid (CMS), to allow concurrent curative and palliative care for children, children with life-limiting illnesses would be eligible to receive some services that they can receive now only if they are in hospice.

These services could include:

- care coordination
- respite care for the child's parents or caregivers
- expressive therapies such as art, music, and play therapies
- training for family members on palliative care principles and care needs, and bereavement counseling for family members.

These additional services could be provided to a child and the child's family as needed, subject to defined limits, for the duration of the child's illness.

There are many other services that families of terminally ill children need that cannot, unfortunately, be provided using Medicaid funds. Based on information received by OVHA from families and community organizations supporting families, these services could include:

- home adaptations and cleaning
- heating and air conditioning
- help with mortgage/rent and utilities
- vehicle repairs
- acupuncture and massage therapy
- help with funeral expenses, and
- travel expenses for families whose children are being treated away from their home community.

OVHA wishes to recognize and commend the excellent work community organizations and private foundations are doing to meet families' needs in these areas in spite of limited resources.

Waiver amendment process

The Social Security Act authorizes multiple waiver and demonstration authorities to allow states flexibility in operating Medicaid programs. Each authority has a distinct purpose, and distinct requirements.

Section 1115 Research & Demonstration Projects: This section provides the Secretary of Health and Human Services broad authority to approve projects that test policy innovations likely to further the objectives of the Medicaid program.

Section 1915(b) Managed Care/Freedom of Choice Waivers: This section provides the Secretary authority to grant waivers that allow states to implement managed care delivery systems, or otherwise limit individuals' choice of provider under Medicaid.

Section 1915(c) Home and Community-Based Services Waivers: This section provides the Secretary authority to waive Medicaid provisions in order to allow long-term care services to be delivered in community settings. This program is the Medicaid alternative to providing comprehensive long-term services in institutional settings.

Vermont is unique among states in its Section 1115 Global Commitment waiver that encompasses most Medicaid services offered in the state. After consultation with CMS central office staff in Baltimore, OVHA concluded that, were a decision made to move forward on a palliative care program, Vermont would most likely request an amendment to incorporate a pediatric palliative care program as part of its existing 1115 waiver, rather than request a separate waiver.

However, there is a potential problem with children covered by the federal State Children's Health Insurance Program (SCHIP). In Vermont, these are children on Dr. Dynasaur who have family incomes between 225% and 300 % FPL and who have no private insurance. SCHIP children are not covered by the 1115 Global Commitment waiver; rather, they are covered under the SCHIP state plan. Since there is no waiver authority under SCHIP, and since palliative care is not a state plan service under SCHIP, it is possible that palliative care services to SCHIP children would have to be paid for with state funds. However, if the legislature's decision is to move forward on a waiver amendment request, the administration would work with CMS to determine if there is a way to include SCHIP children in the federally-funded palliative care program. SCHIP children have not been included in other states' palliative care programs, except for Washington's program, which is not operating under a waiver.

There was pending federal legislation that, if passed, would have allowed Vermont to implement a palliative care program without a waiver amendment. H.R. 722, the ChiPACC (Children's program of all-inclusive coordinated care) Act of 2009, aka the "Mattie and Melinda bill," was co-sponsored by Representative James Moran of Virginia and Representative C.W. Young of Florida in January of 2009. It was in the House Energy and Commerce Committee when discussion began on the broader health care reform plan. Section 1632 of the Senate health care reform bill would allow states to provide hospice care to a child without requiring the child to give up rights to services related to treatment of the child's condition. There is no comparable provision in the House bills.

Pediatric palliative care programs in other states

Although there have been numerous pediatric palliative care programs in place for many years as collaborations between children's hospitals and hospice agencies, there are only a few states that have implemented programs utilizing federal Medicaid funds.

The Children's Hospice International Program for All-Inclusive Care for Children and Their Families (CHI PACC®) was developed by Children's Hospice International (CHI) in coordination with the Centers for Medicare and Medicaid (CMS). The CHI PACC® model eliminates the requirement that patients decline further curative treatments and have a prognosis of death within six months.

The U.S. Congress appropriated funds for FY 2000-2003 to enable CHI, through the Department of Health and Human Services, to conduct state demonstration model programs of the CHI PACC® model. Organizations (some of which were private hospitals or hospice associations) in six states were included in the demonstration:

Colorado, Florida, Kentucky, New York, Utah, and Virginia. The intent was that states would apply for a CMS waiver to continue the programs. To date, only Florida and Colorado have applied for waivers.

Below are descriptions of operating programs in states using federal Medicaid funds:

Florida's Partners in Care: Together for Kids

In 2005 Florida amended an existing 1915(b) waiver to create the first publicly financed program in the nation to support concurrent pediatric palliative and curative care. Partners in Care: Together for Kids (PIC) is administered by Florida's Title V program for children with special health needs (CSHN). To be eligible, children must be under age 21 and enrolled in CSHN, have an illness that puts them at risk of death before age 21, and be certified by a nurse case manager. The program began in seven pilot sites, and as of January 2008 there were nine sites serving a total of 468 children. Any hospice program approved by the state may participate if staff completes modules in a nationally-recognized palliative care curriculum within 24 months from start-up. According to a 2008 report produced by the University of Florida's Institute for Child Health Policy, 85% of parents were satisfied with the program.

