

**Agency of Human Services  
Office of Vermont Health Access  
(OVHA)  
BUDGET DOCUMENT**

*The mission of OVHA is to:*

- *Assist beneficiaries in accessing clinically appropriate health services*
- *Administer Vermont's public health insurance system efficiently and effectively*
- *Collaborate with other health care system entities in bringing evidence-based practices to Vermont Medicaid beneficiaries*

**State Fiscal Year  
2006**

## Table of Contents

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### Sections

Section 1: Contact Information	3
Section 2: Fast Facts	4
Section 3: Program Descriptions and Fiscal History	5
Section 4: Global Commitment Approach	19
Section 5: Provider Savings	21
Section 6: Policy Savings Options	28
Section 7: Policy Savings Options Details	31

### Tables

Table 1: SFY '05 Appropriated to SFY '06 Budget w/o Changes	23
Table 2: Crosswalk – SFY '06 Budget w/o Changes to SFY '06 Budget – Governor's Recommend	24
Table 3: SFY '06 Budget – Governor's Recommend	25
Table 4: Summary of Expenditures SFY '05 – '06	26
Table 5: Enrollment Report - Programs with Premiums – Actual Data – Calendar Year '04	35
Table 6: Enrollment in Programs with Premiums by FPL with Counts – SFY '05 Projected	36
Table 7: Enrollment in Programs with Premiums/ESI by FPL with Counts – SFY '06 Projected	37
Table 8: Five-Year Projection of Revenue and Expenditures – Unabated	67
Table 9: Five-Year Projection of Revenue and Expenditures – Governor's Recommend	68
Table 10: Total Program Expenditures by State Fiscal Year	69
Table 11: Total Program Enrollment by State Fiscal Year	70
Table 12: Total Caseload and Percent Change by State Fiscal Year	71
Table 13: SFY '06 Governor's Recommend Program Expenditures by Enrollment Group	72
Table 14: SFY '06 Governor's Recommend by Enrollment Group	73
Table 15: Summary of Expenditures for Major Service Categories	74
Table 16: Summary of Inpatient Hospital Expenditures	75
Table 17: Summary of Outpatient Hospital Expenditures	76
Table 18: Summary of Pharmacy Expenditures	77
Table 19: Summary of Physician Expenditures	78

### Appendices

Appendix 1: Acronyms	79
Appendix 2: Medicaid Rule M103-Dated 7/1/99	81
Appendix 3: Federal Poverty Level (FPL) Guidelines – Monthly Household Income – Effective 1/1/05	82
Appendix 4: Medicare Modernization Act (MMA)	83
Appendix 5: Organization Chart	88

## Section 1: Contact Information

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## Section 2: Fast Facts

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- The Governor's recommend for SFY '06 is \$630,029,375
- State of Vermont's largest single programmatic expenditure
  - 11 Enrollment/Eligibility Groups ~ Aged, Blind and Disabled (ABD), Families, Ladies First, SCHIP, Underinsured Children, Caretakers, Vermont Health Access Plan (VHAP), VHAP-Pharmacy, VScript, VScript expanded, Healthy Vermonters
  - 7 Programs ~ Traditional Medicaid, Dr. Dynasaur, Vermont Health Access Plan (VHAP), VHAP-Pharmacy, VScript, VScript expanded, Healthy Vermonters
  - 59 Employees ~ see Appendix 5 for Organizational Chart
- Largest insurer in Vermont
  - 1st ~ Dollars spent
  - 2nd ~ Number of covered lives
- 145,000 covered lives in Vermont's publicly funded health insurance programs
- Pays some or all of the health care costs for 25% of Vermont's population
- 51,200 children receive their health care coverage through OVHA in Vermont
- 9,107 enrolled providers
- 9 million claims processed annually
- 95.4% of all claims received are processed and paid within two weeks; generally 98.8% of all claims are processed within 90 days
- Member services averages close to 20,000 calls a month, about 1,250 a day; calls are picked up by the automatic answerer within 25 seconds and by a live person within 2 minutes 97.6% of the time
- The health care industry is a nearly \$3.2 billion dollar industry in Vermont. Vermont Medicaid represents fully 20% of the spending in that system

### Section 3: Program Descriptions and Fiscal History

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The Office of Vermont Health Access (OVHA) provides medical assistance to 145,000 persons. Individuals are eligible under traditional Medicaid regulations and under a number of expanded programs listed below.

#### *Traditional Medicaid*

The *Traditional Medicaid* population includes those who are eligible under the Medicaid rules in Title XIX of the Social Security Act. This population includes: the Aged, Blind, and Disabled (ABD) enrollment/eligibility group; that is, those who are aged (age 65 or over) and those who are blind or have disabilities.

#### Aged, Blind and Disabled

Year	Caseload	Expenditures
SFY '04 Actual	23,083	145,321,331
SFY '05 Projected	23,728	166,904,824
SFY '06 w/o Changes	24,305	181,780,644
SFY '06 Gov. Rec.	24,305	168,920,791

The *Families* population includes the Reach Up financial assistance related group: children, their parents or caretaker relatives, and pregnant women.

#### Families

Year	Caseload	Expenditures
SFY '04 Actual	67,690	126,008,998
SFY '05 Projected	68,565	144,627,218
SFY '06 w/o Changes	69,611	151,209,305
SFY '06 Gov. Rec.	68,435	138,650,944

Aged, Blind, and Disabled and Families groups can include people who are “medically needy” according to Medicaid rules (they meet other criteria but must also spend a portion of their income or resources on health care to become eligible). All Medicaid individuals must meet certain eligibility tests, such as income and resources. Unless individuals meet certain exemption criteria (see Appendix 2), they must enroll in Primary Care Plus, the state's primary care case management program, as their benefit delivery system.

The *Ladies First* program is for women under age 65 who have been diagnosed with breast or cervical cancer through the national screening program, are uninsured, and otherwise not eligible for Medicaid.

#### Ladies First

Year	Caseload	Expenditures
SFY '04 Actual	40	516,741
SFY '05 Projected	67	1,221,751
SFY '06 w/o Changes	68	1,000,690
SFY '06 Gov. Rec.	68	925,907

### Section 3: Program Descriptions and Fiscal History

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#### *Dr. Dynasaur*

The *Dr. Dynasaur* program provides health care for children under age 18 not eligible for traditional Medicaid with incomes up to 300% of the Federal Poverty Level (FPL) and for pregnant women with incomes up to 200% of the FPL.

The *State Children's Health Insurance Program* (SCHIP) is for uninsured children who are eligible under the SCHIP eligibility rules in Title XXI of the Social Security Act.

#### SCHIP

Year	Caseload	Expenditures
SFY '04 Actual	2,924	3,607,885
SFY '05 Projected	3,077	3,865,572
SFY '06 w/o Changes	3,165	4,284,028
SFY '06 Gov. Rec.	2,997	2,932,532

*Underinsured* children are those eligible for Medicaid through an 1115 waiver to Title XIX.

#### Underinsured

Year	Caseload	Expenditures
SFY '04 Actual	1,842	1,141,586
SFY '05 Projected	1,944	1,263,791
SFY '06 w/o Changes	2,191	1,533,691
SFY '06 Gov. Rec.	1,774	1,125,031

Individuals may qualify for *Dr. Dynasaur* even if they work or have other health insurance. Members may have to pay a premium. Unless individuals meet certain exemption criteria (see Appendix 2), they must enroll in Primary Care Plus as their benefit delivery system.

#### *Vermont Health Access Plan (VHAP)*

The *VHAP* program was designed as part of an 1115 waiver to Title XIX of the Social Security Act to provide health care coverage for adults who would otherwise be uninsured or underinsured. This population includes:

- VHAP adults with incomes up to 150% of the FPL and
- Caretakers who are parents and/or caretaker relatives with incomes from 150% up to 185% of the FPL.

#### Caretakers

Year	Caseload	Expenditures
SFY '04 Actual	2,590	3,941,420
SFY '05 Projected	2,458	5,125,017
SFY '06 w/o Changes	2,554	5,692,810
SFY '06 Gov. Rec.	0	0

### Section 3: Program Descriptions and Fiscal History

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Members may have to pay a premium, and co-payments are required for some services. Members are to enroll in a managed health care plan, which is currently the state's primary care case management program, Primary Care Plus.

#### VHAP

Year	Caseload	Expenditures
SFY '04 Actual	21,739	55,500,942
SFY '05 Projected	22,127	60,686,924
SFY '06 w/o Changes	22,733	64,375,080
SFY '06 Gov. Rec.	21,250	52,317,223

#### ***VHAP-Pharmacy***

The *VHAP-Pharmacy* program, also part of the 1115 waiver to Title XIX of the Social Security Act, covers medications for low-income individuals (up to 150% of the FPL) who are Medicare eligible or receive social security disability payments. Beneficiaries pay a monthly premium of \$13.00 and have no co-payments or deductibles.

#### VHAP-Pharmacy

Year	Caseload	Expenditures
SFY '04 Actual	8,424	16,221,334
SFY '05 Projected	8,646	20,620,792
SFY '06 w/o Changes	8,818	23,381,440
SFY '06 Gov. Rec.	8,818	21,527,839

#### ***VScript***

The *VScript* program covers only maintenance drugs for low-income individuals (up to 175% of the FPL) who are Medicare eligible or receive social security disability payments and are not eligible for *VHAP-Pharmacy*. Beneficiaries pay a monthly premium of \$17.00 and have no co-payments or deductibles.

#### VScript

Year	Caseload	Expenditures
SFY '04 Actual	2,949	5,579,045
SFY '05 Projected	2,795	6,052,926
SFY '06 w/o Changes	2,847	7,117,717
SFY '06 Gov. Rec.	2,847	6,517,014

#### ***VScript expanded***

The *VScript expanded* program covers only maintenance drugs for low-income individuals (up to 225% of the FPL) who are Medicare eligible or receive social security disability payments and

**Section 3: Program Descriptions and Fiscal History**

are not eligible for VHAP-Pharmacy. Beneficiaries pay a monthly premium of \$35.00 and have no co-payments or deductibles.

VScript expanded

Year	Caseload	Expenditures
SFY '04 Actual	2,860	2,891,798
SFY '05 Projected	2,641	5,719,467
SFY '06 w/o Changes	2,695	6,737,716
SFY '06 Gov. Rec.	2,695	6,131,914

***Healthy Vermonters***

The *Healthy Vermonters* program allows beneficiaries to obtain their prescriptions at the Medicaid rate. Medicare beneficiaries (or those receiving social security disability benefits) up to 400% of the FPL and all others up to 300% of the FPL are eligible.

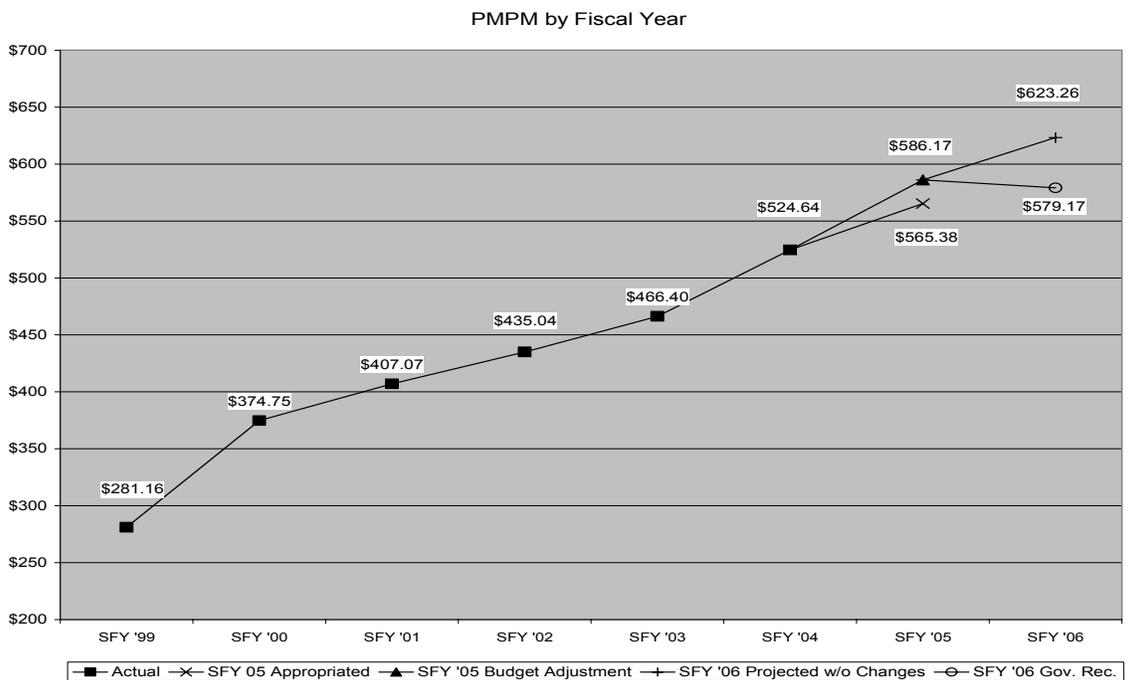
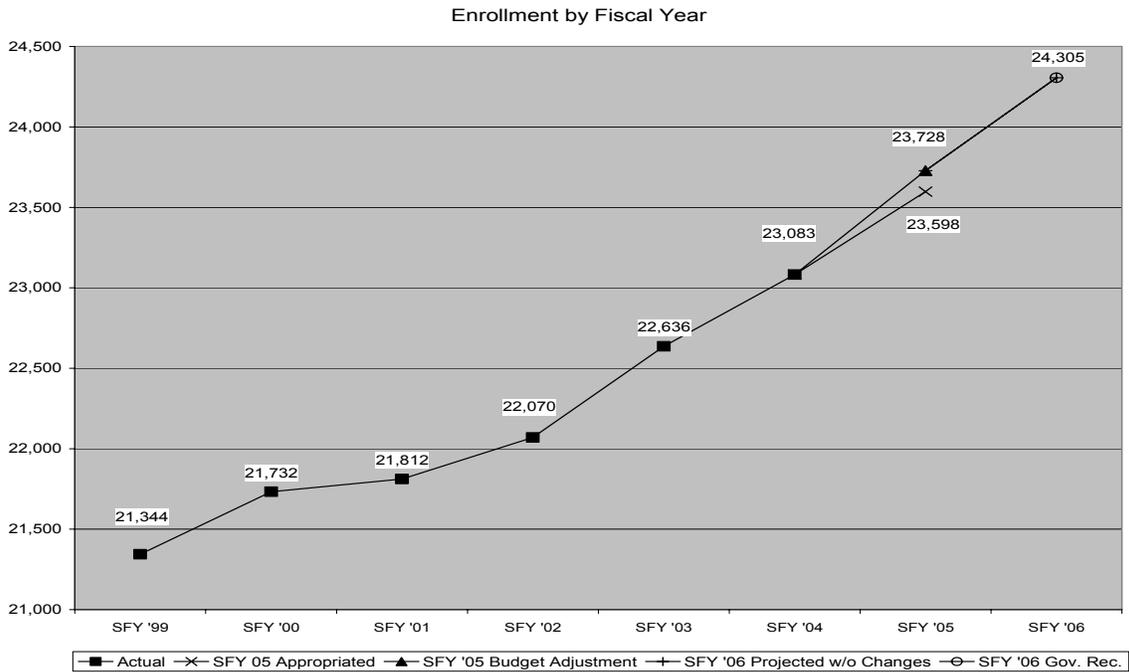
Healthy Vermonters

Year	Caseload	Expenditures
SFY '04 Actual	11,159	0
SFY '05 Projected	11,321	0
SFY '06 w/o Changes	11,355	0
SFY '06 Gov. Rec.	11,355	0

### Section 3: Program Descriptions and Fiscal History

The graphics on the following pages summarize program expenditures and enrollment for State Fiscal Years 1999-2006. The *Ladies First* table summarizes program expenditures and enrollment for State Fiscal Years 2002-2006 as the program was instituted in SFY '02.

*Summary of Enrollment and Per Member Per Month (PMPM): State Fiscal Years 1999 – 2006 Aged, Blind & Disabled*

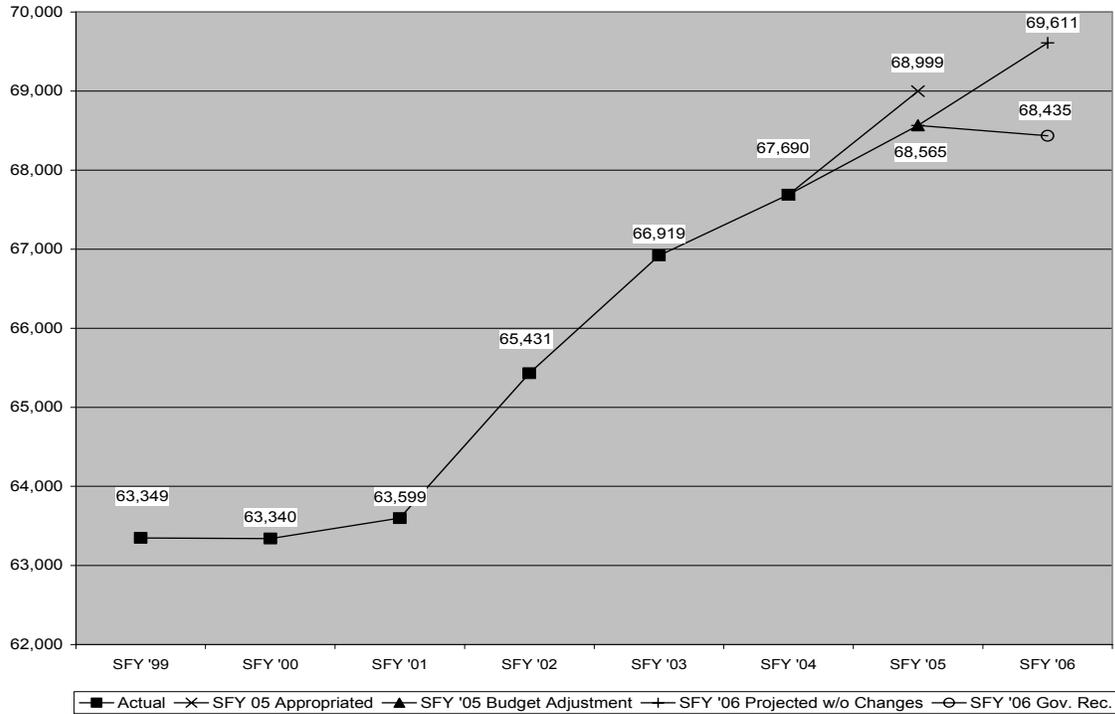


### Section 3: Program Descriptions and Fiscal History

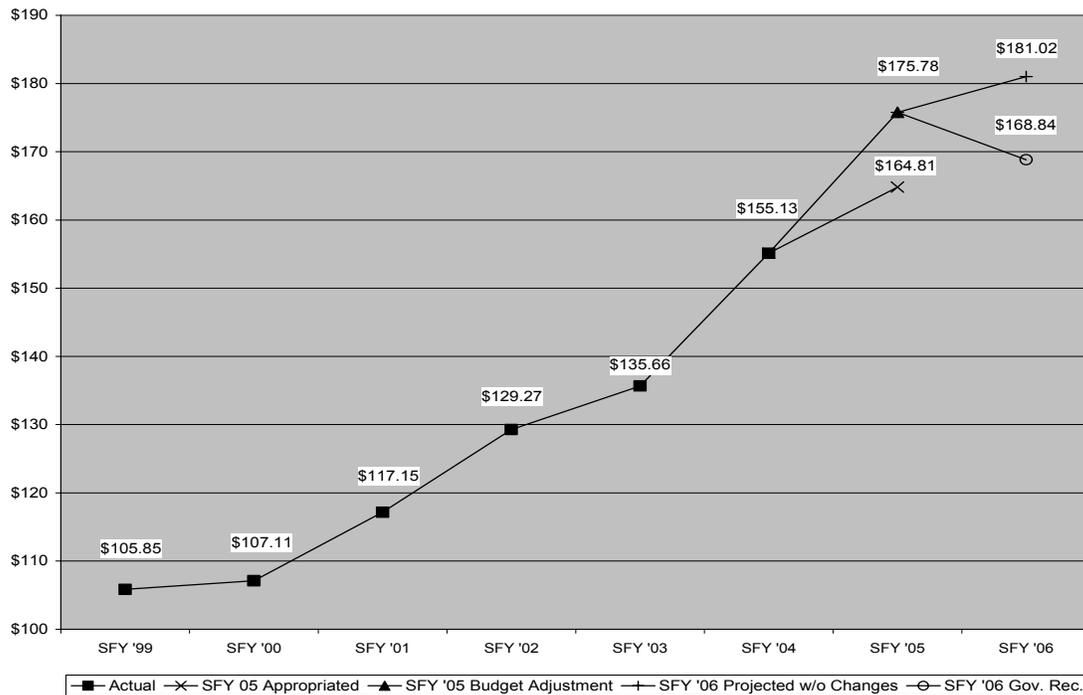
Summary of Enrollment and Per Member Per Month (PMPM): State Fiscal Years 1999 – 2006

#### Families

Enrollment by Fiscal Year



PMPM by Fiscal Year

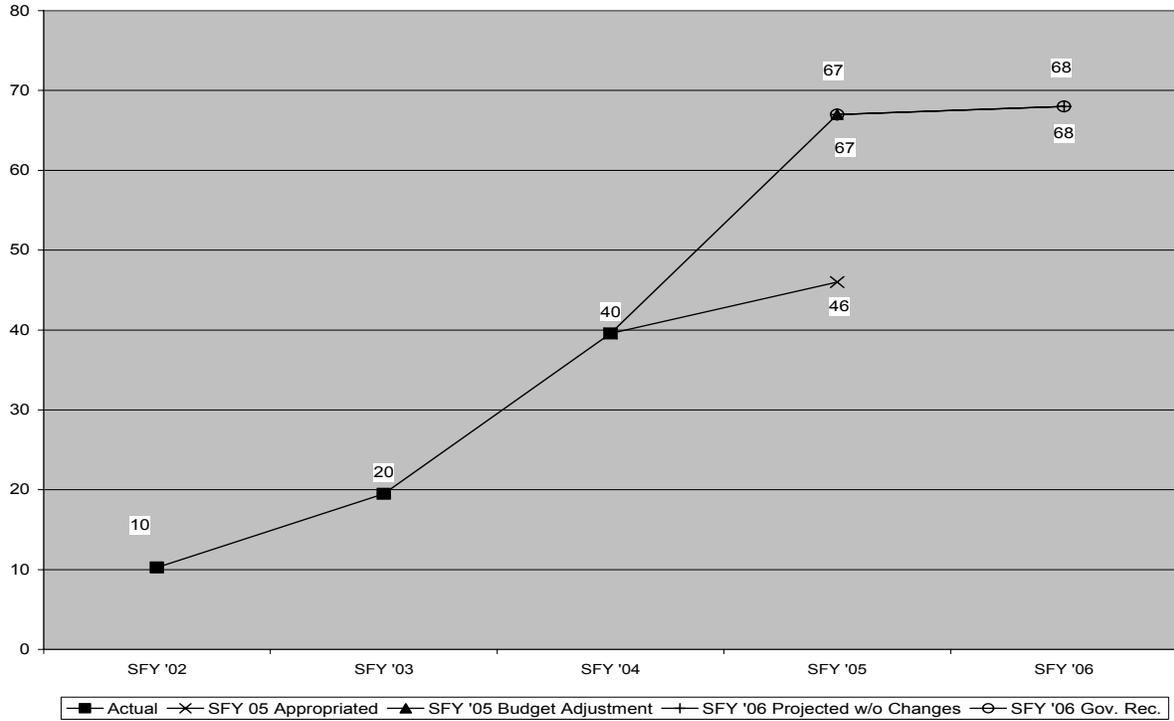


### Section 3: Program Descriptions and Fiscal History

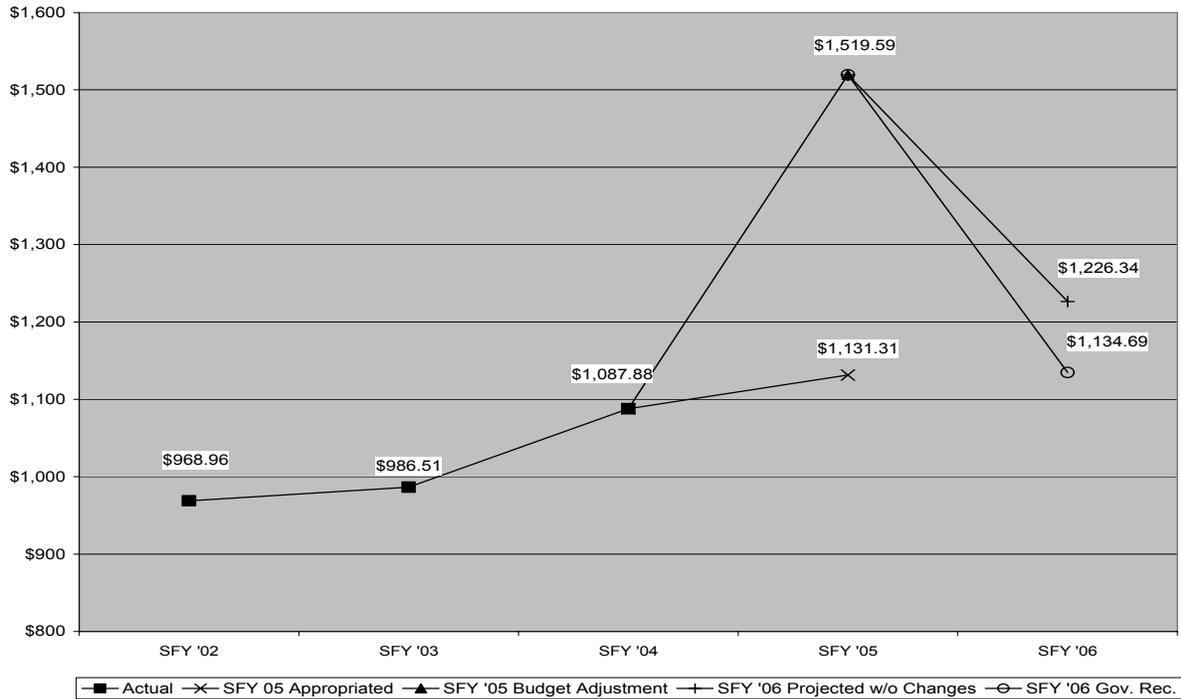
Summary of Enrollment and Per Member Per Month (PMPM): State Fiscal Years 1999 – 2006

#### Ladies First

Enrollment by Fiscal Year



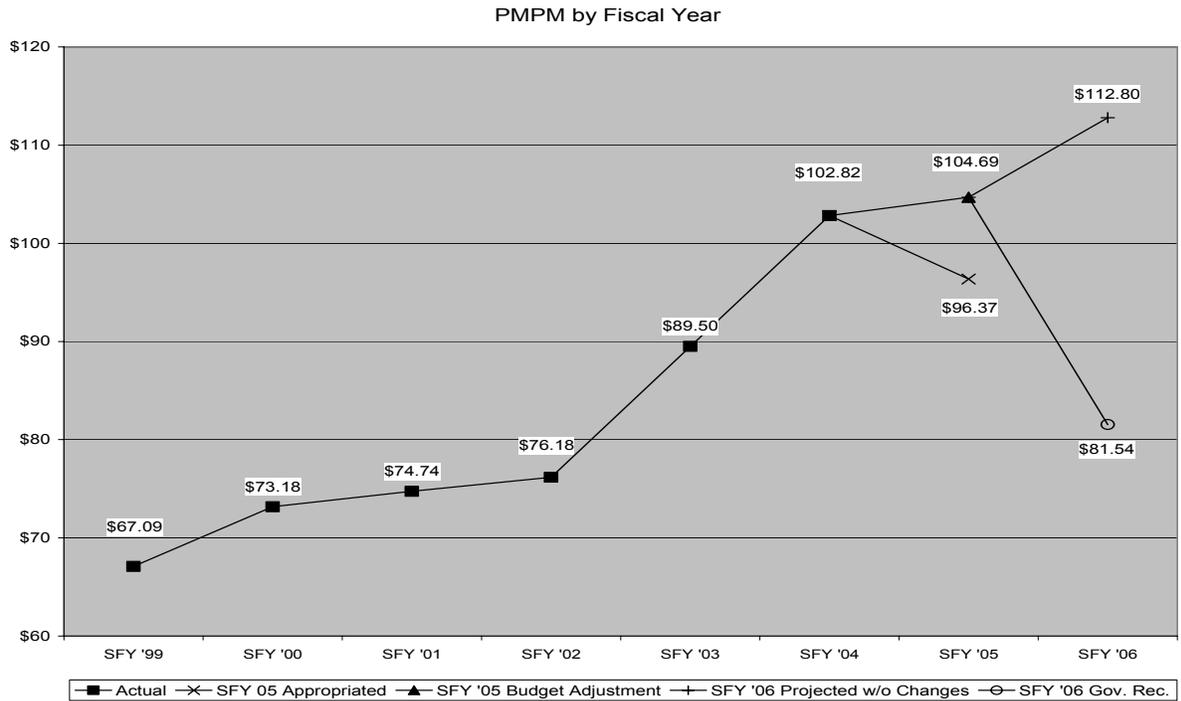
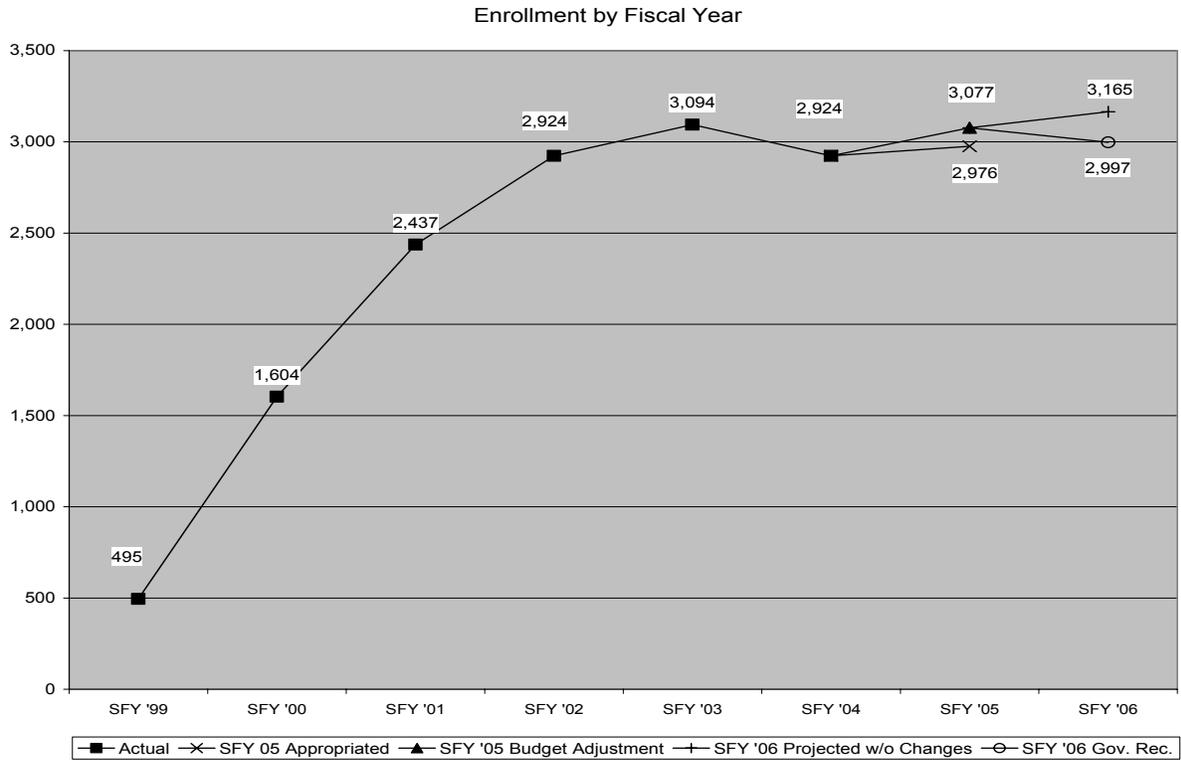
PMPM by Fiscal Year



