Legislative Policy Summit: High Cost of Chronic Care: What can policy makers do about it?

11/16/16

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‘Studies have shown that nearly 30% of health care spending - up to $300 billion each year – is for treatment that may not improve health status, may be redundant, or may be inappropriate for the patient's condition...’

(Wennberg et al., 2002, Wennberg et al., 2004; Fisher et al., 2003, Fisher et al., 2003)
Background Information:
Federal and State Trends
Healthcare System Use & Waste

- Health care costs in the United States account for **16 percent** of the country's **GDP**, and per capita spending is approximately **twice** that of other major industrialized countries (OECD 2008).
- The U.S. system **performance lags** other countries; and with unnecessary expenditures (Commonwealth Fund 2008; 2015).
- **Spending patterns** make health care & health insurance increasingly unaffordable with millions uninsured (DeNavas-Walt et al. 2008).
- U.S. costs are disproportionately concentrated among older adults with multiple chronic conditions - “**high-need**” patients. (Commonwealth Fund, 2016)
Healthcare System Use & Waste, cont

- **U.S. spends more** per person than 12 other high-income nations, with lowest life expectancy and **high rates of infant mortality and obesity** (Commonwealth Fund, 2015).

- PCP/hospitals have **no incentives** to reduce waste or redundancies in a **fee for service, acute care environment**

- **Poor access** to Primary Care Provider versus ‘specialty care’ providers (prevent vs. treat) with resulting high ED rates (Medicaid) for ACS conditions and poor follow-up (US has lower PCP rates/capita)

- Incomplete **EHR infrastructure** to support **proactive, planned care** vs. **reactive acute care**
Health Care Spending as a Percentage of GDP, 1980–2012

GDP refers to gross domestic product.

Source: OECD Health Data 2014.

* 2011.

GDP refers to gross domestic product.
Source: OECD Health Data 2014.
High-Need AdultsWere Less Likely to Report Good Patient–Provider Communication

Total adult population

Three or more chronic conditions, no functional limitations

Three or more chronic conditions, with functional limitations (high need)


Spending per Hospital Discharge, 2012
Adjusted for Differences in Cost of Living

Dollars ($US)

<table>
<thead>
<tr>
<th>Country</th>
<th>2012</th>
<th>2011</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>GER</td>
<td>5,586</td>
<td>5,586</td>
<td>5,586</td>
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<tr>
<td>OECD Median</td>
<td>7,147</td>
<td>7,147</td>
<td>7,147</td>
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<tr>
<td>NZ*</td>
<td>8,434</td>
<td>8,434</td>
<td>8,434</td>
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<tr>
<td>FR</td>
<td>8,785</td>
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<tr>
<td>AUS*</td>
<td>9,346</td>
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<td>SWE**</td>
<td>9,975</td>
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<td>11,363</td>
<td>11,363</td>
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<td>11,472</td>
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<tr>
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<td>14,832</td>
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<td>CAN*</td>
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<td>US**</td>
<td>20,932</td>
<td>20,932</td>
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</tr>
</tbody>
</table>

* 2011.
** 2010.
Source: OECD Health Data 2014.
Deaths per 100,000 population*

* Countries' age-standardized death rates before age 75; including ischemic heart disease, diabetes, stroke, and bacterial infections. Analysis of World Health Organization mortality files and CDC mortality data for U.S.

Public Investment per Capita in Health Information Technology (HIT) as of 2005

<table>
<thead>
<tr>
<th>Country</th>
<th>Investment per Capita</th>
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<tr>
<td>United Kingdom</td>
<td>$192.79</td>
</tr>
<tr>
<td>Canada</td>
<td>$31.85</td>
</tr>
<tr>
<td>Germany</td>
<td>$21.20</td>
</tr>
<tr>
<td>Australia</td>
<td>$4.93</td>
</tr>
<tr>
<td>United States</td>
<td>$0.43</td>
</tr>
</tbody>
</table>

“Within ten years, every American must have a personal electronic medical record...”

