

Re: Revised OVHA Medicaid Budget Document SFY 2011

Date: February 4, 2010

The Office of Vermont Health Access (OVHA) has revised the **Medicaid Budget State Fiscal Year 2011** to clarify some areas. No budget figures (dollars) are revised or changed. This revision expands on and enhances information provided in the original document. Please note that the revision date of 02/04/2010 is indicated in the footer of the document and the main budget document, without reference materials, is expanded from 51 pages to 56 pages.

A Summary of Changes is provided below. Previously printed versions may be updated by:

- replacing pages 7/8 with revised pages 7/8 and
- replacing pages 23 through 51 with revised pages 23 through 56

Summary of changes:

Page 7

Reductions: Nursing Homes – Cut rate paid for 4 of the lowest case mix scores by 50% is changed to read:

Nursing Homes – Reduce 4 of the lowest case-mix weights by 50%.

Pages 23 – 41 (now pages 23 to 46)

This section, titled **GOVERNOR'S RECOMMENDED POLICY INITIATIVES**, has changes to the following initiatives:

Limit PT/OT/ST Visits to 30 per year (page 23/new page 23; additional information)

Prior Authorization for Selected Radiology Services (page 23/new pages 24-25 ; additional information)

Reduce Drug Testing Lab Reimbursement Rates (page 24/new page 26; **The estimated cost of this urine test is \$1.03 per unit** is changed to read:

The estimated cost of the supplies for this urine test is \$1.03 per unit)



Eligibility Determination Quality Control (page 25-26/new pages 27-28 ; As such, OVHA and DCF are jointly proposing to add 6 FTEs from the Human Resource position pool to the DCF QC/Fraud Unit with an estimated savings for SFY '11 of \$2,563,780 is changed to read:

As such, OVHA and DCF are jointly proposing to add 2.3 FTEs from the Human Resources position pool to the DCF QC/Fraud Unit to focus on health care eligibility with an estimated savings for SFY '11 of \$2,563,780.

And additional information)

Reduce AWP on Drugs Historically Overfunded (pages 27-28/new pages 29-32; additional information)

Limit Emergency Room Services to 12 per Year (page 34/new page 37; additional information)

Enhance Program Integrity Activity (pages 35-37/new pages 39-42; additional information page 37 and chart replaced)

Adult Dental Cap Decrease (page 40/new page 45; additional information)

Changes in DDAIL Rates and Rules (page 41/new page 46; additional information)

Pages 42 through 51, now pages 47 to 56 (new page numbers only)

Program Cost Comparison (Insert 2; changes to Enrollment counts for Choices for Care program)

OFFICE of VERMONT HEALTH ACCESS

**MEDICAID BUDGET
STATE FISCAL YEAR 2011**

REVISION DATE 02/04/2010

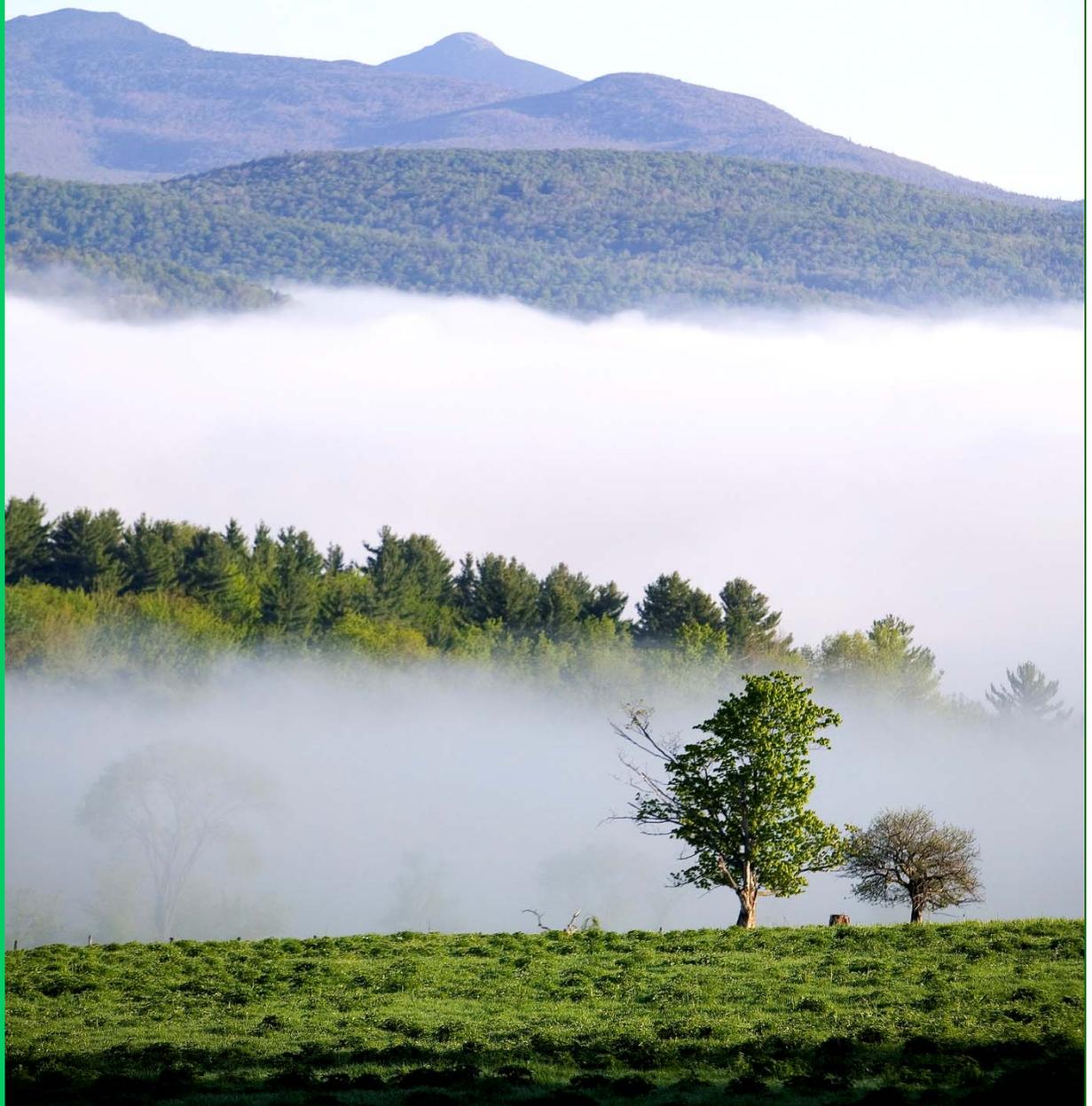


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| CATEGORY OF SERVICE (COS) | INSERT 3 |
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FAST FACTS