### Section 3: Program Descriptions and Fiscal History

Summary of Enrollment and Per Member Per Month (PMPM): State Fiscal Years 1999 – 2006

#### SCHIP – State Children’s Health Insurance Program

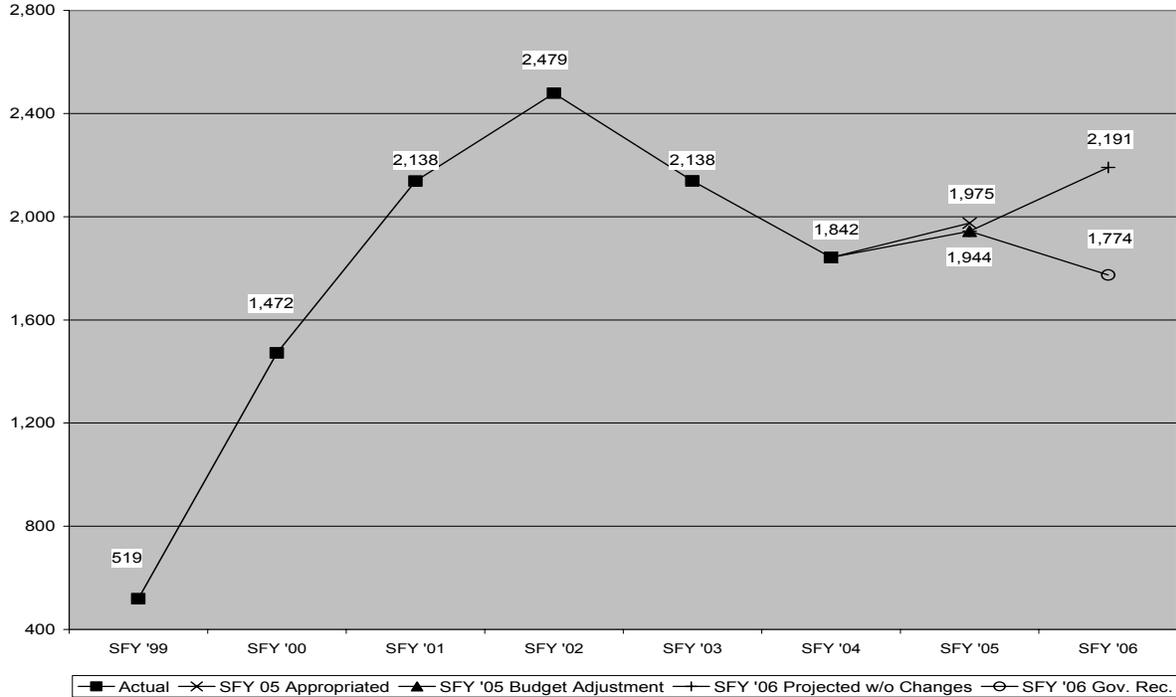


### Section 3: Program Descriptions and Fiscal History

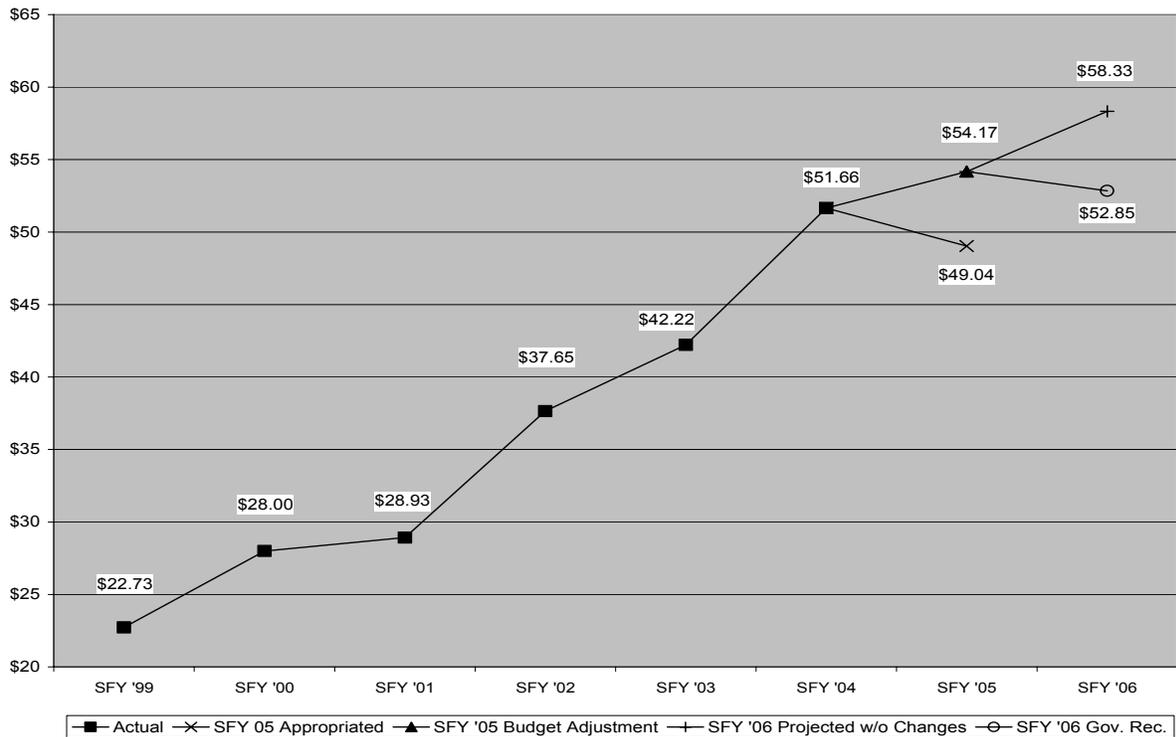
#### Summary of Enrollment and Per Member Per Month (PMPM): State Fiscal Years 1999 – 2006

##### Underinsured Children

Enrollment by Fiscal Year



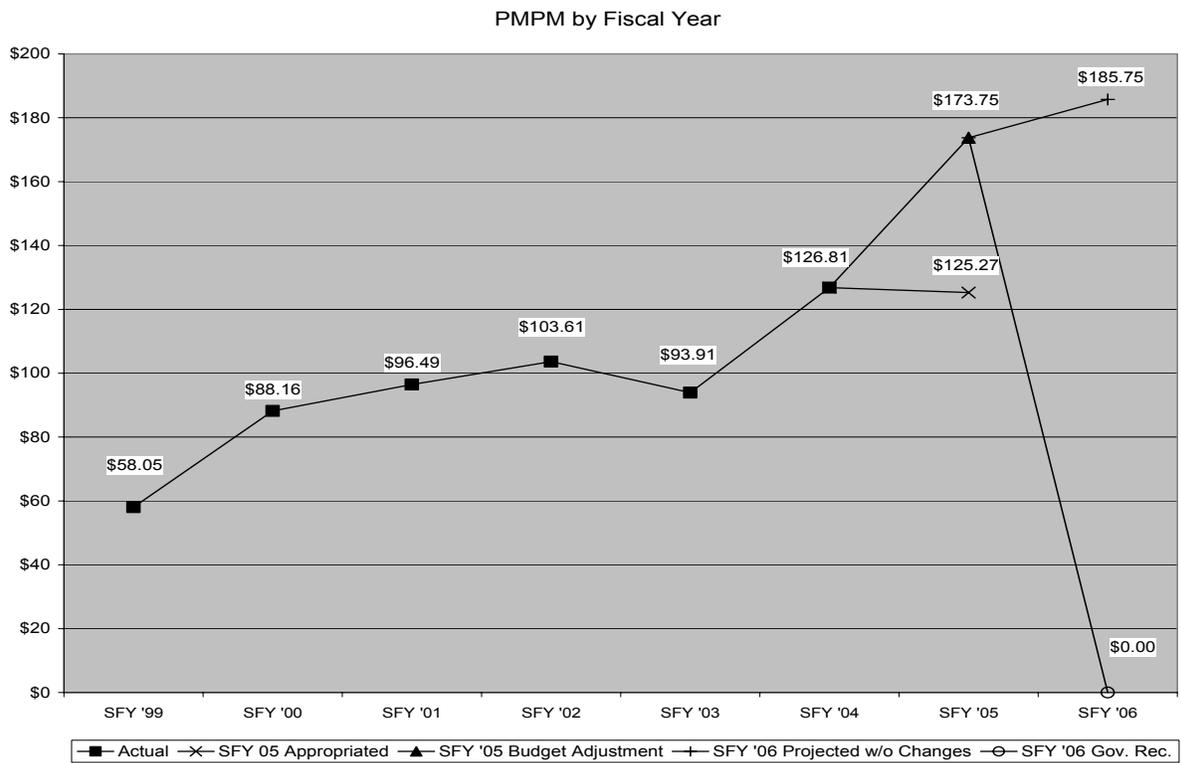
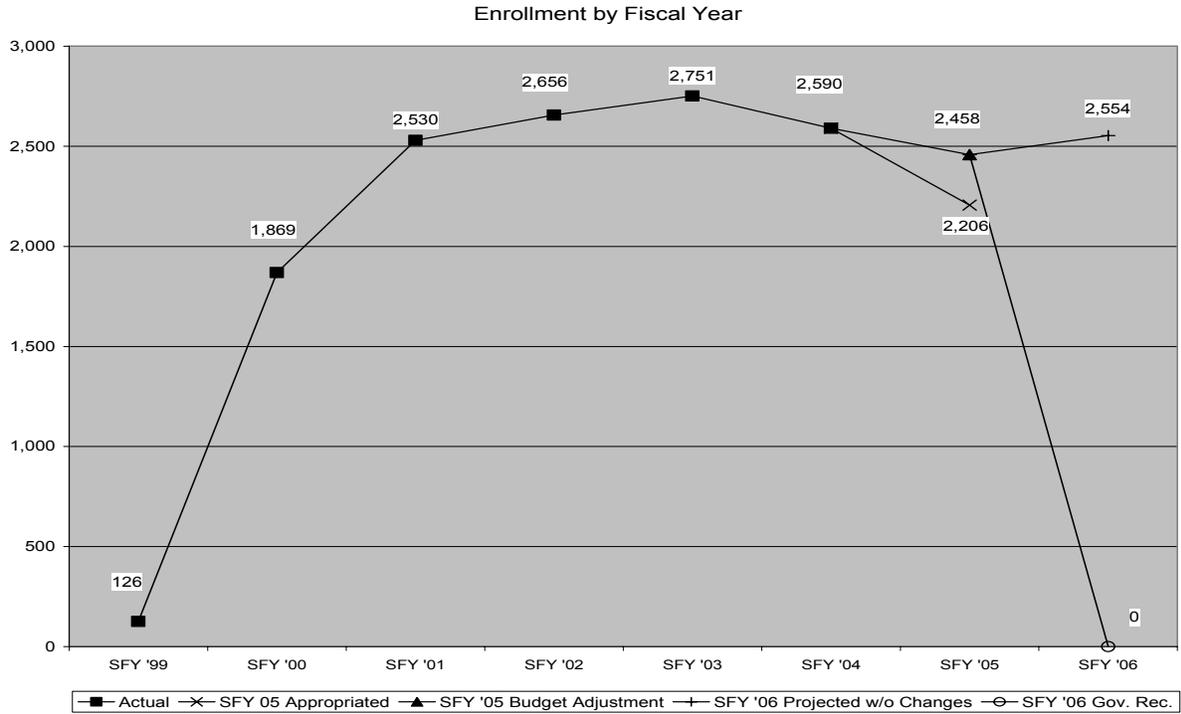
PMPM by Fiscal Year



### Section 3: Program Descriptions and Fiscal History

Summary of Enrollment and Per Member Per Month (PMPM): State Fiscal Years 1999 – 2006

#### Caretakers

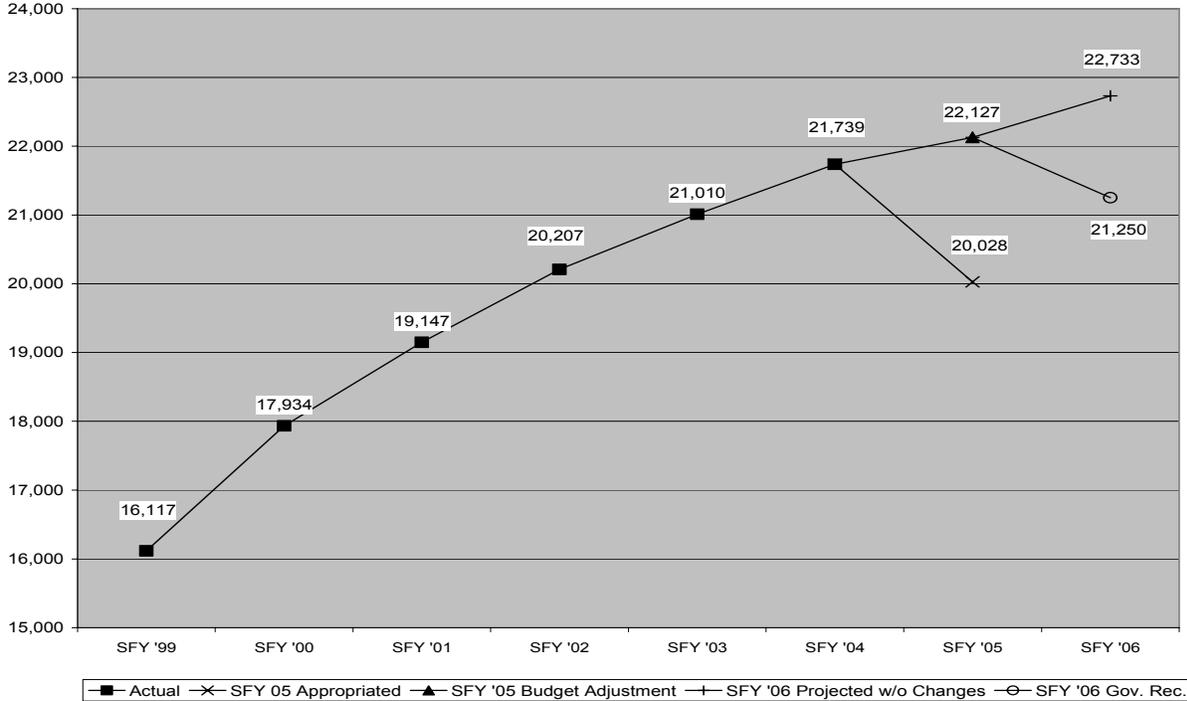


### Section 3: Program Descriptions and Fiscal History

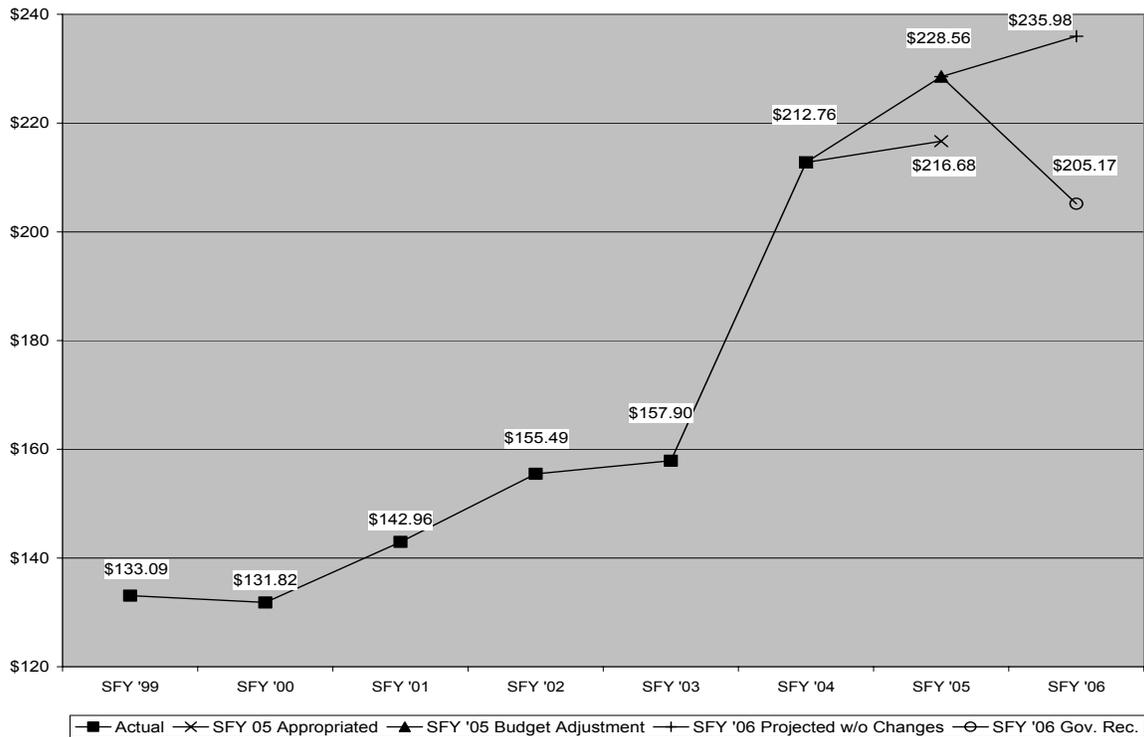
Summary of Enrollment and Per Member Per Month (PMPM): State Fiscal Years 1999 – 2006

#### VHAP

Enrollment by Fiscal Year



PMPM by Fiscal Year

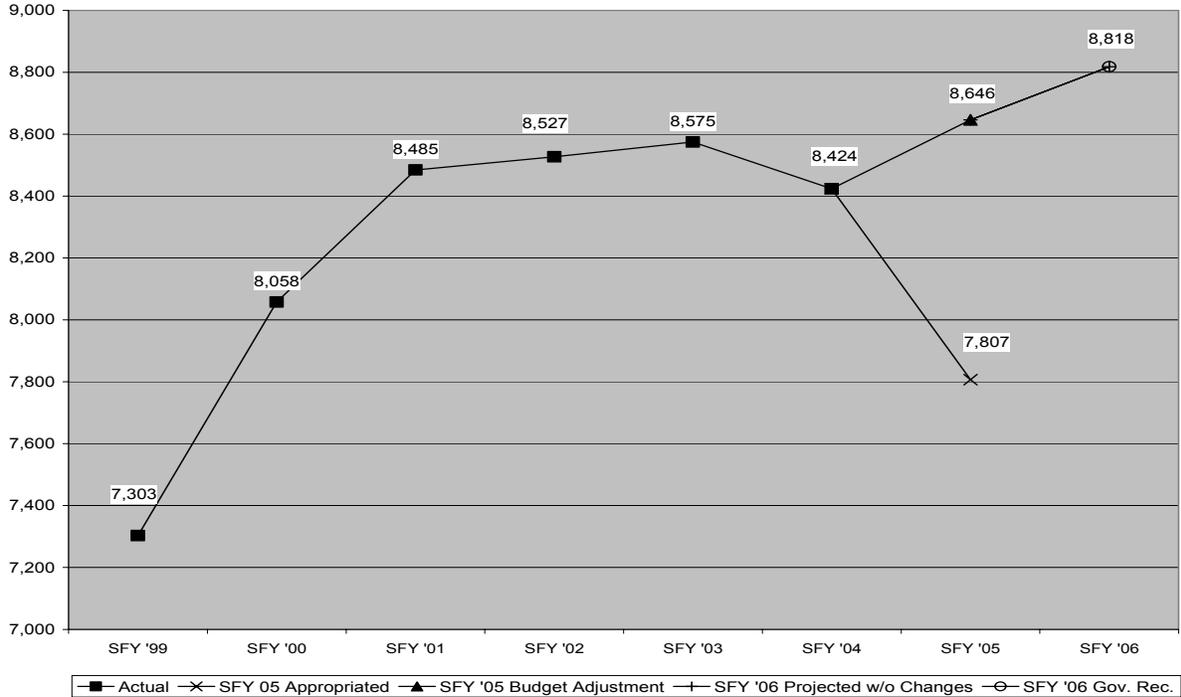


### Section 3: Program Descriptions and Fiscal History

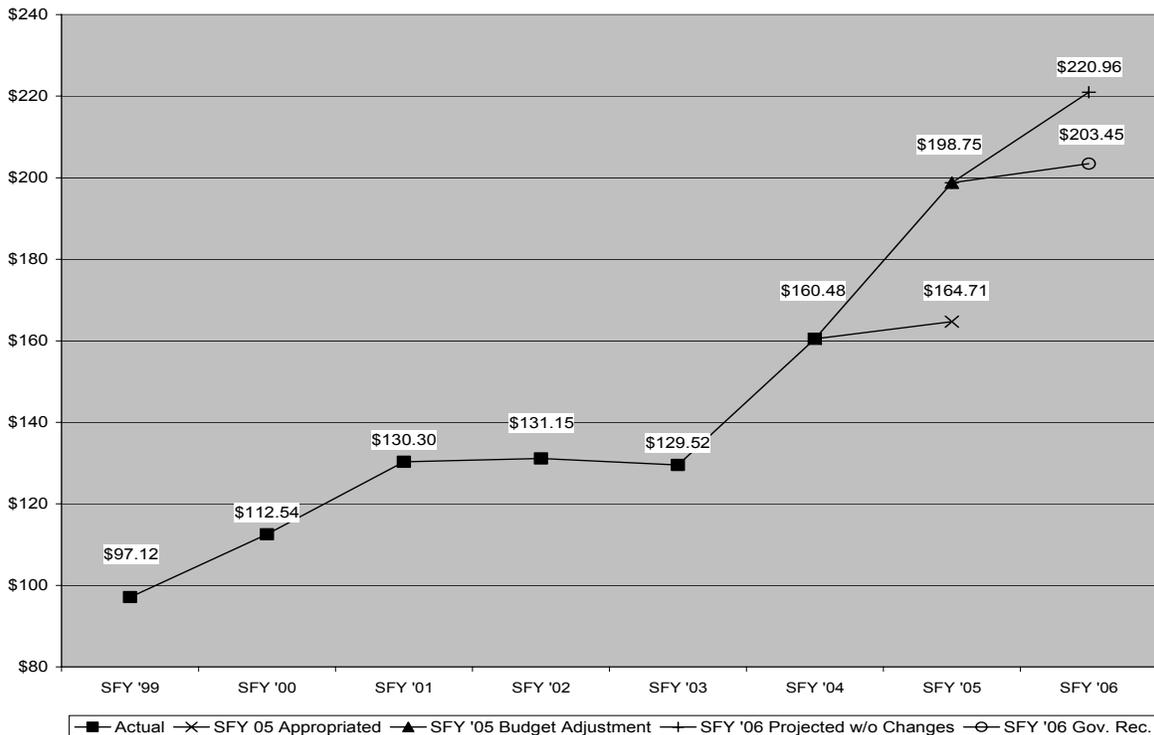
Summary of Enrollment and Per Member Per Month (PMPM): State Fiscal Years 1999 – 2006

#### VHAP Pharmacy

Enrollment by Fiscal Year



PMPM by Fiscal Year

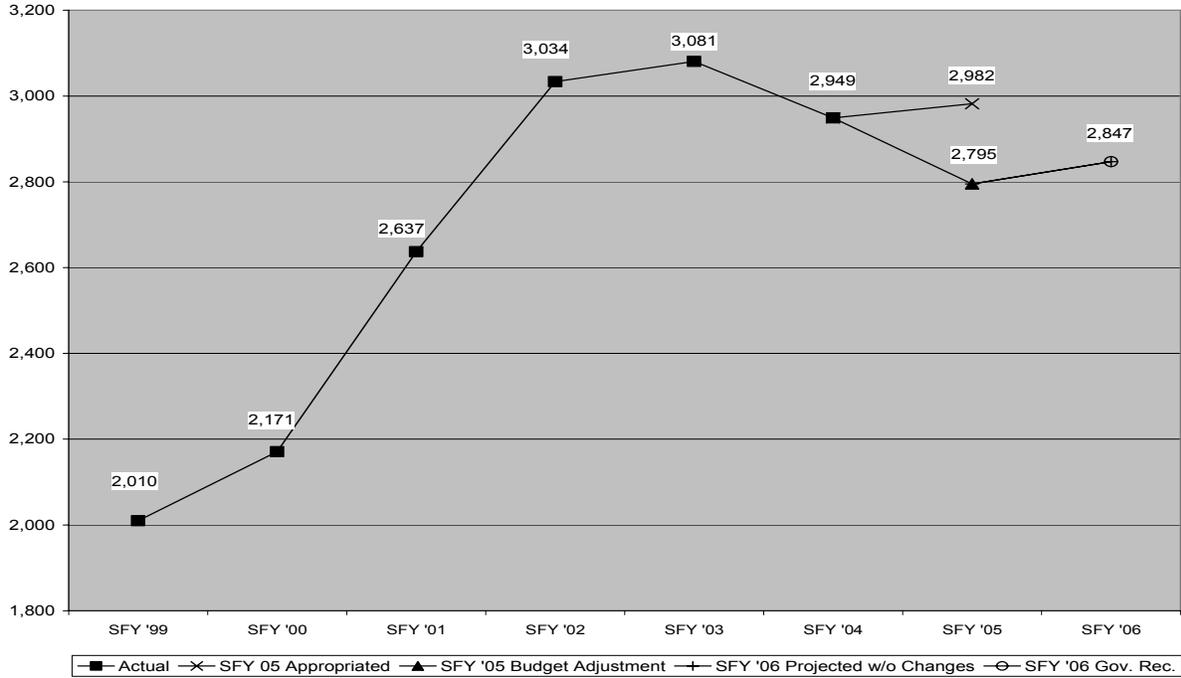


### Section 3: Program Descriptions and Fiscal History

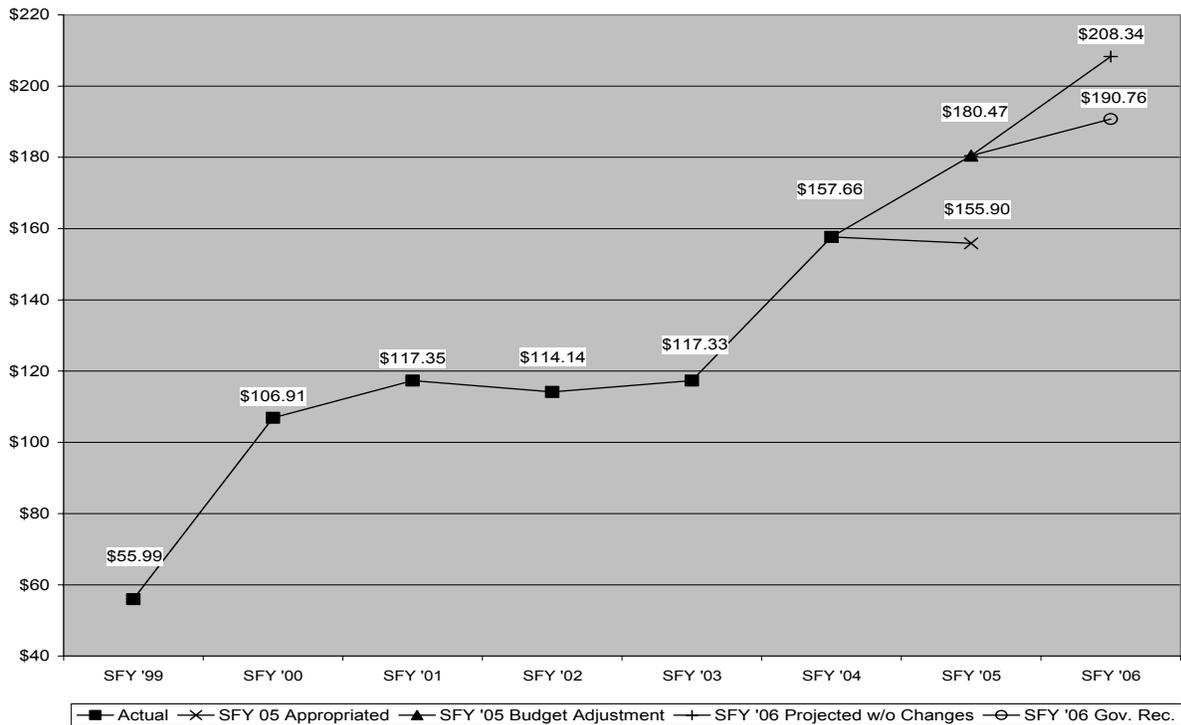
Summary of Enrollment and Per Member Per Month (PMPM): State Fiscal Years 1999 – 2006

