



**AGENCY OF HUMAN SERVICES  
DEPARTMENT OF VERMONT HEALTH ACCESS**



**State Fiscal Year 2013  
Medicaid Budget**



**The mission for the  
Department of Vermont Health Access is to**

- ◇ **Provide leadership for Vermont stakeholders to improve access, quality and cost effectiveness of health care**
- ◇ **Assist Medicaid 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**

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## Organization and Responsibilities

The Department of Vermont Health Access (DVHA) is the state department responsible for the management of Medicaid, the State Children's Health Insurance Program (SCHIP), and other publicly funded health insurance programs in Vermont. DVHA is Vermont's largest insurer, both in terms of dollars spent and in covered lives. As of 2009, DVHA became responsible for state oversight and coordination of Vermont's health care reform (HCR) initiatives, which are designed to increase access, improve quality, and contain the cost of health care for all Vermonters and includes Vermont's Blueprint for Health and health information technology (HIT) strategic planning, coordination and oversight. In accordance with Act 48 of 2011, DVHA has become responsible for the development and implementation of the Health Insurance Exchange (Exchange) required by the Patient Protection and Affordable Care Act (PPACA).

The DVHA leadership team is comprised of the Commissioner, four Deputy Commissioners (for Medicaid Health Services and Managed Care; Medicaid Policy, Fiscal and Support Services; Health Insurance Exchange; and Health Reform), the Director of the Blueprint for Health and the Medicaid Medical Director.

**Commissioner.** Responsible for all DVHA's operations. The Commissioner has led state and federal health care reform implementation and is a member of the Governor's health care leadership team.

**Deputy Commissioner for DVHA's Medicaid Health Services and Managed Care Division.** Oversees the following units: Quality Improvement and Clinical Integrity; Program Integrity; Managed Care Operations [Clinical Operations and the Vermont Chronic Care Initiative (VCCI)]; Pharmacy; and Provider and Member Services.

**Deputy Commissioner for Medicaid Policy, Fiscal and Support Services Division.** Oversees the following units: Coordination of Benefits (COB); Data Management and Analysis; Fiscal and Administrative Operations; Medicaid Payment Reform and Reimbursement; and Program Policy.

**Deputy Commissioner for the Health Reform Division.** Leads coordination of health reform activities across multiple state stakeholders and has primary responsibility for statewide health information technology (HIT) planning and implementation.

**Deputy Commissioner for the Health Insurance Exchange Division.** Responsible for development and implementation of the health insurance exchange (Exchange) required by the Patient Protection and Affordable Care Act.

**Director of the Blueprint for Health Division.** Oversees the statewide multi-insurer program designed to integrate a system of health care for patients, improve the health of the overall population, and improve control over health care costs by promoting health maintenance, prevention, and care coordination and management at the provider level.

Budgeted staff positions total 167. The Medical Director is a faculty member of UVM under contract with DVHA and is not included in this staff count. The budgeted number of positions reflects the increase to meet the requirements of the federal and state Health Reform initiatives.

The DVHA divisions and their units' areas of responsibility and tasks are described below. The descriptions include major areas of responsibility and are not an all-inclusive listing of responsibilities and duties.

### **Medicaid Health Services and Managed Care Division**

The division is responsible for health services provided to individuals by the Managed Care Entity (MCE). The Deputy Commissioner oversees all programs and activities of medical services, including medical management planning and budgeting, and is responsible for overseeing and monitoring many activities related to quality, access to services, measurement and improvement standards, and all utilization management activities. The following units reside in this division:

***Health Services and Managed Care Operations.*** Responsible for planning and implementation of new program initiatives, best practice guidelines and clinical outcomes. Staff administers clinical policies and procedures, oversees performance improvement projects, and manages external clinical contracts. The Managed Care Director oversees the Clinical Operations Unit and the Vermont Chronic Care Initiative Unit.

***Clinical Operations.*** Monitors the quality, appropriateness and effectiveness of health care services requested by providers for enrollees. Clinical Unit staff ensures requests for services are reviewed and processed efficiently and within time frames outlined in Medicaid Rule; identifies over and under utilization of health care services through the Prior Authorization (PA) review process and case tracking; develops and/or adopts clinical criteria for certain established clinical services, new technologies and medical treatments; assures correct coding for medical benefits; reviews provider appeals; provides provider education related to specific medical procedures; and performs quality improvement activities to enhance medical benefits for enrollees.

The unit also manages the Clinical Utilization Review Board (CURB) meetings. The CURB is an independent advisory board comprised of ten (10) members with diverse medical experience who are appointed by the governor upon recommendation of the Commissioner of DVHA. CURB examines existing medical services, emerging technologies and relevant evidence-based clinical practice guidelines and makes recommendations to DVHA regarding coverage, unit limitations, place of service, and appropriate medical necessity of services in Vermont's Medicaid programs. The CURB bases its recommendations on medical treatments and devices that are the safest and most effective for beneficiaries. DVHA retains final authority to evaluate and implement the CURB's recommendations.

***Vermont Chronic Care Initiative (VCCI).*** Identifies and assists Medicaid beneficiaries with chronic health conditions and/or high utilization of medical services to access clinically appropriate health

care information and services; coordinates the efficient delivery of health care to this population by addressing barriers to care, bridging care gaps, and avoiding duplication of services; and educates and empowers this population to eventually self-manage their conditions. DVHA care coordinators are fully integrated core members of existing *Blueprint for Health* Community Health Teams and are co-located in provider practices and medical facilities in several communities.

**Pharmacy.** Responsible for managing the pharmacy benefit programs for beneficiaries enrolled in Vermont's publicly funded health care programs and ensuring those beneficiaries receive medically necessary medications in the most cost-effective manner. The Pharmacy Unit routinely analyzes trends in drug utilization and the resulting impact on pharmaceutical costs. Pharmacy Unit staff and DVHA's contracted Pharmacy Benefit Manager (PBM) work with pharmacies, prescribers and, at times, beneficiaries to resolve benefit and claims processing issues, and to facilitate appeals related to prescription drug coverage within the pharmacy benefit.

The Pharmacy Unit enforces claims rules in compliance with federal and state laws; implements legislative and operational changes to the pharmacy benefit program; and manages all the state and federal drug rebate programs. The Pharmacy Unit also manages the activities of the Drug Utilization Review (DUR) Board, whose members include Vermont physicians, pharmacists, and a member at large. Board members evaluate drugs on the basis of clinical appropriateness and net cost to the state, and make recommendations regarding a drug's clinical management and status on the state's Preferred Drug List (PDL). Board members also review identified utilization events and advise on approaches to management.

**Program Integrity (PI).** Engages in activities to prevent, detect, and investigate Medicaid fraud, waste and abuse by utilizing data mining and analysis, recoupment of provider overpayments, and a Team Care program to help beneficiaries obtain appropriate medical care related to prescription drug use at a frequency or amount that is medically necessary. The PI Unit educates providers about accurate billing and refers cases of suspected provider fraud to the Attorney General's office and potential beneficiary eligibility fraud to DCF.

**Provider and Member Services.** Ensures beneficiaries have access to an adequate provider network to serve their medical needs. The unit is responsible for linking beneficiaries with primary care providers, and ensuring beneficiaries are served in accordance with MCE requirements. Staff also oversees provider contracting and enrollment, nine (9) transportation brokers/contractors, the member services contract, and other various contracts (eyeglasses; State Dental Clinic). Lastly, the staff maintains the provider and member sections of DVHA's website.

**Quality Improvement and Clinical Integrity.** Collaborates with DVHA's Agency of Human Services (AHS) partners to maintain quality standards as required by the Code of Federal Regulations (CFR); monitors the Intergovernmental Agreements (IGA); prepares for the annual external quality reviews as required under the *Global Commitment to Health Waiver*, as well as state quality audits; maintains the Managed Care Entity Quality Plan; coordinates quality initiatives with the DVHA Managed Care Medical Committee; and provides concurrent review and authorization of psychiatric inpatient and detoxification admissions.

## **Medicaid Policy, Fiscal and Support Services Division**

The following units are designated in the division that reports to the Deputy Commissioner for Medicaid Policy, Fiscal and Support Services:

***Coordination of Benefits (COB).*** Works with providers, beneficiaries, and other insurance companies to ensure that Medicaid is the payer of last resort, through coordination of benefits and collections practices. COB also administers the Catamount Health and Employer-Sponsored Insurance Assistance programs by performing analyses to ensure beneficiaries are placed in the most cost-effective program.

***Data Management and Analysis.*** Provides data analysis and distribution of Medicaid data extracts, such as Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES), to state agencies, the legislature and other stakeholders and vendors; provides mandatory federal reporting to the Centers for Medicare and Medicaid Services (CMS), annual Healthcare Effectiveness Data and Information Set (HEDIS) reporting, and other reporting initiatives for federal and state agencies and departments requiring Medicaid data; provides ad hoc data management and analysis for internal DVHA divisions and units including the budget development process.

***Fiscal and Administrative Operations.*** Supports, monitors, manages and reports all aspects of fiscal planning and responsibility. Functions include provider assessment receipts, vendor payments, timesheets, expense reports, grants, contracts, purchasing, financial monitoring, budgeting, human resource support, space and operational duties as well as other relevant practices, procedures and processes.

***Medicaid Payment Reform and Reimbursement.*** Oversees the provider payments and reimbursement methodologies for Vermont's Medicaid Program including the oversight of Vermont's provider assessment, Disproportionate Share Hospital (DSH) payments, and cost settlement process. This Unit also actively works with the Medicaid providers and other stakeholders to transition Vermont's Medicaid program to a system of value based reimbursements.

***Program Policy.*** Responsible for coverage rules, fair hearings, grievances and appeals, Health Insurance Portability and Accountability Act (HIPAA) compliance, legislative activities, public record requests, requests for non-covered services, State Plan Amendments, and the State Children's Health Insurance Program (SCHIP). Staff coordinates initiatives resulting from federal health care reform and state legislative sessions and may serve as the primary communicators to Vermont's Congressional Delegation, the media and the Centers for Medicare and Medicaid Services (CMS).

## **Health Reform Division**

Vermont's Health Reform (HR) became a DVHA division in 2009, with responsibility for oversight and coordination of state health reform initiatives designed to increase access, improve quality and

contain the cost of health care for all Vermonters. DVHA HR is also responsible for Vermont's health information technology (HIT) strategic planning, coordination and oversight.

The Health Reform Division, in partnership with other public and private entities, provides oversight and coordination across state government to foster collaboration, inclusiveness, consistency, and effectiveness in matters related to state and federal health care reform.

Vermont's latest legislation, Act 48 (H.202), was signed into law by Governor Shumlin in June 2011. The law recognizes the economic and moral imperative for Vermont to undertake fundamental reform of its health care system. Health care costs have been growing between 6.5 and 8.5 percent annually in recent years at a time when growth in our economy was negligible. Act 48 puts Vermont on a path to a single payer system, but the state must take several additional steps to reach that goal. These include development of a financing plan that assures a single payer will cost less than the current system.

The HR Division functions include:

***Policy Implementation.*** Ensures that state government activities related to state and federal reform efforts are aligned with the Governor's policy direction; in collaboration with the DVHA Policy Unit, monitors Vermont legislative activity regarding health reform deliberations. Leads "system transformation" efforts associated with the implementation of health reform to ensure state government effectively supports and is aligned with the health reform initiatives being implemented in the private sector.

***Health Information Technology.*** Responsible for Vermont's Health Information Technology (HIT) and Health Information Exchange (HIE) policy, planning and oversight. This includes writing and implementing the State HIT Plan and the State Medicaid HIT Plan, implementing the Medicaid Electronic Health Record (EHR) Provider Incentive program, overseeing the State Health IT Fund, and managing the contract with Vermont Information Technology Leaders (VITL) for HIE operations and HIT expansion. Works with the State Public Health HIT Coordinator at VDH for integration of the Public Health Infrastructure with HIT/HIE. In close collaboration with the AHS CIO, helps to support implementation of Agency Service Oriented Architecture (SOA) and its integration with HIT/HIE and Health Insurance Exchange systems, including Provider Directory and Enterprise Master Persons Index.

***Health Reform Technology.*** Vermont brings together coverage reforms, delivery system and process reforms, technical and data advances, administrative simplification, and financing and payment reforms that, in combination, are intended to lead the state to a single system of care and eventually to a single-payer health care system. Building on the strengths of its achievements to date, and further authorized by Act 48, Vermont is leveraging state initiatives with opportunities provided by the Affordable Care Act (ACA) and other federal programs supporting health and health reform. Taken together, these provide the opportunity to expand health benefit coverage and to create a fully integrated digital infrastructure for a learning health system to improve care, improve health and reduce costs.

To create an information ecosystem that supports this vision, the Division, in close collaboration with AHS IT and the Department for Information & Innovation (DII), is leading the State effort to wire the “neural network” of its health care system to provide real time, and close-to-real time, clinical and financial information for the management of the health care system *as a system*. DVHA is leading a systematic and sequential approach for procuring services which support the integration and leveraging of technologies and business processes across the AHS, across programs, initiatives, and systems to support our health care transformation.

***Health Information Technology Fund.*** Established during the 2008 legislative session in the state treasury to further progress on Health IT, this Fund is used for health care information technology programs and initiatives such as those outlined in the Vermont Health Information Technology Plan. The Fund is financed through an assessment of 0.199 of one percent of all health insurance claims for Vermont members, beginning with quarterly payments in November 2008. This Fund is utilized to provide resources that can be matched under new federal HIT initiatives. Overseen by the DVHA Health Reform Division, billing and administrative support is from the DVHA Fiscal and Administrative Support unit and enforcement is through the Health Care Administration (HCA) Division of BISHCA.

***Delivery System Reform.*** Responsible for supporting expansion of the Blueprint for Health in coordination with build out of the statewide HIE network, including integration with public health, mental health and substance abuse providers, long term care, home health, and AHS initiatives including Children’s Integrated Services (CIS) and Integrated Family Services (IFS).

### **Health Insurance Exchange Division**

The Health Insurance Exchange (Exchange) Division was added to DVHA in 2011 as a result of the Patient Protection and Affordable Care Act (PPACA) signed into law in March of 2010 and Vermont Act 48. The Exchange Division is tasked with the creation of a system for the exchange of health insurance information that offers Vermonters the means to compare information on available health benefits plans, including private insurance plans and state public plans, enroll in plans, and receive tax credits or public assistance, if eligible.

In addition, the Exchange will approve “qualified health plans” to be offered on the Exchange, rate those plans based on quality, maintain a website and toll-free number, provide an online calculator for consumers to determine the amount of their tax credit, require insurance plans to justify rate increases and contract for navigators to provide public education and help people enroll. The Exchange will also offer small businesses the opportunity to assist their employees in enrolling in health plans offered on the Exchange. Exchanges must be up and running by January 1, 2014. Vermont’s Exchange will become the platform for Vermont’s single-payer health system.

Marketing and outreach for **Green Mountain Care**, which includes public health insurance options such as Medicaid, Vermont Health Access Plan (VHAP), Dr. Dynasaur, premium assistance programs for Catamount Health and employer-sponsored insurance and a number of pharmacy

assistance programs, will transition into the Exchange over time.

More specifically, the Exchange team will design the following components for implementation:

- Call Center: toll-free telephone hotline to assist individuals and small employers in all aspects of the Exchange process, including plan selection
- Financial Management: system that offers integrity and a thoughtful and detailed approach to maintaining efficient spending and revenue streams
- Program Integrity: system to combat waste, fraud, and abuse, including its financial management system, the eligibility determination process, appeals for exemptions to the individual mandate, and overall information and funds that flow through the Exchange
- Exchange Staffing: development of job descriptions and management structure for the exchange as 25 to 30 additional positions will be created to perform Exchange functions.
- Exchange Evaluation Plan: including consumer satisfaction surveys
- Small Business Health Options Program (SHOP) Exchange: development and marketing of the Exchange for small employers
- Individual and Employer Responsibility Determinations: process to determine whether an individual should be exempt from complying with the insurance mandate based on the lack of Minimum Essential Coverage, the lack of an affordable plan, and process to determine whether individual employers are subject to tax penalties for employees who do not have access to Minimum Essential Coverage through the employer
- Qualified Health Plans: development, certification process for, and enrollment of, individuals into Qualified Health Plans (QHPs), including presentation of participating employers with consolidated bills, premium collection from employers, and creation of standardized forms and formats for presenting health benefit options
- Risk Leveling and Management Processes
- Navigator Program: provide grants to qualified individuals and/or organizations to educate and assist individuals and small businesses in enrolling in health coverage through the Exchange
- Stakeholder Consultation: establishment of a Joint Advisory Committee for both Medicaid and the Exchange
- Outreach and Education: comprehensive outreach, education, and marketing campaign aimed at both consumers and employers, meeting the needs of individuals with disabilities, limited English-speaking proficiency, and other potential barriers to enrollment
- Integration of Existing Coverage Groups: comprehensive strategy to integrate or align Medicaid (including Dr. Dynasaur and other Medicaid-funded programs), the Medicaid-Medicare dual-eligible demonstration project, private insurance, associations, and coverage for State and municipal employees
- Administrative Simplification
- Quality Program and Rating System
- Wellness and Prevention Program.

## **Blueprint for Health Division**

The State of Vermont has demonstrated an intensive commitment to comprehensive health reform that includes the following components: universal coverage, a novel delivery system built on a foundation of medical homes and community health teams, a focus on prevention across the continuum of public health and health care delivery, a statewide health information exchange, and a robust evaluation infrastructure to support ongoing improvement with quality and cost effectiveness as guiding principles. From policy to implementation, Vermont's reforms are designed to provide access to high quality health care for all of its residents, and to improve control of health care costs.

As an agent of change, the Blueprint is charged with guiding a process that results in sustainable health reform, centered on the needs of patients and families. In effect, the program is intended to bring "system-ness" to a health delivery world that is characterized by independent organizations, segregated services, poor communication within and across organizations, and funding streams that are often not aligned with health related goals.

Guiding legislation calls for a highly coordinated statewide approach to health, wellness, and disease prevention. Vermont's Blueprint for Health is leading this transformation with an Advanced Model of Primary Care statewide. This program includes nationally recognized Patient Centered Medical Homes (PCMHs) supported by Community Health Teams (CHTs), and a health information technology infrastructure that supports guideline based care, population reporting, and health information exchange. Vermont Act 128 of 2010 called for full implementation in every willing primary care practice by October of 2013. Vermont Act 48 of 2011 echoed this commitment. The CHTs include members such as nurse coordinators, social workers, and behavioral health counselors who provide support and work closely with clinicians and patients at a local level. Services include individual care coordination, outreach and population management, counseling, and close integration with other social and economic support services in the community.

The link from the CHTs to targeted services is essential in order to serve the needs of the spectrum of acuity and intensity in a given site. To that end, the Support and Services at Home (SASH) concept is being expanded throughout the state in line with the Blueprint statewide spread, funded by CMS. This is a direct result of the Blueprint's successful competitive bid to become a demonstration site for the CMS Multi-payer Advanced Primary Care Program, and an extraordinary opportunity to leverage federal funds for local use. None of the new SASH Coordinator or Wellness Nurse positions would be viable without this support.

Underlying the Blueprint model is financial reform that aligns fiscal incentives with health care goals. All major commercial insurers, Medicare and Vermont Medicaid are participating in financial reform that includes two major components. First, primary care practices receive an enhanced per patient per month (PPPM) payment based on the quality of care they provide. The payment is based on the practices' official National Committee for Quality Assurance's Physician Practice Connections – Patient Centered Medical Home (NCQA PPC-PCMH) scores and is in addition to their normal fee-for-service or other payments. This provides an incentive for ongoing

quality improvement as payment is adjusted up or down based on 5 point incremental changes in the score. Payments can range from \$1.20 to \$2.39 PPPM, providing a substantive incentive for thorough outpatient care. In addition, insurers share the costs for the CHTs, which in turn does not charge for its services or use eligibility requirements. The proportional ratio is approximately 5 full time equivalent positions (FTEs) to provide care support for a general population of ~ 20,000 patients at an annual cost of \$350,000. The staffing mix for the CHT is designed by personnel in each community reflecting local needs. The team members form a nucleus that works closely to coordinate with other personnel and services in the community, establishing a functional group that is larger than the CHT's 5 FTEs.

The foundation of medical homes and CHTs is supported by a robust health information and evaluation infrastructure. This infrastructure includes data sources to evaluate the clinical and financial impacts of the model. Data sources include the following: direct clinical chart reviews (electronic and paper); analysis of the statewide web-based registry (DocSite); qualitative assessment of patient, provider and practice experience; multivariate analysis of existing public health databases; and Vermont's multi-payer claims database (VHCURES) which populated the Blueprint financial impact ("Return on Investment") model. Routine reporting provides a basis for ongoing quality improvement and planning for statewide expansion. Financial sustainability is based on a reduction in unnecessary acute care (specifically a reduction in hospital admissions), and insurers shifting their current expenditures from contracted disease management services to CHTs.

The sustainable program described above provides a firm foundation for reform. The next stage of the program is extending the model to include pediatric age groups and to integrate specialty services such as mental health, substance abuse, and targeted disease management programs (e.g. congestive heart failure, pulmonary and endocrine disorders). More formalized linkages will be established with social services, economic services, and public health services. An overarching emphasis will be placed on strategies and decision support systems that improve self management and help people to make healthy choices. Best practices and strategies from established programs will be adopted and incorporated as the program builds on top of its base, an Advanced Model of Primary Care.

### **DVHA's Strategic Plan**

DVHA has been actively engaged in developing a strategic plan that aligns with the Governor's initiatives. The plan is the result of the collective input of all DVHA staff and the Medicaid Advisory Board (MAB), and is informed by the Governor's statewide priorities and the State Health Care Strategic Plan. The plan also is guided by the Legislative Act 48, which creates **Green Mountain Care** to contain costs and provide comprehensive, affordable, high-quality, publicly financed health care coverage for all Vermont residents. DVHA's Strategic Plan will help maintain focus on key priorities and assist in performance improvement.

After participating in an AHS-wide strategic planning session in early SFY 2012, DVHA's strategic planning committee assessed the department's mission for consistency with the Governor's

statewide priorities, considered current driving forces in Vermont as well as the department's strengths, weaknesses and opportunities, and identified the following six (6) strategic goals:

- Reduce health care costs and cost growth
- Assure that all Vermonters have access to and coverage for high-quality health care (health care includes mental health, physical health and substance abuse treatment)
- Reduce the complexities of health care interactions and transactions
- Support improvement in the health of Vermont's population
- Improve customer and provider satisfaction
- Establish an infrastructure that assures professional workforce competency and staff satisfaction.

Strategies, action steps and measures have been developed for each goal, targeting areas such as reduced administrative costs, improved coordination of care, increased efficiency, greater innovation in payment structures, improved access to health care, and workforce competency and satisfaction.

### **Measures:**

#### Measures for all Programs

- Impact of health reforms on rates of utilization and related costs for Medicaid beneficiaries
- (%) of expenditures based on value vs. volume
- (%) of cost avoidance in Medicaid expenditures

#### Vermont Chronic Care Initiative (VCCI)

- Impact of health reforms on shifting high risk Medicaid beneficiaries from patterns of acute episodic care to patterns of preventive care
- (%) of eligible beneficiaries receiving direct care management services through VCCI
- (%) of inappropriate emergency room use
- (%) of Medicaid beneficiaries receiving guideline based care for chronic conditions
- (%) of Medicaid beneficiaries at risk for poor health outcomes who are provided access to enhanced self-management support services

#### Clinical Operations

- (%) of avoidable inpatient admissions and readmissions
- (%) of inappropriate emergency room use
- (%) of Medicaid beneficiaries receiving age and gender appropriate health maintenance and preventive health care services

#### Blueprint for Health

- (%) of Medicaid beneficiaries with access to Blueprint integrated health services model, including Patient Centered Medical Homes and Community Health Teams
- (%) of primary care providers in Vermont participating in the Blueprint for Health

- (%) of physicians meeting the meaningful use standards

Fiscal Operations

- Annual incremental growth in total cost of care per Medicaid beneficiary
- Actual vs. projected growth rates in total cost of care per Medicaid beneficiary
- (%) of cost avoidance in Medicaid expenditures
- (%) of applicable new contracts and renewals of existing contracts that have performance based metrics.

## Budget Request ~ State Fiscal Year 2013

	GF	SF	IdptIT	FF	ARRA Fed	Medicaid GCF	Invmnt GCF	Total
<b>FOR FY 2013 DVHA</b>								
Administration - As Passed FY12	945,014	1,579,123	4,077,117	43,169,600	2,505,044	37,872,530	6,043,568	96,191,996
Retirement rate reduction GF savings	(558)							(558)
Benefit Rate Reductions	(2,009)							(2,009)
Voluntary Furlough Reduction	(610)							(610)
FY12 BAA Subtotal Challenges:	(3,177)	-	-	-	-	-	-	(3,177)
FY12 Post Challenges	941,837	1,579,123	4,077,117	43,169,600	2,505,044	37,872,530	6,043,568	96,188,819
<b>FY13 Request</b>								
Personal Services:								
Annualization of salaries - RFR's, HIR, transfers						126,290		126,290
Increase in Health Insurance						50,178		50,178
Increase in Dental Insurance						3,410		3,410
Increase in EAP						356		356
Increase in Workers Comp insurance						12,700		12,700
Increase <decrease> in Retirement Rate (2012)				(1,321)		(74,394)		(75,715)
Increase in Retirement Rate (2013 - 16.13% to 17.11%)				-		97,134		97,134
3 FTE - Sub Abuse Director & Look-in Administrators (Program Savings)						239,034		239,034
2 FTE - High Risk Pregnancy (Program Savings)						169,237		169,237
9 FTE - VCCI Expansion (Program savings)						720,496		720,496
Estimated cost of Market Factor Increase for VCCI Nurses						341,508		341,508
1 FTE - Concurrent Reviews (program savings)						80,418		80,418
2 FTE - MH Case management and reviews (Program savings)						148,837		148,837
4 FTE - Fiscal and Data needs for VHURES, DSH, HIT, Assessments						348,169		348,169
1 FTE - Pharmacy						-		68,157
1 FTE - Blueprint statewide expansion						72,192		72,192
Transfer Development Position to AHS IT (net zero)						(68,900)		(68,900)
Reduce Member services contract based on Re-bid						(250,000)		(250,000)
5 FTE - Increase for MMIS PAPP Portfolio - personnel -Match DII		53,920		485,288				539,208
5 FTE - Increase for SMHP HIT IAPD - personnel (90/10)		53,003		477,027				530,030
Increase for SMHP HIT IAPD - Contracts (90/10)		18,667		167,999				186,666
13 FTE - Increase for Exchange Grant personnel - 100% federal				1,138,699				1,138,699
Increase for Exchange Grant contracts - 100% federal				15,560,000				15,560,000
Decrease for ONC 3013 grant		(150,000)			(1,350,000)			(1,500,000)
Operating Expenses:								
Net increase in Leases (312 and 289 base space)						17,087		17,087
Decrease in General Liability Insurance						(2,178)		(2,178)
DII Allocation	(43)			(97)		(7,035)		(7,175)
VISION	(563)			(1,267)		(92,034)		(93,864)
Human Resources Allocation	(264)			(593)		(43,072)		(43,929)
Fee For Space	92			207		1,240		1,539
Operating for New FTE's Base Increase - 14 FTE (\$7,900)						110,600		110,600
Operating for New FTE's Base Increase VCCI - 9 FTE (\$12,100)						108,900		108,900
Operating for New FTE's - Exchange (100% federal) (\$7,900)				102,700				102,700

	GF	SF	ldptT	FF	ARRA Fed	Medicaid GCF	Invmt GCF	Total
<b>FOR FY 2013 DVHA</b>								
Operating for New FTE's - SMHP HIT (90/10) (\$7,900)		7,110		63,990				71,100
Operating for New FTE's - MMIS		3,950		35,550				39,500
Funding Adjustment for HCR and Blueprint MCO (37.1% GC)						(1,874,516)	1,874,516	-
Transfer to AHS IT (Net Zero)						(2,000)		(2,000)
<b>Grants:</b>								
MOU's to BISHCA, AoA, others for Exchange grant				500,000				500,000
Increase for SMHP Incentive Payments to Providers and Hospitals				16,280,000				16,280,000
Transfer HIT Fund to AHS for Increased FMAP (HCR GC \$3,762,836)		(53,810)						(53,810)
Transfer to DMH grant for CHCB (net zero)						(21,500)		(21,500)
Transfer funds from SMHP-PAPD ARRA to SMHP-IAPD Federal				1,078,254	(1,078,254)			
Funding Transfer to GMCB						(25,970)	(44,030)	(70,000)
One-Time - Base Funding replaced by Federal grants		41,000		731,792		(271,495)	(501,297)	-
<b>FY13 Changes</b>	(778)	(26,160)	-	36,618,228	(2,428,254)	(17,151)	1,329,189	35,475,074
<b>FY13 Request</b>	941,059	1,552,963	4,077,117	79,787,828	76,790	37,855,379	7,372,757	131,663,893
<b>FY13 Changes</b>								
<b>FY13 Subtotal of Legislative Changes</b>								
<b>FY13 As Passed - Dept ID 3410010000</b>	941,059	1,552,963	4,077,117	79,787,828	76,790	37,855,379	7,372,757	131,663,893