Colorado's Hopeful Program

Colorado implemented its palliative care program in January of 2008 after approval of its 1915(c) waiver request by CMS in 2007. The Hopeful program, administered by Colorado's Medicaid agency, operates statewide and serves a maximum of 200 children under the age of 19 each year. To participate, children must be Medicaid eligible, have an illness that will result in probable death before adulthood, be at risk of hospitalization within one month, and be certified by a case manager. As of September of 2009 there were 85 children in the program. An additional 24 children were served prior to leaving the program for various reasons, such as death, reaching the age of 19, moving to traditional hospice services, moving to a group home, or moving out of state.

California's Pediatric Palliative Care Program

California's 1915(c) waiver, which was approved in December of 2008, will result in the implementation of pilot programs in five counties in its first year (beginning April 2009) and 11 counties in year two. They are expecting 300 children to be served in the first year and 800 in the second year. To be eligible, children must be from families with income below 100% of the federal poverty level, be under age 21, have been diagnosed with specific life-limiting conditions, be at risk of hospitalization, and certified by a nurse case manager or physician.

Washington State's Pediatric Palliative Care Program

Washington State did not request a waiver, but rather broadly interpreted the federal Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program to include certain palliative care benefits. To be eligible, children must be eligible for Medicaid, under the age of 21, and have a life-limiting medical condition with complex needs that requires case management and coordination of medical services. A limitation of the EPSDT approach is that services are not available to the child's family.

Although not programs that use federal Medicaid funds, a description of other New England programs is included here:

Massachusetts' Pediatric Initiative

Massachusetts' Health Care Reform Law included a pediatric initiative with a one-time appropriation of \$800,000 in state funds to pay for hospice services for children. Grants of \$55,000 each were awarded by the Department of Public Health to 10 hospice agencies for training, development, and implementation of an integrated pediatric palliative care program. The state sees itself as the "payer of last resort." Any costs for services not underwritten by the appropriation or reimbursed by private insurance become the responsibility of the hospice. Children under the age of 19 are eligible if they are determined by a physician to have a life-limiting illness.

Maine's Jason Program

The Jason Program, which began operation in November 2007, operates as a medical practice with an independent physician, full-time nurse and social worker, and part-time child life specialist and spiritual counselor. The program approaches care using a chronic care model along with palliative care. The Jason Program is a private enterprise, but obtained initial funding through Maine Medicaid program grant carved out of state-only funds and a gift from a local philanthropist.

A side-by-side comparison of programs in Colorado, Florida, and California is included as Attachment 2.

Analysis of Vermont Claims Data for Children with Life-limiting Illnesses

OVHA had hoped to obtain cost/savings data from other states that have pediatric palliative care programs already in place. In submitting their waiver requests, Florida, Colorado, and California predicted that new costs for palliative services would be more than offset by savings in acute services. For example, better coordination of treatment and good case management should reduce the number of emergency room visits, shorten hospital stays, or avoid hospital stays by providing services in the child's home. In fact, Colorado's and California's 1915(c) waiver requests are based on the assumption that children eligible for waiver services would be hospitalized were it not for the availability of the services provided under the waiver.

At the time this report was developed, however, there were no cost/savings data available based on actual program experience in these three programs. Because Florida's pediatric palliative care program is only one component of its 1915(b) waiver, it cannot stratify cost/savings data by program. Colorado will begin working on its first evaluative report to CMS later this fall, and California's program has been up and running for only a few months.

There has been some research on the cost savings associated with hospice and palliative care. Some studies have found that hospice care reduced Medicare spending by

significant amounts; however, these studies primarily involved adults who were in their last few months of life and so may or may not have relevance to a pediatric palliative care program that provides services to children at earlier stages of illness.

To analyze the potential costs of pediatric palliative care waiver services in Vermont, OVHA obtained a list from Children’s Hospice International of diagnosis codes for life-limiting illnesses and matched the list against its claims database for the period of SFY 2008 (July 1, 2007, through June 30, 2008). This match revealed 170 children on Medicaid and SCHIP with claims with one or more of these diagnosis codes.

The following chart shows the age and gender of these children:

Children with life-limiting illnesses			
	M	F	Total
Age			
0 to 5	8	7	15
6 to 12	39	25	64
13 to 17	29	16	45
18 to 20	16	13	29
21+ *	11	6	17
Total	103	67	170
*These children were included because they were under 21 on the date of service for the claims included in this analysis.			