#### VScript

Enrollment by Fiscal Year



PMPM by Fiscal Year

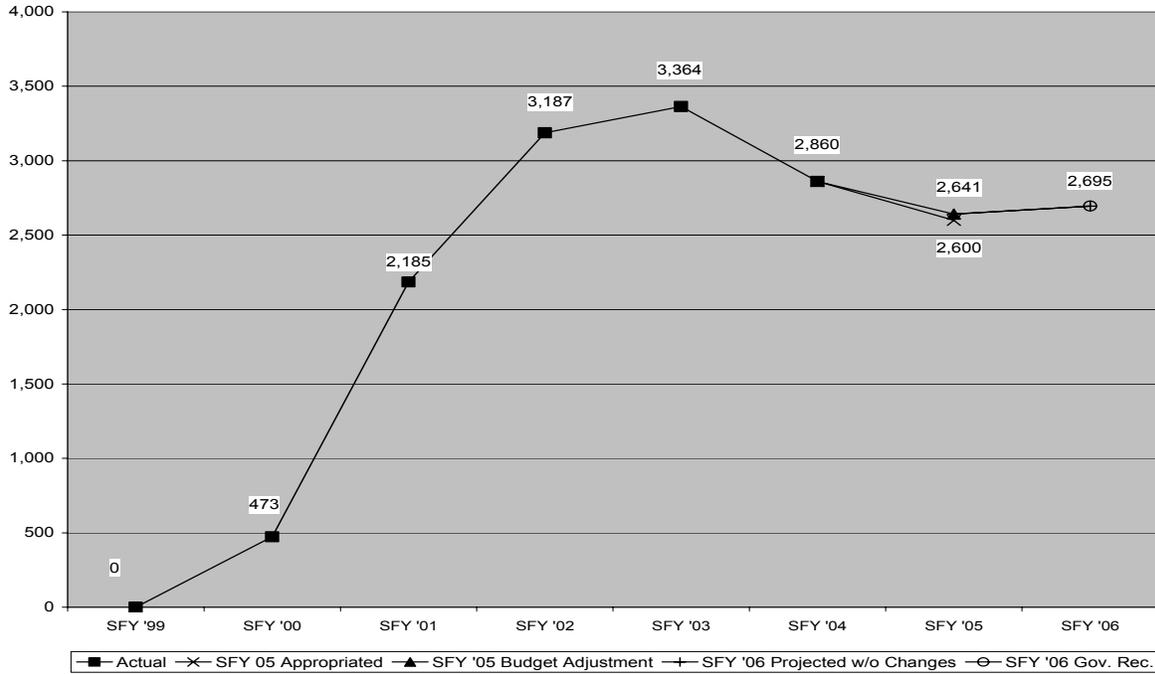


### Section 3: Program Descriptions and Fiscal History

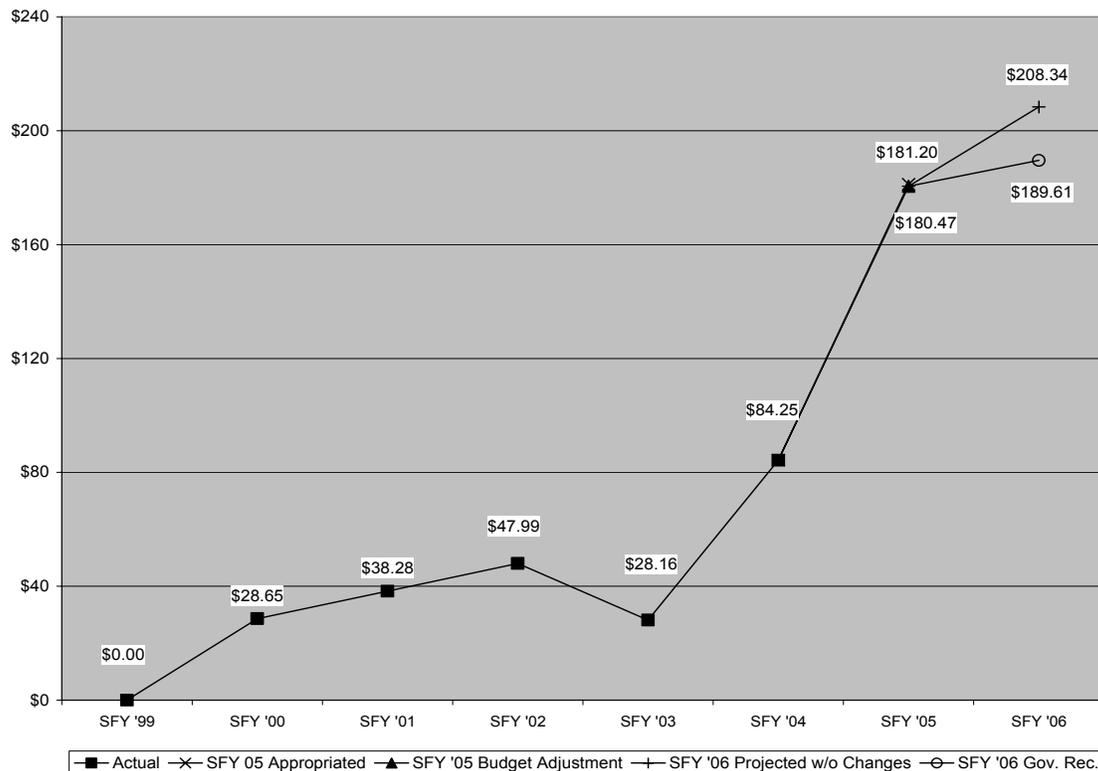
Summary of Enrollment and Per Member Per Month (PMPM): State Fiscal Years 1999 – 2006

#### VScript Expanded

Enrollment by Fiscal Year



PMPM by Fiscal Year



## **Section 4: Global Commitment Approach**

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Medicaid is a federal program, funded primarily with federal dollars, but with a contribution of approximately 40% from the state. The program is governed under a vast and complex set of federal regulations, all of which are administered by state government. Vermont has been creative and aggressive in “drawing down” federal Medicaid funds to pay for a wide array of services. As such, from the federal point of view, Vermont is a disproportionately expensive Medicaid partner.

In recent years, the federal Medicaid expenditure in Vermont has grown at an average annual rate of 13%. In a similar time period, total Medicaid expenditures (which include substantial expenditures outside the Health Access Trust Fund) have grown between 10% and 11%. We must reduce both of these growth rates. Accordingly, the core elements of the Global Commitment are:

- The state and federal government enter a five-year agreement;
- The federal government commits to an acceptable, annual funding growth rate that is less than its growth rate in recent years;
- The state commits to controlling the cost growth of the Medicaid program to less than the federal trend rate commitment;
- The federal government allows Vermont to operate the Medicaid program with much more flexibility to innovate.

Under this framework, the federal government will achieve savings and cost predictability. Vermont will achieve fiscal predictability and make substantial progress in bringing a crushing Medicaid deficit under control. In addition, Vermont will have more ability to innovate with the health delivery system. This is, potentially, a classic “win-win” situation.

Strategic Theory: The belief that an appropriate Global Commitment can be achieved is based on several core concepts:

- First, the concept needs to work for both parties.
- Second, the federal government seems eager to have a state join in a partnership of this type, to prove the efficacy of the concept.
- Third, Vermont is an ideal partner for the federal government because we are small and have credibility as a humane provider of services.

Timetable: In order to meet the fiscal goals envisioned for SFY '06, and in order to provide the plan in time for full legislative consideration, the negotiations with the Center for Medicare and Medicaid Services (CMS) must be substantially complete by March 31, 2005. This is a very aggressive, but essential, timetable.

### Other Considerations

Program Flexibility: The Global Commitment would offer the flexibility to move quickly on health strategies. Possible examples include:

## Section 4: Global Commitment Approach

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- For 18 months, we have been negotiating a long-term care 1115 waiver, to equalize the Medicaid entitlement between home health and nursing home services. Going forward, we would not need to engage in these excruciatingly slow, detailed negotiations to accomplish a sensible, cost-effective change.
- We could strategically engage in chronic disease management to reduce future demand for expensive care.
- We could use funds to be more innovative in coordinating mental and physical health, and substance abuse services.
- We could fund premium subsidies to encourage VHAP participants (i.e., non-traditional, employed Medicaid recipients) and uninsured Vermonters up to 300% of poverty, to buy into private employer plans.
- We could fund employer health plan incentives.
- We could potentially use employer premiums for Medicaid matching funds.
- We could potentially offer “healthy choice” discounts or incentives within the Medicaid program.

Necessary Protections: Any Global Commitment would need to include protections such as:

- Vermont would share in any special arrangement that might be enacted in the future to assist the states.
- Vermont would require a “*force majeure*” clause for relief in the event of a medical catastrophe.

## Section 5: Provider Savings

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The Governor has asked provider groups to bring their expertise and experience to the table and join with the state in achieving a \$21 million savings in Medicaid provider expenses. These reductions must be made without adding to the insurance burden of other insured Vermonters through the “cost shift.” While these cost reductions must be made in SFY '06, there may be more effective ways to achieve savings than spreading these reductions proportionally across all provider groups. The Governor will engage providers in exploring more creative approaches to achieve these savings, such as global budgeting with physician hospital organizations, aligning payment incentives, and/or redesign of the delivery system.

Potential mechanisms for realizing savings could also include, but are not limited to:

- Rebalancing the system using methods employed by many health plans and Medicare as a basis of determining reimbursement, thereby creating a more equitable payment structure across various types of providers.
- Adopting an inpatient case rate that more closely reflects resource utilization, and shifting away from a system of inpatient reimbursement that does not encourage efficiencies and does not take into account resource utilization.
- Shifting to fee schedules or case rates from cost-based rates of reimbursement for outpatient services.
- Prior authorization for high-cost care, where potential for savings exist (e.g., MRIs, extended treatment plans for home health care, etc.)
- Group visits
- Phone/email consults

Every Vermonter needs to assume greater responsibility for managing their care, becoming a knowledgeable and smart consumer of health services, and using the formal health care system only when it is necessary.

At present, nearly 50% of all emergency room visits for children are made by Medicaid beneficiaries. People often go to the emergency room because care in another setting would cause them to miss work, they may not have transportation available to them when that care is available, or the other setting does not have any available appointments. By default, the emergency room becomes an expensive walk-in clinic for after-hours care. An attempt will be made to identify alternative care settings to provide beneficiaries a place to be treated after hours and to ensure appropriate care is available when needed.

A growing area of research in the commercial sector is patient education. Studies have shown that patients often do not understand instructions from their provider, resulting in additional care that may have been preventable. A major component of the Vermont Blueprint for Health's Chronic Care Model will be the engagement of patients and families so they can become more informed and active health care managers. All Vermonters benefit from having a tool set available to manage their care and to make informed decisions as to when and where to seek care.

## **Section 5: Provider Savings**

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By working together with providers and health plans in the state, Vermont can create a more integrated system of care which improves quality, slows the rate of cost increases and avoids drastic ongoing cuts.

**Table 1: SFY '05 Appropriated to SFY '06 Budget w/o Changes**

	Office of Vermont Health Access SFY '06 Budget Proposal ~ Without Changes								Total
	General	Special	Tobacco	Transportation	Inter'd Transfers	Internal Service	Permanent Trust	Federal	
<b>Office of Vermont Health Access Appropriation</b>	<b>1,166,438</b>	<b>227,957,547</b>						<b>356,258,604</b>	<b>585,382,589</b>
<b>Personal Services:</b>									
Shift from GF to SF	(1,166,438)	1,166,438						0	0
Pay Act	0	46,894						67,204	114,098
Other Benefits		9,943						14,250	24,193
Vacancy Savings	0	261,481						636,960	898,441
Third Party Personal Services		55,610						79,001	134,611
<b>Total Personal Services</b>	<b>(1,166,438)</b>	<b>1,540,367</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>797,414</b>	<b>1,171,343</b>
<b>Operating Expenses:</b>									
Vision Charge	0	83,698						83,698	167,395
Communications - DII Charge	0	999						999	1,998
Quality	0	2,764,063						831,937	3,596,000
<b>Total Operating Expenses</b>	<b>0</b>	<b>2,848,760</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>916,634</b>	<b>3,765,393</b>
<b>Grants:</b>									
<b>Caseload:</b>									
ABD (23,598 to 24,305 @ \$623.26 PMPM) ~ Δ 707		2,173,269						3,114,488	5,287,757
Families (68,999 to 69,611 @ \$181.02 PMPM) ~ Δ 612		546,379						783,010	1,329,389
Ladies First (46 to 68 @ \$1,226.34) ~ Δ 22		133,062						190,690	323,753
SCHIP (2,976 to 3,165 @ \$112.80) ~ Δ 189		105,143						150,690	255,823
Underinsured Children (1,975 to 2,191 @ \$58.33) ~ Δ 216		62,143						89,056	151,199
Caretakers (2,206 to 2,554 @ \$185.75) ~ Δ 348		318,806						456,878	775,684
VHAP (20,028 to 22,733 @ \$235.98) ~ Δ 2,705		3,148,257						4,511,735	7,659,992
VHAP-Pharmacy (7,807 to 8,818 @ \$209.15) ~ Δ 1,011		1,101,778						1,578,947	2,680,725
VScript (2,982 to 2,847 @ \$208.34) ~ Δ (135)		(138,717)						(198,794)	(337,510)
VScript expanded (2,600 to 2,695 @ \$208.34) ~ Δ 95		237,508							237,508
<b>Total Caseload Pressures</b>	<b>0</b>	<b>7,687,628</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>10,676,692</b>	<b>18,364,320</b>
<b>Utilization/Cost:</b>									
ABD (\$565.38 to \$623.26 PMPM) ~ Δ \$57.88		6,736,749						9,654,368	16,391,118
Families (\$164.81 to \$181.02 PMPM) ~ Δ \$16.21		5,514,416						7,902,655	13,417,071
Ladies First (\$ 1,131.31 to \$1,226.34 PMPM) ~ Δ \$95.03		21,560						30,897	52,457
SCHIP (\$ 96.37 to \$112.80 PMPM) ~ Δ \$16.43		241,149						345,588	586,737
Underinsured Children (\$49.04 to \$58.33 PMPM) ~ Δ \$9.29		90,538						129,749	220,287
Caretakers (\$125.27 to \$185.75 PMPM) ~ Δ \$60.48		657,972						942,933	1,600,906
VHAP (\$216.68 to \$235.98 PMPM) ~ Δ \$19.30		1,906,942						2,732,819	4,639,761
VHAP-Pharmacy (\$ 164.71 to \$ 209.15 PMPM) ~ Δ \$44.44		2,165,878						3,103,898	5,269,775
VScript (\$155.90 to \$208.34 PMPM) ~ Δ \$52.44		771,308						1,105,354	1,876,661
VScript expanded (\$181.20 to \$208.34) ~ Δ 27.14		846,651							846,651
<b>Total Utilization/Cost Pressures</b>	<b>0</b>	<b>18,953,163</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>25,948,261</b>	<b>44,901,424</b>
<b>Other Program Cost:</b>									
DSH		290,596						416,451	707,047
Rate Setting		22,980						22,980	45,960
Lund Home Family Center		10,273						14,723	24,996
Buy-In		798,549						1,144,392	1,942,941
<b>Total Other Program Cost:</b>	<b>0</b>	<b>1,122,398</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1,598,546</b>	<b>2,720,944</b>
<b>Long-Term Care:</b>									
Long-Term Care Increases:		4,567,781						6,546,045	11,113,826
<b>Total Long Term Care:</b>	<b>0</b>	<b>4,567,781</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>6,546,045</b>	<b>11,113,826</b>
<b>Revenue Changes:</b>									
Special Funds Adjustment	0	4,041,523						(4,041,523)	0
Decrease in Federal Match Rate	0	8,489,829						(8,489,829)	0
<b>Total Revenue Changes:</b>	<b>0</b>	<b>12,531,352</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(12,531,352)</b>	<b>0</b>
<b>Sub-total</b>	<b>(1,166,438)</b>	<b>49,251,449</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>33,952,239</b>	<b>82,037,250</b>
State Fiscal Year '06 - Office of Vermont Health Access Appropriation Request	0	277,208,996	0	0	0	0	0	390,210,843	667,419,839
<b>Total OVHA Base SFY '05 Appropriation</b>	<b>1,166,438</b>	<b>227,957,547</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>356,258,604</b>	<b>585,382,589</b>
<b>Total OVHA Increase/Decrease</b>	<b>(1,166,438)</b>	<b>49,251,449</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>33,952,239</b>	<b>82,037,250</b>
State Fiscal Year '06 - Office of Vermont Health Access Budget Proposal Without Changes	0	277,208,996	0	0	0	0	0	390,210,843	667,419,839

**Table 2: Crosswalk - SFY '06 Budget w/o Changes to SFY '06 Budget - Governor's Recommend**

State Fiscal Year '06 ~ Office of Vermont Health Access Budget Proposal Without Changes	0	277,208,996
<b>Quality Initiatives (numbers refer to items listed in Section 6)</b>		
<b>Program Cost Reductions:</b>		
<b>Pharmacy:</b>		
Preferred Drug List Update ~ (# 1)		2,392,020
Manage Six Currently Exempt Therapeutic Classes ~ (# 2)		1,536,277
Pharmacy Mail Order ~ (# 19)		120,212
Pharmacy Premium Rebate (Generic) to Beneficiaries ~ (# 20)		706,228
Allow Greater Day Supply ~ (# 21)		24,997
Limit VScript Coverage to a More Common Definition of Maintenance Drugs ~ (# 22)		60,912
		<b>4,840,646</b>
<b>Long-Term Care</b>		
Tighten up Financial Eligibility for Long Term Care Medicaid, Changing the "Look Back" Period to 3 to 5 Years ~ (#5)		411,000
Implement 1115 LTC Waiver ~ (# 7)		102,750
Raise Nursing Home Occupancy Threshold on all Cost Centers to 95% ~ (# 8)		1,027,500
Geriatric Nurse Practitioners ~ (# 17)		205,500
Eliminate Statutory Requirement for Annual Nursing Home Inflation Adjustment ~ (# 10)		1,200,000
		<b>2,946,750</b>
<b>VHAP</b>		
Freeze VHAP Enrollment & Convert to Premium Assistance ~ (# 3)		<b>2,326,716</b>
<b>Caretakers</b>		
Eliminate Caretaker Coverage ~ (# 4)		<b>2,339,745</b>
<b>Physician</b>		
Crossover Claims Adjustment ~ (# 9)		<b>1,356,300</b>
<b>Inpatient</b>		
Concurrent Review of Inpatient and Home Health Care ~ (# 15)		<b>39,033</b>
<b>Outpatient</b>		
24/7 Doctor/Nurse Line ~ (# 13)		<b>375,000</b>
<b>OTHER</b>		
Case Management of High Cost/Complicated Services ~ (# 14)		575,000
PACE ~ The Program for All-Inclusive Care for the Elderly (# 16)		258,720
Provider Reimbursement Decrease		8,631,000
Increase Premiums by Specified Amount		1,676,612
Transfer of State funds to Federal Funds under Global Commitment		16,972,224
		<b>28,113,556</b>
<b>Total</b>		
Hospital Provider Tax & Pharmacy Prescription Proposal ~ (# 11 & # 12)		9,641,224
		<b>9,641,224</b>
State Fiscal Year '06 ~ Office of Vermont Health Access Governor's Budget Recommend	0	244,512,474

**Table 3: SFY '06 Budget - Governor's Recommend**

Office of Vermont Health Access  
SFY '06 Budget Proposal ~ Governor's Recommend

	Funding Source							Federal	Total
	General	Special	Tobacco	Transportation	Inter'd Transfers	Internal Service	Permanent Trust		
<b>Office of Vermont Health Access Appropriation</b>	<b>1,166,438</b>	<b>227,957,547</b>						<b>356,258,604</b>	<b>585,382,589</b>
<b>Personal Services:</b>									
Shift from GF to SF	(1,166,438)	1,166,438						0	0
Pay Act	0	46,894						67,204	114,098
Other Benefits		9,943						14,250	24,193
Vacancy Savings	0	261,481						636,960	898,441
Third Party Personal Services		55,610						79,001	134,611
<b>Total Personal Services</b>	<b>(1,166,438)</b>	<b>1,540,367</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>797,414</b>	<b>1,171,343</b>
<b>Operating Expenses:</b>									
Vision Charge	0	83,698						83,698	167,395
Communications - DII Charge	0	999						999	1,998
Quality	0	2,764,063						831,937	3,596,000
<b>Total Personal Services</b>	<b>0</b>	<b>2,848,760</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>916,634</b>	<b>3,765,393</b>
<b>Caseload:</b>									
ABD (23,598 to 24,305 @ \$579.17 PMPM) ~ Δ 707		2,019,523						2,894,156	4,913,679
Families (68,999 to 68,435 @ \$168.84 PMPM) ~ Δ (564)		(469,640)						(673,037)	(1,142,677)
Ladies First (46 to 68 @ \$1,134.69) ~ Δ 22		123,118						176,440	299,558
SCHIP (2,976 to 2,997 @ \$81.54) ~ Δ 21		8,445						12,103	20,548
Underinsured Children (1,975 to 1,774 @ \$52.85) ~ Δ (201)		(52,390)						(75,080)	(127,470)
Caretakers (2,206 to 0 @ \$0.00) ~ Δ (2,206)		(1,362,966)						(1,953,254)	(3,316,220)
VHAP (20,028 to 21,250 @ \$205.17) ~ Δ 1,222		1,236,513						1,772,035	3,008,548
VHAP-Pharmacy (7,807 to 8,818 @ \$203.45) ~ Δ 1,011		1,014,433						1,453,774	2,468,207
VScript (2,982 to 2,847 @ \$290.76) ~ Δ (135)		(127,010)						(182,016)	(309,026)
VScript expanded (2,600 to 2,695 @ \$189.61) ~ Δ 9+A25		216,153							216,153
<b>Total Caseload Pressures</b>	<b>0</b>	<b>2,606,179</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>3,425,121</b>	<b>6,031,299</b>
<b>Utilization/Cost:</b>									
ABD (\$565.38 to \$579.17 PMPM) ~ Δ \$13.79		1,605,094						2,300,246	3,905,340
Families (\$164.81 to \$168.84 PMPM) ~ Δ \$4.03		1,368,949						1,961,828	3,330,777
Ladies First (\$1131.31 to \$1,134.69 PMPM) ~ Δ \$3.38		768						1,100	1,868
SCHIP (\$96.37 to \$81.54 PMPM) ~ Δ (\$14.83)		(217,618)						(311,866)	(529,484)
Underinsured Children (\$49.04 to \$52.85 PMPM) ~ Δ \$3.81		37,112						53,184	90,296
Caretakers (\$125.27 to \$0.00 PMPM) ~ Δ (\$125.27)		0						0	0
VHAP (\$216.68 to \$205.17 PMPM) ~ Δ (\$11.51)		(1,137,094)						(1,629,558)	(2,766,652)
VHAP-Pharmacy (\$164.71 to \$203.55 PMPM) ~ Δ \$38.84		1,491,393						2,137,300	3,628,693
VScript (\$155.90 to \$190.76 PMPM) ~ Δ \$34.86		512,712						734,762	1,247,474
VScript expanded (\$181.20 to \$189.61 PMPM) ~ Δ \$8.41		262,205							262,205
<b>Total Utilization/Cost Pressures</b>	<b>0</b>	<b>3,923,520</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>5,246,997</b>	<b>9,170,516</b>
<b>Other Program Cost:</b>									
DSH		9,931,820						14,233,193	24,165,013
Rate Setting		22,980						22,980	45,960
Lund Home Family Center		10,273						14,723	24,996
Buy-in		798,549						1,144,392	1,942,941
<b>Total Other Program Cost:</b>	<b>0</b>	<b>10,763,622</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>15,415,288</b>	<b>26,178,910</b>
<b>Long-Term Care:</b>									
Long-Term Care Increases		(686,648)						(984,029)	(1,670,677)
<b>Total Long Term Care:</b>	<b>0</b>	<b>(686,648)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(984,029)</b>	<b>(1,670,677)</b>
<b>Revenue Changes:</b>									
Special Funds Adjustment	0	4,041,523						(4,041,523)	0
Decrease in Federal Match Rate	0	8,489,829						(8,489,829)	0
Global Commitment Impact		(16,972,224)						16,972,224	0
<b>Total Revenue Changes:</b>	<b>0</b>	<b>(4,440,872)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>4,440,872</b>	<b>0</b>
<b>Sub-total</b>	<b>(1,166,438)</b>	<b>16,554,927</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>29,258,296</b>	<b>44,646,785</b>
State Fiscal Year '06 ~ Office of Vermont Health Access Appropriation Request	0	244,512,474	0	0	0	0	0	385,516,900	630,029,374
<b>Total OVHA Base SFY '05 Appropriation</b>	<b>1,166,438</b>	<b>227,957,547</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>356,258,604</b>	<b>585,382,589</b>
<b>Total OVHA Increase/Decrease</b>	<b>(1,166,438)</b>	<b>16,554,927</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>29,258,296</b>	<b>44,646,785</b>
State Fiscal Year '06 ~ Office of Vermont Health Access Request	0	244,512,474	0	0	0	0	0	385,516,900	630,029,374

**Table 4: Summary of Expenditures SFY '05-'06**

**Office of Vermont Health Access  
Summary of Expenditures SFY '05 Appropriated & SFY '06**

	SFY '05 Appropriated			SFY '06 Projected w/o Changes			SFY '06 Governor's Recommend		
	Enrollment	Costs	PMPM	Enrollment	Costs	PMPM	Enrollment	Costs	PMPM
<b>Program Costs</b>									
ABD	23,598	\$ 160,101,770	\$ 565.38	24,305	\$ 181,780,645	\$ 623.26	24,305	\$ 168,920,791	\$ 579.17
Families	68,999	\$ 136,462,845	\$ 164.81	69,611	\$ 151,209,305	\$ 181.02	68,435	\$ 138,650,944	\$ 168.84
Ladies First	46	\$ 624,481	\$ 1,131.31	68	\$ 1,000,690	\$ 1,226.34	68	\$ 925,906	\$ 1,134.69
SCHIP	2,976	\$ 3,441,468	\$ 96.37	3,165	\$ 4,284,028	\$ 112.80	2,997	\$ 2,932,532	\$ 81.54
Underinsured Children	1,975	\$ 1,162,205	\$ 49.04	2,191	\$ 1,533,691	\$ 58.33	1,774	\$ 1,125,031	\$ 52.85
Caretakers	2,206	\$ 3,316,220	\$ 125.27	2,554	\$ 5,692,810	\$ 185.75	0	\$ -	\$ -
<b>Total Traditional</b>	<b>99,800</b>	<b>\$ 305,108,989</b>	<b>\$ 254.77</b>	<b>101,894</b>	<b>\$ 345,501,169</b>	<b>\$ 282.57</b>	<b>97,579</b>	<b>\$ 312,555,204</b>	<b>\$ 266.92</b>
VHAP	20,028	\$ 52,075,327	\$ 216.68	22,733	\$ 64,375,080	\$ 235.98	21,250	\$ 52,317,223	\$ 205.17
VHAP-Pharmacy	7,807	\$ 15,430,939	\$ 164.71	8,818	\$ 23,381,440	\$ 220.96	8,818	\$ 21,527,839	\$ 203.45
VScript	2,982	\$ 5,578,566	\$ 155.90	2,847	\$ 7,117,717	\$ 208.34	2,847	\$ 6,517,014	\$ 190.76
VScript expanded	2,600	\$ 5,653,557	\$ 181.20	2,695	\$ 6,737,716	\$ 208.34	2,695	\$ 6,131,914	\$ 189.61
<b>Total VHAP</b>	<b>33,417</b>	<b>\$ 78,738,389</b>	<b>\$ 196.35</b>	<b>37,093</b>	<b>\$ 101,611,953</b>	<b>\$ 228.28</b>	<b>35,610</b>	<b>\$ 86,493,990</b>	<b>\$ 202.41</b>
Healthy Vermonters Program	10,584	\$ -	\$ -	11,355	\$ -	\$ -	11,355	\$ -	\$ -
<b>Total Program Costs</b>	<b>143,801</b>	<b>\$ 383,847,378</b>	<b>\$ 222.44</b>	<b>150,342</b>	<b>\$ 447,113,122</b>	<b>\$ 247.83</b>	<b>144,544</b>	<b>\$ 399,049,195</b>	<b>\$ 230.06</b>
<b>Other Costs</b>									
DSH	n/a	\$ 34,550,315	n/a	n/a	\$ 35,257,362	n/a	n/a	\$ 58,715,328	n/a
Legal Aid	n/a	\$ 384,375	n/a	n/a	\$ 384,375	n/a	n/a	\$ 384,375	n/a
Rate Setting	n/a	\$ 574,507	n/a	n/a	\$ 620,468	n/a	n/a	\$ 620,468	n/a
DDMHS Transfer of General Funds	n/a	\$ -	n/a	n/a	\$ -	n/a	n/a	\$ -	n/a
Lund Home Family Center	n/a	\$ 600,004	n/a	n/a	\$ 625,000	n/a	n/a	\$ 625,000	n/a
CMS Refugee Resettlement Adjustment	n/a	\$ -	n/a	n/a	\$ -	n/a	n/a	\$ -	n/a
Buy-In (1)	n/a	\$ 11,298,742	n/a	n/a	\$ 13,241,683	n/a	n/a	\$ 13,241,683	n/a
Other	n/a	\$ -	n/a	n/a	\$ -	n/a	n/a	\$ -	n/a
<b>Total Other</b>		<b>\$ 47,407,943</b>			<b>\$ 50,128,888</b>			<b>\$ 73,586,854</b>	
Total Medicaid Without-Long Term Care	143,801	\$ 431,255,321	\$ 249.91	150,342	\$ 497,242,010	\$ 275.62	144,544	\$ 472,636,049	\$ 272.49
Long-Term Care Costs	n/a	\$ 133,919,791	n/a	n/a	\$ 145,033,617	n/a	n/a	\$ 132,249,114	n/a
<b>Total</b>	<b>143,801</b>	<b>\$ 565,175,112</b>	<b>\$ 327.52</b>	<b>150,342</b>	<b>\$ 642,275,627</b>	<b>\$ 356.01</b>	<b>144,544</b>	<b>\$ 604,885,162</b>	<b>\$ 348.73</b>
<b>Operating Expenses</b>									
Fiscal Intermediary - EDS	n/a	\$ 8,910,499	n/a	n/a	\$ 9,071,232	n/a	n/a	\$ 9,071,232	n/a
Pharmacy Program Management - First Health	n/a	\$ 2,546,911	n/a	n/a	\$ 3,052,920	n/a	n/a	\$ 3,052,920	n/a
MMIS - Consultant	n/a	\$ 74,964	n/a	n/a	\$ -	n/a	n/a	\$ -	n/a
Health Care P/S Contract - MAXIMUS	n/a	\$ 2,384,100	n/a	n/a	\$ 2,068,372	n/a	n/a	\$ 2,068,372	n/a
Health Care P/S Contract - Ombudsman	n/a	\$ 205,000	n/a	n/a	\$ 217,000	n/a	n/a	\$ 217,000	n/a
Health Care P/S Contract - Pacific Health Policy	n/a	\$ 634,486	n/a	n/a	\$ 587,860	n/a	n/a	\$ 587,860	n/a
Health Care P/S Contract - Delmarva	n/a	\$ 420,000	n/a	n/a	\$ -	n/a	n/a	\$ -	n/a
Health Care P/S Contract - UVM VCHIP	n/a	\$ 200,000	n/a	n/a	\$ 257,744	n/a	n/a	\$ 257,744	n/a
Health Care P/S Contract - PSI	n/a	\$ 807,820	n/a	n/a	\$ 564,225	n/a	n/a	\$ 564,225	n/a
Health Care P/S Contract - Personal Care Evaluation	n/a	\$ 200,000	n/a	n/a	\$ -	n/a	n/a	\$ -	n/a
Health Care P/S Contract - Miscellaneous	n/a	\$ -	n/a	n/a	\$ 792,124	n/a	n/a	\$ 792,124	n/a
OVHA Operating Expense/Personnel Services	n/a	\$ 3,823,697	n/a	n/a	\$ 4,936,735	n/a	n/a	\$ 4,936,735	n/a
Quality	n/a	\$ -	n/a	n/a	\$ 3,596,000	n/a	n/a	\$ 3,596,000	n/a
<b>Total Direct Administrative Costs</b>	<b>143,801</b>	<b>\$ 20,207,477</b>	<b>\$ 11.71</b>	<b>150,342</b>	<b>\$ 25,144,212</b>	<b>\$ 13.94</b>	<b>144,544</b>	<b>\$ 25,144,212</b>	<b>\$ 14.50</b>
<b>Total Program and Administrative Costs</b>	<b>143,801</b>	<b>\$ 585,382,589</b>	<b>\$ 339.23</b>	<b>150,342</b>	<b>\$ 667,419,839</b>	<b>\$ 369.95</b>	<b>144,544</b>	<b>\$ 630,029,374</b>	<b>\$ 363.23</b>
<b>State Funds</b>		<b>\$ 229,123,985</b>			<b>\$ 277,208,996</b>			<b>\$ 244,512,474</b>	
<b>Increase of State Funds from Prev SFY</b>		<b>\$ 36,040,356</b>	<b>18.67%</b>		<b>\$ 48,085,011</b>	<b>20.99%</b>		<b>\$ 15,388,489</b>	<b>6.72%</b>