| | |
|--|----------------------|
| The Governor's Recommend for SFY 2011: | \$916,396,516 |
| Number of covered lives in Vermont's publicly funded health insurance programs (excluding Healthy Vermonters): | 173,087 |
| Number of children included in the above: | 64,651 |
| Number of OVHA employees: | 88.2 |
| Rank in State of Vermont's programmatic expenditure: | Largest |
| Rank as insurer in Vermont: | Largest |
| Comparison in dollars spent: | First |
| Comparison in number of covered lives: | Second |
| Percentage of Vermont's population receiving some or all of health care cost benefit: | 28% |
| Number of enrolled providers: | 11,216 |
| Claims processed annually: | 9,374,991 |
| Percentage of claims received electronically: | 90% |
| Percentage of all claims processed within 30 days: | 99.5% |
| Average time from claim receipt to provider payment: | 9 days |
| Average number of calls to Member Services per month: | 31,000 |
| Average number of calls handled by staff per day: | 1400 |
| Average time to wait to speak with a live person: | 27 seconds |
| Calls answered by a live person within 2 minutes: | 97% of time |
| Expected 2011 health care expenditures for Vermont residents*: | \$5.5 billion |

*Per BISHCA's 2007 Expenditure Analysis and 3-year forecast

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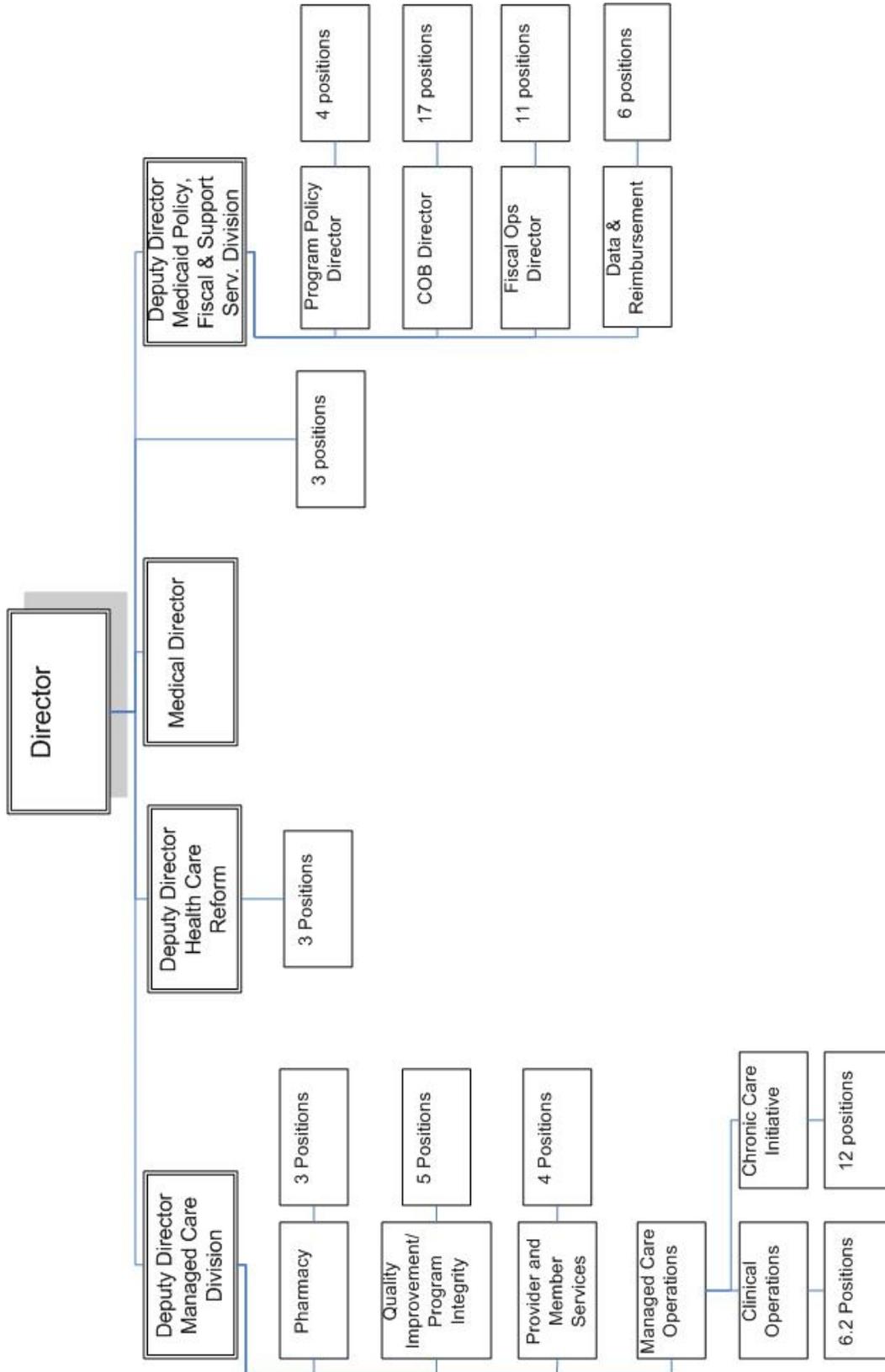
802-879-5900

Fax

802-879-5651

Websitewww.ovha.vermont.gov**Additional Resources**Vermont Health Care Reform
www.hcr.vermont.govVermont Medicaid
www.vtmedicaid.comGreen Mountain Care
www.greenmountaincare.orgVermont Chronic Care Initiative
www.vtccmp.com