Leukemia and other forms of cancer accounted for the majority of the illnesses diagnosed. The following is a chart showing the illnesses diagnosed and the number of children diagnosed with each one:

Diseases and Conditions by Number Of Children	
Disease	Number of children
Leukemia	43
Other cancers	65
Muscular Dystrophy	23
Chronic liver disease	14
Other*	25
Total	170
*Includes cerebral palsy, Werdnig-Hoffmann disease, Patau's Syndrome, congenital heart disease, aplastic anemia, Fragile X Syndrome	

Total Vermont Medicaid expenditures on claims for these 170 children were \$4,551,636.99 for SFY08, a total of 18,968 individual services. Per-child expenditures averaged \$26,774.34; however, per-child expenditures varied widely from a low of \$83.58 to a high of \$355,822.63, with approximately half of the children having claims of less than \$10,000. Forty-three of the 170 children had at least some claims paid by private insurance or Medicare.

The following table shows the number of children in various Medicaid claims expenditure ranges:

Claims Cost Ranges				
Cost range	Number children	Total Amt Paid	% of Children	% of Costs
\$0 to \$1000	17	\$8,247.31	10.00%	0.18%
\$1001 to \$10,000	69	\$302,270.51	40.59%	6.64%
\$10,001 to \$20,000	20	\$291,551.21	11.76%	6.41%
\$20,001 to \$30,000	18	\$431,074.58	10.59%	9.47%
\$30,001 to \$40,000	11	\$386,937.56	6.47%	8.50%
\$40,001 to \$50,000	7	\$313,315.82	4.12%	6.88%
\$50,001 to \$100,000	19	\$1,281,955.48	11.18%	28.16%
\$100,000+	9	\$1,536,284.52	5.29%	33.75%
Total	170	\$4,551,636.99	100%	100%

The 170 children live in towns across the state. The following table shows the percentage of children in each region of the state:

Region	Percentage of children
Northeast	10%
Northwest	33%
Central	20%
Southeast	17%
Southwest	20%
Total	100%

The children were receiving Medicaid through a variety of program components, including Reach Up, disabled child, Dr. Dynasaur, foster child, Katie Beckett, and VHAP. The largest categories were children receiving SSI disability benefits, Dr. Dynasaur, and Katie Beckett (Katie Beckett is a Medicaid component that allows the parents' income to be disregarded if the child meets certain disability criteria).

Financial impact of a waiver amendment

The provision of concurrent palliative care and curative care to Medicaid children could cost as much as \$1 million per year in state dollars, or as little as \$160,000 per year based on current rates for services (this cost may be approximately 4.2% higher for each subsequent year based on the Bureau of Labor Statistics Consumer Price Index five-year average for the Medical Care category). Attachments 3 and 4 show how the high- and low-cost estimates were derived. The high-cost estimate was based on an assumption that all 170 children with life-limiting illnesses would receive palliative care services during a given year, whereas the low-cost estimate assumes that only the highest-need children would receive services. The actual cost of the program would probably be closer to the lower-cost estimate for a number of reasons:

- Although all of the 170 children had at least one life-limiting diagnosis, many of the children had very few claims submitted under that diagnosis code, indicating that the illness was probably in an early stage or in remission, in which case palliative services may not yet be necessary.
- It is likely that there would not be an expectation of death before age 21 for at least some of the 170 children, in which case they would not qualify for hospice-like services under this program.
- Other states that have implemented similar programs are serving a relatively small number of children. For example, Florida has 468 children in its palliative care program out of a population of Medicaid children of 1,095,400 (as of 2008), or .04%. Colorado has 85 children out of a population of 232,500, or .037%. The 29 children in the low-cost estimate would represent .05% of Vermont's Medicaid children enrolled in 2008.
- Some of the children are receiving services through other state programs, such as Developmental Disability Services and Children's Personal Care Services, both programs administered by the Department of Disabilities, Aging, and Independent Living (DAIL). To the extent that other programs are providing case management, care coordination, home supports, respite care, crisis services, and other types of services, these same services would not be add-ons to the palliative care program. Both the high- and low-cost estimates do subtract personal care services from the additional costs, since the provision of personal care services would reduce the added cost for respite care.

Based on the advice of clinicians, OVHA has included in its cost analysis an estimate of inpatient and outpatient savings based on an assumption that some emergency room and hospital readmissions could be avoided through effective case management.

Conclusions

Although other states have projected cost neutrality for their palliative care programs, no state has yet been able to prove cost neutrality using actual program experience. Based on actual claims data for SFY 08 for children with life-limiting illnesses, OVHA estimates that a palliative care program in Vermont could cost as little as \$160,000 per year in state funds, provided that additional palliative care services are provided only to children in advanced stages of illness.