**Table 4: Summary of Expenditures SFY '05-'06**

**Office of Vermont Health Access**  
**Summary of Expenditures SFY '05 Projected & SFY '06**

	SFY '05 Projected			SFY '06 Projected w/o Changes			SFY '06 Governor's Recommend		
	Enrollment	Costs	PMPM	Enrollment	Costs	PMPM	Enrollment	Costs	PMPM
<b>Program Costs</b>									
ABD	23,728	\$ 166,904,824	\$ 586.17	24,305	\$ 181,780,645	\$ 623.26	24,305	\$ 168,920,791	\$ 579.17
Families	68,565	\$ 144,627,218	\$ 175.78	69,611	\$ 151,209,305	\$ 181.02	68,435	\$ 138,650,944	\$ 168.84
Ladies First	67	\$ 1,221,751	\$ 1,519.59	68	\$ 1,000,690	\$ 1,226.34	68	\$ 925,906	\$ 1,134.69
SCHIP	3,077	\$ 3,865,572	\$ 104.69	3,165	\$ 4,284,028	\$ 112.80	2,997	\$ 2,932,532	\$ 81.54
Underinsured Children	1,944	\$ 1,263,791	\$ 54.17	2,191	\$ 1,533,691	\$ 58.33	1,774	\$ 1,125,031	\$ 52.85
Caretakers	2,458	\$ 5,125,017	\$ 173.75	2,554	\$ 5,692,810	\$ 185.75	0	\$ -	\$ -
<b>Total Traditional</b>	<b>99,839</b>	<b>\$ 323,008,173</b>	<b>\$ 269.61</b>	<b>101,894</b>	<b>\$ 345,501,169</b>	<b>\$ 282.57</b>	<b>97,579</b>	<b>\$ 312,555,204</b>	<b>\$ 266.92</b>
VHAP	22,127	\$ 60,686,924	\$ 228.56	22,733	\$ 64,375,080	\$ 235.98	21,250	\$ 52,317,223	\$ 205.17
VHAP-Pharmacy	8,646	\$ 20,620,792	\$ 198.75	8,818	\$ 23,381,440	\$ 220.96	8,818	\$ 21,527,839	\$ 203.45
VScript	2,795	\$ 6,052,976	\$ 180.47	2,847	\$ 7,117,717	\$ 208.34	2,847	\$ 6,517,014	\$ 190.76
VScript expanded	2,641	\$ 5,719,467	\$ 180.47	2,695	\$ 6,737,716	\$ 208.34	2,695	\$ 6,131,914	\$ 189.61
<b>Total VHAP</b>	<b>36,209</b>	<b>\$ 93,080,160</b>	<b>\$ 214.22</b>	<b>37,093</b>	<b>\$ 101,611,953</b>	<b>\$ 228.28</b>	<b>35,610</b>	<b>\$ 86,493,990</b>	<b>\$ 202.41</b>
Healthy Vermonters Program	11,321	\$ -	\$ -	11,355	\$ -	\$ -	11,355	\$ -	\$ -
<b>Total Program Costs</b>	<b>147,369</b>	<b>\$ 416,088,332</b>	<b>\$ 235.29</b>	<b>150,342</b>	<b>\$ 447,113,122</b>	<b>\$ 247.83</b>	<b>144,544</b>	<b>\$ 399,049,195</b>	<b>\$ 230.06</b>
<b>Other Costs</b>									
DSH	n/a	\$ 34,465,154	n/a	n/a	\$ 35,257,362	n/a	n/a	\$ 58,715,328	n/a
Legal Aid	n/a	\$ 384,375	n/a	n/a	\$ 384,375	n/a	n/a	\$ 384,375	n/a
Rate Setting	n/a	\$ 574,507	n/a	n/a	\$ 620,468	n/a	n/a	\$ 620,468	n/a
DDMHS Transfer of General Funds	n/a	\$ -	n/a	n/a	\$ -	n/a	n/a	\$ -	n/a
Lund Home Family Center	n/a	\$ 625,000	n/a	n/a	\$ 625,000	n/a	n/a	\$ 625,000	n/a
CMS Refugee Resettlement Adjustment	n/a	\$ -	n/a	n/a	\$ -	n/a	n/a	\$ -	n/a
Buy-In (1)	n/a	\$ 12,280,862	n/a	n/a	\$ 13,241,683	n/a	n/a	\$ 13,241,683	n/a
Other	n/a	\$ 900,000	n/a	n/a	\$ -	n/a	n/a	\$ -	n/a
<b>Total Other</b>		<b>\$ 49,229,898</b>			<b>\$ 50,128,888</b>			<b>\$ 73,586,854</b>	
Total Medicaid Without Long-Term Care	147,369	\$ 465,318,230	\$ 263.13	150,342	\$ 497,242,010	\$ 275.62	144,544	\$ 472,636,049	\$ 272.49
Long-Term Care Costs	n/a	\$ 136,500,000	n/a	n/a	\$ 145,033,617	n/a	n/a	\$ 132,249,114	n/a
<b>Total</b>	<b>147,369</b>	<b>\$ 601,818,230</b>	<b>\$ 340.31</b>	<b>150,342</b>	<b>\$ 642,275,627</b>	<b>\$ 356.01</b>	<b>144,544</b>	<b>\$ 604,885,162</b>	<b>\$ 348.73</b>
<b>Operating Expenses</b>									
Fiscal Intermediary - EDS	n/a	\$ 8,910,499	n/a	n/a	\$ 9,071,232	n/a	n/a	\$ 9,071,232	n/a
Pharmacy Program Management - First Health	n/a	\$ 2,546,911	n/a	n/a	\$ 3,052,920	n/a	n/a	\$ 3,052,920	n/a
MMIS - Consultant	n/a	\$ 74,964	n/a	n/a	\$ -	n/a	n/a	\$ -	n/a
Health Care P/S Contract - MAXIMUS	n/a	\$ 2,384,100	n/a	n/a	\$ 2,068,372	n/a	n/a	\$ 2,068,372	n/a
Health Care P/S Contract - Ombudsman	n/a	\$ 205,000	n/a	n/a	\$ 217,000	n/a	n/a	\$ 217,000	n/a
Health Care P/S Contract - Pacific Health Policy	n/a	\$ 634,486	n/a	n/a	\$ 587,860	n/a	n/a	\$ 587,860	n/a
Health Care P/S Contract - Delmarva	n/a	\$ 420,000	n/a	n/a	\$ -	n/a	n/a	\$ -	n/a
Health Care P/S Contract - UVM VCHIP	n/a	\$ 200,000	n/a	n/a	\$ 257,744	n/a	n/a	\$ 257,744	n/a
Health Care P/S Contract - PSI	n/a	\$ 807,820	n/a	n/a	\$ 564,225	n/a	n/a	\$ 564,225	n/a
Health Care P/S Contract - Personal Care Evaluation	n/a	\$ 200,000	n/a	n/a	\$ -	n/a	n/a	\$ -	n/a
Health Care P/S Contract - Miscellaneous	n/a	\$ -	n/a	n/a	\$ 792,124	n/a	n/a	\$ 792,124	n/a
OVHA Operating Expense/Personnel Services	n/a	\$ 3,823,697	n/a	n/a	\$ 4,936,735	n/a	n/a	\$ 4,936,735	n/a
Quality	n/a	\$ -	n/a	n/a	\$ 3,596,000	n/a	n/a	\$ 3,596,000	n/a
<b>Total Direct Administrative Costs</b>	<b>147,369</b>	<b>\$ 20,207,477</b>	<b>\$ 11.43</b>	<b>150,342</b>	<b>\$ 25,144,212</b>	<b>\$ 13.94</b>	<b>144,544</b>	<b>\$ 25,144,212</b>	<b>\$ 14.50</b>
<b>Total Program and Administrative Costs</b>	<b>147,369</b>	<b>\$ 622,025,707</b>	<b>\$ 351.74</b>	<b>150,342</b>	<b>\$ 667,419,839</b>	<b>\$ 369.95</b>	<b>144,544</b>	<b>\$ 630,029,374</b>	<b>\$ 363.23</b>
<b>State Funds</b>		<b>\$ 247,031,227</b>			<b>\$ 277,208,996</b>			<b>\$ 244,512,474</b>	
<b>Increase of State Funds from Prev SFY</b>		<b>\$ 53,947,598</b>	<b>18.67%</b>		<b>\$ 30,177,769</b>	<b>12.22%</b>		<b>\$ (2,518,753)</b>	<b>-1.02%</b>

## Section 6: Policy Savings Options

ITEM	CATEGORY	OPTION NAME	STRATEGY	SFY '06 STATE TOTALS	
				INVESTMENT	SAVINGS/ REVENUE
1	Pharmacy	Preferred Drug List Update	Vermont and eight other states have partnered in the National Multi-State Pooling/Purchasing Initiative to obtain supplemental rebates from pharmacy manufacturers for drugs used in Vermont's publicly funded programs. Each year manufacturers are given a new opportunity to offer rebates or improve the conditions of the rebates they have offered. The acceptance of these rebates results in changes to the Preferred Drug List since the List presents the clinically appropriate choices that are most cost effective in the drug classes Vermont manages. This option is premised on the assumption that any existing "grandfather" period will be reconsidered and preferred products will be aggressively marketed to generate savings beginning July 1, 2005.	\$0	\$2,392,020
2	Pharmacy	Manage Six Currently Exempt Therapeutic Classes	Vermont's Preferred Drug List manages drug classes with high utilization and high costs. Drugs that are not preferred in managed classes cannot be obtained without prior authorization. Drugs prescribed for the treatment of severe and persistent mental illness (SPMI) are exempt from prior authorization. Pharmacy spending by therapeutic class indicates that there are six classes in the top twenty of all classes that are largely unmanaged because of the SPMI exemption. This option is premised on the assumption that these classes would be managed effective July 1, 2005.	\$0	\$1,536,277
3	Program Design	Premium Assistance for Individuals in VHAP & Dr. Dynasaur Who Have Access to Employer Sponsored Insurance	Some applicants for the Vermont Health Access Plan (VHAP) and Dr. Dynasaur have access to health insurance through their employers but cannot afford their share of the premium. This option is premised on the assumption that effective July 1, 2005, any applicant with income >50% of FPL and access to employer sponsored insurance who was found eligible for VHAP or Dr. Dynasaur, would not be enrolled in VHAP or Dr. Dynasaur. Instead s/he would get coverage through the available employer sponsored insurance, with a contribution from VHAP or Dr. Dynasaur designed to reduce the cost of the insurance premium for the beneficiary.	\$150,000	\$2,326,716
4	Program Design	Caretakers	This option is premised on the assumption that effective July 1, 2005, VHAP coverage would no longer be available to caretaker relatives whose income was between 150 and 185% of the Federal Poverty Level (FPL). This group will be able to participate in the Governor's Premium Assistance Plan.	\$0	\$2,339,745
5	Program Design	Tighten up Financial Eligibility for Long Term Care Medicaid, Changing the "look back" Period from Three to Five Years	Financial eligibility rules for coverage for long-term care consider assets available to meet needs. Available income and resources are counted. This option is premised on legislative authorization effective upon passage requiring the following changes to be made by emergency rulemaking no later than July 1, 2005 to prevent available assets from being sheltered. Obtain a federal waiver so transfers made three to five years before application would be penalized on the date of the Medicaid application or discovery, whichever is later, instead of upon the date of the transfer for transfers made. Hire an experienced licensed attorney dedicated to long-term-care Medicaid.	\$34,500	\$411,000
6	Revenue	Increase Premiums by Specified Amounts	This option is premised on the assumption that all existing program premiums would increase and the amount of premiums paid would correspond to similar percentages of income. Beneficiaries under 50% of FPL would be exempt from premiums. Increases would be effective as of July 1, 2005.	\$0	\$3,751,017
7	Program Design	Implement 1115 LTC Waiver	This option is premised on the implementation of Vermont's 1115 Long Term Care waiver to allow greater flexibility in applying Medicaid long-term care eligibility rules to individuals who remain in community settings.	\$0	\$102,750
8	Program Design	Raise Nursing Home Occupancy Threshold on all Cost Centers to 95%	This option is premised on increasing the occupancy threshold in the Nursing Home Rate Setting process from 90% to 95% beginning July 1, 2005. Currently, there is no occupancy threshold limit for the nursing portion (RN/LPN/Aid) of the rate.	\$0	\$1,027,500

## Section 6: Policy Savings Options

ITEM	CATEGORY	OPTION NAME	STRATEGY	SFY '06 STATE TOTALS	
				INVESTMENT	SAVINGS/ REVENUE
9	Reimbursement	Crossover Claims Adjustment	Claims that are covered by both Medicare and Medicaid are paid by Medicare first and then "crossover" automatically for payment by Medicaid. Currently, Medicaid pays the balance of the Medicare allowed amount. Effective July 1, 2005, Medicaid will pay the lesser of the balance of the Medicare or Medicaid allowed amount.	\$0	\$1,356,300
10	Revenue	Eliminate the Statutory Requirement for Annual Nursing Home Inflation	This is premised on the assumption that beginning July 1, 2005, the annual guaranteed nursing home rate adjustment for inflation will be discontinued.	\$0	\$1,200,000
11	Revenue	One-time Provider Tax/Provider Disproportionate Share Payment Change	This option is premised on a one-time adjustment to the schedule for billing and collecting the provider tax and paying the disproportionate share payments.	\$0	\$11,000,000
12	Revenue	Pharmacy Fee	This option extends the existing provider tax to a new category of providers. There will be an increase in the amount paid for the dispensing fee.	\$0	\$1,640,200
13	Quality	24/7 Doctor/Nurse Line	This option is premised on the assumption that program savings will occur when a staffed information line is provided. Beneficiaries and their families will have access to skilled professionals when seeking medical advice and may not require physician and/or hospital services, thus saving the cost of outpatient hospital, physician or visits to other professionals. This line will coordinate with any care management/registry and other functionality being created.	\$175,000	\$375,000
14	Quality	Case Management of High Cost/ Complicated Services	This option is premised on the assumption that program savings will occur when case management support is available to beneficiaries requiring high cost or clinically complicated care by providing guidance and advice on when and what care is necessary.	\$471,500	\$575,000
15	Quality	Concurrent Review of Inpatient and Home Health Care	Onsite reviews will be conducted in "real time". This service will coordinate closely with care case management and information referral services to obtain efficiencies.	\$80,000	\$39,033
16	Quality	Fully Capitalize PACE Centers in Burlington and Rutland	The PACE centers in Burlington and Rutland will receive substantial one-time state support in order to help insure the initial capitalization and opening of two new programs aimed at providing All Inclusive Care for the Elderly. The need for initial capitalization and start up costs for PACE is approximately \$2,000,000. Thus far PACE Vermont has a \$750,000 grant from a one time federal appropriation. This funding was acquired with the assistance of staff from Senator Jeffords' office. It also has an \$80,000 grant from the Bowse Trust. The Bowse Trust is affiliated with the Rutland Regional Medical Center and can only be used for services in Rutland.	\$604,380	\$258,720
17	Quality	Geriatric Nurse Practitioners	These providers would review and monitor care for expensive long term care cases in order to ensure the ongoing need for such care and to assist in identifying less expensive community based services that can meet their needs.	\$50,000	\$205,500
18	Quality	NGA Policy – Diabetes Registry	A piece of the Chronic Care Initiative, this pilot registry will be rolled out in three phases. Phases one and two over the next twelve months will provide access to claims and lab information to doctors of record for patients with Diabetes. This is designed to improve the care of beneficiaries with diabetes and thereby avoid more expensive care.	\$35,000	\$0
19	Reimbursement	Pharmacy Mail Order	This option is premised on the assumption that savings can be realized when using mail order supplies on select pharmacy products: diabetic supplies, multiple sclerosis drugs, growth hormone drugs, hemophilic drugs, and the drug Synagis used in the treatment of respiratory syncytial virus (RSV).	\$0	\$120,212

## Section 6: Policy Savings Options

ITEM	CATEGORY	OPTION NAME	STRATEGY	SFY '06 STATE TOTALS	
				INVESTMENT	SAVINGS/ REVENUE
20	Reimbursement	Pharmacy Premium Rebate to Beneficiaries (Generic)	This option is premised on the assumption that effective July 1, 2005, the use of generic drugs can be increased if beneficiaries receive a cash incentive for the use of generics. The cash incentive would encourage the use of these lesser cost alternatives.	<b>\$125,000</b>	<b>\$706,228</b>
21	Reimbursement	Allow Greater Day Supply	This option is premised on the assumption that dispensing costs can be reduced by allowing beneficiaries to get a greater number of days dispensed when the drug is a maintenance drug, the patient has a proven record of being able to use the drug, and it is unlikely that the patient's eligibility status is likely to change during the period for which the drug is dispensed.	<b>\$0</b>	<b>\$24,997</b>
22	Program Design	Limit VScript Coverage to a More Common Definition of Maintenance Drugs	VScript coverage is based on the definition of "maintenance drugs" identified in pharmacy claims reporting at the time of the inception of the program in 1989. This results in more expansive coverage than would be available if the common definitions of "maintenance drugs" used by other health plans were applied. This option is premised on the assumption that the more common definitions would apply.	<b>\$0</b>	<b>\$60,912</b>
23	System Management	Vermont Blueprint for Health	The "Vermont Blueprint for Health" is dedicated to achieving a new health system for Vermont. The Blueprint is several things: it is the vision that health care can be made better for Vermonters; it is a plan that provides the structure and outcomes to achieve that vision; and, it is a partnership of organizations, public and private, that are committed to its implementation. The goals are to: 1) implement a statewide system of care that enables Vermonters with, and at risk for, chronic disease to lead healthier lives, 2) develop a system of care that is financially sustainable, and 3) forge a public-private partnership to develop and sustain the new system of care.	<b>\$1,038,683</b>	
<b>TOTALS</b>				<b>\$2,764,063</b>	<b>\$31,449,127</b>

## Section 7: Policy Savings Options Details

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ITEM: #1

CATEGORY: Pharmacy

OPTION NAME: Preferred Drug List Update

REQUIRES FEDERAL APPROVAL: No

STATE LEGISLATION AND OTHER POLICY CHANGES REQUIRED: Requires a change to the Preferred Drug List (PDL).

SFY '06 STATE TOTALS	
INVESTMENT	SAVINGS
\$0	\$2,392,020

Vermont and eight other states have partnered in the National Multi-State Pooling Initiative (NMPI) - sometimes referred to as the National Multi-State Purchasing Initiative. The NMPI makes it possible to

obtain supplemental rebates from pharmacy manufacturers for drugs used in Medicaid programs. Of the other states, seven have been approved by the Centers for Medicare and Medicaid Services (CMS): Alaska, Hawaii, Michigan, Minnesota, Montana, Nevada, and New Hampshire. Kentucky's request is outstanding.

Each year manufacturers are given a new opportunity to offer rebates or improve the conditions of the rebates they have offered. The acceptance of these rebates results in changes to the Vermont Health Access Preferred Drug List since the List presents the clinically appropriate choices that are most cost effective in the drug classes Vermont manages. When changes occurred as a result of this updating process in the summer and fall of 2004 some drugs were "grandfathered"; that is, prescribers and beneficiaries were not asked to make immediate changes. This option is premised on the assumption that any existing "grandfather" period will be reconsidered. In addition all existing preferred products will be aggressively marketed to assure that savings are generated beginning July 1, 2005.

"Changes to the Preferred Drug List and Drugs Requiring Prior Authorization Summer and Fall 2004" for the list of drugs affected in 2004 and the complete "OVHA Quick List, January 1, 2005 Pharmacy Benefit Management Program Preferred Drug List and Drugs Requiring PA" are available on the OVHA web page at <http://www.ovha.state.vt.us/docs/VTQuicklist.pdf>.

Previously implementation strategies for these changes had allowed a greater degree of transition from now non-preferred drugs to preferred drugs with full realization not planned until January 2, 2006. The savings projected are premised on producing savings beginning July 1, 2005.

## Section 7: Policy Savings Options Details

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ITEM: #2

CATEGORY: Pharmacy

OPTION NAME: Manage Six Currently Exempt Therapeutic Classes

REQUIRES FEDERAL APPROVAL: No

STATE LEGISLATION and OTHER POLICY CHANGES REQUIRED: Requires statutory change.

SFY '06 STATE TOTALS	
INVESTMENT	SAVINGS
\$0	\$1,536,277

Under Act 127 (2002), Sec. 1. 33 V.S.A. chapter 19, subchapter 5, §1998, Vermont's Preferred Drug List manages drug classes with high utilization and high costs. Drugs that are not preferred in managed classes

cannot be obtained without prior authorization. Drugs prescribed for the treatment of severe and persistent mental illness (SPMI) are exempt from prior authorization (§1999(d)).

Pharmacy spending by therapeutic class indicates that there are six classes in the top twenty of all classes that are largely unmanaged because of the SPMI exemption. They are not all of the classes affected by the SPMI exemption. In addition they are not used solely for the treatment of SPMI. However they are exempt from prior authorization for anyone designated with SPMI.

The classes are:

1. Antipsychotics, atypical, dopamine, and serotonin antagonists
2. Anticonvulsants
3. Selective serotonin reuptake inhibitors (SSRIS) - antidepressants
4. Norepinephrine and dopamine reuptake inhibitors (NDRIS) - antidepressants
5. Treatment for attention deficit/hyperactivity disorder (ADHD)/narcolepsy
6. Serotonin-norepinephrine reuptake-inhibitors (SNRIS) - antidepressants

The criteria for exemption are as follows:

- Patient is diagnosed with schizophrenia or bipolar disorder.
- Patient is diagnosed with an ICD 9 mental health or substance abuse diagnosis (including major depression) (290.00 - 319.00) **and** has or has had a history of impairment due to the mental illness that affects his/her ability to function such that the patient is suicidal, has no friends, neglects family, is unable to work or keep a job, is withdrawn to home or room, stays in bed all day, becomes violent or has even lesser degrees of functioning (Global Assessment of Functioning Scale score of 50 or less). Patient is a past or current user of traditional or atypical antipsychotic medication.
- Patient has received chronic therapy with any antidepressant medication (received at least 300 days supply of medication during a 365 day period).
- Patient has received chronic therapy with any central nervous system stimulant medication (received at least 240 days supply of medication during a 365 day period).
- Presence of a CRT code in eligibility file.
- Patients less than 18 years of age.

## **Section 7: Policy Savings Options Details**

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In the first six months of this state fiscal year, spending in the six classes alone was \$25.5 million dollars. That was 26.8% of total spending for the period.

This option is premised on the assumption that these classes and related classes used in the treatment of SPMI will be managed in a manner to reflect appropriate best practice and cost containment measures effective July 1, 2005. OVHA proposes to:

1. Inventory best practices in the public administration of a mental health pharmacy package.
2. Assess the use of mental health treatment drugs in Vermont's publicly funded pharmacy programs.
3. Review the application of the SPMI exemption as currently defined.
4. Determine the extent that this or an alternative exemption for SPMI is an appropriate practice with the assistance and advice of the Drug Utilization Board.

The savings projected on this are premised on the assumption that sufficient change can be produced in the prescribing of behavioral health drugs to generate at least the equivalent of the savings that would be generated if all beneficiaries were limited to the use of preferred products that are less expensive because of their price in the marketplace or as a result of rebates.

**Section 7: Policy Savings Options Details**

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ITEM: #3

CATEGORY: Program Design

OPTION NAME: Premium Assistance for Individuals in VHAP & Dr. Dynasaur Who Have Access to Employer Sponsored Insurance

REQUIRES FEDERAL APPROVAL: Requires waiver amendment

STATE LEGISLATION and OTHER POLICY CHANGES REQUIRED: Requires rule and protocol changes.

SFY '06 STATE TOTALS	
INVESTMENT	SAVINGS
\$150,000	\$2,326,716

The Employer Sponsored Initiative (ESI) is designed to make coverage more affordable for individuals with access to employer-sponsored coverage. This initiative facilitates the use of commercial, market-

based coverage, representing a step towards addressing the Medicaid cost shifting issue. The ESI initiative contains a program designed for expansion groups, similar to the Governor's Premium Assistance Program.

Individuals currently enrolled in VHAP (with the exception of caretakers at 150-185% of FPL) and Dr. Dynasaur programs would continue that coverage unless their enrollment is interrupted. New program participants who do not have access to employer-sponsored insurance will receive the current VHAP or Dr. Dynasaur coverage at the new premium rates.

Newly eligible Dr. Dynasaur participants in households below 100% of the FPL and VHAP eligibles in households below 50% of the FPL also will continue to access benefits through the current programs.

Other, newly eligible program participants who have access to employer-sponsored coverage will receive program subsidies to make such coverage more affordable. Compared to existing program costs, the subsidy represents approximately one-half the cost of coverage under the VHAP program and seventy percent of the cost of coverage under the current Dr. Dynasaur program.

Effective July 1, 2005, uninsured parents and caretakers with incomes between 150 and 185% of the FPL will only be eligible for the Governor's Premium Assistance Program.

Because the ESI program does not impact individuals currently and continuously enrolled, the transition to ESI will be gradual. Estimated enrollment in the current program and the ESI subsidy program, as well as the estimated number of individuals who will no longer participate, is presented in the table below. The table also presents the estimated state savings resulting from the transition to an ESI subsidy program.

**Table 5: Enrollment Report - Programs with Premiums – Actual Data – Calendar Year '04**

Program	% FPL	Premiums	Jan-04	Feb-04	Mar-04	Apr-04	May-04	Jun-04	Jul-04	Aug-04	Sep-04	Oct-04	Nov-04	Dec-04
Dr. Dynasaur	0-185%	None	16,357	15,915	15,860	15,604	15,553	15,559	15,464	15,189	14,998	15,177	15,337	15,344
Dr. Dynasaur	185-225%	\$25/family/mo	4,781	5,325	5,441	5,500	5,483	5,438	5,436	5,402	5,512	5,542	5,482	5,393
Dr. D with ins.	225-300%	\$35/family/mo	1,704	1,683	1,712	1,776	1,808	1,813	1,844	1,861	1,883	1,906	1,867	1,867
Dr. D without ins.	225-300%	\$70/family/mo	2,834	2,654	2,655	2,716	2,744	2,818	2,955	2,942	3,111	3,231	3,397	3,363
Dr. D Total			25,676	25,577	25,668	25,596	25,588	25,628	25,699	25,394	25,504	25,856	26,083	25,967
VHAP	0-50%	None	7,371	7,644	7,920	8,093	8,059	7,982	8,085	8,086	8,191	8,128	8,024	8,083
VHAP	50-75%	\$10/mo	2,612	2,595	2,636	2,620	2,536	2,510	2,532	2,469	2,427	2,424	2,401	2,396
VHAP	75-100%	\$35/mo	3,083	3,345	3,472	3,591	3,597	3,391	3,350	3,311	3,358	3,363	3,352	3,327
VHAP	100-150%	\$45/mo	8,108	7,892	7,898	7,970	7,924	7,834	7,786	7,796	7,799	7,861	7,880	7,890
VHAP	150-185%	\$65/mo	2,500	2,253	2,288	2,239	2,309	2,323	2,364	2,336	2,395	2,463	2,426	2,473
VHAP Total			23,674	23,729	24,214	24,513	24,425	24,040	24,117	23,998	24,170	24,239	24,083	24,169
VHAP Pharmacy	0-150%	\$13/mo	8,353	8,031	8,245	8,407	8,499	8,687	8,216	8,219	8,243	8,304	8,361	8,379
VScript	150-175%	\$17/mo	2,968	2,788	2,827	2,828	2,814	2,784	2,679	2,681	2,687	2,706	2,734	2,759
VScript Expanded	175-225%	\$35/mo	2,900	2,439	2,519	2,551	2,536	2,455	2,533	2,537	2,560	2,579	2,619	2,631
Pharmacy Total			14,221	13,258	13,591	13,786	13,849	13,926	13,428	13,437	13,490	13,589	13,714	13,769
Total			63,571	62,564	63,473	63,895	63,862	63,594	63,244	62,829	63,164	63,684	63,880	63,905

**Table 6: Enrollment in Programs with Premiums by FPL with Counts – SFY '05 Projected**

Monthly Premiums By Program	Program	Premium	Enrollment per Program							
	Pharmacy Programs	\$35.00							2,641	
		\$17.00					2,795			
		\$13.00	8,646							
	Dr. Dynasaur	\$70.00 w/o insurance								3,077
		\$35.00 w/ insurance								1,944
		\$25.00							5,463	
		\$0	15,542							
	VHAP	\$65.00						2,516		
		\$45.00				8,026				
\$35.00				3,384						
\$10.00			2,437							
\$0		8,222								
FPL		0-50%	50%-75%	75%-100%	100%-150%	150%-175%	175%-185%	185%-225%	225%-300%	
Annual Income - (Household=2)		\$6,396	\$9,588	\$12,780	\$19,176	\$22,368	\$23,652	\$28,764	\$38,340	

**Table 7: Enrollment in Programs with Premiums/ESI by FPL with Counts – SFY '06 Projected**

	Proposed Premium	Enrollment per Program											
		\$0	\$20				13,421						
<b>Dr. Dynasaur</b>	<b>ESI</b>					1,627							
	\$25	\$35				4,781							
	\$35 w/ ins	\$50 w/ ins									1,774		
	\$70 w/o ins	\$90 w/o ins									2,997		
	Estimated Eligible Uninsured			2,828			1,819			1,242		842	
<b>VHAP</b>	\$0	\$0	8,479										
	<b>ESI</b>				2,074								
	\$10	\$25		1,883									
	\$35	\$40			2,614								
	\$45	\$60				6,200							
Estimated Eligible Uninsured			17,643										
<b>Pharmacy Programs</b>	\$13	\$13	8,818										
	\$17	\$17				2,847							
	\$35	\$35							2,695				
<b>FPL</b>			0-50%	50%-75%	75%-100%	100%-150%	150%-175%	175%-185%	185%-200%	200%-225%	225%-250%	250%-300%	>300%
<b>Annual Income - (Household=2)</b>			\$6,396	\$9,588	\$12,780	\$19,176	\$22,368	\$23,652	\$25,567	\$28,764	\$31,958	\$38,340	>\$38,340
<b>Governor's Recommendation</b>	<b>Insurance</b>	<b>Coverage Type</b>	<b>Estimated Eligible Uninsured</b>				<b>3,648</b>			<b>6,588</b>		<b>3,387</b>	<b>14,327</b>
			<b>Premium &amp; Deductible</b>				<b>60% Reduction</b>			<b>40% Reduction</b>		<b>20% Reduction</b>	
	<b>Small Business</b>	<b>Individual</b>					\$ 43.98 w/ \$1000 deductible			\$ 65.97 w/ \$1500 ded		\$ 87.96 w/ \$2000 ded	
		<b>2 People</b>					\$ 73.73 w/ \$2000 deductible			\$110.60 w/ \$3000 ded		\$147.47 w/ \$4000 ded	
		<b>Family</b>					\$109.89 w/ \$2800 deductible			\$164.83 w/ \$4200 ded		\$219.78 w/ \$4000 ded	
	<b>Individual Market</b>	<b>Individual</b>					\$128.84 w/ \$1400 deductible			\$193.26 w/ \$2100 ded		\$257.68 w/ \$2800 ded	\$378.94 w/ \$3500 ded
		<b>2 People</b>					\$257.68 w/ \$2800 deductible			\$386.51 w/ \$4200 ded		\$515.36 w/ \$5600 ded	\$757.88 w/ \$7000 ded
		<b>Family</b>					\$347.87 w/ \$4200 deductible			\$521.80 w/ \$6300 ded		\$695.74 w/ \$8400 ded	\$1023.14 w/ \$10,500 ded

1. Small business premium and deductible assistance are calculated at the 2004 adjusted HSA rates with first dollar coverage for preventive care and deductibles at \$2,500 – Single, \$5,000 – 2 person and \$7,000 – family.
2. Individual market subsidies are calculated on the 2004 individual market rates at a \$3,500 deductible and include a 15% premium reduction.