FOR FY 2013 DVHA	GF	SF	IdptT	FF	ARRA Fed	Medicaid GCF	Invmt GCF	Total
Program Appropriations - As Passed FY12	130,421,781	-	-	143,519,013	-	640,777,596	1,083,464	915,801,854
FY12 Challenges for Change:								
FY12 BAA Subtotal Challenges:	-	-	-	-	-	-	-	-
FY12 Post Challenges	130,421,781	-	-	143,519,013	-	640,777,596	1,083,464	915,801,854
FY13 Request								
Grants:								
GC Caseload						(5,060,836)		(5,060,836)
CFC Acute Caseload	(804,497)			(1,041,950)				(1,846,447)
State-Only Pharmacy Caseload	(402,286)							(402,286)
Civil Union or Marriage Caseload							318,495	318,495
HIV Caseload							(31,171)	(31,171)
SCHIP Caseload	187,523			427,307				614,830
Refugee Caseload				98,097				98,097
Subtotal Caseload	(1,019,260)	-	-	(516,546)	-	(5,060,836)	287,324	(6,309,317)
GC Utilization								
CFC Acute Utilization	(1,439,947)			(1,864,958)				(3,304,906)
State-Only Pharmacy Utilization	465,445							465,445
Civil Union Utilization							110,702	110,702
HIV Utilization							15,228	15,228
SCHIP Utilization	(138,512)			(315,626)				(454,137)
Refugee Utilization				120,771				120,771
Subtotal Utilization	(1,113,015)	-	-	(2,059,812)	-	5,192,670	125,930	2,145,773
Change in GC Buy-In						2,684,172		2,684,172
Change in CFC Buy-In	11,565			14,978				26,543
Change in State Only Buy-In							(69,971)	(69,971)
Change in Federal Only Buy-In				(46,565)				(46,565)
Subtotal Buy-In	11,565	-	-	14,978	-	2,684,172	(69,971)	2,640,744
Change in Clawback	1,863,550							1,863,550
ACA Rebate				1,620,280				1,620,280
Change in Federal Financial Participation	3,548,896	-	-	(3,548,896)	-	-	-	-
Birth Control Plus Program Implementation						2,005,915		2,005,915
Implementation of GME Initiative						30,000,000		30,000,000
Hospital Rate Increases	51,081	-	-	79,762	-	3,572,338	6,423	3,709,604
Increase Home Health Rates by 1 1/2%	1,632	-	-	2,548	-	110,362	205	114,746
Increase Home Health Rates by 2 1/2%	2,522	-	-	3,938	-	170,588	317	177,366

FOR FY 2013 DVHA	GF	SF	IdptT	FF	ARRA Fed	Medicald GCF	Invmnt GCF	Total
ONE TIME: COB Case Near Resolution						(500,000)		(500,000)
Require Insurance Co.'s to Ck for XIX Eligibility (Casualty)	(11,587)	-	-	(14,156)	-	(74,112)	(144)	(99,999)
Manage High-Risk Pregnancies						(450,000)		(450,000)
Manage Substance Abuse Services						(609,059)		(609,059)
Expand VCCI Initiatives / Savings	(22,348)	-	-	(34,879)	-	(1,442,046)	(2,030)	(1,501,303)
Perform Concurrent Reviews for all Medical Surgical Extended LOS & Post-Pymt Review	(32,957)	-	-	(48,457)	-	(1,916,594)	(1,992)	(2,000,000)
Increase Utilization Review of MH Discharge Planning and Case Manage Psych. Inpatient Transportation Quality Assurance & Coordination	(12,359)	-	-	(18,171)	-	(718,723)	(747)	(750,000)
CURB: Out-of-Network Prior Authorizations for Non-Emergency Outpatient	(102,430)	-	-	(133,538)	-	(662,703)	(1,328)	(900,000)
CURB: Earlier PT/OT/ST Utilization Reviews	(3,787)	-	-	(5,913)	-	(264,824)	(476)	(275,000)
Reduce Payments on Contiguous Body Parts Ultrasounds	(1,514)	-	-	(2,695)	-	(95,620)	(171)	(100,000)
Increase "Pay and Chase" Receipts due to New Pharmacy Data Match Tool	(2,264)	-	-	(3,892)	-	(158,601)	(244)	(165,000)
Enhanced Pharmacy Edits (Limit 1st Fills to 15 Day Supply, Tighten up on 90-Day Refill Mgmt.)	(135,505)	-	-	(40,327)	-	(1,818,141)	(6,026)	(2,000,000)
Contract for Nutritional Supplements	(8,469)	-	-	(2,520)	-	(113,634)	(377)	(125,000)
Savings Associated With Challenges for Change Initiatives	(1,694)	-	-	(504)	-	(22,727)	(75)	(25,000)
Co-Pay Restructuring	(28,473)	-	-	(44,437)	-	(1,837,207)	(2,587)	(1,912,704)
Subtotal Program Savings Initiatives	(5,288)	-	-	(8,257)	-	(369,830)	(665)	(384,040)
	(368,674)	-	-	(357,746)	-	(11,053,821)	(16,863)	(11,797,105)
Estimate Nursing Home Statutory Increases (estimate)	1,477,310			1,913,348				3,390,658
NH Utilization decrease 2 1/2%	(1,219,960)			(1,580,040)				(2,800,000)
Replace one-time FY '12 carry forward from LTC portion	653,550			846,450				1,500,000
Buying back of HCBS- implement 10% discount for Flex Choices budgets, eliminate annual carryover of \$500 (one-time)	135,938			176,062				312,000
Buying back of remaining 40% cut in IADL and Respite with SFY11 Carryforward money (one-time)	907,640			1,175,536				2,083,176
pressure to meet minimum wage increase for small set cfc services in 1/2 of SFY13	19,990			25,890				45,880
Estimated carryover from SFY12	(1,089,250)			(1,410,750)				(2,500,000)
CFC-HCBS - case mgmt - change from 15 minute units with cap of 48 hours/year to monthly rate of \$110	(130,710)			(169,290)				(300,000)
CFC-ERC - eliminate ERC case management	(130,710)			(169,290)				(300,000)
CFC-HCBS - change reimbursement rates from \$15/hour to half-day and full-day rates.	(78,417)			(101,562)				(179,979)
CFC-Moderate Needs: Increase funding due to \$100K transfer from DAIL GF only grants	100,000			129,515				229,515
Subtotal Choices for Care Initiatives	645,381	-	-	835,869	-	-	-	1,481,250

	GF	SF	IdptT	FF	ARRA Fed	Medicaid GCF	Invmt GCF	Total
<b>FOR FY 2013 DVHA</b>								
Technical Adj. to CFC Due to Conf. Committee Chgs.	(84,910)	-	-	(116,586)	-	201,496	-	-
Technical Adj. to State Only Due to Conf. Committee Chgs.	72,848	-	-	-	-	(70,946)	(1,902)	-
Technical Adj. to Non Waiver Due to Conf. Committee Chgs.	-	-	-	(5,920)	-	5,920	-	-
Subtotal Technical Adjustments	(12,062)	-	-	(122,506)	-	136,470	(1,902)	-
FY13 Changes	3,611,615	-	-	(4,094,696)	-	27,757,857	331,463	27,606,241
FY13 Request	134,033,396	-	-	139,424,317	-	668,535,453	1,414,927	943,408,095
FY13 Changes								
Grants:								
FY13 Subtotal of Legislative Changes								
FY13 As Passed - Dept ID 3410015000	134,033,396	-	-	139,424,317	-	668,535,453	1,414,927	943,408,095
TOTAL FY12 OVHA Big Bill As Passed	131,366,795	1,579,123	4,077,117	186,688,613	2,505,044	678,650,126	7,127,032	1,011,993,850
TOTAL FY12 OVHA Challenges for Change	(3,177)	-	-	-	-	-	-	(3,177)
TOTAL FY13 OVHA Starting Point	131,363,618	1,579,123	4,077,117	186,688,613	2,505,044	678,650,126	7,127,032	1,011,990,673
TOTAL FY13 OVHA Ups & Downs	3,610,837	(26,160)	-	32,523,532	(2,428,254)	27,740,706	1,660,652	63,081,315
TOTAL FY13 OVHA Gov Recommended	134,974,455	1,552,963	4,077,117	219,212,145	76,790	706,390,832	8,787,684	1,075,071,988
TOTAL FY13 OVHA Legislative Changes	-	-	-	-	-	-	-	-
TOTAL FY13 OVHA As Passed	134,974,455	1,552,963	4,077,117	219,212,145	76,790	706,390,832	8,787,684	1,075,071,988

## Budget Considerations ~ State Fiscal Year 2013

The Department of Vermont Health Access (DVHA) budget request includes an increase in administration of \$35,475,074 and in program of \$27,606,241 for a total of \$63,081,315 in new appropriations (i.e., a combination of new funds and new expenditure authority).

The programmatic changes in DVHA’s budget are spread across four different covered populations – Global Commitment, Choices for Care, State Only, and Medicaid Matched Non-Waiver; however, the descriptions of the changes are similar across these populations so we are consolidating these items for purposes of testimony and have provided a spreadsheet at the beginning of this narrative that consolidates the official state budget ups and downs to track with our testimony.

**ADMINISTRATION . . . . . \$35,475,074 gross / \$570,877 state**

**PERSONAL SERVICES. . . . . \$4,472,538**  
*\$1,017,281 state*

**Payact and Related Fringe . . . . . \$555,861**  
*\$242,764 state*

When budgeting for vacant positions, we are required to assume a step 2 for the starting pay rate. However, when filling the VCCI nursing positions it has been necessary to hire into range (HIR). Combining this funding pressure with the impact of upgrading a few staff due to expanded scopes of work resulted in a \$126,290 additional appropriation need. Moreover, in one of our program areas where we are seeking to expand (VCCI), there has been high turnover due to non-competitive wages. We are therefore seeking market factor adjustments for these individuals requiring an additional \$341,508. The balance of this request - \$88,063 - is due to fringe (health insurance, EAP, etc.) rate changes.

**Transfer of Development Position to AHS . . . . . (\$68,900)**  
*(\$30,020) state*

As part of the centralization of information technology (IT) functions, DVHA is transferring one IT position to AHS.

**New Positions . . . . . \$4,054,477**  
*\$804,537 state*

DVHA has undergone significant change over the past six years. DVHA began as OVHA – the Office of Vermont Health Access - and acted primarily as a claims processing engine for Medicaid claims. There was one appropriation that was comprised of administrative costs (charged at 50% state / 50% federal) and program costs (charged at 40% state / 60% federal).

In SFY '07, the number of appropriations grew from one to five. The funding streams changed from the traditional match as identified above to multiple approaches depending upon the waiver applied for and approved through Centers for Medicare and Medicaid Services (CMS). A start was made toward operating as a Managed Care Entity for the Global Commitment (GC) to Health Waiver population. The Vermont Chronic Care / Care Coordination Initiative (VCCI) was launched, and Program Integrity (PI) was identified as a necessary resource.

In SFY '10, Health Care Reform (HCR), Health Information Technology (HIT) and Health Information Exchange (HIE) responsibilities were transferred to OVHA. Additionally, the Medicaid Information Technology Architecture/Modernization of Vermont's Enterprise (MITA/MOVE) initiative was launched.

In SFY '11, the Vermont Blueprint for Health joined the organization, the responsibility for the Evidence Based Practices and the Health Information Technology Funds were assigned to OVHA, Program Integrity activities were expanded, Payment Reform was initiated and OVHA became DVHA.

In SFY '12, DVHA gained the responsibility of developing and implementing the Health Insurance Exchange (Exchange), billing and collecting for the new Healthcare Claims Assessment and studying the feasibility of expanding the Provider Tax option.

Many of the changes detailed above occurred during a time in which resources for state staff employment were scarce. The administration and legislature were very supportive in increasing staff where there was a direct link to program savings or health care reform goals such as in Program Integrity, Chronic Care Initiative/Care Coordination, and Health Reform. However, in other areas of the Department where workloads increased, positions were either not considered or there were position eliminations. In order for DVHA to effectively manage its expanding responsibilities, the following resources were identified:

4 FTE - Fiscal and Data needs for VHCURES, DSH, HIT, Assessments	348,169
1 FTE - Pharmacy	68,157
1 FTE - Blueprint statewide expansion	72,192
<b>Subtotal of Positions Needed to Support Current Operational Needs</b>	<b>488,518</b>

Additionally, DVHA has identified areas where new savings can be attained. In order for this to occur, however, the following positions are needed (and please note that the savings associated is described in our program budget request section following our administration request):

3 FTE - Substance Abuse Director & Lock-in Administrators (Program Savings)	239,034
2 FTE - High Risk Pregnancy (Program Savings)	169,237
9 FTE - VCCI Expansion (Program savings)	720,496
1 FTE - Concurrent Reviews (program savings)	80,418
2 FTE - MH Case management and reviews (Program savings)	148,837
<b>Subtotal of Positions Where Program Savings Will Be Realized</b>	<b>1,358,022</b>

DVHA is also responsible for implementing many new initiatives, all of which require significant staff resources. Costs for such are covered either through 100% federal funding or through a blend of enhanced federal participation and existing state resources (such as the HIT fund). These responsibilities include development of the new Medicaid Management Information System (MMIS), implementing the State Health Insurance Exchange, and executing the State Medicaid Health Information Technology Plan (SMHP).

5 FTE - Increase for MMIS PAPD Portfolio - personnel -Match DII	539,208
5 FTE - Increase for SMHP HIT IAPD - personnel (90/10)	530,030
13 FTE - Increase for Exchange Grant personnel - 100% federal	1,138,699
<b>Subtotal of Positions Needed for New Initiatives</b>	<b>2,207,937</b>

**OPERATING** ..... **\$302,280**  
*\$39,092 state*

The DVHA receives allocations from the Department of Buildings and General Services (BGS) to cover our share of the VISION system and Department of Information and Innovation (DII) costs. BGS notifies each department every year of increases or decreases in their relative share in order to incorporate these changes into budget requests. For SFY '13, it is anticipated that VISION costs for the DVHA will decrease by \$93,864 and DII costs by \$7,175. Additionally, it is projected that DVHA will have a decrease in human resources' allocated costs of \$43,929 by the Department of Human Resources.

The balance of the operating changes represents costs associated with the new positions identified above (in the amount of \$447,248).

**GRANTS AND CONTRACTS** ..... **\$30,631,356**  
*(\$485,497) state*

**Reduction in Member Services Contract due to Re-Bid** ..... **(\$250,000)**  
*(\$108,925) state*

As part of the competitive bidding process for contractual services, DVHA was able to reduce the costs of the member services call center by \$250,000.

**State Medicaid Health Information Technology Plan Contracts . . . . . \$186,666**  
*\$0 state*

The State Medicaid Health Plan (SMHP) has moved into the implementation stage. This increase has been approved by CMS and is needed for contractual services to develop and implement the program.

**Increase for Exchange Grants . . . . . \$15,560,000**  
*\$0 state*

One of the key initiatives under the Affordable Care Act (ACA) is the development of a Health Benefit Exchange, and DVHA has taken on this initiative with the development of the Health Insurance Exchange (Exchange). The State Health Insurance Exchange project has been approved by the Office of Consumer Information and Insurance Oversight (OCIIO), and spending authority is needed for contractual services to design and develop the exchange network.

**Decrease in ONC 3013 Grant . . . . . (\$1,500,000)**  
*\$0 state*

DVHA received \$5 million of American Recovery and Reinvestment Act of 2009 (ARRA) funding through the Office of the National Coordinator for Health Information Technology (ONC). Other than continued funding for one position through FFY '14, all of the contractual funds have been obligated, and this large amount of spending authority is no longer needed.

**New MOU's with BISHCA and Agency of Administration . . . . . \$500,000**  
*\$0 state*

One of the key initiatives under ACA is the development of a State Health Insurance Exchange; and DVHA has taken on this initiative. The State Health Insurance Exchange project has been approved by OCIIO and is this transfer is needed to fund the BISCHA and Agency of Administration portion of these activities.

**State Medicaid Health Information Technology Plan Grants . . . . . \$16,280,000**  
*\$0 state*

Under the HIT for Economic and Clinical Health (HITECH) Act, part of the American Recovery and Reinvestment Act of 2009, states can choose to establish an incentive payment program for the adoption and meaningful use of Electronic Health Record (EHR) systems by eligible hospitals and professionals. Vermont has chosen to implement and support an Electronic Health Record Incentive Program (EHRIP). The State's proposed program was approved by CMS in September and was officially launched on October 3, 2011. Our proposal included funding for the operation of the program and estimated the actual incentive payments to providers.

There are two significant points to be made about the incentive payment portion of the estimated spending for this program: 1) the incentive payments are 100% Federal Financial Participation (FFP); and 2) the State’s proposal included an estimated incentive payment schedule for the two fiscal years covered by the initial grant (FFY 2012 and FFY 2013), but the actual process of spending and accounting for the incentive payments occurs through established CMS quarterly reporting and estimating. Vermont anticipates spending \$32,330,000 for incentive payments during the two federal fiscal years (FFY) ending on September 30, 2013.

**Transfer HIT funds to AHS to be used as state match on HCR Initiatives . . . . .**  
 . . . . . **(\$53,810)**  
*\$0 state*

Many of our health care reform initiatives underway qualify as Medicaid administrative costs. As such, we can use our Health Information Technology Fund revenue as match for a Global Commitment dollar. We are therefore transferring this funding to AHS in support of the GC waiver expenditures.

**Cost Neutral Transfer to the Dept. of Mental Health . . . . . (\$21,500)**  
*(\$9,368) state*

Historically DVHA has granted funds to the Community Health Center of Burlington. Due to its historical nature, performance-based deliverables were not inherent in the agreement. Since the Department of Mental Health (DMH) has much more involvement with this organization, DVHA felt it would be in everyone’s best interest to transfer funding to DMH in order to establish better programmatic deliverables.

**Transfer SMHP-PAPD ARRA funds to SMHP-IAPD Federal . . . . . \$0**  
*\$0 state*

The State Medicaid Health Plan (SMHP) has moved into the implementation stage, and original planning (*PAPD or planning advance planning document*) funds were considered ARRA funding. However, the implementation (*IAPD or implementation advance planning document*) funds are federal. This moves the original approved spending authority to the correct federal bucket.

**Transfer to Green Mountain Care Board (GMCB) . . . . . (\$70,000)**  
*(\$30,499) state*

During the SFY ‘11 legislative session, DVHA was appropriated funding for Payment Reform activities. With the creation of the Green Mountain Care Board, it was agreed that \$70,000 would be transferred to it to support its activities in this area.

**Base Funding Replaced by Federal Grants** ..... **\$0**  
*(\$336,705) state*

DVHA is required by the federal Department of Cost Allocation (DCA) to allocate indirect costs to all relevant federally funded programs based upon an approved statistic. Because DVHA has been awarded myriad new federal grants, costs that were previously paid for with Global Commitment dollars are now allocated to these new federal funding streams freeing up state match that was previously used to pay for those Global Commitment dollars.

**PROGRAM** ..... **\$27,606,241 gross / \$15,899,568 state**

**UPDATED TREND CHANGES** ..... **\$1,961,030**  
*\$4,668,238 state*

**Caseload and Utilization Impact** ..... **(\$4,163,544)**  
*(\$1,894,780) state*

**Caseload** ..... **(6,309,317)**  
*(\$3,099,079) state*

DVHA engages in a consensus caseload estimate process with the Joint Fiscal Office, the Department of Finance and Management and the Agency of Human Services when projecting caseload growth. We are now seeing a leveling off in caseload growth resulting in a more modest increase than what was utilized in the SFY '12 budget build process. Please see program descriptions below to view caseload trend data by Medicaid Eligibility Group.

**Utilization** ..... **\$2,145,773**  
*\$1,204,299 state*

Utilization impacts are derived by comparing year-over-year changes in per-member per-month (PMPM) costs by category of service (COS), taking into consideration any policy changes that might drive that change (such as rate increases or reductions). A historical picture of category of service costs can be reviewed on insert 4.

**Green Mountain Care** is the umbrella name for the state-sponsored family of low-cost and free health coverage programs for uninsured Vermonters. Offered by the State of Vermont and its partners, **Green Mountain Care** programs offer access to quality, comprehensive health care coverage at a reasonable cost. No or low co-payments and premiums keep out-of-pocket costs reasonable.



**Medicaid for Adults**

Medicaid programs for adults provide low-cost or free coverage for low-income parents, pregnant women, caretaker relatives, people who are blind or disabled, and those age 65 or older. Eligibility is based on income and resources (e.g., cash, bank accounts, etc.).

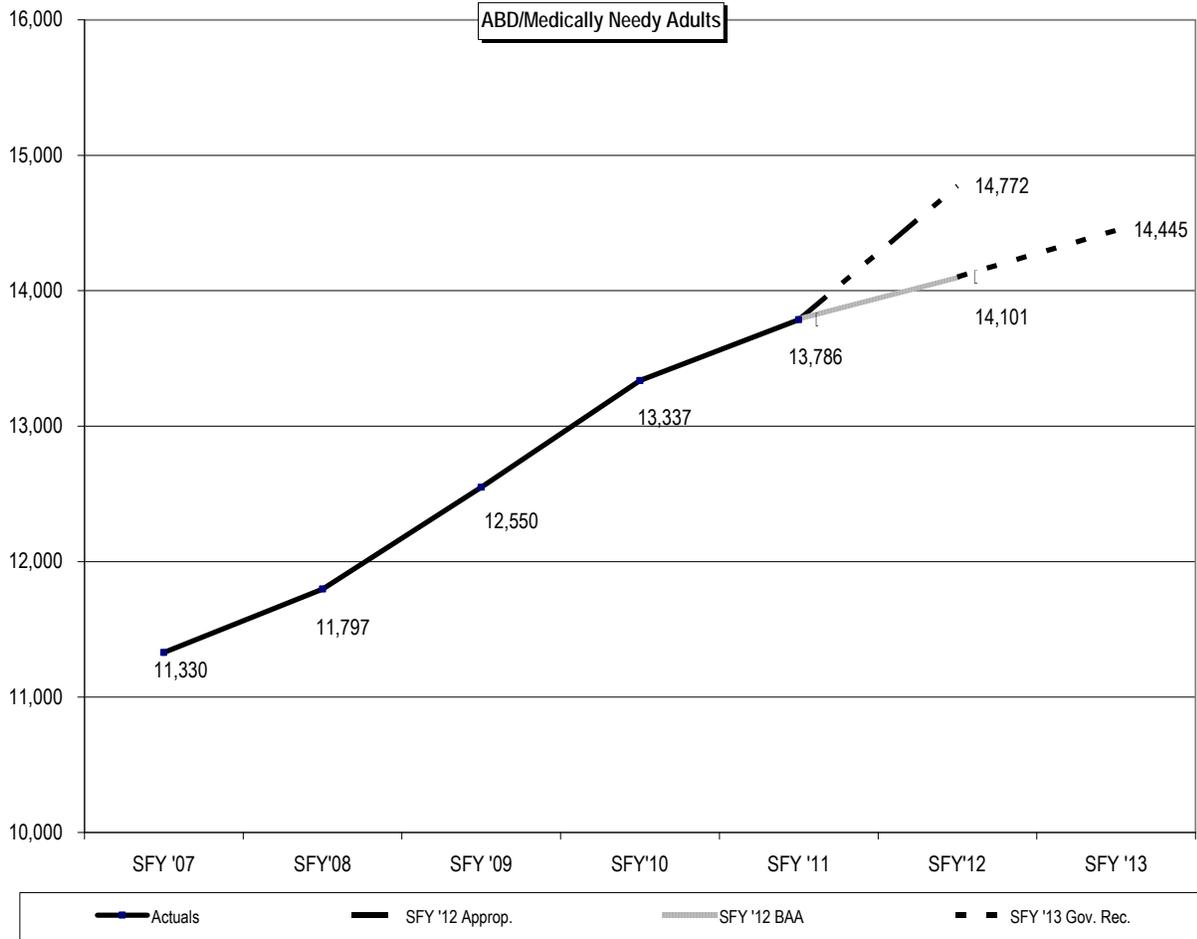
Medicaid programs cover most physical and mental health care services such as doctor visits, hospital care, prescription medicines, vision and dental care, long-term care, physical therapy, medically-necessary transportation and more. Services such as dentures or eyeglasses are not covered, and other services may have limitations.

***Aged, Blind, or Disabled (ABD) and/or Medically Needy Adults***

The general eligibility requirements for the ABD and/or Medically Needy Adults are: age 18 and older; categorized as aged, blind, or disabled but ineligible for Medicare; generally includes Supplemental Security Income (SSI) cash assistance recipients, working disabled, hospice patients, Breast and Cervical Cancer Treatment (BCCT) participants, or Medicaid/Qualified Medicare Beneficiaries (QMB); and medically needy [i.e., eligible because their income is greater than the cash assistance level but less than the protected income level (PIL)]. Medically needy adults may be ABD or the parents/caretaker relatives of minor children.

The following table depicts the caseload and expenditure information by SFY, including the Governor’s Recommend for SFY ’13 for ABD and/or Medically Needy Adults:

Aged, Blind, & Disabled (ABD) and/or Medically Needy Adults			
SFY	Caseload	Expenditures	P.M.P.M.
SFY '10 Actual	13,337	\$ 87,006,993	\$ 543.63
SFY '11 Actual	13,786	\$ 88,592,211	\$ 535.50
SFY '12 Appropriated	14,772	\$ 103,481,068	\$ 583.76
SFY '12 Budget Adjustment	14,101	\$ 96,357,476	\$ 569.46
SFY '13 Governor's Recommend	14,445	\$ 99,883,344	\$ 576.24

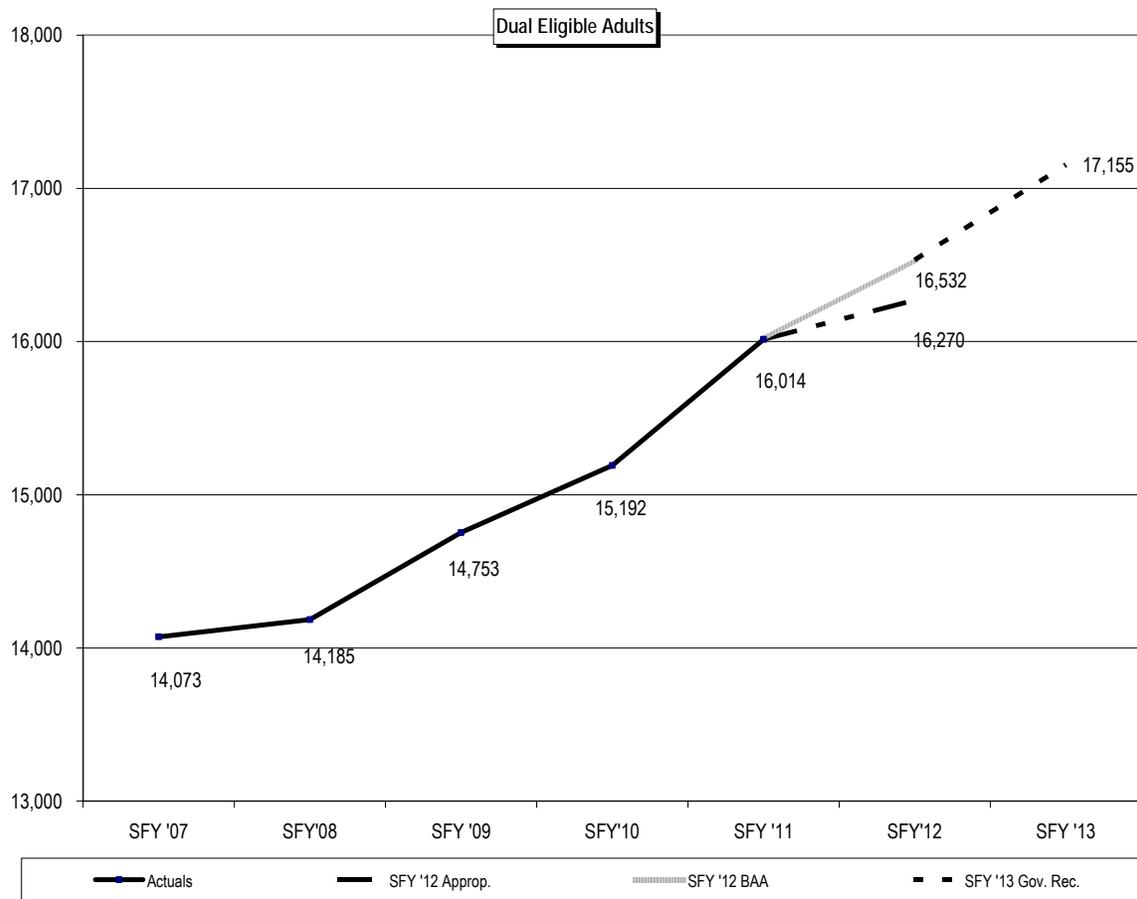


**Dual Eligibles**

Dual Eligibles are eligible for both Medicare and Medicaid. Medicare eligibility is either due to being at least 65 years of age or categorized as blind, or disabled, and below the protected income level (PIL).

