

Vermont Chronic Care Initiative

The Vermont Chronic Care Initiative (VCCI) is a statewide program that provides care coordination and intensive case management services to non-dually-eligible Medicaid beneficiaries with one or more chronic conditions, with a focus on improving outcomes and reducing unnecessary utilization. The VCCI modified its approach to focus on the top five percent of Vermont Medicaid beneficiaries with the highest utilization in state fiscal year 2012. The program is funded and operated by the state's Department of Vermont Health Access (DVHA). Because most providers are reimbursed by the state's Medicaid program through a fee-for-service model, reductions in unnecessary spending achieved by the program translate directly to savings to Vermont's Medicaid program budget.

The DVHA works with a vendor that provides extensive data analytical and decision support services for the VCCI which include: disease stratification and predictive modeling for population identification; centralized health intelligence including data analysis and statistical support; and program monitoring and evaluation of clinical and financial metrics. A proprietary data management system for VCCI documentation offers targeted decision support tools for prioritizing outreach and engagement of high-risk individuals by case managers, including clients with gaps in evidence-based care or with recent hospitalizations. Multiple hospitals statewide provide the VCCI with daily ED and inpatient admission data via secure protocols. This real-time data helps to inform and prioritize outreach to clients during ED visits and hospitalizations, when they are most receptive to services. Many VCCI staff also can access hospital and primary care practice EMRs to further supplement access to clinical information such as laboratory test results, changes in treatment plans, and specialty referrals, which enhance case management and care coordination services.

The VCCI is a hybrid model that includes a combination of state and vendor staff using the same data system. The vendor provides a team of telephonic nurses and social workers for individual and population management, as well as local and centralized data analytic staff, administrative leadership, a program pharmacist, and a part-time medical director. The state employs a team of field-based case managers and care coordinators – usually nurses or social workers – who provide individual case management to clients and population support to local primary care practices. The case managers and care coordinators operate either as field-based agents serving a region or as permanently embedded resources within provider organizations with high volumes of program clients. Locations include private primary care practices, FQHCs, and several high volume hospitals.

Clients qualify for the program if they are in the top five percent of highest utilizers or demonstrate high utilization patterns including multiple ED visits and inpatient admissions. Generally, they will have one or more chronic conditions such as asthma, congestive heart failure, depression, diabetes, coronary artery disease, chronic obstructive pulmonary disease, low back pain, mental health and substance use/abuse disorders, as well as polypharmacy. The program further targets clients determined to be “impactable” based on an analysis of clinical acuity and recent utilization patterns. This analysis is conducted by the program analytics contractor, and considers each candidate client's Chronic Disability and Payment System

(CDPS) score, their actual per-member-per-month cost to the Medicaid program, the number of chronic conditions, the number of ED and inpatient encounters, and evidence of fragmented, uncoordinated care – for example, several encounters with different providers in a short amount of time. Potential clients are also identified through direct referrals from primary care providers, ED staff, and field and embedded program staff, as well as other internal and external statewide partners.

When possible, providers arrange a “warm hand-off” of prospective clients to program staff while the client is in the provider setting. In the absence of this direct introduction, program field staff use a number of other methods to engage new clients. These alternative methods can often be more time-consuming and challenging, both in terms of making contact with potential clients and establishing a trusting relationship.

Clients successfully on-boarded into the program receive a “social needs assessment” and a “behavioral risk assessment.” Depending on the client's specific needs, a number of other disease-specific assessments (e.g., low back pain, diabetes, chronic obstructive pulmonary disease, etc.) are performed, as well as a “transitions in care assessment” for clients exiting inpatient care.

The program provides several types of support to clients on an ongoing basis including: coaching clients on motivation, health literacy, and self-management skills; facilitating client engagement with their primary care providers and mental health agencies; developing a care plan and action plan in collaboration with the client and their providers; assessing social and other non-clinical barriers to health and coordinating client access to available state or local resources (e.g., for housing, food and fuel, transportation, drug rehabilitation services, and financial support for medications or other treatment needs); reviewing medication lists to ensure that evidence-based prescribing guidelines are followed; and providing more intensive transitional supports following inpatient admissions or ED visits. Selecting the appropriate mix of support for each client is informed by the real-time analytics provided by the program contractor, which help to identify gaps in care and other opportunities to intervene with the client. Interactions with higher-risk clients are typically performed face-to-face while interactions with lower-risk clients are more likely to be telephonic.

The VCCI is funded through the state Medicaid office. Additional grant funding to local Health Service Areas supports Medicaid beneficiaries who do not fall into the top 5 percent of highest utilizers. Services are provided by the state's Blueprint for Health program, a statewide, multi-payer initiative to improve primary care through the creation of Patient-Centered Medical Homes and Community Health Teams.

In state fiscal year 2011, members with one of 11 chronic conditions who participated in the VCCI demonstrated significant improvements in adherence to evidence-based care when compared with members with the same conditions who did not receive VCCI interventions. The program also documented a reduction in ED visits of 10 percent from baseline, as well as a 14 percent decline in inpatient admissions.