## Section 7: Policy Savings Options Details

ITEM: #4

CATEGORY: Program Design

OPTION DESIGN: Caretakers

REQUIRES FEDERAL APPROVAL: No

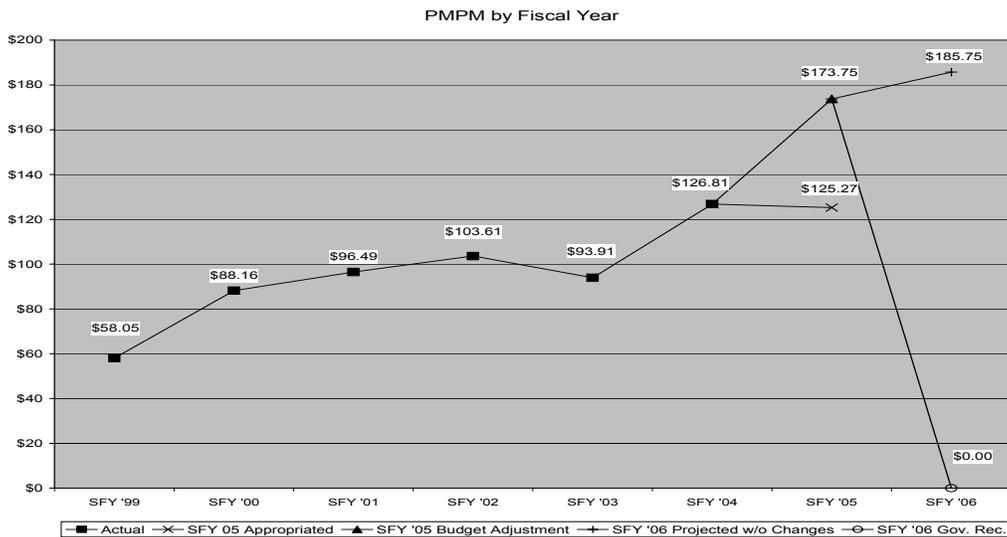
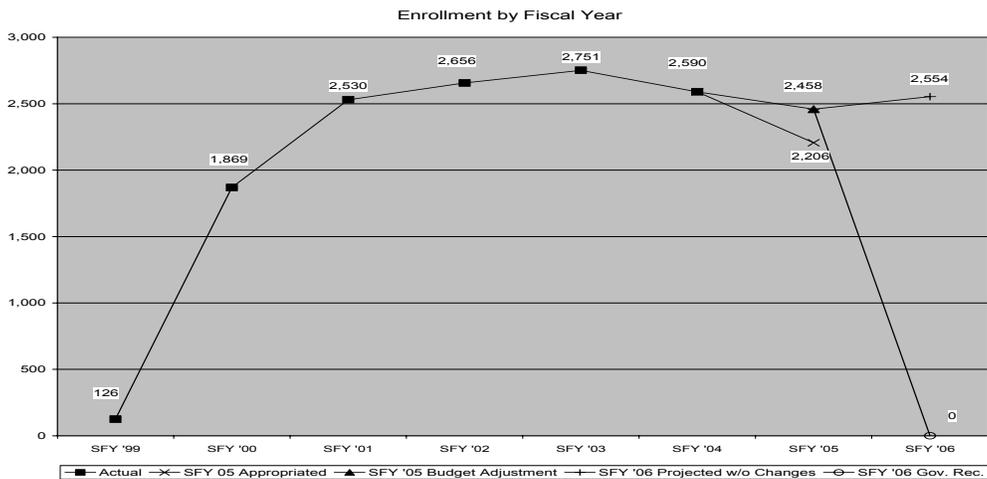
STATE LEGISLATION and OTHER POLICY CHANGES REQUIRED: Requires rule and protocol changes.

SFY '06 STATE TOTALS	
INVESTMENT	SAVINGS
\$0	\$2,339,745

Reference the following graphs.

Summary of Enrollment and Per Member Per Month (PMPM): State Fiscal Years 1999 – 2006

### Caretakers



## Section 7: Policy Savings Options Details

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ITEM: #5

CATEGORY: Program Design

OPTION NAME: Tighten up Financial Eligibility for Long-Term Care Medicaid, Changing the “look back” Period from Three to Five Years

REQUIRES FEDERAL APPROVAL: Requires State Plan Amendment

STATE LEGISLATION and OTHER POLICY CHANGES REQUIRED: Requires rule changes.

SFY '06 STATE TOTALS	
INVESTMENT	SAVINGS
\$34,500	\$411,000

Financial eligibility rules for coverage for long-term care consider assets available to meet needs. Available income and resources are counted.

This option is premised on legislative authorization effective upon passage requiring the following changes to be made by emergency rulemaking no later than July 1, 2005 to prevent available assets from being sheltered:

1. Prescribe requirements for private contracts for care.
2. Modify life expectancy tables used to measure whether a transfer is for fair market value.
3. Restrict transfers by the community spouse (e.g. treat excess resources placed in a resalable spousal annuity as a countable resource; penalize post-eligibility transfers by community spouse to the extent permitted by federal law).
4. Place reasonable limits on “past medical expenses” permitted to reduce patient share of costs, including eliminating the deduction for nursing home charges assessed before the date of Medicaid LTC eligibility, to the extent permitted by federal law.
5. Limit life estate exclusion and transfer exemption when the individual retains the power to fully mortgage the property.
6. Set criteria for excludable private loans to the extent permitted by federal law.
7. Automate and streamline a system to efficiently perform accurate statewide bank verification.

Currently, resources transferred three to five years before the individual applies are subject to a penalty period which begins to run effective upon the date of the transfer. This option is premised on the assumption that Vermont would obtain a federal waiver so transfers made three to five years before application would be penalized on the date of the Medicaid application or discovery, whichever is later, instead of upon the date of the transfer.

This proposal includes monies to hire an experienced licensed attorney dedicated to long-term care Medicaid research. This position would draft and promulgate state plan amendments, legislation and regulations; provide technical assistance on rule application; collaborate with the Assistant Attorneys General to avoid litigation and consult on individual cases; and respond to questions from private attorneys working in the area of Medicaid estate planning.

## Section 7: Policy Savings Options Details

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ITEM: #6

CATEGORY: Revenue

OPTION NAME: Increase Premiums by Specified Amounts

REQUIRES FEDERAL APPROVAL: No

STATE LEGISLATION and OTHER POLICY CHANGES REQUIRED: Requires rule and protocol changes.

SFY '06 STATE TOTALS	
INVESTMENT	REVENUE
\$0	\$3,751,017

Given the overall growth in Medicaid expenditures relative to revenue sources, more cost sharing from participants will be needed. Health care expenditures will be offset through a greater reliance on monthly

premiums. The new premiums do not apply to individuals with very low incomes, nor traditional eligibility groups (i.e. Aged, Blind, and Disabled and Families.).

Vermont has relied on enrollee premiums to offset program costs for several years. In SFY '04, the Legislature increased monthly premiums in conjunction with elimination of point-of-service cost sharing obligations.

Proposed changes to the premium structure for SFY '06 include the introduction of premiums for Dr. Dynasaur enrollees in households with incomes between 100 and 185% of the FPL and increased premium levels for other, higher-income Dr. Dynasaur enrollees, and for VHAP enrollees with incomes above 50% of the FPL.

Currently, the State of Vermont retains the state share of premium collections, while the majority (approximately 60%) of premium collections are returned to the federal government. As part of the Global Commitment, the state intends to seek authority to retain 100% of premiums collected.

The revised premium structure has been designed to equitably distribute enrollees' financial obligations as a percentage of total household income. Children in households with incomes below 100% of the FPL will continue to be eligible without a monthly premium obligation. Adults in the VHAP program with incomes below 50% of the FPL will have no monthly premium obligation. These VHAP beneficiaries account for 37% of total VHAP enrollment.

**Section 7: Policy Savings Options Details**

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ITEM: #7

CATEGORY: Program Design

OPTION NAME: Implement 1115 LTC Waiver

REQUIRES FEDERAL APPROVAL: Requires waiver approval

STATE LEGISLATION and OTHER POLICY CHANGES REQUIRED: No.

SFY '06 STATE TOTALS	
INVESTMENT	SAVINGS
\$0	\$102,750

The State of Vermont has a long history of significant health care reform and expansion of health coverage for its uninsured residents. Building on the substantial achievements of the Vermont Health Access Plan

Demonstration Waiver, the State is now turning its focus to the long-term care arena. This proposal for a long-term care demonstration program is the result of a year-long planning and development initiative. The proposed program addresses both shortcomings in service availability and the inherent bias in the current funding mechanisms for long-term care.

This Demonstration is aimed at giving adults with physical disabilities and the frail elderly real choices. That means giving them the option to receive the long-term care services they need in a home- and community-based setting without having to wait for a “slot” to open up in a 1915(c) waiver program, or to choose care in a nursing facility. Individuals who can maintain themselves in the community with home- and community-based services should have that option. Often, under the existing federal Medicaid system, this important goal cannot be achieved. Therefore Vermont is proposing a bold new approach to the delivery and financing of long-term care services for adults with physical disabilities and the elderly.

The long-term care program described in this Demonstration Waiver proposal will constitute a wholesale replacement of most of Vermont’s existing Long-Term Care Medicaid program. All individuals currently eligible for Medicaid and in receipt of long-term care services in a nursing facility, Home and Community-Based Services (HCBS) Waiver or Enhanced Residential Care (ERC) Waiver, will be enrolled in the demonstration. The program will be administered by the Department of Aging and Independent Living, within the Vermont Agency of Human Services – the single state agency for Medicaid in the State of Vermont. It will be operated as a managed care model under a global budget.

The primary goals of the demonstration are to provide consumers with equal access to long-term care options (nursing facility and home- and community-based services) and promote early intervention for at-risk populations.

The Demonstration is designed to test the hypothesis that targeted early interventions, assessment, case management and the provision of home- and community-based services to the frail elderly and physically disabled adults will:

- ensure enrollee satisfaction with the long-term care services received;
- reduce utilization of institutional settings; and
- control overall costs for long-term care in the State.

## **Section 7: Policy Savings Options Details**

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Under this demonstration Vermont will seek to create a program without institutional bias, financial or otherwise. It is specifically designed to help elders and younger adults with physical disabilities to live as independently as possible for as long as possible, in the settings of their choice.

Vermont also recognizes that funding constraints are a reality. Accordingly, it has developed a prioritization strategy which ensures that those with the “highest needs” are served first and to the full extent of their needs. The program categorizes eligibles into three distinct groups: Highest Need; High Need; and Moderate Need. High and Moderate Needs groups are further prioritized and individuals are served based on the level of available resources.

The Highest Need group will be entitled to either nursing facility or home- and community based care. This entitlement to either setting represents a dramatic change in the way long-term care services are provided in Vermont. Today approximately 2,200 individuals are benefiting from the entitlement to nursing facility care. With this change in entitlement, Vermont projects that nearly 3,000 individuals will benefit from the broader entitlement to both nursing facility and HCBS by allowing the additional 800 individuals equal access to either category of service. All Demonstration participants in the Highest Need group must also meet the financial eligibility criteria for Vermont long-term care Medicaid.<sup>1</sup> Vermont anticipates that given equal access to either nursing facility or home-based care, more individuals will choose home- and community based care. This will allow the State to serve more individuals for the same amount of money.

The High Needs Group will not be legally “entitled” to long-term care services, but will be served to the extent that funds are available. These individuals will also have to meet existing long-term care Medicaid financial eligibility criteria,<sup>2</sup> but will not have care needs at a level which meets the existing clinical criteria for long-term care Medicaid. Given historical utilization, the State expects that this group will consist of approximately 200-300 individuals each year. Vermont fully expects that the individuals in this subgroup will all be served under the waiver; however, there is the remote possibility that they would not be served if there were no funds left after serving the Highest Need group. These individuals would still be eligible for the many home- and community-based and Medicaid State Plan services that would continue outside this Demonstration.

The Moderate Needs group will include individuals who do not meet current nursing facility or HCBS Waiver eligibility criteria, but are believed to be at risk of institutional placement based on their assessed care needs. Vermont believes that if services can be provided to these individuals earlier than the current practices allow, their conditions can be stabilized or improved, thus avoiding or delaying more costly institutional care. These individuals will be assessed and provided with preventive and supportive services necessary to help maintain their well-being and independence. This might be as little as a weekly homemaker visit, or a monthly case management visit. They will be served to the extent funds are available after serving all eligibles in the Highest and High Need groups.

In summary, the Demonstration offers the Department of Health and Human Services and the Centers for Medicare and Medicaid Services the opportunity to test a new and innovative model

## **Section 7: Policy Savings Options Details**

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of long-term care service delivery and financing. The imperative exists. There will be incredible pressure on the long-term care financing system under Medicaid as the “Baby Boom” generation ages. This demonstration has tremendous merit and will provide invaluable experience and data to assist HHS and CMS in their planning efforts and policy-making activities going forward.

<sup>1</sup> The one exception is with respect to resources. Demonstration participants electing home-based services may retain up to \$10,000 in resources. <sup>2</sup> Ibid

## Section 7: Policy Savings Options Details

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ITEM: #8

CATEGORY: Program Design

OPTION NAME: Raise Nursing Home Occupancy Threshold on all Cost Centers to 95%

REQUIRES FEDERAL APPROVAL: Requires State Plan Amendment

STATE LEGISLATION and OTHER POLICY CHANGES REQUIRED: Requires rule change.

SFY '06 STATE TOTALS	
INVESTMENT	SAVINGS
\$0	\$1,027,500

Currently, the rate setting methodology for nursing homes assumes that a facility has at least 90% occupancy. The facility's allowed costs are then divided by the number of days of service provided to

determine the facility's rate for Medicaid.

As the state has expanded its set of Home and Community Based alternatives, some facilities have experienced lower occupancy rates. The state cannot afford to pay for empty beds. This increase in the occupancy threshold would promote efficiency in the system. Facilities who could not maintain this level of occupancy would have an incentive to "right size" the number of licensed beds.

This option is premised on the belief that 95% occupancy provides nursing homes with the flexibility needed to respond to various admission requests and better reflects a healthy and efficient facility.

**Section 7: Policy Savings Options Details**

ITEM: #9

CATEGORY: Reimbursement

OPTION NAME: Crossover Claims Adjustment

REQUIRES FEDERAL APPROVAL: Requires State Plan Amendment

STATE LEGISLATION and OTHER POLICY CHANGES REQUIRED: No changes required.

SFY '06 STATE TOTALS	
INVESTMENT	SAVINGS
\$0	\$1,356,300

Medicare crossover claims are claims for individuals who are covered by both Medicare and Medicaid or dual eligibles. Medicaid is always the payor of last resort; therefore, Medicare would process the claim

first as primary, and then Medicaid would process any balances as secondary. Medicare covered claims are subject to an annual deductible. Once that is met, Medicare will pay 80% up to the allowed amount with a couple of exceptions. This leaves non-covered services, deductible and co-insurance to be considered by Medicaid for payment.

Claims covered by Medicare that are presently submitted to Medicaid for consideration are paid without regard to Medicaid's fee schedule, paying both the deductible and co-insurance left after they are processed by Medicare. These claims are paid at a rate higher than individuals covered only by Medicaid for services when Medicare's fee schedule is higher than Medicaid. The following is an example of three different scenarios showing how the claims presently process, how they will process and how Medicaid would have a savings.

HCPCS	Description	Code	Medicare Allowed	Medicare Pays 80%	Balance 20%	Medicaid Allowed	Current Medicaid Payment	New Medicaid Payment	Medicaid Savings
			A	B	C	D	E	F	G
								( D - B )	( E - F )
<b>Medicaid Rate Higher than 80% of Medicare Rate</b>									
99212	Office/Outpatient Visit, est.	A	\$35.16	\$28.13	\$7.03	\$30.00	\$7.03	\$1.87	\$5.16
<b>Medicaid Rate Lower than 80% of Medicare Rate</b>									
99213	Office/Outpatient Visit, est.	A	\$48.26	\$38.61	\$9.65	\$35.17	\$9.65	\$0.00	\$9.65
<b>Medicaid Rate Higher than Medicare Rate</b>									
99233	Subsequent hospital care	A	\$70.77	\$56.62	\$14.15	\$77.40	\$14.15	\$14.15	\$0.00

Once this change has been made, Medicaid will show overall savings of approximately \$3,300,000 (\$1,356,300 in state dollars) in the first year. There are many factors that could impact future savings such as an increase/decrease in Medicaid's or Medicare's fee schedules, an increase in Medicare's deductible, or a change in covered service by either Medicaid or Medicare.

## Section 7: Policy Savings Options Details

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ITEM: #10

CATEGORY: Revenue

OPTION NAME: Eliminate the Statutory Requirement for Annual Nursing Home Inflation

REQUIRES FEDERAL APPROVAL: Requires State Plan Amendment

STATE LEGISLATION and OTHER POLICY CHANGES REQUIRED: Requires statute and rule changes.

SFY '06 STATE TOTALS	
INVESTMENT	SAVINGS
\$0	\$1,200,000

Nursing homes are the only health care provider that benefit from a statutory requirement for an annual inflation increase. Removing this requirement would mean the legislature each year would determine any

increase for nursing homes along with all the competing needs in the system. Nursing homes could receive some or no increase, the same situation most providers find themselves in each session.

**Section 7: Policy Savings Options Details**

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ITEM: #11

CATEGORY: Revenue

OPTION NAME: One-time Provider Tax/Provider Disproportionate Share Payment Change

REQUIRES FEDERAL APPROVAL: No

STATE LEGISLATION and OTHER POLICY CHANGES REQUIRED: No changes required.

SFY '06 STATE TOTALS	
INVESTMENT	REVENUE
\$0	\$11,000,000

Federal law limits Disproportionate Share Hospital (DSH) payments per federal fiscal year (FFY). This option would make two DSH payments in SFY '06 using up the FFY '05 limit and a portion of the FFY

2006 limit. Provider tax limits prevent using more of the FFY '06 allowed DSH.

**Provider Tax and DSH Payment Timing**

	June 05	July 05	October 05
<b>Tax Revenue</b>	\$9.5M	\$24.5M	\$24M
<b>DSH Payment</b>		\$35M	\$25M

**Section 7: Policy Savings Options Details**

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ITEM: #12

CATEGORY: Revenue

OPTION NAME: Pharmacy Fee

REQUIRES FEDERAL APPROVAL: Requires State Plan Amendment

STATE LEGISLATION and OTHER POLICY CHANGES REQUIRED: No changes required.

SFY '06 STATE TOTALS	
INVESTMENT	NET REVENUE
\$0	\$1,640,200

This option is premised on the assumption that pharmacies will pay a per prescription fee to the state in support of publicly funded health insurance programs. The fee will be based on all individual

pharmacy scripts filled, Medicaid or otherwise. The amount of the fee is proposed to be \$0.10 for each prescription or refill.

To project the impact on this, the OVHA determined the number of claims that were processed in State Fiscal Year 2004 for each of the following populations: aged, blind/disabled, and others. The OVHA used the average monthly beneficiaries per eligibility category to calculate the average annual number of claims per individual in each eligibility category:

**OVHA Experience SFY '04**  
*Paid Claims*

	OVHA Claims	Average Beneficiaries	Claims per Beneficiary per Year
Aged	467,811	7,144	65.48
Blind/Disabled	716,152	16,294	43.95
Other	1,541,146	124,736	12.36
Total	2,725,109	148,174	18.39

The OVHA then calculated the general population as reported in by the U. S. Census Bureau. The Census reported an estimate of the total population for 2003. The 2000 estimations indicate that 12.7% of the total population is aged. The most concrete information on the number of people who are blind or disabled is the number receiving Medicaid.

***Total Vermont Residents***

619,107 Total  
78,627 Estimated Aged  
  
16,294 Medicaid Blind or Disabled  
  
524,186 Other

**Section 7: Policy Savings Options Details**

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The OVHA then applied the claims' experience to the Vermont residents' estimation:

**OVHA Claims Experience Applied to Census Estimates**  
*Paid Claims/Vermont Residents*

Aged	5,148,710
Blind/Disabled	716,152
Other	6,476,461
<b>Total</b>	<b>12,341,322</b>

Projecting an increased dispensing fee of \$0.50 for each prescription and refill for Vermont's publicly funded programs the OVHA anticipates net revenue to be \$1.6 million.

<b>Number of Scripts</b>		12,341,322
<b>Fee per script for all the Pharmacy population</b>	\$	0.10
<b>Collections</b>	\$	1,234,132
<b>FMAP</b>		0.411
<b>Gross funding available</b>	\$	3,002,755
<b>Increased dispensing fee (\$0.50 per script on Medicaid scripts)</b>	\$	1,362,555
<b>Net Revenue</b>	\$	1,640,200

**Section 7: Policy Savings Options Details**

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ITEM: #13

CATEGORY: Quality

OPTION NAME: 24/7 Doctor/Nurse Line

REQUIRES GLOBAL COMMITMENT: No

STATE LEGISLATION and OTHER POLICY CHANGES REQUIRED: No changes required.

SFY '06 STATE TOTALS	
INVESTMENT	SAVINGS
\$175,000	\$375,000

**Problem Statement**

The use of emergency department (ED) services for non-urgent care is a national phenomenon. ED visits, as a proportion of ambulatory care visits for Medicaid

beneficiaries, was more than double that of private and Medicare beneficiaries in 2000-01. It is estimated that 40% of ED visits were not urgent and were two to three times more costly than visits to office based physicians. In addition, there is reduced continuity of care and scope of medical services when emergency care is substituted for primary care.

**Vermont ED Utilization**

Vermont Total Medicaid Emergency Department Utilization October 2003-September 2004		
TOTAL ED VISITS	TOTAL NUMBER OF BENEFICIAIRES	TOTAL EXPENSE
37,338	34,421	\$11,425,256.00

Source: Medicaid Management Information System (MMIS)

Vermont Selected Medicaid Emergency Department Utilization October 2003-September 2004		
Visit Reason	Number of visits	Total Costs
Sprains	2579	361,827.20
Colds, cough, sore throat etc	2716	304,501.65
Headaches(non-migraine)	825	210,648.53
Sexually transmitted diseases	1036	175,499.99
Otitis Media (earache)	1565	149,312.14
Fever	886	143,846.81
<b>TOTAL</b>	<b>9,607</b>	<b>\$1,345,636.32</b>

Source: Medicaid Management Information System (MMIS)

Successful Emergency Department Initiatives In Other States					
STATE	INSURER	CONDITION	INTERVENTION	RESULTS	COMMENTS
<b>Oklahoma</b>	Medicaid		24/7 Nurse/Doctor line Pilot Project involving 30,000 households	24% decrease in ED visits.	FU Survey 66% satisfaction
<b>Ohio</b>	Medicaid	Pediatric conditions	Pt. Ed. of appropriate use. ER contacted Primary MD	11.1-14.5% visit education within 6 Mo.	Hospital Intervention

**Section 7: Policy Savings Options Details**

Successful Emergency Department Initiatives In Other States					
<b>Mississippi</b>	Medicaid	Asthma, Diabetes, Hyperlipidemia, Coag. disorders	Disease Management Pharmacy Case Management	58% reduction in ER costs	Decrease in ER visits and Hospital admissions; estimated savings of \$100,000 in the first year.
<b>Georgia- one county only</b>	Low income & uninsured	Diabetes Hypertension Heart disease Depression	Case Management- 1,780 enrolled participants. Projects are by County	40% reduction ER visits	36% decrease hospital admissions 1 year total cost savings = \$368,337
<b>Missouri</b>	Medicaid Managed Care((1998-current)	Asthma	Pharmacy Case Management Disease Management	Reduced Hosp. and emergency room visits by approx 50%	Case managers review of care plan incl prescription drug regimen with direct recomm. to prescribe. MD

*Proposed Emergency Department Quality Initiative*

**Mission**

Assist beneficiaries in accessing clinically appropriate health services and foster relationships between patients and their primary care practitioners.

**Goal**

- Reduction of non-urgent ED visits
- Educate beneficiaries in the appropriate use of ED use
- Facilitate closer linkage and communication between patients and primary care practitioners

**Method**

Introduce an oversight strategy aimed at identifying ambulatory care sensitive diagnoses with subsequent referral to alternate appropriate clinical setting.

**Pre-Implementation**

As an initial step, prior to implementation, OVHA will be vigorously soliciting input in a collaborative fashion from providers, beneficiaries and other stakeholders as to the goals, objectives and strategies best suited for this program.

**Program Implementation**

Although the on call help line will be available to all Medicaid beneficiaries, its target use will be for Medicaid beneficiaries receiving care management services. Key elements of the Nurse/Doctor clinical help line – the nurse will:

- Triage incoming calls and will consult with patient’s primary or on-call physician as needed.
- Communicate with both the primary care practitioner and beneficiary following each non-urgent ED visit.

## Section 7: Policy Savings Options Details

- Facilitate with hospital ways to redirect care, follow collaboration with primary practitioner and follow-up on aftercare arrangements.
- Evaluate access problems/barriers paying particular attention to new patients and their primary care providers.
- Evaluate transport appropriateness to ED (ambulance utilization).

OVHA is currently piloting a case tracking system that will be ready for full implementation with the care management program.

### Measurement and Evaluation

Care coordination will be evaluated thoroughly for improved health outcomes and subsequent cost savings to the Medicaid program. A prospective controlled study of the program will be performed to assess health outcomes using care coordination as well as provider medical records. A retrospective analysis of the implementation will also be performed to determine impact on Medicaid costs as well as health outcomes.

### Cost Benefit Analysis

EXPENSE	ANNUAL BUDGET TOTAL EXPENSE WITH FEDERAL MATCH	MATCH RATE	ANNUAL STATE DOLLARS
Personnel	\$1,120,000	75/25	\$208,000
Operating	140,000	50/50	70,000
<b>TOTAL</b>	<b>\$1,260,000</b>		<b>\$278,000 *</b>
* In SFY '06 only ½ (6 months) would be included @ \$175,000			

### PROJECTED SAVINGS

ED visits averted est. 13% or an annual reduction of 4,900 visits.

Average cost per visit = \$306.00.

**PROJECTED SAVINGS** \$306.00 x 4,900 projected averted visits annually. **\$ 1,499,400.00 \***

\* Actual savings in SFY '06 assumed to be 25% of this amount @ \$375,000.

**Section 7: Policy Savings Options Details**

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ITEM: #14

CATEGORY: Quality

OPTION NAME: Case Management of High Cost/Complicated Services

REQUIRES FEDERAL APPROVAL: Requires State Plan Amendment

STATE LEGISLATION and OTHER POLICY CHANGES REQUIRED: No changes required.

SFY '06 STATE TOTALS	
INVESTMENT	SAVINGS
\$471,500	\$575,000

**Problem Statement**

Increasingly the health and quality of life of beneficiaries with high cost and complicated chronic illnesses requires care coordination on multiple levels

between all service providers.

**Vermont Data**

Vermont Selected Medicaid Chronic Illness Expenditures SFY '04		
CONDITION	DOLLARS	# OF UNIQUE RECIPIENTS
Depression	\$19,567,505.00	34,362
CHF	\$14,037,434.00	2,971
Diabetes	\$10,648,661.00	6,912
Obesity	\$1,578,489.00	4,482
Asthma	\$576,757.00	1,887
<b>TOTAL</b>	<b>\$ 46,408,846.00</b>	<b>50,614 *</b>
* This number may reflect beneficiaries in multiple diagnostic categories.		

**Goal**

The long range goal is to maximize the health and quality of life of beneficiaries in their communities by providing substantive support to provider and patient in the coordination of their care.

**Method**

As an extension of the primary care provider and in concert with their patients, a *Disease and Care Coordination Program* is expected to focus on those with Chronic Disease and other conditions that result in high utilization patterns. Beneficiaries that fall into the above classifications will be assigned a care coordinator.