The following table depicts the caseload and expenditure information by SFY, including the Governor's Recommend for SFY '13 for Dual Eligibles:

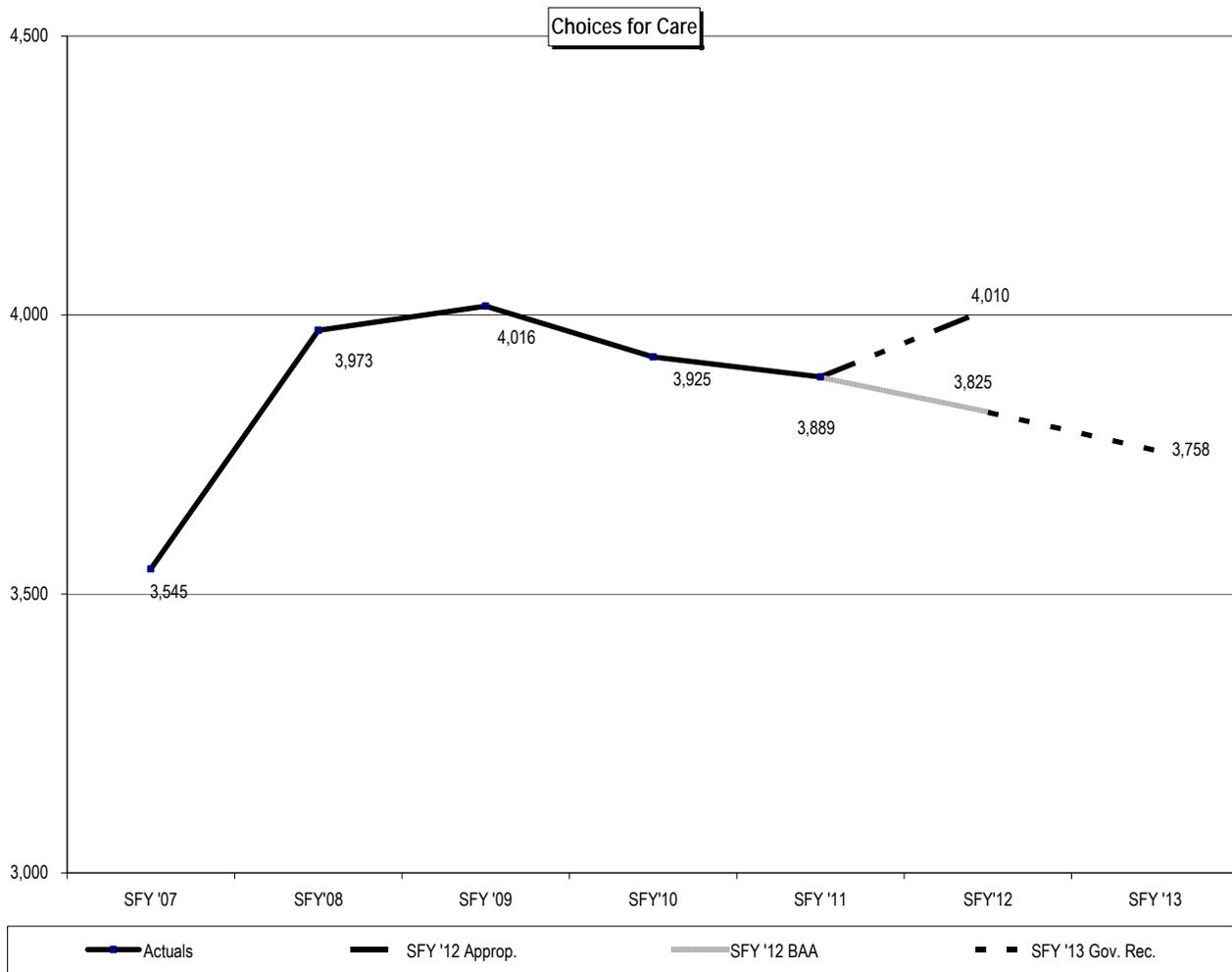
Dual Eligibles			
SFY	Caseload	Expenditures	P.M.P.M.
SFY '10 Actual	15,192	\$ 41,432,987	\$ 227.28
SFY '11 Actual	16,014	\$ 42,746,091	\$ 222.44
SFY '12 Appropriated	16,270	\$ 48,295,234	\$ 247.36
SFY '12 Budget Adjustment	16,532	\$ 45,630,298	\$ 230.00
SFY '13 Governor's Recommend	17,155	\$ 47,882,946	\$ 232.60



***Choices for Care Waiver***

Long-Term Care Waiver participants are a subset of the Duals population. These individuals participate in the Choices for Care 1115 demonstration waiver managed by the Department of Disabilities, Aging, and Independent Living (DAIL), in conjunction with the Department of Vermont Health Access (DVHA) and the Department for Children and Families (DCF). The purpose of this waiver is to equalize the entitlement to both home and community based services and nursing home services for all those eligible. The general eligibility requirements for the waiver are: Vermonters in nursing homes, home-based settings under home and community based services (HCBS) waiver programs, enhanced residential care (ERC), and program for all-inclusive care for the elderly (PACE). Please note that the caseload figures below do not include moderate-need individuals as they are captured under the Global Commitment waiver program. (Only long-term care services for moderates are included in the dollars below.)

Choices for Care Waiver			
SFY	Caseload	Expenditures	P.M.P.M.
SFY '10 Actual	3,925	\$ 194,618,136	\$ 4,132.11
SFY '11 Actual	3,889	\$ 191,968,507	\$ 4,113.32
SFY '12 Appropriated	4,010	\$ 205,289,676	\$ 4,266.20
SFY '12 Budget Adjustment	3,825	\$ 204,857,556	\$ 4,462.73
SFY '13 Governor's Recommend	3,758	\$ 201,240,298	\$ 4,463.05

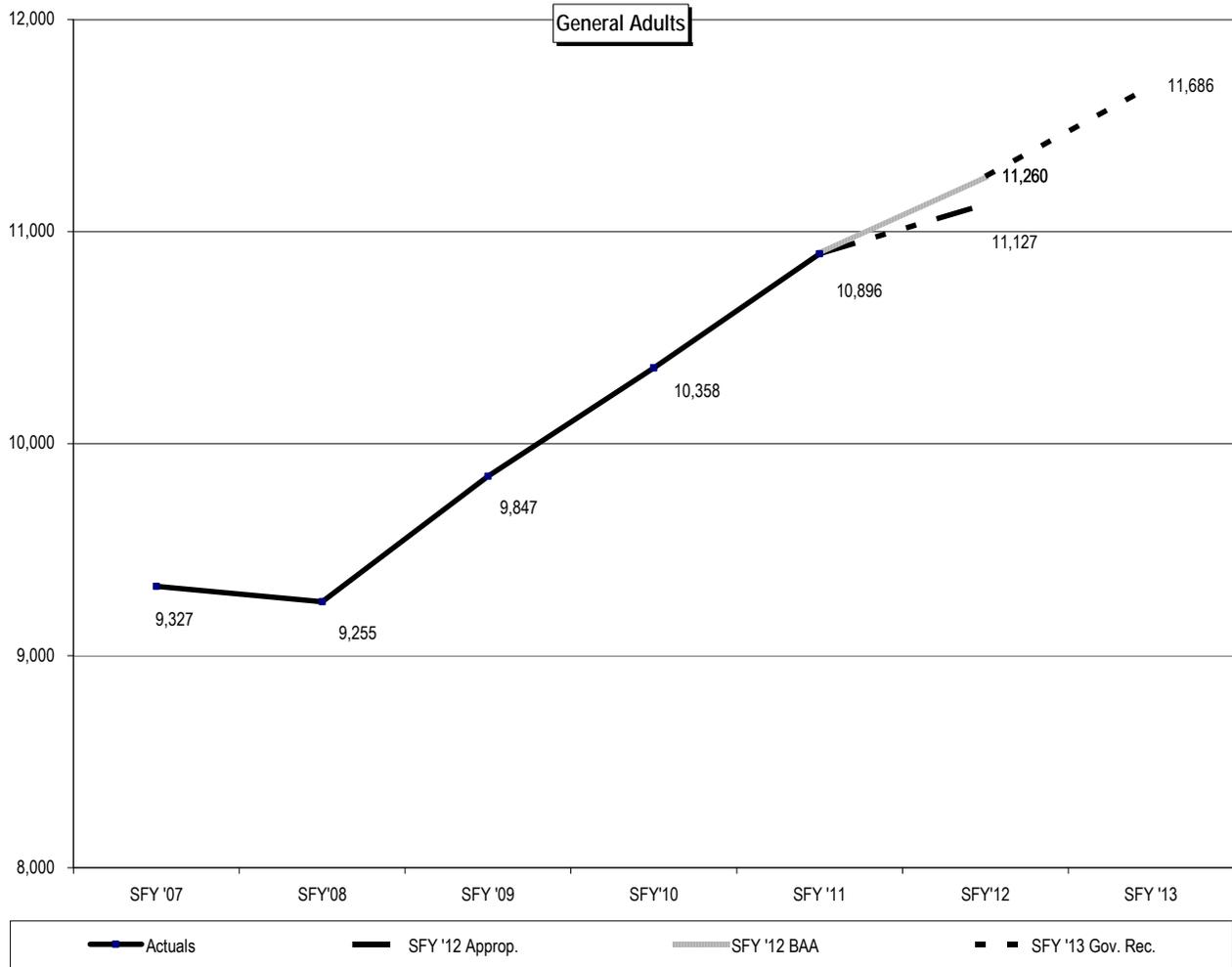


**General Adults**

The general eligibility requirements for General Adults are: parents/caretaker relatives of minor children including cash assistance recipients and those receiving transitional Medicaid after the receipt of cash assistance.

The following table depicts the caseload and expenditure information by SFY, including the Governor's Recommend for SFY '13 for General Adults:

General Adults			
SFY	Caseload	Expenditures	P.M.P.M.
SFY '10 Actual	10,358	\$ 58,325,148	\$ 469.26
SFY '11 Actual	10,896	\$ 61,424,053	\$ 469.78
SFY '12 Appropriated	11,127	\$ 68,941,637	\$ 516.30
SFY '12 Budget Adjustment	11,260	\$ 67,198,737	\$ 497.32
SFY '13 Governor's Recommend	11,686	\$ 70,737,344	\$ 504.45



**Vermont Health Access Plan (VHAP)**

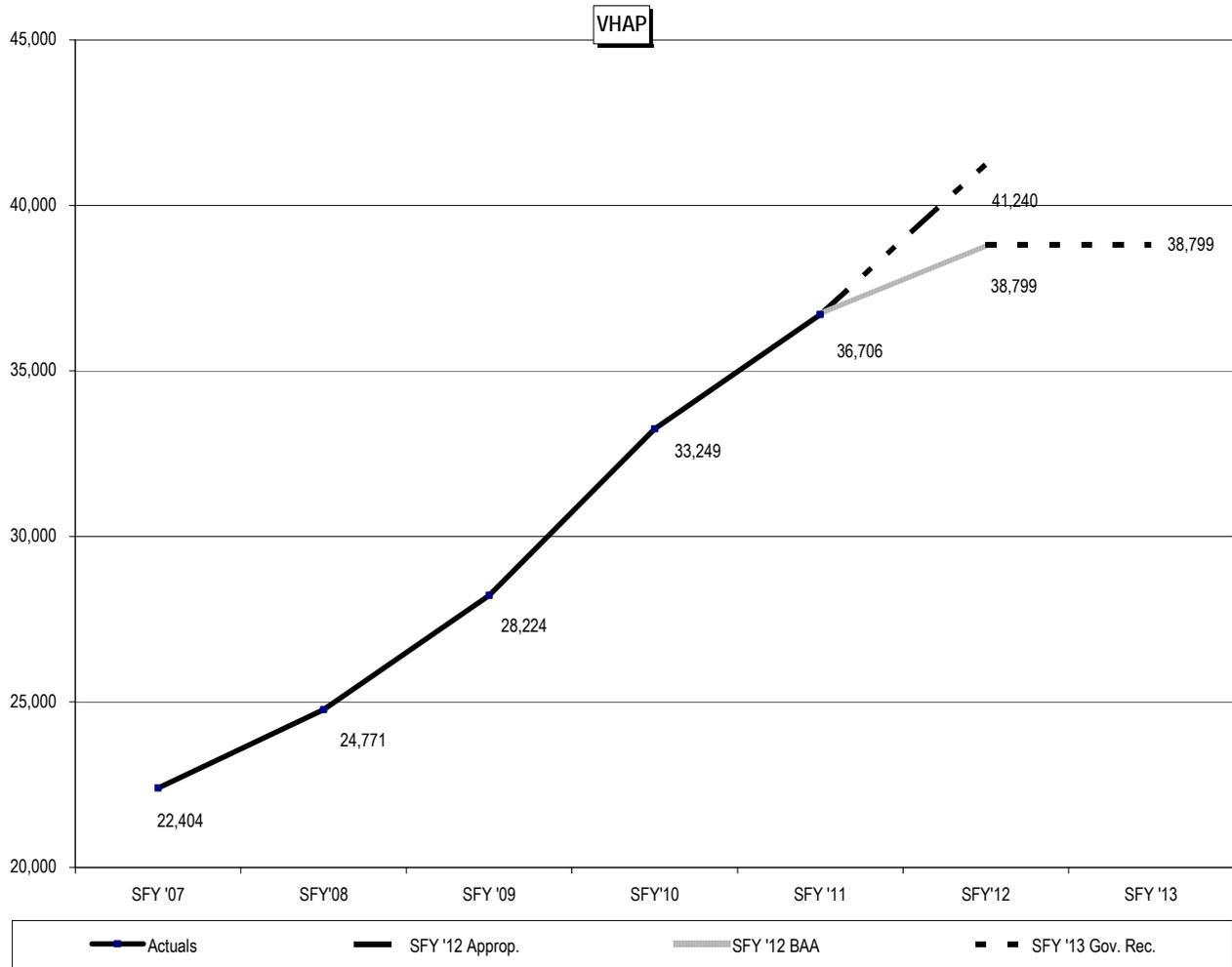
VHAP was created by an 1115 waiver to provide low cost, comprehensive health care benefits to adults without children who have a household income below 150% of the federal poverty level (FPL), and adults with children who have a household income below 185% of the federal poverty level.

Other VHAP eligibility requirements include: age 18 and older; currently have health insurance that covers only hospital care or only doctor visits; have not had health insurance for the past 12 months, or within the past 12 months have lost their insurance because they (1) lost their job, their employer reduced their work hours or their job ended, (2) got divorced or their civil union dissolved, (3) experienced domestic violence or abuse, (4) had insurance through someone who passed away, (5) no longer continue their health insurance through Consolidated Omnibus Budget Reconciliation Act (COBRA) or state continuation coverage ("VIPER"), (6) are no longer a dependent on their parent's or caretaker's health insurance, or (7) were getting their insurance through college and can no longer do so because they graduated, took a leave of absence, reduced their credits or stopped going to college.

VHAP covers most physical and mental health care services such as doctor visits, hospital care, prescription medicines, physical therapy, and more. It does not cover services such as dental/dentures, eyeglasses or transportation, and other services may have limitations.

The following table depicts the caseload and expenditure information by SFY, including the Governor's Recommend for SFY '13 for VHAP:

VHAP			
SFY	Caseload	Expenditures	P.M.P.M.
SFY '10 Actual	33,249	\$ 130,598,440	\$ 327.32
SFY '11 Actual	36,706	\$ 140,821,782	\$ 319.71
SFY '12 Appropriated	41,240	\$ 171,453,467	\$ 346.46
SFY '12 Budget Adjustment	38,799	\$ 158,466,885	\$ 340.36
SFY '13 Governor's Recommend	38,799	\$ 160,785,409	\$ 345.34



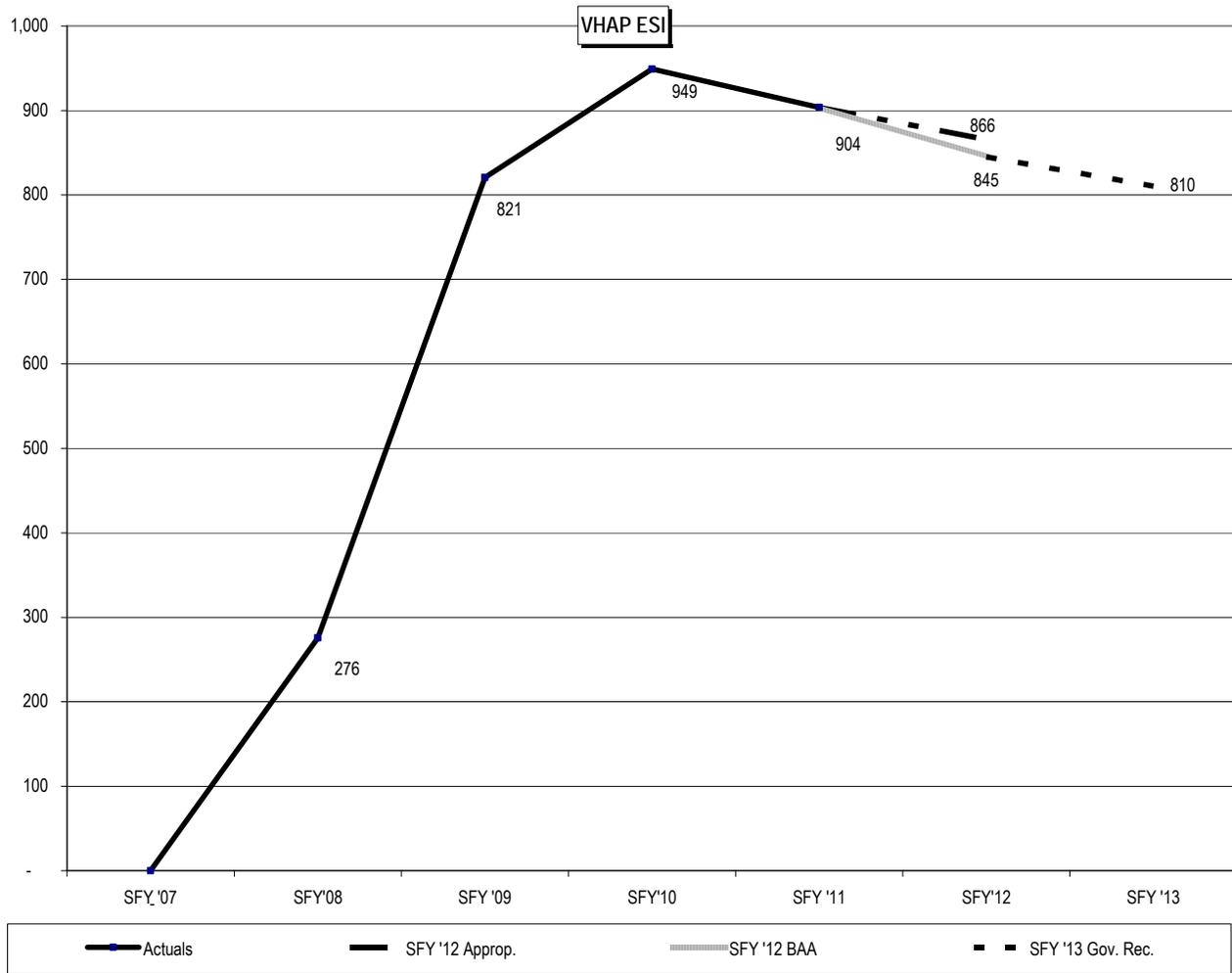
### **VHAP Employer-Sponsored Insurance Premium Assistance**

Employer-Sponsored Insurance (ESI) Premium Assistance is a program for uninsured Vermonters. The State of Vermont is offering premium assistance to eligible employees to help them enroll in their employer-sponsored health insurance plan if all of the following criteria are met:

- The employee meets the eligibility criteria to enroll in Catamount Health or the VHAP;
- The employee's household income is under \$2,763 a month for one person;
- The employer's plan has comprehensive benefits; and
- The cost of providing premium assistance to enroll in an employer's plan is less than the cost of providing premium assistance to enroll in Catamount Health or the VHAP.

The following tables depict the caseload and expenditure information by SFY, including the Governor's Recommend for SFY '13 for VHAP Employer-Sponsored Insurance (ESI) Premium Assistance:

VHAP ESI			
SFY	Caseload	Expenditures	P.M.P.M.
SFY '10 Actual	949	\$ 1,787,708	\$ 156.97
SFY '11 Actual	904	\$ 1,695,350	\$ 156.37
SFY '12 Appropriated	866	\$ 2,527,600	\$ 243.32
SFY '12 Budget Adjustment	845	\$ 1,845,490	\$ 181.96
SFY '13 Governor's Recommend	810	\$ 2,005,682	\$ 206.26



**Catamount Health and Premium Assistance**

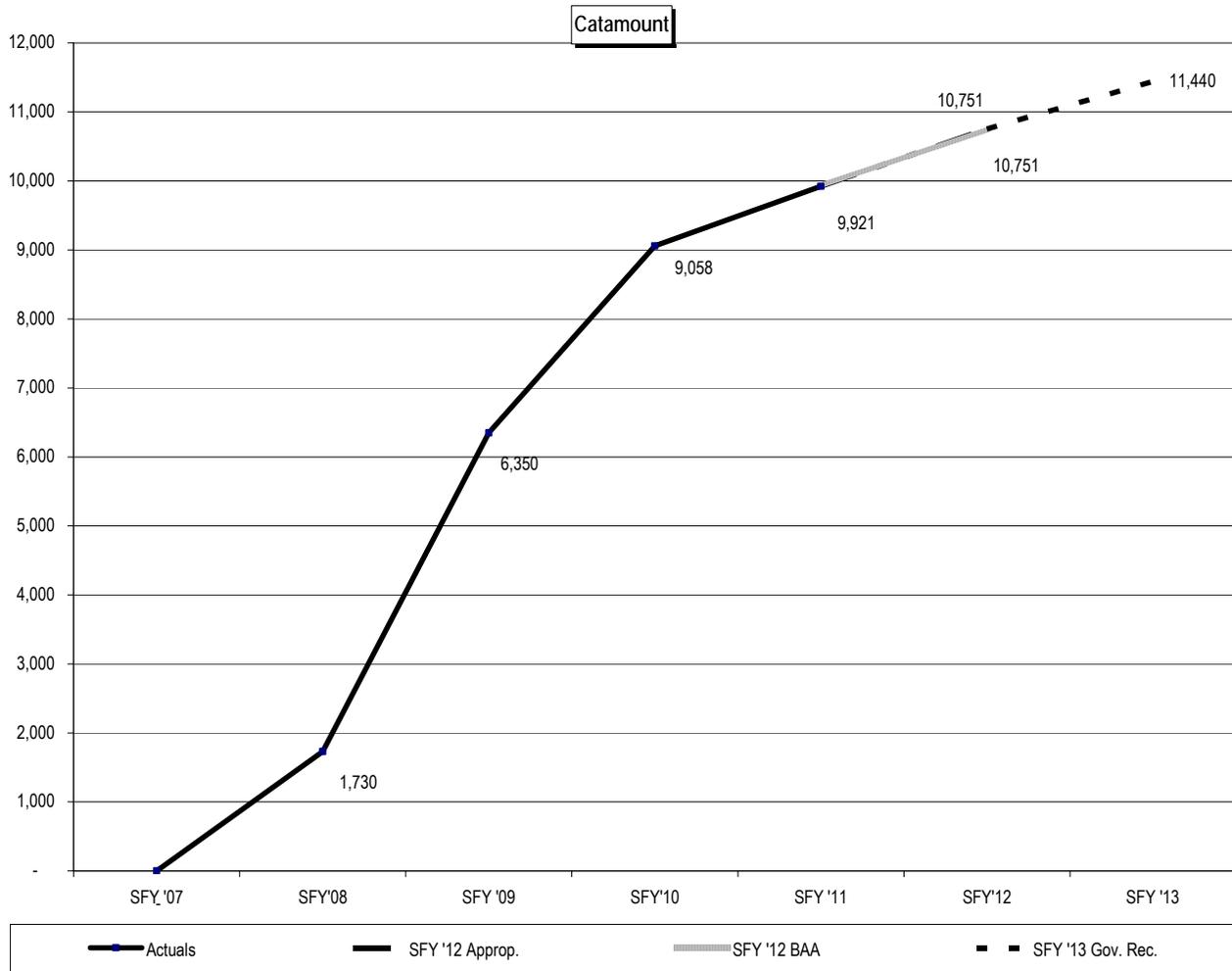
Catamount Health is a health insurance plan offered in cooperation with Blue Cross Blue Shield of Vermont and MVP Health Care. It provides comprehensive, quality health coverage. Assistance also may be available based on income for paying premiums; premium subsidies are available to those who fall at or below 300% of FPL.

Catamount Health is designed for Vermont residents who meet the following qualifications: age 18 or older; families who are not eligible for existing state-sponsored coverage programs such as Medicaid or Vermont Health Access Plan (VHAP); do not have access to insurance through their employer; have been uninsured for 12 months or more, or within the past 12 months have lost their insurance because they (1) lost their job, their employer reduced their work hours or their job ended, (2) got divorced or their civil union dissolved, (3) experienced domestic violence or abuse, (4) had insurance through someone who passed away, (5) no longer continue their health insurance through Consolidated Omnibus Budget Reconciliation Act (COBRA) or state continuation coverage ("VIPER"), (6) are no longer a dependent on their parent's or caretaker's health insurance, or (7) were getting their insurance through college and can no longer do so because they graduated, took a leave of absence, reduced their credits or stopped going to college.

Depending on income, uninsured Vermonters may receive assistance paying their premiums when: access is not available to comprehensive health insurance through their employer as determined by the state; the employer's plan offers comprehensive benefits, but it is more cost-effective for the state to provide premium assistance to enroll in Catamount Health or VHAP than to provide premium assistance to enroll in the employer's plan; or the individual is waiting for the open enrollment period to enroll in their employer's plan.

The following table depicts the caseload and expenditure information by SFY, including the Governor's Recommend for SFY '13 for Catamount Health:

Catamount Health			
SFY	Caseload	Expenditures	P.M.P.M.
SFY '10 Actual	9,058	\$ 45,210,486	\$ 415.95
SFY '11 Actual	9,921	\$ 56,831,908	\$ 477.36
SFY '12 Appropriated	10,751	\$ 52,477,439	\$ 406.76
SFY '12 Budget Adjustment	10,751	\$ 50,668,256	\$ 392.74
SFY '13 Governor's Recommend	11,440	\$ 62,002,768	\$ 451.65

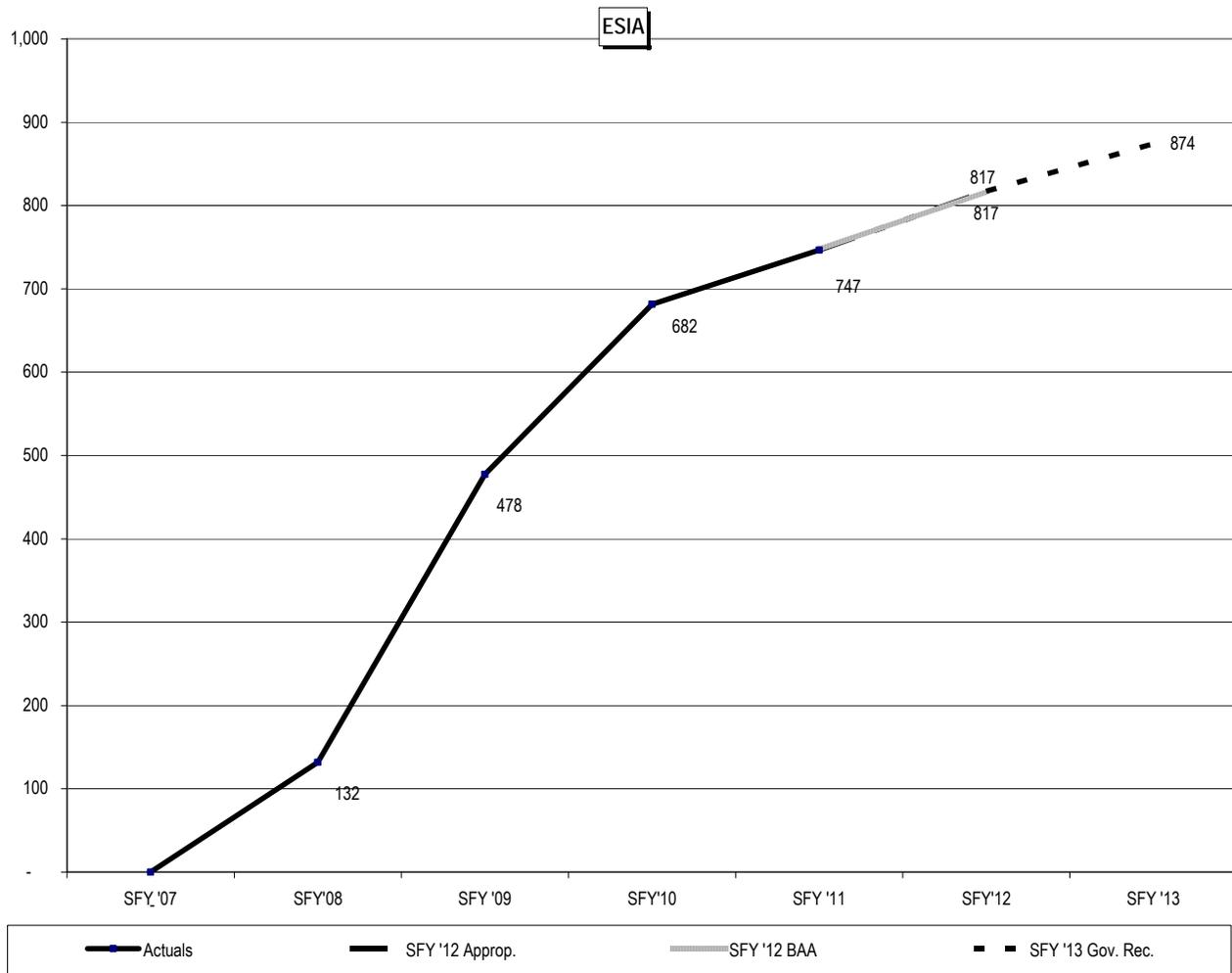


### Catamount Employer-Sponsored Insurance Premium Assistance

The State provides premium assistance to eligible uninsured employees to help them enroll in their employer-sponsored health insurance plan if all of the following criteria are met: the employee meets the eligibility criteria to enroll in Catamount Health or the Vermont Health Access Plan (VHAP); the employee's household income is under 300% FPL for one person; the employer's plan has comprehensive benefits; and the cost of providing premium assistance to enroll in an employer's plan is less than the cost of providing premium assistance to enroll in Catamount Health or the VHAP.

The following tables depict the caseload and expenditure information by SFY, including the Governor's Recommend for SFY '13 for Catamount Employer-Sponsored Insurance (ESI) Premium Assistance:

ESIA			
SFY	Caseload	Expenditures	P.M.P.M.
SFY '10 Actual	682	\$ 900,029	\$ 110.04
SFY '11 Actual	747	\$ 1,056,258	\$ 117.90
SFY '12 Appropriated	817	\$ 1,845,731	\$ 188.24
SFY '12 Budget Adjustment	817	\$ 1,845,758	\$ 188.25
SFY '13 Governor's Recommend	874	\$ 2,270,715	\$ 216.52



**Dr. Dynasaur**

Dr. Dynasaur encompasses all health care programs available for children up to age 18 (SCHIP, Underinsured Children) or up to age 21 [Blind or Disabled (BD) and/or Medically Needy Children and General Medicaid].