President George W. Bush, April 26, 2004
Delayed ‘Knowledge Transfer

‘An average of 17 years is required for evidence based knowledge to be incorporated into practice, and even then application is highly uneven.’

(Balas and Boren, 2000)
State of Vermont
Overview and History
Department of Vermont Health Access: Healthcare Reform Leadership

Goals:

- Quality Coverage for all Vermonters
- Improved Health of Vermonters
- Control Cost and Growth of Health Care
- Assure Financing is Fair and Equitable
Vermont Demographics

Population: 630,000 (29% Medicaid)
Hospitals: 14 (1 academic medical center, 8 critical access...)
PCPs: 800 PCPs in 300 practices in 13 Hospital Service Areas
FQHC’s: 12 organizations some with multiple sites, serving over 125,000
Mental Health: 12 Agencies
Substance Abuse: 7 specialty agencies (‘Hubs’) and PCPs (Spokes)
Health Insurance Carriers: 3 major; plus Medicaid & Medicare
Medicaid ACO pilots – 2
Statewide enabling efforts: VT Medicaid

- ‘Global Commitment’/CMS 1115 waiver: flexible $
- Medicaid a public ‘Managed Care’ entity: flexibility via State Plan Amendment (SPA)
- CMS incentives for EHRs & ‘meaningful use’ $$
- VCCI as a DVHA Health Care Reform strategy, enabled by GC & legislation (2005-2007)
- Health Home Funding for SA management
- SIM grant: ACO pilots, etc.
- HIT funding: Enterprise Care Managed system
VCCI: a DVHA Health Care Reform Strategy for high risk members

- Medicaid largest carrier by expenditure; with budget shortfalls
- Increase in chronic conditions and associated morbidity driving utilization and cost (80% of $$ on chronic care)
- Limited primary care access for Medicaid members, impacting ACS ED, IP and 30 day readmission rates
- Primary Care Provider ‘shortage’, reimbursement structure & capacity of EHRs limits ability to effectively case manage complex Medicaid members
DVHA/VCCI - History

2005 - 2010

- Rising cost of chronic care in an acute care system
- PCP shortage restricting access, driving ACS hospital use
- VCCI enabled by legislation; statewide by 2008
- CMS Global Commitment (1115 waiver) - public MCO
- Initial focus 11 chronic health conditions, primarily adult
- Vendor contract for DM, analytics, data management tool

2011

- Shift focus to top 5% - all conditions, all populations
- Performance based vendor contract with 2:1 ROI required
DVHA/VCCI - History

2011- 2015:
- 27 state staff, plus 15 vendor staff
- State employed licensed field staff in 12 AHS district offices & high volume provider settings, to facilitate care management
- Vendor professional staff provide telephonic management
- Vendor ROI based on actual vs. anticipated cost in top 5%

2015 - 2016
- Sunset legacy vendor contract & 15 support staff
- New AHS Enterprise Care Management vendor transition with 90-10 federal funding
- VCCI ‘go live’ in new system 12/2015; subsequent deployments
VCCI Overview

Mission:
- Improve access to Medical Home
- Increase adherence to evidence based care
- Reduce ACS hospital utilization and 30-day readmission rates

Population: Medicaid high risk and high cost (top 5%)

Structure:
- RNs and LADC/MSWs available statewide - holistic approach
- Provide short-term, intensive case management & care coordination, disease management, health coaching
- Staff co-located in AHS district offices, PCP & hospital
  Members of local Community Health Teams (CHTs)
VCCI Eligibility Criteria

- Medicaid Primary Insurance: no dually insured
- No other CMS reimbursed case management
- No nursing home, assisted living resident, nor incarcerated
- Member profile: high risk/cost including ED utilization, frequent IP, poly-pharmacy and/or high predictability of future health care complications
- Must have ‘impactable’ medical condition
VCCI Population Snapshot

- Top 5%

<table>
<thead>
<tr>
<th>Category</th>
<th>VT Medicaid Population</th>
<th>VCCI Population</th>
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<tbody>
<tr>
<td>Total VT Medicaid costs</td>
<td>39.00%</td>
<td>57.00%</td>
</tr>
<tr>
<td>Avoidable ED visits</td>
<td>20.00%</td>
<td>36.00%</td>
</tr>
<tr>
<td>ACS IP admissions</td>
<td>60.00%</td>
<td>88.00%</td>
</tr>
<tr>
<td>All 30-day readmission costs</td>
<td>88.00%</td>
<td>88.00%</td>
</tr>
</tbody>
</table>

VT Medicaid Population

VCCI population
Obesity prevalence is significantly higher among adults with other chronic conditions.