**Pre-Implementation**

As an initial step, prior to implementation, OVHA will be vigorously soliciting input in a collaborative fashion from providers, beneficiaries and other stakeholders as to the goals, objectives and strategies best suited for this program.

**Program Implementation:**

Nurse Care Coordinators (NCC) will work with individuals with one or more chronic diseases. Beneficiaries will be identified through data analysis. The NCC will work closely with primary medical providers and other relevant support services. Criteria will be established by which providers may refer patients. Collaboration, consistency and sharing of information are key.

## Section 7: Policy Savings Options Details

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Other responsibilities will be that the NCC will provide a one-on-one assessment and education to participants. As a beneficiary demonstrates stability and self-management, and utilization of services declines, the beneficiary will be transitioned to a Patient Care Coordinator for on-going case coordination as determined by program procedures.

Patient Care Coordinators (PCC) will manage lower severity beneficiaries. Patient care coordination will be provided by specialty trained individuals who will provide health assessments and education, including distribution of educational materials.

### Measurement and Evaluation

Care coordination will be evaluated thoroughly for improved health outcomes and subsequent cost savings to the Medicaid program. A prospective controlled study of the program will be performed to assess health outcomes using care coordination as well as provider medical records. A retrospective analysis of the implementation will also be performed to determine impact on Medicaid costs as well as health outcomes.

### Cost Benefit Analysis

EXPENSE	ANNUAL BUDGET TOTAL EXPENSE WITH FEDERAL MATCH	MATCH RATE	ANNUAL STATE DOLLARS
Personnel	\$3,017,600	75/25	\$754,000
Operating	377,200	50/50	188,600
TOTAL	\$3,394,800		\$943,000*
* In SFY '06 only 1/2(6 months) would be included @ \$471,500			

### PROJECTED SAVINGS

Based on other states realized savings of 5% the first year,

**Projected Savings (46,408,846 x 5%) = \$ 2,300,000.00 \***

\* Actual savings in SFY '06 assume to be 25% of this amount @ \$575,000.

## Section 7: Policy Savings Options Details

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ITEM: #15

CATEGORY: Quality

OPTION NAME: Concurrent Review of Inpatient and Home Health Care

REQUIRES FEDERAL APPROVAL: No

STATE LEGISLATION and OTHER POLICY CHANGES REQUIRED: No changes required.

SFY '06 STATE TOTALS	
INVESTMENT	SAVINGS
\$80,000	\$39,033

*Hospital Readmission*

### **Problem Statement:**

An analysis of Vermont health care expenditures produced by the Department of Banking, Insurance and Securities, and Health Care Administration shows that the largest portion of our health care spending is for hospital-based care.

### **Evidence-Based Data**

A widely read article published in the Journal of the American Medical Association (JAMA) in March 2004 entitled "Comprehensive Discharge Planning with Post Discharge Support for Older Patients with Congestive Heart Failure" found significant improvements in Length of Stay (LOS), Quality of Life (QOL) and frequency of re-admissions when comprehensive discharge planning and aftercare was employed. Comprehensive discharge planning involves three critical areas: patient/family self-management skills; hospital-based discharge planning and close contact with the primary care provider at the time of discharge. A fourth critical step in preventing re-admissions is coordinated patient follow-up after discharge. In the above referenced study it is estimated that as many as 25% of re-admissions could have been averted with this approach.

### **Vermont Data**

According to two recent studies, hospital costs represented the highest percentage of total health care expenditures in Vermont in 2001: 41% or 1.0 billion dollars. It will remain the single most important driver of health care costs as it is expected to increase on an average of 7.3% annually for the next several years.

Source: *Vermont Health Care Expenditure Analysis Forecast: 2003-2007*, December 2004, Department of Banking, Insurance, Securities, and Health Care Administration.

The Vermont Health Care Quality Report, 2004, Vermont Program for Quality in Health Care, Inc.

### **Mission**

Decrease the incidence of unnecessary hospital **readmissions** by assisting beneficiaries in accessing clinically appropriate outpatient health services.

### **Goal**

Evaluate factors contributing to preventable readmissions -

- Comprehensiveness of discharge planning
- Access to and resource utilization for aftercare services

## Section 7: Policy Savings Options Details

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- Communication linkages between the hospital and primary practitioners
- Interventions towards improved patient self management

### Method/Program Implementation

1. Perform an analysis of current Vermont Medicaid expenditures for all readmissions within three to six months of hospital discharge.
2. Assign a Nurse Care Coordinator (NCC) to each patient that has had a readmission based on pre-determined criteria to work with patients/families and the healthcare team towards preventing unnecessary hospitalizations.
3. Following discharge, NCC's will provide support to ensure that follow-up care is appropriate, accessible and actually accomplished.

### Pre-Implementation

As an initial step, prior to implementation OVHA will be soliciting input in a collaborative manner from providers, beneficiaries and other stakeholders as to the goals, objectives and strategies best suited for this program

### Measurement and Evaluation

Care coordination will be evaluated thoroughly for improved health outcomes and subsequent cost savings to the Medicaid program. A prospective controlled study of the program will be performed to assess health outcomes using care coordination as well as provider medical records. A retrospective analysis of the implementation will also be performed to determine impact on Medicaid costs as well as health outcomes.

### Cost Benefit Analysis

EXPENSE	ANNUAL BUDGET TOTAL EXPENSE WITH FEDERAL MATCH	MATCH RATE	ANNUAL STATE DOLLARS
Personnel	512,000	75-25	128,000
Operating	64,000	50-50	32,000
<b>TOTAL</b>	<b>576,000</b>		<b>160,000 *</b>
* In SFY '06 only ½ (6 months) would be included @ 80,000			

### PROJECTED SAVINGS

**\$156,132.00 \***

\*In SFY '06 assume total savings to be 25% of this number @ \$39,033.00

**Section 7: Policy Savings Options Details**

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ITEM: #16

CATEGORY: Quality

OPTION NAME: Fully Capitalize PACE Centers in Burlington and Rutland

REQUIRES FEDERAL APPROVAL: No

STATE LEGISLATION and OTHER POLICY CHANGES REQUIRED:

SFY '06 STATE TOTALS	
INVESTMENT	SAVINGS
\$604,380	\$258,720

The Program for All-Inclusive Care (PACE) is a health care system for frail individuals age 55 and older that provides all acute, primary and long-term care needs of the individual by utilizing an

interdisciplinary team. The individual receiving the care is a member of the team along with the physician, nurses, therapists and other caregivers. The team is located at the physician's office that also includes an adult day center. Rather than struggling with the complexities of payment and providers, PACE programs provide a one-stop shop of preventive, primary, acute, and long-term services for their enrolled members. Once a person is enrolled in the program, PACE takes responsibility for managing the medical, mental, and psychosocial needs of each participant.

Nationally, most PACE participants are similar to their counterparts in nursing homes. According to the National PACE Association (NPA), the average participant is 80 years old, has 7.9 medical conditions, and limitations in approximately three of the five major activities of daily living (bathing, dressing, feeding, toileting, and transferring). Almost half are diagnosed with dementia. Savings result from team management and reduction in caseloads for primary/acute care providers.

**Savings:** The projected savings to Vermont Medicaid based on enrollment projections:

Year 1 savings = \$258,720	Year 4 savings = \$651,420
Year 2 savings = \$378,840	Year 5 savings = \$762,300
Year 3 savings = \$540,540	Total Savings at the end of 5 years = \$2,591,820

**Why PACE?**

- **For consumers, PACE provides:**
  - Caregivers who listen to and can respond to their individualized care needs
  - The option to continue living in the community as long as possible
  - One-stop shopping for all health care services
  
- **For health care providers, PACE provides:**
  - A capitated funding arrangement that rewards providers who are flexible and creative in providing the best care possible
  - The ability to coordinate care for the individuals across settings and medical disciplines
  - A way to meet increasing consumer demands for individualized care and supportive services arrangements

## Section 7: Policy Savings Options Details

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- **For those who pay for care, PACE provides:**
  - Cost savings and predictable expenditures
  - A comprehensive service package emphasizing preventive care that is usually less expensive and more effective than acute care and long-term care
  - A model of choice for older individuals focused on keeping them at home and out of institutional settings

### Health Care Services

Services managed by the interdisciplinary team and paid for by capitated payments from Medicare and Medicaid include:

#### *Physician Office/Center Services:*

Physician  
Nurse Practitioner  
Nursing  
Social Work  
Occupational Therapy  
Physical Therapy  
Recreational Therapy  
Nutrition Counseling  
Transportation  
Meals

#### *Specialist Services*

Medical specialists  
Audiology  
Dentistry  
Optometry  
Podiatry  
Speech Therapy

#### *Other Medical Services*

Prescriptions  
Lab Tests/Procedures  
Radiology Services/Procedures  
Durable Medical Equipment  
Outpatient Surgery  
Emergency Room Care  
Medical Transportation

#### *Inpatient Services*

Hospital  
Nursing Home  
Inpatient Specialists

#### *Long-Term Care Services*

Nursing Home  
Personal Care (center & home)  
Homemaker (center & home)

#### *In-Home Services*

Physician  
Nursing  
Social Work  
Physical Therapy  
Occupational Therapy  
Meals

## Section 7: Policy Savings Options Details

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ITEM: #17

CATEGORY: Quality

OPTION NAME: Geriatric Nurse Practitioners

REQUIRES FEDERAL APPROVAL: No

STATE LEGISLATION and OTHER POLICY CHANGES REQUIRED: No changes required.

SFY '06 STATE TOTALS	
INVESTMENT	SAVINGS
\$50,000	\$205,500

This option proposes using Nurse Practitioners to improve the coordination of acute and long term care services for individuals served by the long-term care 1115 Waiver. These nurse practitioners would be the

interface between the individual's physician and the community based providers, such as Home Health and the Area Agency on Aging, to ensure that the individual's complete care plan, including primary care, prescriptions, therapies, nutrition and social services was planned in a coordinated fashion and then monitored for effectiveness. Physicians, Home Health and Aging staff would continue to do the work they have been doing. This service would be value-added to help avoid unnecessary hospitalizations and premature nursing home admissions.

This option has been shown to be effective in other states to improve care and reduce costs. Some experience in Vermont nursing homes shows similar results. The Department of Aging and Disabilities has begun meeting with nurse practitioners to gauge interest in participating in this project and design an implementation strategy.

This option will be coordinated with the Department of Aging and Disabilities (DAIL), and the Case Management effort in OVHA for other Medicaid recipients.

## Section 7: Policy Savings Options Details

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ITEM: #18

CATEGORY: Quality

OPTION NAME: NGA Policy – Diabetes Registry

REQUIRES FEDERAL APPROVAL: No

STATE LEGISLATION and OTHER POLICY CHANGES REQUIRED: No changes required.

SFY '06 STATE TOTALS	
INVESTMENT	SAVINGS
\$35,000	\$0

The OVHA was selected by the National Governors Association, Center for Best Practices, Policy Academy on Chronic Disease Prevention and Management. The OVHA team includes both the

OVHA Director and Medical Director, and representatives from other AHS departments and external entities. The OVHA team vision is to: "Enhance the lives of Vermonters through the prevention, early detection and management of chronic health conditions by implementing the Chronic Care Model, integrating public health and clinical systems, and aligning public and private health policy." Initially, the team will focus on activities which renew its commitment to the Vermont Blueprint for Health and facilitate development of a prototype disease registry to assist in the management of chronic disease.

## Section 7: Policy Savings Options Details

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ITEM: #19

CATEGORY: Reimbursement

OPTION NAME: Pharmacy Mail Order

REQUIRES FEDERAL APPROVAL: Requires State Plan Amendment

STATE LEGISLATION and OTHER POLICY CHANGES REQUIRED: Requires rule and statute changes.

SFY '06 STATE TOTALS	
INVESTMENT	SAVINGS
\$0	\$120,212

This option is premised on the assumption that savings can be realized when using mail order on select pharmacy products. At a minimum we expect that at least \$300,000 in gross savings could be realized in

SFY '06. The five proposed target areas are diabetic supplies, multiple sclerosis drugs, growth hormone drugs, hemophilic drugs, and the drug Synagis® used in the treatment of respiratory syncytial virus (RSV). In the last six months of SFY '04, Vermont's publicly funded programs spent \$1.8 million on these five classes. We believe that savings can be realized because mail order pharmacy companies that specialize in the products can take advantage of pricing options that may not be available to individual local pharmacies simply because of the quantities purchased.

Not only do we envision that this will generate savings for the programs, we believe that we have the opportunity to obtain better health outcomes. With mail order contracts, case management services are often available to assure that patients are appropriate for the drug use and they take the products precisely according to the dispensing instructions. This assures the optimum results from the products. For example, Synagis® alone costs \$1 million per year. RSV is a contagious virus that can be very serious for infants who were born prematurely and thus did not receive natural virus-fighting substances from their mothers before they were born. RSV is seasonal, beginning in the fall and running through the spring. Synagis® has been demonstrated as effective in the prevention of this disease for these high risk children. To be protected a baby must receive an injection each month during the RSV season. If a dosage is missed, the baby is at risk for the remainder of the season because it is not possible to restart the regimen. Synagis® case management services would stress the importance of dosing requirements and the alternative risks.

## Section 7: Policy Savings Options Details

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ITEM: #20

CATEGORY: Reimbursement

OPTION NAME: Pharmacy Premium Rebate to Beneficiaries (Generic)

REQUIRES FEDERAL APPROVAL: Requires State Plan Amendment

STATE LEGISLATION and OTHER POLICY CHANGES REQUIRED: Requires rule and statute changes.

SFY '06 STATE TOTALS	
INVESTMENT	SAVINGS
\$125,000	\$706,228

This option is premised on the assumption that effective July 1, 2005 the use of generic drugs can be increased if beneficiaries receive a cash incentive for the use of generics. The cash incentive would

encourage the use of these lesser cost alternatives.

Generic drug usage in Vermont's publicly funded pharmacy programs has been hovering around 50% in recent months. That is an increase of several points since the inception of the Health Access Pharmacy Benefit Management Program but at this point greater percentages experienced by other states may be difficult to attain. States like Nevada and North Dakota report percentages of 58% and 55% respectively. They indicate that these rates have been achieved by applying a higher copayment on brands than on generics. In the absence of copayments, this option assumes that if reducing out-of-pocket expenses influences generic use then providing a direct financial incentive will do the same thing.

While 50% of current drug use is generic, in some cases our drug costs are no greater than generic use because of the Preferred Drug List. Initially we thought it might be reasonable to assume a 2.5% increase in generic use, half of the North Dakota experience. To assure savings we halved that to 1.3% of total drug spending, reduced the result by an estimated 22% in Medicaid OBRA '90 and supplemental rebates, and allowed a 1% rebate to beneficiaries. The result was a savings of 1% against spending. This 1% was applied to the gross expenditures in the first quarter of this fiscal year, \$4,607,608, to estimate the general fund savings of \$706,228 on this option.

## Section 7: Policy Savings Options Details

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ITEM: #21

CATEGORY: Reimbursement

OPTION NAME: Allow Greater Day Supply

REQUIRES FEDERAL APPROVAL: Requires State Plan Amendment

STATE LEGISLATION and OTHER POLICY CHANGES REQUIRED: Requires rule change.

SFY '06 STATE TOTALS	
INVESTMENT	SAVINGS
\$0	\$24,997

This option is premised on the assumption that dispensing costs can be reduced by allowing beneficiaries to get a greater number of days dispensed when the drug is a maintenance drug, the patient has a proven record of being able to use the drug, and it is unlikely that the patient's eligibility status is likely to change during the period for which the drug is dispensed.

With a limited number of exceptions, current practice allows maintenance drug coverage of 90 days for VScript beneficiaries and 102 days for all other beneficiaries. Non-maintenance drugs are limited to a maximum of 34 days.

Common prescribing is overwhelmingly likely to be for periods of less than 34 days. In the quarter ending December 31, 2004, only 4.9% of the claims were for periods of greater than 34 days. Prescribers will be encouraged to prescribe for longer periods when it is appropriate.

The savings on this option are based on a reduction in the number of claims annually. Each claim includes a dispensing fee of \$4.25. A reduction of 15,000 claims in SFY '06 would produce \$25,000 in savings in general fund on dispensing fees alone.

## Section 7: Policy Savings Options Details

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ITEM: #22

CATEGORY: Program Design

OPTION NAME: Limit VScript Coverage to a More Common Definition of Maintenance Drugs

REQUIRES FEDERAL APPROVAL: No

STATE LEGISLATION and OTHER POLICY CHANGES REQUIRED: Requires rule, statute and protocol changes.

SFY '06 STATE TOTALS	
INVESTMENT	SAVINGS
\$0	\$60,912

VScript coverage is therapeutic classes not primarily used in the treatment of acute conditions. This is the definition of “maintenance drugs” used in the program. At the inception of the program in 1989 it

was left to the pharmacies to determine if a drug was a maintenance drug. An analysis of use indicates that the result has been coverage well beyond what would be considered if the common definitions of “maintenance drugs” used by other health plans were applied. This option is premised on the assumption that the more common definitions would apply.

The \$61,000 general fund savings estimated are based on the assumption of saving at least 1% against expenditures in SFY '06.

Examples of classes that would no longer be covered because they are primarily used for the treatment of acute conditions include:

- Antidiarrheals
- Laxatives
- Antihistamines
- Cough preparations/expectorants
- Cold and cough preparations
- Antibiotics
- Antineoplastics
- Antivirals
- Diagnostics
- Narcotic analgesics
- Sedative barbiturate/non-barbiturate
- Glucocorticoids
- Antidotes
- Fungicides
- Dermatologicals

## Section 7: Policy Savings Options Details

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ITEM: #23

CATEGORY: System Management

OPTION NAME: Vermont Blueprint for Health

REQUIRES FEDERAL APPROVAL: No

STATE LEGISLATION and OTHER POLICY CHANGES REQUIRED: No changes required.

SFY '06 STATE TOTALS	
INVESTMENT	SAVINGS
\$1,038,683	

The State of Vermont is currently poised to be the first state in the country to unveil multiple projects aimed at implementing the Chronic Care Model statewide.

To this end, the Governor has established the

"Vermont Blueprint for Health: The Chronic Care Initiative." This project has three goals:

1. Implement a statewide system of care that enables Vermonters with, and at risk for, chronic disease to lead healthier lives.
2. Develop a system of care that is financially sustainable.
3. Forge a public-private partnership to develop and sustain the new system of care.

In furtherance of the above goals, the Global Commitment, as conceptualized by the State of Vermont, would provide the necessary flexibility to allow all of Vermont's current Medicaid recipients to be involved in evidence-based best practices as implemented utilizing the Chronic Care Model, without regard to their eligibility category.

The effect of chronic conditions on the health of Americans and health care costs is staggering. Individuals with chronic conditions account for 72% of all visits to physicians, 76% of hospital admissions, and overall, 84% of all health care expenditures. In Vermont, 51% of all adults have one or more chronic conditions. In the population from 45 to 64 years old, 68% of individuals have chronic conditions, and in the population 65 years and over, the rate is 88%, with 20% of this population having at least four chronic conditions. Thirty percent of the population with a chronic condition have their daily activity limited by the condition, which impacts productivity in the workplace.

Just one common chronic condition – cardiovascular disease – accounts for 20% of all hospital admissions, or more than 47,000 patient days, at an expense of over \$47 million. It is the leading cause of permanent, premature disability, and drives up disability premiums. It is the leading cause of death in Vermont, accounting for 27% of all deaths. Cardiovascular disease is largely preventable, and once obtained, is largely controllable. It is one of the chronic conditions that will be addressed through the Blueprint for Health.

The prevalence of chronic conditions has increased in our society due to unhealthy behaviors, including excessive caloric intake, lack of physical activity and smoking. However, our system of care has not changed, and the system, designed for acute care problems, is ill equipped to deal with chronic conditions. According to the Institute of Medicine, more than 50% of individuals with chronic conditions such as diabetes, cardiovascular disease, and asthma are inadequately

## **Section 7: Policy Savings Options Details**

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managed. In other words, they do not get appropriate care to minimize the impact of their condition on their health, quality of life and ability to be productive members of our community. This results in the exacerbation of their condition, the development of related medical problems and increased use of health care resources.

“The Vermont Blueprint for Health: The Chronic Care Initiative” is a public-private partnership formed to address the increasing burden of chronic care on individuals, the health care system, businesses and government programs such as Medicaid. The initiative envisions a future in Vermont where informed, activated patients interact with prepared, proactive practice teams, with the results being effective encounters with the health care system, improved health outcomes and decreased utilization of the health care system.

The Blueprint includes active roles for individuals, communities and providers. This will be assisted by information systems, such as a patient registry, that will facilitate proactive care management by providers and patients by furnishing them with the information they need when they need it. It will allow us to move from a system of reactive care to one of planned care, which will slow disease progression, reduce the number of hospitalizations for complications associated with chronic conditions (e.g., amputations due to diabetes) and decrease the number of premature deaths, while allowing Vermonters to lead productive lives.

We commend all the Vermont partners, public and private, who have invested in the success of the “Vermont Blueprint for Health: The Chronic Care Initiative”. To achieve the needed systemic improvements to our health care system, we must redouble our efforts, engage further essential partners, and implement the chronic care model throughout Vermont as swiftly and effectively as possible.

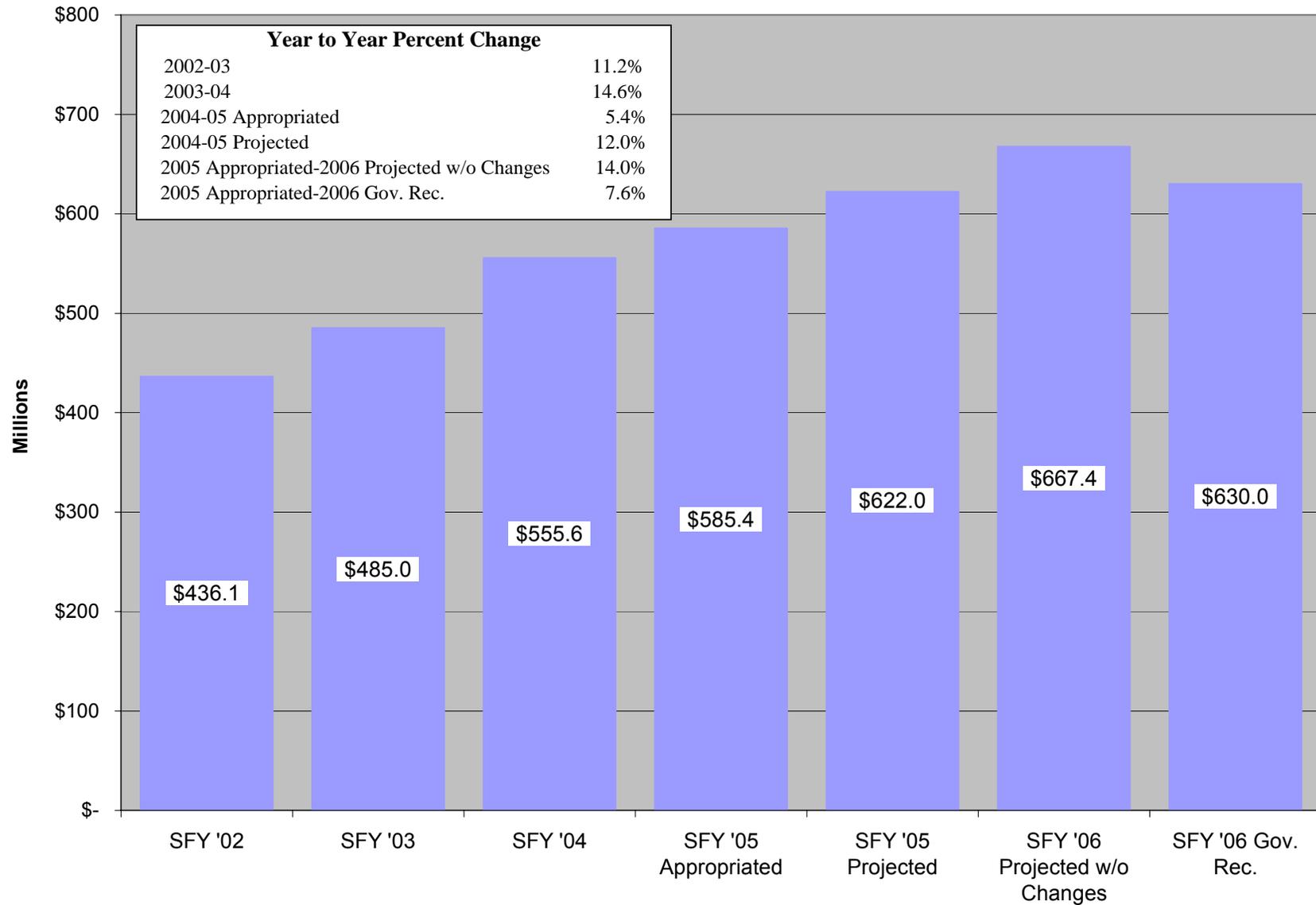
**Table 8: Five-Year Projection of Revenue and Expenditures – Unabated**

Office of Vermont Health Access 5 Year Projection of Revenue and Expenditures - Without Changes								
	SFY '04 Actual	SFY '05 Appropriated	SFY '05 Projected	SFY '06 Projected	SFY '07 Projected	SFY '08 Projected	Global Commitment	
							SFY '09 Projected	SFY '10 Projected
<b>Expenditures</b>								
ABD	\$ 145,321,331	\$ 160,101,770	\$ 166,904,824	\$ 181,780,644	\$ 197,050,219	\$ 213,602,437	\$ 231,545,042	\$ 250,994,825
Families	\$ 126,008,998	\$ 136,462,845	\$ 144,627,218	\$ 151,209,305	\$ 163,910,887	\$ 177,679,401	\$ 192,604,471	\$ 208,783,246
Ladies First	\$ 516,741	\$ 624,481	\$ 1,221,751	\$ 1,000,690	\$ 1,084,748	\$ 1,175,867	\$ 1,274,640	\$ 1,381,710
SCHIP	\$ 3,607,885	\$ 3,441,468	\$ 3,865,572	\$ 4,284,028	\$ 4,643,886	\$ 5,033,973	\$ 5,456,827	\$ 5,915,200
Underinsured Children	\$ 1,141,586	\$ 1,162,205	\$ 1,263,791	\$ 1,533,691	\$ 1,662,521	\$ 1,802,173	\$ 1,953,555	\$ 2,117,654
Caretakers	\$ 3,941,420	\$ 3,316,220	\$ 5,125,017	\$ 5,692,810	\$ 6,171,006	\$ 6,689,371	\$ 7,251,278	\$ 7,860,385
Total Traditional Expenditures	\$ 280,537,961	\$ 305,108,989	\$ 323,008,173	\$ 345,501,169	\$ 374,523,267	\$ 405,983,222	\$ 440,085,812	\$ 477,053,020
VHAP	\$ 55,500,942	\$ 52,075,327	\$ 60,686,924	\$ 64,375,080	\$ 69,782,586	\$ 75,644,323	\$ 81,998,447	\$ 88,886,316
VHAP-Pharmacy	\$ 16,221,334	\$ 15,430,939	\$ 20,620,792	\$ 23,381,440	\$ 25,345,481	\$ 27,474,501	\$ 29,782,359	\$ 32,284,077
VScript	\$ 5,579,045	\$ 5,578,566	\$ 6,052,976	\$ 7,117,717	\$ 7,715,605	\$ 8,363,716	\$ 9,066,269	\$ 9,827,835
VScript expanded	\$ 2,891,798	\$ 5,653,557	\$ 5,719,467	\$ 6,737,716	\$ 7,303,684	\$ 7,917,194	\$ 8,582,238	\$ 9,303,146
Total VHAP Expenditures	\$ 80,193,119	\$ 78,738,389	\$ 93,080,159	\$ 101,611,953	\$ 110,147,357	\$ 119,399,735	\$ 129,429,312	\$ 140,301,374
Healthy Vermonters Program	\$ 17	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total Program Expenditures	\$ 360,731,097	\$ 383,847,378	\$ 416,088,332	\$ 447,113,122	\$ 484,670,624	\$ 525,382,956	\$ 569,515,124	\$ 617,354,395
Other Expenditures	\$ 42,286,608	\$ 47,407,943	\$ 49,229,898	\$ 50,128,888	\$ 54,339,715	\$ 58,904,251	\$ 63,852,208	\$ 69,215,793
Long-Term Care Expenditures	\$ 130,782,955	\$ 133,919,791	\$ 136,500,000	\$ 145,033,617	\$ 157,216,441	\$ 170,422,622	\$ 184,738,122	\$ 200,256,124
Operating Expenses	\$ 21,799,865	\$ 20,207,477	\$ 20,207,477	\$ 25,144,212	\$ 26,401,423	\$ 27,721,494	\$ 29,107,568	\$ 30,562,947
Grand Total Expenditures	\$ 555,600,525	\$ 585,382,589	\$ 622,025,707	\$ 667,419,839	\$ 722,628,202	\$ 782,431,322	\$ 847,213,023	\$ 917,389,259.1
State Funds Prior to Global Commitment	\$ 193,083,629	\$ 229,123,985	\$ 247,031,227	\$ 277,208,996	\$ 303,503,845	\$ 328,621,155	\$ 351,593,404	\$ 380,716,543
<b>Sources of Revenue</b>								
<b>Inflows</b>								
Tobacco Settlement	\$ 17,250,000	\$ 17,250,000	\$ 17,250,000	\$ 17,250,000	\$ 17,250,000	\$ 17,250,000	\$ 17,250,000	\$ 17,250,000
General Funds	\$ 75,550,857	\$ 70,232,010	\$ 89,305,690	\$ 73,743,611	\$ 76,324,637	\$ 78,843,350	\$ 81,445,181	\$ 84,132,872
Provider Tax Receipts	\$ 54,816,916	\$ 59,578,887	\$ 59,619,607	\$ 60,800,077	\$ 62,928,080	\$ 65,130,562	\$ 67,410,132	\$ 69,769,487
Cigarette/Tobacco Tax	\$ 53,416,813	\$ 49,900,000	\$ 49,000,000	\$ 47,400,000	\$ 45,900,000	\$ 43,605,000	\$ 41,424,750	\$ 39,353,513
Transfer from Veterans Home	\$ 911,786	\$ 900,000	\$ 900,000	\$ -	\$ -	\$ -	\$ -	\$ -
Recoveries (Glaxo & Bayer)	\$ 809,586	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Interest	\$ 116,775	\$ 500,000	\$ 150,000	\$ 150,000	\$ 150,000	\$ 150,000	\$ 150,000	\$ 150,000
Other Income	\$ 1,611,421	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Enrollment/Premium Fees	\$ 2,780,969	\$ 4,900,000	\$ 5,000,000	\$ 4,074,516	\$ 4,176,379	\$ 4,280,788	\$ 4,387,808	\$ 4,497,503
General Fund Transfer for Carryforward	\$ 2,000,000	\$ -	\$ 20,000,000	\$ -	\$ -	\$ -	\$ -	\$ -
Total Inflows	\$ 209,265,122	\$ 203,260,897	\$ 241,225,297	\$ 203,418,204	\$ 206,729,096	\$ 209,259,701	\$ 212,067,871	\$ 215,153,374
<b>Outflows</b>								
State Funds Expended	\$ 193,083,629	\$ 229,123,985	\$ 247,031,227	\$ 277,208,996	\$ 303,503,845	\$ 328,621,155	\$ 351,593,404	\$ 380,716,543
Transfer costs	\$ 2,185,627	\$ 150,000	\$ 2,204,500	\$ 2,536,559	\$ 2,536,559	\$ 2,536,559	\$ 2,536,559	\$ 2,536,559
Total Outflows	\$ 195,269,256	\$ 229,273,985	\$ 249,235,727	\$ 279,745,555	\$ 306,040,404	\$ 331,157,714	\$ 354,129,963	\$ 383,253,102
Projected Annual Change State Funds Excess/(Deficit)	\$ 13,995,866	\$ (26,013,088)	\$ (8,010,430)	\$ (76,327,351)	\$ (99,311,308)	\$ (121,898,013)	\$ (142,062,093)	\$ (168,099,727)
<b>Summary - Cumulative Changes to Health Access Trust Fund</b>								
Beginning Balance SFY Carry Forward Prior SFY Excess/(Deficit)	\$ 9,721,691	\$ 24,317,557	\$ 24,317,557	\$ 16,307,127	\$ (60,020,224)	\$ (159,331,532)	\$ (281,229,546)	\$ (423,291,638)
Transfers into Health Access Trust Fund	\$ 600,000	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Projected Annual Change State Funds Excess/(Deficit)	\$ 13,995,866	\$ (26,013,088)	\$ (8,010,430)	\$ (76,327,351)	\$ (99,311,308)	\$ (121,898,013)	\$ (142,062,093)	\$ (168,099,727)
Projected SFY Cumulative Changes State Funds Excess/(Deficit)	\$ 24,317,557	\$ (1,695,531)	\$ 16,307,127	\$ (60,020,224)	\$ (159,331,532)	\$ (281,229,546)	\$ (423,291,638)	\$ (591,391,366)
State Match Rates:	34.48%	39.58%	39.58%	41.10%	42.00%	42.00%	41.50%	41.50%