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Attachment 1

Section 7 of Act 25, An Act Relating to Palliative Care

- (a) No later than October 1, 2009, the secretary of human services shall submit to the house committees on appropriations and on human services and the senate committees on appropriations and on health and welfare a report on the programmatic and cost implications of a Medicaid and a State Children's Health Insurance Program (SCHIP) waiver amendment allowing Vermont to provide its Medicaid- and SCHIP-eligible children who have life-limiting illnesses with concurrent palliative services and curative care.
- (b) For purposes of this section:
 - (1) "Life-limiting illness" means a medical condition that, in the opinion of the child's treating health care provider, has a prognosis of death that is highly probable before the child reaches adulthood.
 - (2) "Palliative services" means personal care, respite care, hospice-like services, and counseling.

Attachment 2

COMPARISON OF PEDIATRIC PALLIATIVE CARE PROGRAM IN THREE STATES

	Colorado	Florida	California
Implementation date	January 1, 2008	January 1, 2005	April 1, 2009
Name of program	Hopeful (Pediatric Hospice waiver)	FL Partners in Care: Together for Kids	CA Pediatric Palliative Care
Waiver type	1915c HCBS	1915b managed care	1915c HCBS
Regions	Statewide	7 sites to start, 9 sites in 2008	5 counties in Yr 1, 11 in Yr 2
Age	Up to age 19	Up to age 21	Up to age 21
Number served	Up to 200 per year, currently 85	Up to 1000/yr, 251 in 2007, 468 in 2008	300 Yr 1, 801 Yr 2, 1802 Yr 3
Agency	Dept. of HC Policy & Financing (Medicaid agency)	Children's Medical Services Network Title V - CSHN	Medi-Cal (Medicaid agency) CA Children's Services
Eligibility criteria	Medicaid-eligible Probable death before adulthood At risk of hospitalization within 1 mo. Certification by case manager At least one benefit per month	Enrolled in CSHN At risk of death prior to age 21 Certification by nurse case manager	100% FPL (Medi-Cal eligible) Diagnosed with specified conditions At risk of hospitalization Certification by nurse case mgr or phys
Covered services	In-home respite care (30 days/year) Personal care Nursing or home health aide Individual/family counseling (98 hrs/yr) Expressive therapies (39 hrs/yr) Palliative/supportive care (per diem) Hospice-like services such as: PT/OT Speech pathology Alternative therapies Dietary counseling Case management (admin, not benefit)	Provided by 7 hospice agencies: Art, music, play therapies Pain and symptom control In-home nursing In-home personal care (up to 6 hrs/day) Respite care (7 days/yr) Individual/group counseling	Care coordination (fixed fee 4-12 hrs/mo) Respite care (in and out of home) (30 days/yr) Family counseling (52 hrs/yr) Expressive therapies (30 hrs/90 days) Family training on palliative care (100 hrs/yr)

Attachment 3: ADDITIONAL PALLIATIVE CARE COSTS--HIGH ESTIMATE

COSTS						
Type of service	Max units/child	# Children ⁴	Units/child	Cost/unit ⁵	Gross cost/year	
Family training/counseling	98 hours ¹					
High need		35	98	\$70.56	\$242,020.80	
Medium need		49	49	\$70.56	\$169,414.56	
Low need		86	24	\$70.56	\$145,635.84	
In-home respite care	720 hours ¹					
Skilled	High need	35	720	\$40.68	\$1,025,136.00	
Unskilled	Medium need	49	360	\$23.08	\$407,131.20	
	Low need	86	180	\$23.08	\$357,278.40	
Expressive therapy	39 hours ¹					
	High need	35	39	\$46.96	\$64,100.40	
	Medium need	49	20	\$46.96	\$46,020.80	
	Low need	86	10	\$46.96	\$40,385.60	
Bereavement counseling	26 hours ²	5	26	\$70.56	\$9,172.80	
Care coordination/case mgt.	2 positions ³		2	\$77,625.00	\$155,250.00	
GROSS COSTS					\$2,661,546.40	
Minus personal care⁶					\$473,314.83	
ADJUSTED COSTS					\$2,188,231.57	
SAVINGS⁷						
Type of service	Claims cost	Reduction		Gross savings		
Inpatient claims	\$942,920.53	20%		\$188,584.11		
Outpatient claims	\$387,319.55	10%		\$38,731.96		
GROSS SAVINGS				\$227,316.06		
NET COSTS					\$2,434,230.34	
STATE SHARE⁸					\$1,005,093.71	

¹Maximum units are based on Colorado's program.

²Payment would occur at time of child's death; sessions could be spread over a 12-month period following child's death.

³Estimate of # positions is based on a ratio of 1:25, with assumption that not all 170 children would need CM, and some were already receiving CM services.

⁴High/medium/low need categories are based on cost; if program became operational, a clinical evaluation would determine each child's needs.

High need = \$40,000+, medium need = \$10,000-\$40,000, low need = less than \$10,000.

⁵Cost per unit is based on current allowable Medicaid reimbursement rates for same or similar services.

⁶46 of the 170 children were receiving personal care services equivalent to respite care, so these would not be additional costs.

