

**Office of Vermont Health Access**  
**SFY '08**  
**Budget Adjustment**  
Major Factors Impacting Request

Our SFY '08 budget adjustment request, which includes excess receipts requests, is an increase in administration of \$5,910,383 and a decrease to program of \$29,240,026.

	Appropriated	Budget Adjustment*	SFY '08 Revised Request
SFY '08 Admin:	31,393,906	5,910,383	<b>37,304,289</b>
SFY '08 Program:	717,216,390	(29,240,026)	<b>687,976,364</b>
Total:	748,610,296	(23,329,644)	<b>725,280,652</b>

**Program Changes: \$29 million**

**Trend Analysis ..... \$17 M**

While there are net downs to the overall Medicaid budget as part of SFY budget adjustment, the complex Medicaid system includes a number of moving pieces - both ups and downs. The largest five ups and the five biggest downs are included below. Taken together with all other category of services changes, they represent over \$17 million in reductions from SFY '08 appropriated.

Description of Service	Actual SFY '06	Actual SFY '07	Approp. SFY '08	Requested Change	Estimated SFY '08	07 Act-'08 Est. % Chg.
Physician	58,623,126	61,915,454	74,807,063	(7,214,343)	67,592,720	9.2%
Personal Care Services	16,411,319	16,924,620	24,711,626	(4,325,238)	20,386,388	20.5%
Home Health	7,798,335	6,598,664	10,445,806	(3,013,487)	7,432,319	12.6%
Assistive Community Care Services	8,252,128	9,781,892	12,804,642	(2,284,246)	10,520,396	7.5%
Medical Supplies & DME (26-00)	7,019,503	6,913,662	9,595,131	(2,103,840)	7,491,291	8.4%
Rehabilitation/D&P Dept. of Health	3,363,147	4,722,970	4,212,237	1,920,588	6,132,825	29.9%
Inpatient	59,404,188	58,107,259	60,781,526	1,316,010	62,097,536	6.9%
RHC & FQHC	10,946,861	12,235,391	11,791,513	1,253,266	13,044,779	6.6%
Catamount Premium Payments	-	-	13,026,954	1,097,735	14,124,689	N/A
Outpatient	64,519,817	63,509,663	69,534,918	733,077	70,267,995	10.6%
Total All Other Services	435,372,727	429,865,729	462,439,849	(4,723,774)	457,716,075	6.5%
Total Expenditures Excluding Offsets	671,711,152	670,575,303	754,151,265	(17,344,252)	736,807,013	9.9%

This requested budget adjustment down, however, still represents an increase over SFY 2007 expenditure levels of 9.9% .

- 2.5% ~ Catamount Implementation
- 1.5% ~ Inflationary Increases
- 0.8% ~ Increased Caseload
- 8.1% ~ Trend
- (3.0%) ~ Double DSH Impact Reduction

\*includes excess receipts requested

**Revenue Offsets** ..... **\$12 M**

During the budget process determining the SFY '08 appropriations, the actual effects of the Medicare Modernization Act for Part D coverage was not fully known. A large piece of the unknown was the impact on our ability to collect pharmacy rebates. The shifting mix of prescriptions filled where Medicaid was the primary payer did not allow for accurate estimates of new rebate levels. In addition to rebates, part D also brought new Coordination of Benefits (COB) activities in the form of coordinating with the 50 plus different Medicare prescription drug plans. The COB Unit at OVHA has begun collecting revenues by focusing on this new activity. In a similar vein, OVHA has invested heavily in Program Integrity infrastructure and new estimates of collections associated with these new activities are reflected on the COB line. Finally, cost settlements are very difficult to predict on a system wide level from year to year due to a number of factors including changes in billing practices, adjustments to base costs from facility to facility, and changes in the case mix across different providers.