ORGANIZATIONAL CHART



| OVHA - Med Prog-non-GC LTC Waiver-As Passed FY10 | 61,072,899 | 119,767,105 | 22,465,253 | 203,305,257 |
|---|-------------------|-------------|---------------------|--------------------|
| Rescissions: | | | | |
| Contract & Grant disc reduction Sec. B-1104 | 9,738 | | | 9,738 |
| Total Rescissions | 9,738 | 0 | 0 | 9,738 |
| Total After FY10 Rescission | 61,082,637 | 0 | 22,465,253 | 203,314,995 |
| FY10 After Rescission | | | | |
| Both Traditional & Acute: | | | | |
| 53rd EDS pmt | 2,081,148 | 3,426,020 | 327,832 | 5,835,000 |
| Traditional: | | | | |
| Pressures: | | | | |
| Traditional LTC share: ARRA e-FMAP reduced 1/2 | 9,541,907 | | (9,541,907) | 0 |
| NH Inflation 3% approx | 1,008,000 | 1,644,020 | 147,980 | 2,800,000 |
| NH - Add 3% est increase on OOS, Crossover, Swing | 74,999 | 123,302 | 11,799 | 210,000 |
| NH - Case mix creep in post rebase year | 641,999 | 1,056,870 | 101,131 | 1,800,000 |
| Increases in Consumer Directed Unemployment & WC costs | 69,777 | 114,869 | 10,992 | 195,638 |
| Nursing Home extraordinary financial relief | 535,106 | 880,901 | 84,292 | 1,500,300 |
| Reductions: | | | | |
| Nursing Homes - Reduce 4 of the lowest case-mix weights by 50% | (285,333) | (468,720) | (44,947) | (800,000) |
| HCBS - Modify rules to change reimbursement from 15 minute units to monthly rate of \$50. | (108,380) | (178,417) | (17,072) | (303,869) |
| HCBS - Reduce home health agency-directed Personal Care Attendant rate from \$26.15/hr to \$22/hr | (692,522) | (1,140,041) | (109,089) | (1,941,652) |
| HCBS - Modify rules to change reimbursement from 15 minute units to \$110 monthly rate for HB case management services | (151,941) | (250,127) | (23,934) | (426,002) |
| HCBS - Modify rules to lighten personal care variances; maintain variance in service hours for respite and companion services. | (208,217) | (342,771) | (32,799) | (583,787) |
| HCBS - Flexible Choices option, change procedures to reduce authorized budgets and actual expenditures by 10%. Eliminate annual carryover of unspent funds. | (90,316) | (148,680) | (14,227) | (253,224) |
| HCBS - Modify regulations to reduce case management for Enhanced Residential Care participants to 3 hours/year. | (8,806) | (14,497) | (1,387) | (24,690) |
| OVHA - Long Term Care - Continued | | | | |
| Acute: | | | | |
| Buy-in rate increase | 139,801 | 230,142 | 22,022 | 391,965 |
| Acute share: ARRA e-FMAP reduced 1/2 | 1,690,720 | | (1,690,720) | 0 |
| Acute: caseload - assume no increase in home-based caseload | 0 | 0 | 0 | 0 |
| Acute - utilization | (998,048) | (1,627,691) | (155,480) | (2,781,219) |
| FMAP adjustment | 197,068 | (395,982) | 198,914 | 0 |
| FY11 Changes | 13,436,863 | 0 | (10,725,602) | 5,618,459 |
| FY11 Gov Recommended | 74,519,500 | 0 | 11,738,651 | 208,933,454 |
| FY11 Legislative Changes | 0 | 0 | 0 | 0 |
| FY11 Subtotal of Legislative Changes | 0 | 0 | 0 | 0 |
| FY11 As Passed - Dept ID 3410016000 | 74,519,500 | 0 | 11,738,651 | 208,933,454 |

| OWHA - Medicaid Program - State Only - As Passed FY10 | 28,195,859 | 3,318,828 | 1,510,264 | 33,024,951 |
|---|--------------------|-------------------|--------------------|--------------------|
| Rescissions: | | | | |
| Use FY09 GF carryforward | (1,196,067) | | | (1,196,067) |
| CMS approval for Vpharm in GC waiver | (2,666,906) | | | (2,666,906) |
| Total Rescissions | (3,862,973) | 0 | 0 | (3,862,973) |
| Total After FY10 Rescission | 24,332,886 | 0 | 1,510,264 | 29,161,978 |
| FY10 After Rescission | | | | |
| Grants: | | | | |
| One-time carry-forward funds rescinded as on going | 1,196,067 | | | 1,196,067 |
| Clawback Increase | 1,301,613 | | | 1,301,613 |
| Annualization of Vpharm in waiver | (2,415,819) | | | (2,415,819) |
| Annualization of Catamount in waiver | | (3,318,828) | | (3,318,828) |
| Civil Union & HIV Caseload | | | 256,639 | 256,639 |
| Civil Union & HIV Utilization | | | (132,954) | (132,954) |
| Buy-in rate increase | | | 75,560 | 75,560 |
| FY11 Changes | 81,861 | 0 | 0 | (3,037,722) |
| FY11 Gov Recommended | 24,414,747 | 0 | 1,709,509 | 26,124,256 |
| FY11 Subtotal of Legislative Changes | 0 | 0 | 0 | 0 |
| FY11 As Passed - Dept ID 3410017000 | 24,414,747 | 0 | 1,709,509 | 26,124,256 |
| OWHA - Medicaid Matched NON Waiver Expenses - As Passed FY10 | 16,976,310 | 28,515,058 | 1,060,380 | 46,551,748 |
| FY10 After Rescission | | | | |
| Grants: | | | | |
| Correct DSH appropriation related to ARRA funding | 1,060,380 | | | 1,060,380 |
| CHIP Caseload | 469,790 | | | 469,790 |
| CHIP Utilization | 170,064 | | | 170,064 |
| Refugee Caseload & Utilization | 195,473 | | | 195,473 |
| Buy-in rate increases | 512,441 | | | 512,441 |
| FMAP Changes - multiple - DSH and CHIP | (34,246) | | | (34,246) |
| FY11 Changes | 292,559 | 0 | 0 | (1,060,380) |
| FY11 Gov Recommended | 17,268,869 | 0 | 30,888,960 | 48,157,829 |
| FY11 Subtotal of Legislative Changes | 0 | 0 | 0 | 0 |
| FY11 As Passed - Dept ID 3410018000 | 17,268,869 | 0 | 30,888,960 | 48,157,829 |
| TOTAL FY10 OVHA Big Bill As Passed | 106,874,175 | 400,000 | 151,130,621 | 264,404,796 |
| TOTAL FY10 OVHA Reductions/Rescissions | (3,862,973) | 0 | (3,736,872) | (7,599,845) |
| TOTAL FY11 OVHA Starting Point | 102,811,776 | 400,000 | 151,130,621 | 254,342,401 |
| TOTAL FY11 OVHA ups & downs | 14,941,283 | 2,616,174 | 15,317,101 | 32,874,558 |
| TOTAL FY11 OVHA Gov Recommended | 117,753,059 | 3,016,174 | 166,447,722 | 227,216,955 |
| TOTAL FY11 OVHA Legislative Changes | 0 | 0 | 0 | 0 |
| TOTAL FY11 OVHA As Passed | 117,753,059 | 3,016,174 | 166,447,722 | 227,216,955 |