⁷Savings estimates are based on the assumption that some inpatient and emergency room claims can be avoided with effective case management.

Attachment 4

ADDITIONAL PALLIATIVE CARE COSTS--LOW ESTIMATE

COSTS					
Type of service	Max units/child	# Children	Units/child	Cost/unit ⁴	Gross cost/year
Family training/counseling	98 hours ¹	29	98	\$70.56	\$200,531.52
In-home respite care ⁵	720 hours ¹	5	720	\$40.68	\$146,448.00
Expressive therapy	39 hours ¹	29	39	\$46.96	\$53,111.76
Bereavement counseling	26 hours ²	3	26	\$70.56	\$5,503.68
Care coordination/case mgt.	1 positions ³		1	\$77,625.00	\$77,625.00
GROSS COSTS					\$483,219.96
SAVINGS⁶					
Type of service	Claims cost	Reduction	Gross savings		
Inpatient claims	\$708,726.49	20%	\$141,745.30		
Outpatient claims	\$191,233.88	10%	\$19,123.39		
GROSS SAVINGS					\$160,868.69
NET COSTS					\$322,351.27
STATE SHARE					\$133,098.84

¹Maximum units are based on Colorado's program.

²Payment would occur at time of child's death; sessions could be spread over a 12-month period following child's death.

³Estimate of # positions is based on a ratio of 1:25, with the assumption that not all 170 children will need CM, and some children were already receiving CM.

⁴Cost per unit is based on current allowable Medicaid reimbursement rates for same or similar services.

⁵Only 5 of the 29 children were not receiving personal care.

⁶Savings estimates are based on the assumption that some inpatient and emergency room claims can be avoided with effective case management.

Costs and savings have not been adjusted for medical inflation, assuming a potential program implementation date of SFY11.

The Dental Dozen

Updated 2/17/11

Many Vermonters face challenges in receiving appropriate oral health care due to the limited number of practicing professionals, the affordability of services and a lack of emphasis on the importance of oral health care. Challenges frequently are more acute for low-income Vermonters, including those Vermonters participating in the State's public health care programs. The Dental Dozen recognizes oral health as a fundamental component of overall health and moves toward creating parity between oral health and other health care services. Starting in mid 2007, the Department of Vermont Health Access (DVHA), in conjunction with the Vermont Department of Health (VDH), began implementing 12 targeted initiatives listed below to provide a comprehensive, balanced approach to improve oral health and oral health access for all Vermonters. Updates as of February 17, 2011 are summarized below:

Initiative #1: Ensure Oral Health Exams for School-age Children - VDH, DVHA and the Department of Education (DOE) collaborated to reinforce the importance of oral health exams and encourage preventive care. Brochures were provided to schools for distribution in October, 2008 to educate parents and children on the importance of fluoride, sealants and regular checkups.

Initiative #2: Increase Dental Reimbursement Rates - DVHA committed to increase Medicaid reimbursement rates over a three-year period to stabilize the current provider network, encourage new dentists to enroll as Medicaid providers and encourage enrolled dentists to see more Medicaid beneficiaries. Rates were increased by \$637,862 in SFY 2008 and by \$1,412,441 for SFY 2009. Rates were not increased for SFY 2010 due to budgetary constraints; however, dentists were held harmless from a 2% provider rate reduction experienced by many other Medicaid providers.

Initiative #3: Reimburse Primary Care Physicians for Oral Health Risk Assessments - In February, 2008, DVHA began reimbursing Primary Care Providers (PCPs) for performing Oral Health Risk Assessments (OHRAs) to promote preventive care and increase access for children from ages 0-3. An action plan was developed to educate/train physicians on performing OHRAs, including online web links. From February '08 – June '10, there were 2,565 OHRAs claimed and approximately 1 of every 4 OHRAs claimed was from a physician.

Initiative #4: Place Dental Hygienists in Each of the 12 District Health Offices – Dental hygienists in district offices can be a valuable resource in providing fluoride varnish treatments, dental health education, early risk assessment and helping to connect children with a dental home. A successful pilot project resulted in the start of placement of 3 part-time dental hygienists in District Health Offices. This effort was scaled back due to budget constraints; current funding now covers one half-time dental hygienist in the Newport district office. If resources improve and funding is allocated, this program remains well planned/tested and would be ready to expand.

Initiative #5: Selection/Assignment of a Dental Home for Children – Starting in May, 2008, DVHA introduced the capability to select/assign a primary dentist for a child, allowing for the same continuity of care as assigning a Primary Care Physician (PCP) for health improvement. Most new enrollees now select a dental home, emphasizing the importance of keeping oral health care on par with regular physicals and health checkups. If enrollees do not select a dental home, member services will assign one whenever possible, unless an enrollee formally declines this option. Through January, 2011, there 62,828 eligible children (ages 0-17) have been identified since the program began in early 2008; of these, dental homes have been selected for 52,422 Vermont children and 10,406 enrollees have declined.