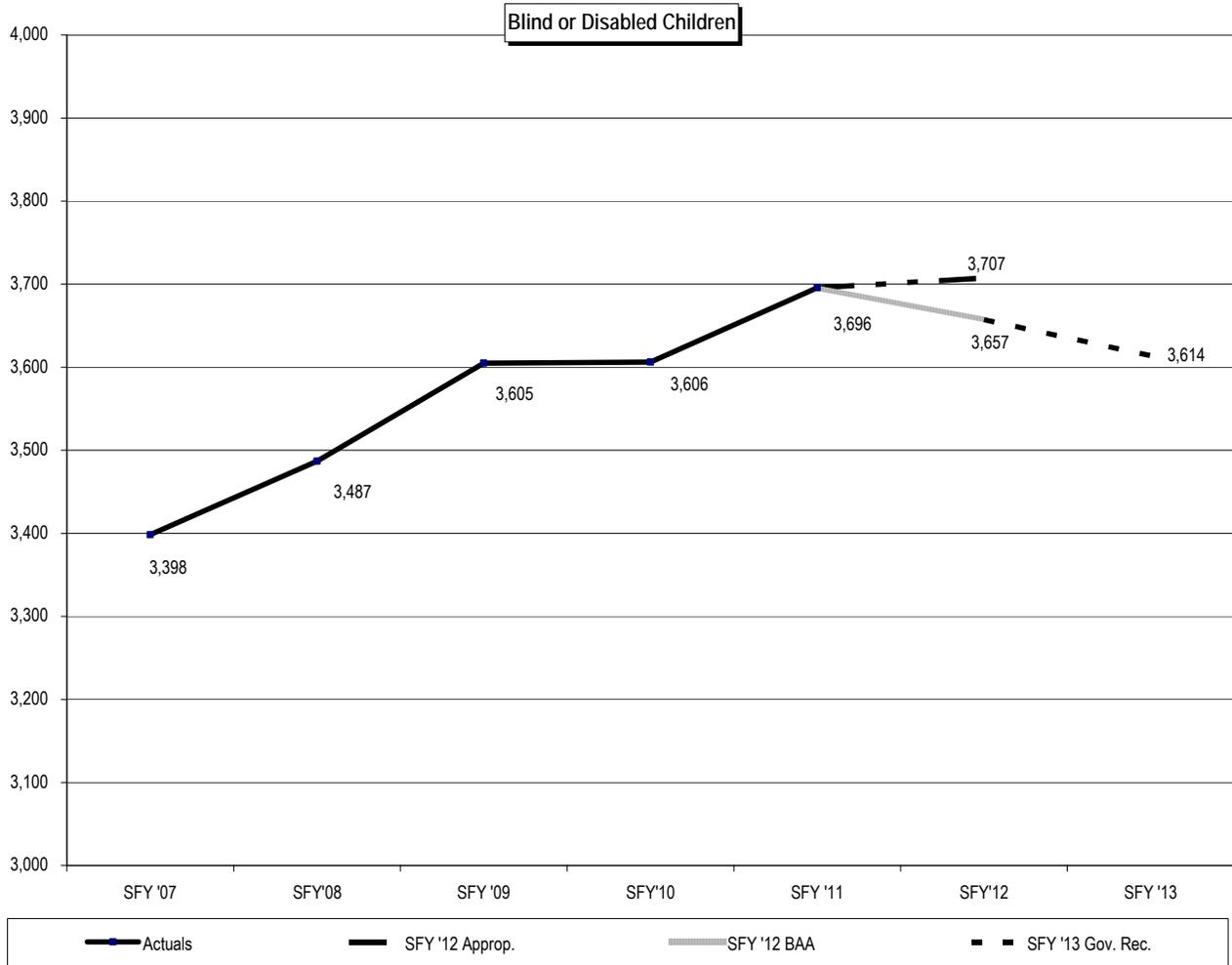
Benefits include doctor visits, prescription medicines, dental care, skin care, hospital visits, vision care, mental health care, immunizations and special services for pregnant women such as lab work and tests, prenatal vitamins and more.

***Blind or Disabled (BD) and/or Medically Needy Children***

The general eligibility requirements for BD and/or Medically Needy Children are: under age 21; categorized as blind or disabled; generally includes Supplemental Security Income (SSI) cash assistance recipients; hospice patients; those eligible under “Katie Beckett” rules; and medically needy Vermonters [i.e., eligible because their income is greater than the cash assistance level but less than the protected income level (PIL)]. Medically needy children may or may not be blind or disabled.

The following table depicts the caseload and expenditure information by SFY, including the Governor’s Recommend for SFY ’13 for BD and/or Medically Needy Children:

Blind or Disabled and/or Medically Needy Children			
SFY	Caseload	Expenditures	P.M.P.M.
SFY '10 Actual	3,606	\$ 31,605,170	\$ 730.35
SFY '11 Actual	3,696	\$ 34,724,216	\$ 783.01
SFY '12 Appropriated	3,707	\$ 35,172,968	\$ 790.61
SFY '12 Budget Adjustment	3,657	\$ 35,895,708	\$ 817.97
SFY '13 Governor's Recommend	3,614	\$ 35,556,239	\$ 819.92

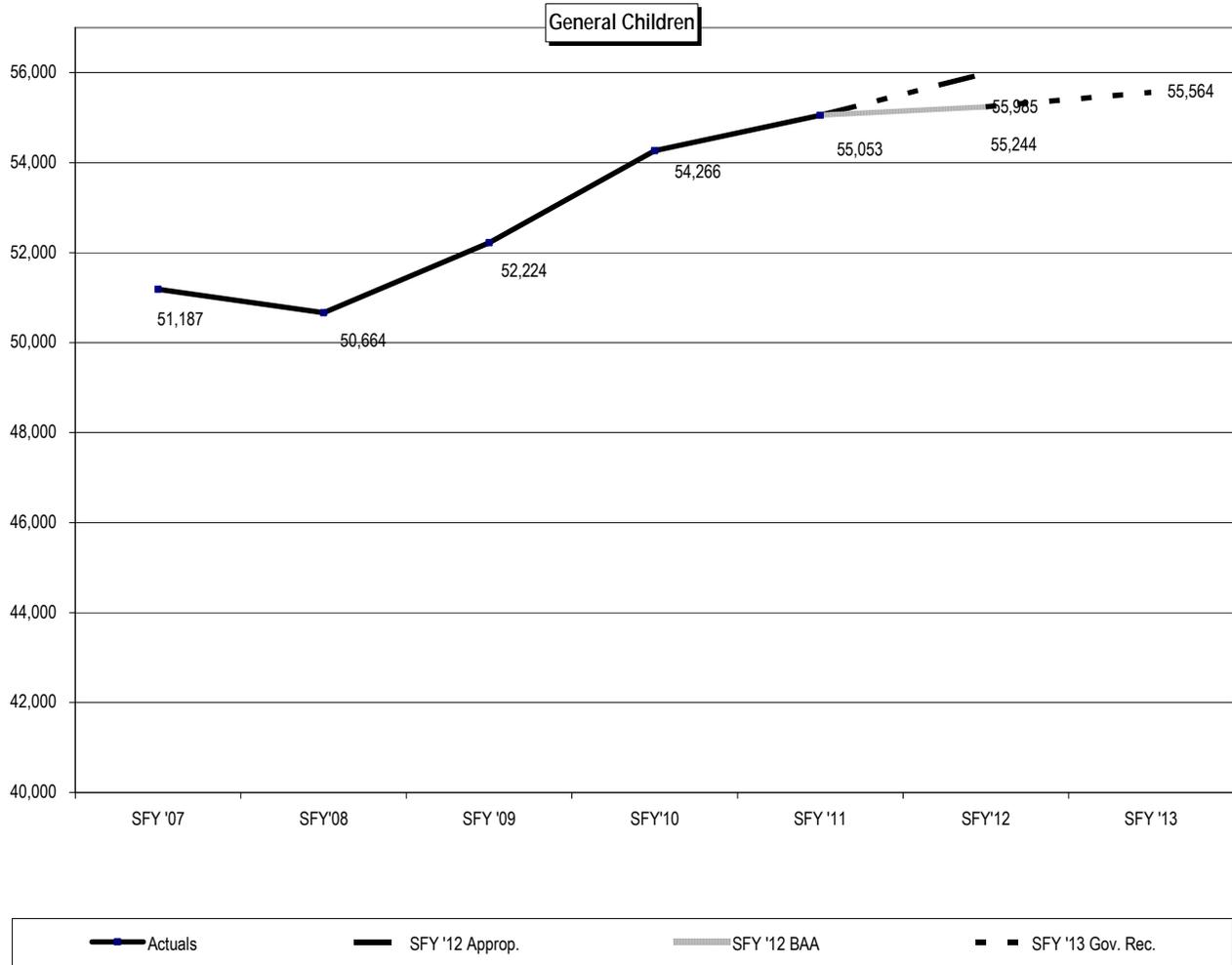


**General Children**

The general eligibility requirements for General Children are: under age 21 and below the protected income level (PIL), categorized as those eligible for cash assistance including Reach Up (Title V) and foster care payments (Title IV-E).

The following table depicts the caseload and expenditure information by SFY, including the Governor's Recommendation for SFY '13 for General Children:

General Children			
SFY	Caseload	Expenditures	P.M.P.M.
SFY '10 Actual	54,266	\$ 108,508,732	\$ 166.63
SFY '11 Actual	55,053	\$ 111,924,219	\$ 169.42
SFY '12 Appropriated	55,985	\$ 125,147,519	\$ 186.28
SFY '12 Budget Adjustment	55,244	\$ 119,002,701	\$ 179.51
SFY '13 Governor's Recommend	55,564	\$ 122,178,332	\$ 183.24

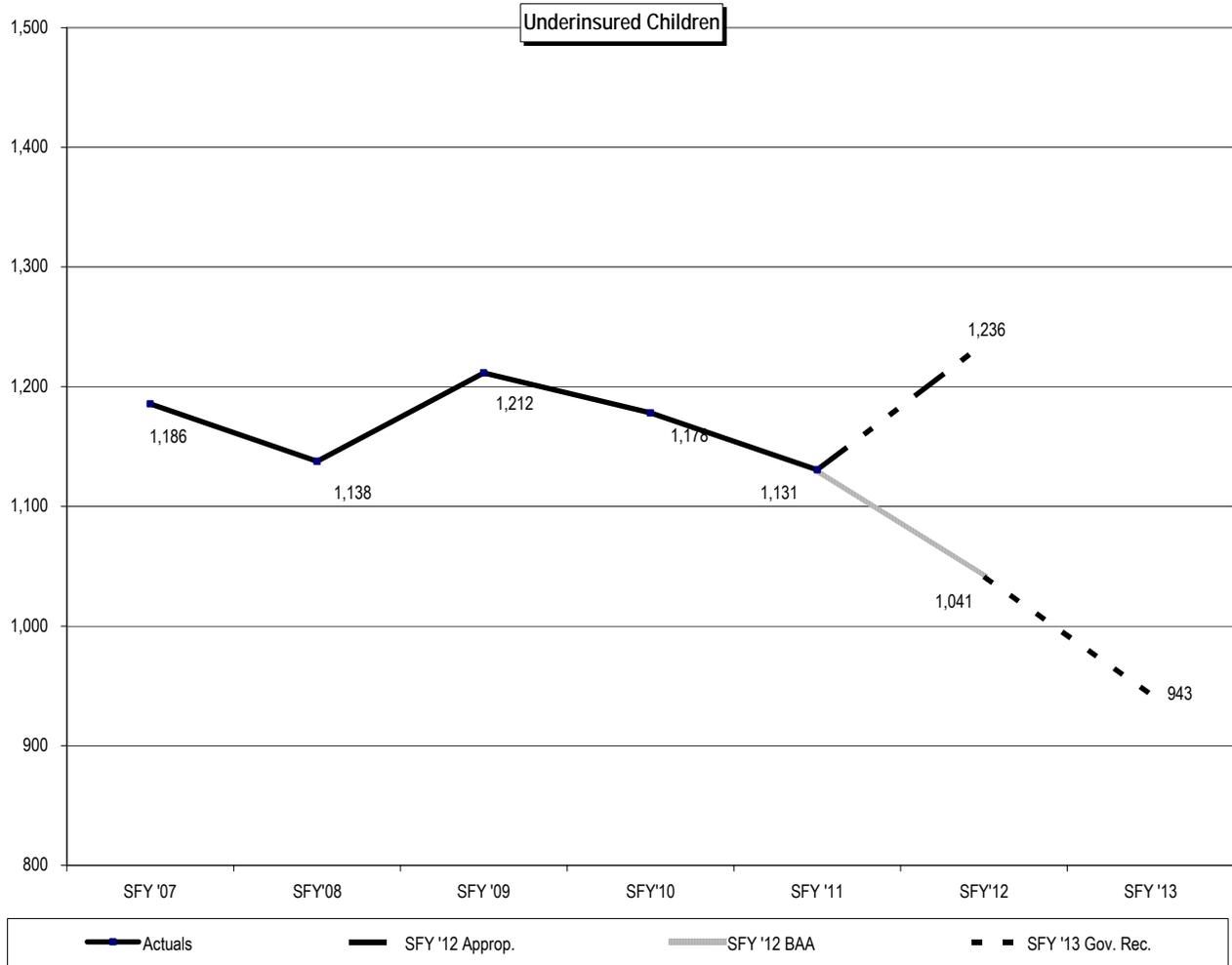


***Underinsured Children***

The general eligibility requirements for Underinsured Children are: up to age 18 and up to 300% FPL. This program was designed as part of the original 1115 Waiver to Title XIX of the Social Security Act to provide health care coverage for children who would otherwise be underinsured.

The following table depicts the caseload and expenditure information by SFY, including the Governor’s Recommend for SFY '13 for Uninsured Children:

Underinsured Children			
SFY	Caseload	Expenditures	P.M.P.M.
SFY '10 Actual	1,178	\$ 812,299	\$ 57.46
SFY '11 Actual	1,131	\$ 806,332	\$ 59.43
SFY '12 Appropriated	1,236	\$ 942,371	\$ 63.54
SFY '12 Budget Adjustment	1,041	\$ 731,951	\$ 58.58
SFY '13 Governor's Recommend	943	\$ 674,907	\$ 59.65

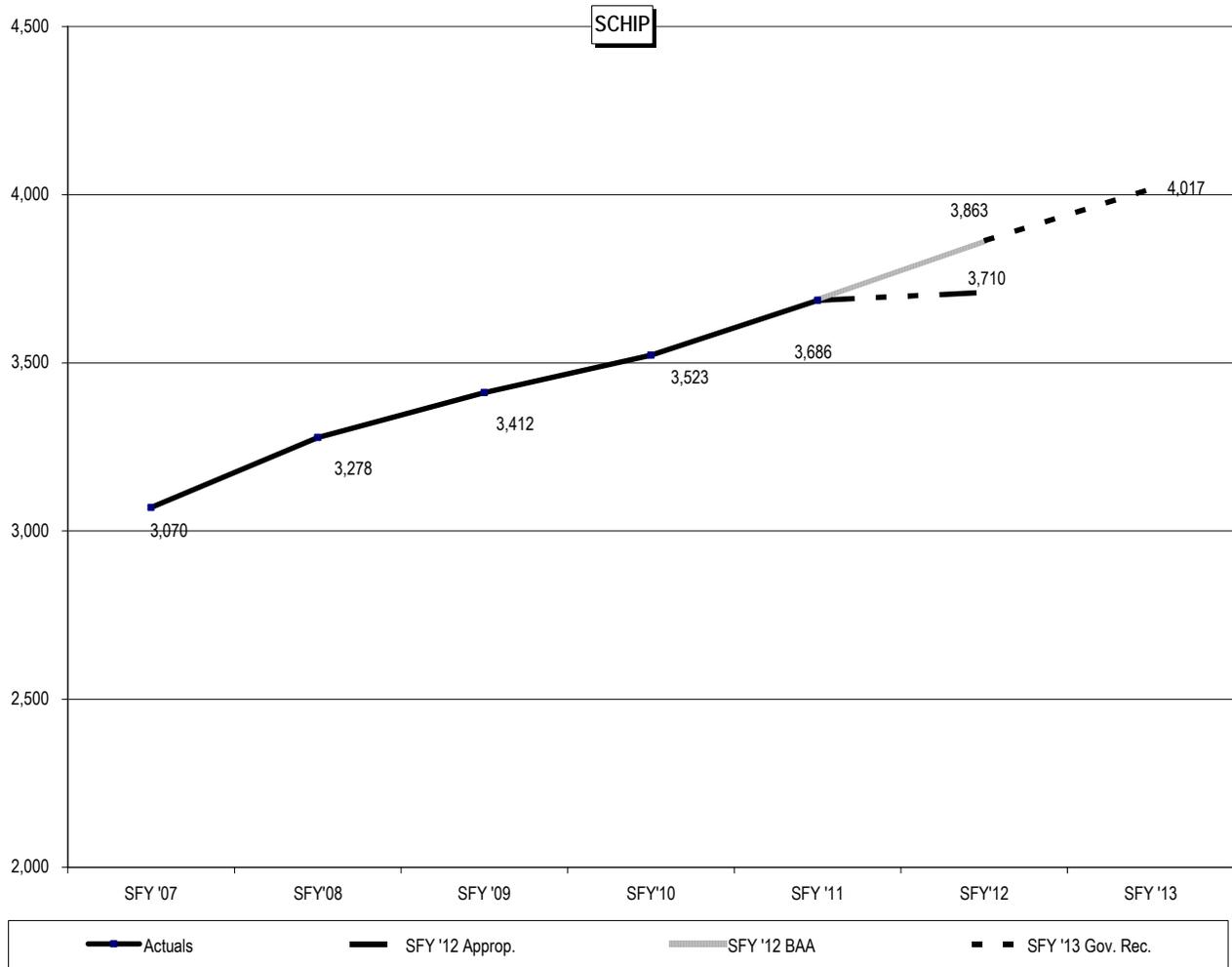


**State Children’s Health Insurance Program (SCHIP)**

The general eligibility requirements for the State Children’s Health Insurance Program (SCHIP) are: up to age 18, uninsured, and up to 300% Federal Poverty Limit (FPL), and eligible under the SCHIP eligibility rules in Title XXI of the Social Security Act.

The following table depicts the caseload and expenditure information by SFY, including the Governor’s Recommend for SFY '13 for the State Children’s Health Insurance Program (SCHIP):

SCHIP (Uninsured)			
SFY	Caseload	Expenditures	P.M.P.M.
SFY '10 Actual	3,523	\$ 5,629,939	\$ 133.17
SFY '11 Actual	3,686	\$ 6,295,264	\$ 142.34
SFY '12 Appropriated	3,710	\$ 7,429,724	\$ 166.89
SFY '12 Budget Adjustment	3,863	\$ 7,112,126	\$ 153.43
SFY '13 Governor's Recommend	4,017	\$ 7,534,112	\$ 156.30



### Prescription Assistance Pharmacy Only Programs

Vermont provides prescription assistance programs to help Vermonters pay for prescription medicines based on income, disability status and age. There is a monthly premium based on income and co-pays based on the cost of the prescription.

**VPharm** assists Vermonters enrolled in Medicare Part D with paying for prescription medicines. Those eligible include people age 65 and older and Vermonters of all ages with disabilities with household incomes up to 225% FPL.

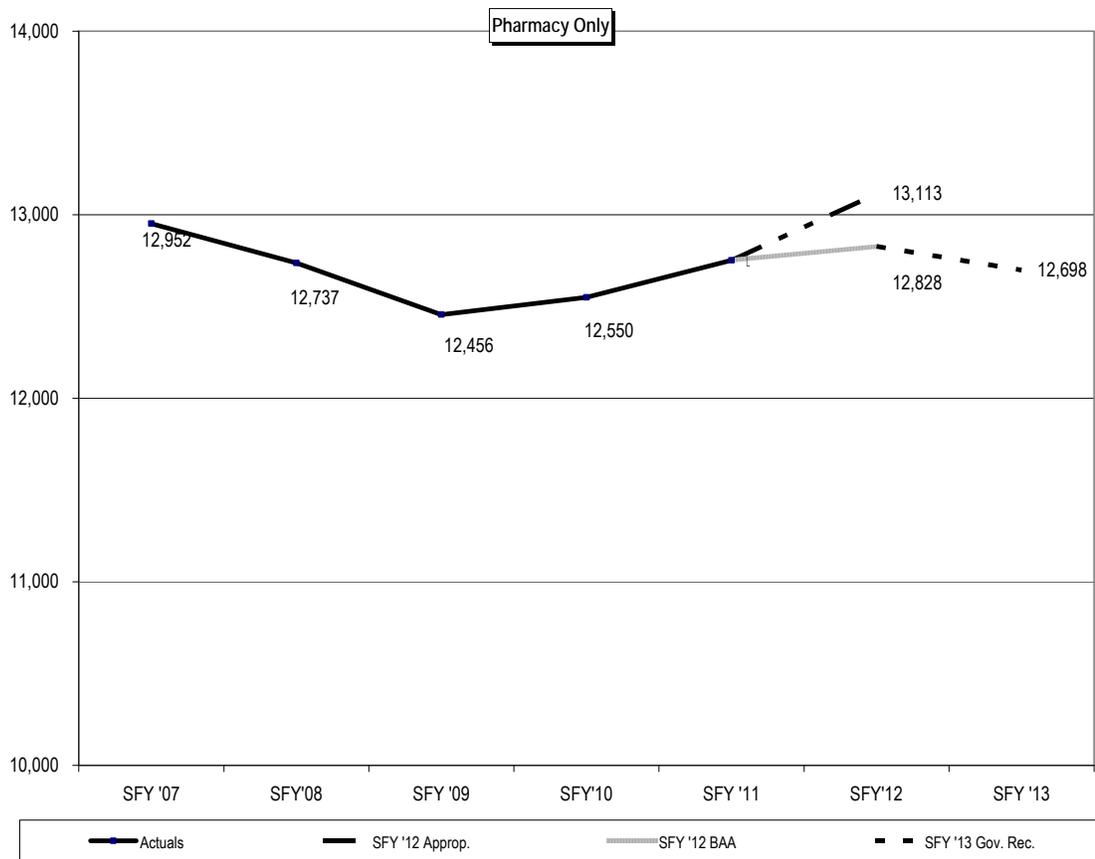
**VHAP-Pharmacy** assists Vermonters age 65 and older and people with disabilities who are not enrolled in Medicare and who have household incomes up to 150% FPL pay for eye exams and prescription medicines for short-term and long-term medical problems.

**VScript** assists Vermonters age 65 and older and people of all ages with disabilities who are not enrolled in Medicare and who have household incomes between 150% and 225% FPL pay for prescription medicines for long-term medical problems.

**Vscript Expanded** helps Vermonters 65 and older and people of all ages with disabilities who are not enrolled in Medicare and who have household incomes between 175% and 225% FPL, pay for prescription and over the counter maintenance drugs.

The following table depicts the caseload and expenditure information by SFY, including the Governor’s Recommend for SFY ’13 for the Pharmacy Programs:

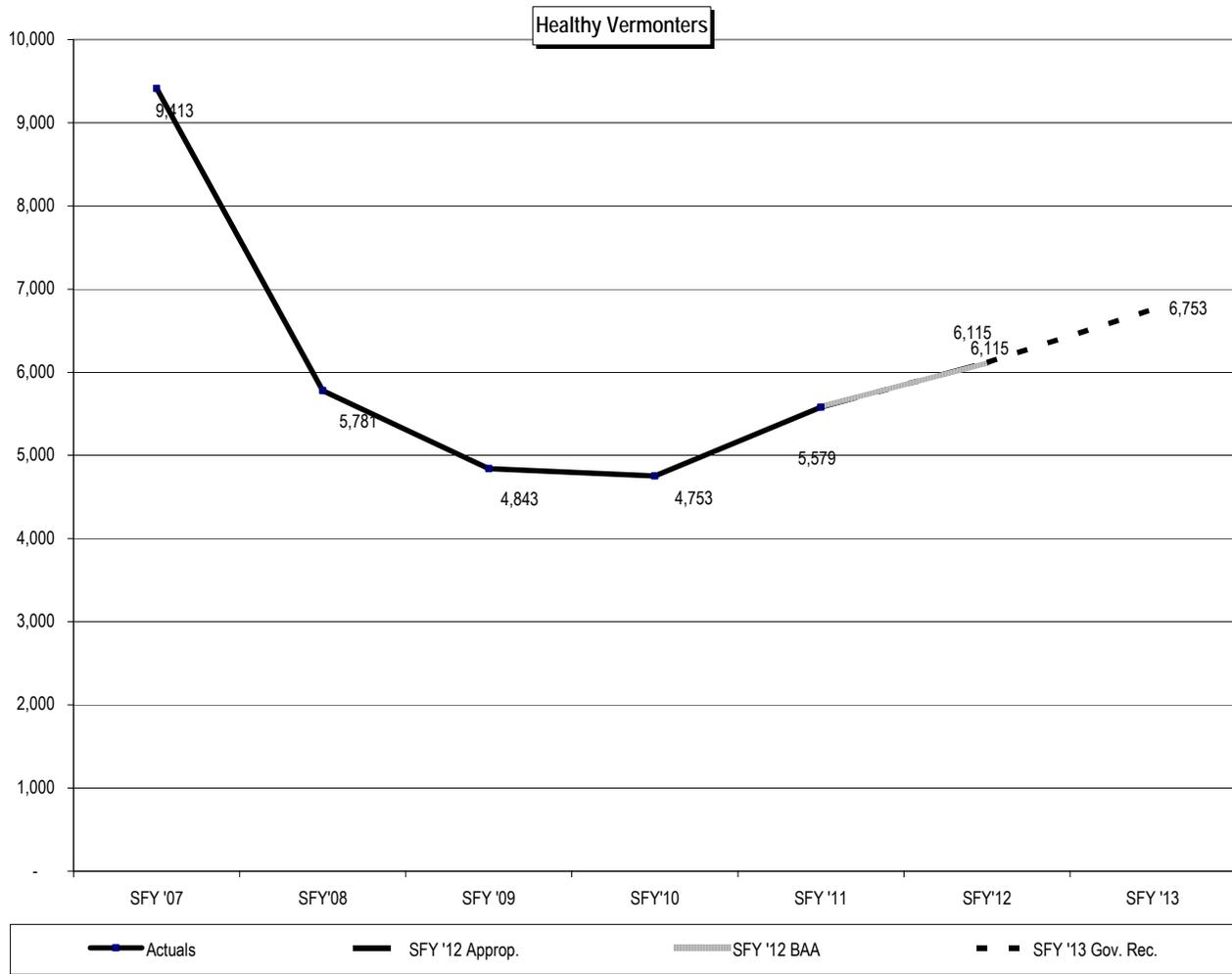
Pharmacy Only Programs			
SFY	Caseload	Expenditures	P.M.P.M.
SFY '10 Actual	12,550	\$ 3,929,059	\$ 26.09
SFY '11 Actual	12,751	\$ 4,427,164	\$ 28.93
SFY '12 Appropriated	13,113	\$ 4,540,342	\$ 28.85
SFY '12 Budget Adjustment	12,828	\$ 4,614,498	\$ 29.98
SFY '13 Governor's Recommend	12,698	\$ 4,763,952	\$ 31.26

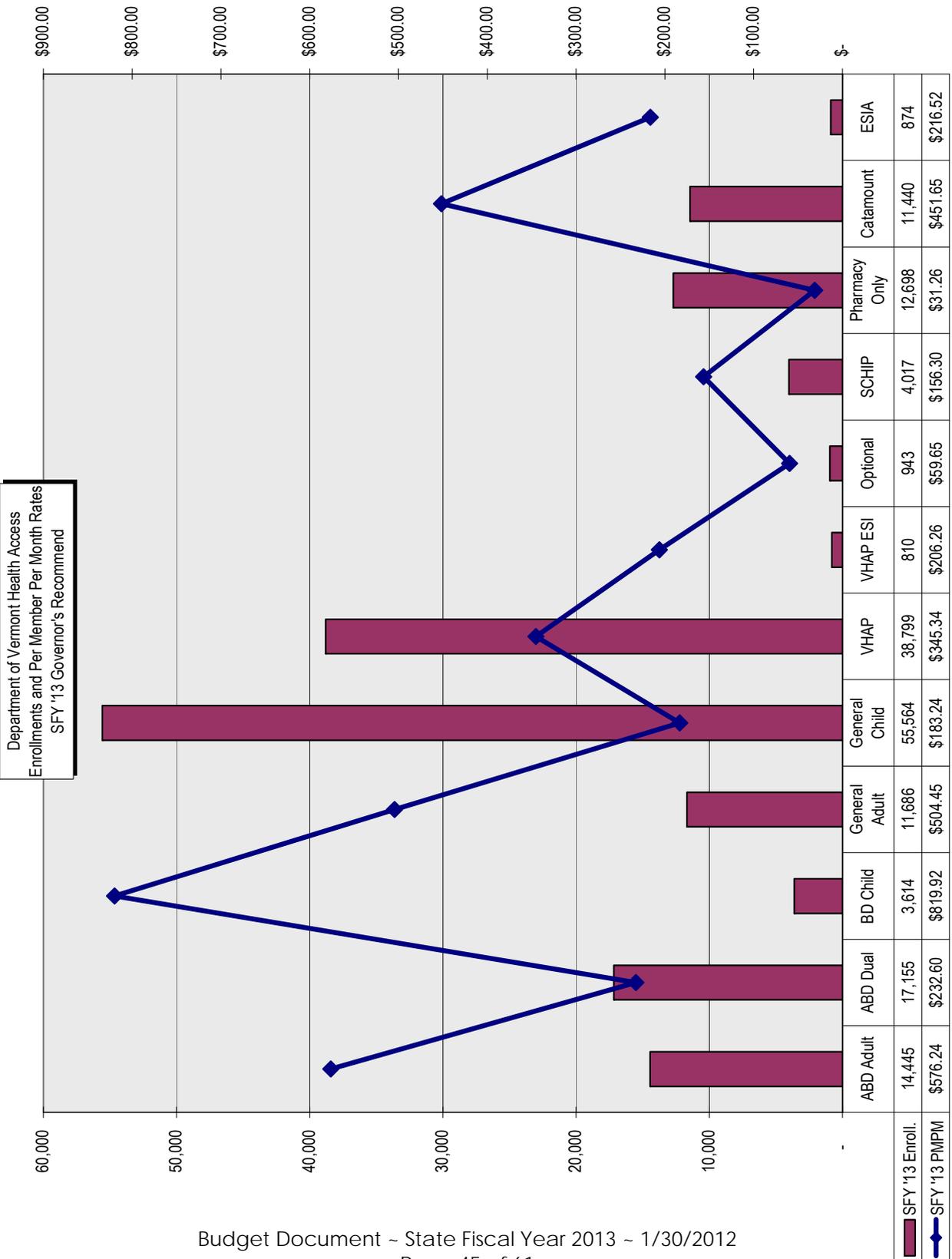


**Healthy Vermonters** provides a discount on short-term and long-term prescription medicines for individuals not eligible for other pharmacy assistance programs with household incomes up to 350% and 400% FPL if they are aged or disabled. There is no cost to the state for this program.