Budget Considerations SFY 2011

January 20, 2010

The Office of Vermont Health Access (OVHA) budget request includes an increase in administration of \$14,976,742 and in program of \$68,456,055 for a total of \$83,432,797 in new appropriations (i.e., a combination of new funds and new expenditure authority). Because it is essential that OVHA consider budget impacts at both an appropriation-specific level and by unique expenditure drivers (such as caseload and utilization), it is sometimes difficult to reconcile testimony to the submitted up/downs. Therefore, we have provided the ups/downs at the beginning of this document and refer you to the last page that details the total increases which match this narrative.

ADMINISTRATION \$14,976,742 (gross)

PERSONAL SERVICES \$801,913

Payact and Related Fringe \$426,913

New Positions to Implement Savings Initiatives \$375,000

Several policy savings initiatives (described in detail on the following pages) require additional staff in order to achieve the estimated reduction in expenditures. The additional full-time-equivalents (FTEs) that will be obtained from the Human Resources position pool are as follows:

HIPP Expansion (1 FTE) \$ 60,000

Program Integrity Expansion (3 FTEs) \$240,000

Transportation Quality Control (1 FTE) \$ 75,000

OPERATING (\$50,845)

The OVHA receives allocations from BGS to cover our share of the Vision system and 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 '11 it is anticipated that for the OVHA, Vision costs will decrease by \$45,834 and DII costs will decrease by \$14,142. Additionally, it is projected that OVHA will have a \$9,131 increase in workers' compensation expenditures.

GRANTS AND CONTRACTS\$14,225,674**The MOVE Initiative (one-time) \$11,150,000**

The Modernization of Vermont's Enterprise, also known as MOVE, is a project to replace key Agency of Human Services (AHS) information systems related to eligibility (current ACCESS) and claims processing (current MMIS system).

The eligibility and MMIS systems are at the heart of supporting health care and other human services systems in Vermont. Transmission of case information from ACCESS to the MMIS is the basis for verifying entitlement to services for beneficiaries and processing Medicaid claims. Incorrect determinations can result in improper service provision and incorrect claim payment.

The current ACCESS system was installed in 1983. This system was modeled and designed on the IT rules of the late 1970's. The MMIS, which supports care management tracking and claims, was built in 1992 and last certified by the Center for Medicare and Medicaid Services (CMS) in 1993. As such,

- Programmers able to work on these types of systems are rare.
- Changes in the system have to occur sequentially, not simultaneously.
- Rather than supporting our efforts, the current systems are often a roadblock.

In addition, CMS requires that states replace their MMIS every 5 to 7 years. Vermont has received its last "pass" by CMS - we must have a new MMIS in place by 2013.

Funds for completion of the ACCESS system replacement (called VIEWS) are being requested through the Capital Budget Bill process. As such, the request in OVHA's proposed SFY '11 budget is specific to continuing the efforts to replace the MMIS.

There are three contractual processes associated with receiving this federal match:

- The technical assistance (TA) contractor is responsible for providing consultative services to the State and assist with planning and development of CMS documents (such as funding requests) and Request for Proposal (RFP) efforts (such as producing the RFP and evaluating the proposals). The State is in final contract negotiations with the TA vendor.
- The Design, Develop and Implementation (DDI) contractor is responsible for developing and/or configuring the desired system as it was specified in the requirements which the TA contractor produced. This RFP is expected to be released in June, 2010.
- The Independent Verification and Validation (IV&V) contractor acts as an independent 3rd party assessor providing quality assurance and validates that the work provided by the DDI contractor is in sync with State and CMS expectations as defined in the RFP and the approved contract. This RFP is expected to be released in June, 2010.

CMS will provide 90% federal matching funds for MMIS procurement. Following is the financial detail related to this budget request:

| Dollars represented in millions | 2010 | | | 2011 | | | 2012 | | | 2013 | | | Total SFY 2010 thru 2013 | | |
|-----------------------------------|---------|---------|---------|---------|---------|---------|--------|---------|---------|--------|---------|---------|--------------------------|---------|---------|
| | State | Fed. | Total | State | Fed. | Total | State | Fed. | Total | State | Fed. | Total | State | Fed. | Total |
| MMIS TA | \$0.090 | \$0.810 | \$0.900 | \$0.210 | \$1.890 | \$2.10 | | | | | | | \$0.30 | \$2.70 | \$3.00 |
| MMIS DDI | | | | \$1.00 | \$9.00 | \$10.00 | \$3.50 | \$31.50 | \$35.00 | \$3.50 | \$31.50 | \$35.00 | \$8.00 | \$72.00 | \$80.00 |
| MMIS IV&V | | | | \$0.10 | \$0.90 | \$1.00 | \$0.20 | \$1.80 | \$2.00 | \$0.20 | \$1.80 | \$2.00 | \$0.50 | \$4.50 | \$5.00 |
| OVHA Budget Need | \$0.090 | \$0.810 | \$0.900 | \$1.31 | \$11.79 | \$13.10 | \$3.70 | \$33.30 | \$37.00 | \$3.70 | \$33.30 | \$37.00 | \$8.80 | \$79.20 | \$88.00 |
| Funding in OVHA Base Budget | \$0.195 | \$1.755 | \$1.950 | \$0.20 | \$1.76 | \$1.95 | \$1.31 | \$11.79 | \$13.10 | \$3.70 | \$33.30 | \$37.00 | | | |
| OVHA Incr./(Decr.) to Base Budget | \$0 | \$0 | \$0 | \$1.12 | \$10.04 | \$11.15 | \$2.39 | \$21.51 | \$23.90 | \$0 | \$0 | \$0 | | | |
| OVHA Total Budget Need | \$0.195 | \$1.755 | \$1.950 | \$1.31 | \$11.79 | \$13.10 | \$3.70 | \$33.30 | \$37.00 | \$3.70 | \$33.30 | \$37.00 | | | |