Initiative #6: Enhance Outreach - DVHA and VDH conducted outreach and awareness activities to support understanding of the Dental Dozen and help ensure the success of the initiatives. In SFY 2009, work continued to promote benefits available to dental providers, highlight incentives designed to bring and keep more dentists in Vermont and continue outreach with schools, parents and children. Also, a retired Vermont dentist, with grant assistance, is helping recruit and retain more dentists.

Initiative #7: Codes for Missed Appointments/Late Cancellations – In 2008, DVHA introduced a code to report missed appointments and late cancellations. The negative impact of missed appointments and late cancellations is three-fold: 1) the originally scheduled beneficiary does not receive care, 2) that appointment could have gone to another beneficiary, and 3) dental office productivity and income is reduced. The DVHA is collecting/evaluating this data with the intent of exploring processes to reduce missed appointments and late cancellations in the future.

Initiative #8: Automation of the Medicaid Cap Information for Adult Benefits - DVHA introduced a system upgrade to allow enrolled dentists to access Medicaid cap information for adult benefits automatically. This system has proven to be a convenient and well-received tool for providers. Currently, the annual cap for adult benefits is set at \$495 and DVHA tracks provider use of this upgrade.

Initiative #9: Loan Repayment Program – In SFY 2008, Vermont awarded \$195,000 in loan repayment incentives to dentists in return for a commitment to practice in Vermont and serve low income populations; thirteen awards ranged from \$5,000 to \$20,000. Funding remained at \$195,000 for SFY 2009. Funding was set at \$125,000 for both SFY 2010 and 2011. Fifteen awards were distributed in SFY 2010 and 14 awards were allocated for SFY 2011. No awards exceed \$20,000.

Initiative #10: Scholarships - Scholarships, administered through the Vermont Student Assistance Corporation, are awarded to encourage new dentists to practice in Vermont. A combined allocation of \$40,000 for SFY 2008/09 was distributed for the 2008-2009 academic year. There was \$20,000 available for SFY 2010 and another \$20,000 for SFY 2011.

Initiative #11: Access Grants - In SFY 2008, VDH awarded a total of \$70,000 as an incentive for dentists to expand access to Medicaid beneficiaries. In order to receive a grant, dentists must meet specific goals for increased access. In SFY2008, seven grants ranged from \$5,000 to \$20,000. Funding remained at \$70,000 for SFY 2009 and for SFY 2010. In the current year, funding will be targeted to ensure adequate recruitment measures are in place to ensure and enhance access.

Initiative #12: Supplemental Payment Program – In SFY 2008, DVHA began distributing \$292,836 annually to recognize and reward dentists serving high volumes of Medicaid beneficiaries. For SFY 2009, a distribution of \$146,418 was made in October, 2008 and another distribution of \$146,418 was made in the spring of 2009, for an annual total of \$292,836. The program has continued on the same cycle and dollar amount for SFY 2010 and into SFY 2011. Typically, 35-40 dentists qualify for semi-annual payouts.

Provider Assessment Overview

- Provider taxes are required to comport with certain federal laws established by Congress in 1991 and modified in 2005 and 2006.
 - New rules effective in April of 2008 conform the administrative regulations to the legislative changes made by Congress in 2005 and 2006.
- The 1991 law required provider taxes be “broad based” and uniformly applied to all providers within specified classes of providers – in other words, states cannot limit the provider taxes only to Medicaid providers.
- The specified classes of providers are the following (Vermont assessments are in parentheses):
 - Inpatient hospital services (33 V.S.A. § 1953)
 - Outpatient hospital services (33 V.S.A. § 1953)
 - Nursing facility services (other than services of intermediate care facilities for the mentally retarded) (33 V.S.A. § 1954)
 - Services of intermediate care facilities for the mentally retarded (33 V.S.A. § 1955)
 - Physicians’ services
 - Home health care services (33 V.S.A. § 1955a)
 - Outpatient prescription drugs (33 V.S.A. § 1955b)
 - Services of managed care organizations (including health maintenance organization, preferred provider organization, and such other similar organizations as the Secretary may specify by regulation)
 - Ambulatory surgical center services, defined to include facility services only and do not include surgical procedures
 - Dental services
 - Podiatric services
 - Chiropractic services
 - Optometric/optician services
 - Psychological services
 - Therapist services, defined to include physical therapy, speech therapy, occupational therapy, respiratory therapy, audiological services, and rehabilitative specialist services;
 - Nursing services, defined to include all nursing services, including services of nurse midwives, nurse practitioners, and private duty nurses
 - Laboratory and x-ray services, defined as services provided in a licensed, free-standing laboratory or x-ray facility. Does not include laboratory or x-ray services provided in a physician’s office, hospital inpatient department, or hospital outpatient department
 - Emergency ambulance services
- Prohibits states from a direct or indirect guarantee that providers receive their money back (hold harmless provision)
 - Safe Harbor: These provider tax programs are exempted from federal scrutiny of the hold harmless provision if the tax is applied at a rate that produces revenues that are less than or equal to 6% of the revenue received by the provider.
 - The Tax Relief and Health Care Act 2006 (THRCA, P.L. 109-432) changed the threshold so that for fiscal years beginning on or after January 1, 2008, through September 30, 2011, taxes at or below 5.5% of revenues could forego such scrutiny. After that period, the threshold would revert to 6% of revenues.