**Obesity by Other Chronic Conditions**

Note: obesity prevalence data are limited to adults 20 and older and is age adjusted to U.S. 2000 population.

Source: 2013 Vermont Behavioral Risk Factor Surveillance System
Adults with Medicaid are significantly more likely to be obese than those with private or self-purchased insurance.

**Obesity by Current Health Insurance Type**

- Medicaid: 34%
- Other Insurance: 27%
- Multiple Types: 27%
- Other Government Program: 25%
- Private Insurance - Through Employer: 23%
- Self Purchased: 19%

Note: obesity prevalence data are limited to adults 20 and older and is age adjusted to U.S. 2000 population.

Source: 2013 Vermont Behavioral Risk Factor Surveillance System
VCCI Strategic approach

- Licensed, decentralized & embedded staff provide short term, intensive case management
- Focus on SA, MH, CAD, CHF, diabetes and related risk factors such as obesity
- Population identification & stratification: risk, cost, and acuity (claims based)
- Secure FTP site data from 6 partner hospitals on ED/IP admissions (warm data vs. claims data)
- Liaison with hospital CM’s and discharge planners
- Access to Hospital/PCP EMRs: clinical & follow up
VCCI Strategic approach

- Facilitate ‘Medical Home’ access & post IP transitions in care, to prevent ED, IP & 30 day readmission rates
- Holistic, evidence based approach: socio-economic (housing, transportation), disease specific tools for evidence based care
- Collaborative approach with shared care plans, and action plans/self-management with PCP and member
- Strength based: MI, health coaching for self-efficacy
- Extensive collaboration: providers, community, AHS
Specialty Case Management

**MOMS**: Medicaid Obstetrical and Maternal Supports

- Obstetrical services large part of Medicaid budget
- SA and MH are factors impacting adverse pregnancy outcomes and related cost (including NICU stays)
- Medication Assisted Therapy critical to successful treatment during pregnancy to reduce risk
- Post partum support indicated to assure MAT adherence and safety of infant and minimize DCF custody
Average Annual Number of Physician Visits per Capita, 2012

<table>
<thead>
<tr>
<th>Country</th>
<th>Visits per Capita</th>
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<tbody>
<tr>
<td>JPN*</td>
<td>13.0</td>
</tr>
<tr>
<td>GER</td>
<td>9.7</td>
</tr>
<tr>
<td>CAN*</td>
<td>7.9</td>
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<tr>
<td>AUS</td>
<td>6.9</td>
</tr>
<tr>
<td>FR</td>
<td>6.7</td>
</tr>
<tr>
<td>OECD Median</td>
<td>6.7</td>
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<tr>
<td>NETH</td>
<td>6.2</td>
</tr>
<tr>
<td>DEN</td>
<td>4.7</td>
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<tr>
<td>NOR</td>
<td>4.4</td>
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<td>4.0</td>
</tr>
<tr>
<td>NZ</td>
<td>3.7</td>
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* 2011.
** 2010.
Source: OECD Health Data 2014.
Health and Social Care Spending
Percent of GDP

<table>
<thead>
<tr>
<th>Country</th>
<th>Health care</th>
<th>Social care</th>
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<td>11</td>
</tr>
<tr>
<td>SWE</td>
<td>12</td>
<td>11</td>
</tr>
<tr>
<td>SWIZ</td>
<td>11</td>
<td>20</td>
</tr>
<tr>
<td>GER</td>
<td>11</td>
<td>18</td>
</tr>
<tr>
<td>NETH</td>
<td>12</td>
<td>15</td>
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<tr>
<td>US</td>
<td>9</td>
<td>16</td>
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<tr>
<td>NOR</td>
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<tr>
<td>UK</td>
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<td>10</td>
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<tr>
<td>AUS</td>
<td>9</td>
<td>11</td>
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Continuum of Care: Level of Service & Support