Movement of HIT Program Management from DII \$2,955,674

During state fiscal year 2009, Healthcare Reform responsibilities transferred from the Agency of Administration to OVHA. In addition, Act 61 of 2009 transferred responsibility for statewide health information technology strategic planning, coordination and oversight from VITL to OVHA, and management of the Health Information Technology (HIT) fund (and related granting activities with VITL) from the Department of Information and Innovation to OVHA. The requested increase of \$2,887,101 reflects the estimated receipts for the Health Information Technology Fund plus other revenues appropriated for VITL.

In addition, language was inadvertently omitted when the original VITL statute was repealed and then re-written in Act 61 of 2009 to reflect new VITL responsibilities. The following language will enable the State to continue its grant relationship with VITL. (Note: This statutory change was also included in our SFY '10 Budget Adjustment Act request).

18 V.S.A. chapter 219 § 9352 is amended to add the underlined sentence:

(c) Health information exchange operation. VITL shall be designated in the health information technology plan pursuant to section 9351 of this title to operate the exclusive statewide health information exchange network for this state. The secretary of administration or designee shall enter into procurement grant agreements with VITL pursuant to § 4089k of Title 8. Nothing in this chapter shall impede local community providers from the exchange of electronic medical data.

VHCURES Data Feed \$ 120,000

These funds will support OVHA's costs associated with data submission, processing, consolidation and reporting related to participation in the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES) administered by BISHCA.

PROGRAM \$68,456,055 (gross)

UPDATED TREND CHANGES \$98,376,751

Caseload and Utilization Impact \$86,669,035

Caseload \$75,951,892

It is evident that the impact of economic pressures felt across the country is directly affecting the Medicaid caseload rolls. This holds true for virtually all Medicaid eligibility groups. Following is a summary chart that represents adjustments between SFY '10 appropriated and the newest consensus caseload estimates:

| | SFY '07 Actuals | SFY '08 Actuals | SFY '09 Actuals | SFY '10 | | SFY '11 Gov. | SFY '11 Chg. From SFY '10 | |
|-----------------------------|-----------------|-----------------|-----------------|--------------|-------------|--------------|---------------------------|---------|
| | # | # | # | Appropriated | SFY '10 BAA | Rec. | Approp. | % |
| ABD/Medically Needy Adults | 11,330 | 11,797 | 12,550 | 12,400 | 13,184 | 13,866 | 1,466 | 11.82% |
| Dual Eligibles Adults | 14,073 | 14,185 | 14,753 | 14,681 | 15,111 | 15,536 | 855 | 5.82% |
| General Adults | 9,327 | 9,255 | 9,847 | 9,333 | 10,297 | 10,786 | 1,453 | 15.57% |
| VHAP | 22,404 | 24,771 | 28,224 | 30,023 | 32,429 | 36,862 | 6,839 | 22.78% |
| VHAP ESI | - | 276 | 821 | 1,215 | 1,195 | 1,564 | 349 | 28.75% |
| Catamount | - | 1,730 | 6,350 | 9,277 | 9,081 | 10,379 | 1,102 | 11.88% |
| ESIA | - | 132 | 478 | 630 | 710 | 2,413 | 1,784 | 283.25% |
| BD/Medically Needy Children | 3,398 | 3,487 | 3,605 | 3,660 | 3,680 | 3,771 | 111 | 3.03% |
| General Children | 51,187 | 50,664 | 52,224 | 51,037 | 53,863 | 55,631 | 4,594 | 9.00% |
| Underinsured Children | 1,186 | 1,138 | 1,212 | 1,170 | 1,248 | 1,282 | 112 | 9.61% |
| SCHIP | 3,070 | 3,278 | 3,412 | 3,559 | 3,721 | 3,966 | 407 | 11.44% |
| Pharmacy Only Programs | 12,952 | 12,737 | 12,456 | 12,498 | 12,659 | 12,580 | 82 | 0.66% |

Utilization \$10,717,143

Utilization increases are due to increased use of healthcare services over the previous year by beneficiaries. This is an expected effect year over year and can be demonstrated most notably by reviewing Insert 3 at the back of this document which is the category of service listing showing historical spending patterns with relevant changes year over year.

Green Mountain Care

Green Mountain Care is the umbrella name for the state-sponsored family of low-cost and free health coverage programs for uninsured and underinsured 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 individuals, 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 covers most health care services such as doctor visits, hospital care, prescription medicines, vision and dental care, long-term care, physical therapy and more. Medicaid is a low-cost program, and costs may include co-payments of \$3 for outpatient visits and dentist visits; co-payments of \$1-\$3 for prescription medicines; and \$75 for an inpatient admission.

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 ABD 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 Medicaid 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 '11 for ABD and/or Medically Needy Adults:

| Aged, Blind, & Disabled (ABD) and/or Medically Needy Adults | | | |
|---|----------|---------------|-----------|
| SFY | Caseload | Expenditures | P.M.P.M. |
| SFY '08 Actual | 11,797 | \$ 72,515,067 | \$ 512.24 |
| SFY '09 Actual | 12,550 | \$ 82,398,879 | \$ 547.15 |
| SFY '10 Appropriated | 12,400 | \$ 87,391,435 | \$ 587.32 |
| SFY '10 Budget Adjustment | 13,184 | \$ 80,842,468 | \$ 510.97 |
| SFY '11 Governor's Recommend | 13,866 | \$ 88,506,243 | \$ 531.93 |

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; expenditures exclude buy-in and clawback.