The following table depicts the caseload and expenditure information by SFY, including the Governor’s Recommend for SFY '13 for the Healthy Vermonters Program:

Healthy Vermonters Program			
SFY	Caseload	Expenditures	P.M.P.M.
SFY '10 Actual	4,753	\$ -	\$ -
SFY '11 Actual	5,579	\$ -	\$ -
SFY '12 Appropriated	6,115	\$ -	\$ -
SFY '12 Budget Adjustment	6,115	\$ -	\$ -
SFY '13 Governor's Recommend	6,753	\$ -	\$ -





**Buy-In Adjustment** ..... **\$2,640,744**  
*\$1,204,299 state*

The federal government allows for states to use Medicaid dollars to “buy-in” to Medicare on behalf of eligible beneficiaries who would otherwise be fully covered by Medicaid programs. Caseload for these programs is coming in higher than expected, resulting in an increased need in our funding.

**Increase in Clawback** ..... **\$1,863,550**  
*\$1,863,550 state*

The Medicare Modernization Act (MMA) was signed into law on December 8, 2003. On January 1, 2006, the Medicare Part D benefit became available. Currently, all beneficiaries of Vermont’s publicly funded pharmacy programs who are also covered by Medicare should receive their primary pharmacy benefit from Medicare. Medicare Part D 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 the Medicare beneficiaries who are or would be eligible for Medicaid drug coverage. This is referred to as “Clawback” or “state phase down.” While the design of this contribution included “phased down” sharing, the rate of inflation exceeds that of the federal phase down percentage resulting in a net increase in the Clawback rate.

**ACA Federal Reimbursement** ..... **\$1,620,280**  
*\$0 state*

In SFY ’11 the Affordable Care Act required that we return 100% of enhanced rebate collections to the federal government. Our original estimate of the impact to Vermont for this requirement was slightly overstated. We therefore need \$1.67 million in additional federal expenditure authority. There is no general fund impact associated with this request.

**Federal Participation Rate Changes** ..... **\$0**  
*\$3,548,896 state*

The federal receipts the State receives is dependent upon a funding formula (Federal Medical Assistance Percentage - FMAP) used by the federal government and is based on economic need for each state across the country. Due to the change in the FMAP formula for SFY ’13, Vermont loses \$3,548,896 as compared to the FMAP for SFY ’12.

**Neutral Adjustments Between DVHA Appropriations** ..... **\$0**  
*\$46,569 state*

During the budget development process, oftentimes the dollars associated with policy decisions are added to or subtracted from the DVHA Global Commitment appropriation. However, these decisions typically impact all DVHA appropriations; therefore, funds are

being redistributed from the Global Commitment appropriation to the other three DVHA program areas.

**GOVERNOR’S RECOMMENDED INITIATIVES ..... \$25,691,776**  
*\$10,613,884 state*

**Birth Control Plus Option Implementation ..... \$2,005,915**  
*\$352,537 state*

It is the Administration’s intention to implement the Family Planning eligibility group pursuant to the Affordable Care Act (ACA). Section 2303 of the ACA establishes a new optional Medicaid (categorically needy) eligibility group for states to begin providing family planning services and supplies to individuals (men and women) who were previously ineligible for Medicaid. ACA section 2303 became effective on March 23, 2010.

Specifically, individuals (men and women) eligible under the new family planning option (FPO) are: 1) not pregnant; and 2) whose income does not exceed the income eligibility level established by the state (the income level established by the state may not exceed the highest income level for pregnant women under the state’s Medicaid or CHIP state plan). In Vermont, the highest income level for pregnant women is ≤200% of the Federal Poverty Level (FPL).

Though the plan is to implement the program as authorized, DVHA is running into challenges. We are exploring other options with the Planned Parenthood of Northern New England as an interim step until such time as the challenges are overcome.

**Graduate Medical Education Initiative ..... \$30,000,000**  
*\$13,071,000 state*

DVHA has worked closely with UVM and Fletcher Allen to develop a new mechanism for reimbursing Fletcher Allen for quality deliverables associated with their graduate medical education programs. The source of the state match is provided by UVM and does not represent an increase in state expenditures.

**Provider Rate Increases ..... \$4,001,716**  
*\$1,737,139 state*

To ensure DVHA beneficiaries continue to have access to necessary services, rate increases are being proposed for all hospitals in the amount of \$3,709,604 and home health agencies of \$292,112.

**Outlier Coordination of Benefits Case Near Resolution . . . . . (\$500,000)**  
*(\$217,850) state*

A law suit was placed against the NYSTA (New York State Thruway Authority). That lawsuit was settled in 2006 for \$12,000,000. Vermont Medicaid had paid \$771,111 in claims and had reduced that lien (required by statute) to \$506,810. The beneficiary’s attorneys wanted to reopen this settlement and apply a state of Arkansas Supreme Court decision known as Ahlborn to this settlement and claimed that instead of the John Doe owing DVHA \$506,810, DVHA actually owed them back \$75,000. DVHA won on this issue last summer as this settlement pre-dated the Ahlborn Supreme Court decision. The courts would not allow this case to be reopened.

Superior Court Judge, Helen Toor concluded that Vermont Medicaid should be entitled to \$380,758. DVHA made the decision to appeal for the full \$506,810 to the Vermont Supreme Court on October 20<sup>th</sup> 2011. DVHA expects to hear in early spring the final VT Supreme Court decision in this case. A positive decision will yield \$506,810 thousand. A negative decision will revert back to the lower court’s decision of \$380,758 in settlement owed to the State of Vermont.

**Require Insurance Companies to Check for Medicaid Eligibility . . . . . (\$100,000)**  
*(\$43,940) state*

DVHA’s Coordination of Benefits (COB) Unit is responsible for conducting “pay and chase” activities. This is done for cases where Medicaid paid health care benefits for a Vermont beneficiary when another payer was ultimately responsible for those claims. These are often cases where private insurance companies settle on cases with beneficiaries in order to eliminate their liability. However, Medicaid had incurred the actual cost and should have been the recipient of those payouts, not the beneficiary. This proposal would require insurance companies verify whether or not an individual had Medicaid coverage prior to initiating the settlement.

**Manage High-Risk Pregnancies. . . . . (\$450,000)**  
*(\$196,065) state*

2011 Act 63 (H.441), §E.300(d) charged the Secretary of AHS with reporting on existing programs and services currently available to high-risk pregnant women and to make recommendations on steps to better coordinate services, as well as other actions to improve maternal and fetal outcomes for pregnancies considered to be high risk to the woman and/or child. As required by the legislature, DVHA in collaboration with VDH convened a 2011 summer study work group that included internal and external stakeholders and subject matter experts, and the Vermont Department of Health Maternal and Child Health (VDH), Department for Children and Families (DCF) and Integrated Family Services (IFS) developed recommendations for an integrated approach to address high risk pregnancies. The report is published at

<http://dvha.vermont.gov/budget-legislative/pregnancy-care-program-report-9-26-2011.pdf>. Many factors known to reduce risk are supported by services already provided by DVHA’s care coordinators through the Vermont Chronic Care Initiative (VCCI), including education and support, care coordination, and linkage with health and community resources. Consequently, one of the group’s recommendations is to strengthen DVHA’s capacity to provide care coordination services to women in potentially high risk pregnancies. DVHA is requesting to add two (2) registered nurses with expertise in maternal-fetal medicine to provide care coordination services and also serve as an internal resource to other DVHA and AHS staff and maintain close collaboration with the VDH Maternal and Child Health (VDH/MCH), Department for Children and Families Children’s Integrated Services (DCF/CIS), and the Agency’s IFS staff who also work with this population. If approved, high risk pregnancy care coordination will focus on enhanced outreach to providers and potentially eligible pregnant women, better education and prevention, improved service coordination, and addressing gaps in available services.

DVHA’s care management vendor, APS, analyzed 2010 Medicaid claims data and identified 1,394 high risk pregnancies (40% of all pregnancies during this period) for which savings could have been generated through better care coordination focused on reducing non-emergency ER use, ambulatory care sensitive admissions, and avoidable readmissions. Savings estimates were conservative as they did not include savings from avoiding preterm births, which are difficult to quantify. Savings will be determined by comparing actual costs with those that would have been expected in the absence of the clinical care management services.

**Manage Substance Abuse Services . . . . . (\$609,059)**  
 (\$265,367) state

Team Care

When DVHA identifies a beneficiary who has received Medicaid services at a frequency or amount not considered medically necessary as determined by established criteria, the beneficiary is enrolled in *Team Care* (formerly called the lock-in program). *Team Care* limits the beneficiary to designated providers for Medicaid services and is designed to improve coordination of care by minimizing duplicate and inappropriate drug utilization.

DVHA has proposed expanding both the size and scope of the *Team Care* program to promote a comprehensive approach to substance abuse care. The enhanced program will employ dedicated clinicians and audit personnel to identify and manage additional cases, work closely with the Medicaid Medical Director on reconsiderations and appeals for all controlled substances, and collaborate with Vermont Chronic Care Initiative (VCCI) care coordinators and DVHA’s Pharmacy unit to provide beneficiary oversight and outreach to providers to assure practices are consistent with established medical guidelines. SFY 2013 savings were estimated using the *Blueprint/VCCI*

financial model and evidence that well-coordinated prescription and care management will result in savings from improved coordination of care and by reductions in over-utilization, misuse of medications, duplicative pharmacy payments, non-emergency health care services, unnecessary emergency room use, and inpatient detoxification. Savings will be determined by comparing actual costs with those that would have been expected in the absence of the enhanced clinical care management services. Three positions have been requested to achieve these savings and to support overall system enhancements for continued advancement toward a fully integrated system, for example the *Hub and Spoke* style health care system proposed below.

*Hub and Spoke Model*

At the direction of AHS, DVHA, including the *Blueprint for Health*, and the Vermont Department of Health Division of Alcohol and Drug Abuse Programs (VDH-ADAP) have been collaborating in an Agency-wide initiative with community substance abuse treatment providers and organizations to develop the proposed *Hub and Spoke* style health care system for patients who require medication-assisted treatment (buprenorphine and methadone) for opiate dependency. While this design focuses primarily on individuals with opiate addiction, it also would create a framework to support and improve the capacity of patient-centered medical homes statewide to provide a more holistic approach to health care for individuals with addiction and mental health conditions. If approved, DVHA and VDH-ADAP will work closely with medical homes and *Blueprint* Community Health Teams to strengthen the use of evidence-based treatment guidelines. The Substance Abuse Care Management Director who would oversee the enhanced *Team Care* program also would help assure current and planned approaches at the community and provider levels.

The departments are currently engaged in discussions with CMS to assess whether the Affordable Care Act, *State Option to Provide Health Homes for Enrollees with Chronic Conditions*, provides an opportunity for Vermont to receive enhanced federal support for stronger integration and coordination of primary care, mental health, and substance abuse services and supports for people across the lifespan.

**Expand VCCI Initiatives . . . . . (\$1,501,303)**  
 (\$651,532) state

DVHA registered nurses and social workers provide care coordination and case management services to high risk beneficiaries through a holistic approach that addresses physical, mental, substance abuse, and socioeconomic barriers to health improvement. DVHA care coordinators are fully integrated core members of existing *Blueprint for Health* Community Health Teams and are co-located in provider practices and medical facilities in several communities. They are knowledgeable about coordinating community resources to best serve beneficiaries and also provide a familiar presence for provider collaboration and referral of high risk Medicaid beneficiaries.

The VCCI already successfully addresses traditional health care service coordination. As implementation of the *Blueprint for Health* continues, the need for similar significant improvements in the substance abuse and mental health areas has become apparent. To effectively manage the VCCI initiative, continue program expansion and integrate with other statewide health care reforms, additional program staff are needed, which will be co-located in high volume primary care offices, specialty practices, and hospitals to assure high quality, integrated, and cost effective health care. Using the *Blueprint/VCCI* financial model, DVHA estimated SFY 2013 net savings among high risk/high cost beneficiaries from better coordinated care in areas such as ER, inpatient admissions and readmissions for ambulatory care sensitive conditions, and pharmacy use. Savings will be determined by comparing actual costs with those that would have been expected in the absence of the enhanced clinical care management services.

**Perform Concurrent Reviews for Medical Surgical Extended Length Of Stay (LOS) ..... (\$2,000,000)**  
 (\$868,885) state

DVHA is charged with evaluating the medical necessity, appropriateness and efficiency of inpatient health care services. One mechanism for performing this function is concurrent utilization review and discharge planning for inpatient stays for medical and surgical services. The goals of concurrent review are to assure services are provided in the most cost effective and clinically appropriate setting. Concurrent review is an effective way to manage inpatient utilization and to ensure collaboration with hospital case managers to assess discharge plans. DVHA has proposed implementing concurrent reviews of all Medical Surgical Lengths of Stay (LOS) exceeding the benchmark LOS as defined by nationally recognized criteria. Analyses of SFY 2011 inpatient claims indicated costs fell outside the DRG payment (outliers) for a total of 703 admissions for 573 unique beneficiaries. A retrospective review on a sample of these beneficiaries revealed that in every case the benchmark LOS had been exceeded, in extreme cases by 100 days or more. DVHA estimates that concurrent review and discharge planning can result in avoiding at least 10% of inpatient costs and subsequent admissions for these outlier cases. Savings will be determined by comparing actual costs with those that would have been expected in the absence of these initiatives to provide enhanced clinical care management.

**Perform Concurrent Reviews and Discharge Planning for Mental Health Hospitalizations ..... (\$750,000)**  
 (\$325,832) state

DVHA is proposing to also expand concurrent review and discharge planning for all inpatient mental health admissions (non-CRT). DVHA previously implemented concurrent review and discharge planning for children hospitalized for mental health conditions and adults hospitalized for detoxification. If approved, DVHA would hire two (2) licensed clinical professionals to perform concurrent review and discharge

planning and to track utilization trends in existing programs, as well as in two new partial hospitalization programs. These positions will work closely with DVHA’s VCCI care coordinators, its Substance Abuse Care Management Director, *Blueprint for Health* Community Health Teams (CHTs), AHS Field Services Directors and Integrated Family Services staff, Department of Mental Health and VDH/ADAP to develop a more coordinated and cohesive system of care for individuals with co-occurring mental health and substance abuse conditions. Savings for this initiative will result from reducing the average length of stay (LOS) by 2-3 days for all adult (non-CRT) admissions over 10 days. DVHA identified a total of 672 days that could be avoided by implementing concurrent review and discharge planning. Days were multiplied by the average per diem to arrive at the estimated savings. By ensuring delivery of the appropriate level of care through better coordination of inpatient and outpatient services, DVHA already has successfully decreased the average length of stay for children’s inpatient psychiatric admissions by three (3) days, resulting in over \$1 million in cost savings. At the same time, readmissions also have decreased indicating children are not being discharged prematurely or without the necessary community supports. Savings will be determined by comparing actual costs with those that would have been expected in the absence of the enhanced clinical care management services.

**Transportation Quality Assurance & Coordination . . . . . (\$900,000)**  
*(\$391,749) state*

Non-Emergency Medical Transportation (NEMT) is a service available to Medicaid and Dr. Dynasaur beneficiaries under certain conditions, including when transportation is not otherwise available, when transportation is to/from a necessary (covered) medical service, and to a medical service that is generally available to and used by other members of the community in which the beneficiary is located. The mode (e.g., van, taxi, volunteer, bus pass) of transportation is determined based on the least costly mode suitable to the medical needs of the beneficiary. Prior authorization is required.

DVHA has been implementing tighter controls and optimizing efficiencies in areas such as case management of high transportation utilizers and proper provider reimbursement. Potential SFY 2013 cost savings have been identified through merging the bus pass program into DVHA’s Member Services contract, which will enable the use of existing call center resources. DVHA also is proposing to require prior authorization for all bus passes to reduce misuse of this benefit. In addition, DVHA will eliminate duplicate charges recently identified through a Program Integrity audit, will restructure its broker contracts into capitated agreements to incentivize efficient and coordinated transportation service delivery, and will continue to strengthen quality assurance and oversight of transportation contractors. Transportation savings for SFY 2013 will be determined by comparing paid transportation claims with those paid in the previous year.

**Prior Authorization Requirement for Out-of-State Outpatient Office Visits . . . . .**  
 . . . . . **(\$275,000)**  
 (\$119,378) state

Medicaid beneficiaries currently are able to seek care from any out-of-state (out-of-network) provider for elective outpatient services, whether or not the service is available within Vermont. This may interfere with providing an in-state medical home, as well as result in unnecessary transportation costs, duplication of services, and additional medical expenses. After evaluating this issue and receiving input from the Clinical Utilization Review Board (CURB), DVHA has introduced Rule changes to institute a prior authorization requirement for Medicaid beneficiaries seeking elective out-of-state (out-of-network) office visits. This change will ensure beneficiaries receive unfragmented quality care with good outcomes from providers within the Medicaid provider network. In addition, this initiative will reduce DVHA’s transportation benefit costs, support Vermont’s in-state and border providers by encouraging beneficiaries to visit them for services previously obtained out-of-state, and allow monitoring of out-of-state outpatient services to ensure the provision of appropriate care. SFY 2013 savings are from anticipated reductions in transportation costs and improved clinically appropriate care coordination from diverting beneficiaries to in-state providers.

**Perform Earlier Pediatric PT/OT/ST Utilization Reviews . . . . .** **(\$100,000)**  
 (\$43,250) state

DVHA and the CURB also identified potential savings from performing earlier physical, occupational, and speech therapy (PT, OT, ST) authorization reviews for Medicaid children (under age 21). Authorizations have not been required until after four months of treatment. Consequently, some children may have received months of therapy without confirmation of medical appropriateness or benefit, while others with serious developmental and acquired medical conditions may have received therapy of insufficient duration to ensure successful rehabilitation. DVHA has introduced Rules to institute a prior authorization requirement for children’s outpatient therapies (PT, OT, ST) after the initial eight (8) visits, and subsequently at each four-month interval. Savings estimates were based on improved coordination with more appropriate services and anticipated reductions in over-utilization. Savings will be determined by comparing actual costs with the previous year’s costs.

**Reduce Payments on Contiguous Body Parts ~ Ultrasounds . . . . .** **(\$165,000)**  
 (\$71,473) state

The proposed multiple procedure payment reduction applies to cases in which multiple outpatient radiology imaging services using the same or a similar modality are performed on the same day by the same provider on contiguous body areas (similar body region) of a beneficiary. Multiple procedure payment reductions for imaging procedures are used by CMS and by Vermont’s commercial insurers. The reduction

will apply only to the technical component of the claims, that is, the performance of the imaging service. Reimbursement for the professional (physician) component will not be affected. In cases for which the multiple procedure payment reduction applies, the procedure with the highest intensity will be reimbursed at 100% of the provider’s fee schedule rate, with subsequent procedures reimbursed at a reduced percentage. If two (2) procedures are performed, the second procedure will be reimbursed at 50%, and if three (3) or more procedures are performed, they will be reimbursed at 25%. DVHA’s fiscal agent HP ran the universe of ultrasound CPT codes that were considered contiguous body areas for SFY 2011 to estimate the savings, which will be determined by comparing actual costs with those that would have been expected in the absence of this initiative.

**Incr. “Pay & Chase” Receipts due to New Pharmacy Data Matching . .(\$2,000,000)**  
*(\$930,295) state*

One of the challenges DVHA’s Coordination of Benefits (COB) team faces is accurately identifying beneficiaries who also have other insurance, especially when beneficiaries do not notify DVHA about the insurance. Since DVHA is the payer of last resort, the COB team conducts outreach to assure any claim is considered first by the primary insurer. Usually, DVHA pays the claim in full, then recoups it, and subsequently pays nothing or only a portion of the claim. This practice is referred to as “Pay and Chase.” Using 2<sup>nd</sup> quarter 2011 pharmacy claims, DVHA’s pharmacy benefits manager (PBM) identified 2,730 individuals with another insurer about which DVHA was not aware. Consequently, DVHA paid the claim as the primary insurer and was unable to subsequently recover the cost.

Through use of a proprietary database and data matching algorithm, the PBM identifies other insurance information and shares it with pharmacies, resulting in avoiding the cost of the claim. The proprietary database retrieves third party eligibility information from pharmacies, pharmacy benefit managers, insurers, and creditors; the information is validated and assigned a reliability score upon which cost avoidance is based. ***Please note: these are net savings anticipated. In order to accomplish this goal, there will need to be an increase given to our administrative contract with our pharmacy benefits management company of \$200,000 resulting in a \$2.2 million programmatic savings.***

**Enhance Pharmacy Edits . . . . . (\$125,000)**  
*(\$58,143)*

Based on feedback from pharmacies who have suggested that DVHA develop methods to avoid excessive waste in the 90 day maintenance drug program, DVHA would allow two initial 30 day fills of maintenance medications. This would allow additional time for physicians to titrate patients to desired doses before a 90 day supply was required. The methodology for this calculation is very complicated, thus DVHA took past

experience with making similar changes in a 90 day program to arrive at a very conservative estimate of savings. In addition, to minimize waste, DVHA would institute a 15 day supply limitation on initial fills of drugs that often require titration and dosing adjustments where a 30 day supply fill may sometimes result in waste. Drugs being considered for this edit implementation include atypical antipsychotics, Chantix, and Nicotine replacement products. DVHA arrived at the savings by calculating the average discontinuation rate (roughly 20%) for the aforementioned drugs by the cost of the wasted medications.

**Contract for Nutritional Supplements . . . . . (\$25,000)**  
*(\$11,629) state*

Oral nutritional supplements are covered under DVHA’s pharmacy benefit programs and must meet medical necessity criteria for approved uses. However, similar to diabetic supplies, nutritional supplements are not considered “drugs,” and therefore DVHA does not receive federal rebates for these products. Through its rebate contractor, DVHA has successfully negotiated preferred pricing on diabetic supplies, saving over \$1,000,000 annually. DVHA will similarly attempt to secure preferred pricing on oral nutritional supplements, taking adequate choice and product quality into consideration. If successful, savings are projected to be 10% of spend for these supplements.

**Savings due to Other Dept.s’ Challenges for Change Programs . . . . . (\$1,912,704)**  
*(\$830,071) state*

There are myriad AHS Department initiatives that were created by virtue of the Challenges for Change directive. Many of these involve more coordinated care for complex individuals whose needs cross multiple departments and often end up “slipping through the cracks”. By providing upstream services to these people, it is anticipated that there will be health care savings through reduced emergency room and inpatient care.

**Co-Pay Restructuring . . . . . (\$384,000)**  
*(\$166,713) state*

DVHA is proposing a revised co-payment structure. The highlights of the proposal include: 1) eliminating the Medicaid \$75 inpatient admission co-pay; 2) enacting an outpatient hospital visit co-pay of \$3 for VHAP to align with Medicaid; 3) enacting a \$3 drug co-pay for VHAP and the pharmacy programs to align with Medicaid; and 4) enacting a \$1, \$2, \$3 co-pay for Durable Medicaid Equipment (DME) for Medicaid and VHAP. The below chart depicts Current Cost Sharing by Program and the Proposed Cost Sharing by Program; the rows that are highlighted depict the proposed changes.

Under current cost sharing for Medicaid, there are no premiums; the only cost sharing incurred is co-pays. Currently, an estimated 38,245 Medicaid beneficiaries account for

approximately \$1,704,305 in co-pays per month (an average of \$44.56 per Medicaid beneficiary); under the co-pay restructuring proposal an estimated 50,913 Medicaid beneficiaries will account for approximately \$1,795,233 in co-pays per month (an average of \$35.26 per Medicaid beneficiary). There is a federal requirement that cost sharing for Medicaid beneficiaries not exceed 5% of family income; a reporting system will be implemented to track out-of-pocket costs in relation to the 5% and will generate a refund to Medicaid beneficiaries if their cost sharing exceeds the 5%.

Under current and proposed cost sharing for VHAP, premiums are applied by FPL (see chart); premiums are unchanged in the proposal. Currently, an estimated 31,107 VHAP beneficiaries account for approximately \$1,162,717 in co-pays per month (an average of \$37.38 per VHAP beneficiary); under the co-pay restructuring proposal an estimated 33,321 VHAP beneficiaries will account for approximately \$1,424,535 in co-pays per month (an average of \$42.75 per VHAP beneficiary). Currently, total cost sharing (premiums and co-pays) for an estimated 31,107 VHAP beneficiaries averages \$45.56 per beneficiary per month; under the co-pay restructuring proposal for an estimated 33,321 VHAP beneficiaries the average is \$43.98 per VHAP beneficiary per month.

The impacted providers are hospitals, Durable Medical Equipment (DME) providers and pharmacies.

PROGRAM	CURRENT COST SHARING	PROPOSED COST SHARING
Medicaid*	No Monthly Premiums	No Monthly Premiums
	\$1,\$2,\$3 Prescription Drug co-pay if not enrolled in Part D	\$1,\$2,\$3 Prescription Drug co-pay if not enrolled in Part D
	\$3 dental visit	\$3 dental visit
	\$75 inpatient hospital visits	None
	\$0 DME/medical supplies	\$1,\$2,\$3 DME/medical supplies
	\$3 outpatient hospital visits	\$3 outpatient hospital visits
*Cost sharing capped at 5% of FPL		
Dr Dynasaur - Pregnant Women	Up to 185% FPL No Monthly Premium	Up to 185% FPL No Monthly Premium
	Up to 200% FPL: \$15/family/month Premium	Up to 200% FPL: \$15/family/month Premium
	No co-pays	No co-pays
Dr Dynasaur - Children	Up to 185% FPL No Monthly Premium	Up to 185% FPL No Monthly Premium
	Up to 225% FPL: \$15/family/month Premium	Up to 225% FPL: \$15/family/month Premium
	Up to 300% FPL: \$20/family/month Premium or \$60 w/o insurance	Up to 300% FPL: \$20/family/month Premium or \$60 w/o insurance
	No co-pays	No co-pays
VHAP	Up to 50% FPL No Monthly Premium	Up to 50% FPL No Monthly Premium
	Up to 75% FPL : \$7/person/month	Up to 75% FPL : \$7/person/month
	Up to 100% FPL : \$25/person/month	Up to 100% FPL : \$25/person/month
	Up to 150% FPL : \$33/person/month	Up to 150% FPL : \$33/person/month
	Up to 185% FPL : \$49/person/month	Up to 185% FPL : \$49/person/month
	\$1,\$2 Prescription Drug (at or above 100% FPL)	\$1,\$2,\$3 Prescription Drug (at or above 100% FPL)
	\$25 ER Visit	\$25 ER Visit
	\$0 DME/medical supplies	\$1,\$2,\$3 DME/medical supplies
	\$0 outpatient hospital visits	\$3 outpatient hospital visits
VHAP Pharmacy / VPharm 1	\$15/person/month premium	\$15/person/month premium
VScript / VPharm 2	\$20/person/month premium	\$20/person/month premium
VScript Expanded / VPharm 3	\$50/person/month premium	\$50/person/month premium
	\$1,\$2 Prescription Drug co-pay	\$1,\$2,\$3 Prescription Drug co-pay

\$1.00 for prescription drugs and DME/medical supplies costing less than \$30.00

\$2.00 for prescription drugs and DME/medical supplies costing \$30.00 or more but less than \$50.00

\$3.00 for prescription drugs and DME/medical supplies costing \$50.00 or more

**DAIL Managed Policy Decisions . . . . . \$1,481,250**  
*\$645,381 state*

DVHA pays for the Choices for Care expenditures, but DAIL is responsible for managing the long-term care component. DAIL is implementing the following changes in the program and will provide documentation in support of their decisions during their budget testimony:

- Nursing home inflation: \$3,390,658 (\$1,477,310 state)
- Nursing home utilization decrease: (\$2,800,000) ((\$1,219,960) state)
- Replacement of SFY '12 one-time carry-forward: \$1,500,000 (\$653,550 state)
- Buy-back of 10% discount for Flex Choices: \$312,000 (\$135,938 state)
- Buy-back of IADL and respite cuts: \$2,083,176 (\$907,640 state)
- Minimum wage increase on select services: \$45,880 (\$19,990 state)
- Estimated carryover from SFY '12: (\$2,500,000) (\$1,089,250 state)
- HCBS case management payment structure: (\$300,000) ((\$130,710 state))
- Eliminate ERC case management: (\$300,000) ((\$130,710) state)
- HCBS reimbursement rates from hourly to half- and full-day (179,979) (78,417)
- Increased funding for moderate needs: \$229,515 (\$100,000 state)

**Other Requested Statutory Changes . . . . . \$ 0**

**DVHA requests the following change to statute governing the Health IT Fund:**

8 V.S.A. § 4089k is amended to read

§ 4089k. HEALTH CARE INFORMATION TECHNOLOGY REINVESTMENT FEE

(a)(1) Beginning October 1, ~~2009~~ 2012 and annually thereafter, each health insurer shall pay a fee into the health IT fund established in 32 V.S.A. § 10301 in the amount of 0.199 of one percent of all health insurance claims paid by the health insurer for its Vermont members in the previous fiscal year ending June 30. The annual fee shall be paid in one annual installment ~~installments~~ due by ~~November 1, January 1, April 1, and June 1.~~

(2) On or before ~~September 1, 2009~~ ~~October 1, 2011~~ December 1, 2012 and annually thereafter, the secretary of administration, in consultation with the commissioner of banking, insurance, securities, and health care administration, shall publish a list of health insurers subject to the fee imposed by this section, together with the paid claims amounts attributable to each health insurer for the previous fiscal year. The costs of the department of banking, insurance, securities, and health care administration in calculating the annual claims data shall be paid from the Vermont health IT fund.

Rationale: The October 1 submission date does not give sufficient time to meet the invoicing requirement for the November 1 payment date which requires invoices to be mailed on the same day

the information is received. Annual versus quarterly payments provide for administrative simplification.