Advanced Primary Care Practice
- Health Maintenance
- Prevention
- Access
- Communication
- Self Management Support
- Guideline Based Care
- Coordinate Referrals
- Coordinate Assessments
- Panel Management

Community Health Teams
- Support Patients & Families
- Support Practices
- Coordinate Care
- Coordinate Services
- Referrals & Transitions
- **Case Management**
  - MCAID CMs
  - SASH Teams
- Self Management Support
- Counseling
- Population Management

Specialized & Targeted Services
- Specialty Care
- Advanced Assessments
- Advanced Treatments
- Advanced Case Management
- Social Services
- Economic Services
- Community Programs
- Self Management Support
- Public Health Programs
- **Medicaid/VCCI Case Mgn’t**
  - High Risk & Acuity (top 5%)
  - MOMS (Medicaid Obstetrical and Maternal Supports)

Level of Need

Higher Acuity & Complexity

Lower Acuity & Complexity

Blueprint for Health
Smart choices. Powerful tools.
## VCCI Performance: SFY 2014

<table>
<thead>
<tr>
<th>Top 5%</th>
<th>ACS IP Admissions</th>
<th>30-Day Readmissions</th>
<th>ED Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>SFY 2013 Rate</td>
<td>610</td>
<td>111</td>
<td>1529</td>
</tr>
<tr>
<td>SFY 2014 Rate</td>
<td>426</td>
<td>77</td>
<td>1299</td>
</tr>
<tr>
<td>% Change SFY13 to SFY14</td>
<td>-30%</td>
<td>-31%</td>
<td>-15%</td>
</tr>
</tbody>
</table>

**Net savings over anticipated cost SFY 2014:** $30.5 M
VCCI savings 2012-2014

VCCI Savings for Eligible Members in the ‘Top 5%’ of Medicaid

Millions of Dollars

Fiscal Year 2012  Fiscal Year 2013  Fiscal Year 2014
# VCCI Performance: SFY 2014-2015

<table>
<thead>
<tr>
<th></th>
<th>Inpatient Admissions</th>
<th>Readmissions</th>
<th>Emergency Room Visits</th>
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<tr>
<td><strong>FY14 Rate</strong></td>
<td>442</td>
<td>78</td>
<td>1141</td>
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<tr>
<td><strong>FY15 Rate</strong></td>
<td>371</td>
<td>43</td>
<td>1428</td>
</tr>
<tr>
<td><strong>Percentage Change from FY 2014 to FY 2015</strong></td>
<td>-16.21%</td>
<td>-44.96%</td>
<td>25.08%</td>
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</tbody>
</table>
Future Integration Efforts

AHS Enterprise level Care Management System:

- VCCI first to ‘go live’ 12/31/15
- Evidence based tools, predictive analytics, population stratified by risk, UR and cost data
- VITL data feed in 2017
- Additional programs on board 2017
- Provider/consumer portals for shared care plans
- Next gen ACO tracking capacity
“If you don’t know where you are going, you might wind up someplace else.”

– Yogi Berra
The US health care system is the most costly in the world, accounting for 17% of our GDP with estimates that percentage will grow to nearly 20% by 2020.

Commonwealth Group
Total health care investment in US is less

In OECD, for every $1 spent on health care, about $2 is spent on social services.
In the US, for $1 spent on health care, about 55 cents is spent on social services.
老牌
Using the Public Health Model to Improve Health Outcomes & Reduce Health Care Costs
Using the Public Health Model to Improve Health Outcomes & Reduce Health Care Costs