The following table depicts the caseload and expenditure information by SFY, including the Governor's Recommend for SFY '11 for Dual Eligibles:

| Dual Eligibles | | | |
|------------------------------|----------|---------------|-----------|
| SFY | Caseload | Expenditures | P.M.P.M. |
| SFY '08 Actual | 14,185 | \$ 35,614,807 | \$ 209.23 |
| SFY '09 Actual | 14,753 | \$ 38,596,281 | \$ 218.02 |
| SFY '10 Appropriated | 14,681 | \$ 42,783,829 | \$ 242.85 |
| SFY '10 Budget Adjustment | 15,111 | \$ 42,040,322 | \$ 231.85 |
| SFY '11 Governor's Recommend | 15,536 | \$ 43,787,312 | \$ 234.88 |

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 '11 for General Adults:

| General Adults | | | |
|------------------------------|----------|---------------|-----------|
| SFY | Caseload | Expenditures | P.M.P.M. |
| SFY '08 Actual | 9,255 | \$ 43,797,118 | \$ 394.36 |
| SFY '09 Actual | 9,847 | \$ 53,060,215 | \$ 449.06 |
| SFY '10 Appropriated | 9,333 | \$ 51,435,872 | \$ 459.27 |
| SFY '10 Budget Adjustment | 10,297 | \$ 55,295,379 | \$ 447.51 |
| SFY '11 Governor's Recommend | 10,786 | \$ 59,173,662 | \$ 457.17 |

Vermont Health Access Plan (VHAP)

The general eligibility requirements for the Vermont Health Access Plan (VHAP) are: 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 a wide range of services including hospital care, prescription medicines, mental health and doctor visits.

The following table depicts the caseload and expenditure information by SFY, including the Governor's Recommend for SFY '11 for VHAP:

| VHAP | | | |
|------------------------------|----------|----------------|-----------|
| SFY | Caseload | Expenditures | P.M.P.M. |
| SFY '08 Actual | 24,771 | \$ 89,891,925 | \$ 302.40 |
| SFY '09 Actual | 28,224 | \$ 111,730,898 | \$ 329.89 |
| SFY '10 Appropriated | 30,023 | \$ 118,932,948 | \$ 330.12 |
| SFY '10 Budget Adjustment | 32,429 | \$ 122,905,750 | \$ 315.83 |
| SFY '11 Governor's Recommend | 36,862 | \$ 148,458,099 | \$ 335.62 |

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 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 table depicts the caseload and expenditure information by SFY, including the Governor's Recommend for SFY '11 for VHAP Employer-Sponsored Insurance (ESI) Premium Assistance:

| VHAP ESI | | | |
|------------------------------|----------|--------------|-----------|
| SFY | Caseload | Expenditures | P.M.P.M. |
| SFY '08 Actual | 276 | \$ 571,218 | \$ 172.63 |
| SFY '09 Actual | 821 | \$ 1,525,747 | \$ 154.95 |
| SFY '10 Appropriated | 1,215 | \$ 3,146,430 | \$ 215.84 |
| SFY '10 Budget Adjustment | 1,195 | \$ 2,389,512 | \$ 166.61 |
| SFY '11 Governor's Recommend | 1,564 | \$ 4,172,221 | \$ 222.30 |

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 at a reasonable cost no matter how much an individual earns. The intent of this program is to reduce the number of uninsured citizens of Vermont. Help is also available in paying premiums, based on income. Premium subsidies are available to those who fall at or below 300% of the federal poverty level (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);
- 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;
- Do not have access to insurance through their employer.

Uninsured Vermonters can get help with paying premiums depending on income when:

- Access is not available to comprehensive health insurance through their employer as determined by the state; or
- 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 employer's plan; or
- Waiting for the open enrollment period to enroll in employer's plan.

Benefits include doctor visits, check-ups and screenings, hospital visits, emergency care, chronic disease care, prescription medicines and more.

Premium assistance is available for Catamount Health based on income and eligibility. Monthly premiums range from \$60-\$393 based on income, office visit co-payments are \$10, prescriptions range from \$10-\$50 and deductibles are \$250 for individuals and \$500 for families (in network).

The following table depicts the caseload and expenditure information by SFY, including the Governor's Recommend for SFY '11 for Catamount Health:

| Catamount Health | | | |
|------------------------------|----------|---------------|-----------|
| SFY | Caseload | Expenditures | P.M.P.M. |
| SFY '08 Actual | 1,730 | \$ 7,995,765 | \$ 385.15 |
| SFY '09 Actual | 6,350 | \$ 30,293,232 | \$ 397.55 |
| SFY '10 Appropriated | 9,277 | \$ 50,124,827 | \$ 450.27 |
| SFY '10 Budget Adjustment | 9,081 | \$ 44,329,429 | \$ 406.79 |
| SFY '11 Governor's Recommend | 10,379 | \$ 49,765,094 | \$ 399.57 |

Catamount Employer-Sponsored Insurance Premium Assistance

The following table depicts the caseload and expenditure information by SFY, including the Governor's Recommend for SFY '11 for Catamount Employer-Sponsored Insurance (ESI) Premium Assistance:

| ESIA | | | |
|------------------------------|----------|--------------|-----------|
| SFY | Caseload | Expenditures | P.M.P.M. |
| SFY '08 Actual | 132 | \$ 168,977 | \$ 106.81 |
| SFY '09 Actual | 478 | \$ 688,592 | \$ 120.17 |
| SFY '10 Appropriated | 630 | \$ 1,095,532 | \$ 144.99 |
| SFY '10 Budget Adjustment | 710 | \$ 1,247,392 | \$ 146.50 |
| SFY '11 Governor's Recommend | 2,413 | \$ 4,512,365 | \$ 155.82 |

Dr. Dinosaur

Dr. Dinosaur is the umbrella name that encompasses all of the health care coverage 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, 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 Medicaid 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 ’11 for BD and/or Medically Needy Children:

| Blind or Disabled and/or Medically Needy Children | | | |
|---|----------|---------------|-----------|
| SFY | Caseload | Expenditures | P.M.P.M. |
| SFY '08 Actual | 3,487 | \$ 27,775,036 | \$ 663.78 |
| SFY '09 Actual | 3,605 | \$ 31,686,636 | \$ 732.47 |
| SFY '10 Appropriated | 3,660 | \$ 33,942,009 | \$ 772.74 |
| SFY '10 Budget Adjustment | 3,680 | \$ 31,709,593 | \$ 718.12 |
| SFY '11 Governor's Recommend | 3,771 | \$ 33,052,202 | \$ 730.34 |