Provider Assessments

Health Care Provider	Current Methodology	SFY '11 Generated Revenue	Proposed Methodology	SFY '12 Generated Revenue	SFY '12 Gross Medicaid Expenditures
Hospitals 33 V.S.A. § 1953	Hospitals are assessed 5.5% of net patient revenues (less chronic, skilled and swing bed revenues). The assessment is based on data from the hospital's most recent full fiscal year for which data has been reported to BISCHA.	\$94,139,184	Hospitals are assessed 5.5% of net patient revenues (less chronic, skilled and swing bed revenues). The assessment is based on data from the hospital's most recent full fiscal year for which data has been reported to BISCHA. As of 10/01/11, hospitals are assessed 6%. The assessment is based on the hospitals most current year's budget information available through BISCHA.	\$111,537,339 (\$17.4 million increase)	\$280,415,470 <i>(excludes hospital managed physician service revenues)</i>
Nursing Homes 33 V.S.A. § 1954	Nursing homes are assessed \$3,962.66 per licensed bed. The assessment for each licensed bed is prorated for the number of days during which the bed was actually licensed. As more people choose to remain in the community rather than nursing homes, the number of licensed beds is likely to decrease.	\$13,060,927	Nursing homes are assessed \$4,509.57 per licensed bed for 7/1/11 through 9/30/11 (this is equivalent to 5.5% of net operating revenues). As of 10/1/11, nursing homes are assessed \$4,919.93 per licensed bed (this is equivalent to 6% of net operating revenues). The assessment for each licensed bed is prorated for the number of days during which the bed was actually licensed. As more people choose to remain in the community rather than nursing homes, the number of licensed beds is likely to decrease.	\$15,875,054 (\$2.8 million increase)	\$116,030,498

Health Care Provider	Current Methodology	SFY '11 Generated Revenue	Proposed Methodology	SFY '12 Generated Revenue	SFY '12 Gross Medicaid Expenditures
ICF/MR (Intermediate Care Facilities for Persons with Mental Retardation) 33 V.S.A. § 1955	Each ICF/MR is assessed 5.5% of their total annual direct and indirect expense for the most recently settled ICF/MR audit.	\$66,002	Each ICF/MR is assessed 5.5% of their total annual direct and indirect expense for the most recently settled ICF/MR audit. As of 10/1/11, ICF/MRs are assessed 6%.	\$70,961 <i>(\$4,959 increase)</i>	\$1,261,329
Home Health 33 V.S.A. § 1955a	Each home health agency is assessed 17.69% of net operating revenues from core home health care services, excluding revenues for services provided under Title XVIII of the federal Social Security Act. The assessment is based on the agency's most recent audited financial statements at the time of submission (which are provided to the state on or before December 1 of each year).	\$4,088,575	Each home health agency is assessed 17.69% of net operating revenues (this is equivalent to 3.8% of gross revenues) from core home health care services, excluding revenues for services provided under Title XVIII of the federal Social Security Act. As of 10/1/11, each home health agency is assessed 19.30% of net operating revenues (this is equivalent to 3.9% of gross revenues) from core home health care services, excluding revenues for services provided under Title XVIII of the federal Social Security Act. The assessment is based on the agency's most recent audited financial statements at the time of submission (which are provided to the state on or before December 1 of each year).	\$4,325,879 (\$237,304 increase)	\$32,625,250 (includes such services as acute home health, home & community based supports, hospice, adult day, traumatic brain injury, and high tech)
Pharmacy 33 V.S.A. § 1955b	Each pharmacy is assessed \$0.10 for each prescription filled or refilled. Pharmacies submit their assessment payments monthly.	\$800,000	Each pharmacy is assessed \$0.10 for each prescription filled or refilled. Pharmacies submit their assessment payments monthly.	\$800,000	\$167,719,326

Health Care Provider	Current Methodology	SFY '11 Generated Revenue	Proposed Methodology	SFY '12 Generated Revenue	SFY '12 Gross Medicaid Expenditures
Managed Care Organization (MCO)	N/A	\$0	As of 7/1/11, managed care organizations are assessed 1.33% of all health insurance premiums paid to the managed care organization by its Vermont members in the previous fiscal year ending 12/31.	\$10,000,000	\$0
Dental	N/A	\$0	As of 7/1/11, each practicing dentist's assessment shall be 3% of the dentist's gross revenues from performing dental and other healthcare services. The amount of the tax shall be determined annually by the Commissioner based on the practicing dentist's calendar year gross revenues as reported to DVHA. The annual assessment for SFY '12 shall be based on each practicing dentist's 2010 gross revenues as reported to the Department on or before July 30, 2011. Each succeeding year's assessment will be based upon the calendar year's gross revenue as reported to the department no later than March 1.	\$6,000,000	\$32,389,922