Description of Offset	Actual SFY '06	Actual SFY '07	Approp. SFY '08	Requested Change	Estimated SFY '08	07 Act-'08 Est. % Chg.
Drug Rebates	(50,625,315)	(27,355,487)	(20,827,255)	(10,608,950)	(31,436,204)	14.9%
Supplemental Drug Rebates	(10,409,819)	(4,746,226)	(4,282,600)	(1,258,628)	(5,541,227)	16.8%
TPL	(6,620,029)	(5,449,974)	(4,311,258)	(3,000,000)	(7,311,258)	34.2%
Costs Settlements	(7,701,764)	(2,119,967)	(7,513,762)	2,971,803	(4,541,960)	114.2%
<b>Total Offsets</b>	<b>(75,356,927)</b>	<b>(39,671,654)</b>	<b>(36,934,875)</b>	<b>(11,895,775)</b>	<b>(48,830,649)</b>	<b>23.1%</b>

**Administrative Adjustments** ..... **\$6 M**

There are many issues impacting the SFY '08 administrative budget adjustment and excess receipts requests. The OVHA has \$5.9 million of SFY '08 needs due to: (1) marketing and outreach for Catamount Health; (2) implementation of the Chronic Care Management program; (3) additional staffing in support of Catamount; and (4) execution of Act 80 pharmacy transparency.

SFY '08 Administrative Budget Adjustment Changes		Total
1	Catamount Health Marketing & Outreach Funded in '07, Expensed in '08	2,853,992
2	Chronic Care Management Contract Additional Need for SFY '08	2,270,714
3	Admin Increase to Support Full Catamount Implementation Need	307,839
4	Claims Processing Program Changes to Support Act 80 Generic Drug Voucher Program	103,000
5	Miscellaneous	374,837
<b>SFY '08 Subtotal of Administrative Changes</b>		<b>5,910,382</b>

**National Provider Identifier ~ Implementation Effect on Medicaid Claims**

The National Provider Identifier (NPI) is a federally mandated initiative under the Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for (covered) health care providers (e.g., physicians, hospitals, dentists, etc). Health care providers, health plans and health care clearinghouses will use NPIs in the administrative and financial transactions (e.g., billing) adopted under HIPAA. The NPI is a 10-digit number. The compliance deadline is May 23, 2008.

As of November 30, 2007, 90% of Vermont Medicaid providers who are required to have and use an NPI, have one.

Currently, there is a subset of Vermont Medicaid providers who are submitting claims incorrectly in an attempt to comply with NPI requirements, which results in claims being deleted. This means that these providers are either not being paid, resulting in OVHA's budget reserve being artificially inflated, or that they are resubmitting claims in the correct format after multiple attempts. Recent data indicates that only 27.5% of electronic claims and 58% of paper claims are NPI compliant (appropriately submitting NPI data). Although the deadline for mandated compliance is May 23, 2008, OVHA is collaborating with EDS on an extensive and intensive provider outreach plan to help providers submit their NPI claims accurately. The goal is to reach 100% compliance prior to the May 2008 deadline. OVHA has instituted a methodology to estimate and track the value of the outstanding claims; the current estimate is that \$13,587,120 in claims are outstanding due to non-compliance with NPI.

**NDC Codes**

The Deficit Reduction Act of 2005 (DRA) included new provisions regarding State collection and submission of data for the purpose of collecting Medicaid drug rebates from manufacturers for physician-administered drugs. The DRA requires States to collect rebates on physician-administered drugs. States were required to meet this mandate by January 2008. The Secretary was given authority to delay applications of the collection and submission requirements to prevent hardship to States. Providers have petitioned OVHA to request a waiver to delay implementation for six months and OVHA has done that.

**Hospital Payment Changes ~ DRGs and APCs (Diagnostic-Related Groupings and Ambulatory Payment Classification)**

Effective January 1, 2008, the OVHA will implement Diagnostic Related Grouping (DRG) pricing logic for all inpatient claims. This will replace the previous per diem methodology. The importance of this change is that it represents one additional step on the road to transforming the Vermont Health Care System from one focused on acute interventions to one focused on chronic care across the lifespan and driven by outcome improvements. Alone this change is simply a small methodological pricing change. However, it will begin to place the Vermont Medicaid program in a position to better measure, evaluate, and pay for outcome improvements as we move forward. The \$1,000,000 appropriated to increase rates effective 1/1/08 will all be applied to inpatient rates. This half year increase will be annualized in the SFY 2009 budget.