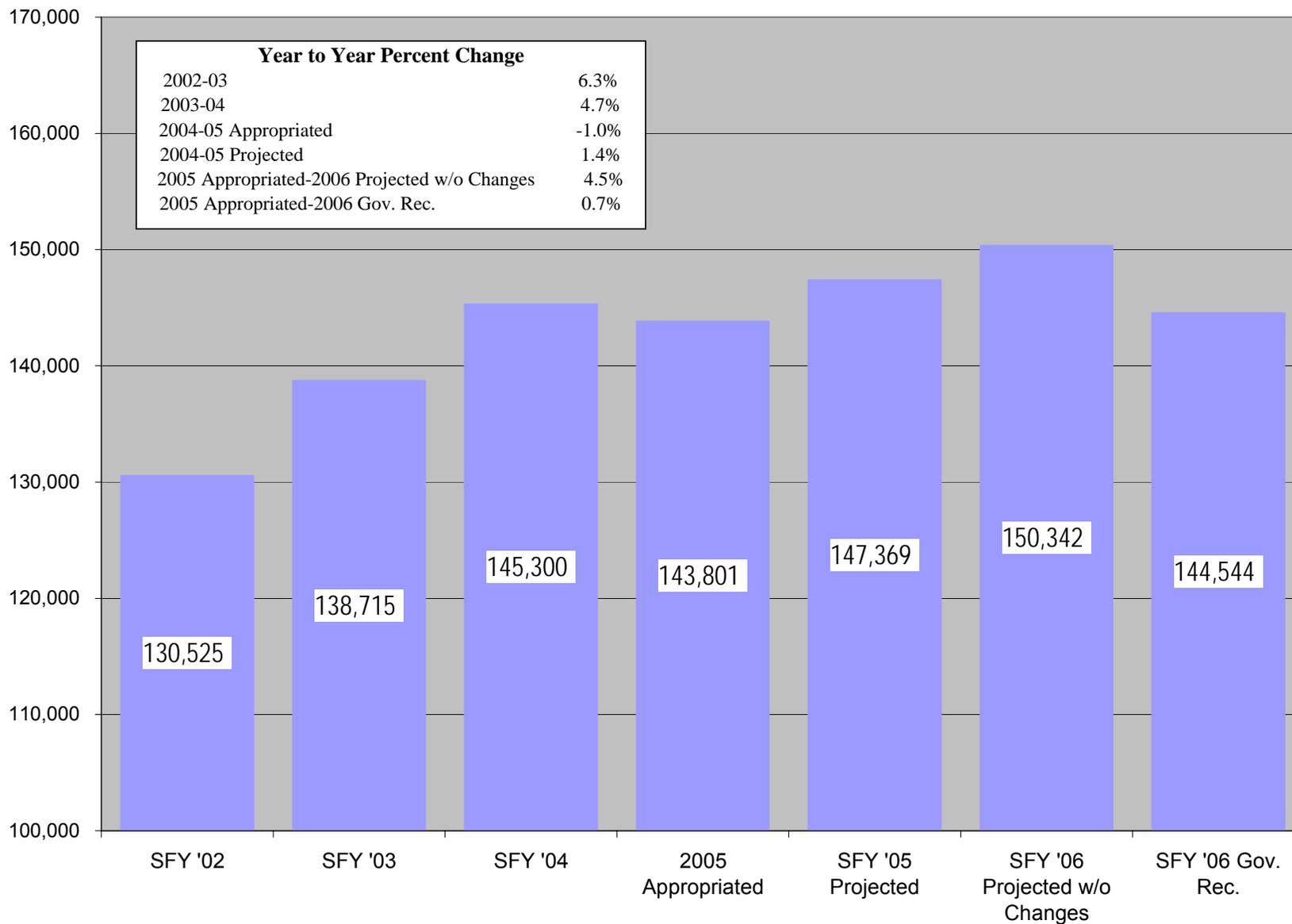
**Table 9: Five-Year Projection of Revenue and Expenditures – Governor’s Recommend**

<b>Office of Vermont Health Access</b>									
<b>5 Year Projection of Revenue and Expenditures - Governor's Recommend</b>									
	SFY '04	SFY '05	SFY '05	SFY '06	SFY '06	SFY '07	SFY '08	SFY '09	SFY '10
	Actual	Appropriated	Projected	w/out Options	Gov. Rec.	Projected	Projected	Projected	Projected
Global Commitment									
<b>Expenditures</b>									
ABD	\$ 145,321,331	\$ 160,101,770	\$ 166,904,824	\$ 181,780,644	\$ 168,920,791	\$ 179,900,642	\$ 194,292,693	\$ 209,836,108	\$ 226,622,997
Families	\$ 126,008,998	\$ 136,462,845	\$ 144,627,218	\$ 151,209,305	\$ 138,650,944	\$ 147,663,256	\$ 159,476,316	\$ 172,234,421	\$ 186,013,175
Ladies First	\$ 516,741	\$ 624,481	\$ 1,221,751	\$ 1,000,690	\$ 925,907	\$ 986,091	\$ 1,064,978	\$ 1,150,176	\$ 1,242,190
SCHIP	\$ 3,607,885	\$ 3,441,468	\$ 3,865,572	\$ 4,284,028	\$ 2,932,532	\$ 3,123,146	\$ 3,372,998	\$ 3,642,838	\$ 3,934,265
Underinsured Children	\$ 1,141,586	\$ 1,162,205	\$ 1,263,791	\$ 1,533,691	\$ 1,125,031	\$ 1,198,158	\$ 1,294,011	\$ 1,397,532	\$ 1,509,335
Caretakers	\$ 3,941,420	\$ 3,316,220	\$ 5,125,017	\$ 5,692,810	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Total Traditional Expenditures</b>	<b>\$ 280,537,961</b>	<b>\$ 305,108,989</b>	<b>\$ 323,008,173</b>	<b>\$ 345,501,169</b>	<b>\$ 312,555,204</b>	<b>\$ 332,871,293</b>	<b>\$ 359,500,996</b>	<b>\$ 388,261,075</b>	<b>\$ 419,321,962</b>
VHAP	\$ 55,500,942	\$ 52,075,327	\$ 60,686,924	\$ 64,375,080	\$ 52,317,223	\$ 55,717,842	\$ 60,175,269	\$ 64,989,291	\$ 70,188,434
VHAP-Pharmacy	\$ 16,221,334	\$ 15,430,939	\$ 20,620,792	\$ 23,381,440	\$ 21,527,839	\$ 20,836,172	\$ 22,503,066	\$ 24,303,311	\$ 26,247,576
VScript	\$ 5,579,045	\$ 5,578,566	\$ 6,052,976	\$ 7,117,717	\$ 6,517,014	\$ 5,865,868	\$ 6,335,137	\$ 6,841,948	\$ 7,389,304
VScript expanded	\$ 2,891,798	\$ 5,653,557	\$ 5,719,467	\$ 6,737,716	\$ 6,131,914	\$ 5,069,370	\$ 5,474,920	\$ 5,912,914	\$ 6,385,947
<b>Total VHAP Expenditures</b>	<b>\$ 80,193,119</b>	<b>\$ 78,738,389</b>	<b>\$ 93,080,159</b>	<b>\$ 101,611,953</b>	<b>\$ 86,493,990</b>	<b>\$ 87,489,252</b>	<b>\$ 94,488,392</b>	<b>\$ 102,047,464</b>	<b>\$ 110,211,261</b>
Healthy Vermonters Program	\$ 17	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Total Program Expenditures</b>	<b>\$ 360,731,097</b>	<b>\$ 383,847,378</b>	<b>\$ 416,088,332</b>	<b>\$ 447,113,122</b>	<b>\$ 399,049,194</b>	<b>\$ 420,360,545</b>	<b>\$ 453,989,388</b>	<b>\$ 490,308,539</b>	<b>\$ 529,533,223</b>
Other Expenditures	\$ 42,286,608	\$ 47,407,943	\$ 49,229,898	\$ 50,128,888	\$ 73,586,854	\$ 53,387,266	\$ 57,658,247	\$ 62,270,907	\$ 67,252,580
Long-Term Care Expenditures	\$ 130,782,955	\$ 133,919,791	\$ 136,500,000	\$ 145,033,617	\$ 132,249,114	\$ 140,845,307	\$ 152,112,932	\$ 164,281,967	\$ 177,424,524
Operating Expenses	\$ 21,799,865	\$ 20,207,477	\$ 20,207,477	\$ 25,144,212	\$ 25,144,212	\$ 26,024,259	\$ 26,935,108	\$ 27,877,837	\$ 28,853,561
<b>Grand Total Expenditures</b>	<b>\$ 555,600,525</b>	<b>\$ 585,382,589</b>	<b>\$ 622,025,707</b>	<b>\$ 667,419,839</b>	<b>\$ 630,029,374</b>	<b>\$ 640,617,377</b>	<b>\$ 690,695,675</b>	<b>\$ 744,739,250</b>	<b>\$ 803,063,888</b>
State Funds Prior to Global Commitment	\$ 193,083,629	\$ 229,123,985	\$ 247,031,227	\$ 277,208,996	261,488,788	269,059,298	290,092,184	309,066,789	331,263,854
Global Commitment					16,976,314	51,623,823	63,923,283	74,238,579	87,929,314
<b>Net State Funds</b>					<b>\$ 244,512,474</b>	<b>\$ 217,435,475</b>	<b>\$ 226,168,901</b>	<b>\$ 234,828,210</b>	<b>\$ 243,334,540</b>
<b>Sources of Revenue</b>									
<b>Inflows</b>									
Tobacco Settlement	\$ 17,250,000	\$ 17,250,000	\$ 17,250,000	\$ 17,250,000	\$ 17,250,000	\$ 17,250,000	\$ 17,250,000	\$ 17,250,000	\$ 17,250,000
General Fund	\$ 75,550,857	\$ 70,232,010	\$ 89,305,690	\$ 73,743,611	\$ 79,144,652	\$ 83,101,885	\$ 87,256,979	\$ 91,619,828	\$ 96,200,819
Provider Tax Receipts	\$ 54,816,916	\$ 59,578,887	\$ 59,619,607	\$ 60,800,077	\$ 85,900,077	\$ 62,928,080	\$ 65,130,563	\$ 67,410,133	\$ 69,769,488
Cigarette/Tobacco Tax	\$ 53,416,813	\$ 49,900,000	\$ 49,000,000	\$ 47,400,000	\$ 47,400,000	\$ 45,900,000	\$ 43,605,000	\$ 41,424,750	\$ 39,353,513
Transfer from Veterans Home	\$ 911,786	\$ 900,000	\$ 900,000	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Recoveries (Glaxo & Bayer)	\$ 809,586	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Interest	\$ 116,775	\$ 500,000	\$ 150,000	\$ 150,000	\$ 150,000	\$ 150,000	\$ 150,000	\$ 150,000	\$ 150,000
Other Income	\$ 1,611,421	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Enrollment/Premium Fees	\$ 2,780,969	\$ 4,900,000	\$ 5,000,000	\$ 4,074,516	\$ 13,563,626	\$ 14,121,526	\$ 14,545,172	\$ 13,255,961	\$ 13,653,640
General Fund Transfer for Carryforward	\$ 2,000,000	\$ -	\$ 20,000,000	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Total Inflows</b>	<b>\$ 209,265,122</b>	<b>\$ 203,260,897</b>	<b>\$ 241,225,297</b>	<b>\$ 203,418,204</b>	<b>\$ 243,408,355</b>	<b>\$ 223,451,491</b>	<b>\$ 227,937,714</b>	<b>\$ 231,110,672</b>	<b>\$ 236,377,460</b>
<b>Outflows</b>									
State Funds Expended	\$ 193,083,629	\$ 229,123,985	\$ 247,031,227	\$ 277,208,996	\$ 244,512,474	\$ 217,435,475	\$ 226,168,901	\$ 234,828,210	\$ 243,334,540
Transfer costs	\$ 2,185,627	\$ 150,000	\$ 2,204,500	\$ 2,536,559	\$ 2,536,559	\$ 2,536,559	\$ 2,536,559	\$ 2,536,559	\$ 2,536,559
<b>Total Outflows</b>	<b>\$ 195,269,256</b>	<b>\$ 229,273,985</b>	<b>\$ 249,235,727</b>	<b>\$ 279,745,555</b>	<b>\$ 247,049,033</b>	<b>\$ 219,972,034</b>	<b>\$ 228,705,460</b>	<b>\$ 237,364,769</b>	<b>\$ 245,871,099</b>
<b>Projected Annual Change State Funds Excess/(Deficit)</b>	<b>\$ 13,995,866</b>	<b>\$ (26,013,088)</b>	<b>\$ (8,010,430)</b>	<b>\$ (76,327,351)</b>	<b>\$ (3,640,678)</b>	<b>\$ 3,479,457</b>	<b>\$ (767,746)</b>	<b>\$ (6,254,097)</b>	<b>\$ (9,493,639)</b>
<b>Summary – Cumulative Changes to Health Access Trust Fund</b>									
Beginning Balance SFY Carry Forward Prior SFY Excess/(Deficit)	\$ 9,721,691	\$ 24,317,557	\$ 24,317,557	\$ 16,307,127	\$ 16,307,127	\$ 12,666,449	\$ 16,145,906	\$ 15,378,160	\$ 9,124,063
Transfers into Health Access Trust Fund	\$ 600,000	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Projected Annual Change State Funds Excess/(Deficit)	\$ 13,995,866	\$ (26,013,088)	\$ (8,010,430)	\$ (76,327,351)	\$ (3,640,678)	\$ 3,479,457	\$ (767,746)	\$ (6,254,097)	\$ (9,493,639)
<b>Projected SFY Cumulative Changes State Funds Excess/(Deficit)</b>	<b>\$ 24,317,557</b>	<b>\$ (1,695,531)</b>	<b>\$ 16,307,127</b>	<b>\$ (60,020,224)</b>	<b>\$ 12,666,449</b>	<b>\$ 16,145,906</b>	<b>\$ 15,378,160</b>	<b>\$ 9,124,063</b>	<b>\$ (369,577)</b>
State Match Rates:	34.48%	39.58%	39.58%	41.10%	41.10%	42.00%	42.00%	41.50%	41.25%

**Table 10: Total Program Expenditures by State Fiscal Year**



**Table 11: Total Program Enrollment by State Fiscal Year**

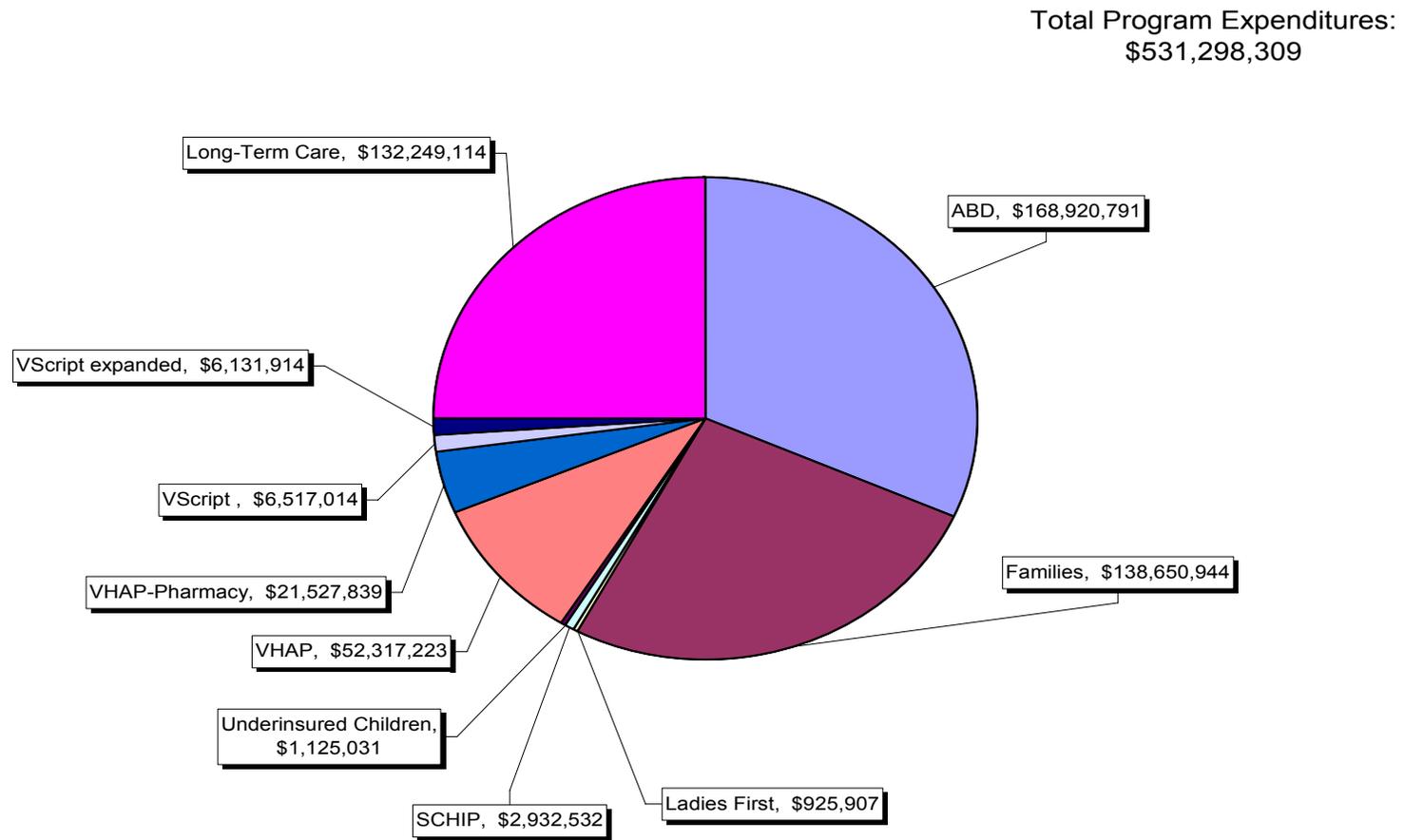


**Table 12: Total Caseload and Percent Change by State Fiscal Year**

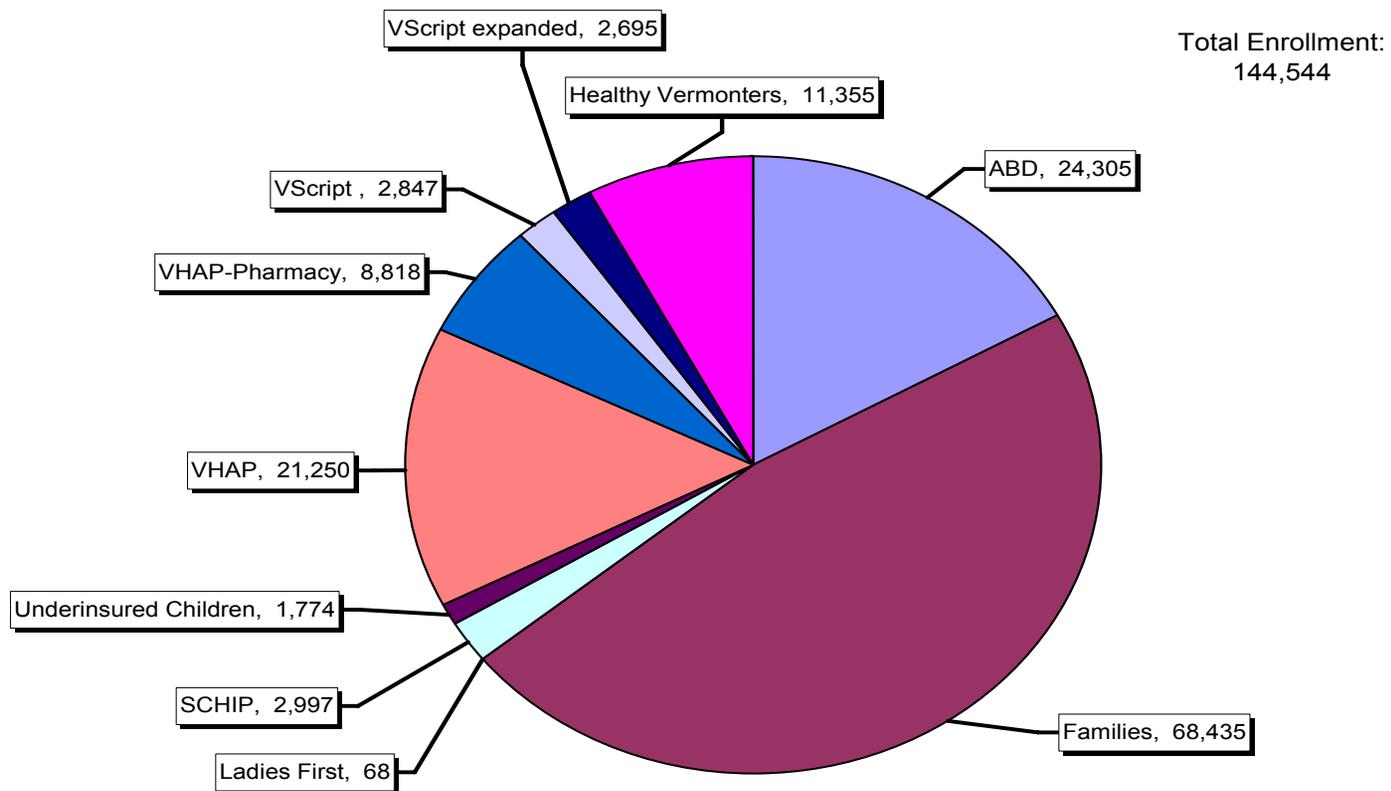
Enrollment Group	SFY '03	SFY '04	SFY '05 Appropriated	SFY '05 Projected	SFY '06 Projected w/o Changes	SFY '06 Gov Rec
ABD	22,636	23,083	23,598	23,728	24,305	24,305
Families	66,919	67,690	68,999	68,565	69,611	68,435
Ladies First	20	40	46	67	68	68
SCHIP	3,094	2,924	2,976	3,077	3,165	2,997
Underinsured Children	2,138	1,842	1,975	1,944	2,191	1,774
Caretakers	2,751	2,590	2,206	2,458	2,554	0
VHAP	21,010	21,739	20,028	22,127	22,733	21,250
VHAP-Pharmacy	8,575	8,424	7,807	8,646	8,818	8,818
VScript	3,081	2,949	2,982	2,795	2,847	2,847
VScript expanded	3,364	2,860	2,600	2,641	2,695	2,695
Healthy Vermonters	5,128	11,159	10,584	11,321	11,355	11,355
<b>Total Caseload</b>	<b>138,716</b>	<b>145,300</b>	<b>143,801</b>	<b>147,369</b>	<b>150,342</b>	<b>144,544</b>

Enrollment Group	Percentage Change				
	SFY '03 - SFY '04	SFY '04 - SFY '05 Appropriated	SFY '04 - SFY '05 Projected	SFY '05 Appropriated - SFY '06 Projected w/o Changes	SFY '05 Appropriated - SFY '06 Gov. Rec.
ABD	2.0%	2.2%	2.8%	3.0%	3.0%
Families	1.2%	1.9%	1.3%	0.9%	-0.8%
Ladies First	103.0%	16.2%	69.3%	47.8%	47.8%
SCHIP	-5.5%	1.8%	5.2%	6.4%	0.7%
Underinsured Children	-13.9%	7.2%	5.6%	10.9%	-10.2%
Caretakers	-5.9%	-14.8%	-5.1%	15.8%	-100.0%
VHAP	3.5%	-7.9%	1.8%	13.5%	6.1%
VHAP-Pharmacy	-1.8%	-7.3%	2.6%	12.9%	12.9%
VScript	-4.3%	1.1%	-5.2%	-4.5%	-4.5%
VScript expanded	-15.0%	-9.1%	-7.7%	3.7%	3.7%
Healthy Vermonters	117.6%	-5.2%	1.5%	7.3%	7.3%
<b>Total Percent(%) Change</b>	<b>4.7%</b>	<b>-1.0%</b>	<b>1.4%</b>	<b>4.5%</b>	<b>0.5%</b>

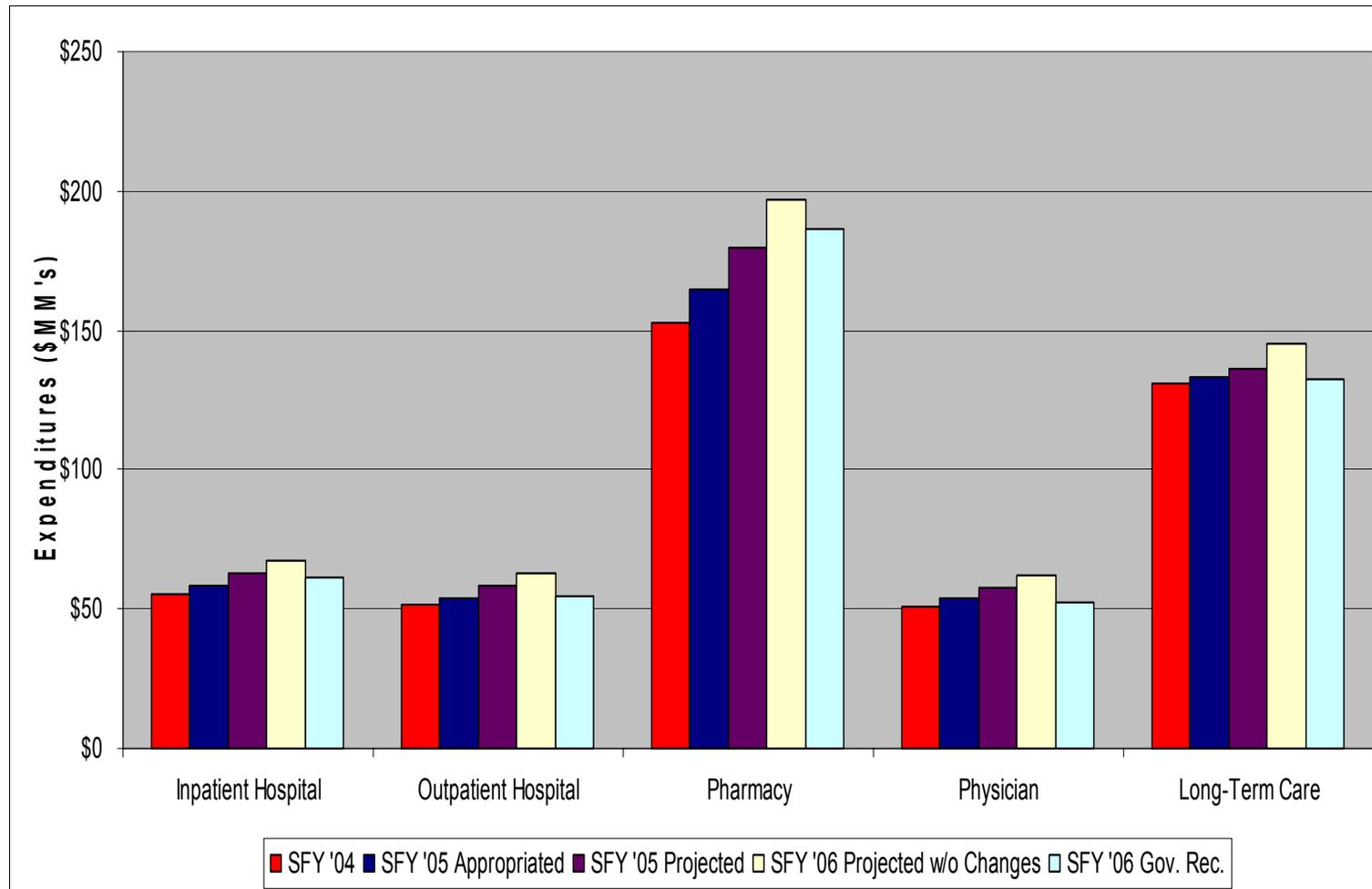
**Table 13: SFY '06 Governor's Recommend Program Expenditures by Enrollment Group**