The New Jim Crow
Mass Incarceration in the Age of Colorblindness
MICHELLE ALEXANDER
Using the Public Health Model
to
Improve Health Outcomes
&
Reduce Health Care Costs
Using the Public Health Model to Improve Health Outcomes & Reduce Health Care Costs
Using the Public Health Model to Improve Health Outcomes & Reduce Health Care Costs
Using the Public Health Model
to
Improve Health Outcomes
&
Reduce Health Care Costs
Using the Public Health Model to Improve Health Outcomes & Reduce Health Care Costs
Using the Public Health Model to Improve Health Outcomes & Reduce Health Care Costs
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Using the Public Health Model
THE 3 ERAS OF PUBLIC HEALTH

• Prior to 1850
  – Magic
  – Mysterious Epidemics
  – Run Away
THE 3 ERAS OF PUBLIC HEALTH

• 1850-1949
  – Science
  – Bacteria & Viruses
  – “Sanitary Reform Movement” through state and local infrastructure
THE 3 ERAS OF PUBLIC HEALTH

• 1950-present
  - Gaps in healthcare service delivery systems
  - Disproportionally effects the poor and disenfranchised
THE 3 ERAS OF PUBLIC HEALTH

- "Winnable Battles:
  - Moving appropriate cohorts of incarcerates (including those suffering from the chronic conditions of mentally illness and addiction) to health and human services in the community
  - Access to mental health services
  - Access to addiction services
  - Integration of services to include veterans
  - Strategic use of the Housing First model
Medicaid Triple Aim:

Better Patient Care

Greater Overall Societal Health

Best Value for Public Health System Resources
Where Does the Health Economist Enter the Picture?

1. Can it work (efficacy)?
2. Does it work (effectiveness)?
3. Is it worth doing (efficiency)?
t0. Define mechanisms underlying health or disease
Yields knowledge about defining mechanisms, targets or lead molecules

t1. Test basic research findings for clinical effect
Yields knowledge about new methods of diagnosis, treatment and prevention

t2. Test new interventions under controlled environments
Yields knowledge about the efficacy of the interventions in optimal settings

t3. Explore ways of applying guidelines in general practice
Yields knowledge about how interventions work in real-world settings

t4. Study influences on the health of populations
T4 research ultimately results in improved global health
Those that respect the law and love sausage should watch neither being made.

~ Mark Twain
Success

what people think it looks like

what it really looks like
Let’s Go Back to the Crisis Board
Criminal Justice Reform

Incarceration Rates for Selected Countries

- United States
- Russia
- Belarus
- Turkmenistan
- Cuba
- Suriname
- Ukraine
- South Africa
- Singapore
- Thailand
- Chile
- Israel
- Iran
- Brazil
- Mexico
- Argentina
- Spain
- United Kingdom
- Australia
- Canada
- Saudi Arabia
- Italy
- Germany
- France
- Denmark
- Norway
- Japan
- India

Incarceration Rate per 100,000.
Criminal Justice Reform

- 1955: First antipsychotic drugs
- 1965: Medicaid & Medicare enacted
Total adult correctional population, 1980–2013

Health Care Reform

Total health care investment in US is less

In OECD, for every $1 spent on health care, about $2 is spent on social services
In the US, for $1 spent on health care, about 55 cents is spent on social services
Health Care Reform

Self Sufficiency Matrix

- Disabilities
- Safety
- Substance Abuse
- Mental Health
- Legal Issues
- Parenting Skills
- Community Involvement
- Mobility/Transportation
- Family/Social Relationships
- Housing
- Employment
- Income
- Food
- Child Care
- Children's Education
- Adult Education
- Health Care Coverage
- Life Skills
Integration of Behavioral & General Healthcare

Economic Impact of integrated medical-behavioral healthcare

Milliman Report Summary
The prevailing tendency in today’s healthcare system is to treat medical and behavioral health conditions, including mental health and substance use disorders, as if they occur in different domains, rather than within the same person.
Key Findings:

• Only 14% of people with insurance are receiving treatment for mental health or substance use disorders, but they account for more than 30% of total health care spending.
Key Findings:

• Because of fragmented care, **general medical costs** for treating people with chronic medical problems, as well as mental conditions, are **2-3 times higher** than those for treating people with general health conditions only.
Key Findings:

- Most of the projected reduced spending is associated with emergency room and hospitalization expenses (i.e. avoidable expenses)
Medicaid Mental Health Spend:

• In Vermont a high proportion of our highest cost members and frequently hospitalized members suffer from mental illness or substance abuse.