General Children

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

The following table depicts the caseload and expenditure information by SFY, including the Governor’s Recommend for SFY ’11 for General Children:

| General Children | | | |
|------------------------------|----------|----------------|-----------|
| SFY | Caseload | Expenditures | P.M.P.M. |
| SFY '08 Actual | 50,664 | \$ 90,807,988 | \$ 149.36 |
| SFY '09 Actual | 52,224 | \$ 100,299,806 | \$ 160.05 |
| SFY '10 Appropriated | 51,037 | \$ 105,463,098 | \$ 172.20 |
| SFY '10 Budget Adjustment | 53,863 | \$ 103,396,604 | \$ 159.97 |
| SFY '11 Governor's Recommend | 55,631 | \$ 111,652,406 | \$ 167.25 |

Underinsured Children

The general eligibility requirements for Underinsured Children are: up to age 18 and up to 300% FPL; 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 ’11 for Uninsured Children:

| Underinsured Children | | | |
|------------------------------|----------|--------------|----------|
| SFY | Caseload | Expenditures | P.M.P.M. |
| SFY '08 Actual | 1,138 | \$ 742,529 | \$ 54.39 |
| SFY '09 Actual | 1,212 | \$ 721,162 | \$ 49.61 |
| SFY '10 Appropriated | 1,170 | \$ 894,887 | \$ 63.74 |
| SFY '10 Budget Adjustment | 1,248 | \$ 696,455 | \$ 46.50 |
| SFY '11 Governor's Recommend | 1,282 | \$ 755,915 | \$ 49.12 |

State Children's Health Insurance Program (SCHIP)

The general eligibility requirements for SCHIP: uninsured, up to age 18 and up to 300% 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 '11 for the State Children's Health Insurance Program (SCHIP):

| SCHIP (Uninsured) | | | |
|------------------------------|----------|--------------|-----------|
| SFY | Caseload | Expenditures | P.M.P.M. |
| SFY '08 Actual | 3,278 | \$ 4,462,004 | \$ 113.42 |
| SFY '09 Actual | 3,412 | \$ 5,386,841 | \$ 131.56 |
| SFY '10 Appropriated | 3,559 | \$ 5,523,528 | \$ 129.34 |
| SFY '10 Budget Adjustment | 3,721 | \$ 5,648,299 | \$ 126.50 |
| SFY '11 Governor's Recommend | 3,966 | \$ 6,421,696 | \$ 134.93 |

Prescription Assistance Pharmacy Only Programs

Vermont currently has several prescription assistance programs to help Vermonters pay for prescription medicines based on income, disability status and age. These programs include:

VPharm 1, 2 and 3 assist Vermonters who are enrolled in Medicare Part D with paying for prescription medicines. This includes people age 65 and older as well as people of all ages with disabilities. There is also an affordable monthly premium based on income.

VHAP-Pharmacy helps Vermonters age 65 and older and people with disabilities who are not enrolled in Medicare pay for eye exams and prescription medicines for short-term and long-term medical problems and includes an affordable monthly premium.

VScript helps Vermonters age 65 and older and people of all ages with disabilities who are not enrolled in Medicare pay for prescription medicines for long-term medical problems. There is also an affordable monthly premium based on income.

VScript Expanded helps Vermonters age 65 and older and people of all ages with disabilities who are not enrolled in Medicare pay for maintenance drugs where the manufacturers have agreed to pay Vermont a rebate. There is also an affordable monthly premium based on income.

The following table depicts the caseload and expenditure information by SFY, including the Governor's Recommend for SFY '11 for the Pharmacy Programs:

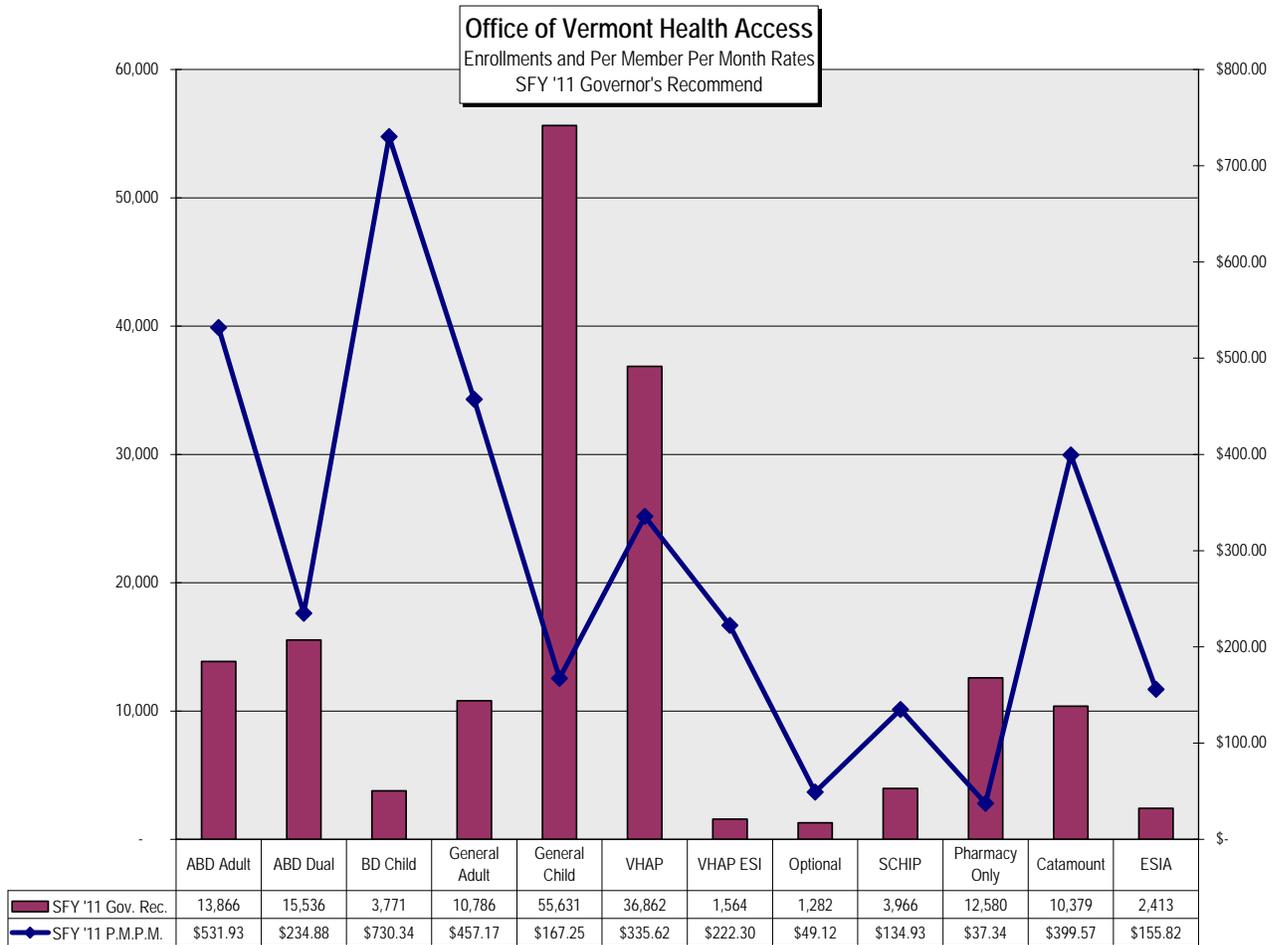
| Pharmacy Only Programs | | | |
|------------------------------|----------|--------------|----------|
| SFY | Caseload | Expenditures | P.M.P.M. |
| SFY '08 Actual | 12,737 | \$ 8,052,596 | \$ 52.69 |
| SFY '09 Actual | 12,456 | \$ 7,535,743 | \$ 50.42 |
| SFY '10 Appropriated | 12,498 | \$ 6,513,896 | \$ 43.43 |
| SFY '10 Budget Adjustment | 12,659 | \$ 1,399,166 | \$ 9.21 |
| SFY '11 Governor's Recommend | 12,580 | \$ 5,637,397 | \$ 37.34 |

