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Agency of Human Services

M E M O R A N D U M

To: Senator Jane Kitchel, Chair, Senate Committee on Appropriations
Claire Ayer, Chair, Senate Committee on Health and Welfare

From: Mark Larson, Commissioner of the Department of Vermont Health Access

Cc: Doug Racine, Secretary, Agency of Human Services

Date: April 4, 2014

Re: Budget Testimony Questions

During committee testimony on March 25th and 26th, the following information was requested. Also, please be advised that the description for the New Adult benefit in the budget book is incomplete (page 50 of the on-line version, page 49 of the budget book). Adults with or without children qualify for this new benefit. Childless adults, however, are eligible for enhanced federal participation.

(1) Please provide more detail around the position request to support providing services to children with autism. Please find attached a memo provided to House Appropriations Committee explaining this request. During testimony, you also requested copies of all memos provided to the various committees. These are also included herein.

(2) A more thorough explanation is needed about the Care Alliance and how the services provided in the Hub & Spoke ensure best practice.

This initiative:

- *Expands access to Methadone treatment* by opening a new methadone program in the Rutland area and supporting providers to serve all clinically appropriate patients who are currently on wait lists

- *Enhances Methadone treatment programs (Hubs)* by augmenting the programming to include Health Home Services to link with the primary care and community services, provide buprenorphine for clinically complex patients, and provide consultation support to primary care and specialists prescribing buprenorphine

- *Embeds new clinical staff (a nurse and a Master's prepared, licensed clinician) in physician practices that prescribe buprenorphine (Spokes)* through the Blueprint CHTs to provide Health Home services, including clinical and care coordination supports to individuals receiving buprenorphine. *Embedding the staff directly in the prescribing practices allows for more direct access to mental health and addiction services, promotes continuity of care, and supports the provision of multidisciplinary team care.*

Under the Hub & Spoke approach, each patient undergoing MAT will have an established medical home, a single MAT prescriber, a pharmacy home, access to existing Blueprint CHTs, and access to Hub or Spoke nurses and clinicians.

ADAP and DVHA/Blueprint have the following joint initiatives to ensure best practices:

1. Joint development and dissemination of a treatment guideline based on the best clinical evidence.
2. Performance contracts for the Hub programs under which key clinical and administrative measures are reported to ADAP
3. Developing system to collect the CMS "Health Home Measures" from all Hubs and Spoke programs (these are HEDIS and hybrid measures (claims & clinical information) for effective and preventative care, coordination, and utilization.
4. The Blueprint and ADAP are hosting regular training forums for the five (5) regional specialty addictions treatment centers (Hubs), the newly hired Spoke nurses and clinicians working with Vermont's buprenorphine providers, and with the practices prescribing buprenorphine. With faculty leadership from the Dartmouth Health System's Addiction Medicine, monthly in-person and phone webinars bring program staff together for program improvement. The goal is to improve care in each practice setting and to standardize care across the statewide system. These networks provide a practical and efficient mechanism to drive improvements in the standard of care and to assure coordination between providers statewide.

Assessing the Evidence Base: Medication Assisted Treatment for Opioid Addiction[1]*:*
Medication Assisted Treatment (MAT), the use of medications, in combination with counseling and behavioral therapies, is a successful treatment approach and is well supported in the addictions treatment literature. The two primary medications used in conjunction with counseling and support services to treat opioid dependence are methadone and buprenorphine. MAT is considered a long-term treatment, meaning individuals may remain on medication indefinitely, akin to insulin use among people with diabetes.

Two different medications, methadone and buprenorphine, are used to reduce cravings for opioids (e.g., heroin, prescription pain relievers, etc.) and allow patients the opportunity to lead normal lives. Medication assisted treatment was originally developed because detoxification followed by abstinence-oriented treatment had been shown to be ineffective in preventing relapse to opiate use. Methadone has been used in this capacity since 1964; buprenorphine was approved for opioid treatment in 2000. Methadone is dispensed in specialty treatment facilities and buprenorphine can be prescribed by specially trained physicians.

There is clear evidence of a high level of effectiveness for both methadone and buprenorphine. Medication assisted treatment outcomes include: abstention from or reduced use of illicit opiates; reduction in non-opioid illicit drug use (e.g., cocaine); decreased criminal behavior; and decreased risk behavior linked to HIV and hepatitis C.

(3) Why would someone being served in the Hub have an increase in DME costs? Though the services being provided in the Hub are to address opioid addictions, there are other co-occurring mental health or addictions conditions such as smoking that people enrolled in the Hub also experience. The most common respiratory diagnoses conditions are typically asthma and COPD/Emphysema. The data shows that most increases in DME costs were associated with respiratory supports or wheelchairs,

[1] *Assessing the Evidence Base Series* is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). The goal of the AEB Series is to provide a framework for decision makers to build a modern addictions and mental health service system for the people who use these services and the people who provide them. The framework is intended to support decisions about the services that are likely to be most effective.

crutches, canes, or walkers. These treatment areas have a logical link to addressing the co-occurring addiction. Given more time, we could break the details down in a more statistical manner; however, it is logical that the increases we're seeing in DME does correlate to better coordination of care.

(4) How much money is in your base budget that is available to support the Vermont Health Connect activities, such as call center costs for Medicaid? $3.5 million.

(5) Does DVHA pay for oral hygienist instruction services? Nutrition counseling? Yes, DVHA pays for oral hygienist instruction services. Medical nutrition therapy has been a Medicaid covered benefit since 1/2010. There are several CPT codes for dietetic professionals to provide medical nutrition therapy assessment or re-assessment and intervention in a face-to-face or group patient setting. After an initial nutritional screening, preventive or therapeutic dietary therapy is initiated to discuss the role of nutrition to improve health. DVHA does not, however, pay for nutritional counseling for the control of periodontal disease.

(6) How much Special Education Medicaid is included in the non-DVHA expenditures included in the charts? $40.5 million.

(7) What is the impact on primary care physicians' rates due to the 100% federal increase going away? Please see attached memo.

(8) Where in the budget book can I see spending by major category? In the book itself, this information is tabbed with the title "Categories of Service, Insert 4" in the back of the book. In the on-line version, it is on page 88.