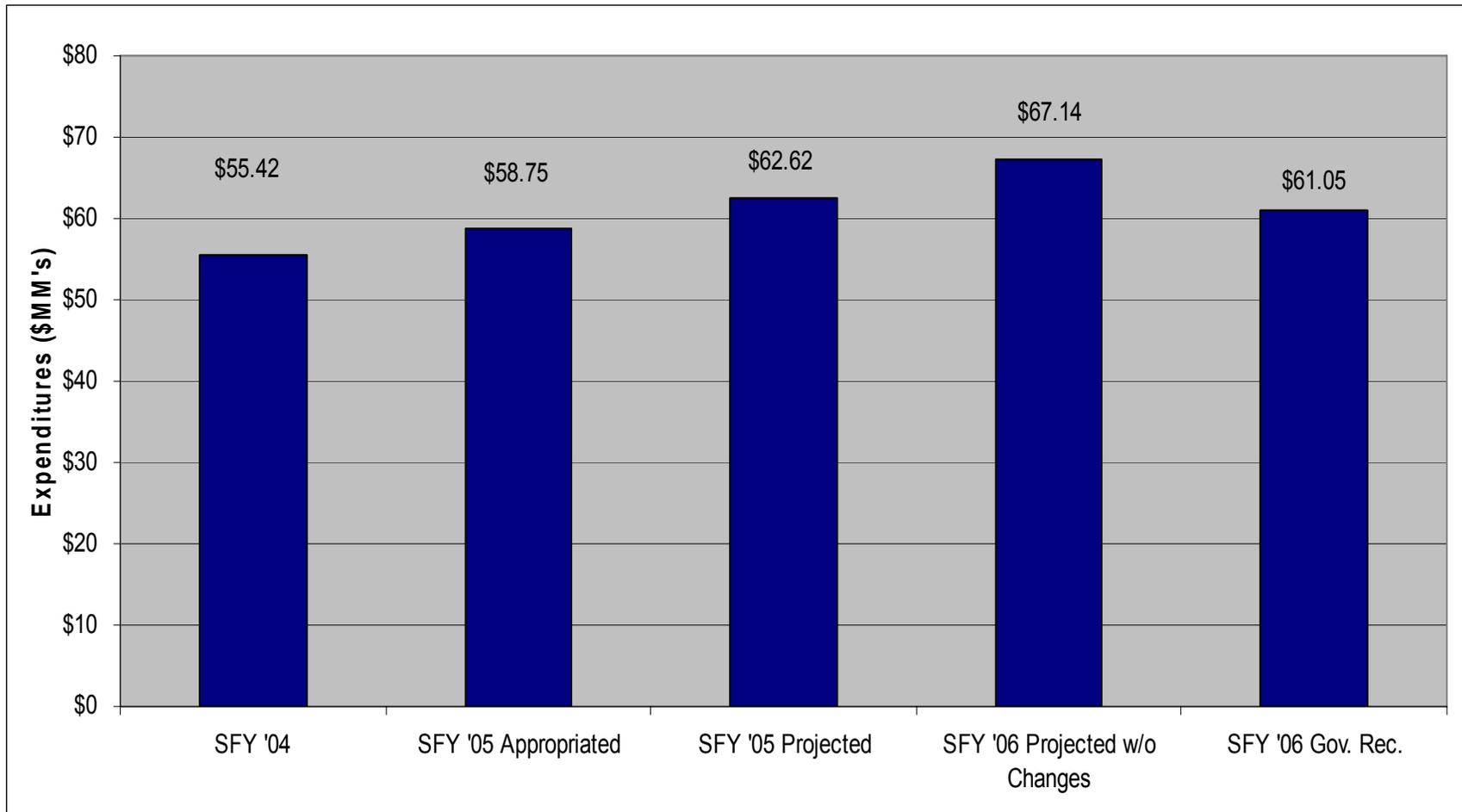
**Table 14: SFY '06 Governor's Recommend by Enrollment Group**



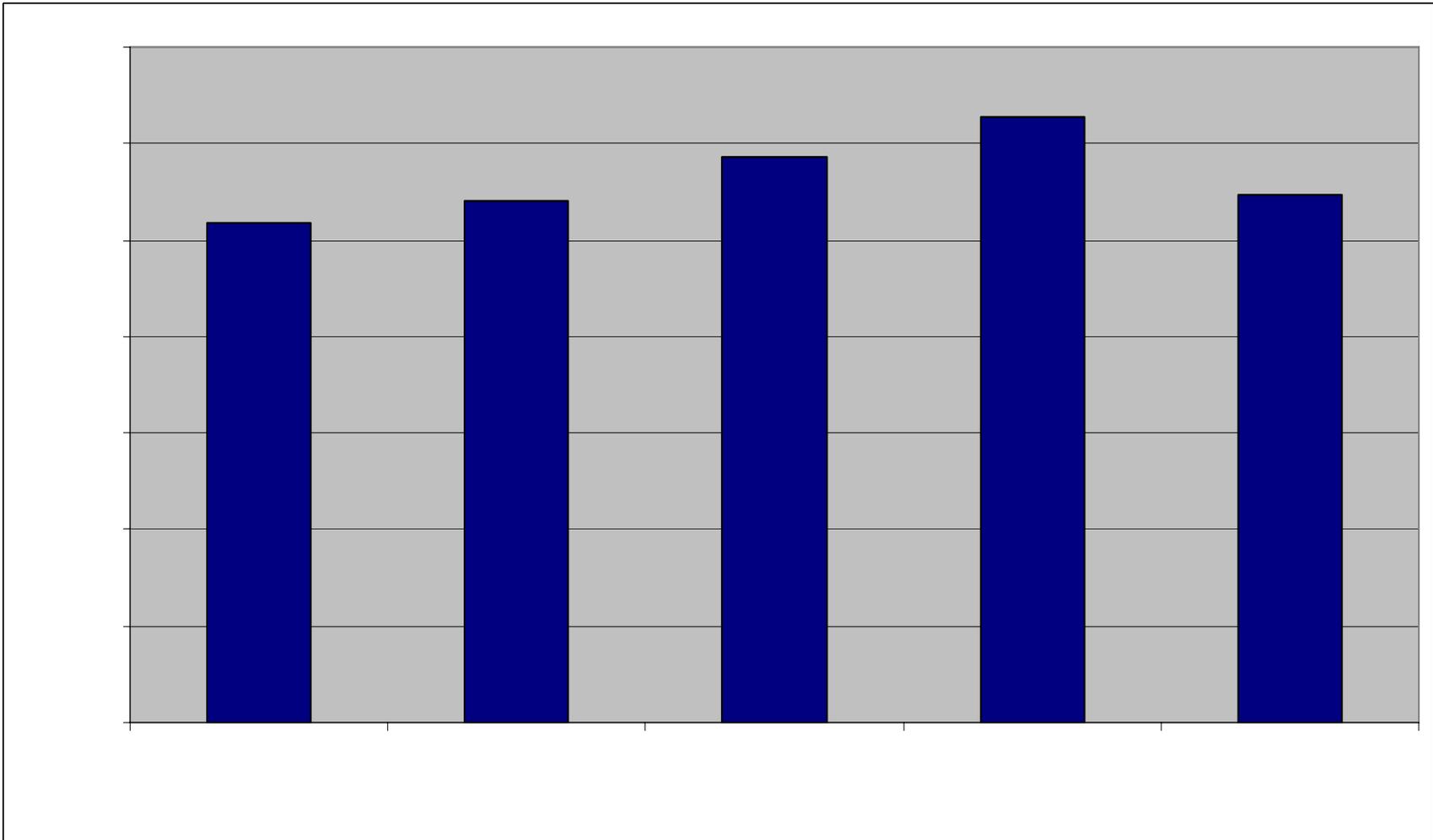
**Table 15: Summary of Expenditures for Major Service Categories**



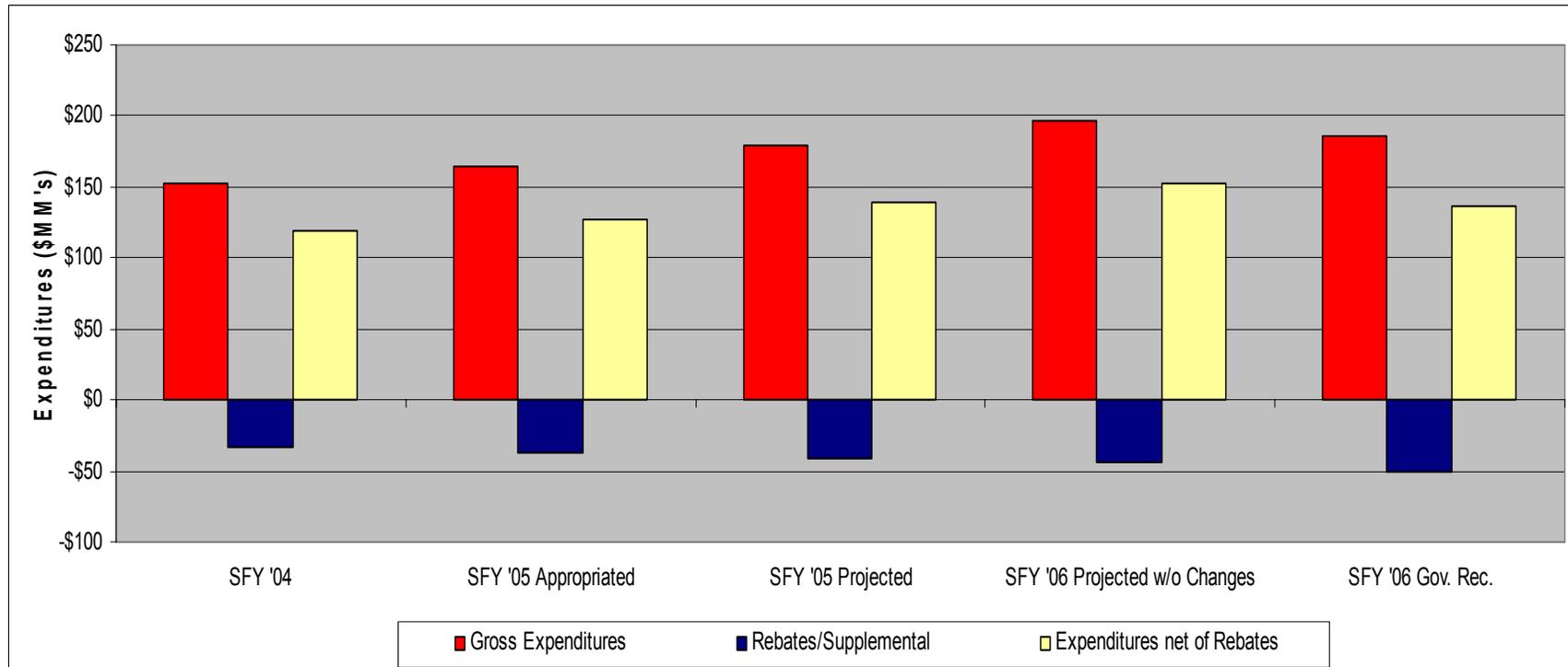
**Table 16: Summary of Inpatient Hospital Expenditures**



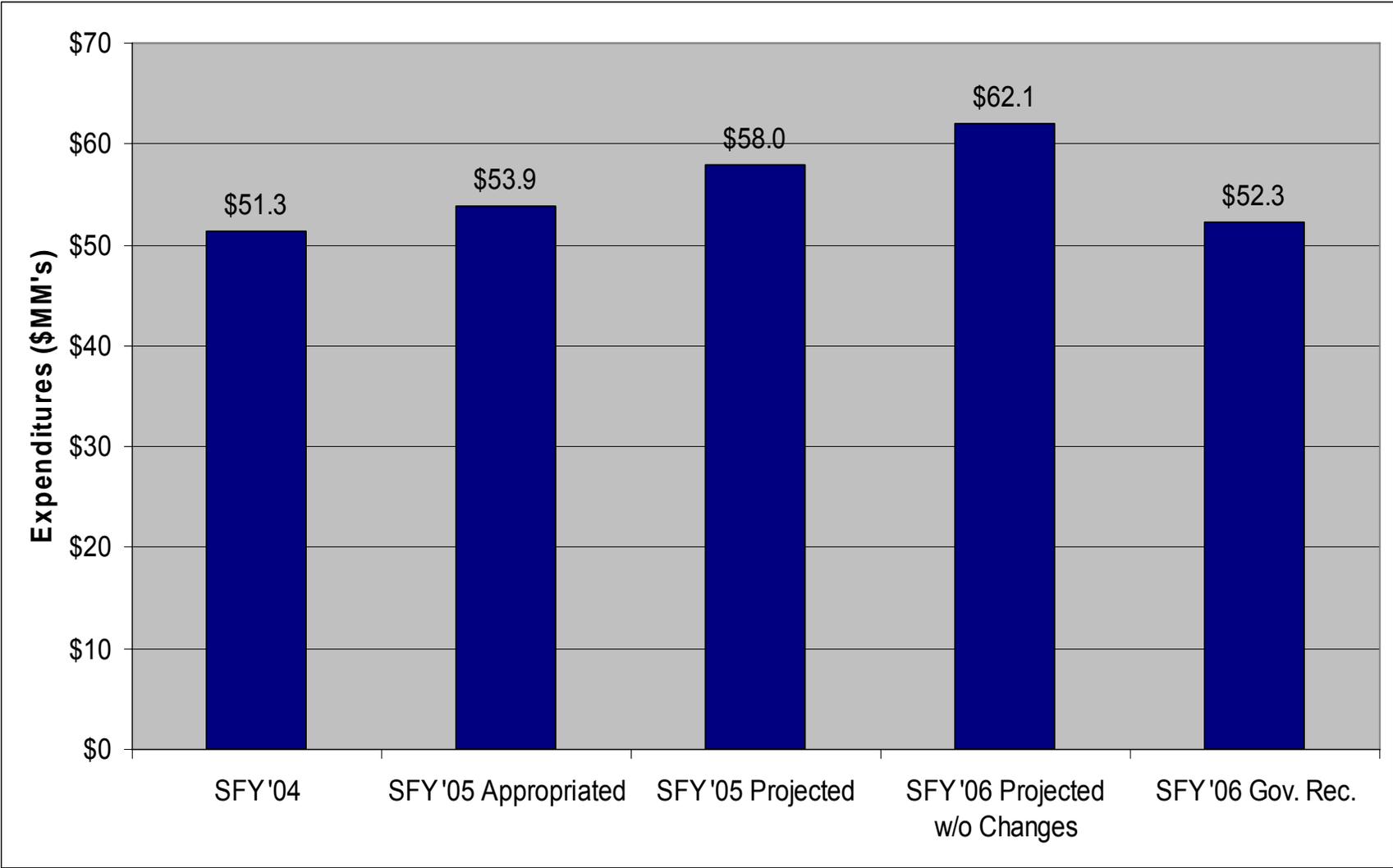
**Table 17: Summary of Outpatient Hospital Expenditures**



**Table 18: Summary of Pharmacy Expenditures**



**Table 19: Summary of Physician Expenditures**



## Appendix 1: Acronyms

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AAA	Area Agency on Aging (Triple “A”)
AABD	Aid to the Aged, Blind, or Disabled
ABD	Aged, Blind and Disabled
ACCESS	The computer software system for eligibility used by DCF and OVHA to track program information
AHS	Agency of Human Services
ANFC	Aid to Needy Families with Children (now Reach Up, although ANFC-related Medicaid still exists)
AWP	Average Wholesale Price (AWP -11.9% +\$4.25 dispensing fee = Medicaid price)
BCCT	Breast and Cervical Cancer Treatment program
BISHCA	Banking, Insurance, Securities, and Health Care Administration
CMS	Centers for Medicare & Medicaid Services (formerly HCFA)
COB	Coordination of Benefits
CSME	Coverage and Services Management Enhancement
DAIL	Department of Aging and Independent Living
DCF	Department for Children and Families
DME	Durable Medical Equipment
DSH	Disproportionate Share Hospital
DUR	Drug Utilization Review Board
EDS	Electronic Data Systems
ESD	Economic Services Division (of the Department for Children and Families)
ESI	Employer Sponsored Insurance
FFP	Federal Financial Participation
FFY	Federal Fiscal Year
FMAP	Federal Medicaid Assistance Participation
FPL	Federal Poverty Level
GA/EA	General Assistance/Emergency Assistance
GCR	Global Clinical Record
HAEU	Health Access Eligibility Unit
HATF	Health Access Trust Fund
HCFA	Health Care Financing Administration (now CMS)
HHA	Home Health Agency
HHS	Health and Human Services
HIFA	Health Insurance Flexibility and Accountability
HIPAA	Health Insurance Portability and Accountability Act
HRSA	Health Resources and Services Administration
HVP	Healthy Vermonters Program
LTC	Long-Term Care
MAB	Medicaid Advisory Board

## Appendix 1: Acronyms

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MAC	Maximum Acquisition Cost
MMA	Medicare Modernization Act
MMIS	Medicaid Management Information System
MOE	Maintenance of Effort
OVHA	Office of Vermont Health Access
NGA	National Governors Association
PA	Prior Authorization
PACE	Program for All-Inclusive Care for the Elderly
PBA/PBM	Pharmacy Benefits Administrator / Management program
PCCM	Primary Care Case Management
PCP	Primary Care Provider
PC Plus	Primary Care Plus
PDL	Preferred Drug List
PIL	Protected Income Level
PMPM	Per Member Per Month
PNMI	Private Non-Medical Institution
QIAC	Quality Improvement Advisory Council
QDWI	Qualified Disabled Working Individual
QI	Qualified Individual
QMB	Qualified Medicare Beneficiary
SAMHSA	Substance Abuse and Mental Health Services Administration
SCHIP	State Children's Health Insurance Program
SFY	State Fiscal Year
SLMB	Specified Low-Income Medicare Beneficiary
SSI	Supplemental Security Income
SURS	Surveillance and Utilization Review Subsystem
TPL	Third Party Liability
VDH/DOH	Vermont Department of Health
VHAP	Vermont Health Access Plan
VISION	Vermont's Integrated Solution for Information and Organizational Needs - the statewide accounting system
VPQHC	Vermont Program for Quality in Health Care

## **Appendix 2: Medicaid Rule M103 – dated 7/1/99**

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### M103      Benefit Delivery Systems

Eligible beneficiaries receive covered services through either the fee-for-service or a managed health care delivery system. Most beneficiaries are required to receive covered services through a managed health care delivery system. The following beneficiaries are exempt from managed health care enrollment and will receive covered services through the fee-for-service delivery system:

- a) Home and community-based waiver beneficiaries;
- b) Beneficiaries living in long-term care facilities, including ICF/MRs;
- c) Beneficiaries who are receiving hospice care when they are found eligible for Medicaid;
- d) Children under age 21 enrolled in the high-tech home care program;
- e) Beneficiaries who have private health insurance that includes both hospital and physician services or beneficiaries who have Medicare (Parts A and/or B);
- f) Beneficiaries who meet a spend-down who are not enrolled in a VHAP managed health care plan; and
- g) Beneficiaries whose requirement to enroll in a managed health care delivery system is anticipated to last for three or fewer months based on known changes, such as imminent Medicare eligibility.

If the beneficiary is not exempt under subsections a-g above, he or she will be required to receive covered services through a managed health care delivery system.

**Appendix 3: Federal Poverty Level (FPL) Guidelines – Monthly Household Income - effective 1/1/05**

<b>FPL</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>
<b>50%</b>	397	533	669	805	940	1,076	1,212	1,348
<b>75%</b>	595	799	1,003	1,207	1,410	1,614	1,818	2,022
<b>100%</b>	794	1,065	1,337	1,609	1,880	2,152	2,424	2,695
<b>150%</b>	1,190	1,598	2,005	2,413	2,820	3,228	3,635	4,043
<b>175%</b>	1,389	1,864	2,340	2,815	3,290	3,766	4,241	4,717
<b>185%</b>	1,468	1,971	2,473	2,976	3,478	3,981	4,484	4,986
<b>200%</b>	1,587	2,130	2,674	3,217	3,760	4,304	4,847	5,390
<b>225%</b>	1,785	2,397	3,008	3,619	4,230	4,842	5,453	6,064
<b>250%</b>	1,984	2,663	3,342	4,021	4,700	5,380	6,059	6,738
<b>300%</b>	2,380	3,195	4,010	4,825	5,640	6,455	7,270	8,085
<b>400%</b>	3,174	4,260	5,347	6,434	7,520	8,607	9,694	10,780

## **Appendix 4: Medicare Modernization Act (MMA)**

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### **OVERVIEW**

The Medicare Modernization Act (MMA) was signed into law on December 8, 2003. On January 21, 2005, the Centers for Medicare and Medicaid Services (CMS) released the final regulations. These are now being reviewed by representatives of the Agency of Human Services.

The provisions of MMA that have the greatest potential impact on Vermont are those related to the pharmacy benefit. As of January 1, 2006, all beneficiaries of Vermont's publicly funded pharmacy programs who are also covered by Medicare will receive their primary pharmacy benefit from Medicare.

### **Traditional Medicaid (primarily below 100% of the FPL)**

The proposed regulations only require a minimum of two drugs per therapeutic class. The proposed classes have been defined; specific drug coverage in each class has not. For Vermonters on both Medicare and traditional Medicaid, this is not as good as the benefit they currently receive. Not only will the Medicare coverage limit access to a more restricted set of drugs, there is likely to be no PA and no broad based exceptions (e.g., nursing home residents, condition exemptions like those with severe and persistent mental illness, etc.). Coverage outside this Medicare formulary may very well be available only if the individual or some other entity pays for it.

### **Vermont's Medicaid Waiver and State Pharmacy Programs (100% to 225% of the FPL)**

Vermont's VHAP-Pharmacy eligibles who share the same benefit package as Medicaid eligibles are likely to have the same reduced coverage. VScript and VScript Expanded eligibles who only have maintenance drug coverage may see a more restricted benefit than they currently receive for those drugs where Vermont currently provides coverage. In addition, most of these beneficiaries will be subject to Medicare premiums and cost-sharing and some will reach the Medicare plan's annual "gap" in coverage. This has been referred to as the "donut hole". For these beneficiaries, their share of the cost including the potential for no coverage in the "donut hole" is a significant issue.

### **Healthy Vermonters Program (primarily greater than 225% of the FPL)**

Even some Healthy Vermonters beneficiaries whose current coverage is only access to drugs at Medicaid prices may experience greater costs under Medicare if they opt to enroll. This is because their Medicare coverage requires a high premium (\$420 per year), a \$250 deductible, and 15% coinsurance. Existing Healthy Vermonters Program coverage will be better for those whose annual drug costs at the Medicaid rates are less than \$670 per year (the premium and deductible).

## **KEY POLICY ISSUES**

### **Wraparound**

States can "wrap-around" benefits lost to citizens currently receiving a pharmacy benefit from a publicly funded program. If a state chooses to contribute to premiums, deductibles, copayments, coinsurance, the "donut hole," or non-formulary drugs, the cost must be entirely state funded. Still unknown is the degree of coverage that will be available under Part D. That information

## **Appendix 4: Medicare Modernization Act (MMA)**

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will be necessary to determine how much will be necessary to provide the benefits that compare to what Vermonters on state programs receive today.

### **Covered Drugs**

The proposed regulations establish the floor for Medicare Prescription Drug Plans (PDP) at two drugs per class. Problematic is what constitutes a class. CMS is considering the classes proposed in the draft guidelines prepared by the United States Pharmacopeial Convention, Inc. (USP). These guidelines propose one hundred and forty-six (146) classes. Vermont Medicaid and many other insurers use the more detailed Hierarchal Ingredient Codes (referred to as HIC3) with which there are over seven hundred (700) classes. While HIC3 classes are represented in the guidelines, the fact that so many HIC3 classes are combined into single model classes is a concern.

Certainly a PDP may opt to cover more than two drugs in a class. Conceptually many will in order to offer a competitive package. Unfortunately, what will be offered will not be certain until well into 2005. The final USP Guidelines will not be submitted to CMS until December 2004. CMS will then make them available to potentially interested PDPs early in 2005 when the MMA rules are finalized. PDP bids must be submitted to CMS by June 2005 so that CMS can select the plans by September 2005. Only at that time will it be clear what drugs will be covered in Vermont by PDPs.

### **Optional Drugs**

Federal financial participation (FFP) may be available for select optional Medicaid covered drugs not covered under Medicare (over-the-counter products; other products for the treatment of weight loss/gain, fertility, cosmetic issues, and hair growth; barbiturates; and benzodiazepines) but any possible conditions and/or limitations are still to be defined when the MMA rules are finalized early in 2005.

### **Phased-Down Contribution**

The pharmacy benefit under Medicare is conceptually a federal benefit but in the case of “dual eligibles”; those Medicare beneficiaries who would be eligible for Medicaid, it is funded in the same way as it is funded under Medicaid, with federal and state monies. What in Medicaid is referred to as the “state share” is called the phased-down state contribution for Medicare. The state contribution design calls for states to annually pay a portion of what they would have paid in Medicaid “state share” in that year for the support of drug coverage of Medicare beneficiaries who are or would be eligible for Medicaid drug coverage. This is the concept sometimes referred to as “clawback”. Key concepts of the phased-down contribution include:

- It will be based on Medicaid state expenditures in calendar year 2003 adjusted for inflation.
- It is calculated on expenditures net of drug rebate.
- States retain a specified portion in support of providing other coverage to their dual eligibles.
- Vermont’s VHAP-Pharmacy and VScript benefits are funded through an 1115 waiver to Medicaid. These programs are pharmacy-only programs within the waiver. By definition in the regulations, only “full benefit” expenditures; that is, those attributed to the full Medicaid benefit; e.g., hospital care, physician services, pharmacy coverage, etc. should be subject to

## **Appendix 4: Medicare Modernization Act (MMA)**

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the contribution. Pharmacy-only expenditures should be excluded. Until the final regulations were published on January 21, 2005, CMS officials indicated that spending for Vermont's pharmacy-only waiver programs must be included in the contribution. The availability of these monies was a critical question. To illustrate, if Vermont had to include pharmacy only individuals as well as full dual eligibles in the phased-down calculation, our contribution was estimated to be \$29,332,545. The final regulations were clear that our 1115 waiver pharmacy programs would be excluded from the phased-down contribution. This means that Vermont will have to include only full duals, lowering the state contribution to \$19,665,167 and saving the state \$9,667,378. This nearly \$10 million dollars can be utilized to assist the state in developing pharmacy coverage that will wrap around Part D.

Beginning January 1, 2006 states are expected to pay the phased-down state contribution of 90% of the estimated calendar year (CY) state share of Medicaid/Medicare pharmacy expenditures net of rebate. The contribution in future years will be progressively less:

CY 2007	88 1/3%
CY 2008	86 2/3%
CY 2009	85%
CY 2010	83 1/3%
CY 2011	81 2/3%
CY 2012	80%
CY 2013	78 1/3%
CY 2014	76 2/3%
CY 2015 and thereafter	75%

### **State-funded VScript expanded**

As previously stated, the 100% state-funded VScript expanded program is not exempt from the impact of the MMA. While Medicare will cover more than the maintenance drugs that VScript expanded covers, the coverage (maintenance and otherwise) may not be as expansive and is likely to be more expensive to the beneficiaries. It is important to consider, though, that since VScript expanded is currently 100% state funded, any amount that should prove to be reduced by Medicare spending will be money available for use in other areas.

### **Administration**

The funding of the states' responsibilities for administration is still not clear. There are many issues around the administration of existing coverage, including but not limited, to providing enrollment and eligibility functionality and data transfers to Medicare; managing our medical coverage for traditional Medicaid eligibles without control of the pharmacy coverage; coordinating any state pharmacy benefits with Medicare pharmacy coverage; and educating/supporting beneficiaries/providers.

## **Appendix 4: Medicare Modernization Act (MMA)**

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### **PROGRAM DETAILS**

#### **Beneficiaries**

As income levels increase beyond 135% of the Federal Poverty Level (FPL) (approximately a mid-point in VHAP-Pharmacy), cost-sharing (premiums, deductibles, copayments, and coinsurance) increase. At or above 150%, people who use the benefit become subject to the “donut hole”, when coverage stops for up to \$2,850 in drug expenses. For those people who are subject to this gap in coverage, catastrophic coverage is available after the gap, with modest copayments.

#### **Asset Test**

Asset tests apply to those who are not full dual eligibles:

- < 135% of FPL: \$6,000 individuals, \$9,000 couples;
- => 135%, <150%: \$10,000 individuals, \$12,000 couples;

Those who fail the asset test for their income level pay higher premium amounts and cost-sharing.

#### **Premiums**

Premiums may apply:

- Beneficiaries with income below 135% of the FPL will pay no premium.
- Those at or above 135% of the FPL will pay on a sliding scale up to \$35 at 150% FPL.
- Everyone above 150% FPL will pay \$35 per month (\$420 per year).
- The premium amount will increase annually.

#### **Plan Selection**

The benefit will be provided by a Medicare selected Prescription Drug Plan (PDP). Every beneficiary will have a choice of at least two PDPs. Beneficiaries will choose their plans annually.

#### **Drug Coverage**

Each Medicare PDP will set the coverage plan (formulary) according to Medicare guidelines.

- The guidelines require mandatory Medicaid class coverage. The full definition of these classes has not been established. Coverage does not include specified optional Medicaid coverage including over-the-counter and selected other products (products for the treatment of weight loss/gain, fertility, cosmetic issues, and hair growth; barbiturates; and benzodiazepines).
- Unlike Medicaid, the formulary can be closed; that is, within the Medicare defined classes, not all drugs need to be covered. The regulations specify at least two drugs to a class.
- The formulary may change monthly. That means that beneficiaries who choose a plan based on specific drugs may not be assured the same coverage throughout the year they are enrolled in the plan.

## **Appendix 4: Medicare Modernization Act (MMA)**

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### ***Deductibles***

An annual deductible of \$50 applies for those with income at or above 135% of the FPL, increasing to \$250 at 150% FPL or higher.

### ***Cost-sharing***

Cost-sharing will apply to the receipt of drugs varying from modest to significant:

- Low-income beneficiaries below 135% of the FPL will have copayments of \$5 or less per drug. When a beneficiary's annual drug expenditures reach \$3,600, copayments no longer apply.
- At or above 135% of the FPL, a coinsurance of 15% applies after the deductible is met.
- At or above 150%, the coinsurance increases to 25%.

At or above 150% of FPL, coverage stops after \$2,250 in drug expenses (paid by Medicare and the beneficiary) for \$2,850 of additional drug expenses (the "donut hole").

At or above 150% of FPL, catastrophic coverage is available with 5% coinsurance after the "donut hole". A beneficiary will incur \$3,600 in out-of-pocket costs before qualifying for catastrophic coverage (catastrophic cap).

Should a PDP opt for a formulary with drugs preferred and non-preferred, they may apply a tiered cost-sharing structure to apply to those drugs with beneficiaries paying higher amounts for non-preferred drugs.

The deductible amount and the catastrophic cap will increase annually.

## Appendix 5: Organizational Chart