**DVHA requests the following change to statute governing the Healthcare Claims Assessment:**

8 V.S.A. § 4089I is amended to read:

§ 4089I. HEALTH CARE CLAIMS ASSESSMENT

(a)(1) Beginning October 1, ~~2011~~ 2012 and annually thereafter, each health insurer shall pay an assessment into the state health care resources fund established in 33 V.S.A. § 1901d in the amount of 0.80 of one percent of all health insurance claims paid by the health insurer for its Vermont members in the previous fiscal year ending June 30. The annual fee shall be paid in one annual installment ~~installments~~ due by ~~November 1, January 1, April 1, and June 1.~~

(2) On or before ~~September 1, 2011~~ December 1, 2012 and annually thereafter, the secretary of administration, in consultation with the commissioner of banking, insurance, securities, and health care administration, shall publish a list of health insurers subject to the fee imposed by this section together with the paid claims amounts attributable to each health insurer for the previous fiscal year. The costs of the department of banking, insurance, securities, and health care administration in calculating the annual claims data shall be paid from the state health care resources fund.

(d) If any health insurer fails to pay the fee established in subsection (a) of this section within ~~45~~ 90 days after notice from the secretary of administration of the amount due, the secretary of administration or his or her designee shall notify the commissioner of banking, insurance, securities, and health care administration of the failure to pay. In addition to any other remedy or sanction provided for by law, if the commissioner finds, after notice and an opportunity to be heard, that the health insurer has violated this section or any rule or order adopted or issued pursuant to this section, the commissioner may take any one or more of the following actions:

(1) Assess an administrative penalty on the health insurer of not more than \$1,000.00 for each violation and not more than \$10,000.00 for each willful violation;

(2) Order the health insurer to cease and desist in further violations;

(3) Order the health insurer to remediate the violation, including the payment of fees in arrears and payment of interest on fees in arrears at the rate of 12 percent per annum. (Added 2011, No. 45, § 28, eff. May 24, 2011.)

Rationale: The October 1 submission date does not give sufficient time to meet the invoicing requirement for the November 1 payment date, which requires invoices to be mailed on the same day the information is received. Annual versus quarterly payments provide for administrative simplification. 45 days after date of notice (this being interpreted as invoice date) would result in notification to BISCHA upon non-receipt after 15 days. This is an overly aggressive requirement that does not comport with standard collections processes.

**DVHA requests the following change to statute governing autism spectrum disorders:**

8 VSA Chapter 4088i. Coverage for diagnosis and treatment of autism spectrum disorders.

Sec. E.300 Sec. 3 of No. 127 of the Acts of the 2009 Adj. Sess. (2010), as amended by Sec. E.300.1 of No. 63 of the Acts of 2011, is further amended to read:

Sec. 3. APPLICABILITY AND EFFECTIVE DATE

(a) Sec. 2 of this act shall take effect on October 1, 2011, and shall apply to all health insurance plans on and after October 1, 2011, on such date as a health insurer offers, issues, or renews the health insurance plan, but in no event later than July 1, 2012. Coverage by the state Medicaid program shall take effect July 1, ~~2012~~ 2013.

Rationale: The ‘autism mandate’ will be part of separate legislative action in FY13. The debate on funding this to include Medicaid and the Vermont health access plan should be a separate discussion as part of that bill.

**DVHA requests the following language be added:**

Sec. E.301.1 CONTIGUOUS BODY PARTS ULTRASOUND

(a) Beginning July 1, 2012 and thereafter, the department of Vermont health access shall reduce spending on ultrasound services by implementing a payment reduction on contiguous body parts.

Rationale: This initiative applies to cases in which multiple outpatient radiology imaging services using the same or a similar modality are performed on the same day by the same provider on contiguous body areas (similar body region) of a beneficiary. The mechanism to implement this initiative is discussed in further detail in DVHA’s budget materials.

**DVHA requests the following change to statute governing co-pays:**

Sec. E.306.1 33 V.S.A. Sec. 2073 is amended to read:

Sec. 2073 VPharm assistance program

(d)(1) An individual shall contribute a co-payment of \$1.00 for prescriptions where the cost-sharing amount required by Medicare Part D is ~~\$29.99~~ or less than \$30.00, and a co-payment of \$2.00 for prescriptions where the cost-sharing amount required by Medicare Part D is \$30.00 or more but less than \$50.00, and a co-payment of \$3.00 for prescriptions where the cost-sharing amount required by Medicare Part D is \$50.00 or more. A pharmacy may not refuse to dispense a prescription to an individual who does not provide the co-payment.

Rationale: This language adds a co-pay of three dollars for VPharm prescriptions where cost-sharing amounts required by Medicare Part D are \$50.00 or more.

Sec. E.306.2 33 V.S.A. Sec. 2074(c) is amended to read:

(c) Benefits under VermontRx shall be subject to payment of a premium and co-payment amounts by the recipient in accordance with the provisions of this section.

(4) A recipient shall contribute a co-payment of \$1.00 for prescriptions costing ~~\$29.99 or less than \$30.00~~, and a co-payment of \$2.00 for prescriptions costing \$30.00 or more but less than \$50.00, and a co-payment of \$3.00 for prescriptions costing \$50.00 or more. A pharmacy may not refuse to dispense a prescription to an individual who does not provide the co-payment.

Rationale: This language adds a co-pay of three dollars for VermontRx prescriptions costing \$50.00 or more.

### Sec. E.306.3 VHAP AND MEDICAID CO-PAYS

(a) The following co-payments for individuals enrolled in the VHAP and Medicaid programs are hereby authorized and set by the general assembly, pursuant to 33 V.S.A. Sec. 1901(b), and may be promulgated in rules by the secretary of human services or designee, in accordance with 33 V.S.A. Sec. 1901(a)(1) :

(1) co-payments that apply to prescriptions and durable medical equipment/supplies: enrolled individuals shall contribute a co-payment of \$1.00 for prescriptions or durable medical equipment/supplies costing less than \$30.00, a co-payment of \$2.00 for prescriptions or durable medical equipment/supplies costing \$30.00 or more but less than \$50.00, and a co-payment of \$3.00 for prescriptions or durable medical equipment/supplies costing \$50.00 or more;

(2) co-payments that apply to hospital outpatient services: \$3.00 per hospital visit;

(3) co-payments that apply to hospital emergency room services: for individuals enrolled in VHAP, \$25.00 per hospital visit;

(4) co-payments that apply to hospital inpatient stays: for individuals enrolled in Medicaid, the \$75.00 co-payment for inpatient hospital stays is eliminated.

Rationale: This language enacts a \$3 co-pay for Durable Medical Equipment (DME) and prescriptions costing \$50 or more, enacts an outpatient hospital visit co-pay of \$3 for VHAP, and eliminates the Medicaid \$75 inpatient admission co-pay.

### **DVHA requests the following change to statute regarding liability of third parties:**

(b) The agency shall have a lien against the insurer, to the extent of the amount paid by the agency for past medical expenses, on any recovery from the insurer, whenever:

(1) the agency pays medical expenses or renders medical services on behalf of a recipient who has been injured or has suffered an injury, illness, or disease; and

(2) the recipient asserts a claim against an insurer as a result of the injury, illness, or disease. The recipient's insurer or alleged liable party's insurer, if any, shall take reasonable steps to discover the existence of medical assistance paid by the agency, including contacting the agency to verify a claimant's eligibility status. Failure to comply, as well as providing payment to a person other than the agency does not discharge the insurer from payment of the agency's claim.

(c) A recipient who has applied for or has received medical assistance under this subchapter and the recipient's attorney, if any, shall cooperate with the agency by informing the agency in writing within a reasonable period of time after learning that the agency has paid medical expenses for the recipient. The recipient's attorney shall take reasonable steps to discover the existence of the agency's medical assistance, including contacting the agency to verify a claimant's eligibility status. Any insurer that fails to contact the agency to verify a claimant's eligibility status shall be assessed \$1,000.00 per failure.

Rationale: This is needed in order to achieve savings detailed in program section above.

**DVHA requests the following change to statute governing positions:**

Sec. E.306 Department of Vermont health access – administration

(a) The establishment of six (6) new classified positions - Nurse Case Manager - is authorized in fiscal year 2013.

Rationale: Four (4) of the staff are needed to expand the Vermont Chronic Care Initiative (VCCI) and two (2) of the staff are needed to implement a High Risk Pregnancy Care Program to improve maternal and infant health outcomes.

**DVHA requests the following language related to the 5-year bar:**

Sec. E.309 HEALTH CARE COVERAGE; LEGAL IMMIGRANT CHILDREN AND PREGNANT WOMEN

(a) Beginning July 1, 2012 and thereafter, in accordance with the provisions of the federal Children's Health Insurance Program Reauthorization Act of 2009, Public Law 111-3, section 214, the agency of human services shall provide coverage under Medicaid and CHIP to legal immigrant children and pregnant women who are residing lawfully in Vermont and who have not met the five-year waiting period required under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

Rationale: Last year's language needs to be re-stated and made continuing because unless otherwise specified, Appropriation Bill language is good only for that year.

# **Reference Materials**

**Overview of Green Mountain Care Programs as of 1/1/12**  
**Created by Vermont Legal Aid's Office of Health Care Ombudsman**  
**1-800-917-7787**

<b>PROGRAM</b>	<b>WHO IS ELIGIBLE</b>	<b>BENEFITS</b>	<b>COST-SHARING</b>
<b>Medicaid<sup>1</sup></b> <b>PIL<sup>2</sup></b>  <b>Medicaid Working Disabled</b> <b>250% FPL<sup>3</sup></b>	<ul style="list-style-type: none"> <li>• Aged, blind, disabled</li> <li>• Parents or caretaker relatives of a dependent child</li> <li>• Youth ages 18-20</li> </ul> Disabled working adults	<ul style="list-style-type: none"> <li>• Covers physical and mental health, dental (\$495 cap/yr), prescriptions, chiro (limited), transportation (limited).</li> <li>• Not covered: eyeglasses (except youth 18-20); dentures.</li> <li>• Additional benefits listed under Dr. Dynasaur (below) covered for youth 18-20.</li> <li>• Covers excluded classes of Medicare Part D drugs for dual-eligible individuals.</li> </ul>	<ul style="list-style-type: none"> <li>• No monthly premium.</li> <li>• \$1/\$2/\$3 prescription co-pay if no Medicare Part D coverage.</li> <li>• \$1.10 -\$6.30 co-pays if have Part D. Medicare Part D is primary prescription coverage for dual-eligible individuals.</li> <li>• \$3 dental co-pay</li> <li>• \$3/outpatient hospital visit</li> <li>• \$75/inpatient admission</li> </ul>
<b>Dr. Dynasaur</b> <b>200% FPL</b>	Pregnant women	Same as Medicaid.	<ul style="list-style-type: none"> <li>• Up to 185% FPL: no premium</li> <li>• Up to 200% FPL: \$15/family/month</li> <li>• No prescription co-pays.</li> </ul>
<b>Dr. Dynasaur</b> <b>300% FPL</b>	Children up to age 18	Same as Medicaid but covers eyeglasses, full dental, & additional benefits.	<ul style="list-style-type: none"> <li>• Up to 185% FPL: no premium</li> <li>• Up to 225% FPL: \$15/family/month</li> <li>• Up to 300% FPL: \$20/family/month (\$60/family/mo. w/out other insurance)</li> <li>• No prescription co-pays.</li> </ul>
<b>VHAP</b> <b>(Vermont Health Access Plan)</b> <b>-or-</b> <b>VHAP-ESIA (Employer Sponsored Insurance Assistance)</b>  <b>150% FPL/</b> <b>185% if have dependent child</b>	Uninsured adults (some exceptions) WITHOUT access to approved ESI  Uninsured adults with access to approved ESI	<ul style="list-style-type: none"> <li>• Same as Medicaid except: <b>no</b> dental or transportation.</li> <li>• If covered by employer-sponsored insurance, VHAP wraps ESI coverage as secondary.</li> </ul>	<ul style="list-style-type: none"> <li>• Up to 50% FPL: no premium</li> <li>• Up to 75% FPL: \$7/person/month</li> <li>• Up to 100% FPL: \$25/person/month</li> <li>• Up to 150% FPL: \$33/person/month</li> <li>• Up to 185% FPL (adults w/child only): \$49/person/month</li> <li>• Only cost-sharing is \$25 ER visit; \$1/\$2 script co-pay if income &gt; 100%.</li> </ul>
<b>Catamount-ESIA (Employer Sponsored Insurance Assistance)</b> <b>150%-300% FPL</b>	Uninsured adults (some exceptions) with access to approved ESI	Covered by employer-sponsored insurance; State provides premium assistance.	<ul style="list-style-type: none"> <li>• Coverage/cost-sharing by ESI.</li> <li>• Wrap-around benefits for some chronic care.</li> <li>• \$60-\$205/person/mo thru employer.</li> </ul>
<b>CHAP (Catamount Health Premium Assistance Program)</b> <b>150%-300% FPL</b>	Uninsured adults (some exceptions) WITHOUT access to approved ESI	Covered by BCBS Catamount Blue -OR- MVP Catamount Choice.	<ul style="list-style-type: none"> <li>• Cost sharing according to plan.</li> <li>• \$60-\$267/person/mo paid to State.</li> </ul>
<b>Catamount Health</b> <b>(no state assistance)</b>	Same as directly above except income over 300% FPL (some exceptions)	Covered by BCBS Cat. Blue or MVP Catamount Choice.	<ul style="list-style-type: none"> <li>• Cost sharing according to plan.</li> <li>• Full premium costs; family plans available.</li> </ul>
<b>VHAP Pharmacy</b> <b>150% FPL</b>  <b>VScript 175% FPL</b> <b>VScript Expanded 225% FPL</b>	Aged or disabled, not eligible for Medicare, and has no script coverage	<ul style="list-style-type: none"> <li>• VHAP Pharmacy: acute and maintenance Medicaid drugs, diabetic supplies, eye exams.</li> <li>• VS &amp; VS Expanded cover maintenance drugs and diabetic supplies only.</li> </ul>	<ul style="list-style-type: none"> <li>• VHAP Pharmacy: \$15/person/month</li> <li>• VScript: \$20/person/month</li> <li>• VS Expanded: \$50/person/month</li> <li>• \$1/\$2 prescription co-pays</li> <li>• VS Expanded only: manufacturer must sign supplemental agreement w/State.</li> </ul>
<b>VPharm1 150% FPL</b>  <b>VPharm2 175% FPL</b> <b>VPharm3 225% FPL</b>	Medicare Part D beneficiaries	<ul style="list-style-type: none"> <li>• VPharm1 covers Part D cost-sharing &amp; excluded classes of Part D meds, diabetic supplies, eye exams.</li> <li>• VPharm 2&amp;3 cover maintenance meds &amp; diabetic supplies only.</li> </ul>	<ul style="list-style-type: none"> <li>• VPharm1: \$15/person/mo. pd to State</li> <li>• VPharm2: \$20/person/mo. pd to State</li> <li>• VPharm3: \$50/person/mo. pd to State</li> <li>• \$1/\$2 prescription co-pays.</li> <li>• VPharm1 must apply for Part D Limited Income Subsidy.</li> </ul>

<sup>1</sup> Medicaid is the only program w/resource limits: \$2000/person, \$3000/couple (MWD is \$5000/person, \$6000/couple). Long Term Care Medicaid (nursing home care; waiver services) is not included in this chart.

<sup>2</sup> PIL: Protected Income Limit. Note: Medicaid income limit for age 18 in households  $\geq 2$  is 100% of FPL.

<sup>3</sup> FPL: Federal Poverty Level

<b>Medicare Savings Programs:</b> <b>QMB 100% FPL</b> Qualified Medicare Beneficiaries <b>SLMB 120% FPL</b> Specified Low-Income Beneficiaries <b>QI-1 135% FPL</b> Qualified Individuals	<ul style="list-style-type: none"> <li>• QMB &amp; SLMB: Medicare beneficiaries w/ Part A</li> <li>• QI-1: Medicare bens. who are not on other fed. med. benefits e.g. Medicaid (LIS for Part D OK).</li> </ul>	<ul style="list-style-type: none"> <li>• QMB covers Medicare Part B (and A if not free) premiums; Medicare A &amp; B cost-sharing.</li> <li>• SLMB and QI-1 cover Medicare Part B premiums only.</li> </ul>	No cost / no monthly premium.
<b>Healthy Vermonters 350% FPL/ 400% FPL if aged or disabled</b>	Anyone who has no/has exhausted script coverage	<ul style="list-style-type: none"> <li>• Discount on medications. (NOT INSURANCE)</li> </ul>	Beneficiary pays the Medicaid rate for all prescriptions.

Coverage Groups	Premium	FPL <sup>3</sup>	1	2 Household	3	4
<b>Medicaid</b> PIL outside Chittenden County <b>Medicaid</b> PIL inside Chittenden County Medicaid Working Disabled		NA NA <250%	\$958.00 <sup>2</sup> \$1033.00 <sup>2</sup> \$2328.00	\$958.00 <sup>2</sup> \$1033.00 <sup>2</sup> \$3153.00	\$1150.00 <sup>2</sup> \$1225.00 <sup>2</sup> \$3978.00	\$1300.00 <sup>2</sup> \$1375.00 <sup>2</sup> \$4803.00
<b>VHAP-ESIA or VHAP</b> (if no ESI) ≤50% FPL No fee >50% but ≤75% FPL \$7/person/month >75% but ≤100% FPL \$25/person/month >100% but ≤150% FPL \$33/person/month >150% but ≤185% FPL * \$49/person/month *families with dependent children only		<185% 50% 75% 100% 150% 185%	\$466.00 \$699.00 \$931.00 \$1397.00 \$1723.00	\$631.00 \$946.00 \$1261.00 \$1892.00 \$2333.00	\$796.00 \$1194.00 \$1591.00 \$2387.00 \$2944.00	\$961.00 \$1441.00 \$1921.00 \$2882.00 \$3554.00
<b>VPharm1/ VHAP Pharmacy</b> \$15/person/mo <b>VPharm2/ VScript</b> \$20/person/mo <b>VPharm3/ VScript Expanded</b> \$50/person/mo		<150% <175% <225%	\$1397.00 \$1629.00 \$2095.00	\$1892.00 \$2207.00 \$2837.00	\$2387.00 \$2784.00 \$3580.00	\$2882.00 \$3362.00 \$4332.00
<b>Dr. Dynasaur (kids up to 18 &amp; pregnant women)</b> Kids ≤185% FPL No Fee Pregnant women ≤ 200% FPL \$15/family/month Kids >185% but ≤ 225% FPL \$15/family/month Kids >225% but ≤ 300% FPL \$20/family/month If otherwise uninsured, \$60/family/month		<300% kids/ <200% women 185% 200% 225% 300%	\$1723.00 \$1862.00 \$2095.00 \$2793.00	\$2333.00 \$2522.00 \$2837.00 \$3783.00	\$2944.00 \$3182.00 \$3580.00 \$4773.00	\$3554.00 \$3842.00 \$4322.00 \$5763.00
<b>Catamount-ESIA</b> >150% but ≤ 200% FPL \$60/person/month >200% but ≤ 225% FPL \$122/person/month >225% but ≤ 250% FPL \$149/person/month >250% but ≤ 275% FPL \$177/person/month >275% but ≤ 300% FPL \$205/person/month Catamount ESIA premium rates may change at start of each calendar yr.		150%-300% 200% 225% 250% 275% 300%	\$1862.00 \$2095.00 \$2328.00 \$2560.00 \$2793.00	\$2522.00 \$2837.00 \$3153.00 \$3468.00 \$3783.00	\$3182.00 \$3580.00 \$3978.00 \$4375.00 \$4773.00	\$3842.00 \$4322.00 \$4803.00 \$5283.00 \$5763.00
<b>CHAP-Catamount Blue</b> >150% but ≤ 200% FPL \$60/person/month >200% but ≤ 225% FPL \$124/person/month >225% but ≤ 250% FPL \$152/person/month >250% but ≤ 275% FPL \$180/person/month >275% but ≤ 300% FPL \$208/person/month >300% FPL: \$453.68 individual/\$907.36 2-person/\$1359.30 family [with billing credit: \$436.15 ind./ \$872.30 2-pers./ \$1306.71 fam.] <b>CHAP-MVP Catamount Choice</b> >150 but ≤ 200% FPL \$119/person/month >200 but ≤225% FPL \$183/person/month >225 but ≤250% FPL \$211/person/month >250 but ≤ 275% FPL \$239/person/month >275 but ≤ 300% FPL \$267/person/month >300% FPL: \$512.60 individual/\$978.45 parent & child/\$1025.20 double/\$1444.31family CHAP premium rates change on July 1st.		150%-300% 200% 225% 250% 275% 300% 150%-300% 200% 225% 250% 275% 300%	\$1862.00 \$2095.00 \$2328.00 \$2560.00 \$2793.00 \$1862.00 \$2095.00 \$2328.00 \$2560.00 \$2793.00	\$2522.00 \$2837.00 \$3153.00 \$3468.00 \$3783.00 \$2522.00 \$2837.00 \$3153.00 \$3468.00 \$3783.00	\$3182.00 \$3580.00 \$3978.00 \$4375.00 \$4773.00 \$3182.00 \$3580.00 \$3978.00 \$4375.00 \$4773.00	\$3842.00 \$4322.00 \$4803.00 \$5283.00 \$5763.00 \$3842.00 \$4322.00 \$4803.00 \$5283.00 \$5763.00
<b>Medicare Savings Programs: QMB</b> <b>SLMB</b> <b>QI-1</b>		<100% <120% <135%	\$931.00 \$1117.00 \$1257.00	\$1261.00 \$1513.00 \$1703.00	N/A	N/A
<b>Healthy Vermonters</b> (any age) <b>Healthy Vermonters</b> (aged, disabled)		<350% <400%	\$3258.00 \$3724.00	\$4413.00 \$5044.00	\$5568.00 \$6364.00	\$6723.00 \$7684.00

Income calculation is based on monthly Gross Income less some deductions. Taxes and FICA are not deductions.

## Percentage of Federal Poverty Level (FPL) Guidelines 01/01/12-12/31/12

### Monthly

Group Size	75%	100%	120%	135%	150%	175%	185%	200%	225%	250%	300%	350%	400%
1	699	931	1117	1257	1397	1629	1723	1862	2095	2328	2793	3258	3724
2	946	1261	1513	1703	1892	2207	2333	2522	2837	3153	3783	4413	5044
3	1194	1591	1909	2148	2387	2784	2944	3182	3580	3978	4773	5568	6364
4	1441	1921	2305	2594	2882	3362	3554	3842	4322	4803	5763	6723	7684
5	1689	2251	2701	3039	3377	3939	4165	4502	5065	5628	6753	7878	9004
6	1936	2581	3097	3485	3872	4517	4775	5162	5807	6453	7743	9033	10324
7	2184	2911	3493	3930	4367	5094	5386	5822	6550	7278	8733	10188	11644
8	2431	3241	3889	4376	4862	5672	5996	6482	7292	8103	9723	11343	12964
9	2679	3571	4285	4821	5357	6249	6607	7142	8035	8928	10713	12498	14284
10	2926	3901	4681	5267	5852	6827	7217	7802	8777	9753	11703	13653	15604
11	3174	4231	5077	5712	6347	7404	7828	8462	9520	10578	12693	14808	16924
12	3421	4561	5473	6158	6842	7982	8438	9122	10262	11403	13683	15963	18244
13	3669	4891	5869	6603	7337	8559	9049	9782	11005	12228	14673	17118	19564
14	3916	5221	6265	7049	7832	9137	9659	10442	11747	13053	15663	18273	20884
15	4164	5551	6661	7494	8327	9714	10270	11102	12490	13878	16653	19428	22204

### Annually

Group Size	75%	100%	120%	135%	150%	175%	185%	200%	225%	250%	300%	350%	400%
1	8388	11172	13404	15084	16764	19548	20676	22344	25140	27936	33516	39096	44688
2	11352	15132	18156	20436	22704	26484	27996	30264	34044	37836	45396	52956	60528
3	14328	19092	22908	25776	28644	33408	35328	38184	42960	47736	57276	66816	76368
4	17292	23052	27660	31128	34584	40344	42648	46104	51864	57636	69156	80676	92208
5	20268	27012	32412	36468	40524	47268	49980	54024	60780	67536	81036	94536	108048
6	23232	30972	37164	41820	46464	54204	57300	61944	69684	77436	92916	108396	123888
7	26208	34932	41916	47160	52404	61128	64632	69864	78600	87336	104796	122256	139728
8	29172	38892	46668	52512	58344	68064	71952	77784	87504	97236	116676	136116	155568
9	32148	42852	51420	57852	64284	74988	79284	85704	96420	107136	128556	149976	171408
10	35112	46812	56172	63204	70224	81924	86604	93624	105324	117036	140436	163836	187248
11	38088	50772	60924	68544	76164	88848	93936	101544	114240	126936	152316	177696	203088
12	41052	54732	65676	73896	82104	95784	101256	109464	123144	136836	164196	191556	218928
13	44028	58692	70428	79236	88044	102708	108588	117384	132060	146736	176076	205416	234768
14	46992	62652	75180	84588	93984	109644	115908	125304	140964	156636	187956	219276	250608
15	49968	66612	79932	89928	99924	116568	123240	133224	149880	166536	199836	233136	266448

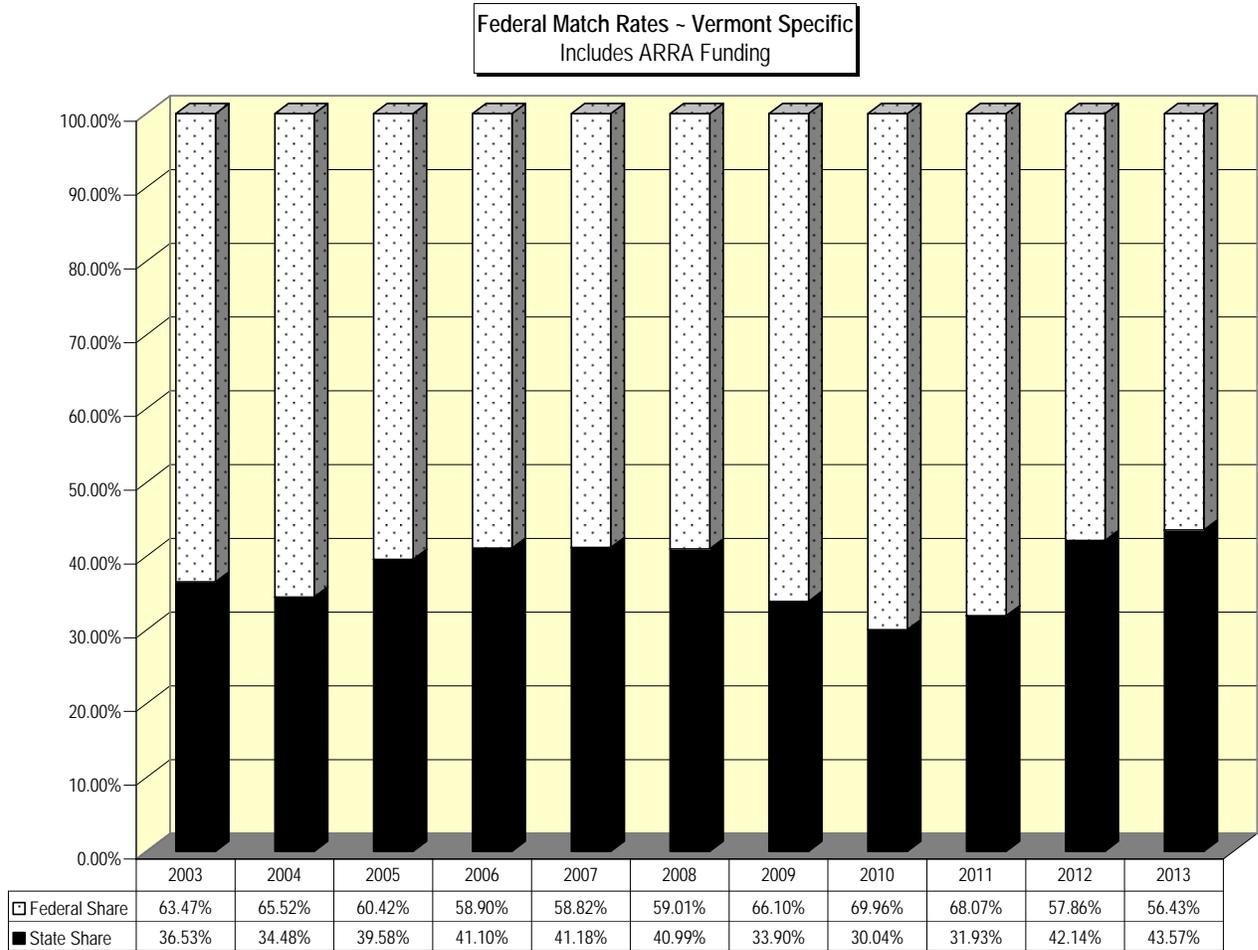
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## Premiums