  – Total Vermont Medicaid Population: ~186,000

  – Total Population receiving mental health or substance abuse services: 77,728 (42% vs 14% of all insured)
Medicaid Mental Health Spend:

• The direct Medicaid costs for mental health and substance abuse treatment for SFY 2015 was $407,350,267. This represents 30% of the total Medicaid spend of approximately $1.3 billion.

• We should see a greater impact on overall healthcare costs than Milliman predicts if Vermont can implement effective strategic interventions using ED visits and lengthy hospitalizations as outcome indicators.
Top 100 High Cost Members – SFY 2015

The Top 100 Members represents 4.05% of total Medicaid Costs

A review of the top 100 members (based on paid amounts) showed that the highest costs were in the above categories.
• Suboxone/buprenorphine
Integrated Health System for Addictions Treatment

HUB
- Assessment
- Care Coordination
- Methadone
- Complex Addictions Consultation

Spokes
- Nurse-Counselor Teams w/prescribing MD

Spokes
- Nurse-Counselor teams w/prescribing MD

Residential Services

In Patient Services

Pain Management Clinics

Medical Homes

Substance Abuse Out-Pt Treatment

Mental Health Services

Family Services

Corrections
Probation & Parole
Table ES2. Two-year costs among 1,000 hypothetical patients treated for opioid dependence.

<table>
<thead>
<tr>
<th>Outcome/Cost</th>
<th>MMT</th>
<th>BMT</th>
<th>SUB/VIV Taper</th>
<th>SUB/Oral NTX Taper</th>
<th>Vivitrol Alone</th>
<th>Oral NTX Alone</th>
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</thead>
<tbody>
<tr>
<td>Treatment outcome</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(per 1,000)</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>In treatment</td>
<td>630</td>
<td>523</td>
<td>550</td>
<td>500</td>
<td>416</td>
<td>277</td>
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<tr>
<td>Relapsed</td>
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<td>292</td>
<td>265</td>
<td>315</td>
<td>400</td>
<td>538</td>
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<tr>
<td>Drug –free</td>
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<td>176</td>
<td>177</td>
<td>176</td>
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<td>Died</td>
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<td>Cost ($, per patient):</td>
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<td></td>
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<tr>
<td>Drug therapy</td>
<td>699</td>
<td>3,655</td>
<td>8,553</td>
<td>1,249</td>
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<td>665</td>
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<td>Other SA services</td>
<td>14,017</td>
<td>7,043</td>
<td>4,146</td>
<td>4,297</td>
<td>2,985</td>
<td>2,446</td>
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<td>Other health care</td>
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<td>25,993</td>
<td>25,454</td>
<td>26,441</td>
<td>28,109</td>
<td>30,844</td>
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<tr>
<td>SUBTOTAL</td>
<td>38,642</td>
<td>36,691</td>
<td>38,153</td>
<td>31,988</td>
<td>37,679</td>
<td>33,954</td>
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<tr>
<td>Social costs</td>
<td>92,068</td>
<td>102,337</td>
<td>98,033</td>
<td>105,917</td>
<td>119,239</td>
<td>141,076</td>
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<tr>
<td>TOTAL</td>
<td>130,710</td>
<td>139,028</td>
<td>136,187</td>
<td>137,905</td>
<td>156,918</td>
<td>175,030</td>
</tr>
</tbody>
</table>

MMT: methadone maintenance treatment; BMT: buprenorphine maintenance treatment; NTX: naltrexone; SUB: Suboxone; VIV: Vivitrol.
The number of people waiting for services has remained steady despite increases in capacity.
Concentration of those not enrolled in Medicaid; haven’t seen a PCP
Helpful Crises

“Opportunism in public health is good”

“Greed is good”
Don’t think of it as failure. Think of it as time-released success.
“Progress might have been alright once, but it’s gone on for too long.”

–Ogden Nash
Questions?

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