Summary of Hospital Revenues and Assessments

Hospital Revenues	SFY 2004	SFY 2005	SFY 2006	SFY 2007	SFY 2008	SFY 2009	SFY 2010
Claims Payments							
Inpatient	\$ 39,416,995.18	\$ 42,393,761.80	\$ 41,770,624.71	\$ 39,012,539.87	\$ 41,183,513.05	\$ 59,989,102.53	\$ 62,777,983.97
Inpatient Crossover	\$ 3,091,879.09	\$ 2,589,372.47	\$ 3,386,897.80	\$ 3,352,459.83	\$ 3,585,811.91	\$ 3,767,014.73	\$ 3,890,807.41
Outpatient	\$ 40,541,462.44	\$ 45,611,800.75	\$ 45,939,525.15	\$ 44,505,957.34	\$ 48,004,784.49	\$ 54,123,668.03	\$ 62,227,396.84
Outpatient Crossover	\$ 4,345,211.60	\$ 3,924,956.11	\$ 6,902,475.09	\$ 7,007,658.96	\$ 8,023,375.09	\$ 8,296,520.65	\$ 9,269,834.98
Claim Refunds	(535,178.37)	(387,652.81)	(191,770.86)	(265,830.98)	(169,722.49)	(203,408.18)	(134,086.31)
Net Institutional Claim Payments	\$ 86,860,369.94	\$ 94,132,238.32	\$ 97,807,751.89	\$ 93,612,785.02	\$ 100,627,762.05	\$ 125,972,897.76	\$ 138,031,936.89
Physician Practices (Hospital Owned)							
Professional Claims	\$ 13,847,700.07	\$ 17,438,693.40	\$ 18,296,091.89	\$ 20,079,412.61	\$ 24,532,485.69	\$ 29,253,937.82	\$ 31,858,348.63
Professional Crossover	\$ 1,358,722.05	\$ 1,908,403.75	\$ 1,967,735.03	\$ 1,792,379.89	\$ 1,913,935.29	\$ 2,209,362.85	\$ 2,517,770.76
Claim Refunds	(\$64,431.19)	(\$105,030.82)	(\$97,002.25)	(\$70,495.22)	(\$90,051.60)	(\$408,281.47)	(\$228,299.74)
Net Professional Claim Payments	\$ 15,141,990.93	\$ 19,242,066.33	\$ 20,166,824.67	\$ 21,801,297.28	\$ 26,356,369.38	\$ 31,055,019.20	\$ 34,147,819.65
Other Hospital Financial Activity							
DSH Payments	\$ 29,259,141.00	\$ 34,793,164.00	\$ 35,205,322.71	\$ 59,377,728.93	\$ 49,003,897.74	\$ 35,648,781.12	\$ 37,448,781.34
Cost Settlement Payments	\$ 710,315.00	\$ 217,487.00	\$ 1,633,081.00	\$ 1,124,039.00	\$ 742,660.00	\$ 1,620,446.00	\$ 1,208,596.00
Cost Settlement Refunds	(2,670,734.00)	(4,064,683.00)	(2,570,941.00)	(2,039,437.00)	(184,878.00)	(2,917,975.31)	(712,954.00)
Other Refunds	(2,688.90)	(264,266.85)	(250,822.72)	(20,303.60)	(8,310.37)	(67,343.83)	(15,530.72)
Other Activity	\$ 27,296,033.10	\$ 30,681,701.15	\$ 34,016,639.99	\$ 58,442,027.33	\$ 49,553,369.37	\$ 34,283,907.98	\$ 37,928,892.62
Total Revenue	\$ 129,298,393.97	\$ 144,056,005.80	\$ 151,991,216.55	\$ 173,856,109.63	\$ 176,537,500.80	\$ 191,311,824.94	\$ 210,108,649.16
Hospital Assessments							
Hospital Tax Receipts	\$ 38,846,106.01	\$ 42,038,470.93	\$ 49,695,493.40	\$ 65,159,935.62	\$ 60,110,408.44	\$ 66,446,984.69	\$ 72,313,923.08
Grossed-Up Value of Assessments	\$ 101,181,496.41	\$ 106,204,688.76	\$ 120,913,609.25	\$ 158,231,995.19	\$ 146,646,519.74	\$ 196,008,804.40	\$ 240,725,443.01
				grossed up value excluding ARRA	\$ 163,421,014.98	\$ 175,989,104.60	
Assessments as a percentage of Medicaid Revenues	30.04%	29.18%	32.70%	37.48%	34.05%	34.73%	34.42%