Program	% FPL	'12 Steady State Enroll	'12 Steady State Premium	'12 Steady State Premiums	'12 BAA Enroll	'12 BAA Premium	'12 BAA Premiums	'13 Steady State Enroll	'13 Steady State Premium	'13 Steady State Premiums
ABD Adults	PIL	14,772	\$ -	\$ -	14,101	\$ -	\$ -	14,445	\$ -	\$ -
ABD Dual Eligible Adults	PIL	16,270	\$ -	\$ -	16,532	\$ -	\$ -	17,155	\$ -	\$ -
Choices for Care Adults	PIL	4,010	\$ -	\$ -	3,825	\$ -	\$ -	3,758	\$ -	\$ -
ANFC Adults	PIL	11,127	\$ -	\$ -	11,260	\$ -	\$ -	11,686	\$ -	\$ -
		46,179		\$ -	45,719		\$ -	47,043		\$ -
Dr. Dynasaur	0-185%	51,675	\$ -	\$ -	54,367	\$ -	\$ -	54,622	\$ -	\$ -
Dr. Dynasaur	185-225%	4,310	\$ 15.00	\$ 484,851	4,534	\$ 15.00	\$ 510,105	4,556	\$ 15.00	\$ 512,501
Dr. D with ins.	225-300%	1,236	\$ 20.00	\$ 185,400	1,041	\$ 20.00	\$ 156,174	943	\$ 20.00	\$ 141,431
Dr. D without ins.	225-300%	3,710	\$ 60.00	\$ 1,669,500	3,863	\$ 60.00	\$ 1,738,284	4,017	\$ 60.00	\$ 1,807,592
Dr. D Total		60,931		\$ 2,339,751	63,805		\$ 2,404,563	64,137		\$ 2,461,524
VHAP	0-50%	14,208	\$ -	\$ -	13,377	\$ -	\$ -	13,366	\$ -	\$ -
VHAP	50-75%	5,089	\$ 7.00	\$ 427,437	4,791	\$ 7.00	\$ 402,444	4,787	\$ 7.00	\$ 402,091
VHAP	75-100%	5,898	\$ 25.00	\$ 1,769,364	5,553	\$ 25.00	\$ 1,665,908	5,548	\$ 25.00	\$ 1,664,445
VHAP	100-150%	13,566	\$ 33.00	\$ 5,372,086	12,773	\$ 33.00	\$ 5,057,976	12,761	\$ 33.00	\$ 5,053,533
VHAP	150-185%	3,346	\$ 49.00	\$ 1,967,184	3,150	\$ 49.00	\$ 1,852,161	3,147	\$ 49.00	\$ 1,850,534
VHAP Total		42,106		\$ 9,536,071	39,644		\$ 8,978,489	39,609		\$ 8,970,603
VPharm 1 & VHAP Pharmacy	0-150%	7,863	\$ 15.00	\$ 1,415,407	7,863	\$ 15.00	\$ 1,415,353	7,921	\$ 15.00	\$ 1,425,731
VPharm 2 & VScript	150-175%	2,791	\$ 20.00	\$ 669,887	2,796	\$ 20.00	\$ 670,922	2,816	\$ 20.00	\$ 675,825
VPharm 3 & VScript Expanded	175-225%	2,560	\$ 50.00	\$ 1,536,541	2,169	\$ 50.00	\$ 1,301,407	1,961	\$ 50.00	\$ 1,176,805
Pharmacy Total		13,215		\$ 3,621,835	12,828		\$ 3,387,683	12,698		\$ 3,278,362
Catamount Health	0-150%	1,601	\$ 60.00	\$ 1,153,056	1,270	\$ 60.00	\$ 914,173	1,591	\$ 60.00	\$ 1,145,238
Catamount Health	150-175%	2,428	\$ 60.00	\$ 1,747,832	2,759	\$ 60.00	\$ 1,986,124	2,411	\$ 60.00	\$ 1,735,981
Catamount Health	175-200%	4,216	\$ 60.00	\$ 3,035,512	3,672	\$ 60.00	\$ 2,643,482	4,187	\$ 60.00	\$ 3,014,930
Catamount Health	200-225%	2,518	\$ 124.00	\$ 3,746,461	1,445	\$ 124.00	\$ 2,150,588	2,463	\$ 124.00	\$ 3,665,307
Catamount Health	226-250%	447	\$ 152.00	\$ 816,158	987	\$ 152.00	\$ 1,800,542	438	\$ 152.00	\$ 798,479
Catamount Health	251-275%	201	\$ 180.00	\$ 433,982	455	\$ 180.00	\$ 982,358	197	\$ 180.00	\$ 424,581
Catamount Health	276-300%	157	\$ 208.00	\$ 391,482	164	\$ 208.00	\$ 409,874	153	\$ 208.00	\$ 383,002
Catamount Total		11,568		\$ 11,324,484	10,751		\$ 10,887,141	11,440		\$ 11,167,519
TOTAL		173,999		\$ 26,822,141	172,746		\$ 25,657,876	174,928		\$ 25,878,008
Federal			57.86%	\$ 14,158,746		57.86%	\$ 13,595,412		56.43%	\$ 13,451,728
GF			42.14%	\$ 12,663,396		42.14%	\$ 12,062,464		43.57%	\$ 12,426,281
Total				\$ 26,822,141			\$ 25,657,876			\$ 25,878,008



## Federal Match Rates ~ Vermont Specific



## MCO Investment Expenditures

Department	Criteria	Investment Description	SFY06 Actuals - 3/4 SFY	SFY07 Actuals	SFY08 Actuals	SFY09 Actuals	SFY10 Actuals	SFY11 Actuals
DOE	2	School Health Services	\$ 6,397,319	\$ 8,956,247	\$ 8,956,247	\$ 8,956,247	\$ 8,956,247	\$ 4,478,124
AOA	4	Blueprint Director	\$ -	\$ -	\$ 70,000	\$ 68,879	\$ 179,284	\$ -
BISHCA	2	Health Care Administration	\$ 983,637	\$ 914,629	\$ 1,340,728	\$ 1,871,651	\$ 1,713,959	\$ 1,898,342
DII	4	Vermont Information Technology Leaders	\$ 266,000	\$ 105,000	\$ 105,000	\$ 339,500	\$ -	\$ -
VVH	2	Vermont Veterans Home	\$ 747,000	\$ 913,047	\$ 913,047	\$ 881,043	\$ 837,225	\$ 1,410,956
VSC	2	Health Professional Training	\$ 283,154	\$ 391,698	\$ 405,407	\$ 405,407	\$ 405,407	\$ 405,407
UVM	2	Vermont Physician Training	\$ 2,798,070	\$ 3,870,682	\$ 4,006,152	\$ 4,006,156	\$ 4,006,152	\$ 4,006,156
AHSCO	2	Designated Agency Undersinsured Services	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 2,510,099
AHSCO	4	2-1-1 Grant	\$ -	\$ -	\$ -	\$ 415,000	\$ 415,000	\$ 415,000
VDH	2	Emergency Medical Services	\$ 174,482	\$ 436,642	\$ 626,728	\$ 427,056	\$ 425,870	\$ 333,488
VDH	2	AIDS Services/HIV Case Management	\$ 152,945	\$ -	\$ -	\$ -	\$ -	\$ -
VDH	2	TB Medical Services	\$ 27,052	\$ 29,129	\$ 15,872	\$ 28,359	\$ 41,313	\$ 36,284
VDH	3	Epidemiology	\$ 326,708	\$ 427,075	\$ 416,932	\$ 204,646	\$ 241,932	\$ 315,135
VDH	3	Health Research and Statistics	\$ 276,673	\$ 403,244	\$ 404,431	\$ 217,178	\$ 254,828	\$ 289,420
VDH	2	Health Laboratory	\$ 1,369,982	\$ 1,908,982	\$ 2,012,252	\$ 1,522,578	\$ 1,875,487	\$ 1,912,034
VDH	4	Tobacco Cessation: Community Coalitions	\$ 938,056	\$ 1,647,129	\$ 1,144,713	\$ 1,016,685	\$ 535,573	\$ 94,089
VDH	3	Statewide Tobacco Cessation	\$ -	\$ -	\$ -	\$ 230,985	\$ 484,998	\$ 507,543
VDH	2	Family Planning	\$ 365,320	\$ 122,961	\$ 169,392	\$ 300,876	\$ 300,876	\$ 275,806
VDH	4	Physician/Dentist Loan Repayment Program	\$ 810,716	\$ 439,140	\$ 930,000	\$ 1,516,361	\$ 970,000	\$ 900,000
VDH	2	Renal Disease	\$ 15,000	\$ 7,601	\$ 16,115	\$ 15,095	\$ 2,053	\$ 13,689
VDH	2	Newborn Screening	\$ 74,899	\$ 166,795	\$ 136,577	\$ -	\$ -	\$ -
VDH	2	WIC Coverage	\$ 161,804	\$ 1,165,699	\$ 562,446	\$ 86,882	\$ -	\$ 36,959
VDH	4	Vermont Blueprint for Health	\$ 92,049	\$ 1,975,940	\$ 753,087	\$ 1,395,135	\$ 1,417,770	\$ 752,375
VDH	4	Area Health Education Centers (AHEC)	\$ -	\$ 35,000	\$ 310,000	\$ 565,000	\$ 725,000	\$ 500,000
VDH	4	Community Clinics	\$ -	\$ -	\$ -	\$ 640,000	\$ 468,154	\$ 640,000
VDH	4	FQHC Lookalike	\$ -	\$ -	\$ 30,000	\$ 105,650	\$ 81,500	\$ 87,900
VDH	4	Patient Safety - Adverse Events	\$ -	\$ -	\$ 190,143	\$ 100,509	\$ 44,573	\$ 16,829
VDH	4	Coalition of Health Activity Movement Prevention Program (CHAMPPS)	\$ -	\$ 100,000	\$ 291,298	\$ 486,466	\$ 412,043	\$ 290,661
VDH	2	Substance Abuse Treatment	\$ 1,466,732	\$ 2,514,963	\$ 2,744,787	\$ 2,997,668	\$ 3,000,335	\$ 1,693,198
VDH	4	Recovery Centers	\$ 171,153	\$ 287,374	\$ 329,215	\$ 713,576	\$ 716,000	\$ 648,500
VDH	2	Immunization	\$ -	\$ -	\$ -	\$ 726,264	\$ -	\$ -
VDH	2	DMH Investment Cost in CAP	\$ -	\$ -	\$ -	\$ 64,843	\$ -	\$ 752
VDH	4	Poison Control	\$ -	\$ -	\$ -	\$ -	\$ 176,340	\$ 115,710
DMH	2	Special Payments for Treatment Plan Services	\$ 101,230	\$ 131,309	\$ 113,314	\$ 164,356	\$ 149,068	\$ 134,791
DMH	2	MH Outpatient Services for Adults	\$ 775,899	\$ 1,393,395	\$ 1,293,044	\$ 1,320,521	\$ 864,815	\$ 522,595
DMH	2	Mental Health Elder Care	\$ 38,563	\$ 37,682	\$ 38,970	\$ -	\$ -	\$ -
DMH	4	Mental Health Consumer Support Programs	\$ 451,606	\$ 546,987	\$ 673,160	\$ 707,976	\$ 802,579	\$ 582,397
DMH	2	Mental Health CRT Community Support Services	\$ 2,318,668	\$ 602,186	\$ 807,539	\$ 1,124,728	\$ -	\$ 1,935,344
DMH	2	Mental Health Children's Community Services	\$ 1,561,396	\$ 3,066,774	\$ 3,341,602	\$ 3,597,662	\$ 2,569,759	\$ 1,775,120
DMH	2	Emergency Mental Health for Children and Adults	\$ 1,885,014	\$ 1,988,548	\$ 2,016,348	\$ 2,165,648	\$ 1,797,605	\$ 2,309,810
DMH	2	Respite Services for Youth with SED and their Families	\$ 385,581	\$ 485,586	\$ 502,237	\$ 412,920	\$ 516,677	\$ 543,635
DMH	2	CRT Staff Secure Transportation	\$ -	\$ -	\$ 52,242	\$ -	\$ -	\$ -
DMH	2	Recovery Housing	\$ -	\$ -	\$ 235,267	\$ -	\$ 332,635	\$ 512,307
DMH	2	Transportation - Children in Involuntary Care	\$ 4,768	\$ 1,075	\$ -	\$ -	\$ -	\$ -
DMH	2	Vermont State Hospital Records	\$ -	\$ -	\$ -	\$ -	\$ 19,590	\$ -
DMH	4	Challenges for Change: DMH	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 229,512
DMH	2	Seriously Functionally Impaired	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 68,713
DVHA	4	Vermont Information Technology Leaders/HIT/HIE	\$ -	\$ -	\$ -	\$ -	\$ 339,500	\$ 646,220
DVHA	4	Vermont Blueprint for Health	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 2,616,211
DVHA	1	Buy-In	\$ 4,594	\$ 314,376	\$ 419,951	\$ 248,537	\$ 200,868	\$ 50,605
DVHA	1	Vscript Expanded	\$ 1,695,246	\$ -	\$ -	\$ -	\$ -	\$ -
DVHA	1	HIV Drug Coverage	\$ 31,172	\$ 42,347	\$ 44,524	\$ 48,711	\$ 38,904	\$ 39,176
DVHA	1	Civil Union	\$ 373,175	\$ 543,986	\$ 671,941	\$ 556,811	\$ 627,976	\$ 999,084
DVHA	1	Vpharm	\$ -	\$ -	\$ -	\$ 278,934	\$ 210,796	\$ -
DVHA	4	Hospital Safety Net Services	\$ -	\$ -	\$ 281,973	\$ -	\$ -	\$ -
DVHA	2	Patient Safety Net Services	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 36,112
DCF	2	Family Infant Toddler Program	\$ -	\$ 199,064	\$ 326,424	\$ 335,235	\$ 81,086	\$ 624
DCF	2	Medical Services	\$ 69,893	\$ 91,569	\$ 120,494	\$ 65,278	\$ 45,216	\$ 64,496
DCF	2	Residential Care for Youth/Substitute Care	\$ 9,181,386	\$ 10,536,996	\$ 10,110,441	\$ 9,392,213	\$ 8,033,068	\$ 7,853,100
DCF	2	AABD Admin	\$ 988,557	\$ -	\$ -	\$ -	\$ -	\$ -
DCF	2	AABD	\$ 2,415,100	\$ -	\$ -	\$ -	\$ -	\$ -
DCF	2	Aid to the Aged, Blind and Disabled CCL Level III	\$ 96,000	\$ 2,617,350	\$ 2,615,023	\$ 2,591,613	\$ 2,827,617	\$ 2,661,246
DCF	2	Aid to the Aged, Blind and Disabled Res Care Level III	\$ -	\$ 143,975	\$ 170,117	\$ 172,173	\$ 137,356	\$ 136,466
DCF	2	Aid to the Aged, Blind and Disabled Res Care Level IV	\$ 210,989	\$ 312,815	\$ 349,887	\$ 366,161	\$ 299,488	\$ 265,812
DCF	2	Essential Person Program	\$ 542,382	\$ 675,860	\$ 614,974	\$ 620,052	\$ 485,536	\$ 736,479
DCF	2	GA Medical Expenses	\$ 254,154	\$ 339,928	\$ 298,207	\$ 380,000	\$ 583,080	\$ 492,079
DCF	2	CUPS/Early Childhood Mental Health	\$ -	\$ -	\$ 52,825	\$ 499,143	\$ 166,429	\$ 112,619
DCF	2	VCRHYP/Vermont Coalition for Runaway and Homeless Youth Program	\$ -	\$ -	\$ 1,764,400	\$ -	\$ -	\$ -
DCF	2	HBKF/Healthy Babies, Kids & Families	\$ -	\$ -	\$ 318,321	\$ 63,921	\$ -	\$ -
DCF	1	Catamount Administrative Services	\$ -	\$ -	\$ -	\$ 339,894	\$ -	\$ -
DCF	2	Therapeutic Child Care	\$ -	\$ -	\$ -	\$ 978,886	\$ 577,259	\$ 570,493
DCF	2	Lund Home	\$ -	\$ -	\$ -	\$ 325,516	\$ 175,378	\$ 196,159
DCF	2	GA Community Action	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 199,762
DCF	3	Prevent Child Abuse Vermont	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 44,119
DCF	4	Challenges for Change: DCF	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 50,622
DDAIL	2	Elder Coping with MMA	\$ 441,234	\$ -	\$ -	\$ -	\$ -	\$ -
DDAIL	2	Mobility Training/Other Svcs.-Elderly Visually Impaired	\$ 187,500	\$ 250,000	\$ 250,000	\$ 250,000	\$ 245,000	\$ 245,000
DDAIL	2	DS Special Payments for Medical Services	\$ 394,055	\$ 192,111	\$ 880,797	\$ 522,058	\$ 469,770	\$ 757,070
DDAIL	2	Flexible Family/Respite Funding	\$ 1,086,291	\$ 1,135,213	\$ 1,341,698	\$ 1,364,896	\$ 1,114,898	\$ 1,103,748
DDAIL	4	Quality Review of Home Health Agencies	\$ -	\$ 77,467	\$ 186,664	\$ 126,306	\$ 90,227	\$ 103,598
DOC	2	Intensive Substance Abuse Program (ISAP)	\$ 382,230	\$ 299,602	\$ 310,610	\$ 200,000	\$ 591,004	\$ 591,000
DOC	2	Intensive Sexual Abuse Program	\$ 72,439	\$ 46,078	\$ 85,542	\$ 88,523	\$ 68,350	\$ 70,002
DOC	2	Intensive Domestic Violence Program	\$ 109,692	\$ 134,663	\$ 230,353	\$ 239,166	\$ 173,938	\$ 174,000
DOC	2	Women's Health Program (Tapestry)	\$ 460,130	\$ 487,344	\$ 487,231	\$ 527,956	\$ -	\$ -
DOC	2	Community Rehabilitative Care	\$ 1,038,114	\$ 1,982,456	\$ 2,031,408	\$ 1,997,499	\$ 2,190,924	\$ 2,221,448
DOC	2	Return House	\$ -	\$ -	\$ -	\$ 51,000	\$ -	\$ -
DOC	2	Northern Lights	\$ -	\$ -	\$ -	\$ -	\$ 40,000	\$ 40,000
			\$ 45,455,809	\$ 55,495,719	\$ 59,918,097	\$ 62,419,988	\$ 55,554,314	\$ 56,275,877

## Acronyms

AAA.....	Area Agency on Aging	BISHCA.....	Banking, Insurance, Securities, & Health Care Administration (Department of)
AABD .....	Aid to the Aged, Blind & Disabled	BP	Blueprint for Health
AAG.....	Assistant Attorney General	BPM	Business Process Management
AAP .....	American Academy of Pediatrics	BPS.....	Benefits Programs Specialist
ABAWD .....	Able-Bodied Adults without Dependents	BROC.....	Bennington-Rutland Opportunity Council
ABD.....	Aged, Blind and Disabled	CAHPS.....	Consumer Assessment of Health Plans Survey
ACA.....	Affordable Care Act	CAP.....	Community Action Program
ACCESS.....	The computer software system used by DCF and DVHA to track program eligibility information	CC.....	Committed Child
ACF.....	Administration for Children & Families	CCI .....	Chronic Care Initiative
ACO.....	Accountable Care Organization	CCMP.....	Chronic Care Management Program
ADA.....	American Dental Association	CCTA.....	Chittenden County Transportation Authority
ADAP.....	Alcohol and Drug Abuse Programs	CF.....	Crisis Fuel
AEP.....	Annual Enrollment Period	CFR.....	Code of Federal Regulations
AGA.....	Adult General Assessment	CHAP.....	Catamount Health Assistance Program
AHCPR.....	Agency for Health Care Policy & Research	CHF.....	Congestive Heart Failure
AHEC.....	Area Health Education Center	CHIPRA.....	Children's Health Insurance Program Re-authorization Act of 2009
AHRQ	Agency for Healthcare Research & Quality	CHPR .....	Center for Health Policy and Research
AHS.....	Agency of Human Services	CIO .....	Chief Information Office
AIM®.....	Advanced Information Management system (see MMIS)	CIS .....	Children's Integrated Services
AIRS.....	Automated Information and Referral System	CM.....	Case Management
A/I/U	Adopt/Implement/Upgrade	CMN.....	Certification of Medical Necessity
ALS .....	Advanced Life Support	CMS.....	Centers for Medicare & Medicaid Services (formerly HCFA)
AMA .....	American Medical Association	CMSO.....	Center for Medicaid & State Operations
AMAP.....	Aids Medication Assistance Program	CNM	Certified Nurse Midwife
AMP.....	Average Manufacturer Price	COA.....	Council on Aging
ANFC.....	Aid to Needy Families with Children	COB .....	Coordination of Benefits
AOA.....	Agency of Administration	COB-MAT....	Coordination of Office Based Medication Assisted Therapy
APA .....	Administrative Procedures Act	CON.....	Certificate of Need
APC.....	Ambulatory Payment Classification	COPD .....	Chronic Obstructive Pulmonary Disease
APD .....	Advance Planning Document	COPS.....	Computer Operations and Problem Solving
APS .....	Adult Protective Services	COS .....	Categories of Service
APS.....	APS Healthcare	CPH.....	Community Public Health (of the VDH)
ARRA.....	American Recovery and Reinvestment Act of 2009	CPI.....	Center for Program Integrity
ASD.....	Administrative Services Division	CPT.....	Common Procedural Terminology
AWP.....	Average Wholesale Price	CPTOD.	Capitated Program for the Treatment of Opiate Dependency
BAFO .....	Best & Final Offer	CRT.....	Community Rehabilitation & Treatment
BC/BS.....	Blue Cross/Blue Shield	CSBG.....	Community Services Block Grant
BCCT.....	Breast and Cervical Cancer Treatment Program	CSD.....	Computer Services Division
BD .....	Blind & Disabled	CSHN .....	Children with Special Health Needs
BHP.....	Basic health Plan		

CSME..... Coverage & Services Management Enhancement  
 CSR..... Customer Service Request  
 CURB..... Clinical Utilization Review Board  
 CY..... Calendar Year  
 DAD..... Department of Aging & Disabilities (see DAIL)  
 DAIL..... Department of Disabilities, Aging and Independent Living  
 DCA Dept. of Cost Allocation (federal)  
 DCF..... Department for Children and Families  
 DDI..... Design, Development & Implementation  
 DDMHS..... Department of Developmental & Mental Health Services  
 DDS..... Disability Determination Services (part of DCF)  
 DHHS..... Department of Health & Human Services (United States)  
 DII..... Department of Information & Innovation  
 DIS..... Detailed Implementation Schedule  
 DME..... Durable Medical Equipment  
 DMC..... Disease Management Coordinators  
 DMH..... Department of Mental Health  
 DO..... District Office  
 DOA..... Date of Application  
 DOB..... Date of Birth  
 DOC..... Department of Corrections  
 DOE..... Department of Education  
 DOH..... Department of Health (see VDH)  
 DOL..... Department of Labor  
 DOS..... Date of Service  
 DR..... Desk Review  
 DRA..... Deficit Reduction Act  
 DR. D..... Dr. Dinosaur Program  
 DRG..... Diagnosis Related Grouping  
 DSH..... Disproportionate Share Hospital  
 DSW..... Department of Social Welfare (see PATH)  
 DUR..... Drug Utilization Review (Board)  
 DVHA..... Department of Vermont Health Access  
 EA..... Emergency Assistance  
 EAC..... Estimated Acquisition Cost  
 EBT..... Electronic Benefit Transfer  
 ECS..... Electronic Claims Submission  
 EDI..... Electronic Data Interchange  
 EDS..... Electronic Data Systems Corporation, now HP Enterprise Services  
 EFT..... Electronic Funds Transfer  
 EGA..... Estimated Gestational Age  
 EHB..... Essential Health Benefits

EHR..... Electronic Health Record  
 EHRIP..... EHR Incentive Program  
 EITC..... Earned Income Tax Credit  
 EOMB..... Explanation of Medicare (or Medicaid) Benefits  
 EP..... Essential Person  
 EPSDT..... Early & Periodic Screening, Diagnosis & Treatment  
 EQR..... External Quality Review  
 ER..... Emergency Room  
 ERA..... Electronic Remittance Advice  
 ERC..... Enhanced Residential Care  
 ESD..... Economic Services Division (of the DCF)  
 ESI..... Employer Sponsored Insurance  
 ESRD..... End Stage Renal Disease  
 EST..... Eastern Standard Time  
 EVAH..... Enhanced VT Ad Hoc (query & reporting system)  
 EVS..... Eligibility Verification System  
 FA..... Fiscal Agent  
 FADS..... Fraud Abuse & Detection System  
 FDA..... Food & Drug Administration  
 FEIN..... Federal Employer's Identification Number  
 FFP..... Federal Financial Participation  
 FFS..... Fee for Service  
 FFY..... Federal Fiscal Year  
 FH..... Fair Hearing  
 FICA..... Federal Insurance Contribution Act  
 FMAP..... Federal Medical Assistance Percentage  
 FPL..... Federal Poverty Level  
 FPO..... Family Planning Option  
 FQHC..... Federally Qualified Health Centers  
 FUL..... Federal Upper Limit (for pricing & payment of drug claims)  
 GA..... General Assistance  
 GAO..... General Accounting Office  
 GC..... Global Commitment  
 GCR..... Global Clinical Record (application of the MMIS)  
 GF..... General Fund  
 GMC..... Green Mountain Care  
 GMCB..... Green Mountain Care Board  
 GME..... Graduate Medical Education  
 HAEU..... Health Access Eligibility Unit  
 HATF..... Health Access Trust Fund  
 HBE..... Health Benefit Exchange  
 HCBS..... Home and Community Based Services  
 HCERA..... Health Care & Education Reconciliation Act of 2010

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HCFA.....	Health Care Finance Administration (now CMS)	JCL.....	Job Control Language
HCPCS.....	HCFA Common Procedure Coding System	JFO.....	Joint Fiscal Office
HCR	Health Care Reform	LAMP.....	Legal Aid Medicaid Project
HEDIS.....	Healthcare Effectiveness Data & Information Set	LAN.....	Local Area Network
HHA.....	Home Health Agency	LC.....	Legislative Council
HHS.....	Health and Human Services (U.S. Department of)	LECC.....	Legally Exempt Child Care
HIE.....	Health Information Exchange	LIHEAP.....	Low-Income Home Energy Assistance Program
HIR.....	Hire into Range	LIS.....	Low-Income Subsidy
HIX	Health Insurance Exchange	LIT.....	Local Interagency Team
HIFA.....	Health Insurance Flexibility and Accountability	LTC.....	Long-Term Care
HIPAA.....	Health Insurance Portability & Accountability Act	LUPA.....	Low Utilization Payment Adjustment
HIPP.....	Health Insurance Premium Program	MA.....	Medicare Advantage – Medicare Part C in VT
HIT.....	Health Information Technology	MAB.....	Medicaid Advisory Board
HITECH	HIT for Economic & Clinical Health	MAC.....	Maximum Allowable Cost (refers to drug pricing)
HP.....	HP Enterprise Services, formerly EDS	MAGI	Modified Adjusted Gross Income
HPIU	Health Programs Integration Unit	MAPIR	Medicaid Assistance Provider Incentive Repository
HR.....	Health Reform	MARS.....	Management & Administrative Reporting
HRA.....	Health Risk Assessment	MAT.....	Medication Assisted Therapy
HRAP	Health Resource Allocation Plan	MCE.....	Managed Care Entity
HRSA.....	Health Resources and Services Administration	MCH.....	Maternal and Child Health
HSB.....	Human Services Board	MCMC.....	Managed Care Medical Committee
HVP.....	Healthy Vermonters Program	MCO.....	Managed Care Organization
IAPD.....	Implementation Advance Planning Document	MCP.....	Managed Care Plan
IBNR.....	Incurred But Not Reported	MDB.....	Medicare Database
IC.....	Individual Consideration	MEQC.....	Medicaid Eligibility Quality Control
ICD.....	International Classification of Diseases	MES.....	Medicaid Enterprise Solution
ICEHR	Integrated Care Electronic Health Record	MFP.....	Money Follows the Person
ICF/MR.....	Intermediate Care Facility for the Mentally Retarded	MFRAU.....	Medicaid Fraud & Residential Abuse Unit
ICM	Integrated Care Management	MID.....	Beneficiary Medicaid Identification Number (see UID)
ICN.....	Internal Control Number	MIC.....	Medicaid Integrity Contractor
ICU.....	Intensive Care Unit	MIG	Medicaid Integrity Group
ID.....	Identification	MIP	Medicaid Integrity Program
IDN.....	Integrated Delivery Network	MIS.....	Management Information System
IEP.....	Individual Education Plan	MITA.....	Medicaid Information Technology Architecture
IEVS.....	Income Eligibility Verification System	MMA.....	Medicare Modernization Act
IGA.....	Intergovernmental Agreements	MMIS.....	Medicaid Management Information System
IHI.....	Institute for Healthcare Improvement	MNF.....	Medical Necessity Form
IRS.....	Internal Revenue Service	MOE.....	Maintenance of Effort
IT.....	Information Technology	MOE.....	Maintenance of Eligibility
ITF.....	Integrated Test Facility	MOU.....	Memorandum of Understanding
IVS.....	Intervention Services	MOVE.....	Modernization of Vermont's Enterprise
		MSIS.....	Medicaid Statistical Information

MSP..... Medicare Savings Programs  
 MU..... Meaningful Use  
 MVP..... Mohawk Valley Physicians  
 NAMI..... National Association for Mental Illness  
 NCBD..... National CAHPS Benchmarking Database  
 NCCI..... National Correct Coding Initiative  
 NDC..... National Drug Code  
 NEKCA..... Northeast Kingdom Community Action  
 NEMT..... Non-Emergency Medical Transportation  
 NGA..... National Governors Association  
 NP..... Nurse Practitioner or Naturopathic Physician  
 NPA..... Non-Public Assistance  
 NPF..... National Provider File  
 NPI..... National Provider Identifier  
 OADAP..... Office of Alcohol & Drug Abuse Programs  
 OASDI..... Old Age, Survivors, Disability Insurance  
 OASIS..... Organization for the Advancement of Structured Information Standards  
 OCIO..... Office of Consumer Information and Insurance Oversight (CMS)  
 OCS..... Office of Child Support  
 ODAP..... Office of Drug & Alcohol Prevention  
 OEO..... Office of Economic Opportunity  
 OHRA..... Oral Health Risk Assessment  
 OLTP..... Online Transaction Processing  
 ONC..... Office of National Coordinator for HIT  
 OPS..... Operations  
 OPPS..... Outpatient Prospective Payment System  
 OTC..... Over the Counter  
 OVHA... Office of Vermont Health Access (now a department (DVHA)  
 PA..... Prior Authorization or Public Assistance  
 PA..... Physician Assistant  
 PACE..... Program for All-Inclusive Care for the Elderly  
 PAPD..... Planning Advanced Planning Document (CMS)  
 PARIS..... Public Assistance Reporting Information System  
 PATH..... Department of Prevention, Assistance, Transition, & Health Access (now DCF)  
 PBA/PBM... Pharmacy Benefits Administrator / Pharmacy Benefits Manager  
 PC Plus..... VT Primary Care Plus  
 PCCM..... Primary Care Case Management  
 PCIP..... Pre-existing Condition Insurance Plan  
 PCMH..... Patient-Centered Medical Home