Effective April 1, 2008, the OVHA will implement and Outpatient Prospective Payment System modeled after Medicare. This will replace the previous cost-based payment for many services. This change is expected to be budget neutral.

**Qualified Individuals (QI1s)**

The Office of Vermont Health Access, OVHA, implemented a policy change in December 2005 eliminating the asset test for individuals eligible for Medicare Savings Programs (MSP). The Medicare savings programs include 3 different programs which are: Qualified Medicare Beneficiaries (QMB), Specified Low Income Medicare Beneficiaries (SLMB) and Qualified Individuals (QI). By eliminating the asset test for these programs the state is able to make all of these individuals eligible for the low income subsidy, LIS. The LIS pays for many costs after Medicare Part D, the prescription drug plan implemented by the Centers for Medicare and Medicaid Services on January 1, 2006.

QI is a completely federally funded program. Currently 2,900 people are in QI in Vermont. The QI funding is currently tied up with SCHIP legislation at the federal level. The QI program funding is only funded through a continuing resolution through December 31, 2007. If the federal government does not continue to fund the QI program it will cost the state of Vermont an additional \$667,946 in general funds to make up the federal short fall for the time period of January 1, 2008 - June 30, 2008. Additionally, this would require the program become part of the Global Commitment to Health Waiver (GC) and as such would put pressure on the \$4.7 billion 5-year GC cap.

**Vermont State Children's Health Insurance Program - SCHIP**

The Vermont SCHIP program started in 1998 and covers uninsured children between 225-300% of the Federal Poverty Level (FPL). The program provides health care for 3,100 children at any time, and the premiums are \$40.00 per family a month. In SFY 08 enrollment has been projected to increase from an average monthly enrollment of 3,495 to 3,797 the result of increased outreach and reduced premiums.

There are two significant challenges facing the Vermont SCHIP program in the next year. First, authorization for the Federal SCHIP program ended September 30, 2007. Congress has passed two time-limited continuing resolutions that provide funding through December 14, 2007. Unlike many states, the lack of new SCHIP legislation is not having an immediate affect on Vermont. Under SCHIP law each state has up to three years to use the allocated funds, and Vermont has a positive fund balance that it can utilize if needed. If SCHIP is not reauthorized Vermont will run out of SCHIP funds at some point in SFY 09.

Second, in August 2007 the Centers for Medicare and Medicaid Services (CMS) issued a State Health Official letter reinterpreting SCHIP regulations as they relate to concerns of children giving up employer sponsored coverage for publicly funded coverage. When SCHIP was first implemented there were concerns that substitution would occur, and states were required to have plans in place to prevent substitution. The August CMS letter required states covering children above 250% FPL to implement a number of strategies by August 2008. The most challenging of the strategies are:

- Imposing a 12 month period without insurance prior to enrolling.
- Imposing cost sharing in approximation to that of private coverage.
- Assurance that the number of children in the target population insured through private coverage has not decreased over a period of five years.

A number of states have taken issue with the CMS reinterpretation, and New York and New Jersey each have brought lawsuits to prevent CMS from implementation. If the August letter remains in effect, implementing these strategies would require significant changes in the Vermont SCHIP program.

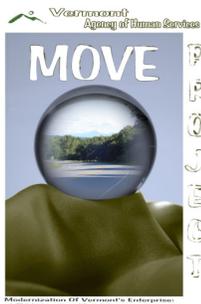
If SCHIP is not reauthorized, Vermont will be able to operate the program using previous unspent SCHIP funds under existing federal law for the remainder of SFY 2008. When the unspent VT SCHIP allocations

are fully utilized Vermont may be able to move SCHIP children into the Global Commitment to Health (GC) waiver. Vermont could also consider this option if it could not live with the requirements outlined in the August 17, 2007 CMS letter. However, moving SCHIP to Global Commitment puts pressure on the 5-year \$4.7 billion cap. Moving children currently served in SCHIP to GC could result in an increase in cumulative expenditures under GCH of up to \$25 million including all department spending. Immediate general fund impact due to the reduced federal match participation would require \$612 thousand in additional annualized state spending for the OVHA managed program (there would be additional general fund need for other department's costs).

