Ensuring the Long-term Sustainability of our Social Safety Net

"The first element of protecting the most vulnerable Vermonters is to ensure the near-term solvency of benefit programs, while working to create sustainability in the long-term."

- Governor Jim Douglas, Inaugural Address, Thursday January 8, 2009

Controlling the Growth in Medicaid Costs

Our first of its kind Global Commitment to Health waiver was a major milestone in addressing our challenges in the Medicaid budget. But even with Global Commitment, caseload increases outpace resources with a bigger and bigger portion of the state budget needed to fill the gap.

Although our federal partner in Medicaid is expected to help with increased funds through the economic recovery package, that alone will not ameliorate increasing pressures on the human service budget. That is why we must take steps to set this vital network of programs on a sustainable path.

Our current expenditures in our Medicaid programs are unsustainable in the long run. Right now 25% of Vermonters receive some form of Medicaid assistance, among the highest percentages in the nation. There are principally two alternatives to make our overall Medicaid program sustainable: We can reduce the scope of some benefits, while asking beneficiaries to share costs, or eliminate programs for whole populations. The option of eliminating health care coverage for many Vermonters in order to preserve full current benefits for some is unjust in such a challenging time. As such, AHS will be proposing changes such as increased premiums and realignment of benefits to ensure the long-term sustainability of programs we have in place today.

Healthy Behavior Incentives

Encouraging Vermonters to make better choices when it comes to their health and well-being is a critical component of our innovative health care reforms, and the Vermont Blueprint for Health is the cornerstone of these efforts. BISHCA (Banking, Insurance and Health Care Administration) also just enacted rules enabling our private insurance carriers to provide differential cost sharing (e.g., reduced premiums or co-pays) for enrollees who adhere to healthy lifestyle requirements. We should align Medicaid with these goals and work to reward beneficiaries who have made the choice to live a healthy lifestyle and those who are willing to move in this direction. This will provide a tangible incentive to empower Medicaid recipients to take responsibility for their own well-being, to improve their health, and at the same, lower health care costs.

While private insurance and employers have created plans that encourage healthy behaviors, there is only emerging experience to date in applying such methods in publicly funded health care programs. Vermont is exploring how other states have begun to approach this type of initiative within their Medicaid programs, in order to develop a design for a Healthy Behaviors program for OVHA (Office of Vermont Health Access) beneficiaries. We also are working with

the Centers for Medicare and Medicaid Services (CMS) to understand the federal parameters for implementing such a program. Program details will be developed over the coming months. The handful of states that are experimenting with rewards for healthy behaviors are including one or more of the following behaviors:

- Participating in weight loss programs
- Participating in smoking cessation programs
- Adhering to recommended chronic care management steps
- Keeping appointments with physicians for well-child visits or adult annual exams
- Completing health risk assessments (HRAs)
- Obtaining flu shots
- Participating in physical fitness programs
- Signing voluntary member pledges to practice healthy behaviors

The incentives offered by other states generally fall into the following categories:

- Coupons for over-the-counter health care and personal hygiene products
- Reduced monthly premiums
- Waived co-pays for treatment of chronic conditions

Asset Testing

We need to fully explore the costs and benefits of asset testing for the state's expansion health care programs. In this difficult fiscal environment, we must be sure we are serving those with the greatest need. Those that are able may need to shoulder more of the cost for their health care coverage.

Vermont and federal guidelines vary widely between programs when it comes to asset testing. For example, there is no asset test for Dr. Dynasaur or the Vermont Health Access Plan (VHAP). There is a $5,000/single, $6,000/couple asset test for people on Medicaid who have disabilities. Reach Up participants have a $2,000 asset limit for the household. The level is $5,000 for home heating assistance.

There are programs that carry a high enough value that assets should be considered, including an analysis of the long-term benefit to the state, the effect on individuals and any increased administrative costs for such a change.

Fraud and Abuse

Most people who benefit from programs are honest and deserving. However, there are some who do not follow the rules and exploit the system for personal gain. In this environment, we must do all we can to prevent this behavior, as each dollar that is not properly spent is a dollar denied to a deserving Vermonter.

Most benefit programs are monitored by the Department for Children and Families (DCF) Quality Control and Fraud Unit. They perform data matches related to social security payments, bank accounts, payrolls, and unemployment compensation. They also audit a random sample of cases to check for errors and possible abuse.

Reports of potential fraud come from this quality assurance process as well as from the general public. Each year, DCF investigates approximately 250 cases. Of those, some are unfounded and some identify client error. Approximately half resulted in findings that disqualified individuals from receiving future benefits. Very few have been referred to the Attorney General for prosecution. Recoupment of overpayment is done in most programs, however, the state does not currently recoup Medicaid premiums.

AHS will review all of its systems to address fraud and payment errors to ensure maximum efficiency of our current systems. We will target opportunities to expand or tighten up existing processes. AHS will evaluate the need for increased resources where there appears to be opportunities for additional savings.

Medicaid Prescription Drug Abuse

The abuse and diversion of prescription medications has become a serious problem in Vermont. Currently the OVHA Program Integrity Unit uses claims analysis and internal and external referrals to investigate fraud, waste and abuse by providers and beneficiaries. If a beneficiary is reported or found to have excess use, misuse and /or diversion of prescription drugs, the Program Integrity Unit reviews the case and puts the beneficiary in the system to prevent them from seeing more than one prescribing provider and using more than one pharmacy to purchase their prescriptions.

These efforts can be strengthened. For example, federal law currently does not allow Medicaid programs to disenroll members who are abusing prescription drugs. In addition, Vermont law prevents OVHA's Program Integrity Unit from reporting beneficiaries to the state and/or local police for drug related incidents. OVHA has been working with the AHS legal department to develop a solution to this legal barrier. OVHA also will be exploring options that are being proposed or implemented by other states. Examples include a Missouri bill that would reward whistleblowers who report fraud in the state's Medicaid program and increase penalties for convictions; and several states have implemented limits on the amounts of OxyContin Medicaid recipients' can obtain on a monthly basis without obtaining prior authorization.

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