PCP..... Primary Care Provider  
 PDF..... Portable Document File  
 PDL..... Preferred Drug List  
 PDP..... Prescription Drug Plan  
 PDSA..... Plan Do Study Act  
 PEP..... Proposal Evaluation Plan or Principal Earner Parent  
 PERM..... Payment Error Rate Measurement  
 PES..... Provider Electronic Solutions  
 PHO..... Physician Hospital Organization  
 PI..... Program Integrity  
 PIL..... Protected Income Level  
 PIRL..... Plan Information Request Letter  
 PM..... Project Manager  
 PMPM..... Per Member Per Month  
 PNMI..... Private Non-Medical Institution  
 POC..... Plan of Care or  
 ..... Public Oversight Commission  
 POS..... Point of Sale or Point of Service  
 PP&D..... Policy, Procedures and Development (Interpretive Rule Memo)  
 PPACA..... Patient Protection & Affordable Care Act  
 PPPM..... Per Patient Per Month  
 PPR..... Planning, Policy and Regulation  
 PRO..... Peer Review Organization  
 PRWORA..... Personal Responsibility & Work Opportunity Reconciliation Act  
 PSE..... Post-Secondary Education  
 PSTG..... Private Sector Technology Group  
 QC..... Quality Control  
 QHP..... Qualified Health Plan  
 QI..... Qualified Individual  
 QIAC..... Quality Improvement Advisory Committee  
 QMB..... Qualified Medicare Beneficiary  
 QWDI..... Qualified Working Disabled Individual  
 RA..... Remittance Advice  
 RAC..... Recovery Audit Contractor  
 RBC..... Risk Based Capital  
 RBUC..... Reported But Unpaid Claims  
 REVS..... Recipient Eligibility Verification System  
 RFI..... Request for Information  
 RFP..... Request for Proposals  
 RN..... Registered Nurse  
 RO..... Regional Office  
 RR..... Railroad Retirement  
 RU..... Reach Up program  
 RVU..... Relative Value Units  
 SAMHSA... Substance Abuse and Mental Health Services Administration

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SAS..... Statement on Auditing Standards  
 SASH ..... Support and Services at Home  
 SCHIP.....State Children’s Health Insurance  
           Program  
 SDO..... Standards Development Organization  
 SDX..... State Data Exchange System  
 SE ..... Systems Engineer  
 SEP..... Special Enrollment Periods  
 SF..... Supplemental Fuel  
 SFY ..... State Fiscal Year  
 SGF..... State General Fund  
 SHOP ..... Small Business Health Options Program  
 SILC ..... Statewide Independent Living Council  
 SLHIE ..... State Level HIE Consensus Project  
 SLMB..... Specified Low-Income Medicare  
           Beneficiary  
 SMDL     State Medicaid Directors Letter  
 SMHP     State Medicaid HIT Plan  
 SMM ..... State Medicaid Manual  
 SNAP ..... State Nutritional Assistance Program  
 SNF..... Skilled Nursing Facility  
 SOA..... Service Oriented Architecture  
 SPA ..... State Plan Amendment  
 SPAP..... State Pharmacy Assistance Program  
 SRS ..... Social & Rehabilitative Services  
           (Department of)  
 SSA..... Social Security Administration or  
           State Self Assessment  
 SSBG ..... Social Services Block Grant  
 SSI ..... Supplemental Security Income  
 SSN ..... Social Security Number  
 SSO..... Standards Setting Organization  
 SUR..... Surveillance & Utilization Review  
 TAD ..... Turnaround Documents  
 TANF ..... Temporary Assistance for Needy  
           Families (Reach Up in VT)  
 TARB ..... Technical Architecture Review Board  
 TBI..... Traumatic Brain Injury  
 TIN..... Taxpayer Identification Number  
 TM..... Transitional Medicaid  
 TPA ..... Third Party Administrator  
 TPL..... Third Party Liability  
 UC ..... Unemployment Compensation  
 UCR..... Usual & Customary Rate  
 UCUM ..... Unified Code for Units of Measure  
 UI..... Unemployment Insurance  
 UIB..... Unemployment Insurance Benefits  
 UID ..... Unique Identification Number  
 UM ..... Utilization Management  
 UMLS..... Unified Medical Language System  
 UR ..... Utilization Review

UVM.....University of Vermont  
 VA ..... Veterans Administration  
 VAB ..... VT Association for the Blind  
 VAHHA.....VT Assembly of Home Health  
           Agencies  
 VAHHS..... VT Association of Hospital & Health  
           Systems  
 VCCI.....Vermont Chronic Care Initiative  
 VCIL     Vermont Center for Independent Living  
 VDH.....VT Department of Health  
 VDHA .....VT Dental Hygienists Association  
 VHAP... ..VT Health Access Plan  
 VHAP-Rx.....VT Health Access Plan Pharmacy  
           Program  
 VHCURES VT Healthcare Claims Uniform  
           Reporting & Evaluation System  
 VIP.....VT Independence Project  
 VISION .....VT’s Integrated Solution for  
           Information and Organizational Needs  
           (the statewide accounting system)  
 VIT.....VT Interactive Television  
 VITL .....VT Information Technology Leaders  
 VLA.....VT Legal Aid  
 VMS.....VT Medical Society  
 VNA ..... Visiting Nurses Association  
 VPHARM ....VT Pharmacy Benefits Program  
 VPQHC.....VT Program for Quality in Health Care  
 VPTA.....Vermont Public Transportation Agency  
 VR.....Vocational Rehabilitation  
 VRS.....Voice Response System  
 VSA.....VT Statutes Annotated  
 VSAC.....VT Student Assistance Corporation  
 VScript.....VT Pharmacy Benefits Program  
 VSIDS .....VT State Dental Society  
 VSEA.....VT State Employees Association  
 VSECU.....VT State Employees Credit Union  
 VSH.....VT State Hospital  
 VSHA.....VT State Housing Authority  
 VT .....State of Vermont  
 VTD.....VT Part D as Primary  
 VTM .....VT Medicaid as Primary  
 VUL .....VT Upper Limit  
 WAC.....Wholesale Acquisition Cost  
 WIC .....Women, Infants & Children  
 WTW.....Welfare to Work

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Title XIX State Plan Groups			
Mandatory; Categorically Needy (Global Commitment Demonstration Population 1)			
Population Description	Green Mountain Care Group	Standards and Methodologies	Benefit Package
Section 1931 low-income families with children	Commonly referred to as Medicaid (for adults) and Dr. Dynasaur (for children)	AFDC standard and methodologies	<ul style="list-style-type: none"> <li>Inpatient hospital services</li> <li>Outpatient hospital services</li> <li>Rural health clinic services</li> <li>Federally qualified health center services</li> <li>Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services</li> <li>Laboratory and X-ray services</li> <li>Family planning services</li> <li>Physician services and Medical and Surgical Services of a Dentist</li> <li>Home health services</li> <li>Nurse Midwife services</li> <li>Nursing facility services Certified Pediatric and Family Nurse Practitioner Services</li> <li>Other Medical/Remedial Care Provided by Licensed Practitioners and Recognized under State Law (chiropractor, podiatrist, optometrist, licensed social worker, licensed mental counselor or licensed marriage and family therapist, psychologist, optician, hi-tech nursing, nurse practitioner, licensed lay midwife)</li> <li>Clinical Services</li> <li>Prescription drugs</li> <li>Diagnostic, Screening, Preventive and Rehabilitative Services</li> <li>Private duty nursing services</li> <li>Other Aids to Vision</li> <li>Dental Services</li> <li>Prosthetic Devices</li> <li>Physical and Occupational therapies, and services for Individuals with Speech, hearing and language disorder services</li> <li>Inpatient Hospital/Nursing Facility/ICF Services for Individuals 65 and Older in IMD</li> <li>ICF/MR Services</li> <li>Inpatient Psychiatric Services for Individuals Under 21</li> <li>Personal Care Services</li> <li>Case Management</li> <li>Respiratory Care for Ventilator Dependent Individuals</li> <li>Primary Care Case Management</li> <li>PACE</li> <li>Hospice</li> <li>Transportation Services</li> <li>Nursing Facility Services for Individuals Under Age 21</li> <li>Emergency Hospital Services</li> <li>Critical Access Hospital</li> <li>Traumatic Brain Injury; HCBS waiver –like services</li> <li>Mental Illness Under 22; HCBS waiver-like services</li> <li>Community Rehabilitation and Treatment; HCBS waiver-like services</li> <li>Developmental Services; HCBS waiver-like services</li> </ul>
Children receiving IV-E payments (IV-E foster care or adoption assistance)		AFDC standard and methodologies	
Individuals who lose eligibility under §1931 due to employment		AFDC standard and methodologies	
Individuals who lose eligibility under §1931 because of child or spousal support		AFDC standard and methodologies	
Individuals participating in a work supplementation program who would otherwise be eligible under §1931		AFDC standard and methodologies	
Individuals receiving SSI cash benefits		SSI standard and methodologies	
Disabled children no longer eligible for SSI benefits because of a change in definition of disability		SSI standard and methodologies	
Qualified severely impaired individuals (as defined in §1905(q))		SSI standard and methodologies	
Individuals under age 21 eligible for Medicaid in the month they apply for SSI		SSI standard and methodologies	
Qualified pregnant women		AFDC standard and methodologies	
Qualified children		AFDC standard and methodologies	
Poverty level pregnant women		Income ≤ to 185% of the FPL	
Poverty level infants		Income ≤ to 185% of the FPL	
Qualified family members		AFDC standard and methodologies	
Poverty level children under age six		Family income ≤ to 133% of FPL	
Poverty level children under age 19, who are born after September 30, 1983 (or, at State option, after any earlier date)		Family income ≤ to 100% of FPL	
Disabled individuals whose earnings exceed SSI substantial gainful activity level		SSI standard and methodologies	
Disabled individuals whose earnings are too high to receive SSI cash benefits		SSI standard and methodologies	
Pickle amendment: individuals who would be eligible for SSI if Title II COLAs were deducted from income (§503 of Public Law 94-566)		SSI standard and methodologies	
Disabled widows and widowers		SSI standard and methodologies	
Disabled adult children		SSI standard and methodologies	
Early widows/widowers		SSI standard and methodologies	
Individuals who would be eligible for AFDC except for increased OASDI income under P.L. 92-336 (July 1, 1972)		AFDC standards and methodologies	
Individuals receiving mandatory State supplements		SSI standard and methodologies	
Individuals eligible as essential spouses in December 1973		SSI standard and methodologies	
Institutionalized individuals who were eligible in December 1973		SSI standard and methodologies	
Blind and disabled individuals eligible in December 1973		SSI standard and methodologies	
Individuals who would be eligible except for the increase in OASDI benefits under Public Law 92-336		SSI standard and methodologies	
Individuals who become eligible for cash assistance as a result of OASDI cost-of- living increases received after April 1977	SSI standard and methodologies		
Individuals who become eligible for cash assistance as a result of OASDI cost-of- living increases received after April 1977	SSI standard and methodologies		
Newborns deemed eligible for one year			
Pregnant women who lose eligibility receive 60 days coverage for pregnancy-related & post partum services		Pregnancy related and post partum services under the State Plan	
Pregnant women losing eligibility because of a change in income remain eligible 60 days post partum		Pregnancy related and post partum services under the State Plan	
Poverty level infants and children receiving inpatient services who lose eligibility because of age must be covered through an inpatient stay		Inpatient hospital services	
Qualified Medicare Beneficiaries	Commonly referred to as QMBs	Medicare beneficiaries with income equal to 100% of the FPL	Payment of Medicare premiums, coinsurance, deductibles, and copayment except Part D copayment
Qualified Disabled and Working Individuals	Commonly referred to as QDWIs	Medicare beneficiaries with income equal to 200% of the FPL and not eligible for Medicaid	Payment of Medicare Part A premiums
Specified Low-Income Medicare Beneficiaries	Commonly referred to as SLMBs	Medicare beneficiaries with income between 100 and 120% of the FPL	Payment of Medicare Part B premiums
Qualifying Individuals	Commonly referred to as QIs	Medicare beneficiaries with income equal to 120% but < 135% of the FPL and not eligible for Medicaid	Payment of Medicare Part B premiums

\* This is not an exhaustive list of mandatory groups covered under the Vermont title XIX State plan. For a complete list, refer to the Vermont approved title XIX State plan.

Optional; Categorically Needy (Global Commitment Demonstration Population 2)			
Population Description	Green Mountain Care Group	Standards and Methodologies	Benefit Package
Individuals who are eligible for but not receiving IV-A, SSI or State supplement cash assistance	Commonly referred to as Medicaid (for adults) and Dr. Dynasaur (for children)		Same comprehensive benefit package as Global Commitment Demonstration Population 1
Individuals who could be eligible for IV-A cash assistance if State did not subsidize child care			
Individuals who are eligible for Title IV-A if State AFDC plan were as broad as allowed			
Individuals who would have been eligible for IV-A cash assistance, SSI, or State supplement if not in a medical institution			
<i>Special income level group:</i> individuals who are in a medical institution for at least 30 consecutive days with gross income that does not exceed 300% of the SSI income standard, or state-specified standard			
Individuals who are terminally ill, would be eligible if they were in a medical institution, and will receive hospice care			
Children under 21 (or at State option 20, 19, or 18) who are under State adoption agreements			
Poverty level pregnant women not mandatorily eligible			
Poverty level infants not mandatorily eligible			
Individuals receiving only an optional State supp. payment more restrictive than the criteria for an optional State supplement under title XVI			
Katie Beckett children			
Individuals under 18 who would be mandatorily categorically eligible except for income and resources			
Pregnant women who lose eligibility receive 60 days coverage for pregnancy-related and post partum services			
Blind and disabled individuals eligible in December 1973			
All individuals under 21 or at State option 20, 19, or 18 or reasonable classifications who would not be covered under mandatory medically needy group of individuals under 18			
Specified relatives of dependent children who are ineligible as categorically needy			
Aged individuals who are ineligible as categorically needy			
Blind individuals who are ineligible as categorically needy but meet the categorically needy definition of blindness			
Disabled individuals who are ineligible as categorically needy that meet the categorically needy definition of blindness			
Individuals receiving HCBS who would only be eligible for Medicaid under the State Plan if they were in a medical institution; individuals who were previously covered under a separate 1915(c) Demonstration. <ol style="list-style-type: none"> <li>1. TBI (traumatic brain injury)</li> <li>2. MI under 22 (Children's mental Health)</li> <li>3. MR/DD (Mental Retardation/Developmental Disabilities)</li> </ol>			
Pregnant women who would be categorically eligible except for income and resources			Pregnancy-related and Post-Partum Services under the State Plan

Expansion Populations			
VHAP Expansion Populations (Global Commitment Demonstration Populations 3-8)			
Population Description	Medicaid Eligibility Group	Standards and Methodologies	Benefit Package
Underinsured children with income between 225% and including 300% of FPL who are not eligible for Medicaid or CHIP	Commonly referred to as Medicaid (for adults) and Dr. Dynasaur (for children)	Children with income between 225% and up to and including 300% of FPL (with other insurance)	Same comprehensive benefit package as Global Commitment Demonstration Population 1 only if not covered by primary insurer.
Adults with children with income between 150% and up to and including 185% of the FPL	Commonly referred to as VHAP	Income between 150% and up to and including 185% of the FPL	<ul style="list-style-type: none"> <li>• Inpatient hospital services</li> <li>• Outpatient hospital services</li> <li>• Rural health clinic services</li> <li>• Federally qualified health center services</li> <li>• Laboratory and X-ray services</li> <li>• Family Planning Services and Supplies</li> <li>• Physician Services and Medical and Surgical Service of a Dentist</li> <li>• Home health services</li> <li>• Certified Pediatric and Family Nurse Practitioner services</li> <li>• Other Medical/Remedial Care Provided by Licensed Practitioners and Recognized under State Law (chiropractor, podiatrist, optometrist, licensed social worker, licensed mental counselor or licensed marriage and family therapist, psychologist, optician, hi-tech nursing, nurse practitioner, licensed lay midwife)</li> <li>• Clinical Services</li> <li>• Prescriptions Drugs</li> <li>• Diagnostic, Screening, Preventive and Rehabilitative Services</li> <li>• Physical and Occupational Therapies, and Services for Individuals with Speech, Hearing, and Language Disorders</li> <li>• Primary Care Case Management</li> <li>• Emergency Hospital Services</li> <li>• Critical Access Hospital</li> <li>• Nursing facility services</li> <li>• Nurse Midwife services</li> <li>• Respiratory care services</li> <li>• Hospice</li> </ul>
Adults with income up to and including 150% of the FPL	Commonly referred to as VHAP	Income up to and including 150% of the FPL	
Medicare beneficiaries and non-Medicare individuals who are 65 years or older or have a disability with income at or below 150% of the FPL	Prescription Assistance Pharmacy Only Program	Income at or below 150 percent of the FPL	Medicaid Prescriptions, eyeglasses and related eye exams
Medicare beneficiaries and non-Medicare individuals who are 65 years or older or have a disability with income above 150% and ≤ 225% of the FPL	Prescriptions Assistance Pharmacy Only Program	Income below 225 percent of the FPL	Maintenance Drugs
Individuals with persistent mental illness with income up to and including 150% of the FPL		Income up to and including 150 percent of the FPL	Day services, diagnosis and evaluation services, emergency care, psychotherapy, group therapy, chemotherapy, specialized rehabilitative services
Premium Assistance Expansion Populations** (Global Commitment Demonstration Population 9 and 10)			
ESI Premium Assistance			
Adults with children with income between 185% and up to and including 300% of the FPL	Commonly referred to as ESI Premium Assistance	Income between 185% and up to and including 300% of the FPL	Premium assistance to purchase ESI. The benefits covered by the plan must be substantially similar to the benefits offered by the Catamount Health Premium Assistance.
Childless adults with income between 150% and up to and including 300% of the FPL	Commonly referred to as ESI Premium Assistance	Income between 150% and up to and including 300% of the FPL	Premium assistance to purchase ESI. The benefits covered by the plan must be substantially similar to the benefits offered by the Catamount Health Premium Assistance.
Catamount Health Premium Assistance			
Adults with children with income between 185% and up to and including 300% FPL	Commonly referred to as Catamount Health	Income between 185% and up to and including 300% of the FPL	Premium assistance to purchase the Catamount Health. Comprehensive benefit as prescribed in Catamount State statute
Childless adults with income between 150% and up to and including 300% of the FPL	Commonly referred to as Catamount Health	Income between 150% and up to and including 300% of FPL	Premium assistance to purchase Catamount Health. Comprehensive benefit as prescribed in Catamount State statute
Population Description	Medicaid Eligibility Group	Standards and Methodologies	Benefit Package
Individuals covered under the Vermont Section 1115 Choices for Care Demonstration not receiving CRT services	Subset of Medicaid for Long-Term Care Services	See Department of Aging and Independent Living	See Department of Aging and Independent Living
Children's Health Insurance Program (CHIP) eligibles	Commonly referred to as Dr. Dynasaur	Income from 225% and up to and including 300% of FPL	Same comprehensive benefit package as Global Commitment Demonstration Population 1



## Program Expenditures SFY 2012 & SFY 2013 Governor's Recommend w/ Funding Description

Medicaid Budget SFY 2013

Insert 3

PROGRAM EXPENDITURES							
	SFY '12 Appropriated		SFY '12 BAA		SFY '13 Gov. Rec.		SFY '12 Funding Description
	Gross Expenses	State Funds	Gross Expenses	State Funds	Gross Expenses	State Funds	
<b>Adults</b>							
Aged, Blind, or Disabled (ABD)/Medically Needy	\$ 103,481,068	\$ 43,606,922	\$ 96,357,476	\$ 40,605,040	\$ 99,883,344	\$ 43,519,173	Global Commitment funded - g.f. @ 43.57%, federal @ 56.43%
Dual Eligibles	\$ 48,295,234	\$ 20,351,612	\$ 45,630,298	\$ 19,228,608	\$ 47,882,946	\$ 20,862,600	Global Commitment funded - g.f. @ 43.57%, federal @ 56.43%
General	\$ 68,941,637	\$ 29,052,006	\$ 67,198,737	\$ 28,317,548	\$ 70,737,344	\$ 30,820,261	Global Commitment funded - g.f. @ 43.57%, federal @ 56.43%
VHAP	\$ 171,453,467	\$ 72,250,491	\$ 158,466,885	\$ 66,777,945	\$ 160,785,409	\$ 70,054,203	Global Commitment funded - g.f. @ 43.57%, federal @ 56.43%
VHAP ESI	\$ 2,527,600	\$ 1,065,131	\$ 1,845,490	\$ 777,689	\$ 2,005,682	\$ 873,876	Global Commitment funded - g.f. @ 43.57%, federal @ 56.43%
Catamount	\$ 52,477,439	\$ 22,113,993	\$ 50,668,256	\$ 21,351,603	\$ 62,002,768	\$ 27,014,606	Global Commitment funded - g.f. @ 43.57%, federal @ 56.43%
ESIA	\$ 1,845,731	\$ 777,791	\$ 1,845,758	\$ 777,802	\$ 2,270,715	\$ 989,351	Global Commitment funded - g.f. @ 43.57%, federal @ 56.43%
<b>Subtotal Adults</b>	<b>\$ 449,022,177</b>	<b>\$ 189,217,945</b>	<b>\$ 422,012,899</b>	<b>\$ 177,836,236</b>	<b>\$ 445,568,209</b>	<b>\$ 194,134,069</b>	
<b>Children</b>							
Blind or Disabled (BD)/Medically Needy	\$ 35,172,968	\$ 14,821,889	\$ 35,895,708	\$ 15,126,451	\$ 35,556,239	\$ 15,491,853	Global Commitment funded - g.f. @ 43.57%, federal @ 56.43%
General	\$ 125,147,519	\$ 52,737,164	\$ 119,002,701	\$ 50,147,738	\$ 122,178,332	\$ 53,233,099	Global Commitment funded - g.f. @ 43.57%, federal @ 56.43%
Underinsured	\$ 942,371	\$ 397,115	\$ 731,951	\$ 308,444	\$ 674,907	\$ 294,057	Global Commitment funded - g.f. @ 43.57%, federal @ 56.43%
SCHIP (Uninsured)	\$ 7,429,724	\$ 2,191,026	\$ 7,112,126	\$ 2,097,366	\$ 7,534,112	\$ 2,297,904	Title XXI - g.f. @ 30.50% and federal @ 69.5%
<b>Subtotal Children</b>	<b>\$ 168,692,581</b>	<b>\$ 70,147,194</b>	<b>\$ 162,742,486</b>	<b>\$ 67,680,000</b>	<b>\$ 165,943,589</b>	<b>\$ 71,316,914</b>	
<b>Pharmacy Only Programs</b>	<b>\$ 4,540,342</b>	<b>\$ 3,064,372</b>	<b>\$ 4,614,498</b>	<b>\$ 3,007,676</b>	<b>\$ 4,763,952</b>	<b>\$ 3,288,401</b>	100% g.f. for +/- 43% of program; bal. is Global Commitment as above
<b>Choices for Care</b>							
Nursing Home, Home & Community Based, ERC	\$ 173,331,521	\$ 73,041,903	\$ 178,032,945	\$ 75,023,083	\$ 174,812,771	\$ 76,165,924	g.f. @ 43.57%, federal @ 56.43%
Acute-Care Services - OVHA	\$ 27,997,571	\$ 11,798,177	\$ 22,502,654	\$ 9,482,619	\$ 22,065,338	\$ 9,613,868	g.f. @ 43.57%, federal @ 56.43%
Acute-Care Services - Other Depts.	\$ 1,328,969	\$ 560,027	\$ 1,557,346	\$ 656,266	\$ 1,704,031	\$ 742,446	g.f. @ 43.57%, federal @ 56.43%
Buy-In	\$ 2,631,615	\$ 1,108,962	\$ 2,764,610	\$ 1,165,007	\$ 2,658,158	\$ 1,158,159	g.f. @ 43.57%, federal @ 56.43%
<b>Subtotal Choices for Care*</b>	<b>\$ 205,289,676</b>	<b>\$ 86,509,069</b>	<b>\$ 204,857,556</b>	<b>\$ 86,326,974</b>	<b>\$ 201,240,298</b>	<b>\$ 87,680,398</b>	
<b>Subtotal Direct Services</b>	<b>\$ 827,544,776</b>	<b>\$ 348,938,580</b>	<b>\$ 794,227,439</b>	<b>\$ 334,850,886</b>	<b>\$ 817,516,048</b>	<b>\$ 356,419,780</b>	
<b>Miscellaneous Program</b>							
GC to CFC Funding Reallocation	\$ (1,328,969)	\$ (560,027)	\$ (1,557,346)	\$ (656,266)	\$ (1,704,031)	\$ (742,446)	Global Commitment funded - g.f. @ 43.57%, federal @ 56.43%
Refugee	\$ 220,950	\$ -	\$ 311,284	\$ -	\$ 436,455	\$ -	100% federally reimbursed
ACA Federal Rebate	\$ (6,646,867)	\$ -	\$ (4,854,102)	\$ -	\$ (5,026,587)	\$ -	100% federally reimbursed
Civil Union or Marriage	\$ 55,880	\$ 23,548	\$ 33,220	\$ 13,999	\$ 39,937	\$ 17,401	MCO Investments - g.f. @ 43.57%, federal @ 56.43%
HIV	\$ 894,479	\$ 376,933	\$ 1,061,163	\$ 447,174	\$ 1,313,758	\$ 572,404	MCO Investments - g.f. @ 43.57%, federal @ 56.43%
DSH	\$ 37,448,781	\$ 15,885,773	\$ 37,448,781	\$ 15,885,773	\$ 37,448,781	\$ 16,462,484	43.96% g.f. and 56.04% federal
Clawback	\$ 23,892,185	\$ 23,892,185	\$ 24,019,167	\$ 24,019,167	\$ 25,755,735	\$ 25,755,735	100% g.f.
Buy-In - GC	\$ 28,280,673	\$ 11,917,476	\$ 29,647,139	\$ 12,493,305	\$ 30,964,845	\$ 13,491,383	Global Commitment funded - g.f. @ 43.57%, federal @ 56.43%
Buy-In - State Only (MCO Invest.)	\$ 131,204	\$ 55,289	\$ 55,666	\$ 23,458	\$ 61,232	\$ 26,679	MCO Investments - g.f. @ 43.57%, federal @ 56.43%
Buy-In - Federal Only	\$ 4,094,581	\$ -	\$ 3,845,526	\$ -	\$ 4,048,016	\$ 1,763,721	100% federally reimbursed
Legal Aid	\$ 547,983	\$ 230,920	\$ 547,983	\$ 230,920	\$ 547,983	\$ 238,756	Global Commitment funded - g.f. @ 43.57%, federal @ 56.43%
Misc. Pymts.	\$ 666,195	\$ 280,734	\$ 30,000,000	\$ 12,642,000	\$ 32,005,915	\$ 13,944,977	Global Commitment funded - g.f. @ 43.57%, federal @ 56.43%
Healthy Vermonters Program	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
<b>Subtotal Miscellaneous Program</b>	<b>\$ 88,257,075</b>	<b>\$ 52,102,831</b>	<b>\$ 120,558,481</b>	<b>\$ 65,099,529</b>	<b>\$ 125,892,039</b>	<b>\$ 71,531,094</b>	
<b>TOTAL PROGRAM EXPENDITURES</b>	<b>\$ 915,801,850</b>	<b>\$ 401,041,411</b>	<b>\$ 914,785,920</b>	<b>\$ 399,950,415</b>	<b>\$ 943,408,088</b>	<b>\$ 427,950,874</b>	

ADMINISTRATIVE EXPENDITURES							
	SFY '12 Appropriated		SFY '12 BAA		SFY '13 Gov. Rec.		
	Gross Expenses	State Funds	Gross Expenses	State Funds	Gross Expenses	State Funds	
<b>Contract</b>							
Claims Processing	\$ 11,771,672	\$ 4,960,583	\$ 11,059,656	\$ 4,660,539	\$ 11,059,656	\$ 4,818,692	Most admin. expenses are funded with: Global Commitment funds - g.f. @ 43.57%, federal @ 56.43% and Title XXI funds (30.50% g.f. and 69.50% federal)  Miscellaneous Includes the \$15M HIX which is 100% federal  Blended based on enhanced federal opportunities (match = s.f.)  10% g.f. and IDT; 90% federal  100% Global Commitment funds - GF @ 43.57%
Member Services	\$ 2,932,427	\$ 1,235,725	\$ 2,826,436	\$ 1,191,060	\$ 2,576,436	\$ 1,122,553	
Pharmacy Benefits Manager	\$ 3,205,195	\$ 1,350,669	\$ 2,975,343	\$ 1,253,810	\$ 2,975,343	\$ 1,296,357	
Care Coordination & Chronic Care Management	\$ 2,670,032	\$ 1,125,151	\$ 2,670,032	\$ 1,125,151	\$ 2,670,032	\$ 1,163,333	
Catamount Outreach	\$ 500,000	\$ 210,700	\$ 500,000	\$ 210,700	\$ 500,000	\$ 217,850	
Miscellaneous	\$ 2,798,285	\$ 1,179,197	\$ 3,324,644	\$ 1,401,005	\$ 19,384,644	\$ 1,933,129	
Health Information Technology/Healthcare Reform	\$ 8,379,691	\$ -	\$ 9,019,691	\$ -	\$ 23,745,881	\$ 3,193,313	
MITA/MOVE	\$ 47,537,564	\$ 4,753,756	\$ 47,537,564	\$ 4,753,756	\$ 47,537,564	\$ 4,753,756	
Blueprint & Payment Reform	\$ 4,149,932	\$ 1,748,781	\$ 4,009,932	\$ 1,689,785	\$ 4,009,932	\$ 1,747,127	
<b>Operating/Personnel Services</b>	<b>\$ 12,247,198</b>	<b>\$ 5,160,969</b>	<b>\$ 7,974,050</b>	<b>\$ 3,360,265</b>	<b>\$ 17,204,405</b>	<b>\$ 6,030,925</b>	
<b>Total Administrative Expenses</b>	<b>\$ 96,191,996</b>	<b>\$ 21,725,532</b>	<b>\$ 91,897,348</b>	<b>\$ 19,646,072</b>	<b>\$ 131,663,893</b>	<b>\$ 26,277,037</b>	
<b>TOTAL ALL EXPENDITURES</b>	<b>\$ 1,011,993,846</b>	<b>\$ 422,766,943</b>	<b>\$ 1,006,683,267</b>	<b>\$ 419,596,486</b>	<b>\$ 1,075,071,981</b>	<b>\$ 454,227,911</b>	

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# History of Program Expansions July 1994 – December 2008