### **Catamount Health**

OHVA will begin producing monthly reports on the ESI and Catamount Health premium assistance programs beginning in January, 2008, as required by Act 191. Reports will be generated around the middle of each month for the prior month. Attached are draft templates for those reports. The templates were presented to the Health Care Reform Commission at their meeting on December 4, 2007. Prior to the implementation of the monthly reports, the administration has been providing an interim report to the Health Care Reform Commission and the Health Access Oversight Committee at their regular monthly meetings. Attached is the most recent version of that interim report. The interim reports will be replaced by the legislatively mandated reports in January.

New staff has been hired to accommodate new Catamount enrollment. During SFY '08 budget development, it was anticipated that OVHA would need 8 new positions in the Coordination of Benefits unit for such. Further work ensued to ensure enrollment projections were viable. Through that process it was determined that enrollment, in fact, would be higher than original expectations. An additional 6 positions were identified as necessary to accommodate the added activity and are included in our budget adjustment request. We have not recruited for these as of yet.



The MOVE Project, the Modernization of Vermont's (Medicaid) Enterprise, is on a fast track to modernize and upgrade system support for the Medicaid program. Over the next several years Vermont will implement a new health care eligibility determination system and claims payment system (Medicaid Management Information System – MMIS) that are modern, flexible, responsive and interoperable so that the key program implementation drivers are our health care vision, optimal customer service, and program needs, and not the constraints of the supporting technology. This vision is the foundation for the MOVE Project, which is charged with making that vision a reality.

### Project Timeline

Task	Anticipated Completion	SFY Budget
1. Required (by CMS) Medicaid Information Technology Architecture State Self Assessment	February 2008	2008
2. Eligibility System Requirements	July 2008	2008 and 2009
3. Federal Funding Request and RFP	December 2008	2009
4. Eligibility System Procurement	June 2009	2009
5. Eligibility System Implementation	December 2010	2010-2011
6. MMIS Requirements	January 2010	2010
7. Federal Funding Request and RFP	June 2010	2010
8. MMIS Procurement	December 2010	2011
9. MMIS Implementation	December 2012	2011, 2012 and 2013

### Required Contracts and Estimated Costs by SFY

Contract Charge	SFY					
	2008	2009	2010	2011	2012	2013
Project Management Support for Eligibility System through Procurement* (Tasks 1-4)	\$ .8 m F \$ .5 m S	\$ .72m F \$ .48m S				
Eligibility System Vendor (Task 5)			\$7.5 m F \$5.0 m S	\$7.5m F \$5.0m S		
IV&V for Eligibility Implementation (Task 5)			\$ .9 m F \$ .6 m S	\$ .9 m F \$ .6 m S		
Operations vendor for legacy eligibility system during implementation (Task 5)			\$ .9 m F \$ .6 m S	\$ .9 m F \$ .6 m S		
Project Management Support for MMIS through Procurement (Tasks 6-8)				\$2.7 m F \$ .3 m S		
MMIS Vendor (Task 9)				\$9.0 m F \$1.0 m S	\$31.5 m F \$ 3.5 m S	\$31.5 m F \$ 3.5 m S
IV&V for MMIS Implementation (Task 9)				\$ .9 m F \$ .1 m S	\$1.8 m F \$ .2 m S	\$1.8 m F \$ .2 m S
Total Federal	\$ .8 m	\$ .72 m	\$9.3 m	\$21.9 m	\$33.3 m	\$33.3 m
Total State	\$ .5 m	\$ .48 m	\$6.2 m	\$7.6 m	\$3.7 m	\$3.7 m
Grand Total	\$1.3 m	\$1.2 m	\$15.5 m	\$29.5 m	\$37.0 m	\$37.0 m

\*Tasks 1-4: Contract awarded to FourThought Group for period 7/2/2007-6/30/2009

Costs listed other than for the existing contract are gross estimates. A cost benefit analysis and recommendations for the eligibility system are due to be completed under the FourThought contract by the end of April 2008, at which time more concrete expenditure estimates for SFY 2010 will be available.