When the VCCI transitioned in state FY 2012 to focus on the five percent of the Medicaid population with the highest utilization, the vendor entered into a 100 percent risk-based contract for program savings. The vendor risk is based on provision of data analytics and decision support tools to guide population selection and care interventions (including employment of nurses and social workers for telephonic support) to ensure clinical improvement and cost savings. The vendor has guaranteed savings of \$2.5 million for state FY 2012 and 2013.

The VCCI achieved financial savings of approximately \$11.5 million (after program expenses) over anticipated costs in state FY 2012. The 2012 evaluation data demonstrate improvement on 6 of 12 clinical measures for Medicaid beneficiaries in the top five percent of utilization who participated in VCCI when compared to beneficiaries in the top five percent who did not receive VCCI services. In addition, when compared with the top five percent of beneficiaries in state FY 2011, the VCCI demonstrated an 8 percent reduction in inpatient utilization, a 4 percent decline in ED utilization and an 11 percent decrease in 30-day readmission rates in state FY 2012.

For more information about the Vermont Chronic Care Initiative, please contact Eileen Girling at Eileen.Girling@state.vt.us.

Excerpt from CMS informational Bulletin: Targeting Medicaid Super Utilizers to Decrease Costs and Improve Quality <http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-07-24-2013.pdf>

Exhibit 1: VCCI Results for Top Five Percent of Medicaid Population with Highest Utilization

	Inpatient Admissions	30-Day Readmissions	ED Visits
State FY11 Rate	517.75	87.02	1521.35
State FY12 Rate	476.02	77.41	1460.92
% Change SFY11 to SFY12	-8.06%	-11.04%	-3.97%

Exhibit 2: VCCI Results on Clinical Outcomes in state fiscal year 2011

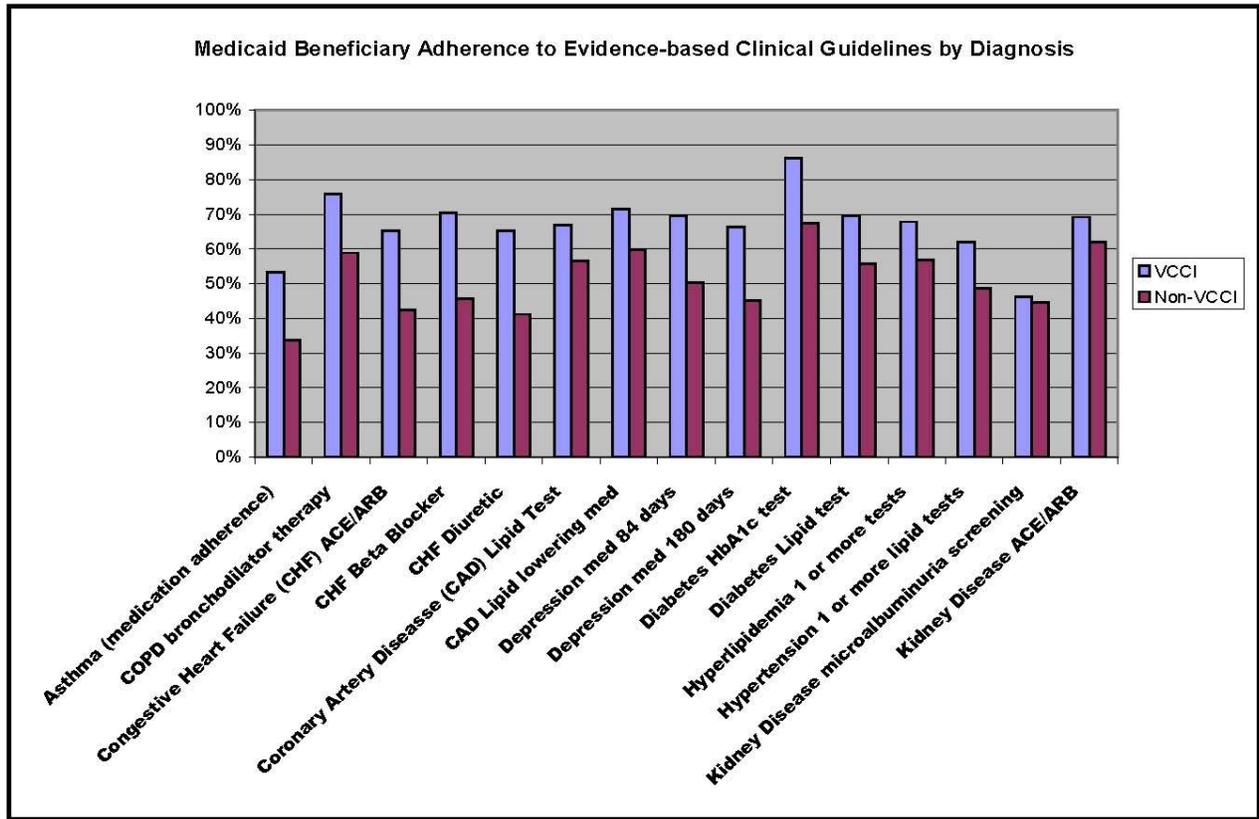


Exhibit 3: VCCI Results on Clinical Outcomes in state fiscal year 2012