Healthy Vermonters provides a discount on short-term and long-term prescription medicines. There are no monthly premiums and eligibility is based on family income.

The following table depicts the caseload and expenditure information by SFY, including the Governor's Recommend for SFY '11 for the Healthy Vermonters Program:

| Healthy Vermonters Program | | | |
|------------------------------|----------|--------------|----------|
| SFY | Caseload | Expenditures | P.M.P.M. |
| SFY '08 Actual | 5,781 | \$ - | \$ - |
| SFY '09 Actual | 4,843 | \$ - | \$ - |
| SFY '10 Appropriated | 9,211 | \$ - | \$ - |
| SFY '10 Budget Adjustment | 4,782 | \$ - | \$ - |
| SFY '11 Governor's Recommend | 4,676 | \$ - | \$ - |

Enrollments and Per Member Per Month Rates SFY 2011



Increase in Clawback Rates \$1,301,613

The Medicare Modernization Act (MMA) was signed into law on December 8, 2003. On January 1, 2006, after many months of preparation, 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.

Increase in Buy-In Rates \$4,639,029

The federal government allows states to use Medicaid dollars to “buy-in” to Medicare on behalf of eligible beneficiaries who would otherwise be fully covered by Medicaid programs. Notice was provided by CMS that the rate of reimbursement for such was increasing from \$96.40 per month to \$110.50.

To DDAIL for Indiv. Service Agreements & Bridges (\$2,000,000)

The OVHA and Department of Disabilities, Aging, and Independent Living (DDAIL) have entered into an interdepartmental agreement whereby DDAIL will individually wrap beneficiaries who traditionally received Medicaid services. These funds are being transferred to DDAIL to add additional beneficiaries under this arrangement.

Transfer From DCF for FIT & From VDH for CSHN Programs \$736,007

Historically VDH billed for Medicaid services on behalf of contractors providing services related to the Family Infant Toddler program (managed by DCF) and the Children with Special Healthcare Needs program (managed by VDH). These costs were recognized by the respective departments through an appropriation that resided at VDH. Effective this year, providers will be billing Medicaid directly for Medicaid eligible services and the respective departments directly for services covered by federal grants. This change shifts the expenses from VDH to OVHA.

53rd Week of Claims Payments. \$5,835,000

All claims are processed through HP Enterprise Services, our Medicaid Management Information System (MMIS) contractor. These claims are paid on a weekly basis. On occasion, the timing of these payments results in a 53rd week of expenditures. This anomaly existed last fiscal year for most claims; though nursing home claims flow into this state fiscal year.

One-Time Carry-Forward Funding Rescinded as Ongoing \$1,196,067

OVHA underspent its SFY '09 state-only appropriation by \$1,196,067 and requested permission to carry these funds forward into SFY '10 to address potential budget pressures if provider rate reductions were delayed and / or caseload expanded more

than expected. The need for such, however, did not come to fruition. These one-time funds were therefore rescinded in August 2009 and were inadvertently included as a base reduction for SFY '11. As such, we need this reduction reversed.

GOVERNOR’S RECOMMENDED POLICY INITIATIVES (\$29,920,696)
Limit PT/OT/ST Visits to 30 per Year (\$135,572)

Currently there are no limits imposed on the number of physical, occupational or speech therapy visits (PT/OT/ST) an individual can receive in a given year. Other state Medicaid programs impose visit limits on these benefits (e.g., Massachusetts, New Hampshire, Wisconsin, and Washington). Likewise, private industry standards in Vermont limit the number of visits to 30 visits per calendar year for combined PT/OT/ST, excluding services provided by home health agencies. OVHA is proposing to institute this same standard for adult beneficiaries. However, OVHA will monitor PT/OT/ST use to identify beneficiaries that may exceed the combined 30 visit limit. Once a beneficiary has been identified as potentially exceeding the visit limit, OVHA registered nurses and physical therapists in the Clinical Operations Department will work collaboratively with the treating provider to identify if there are alternative treatment approaches that are in line with evidenced-based guidelines that could be equally or more effective. The combined strategy will be employed with the goals of reducing utilization while concurrently ensuring quality of care.

Approximately 6,700 unique adults accessed these PT/OT/ST services in SFY 2009. Of those, only 200 people actually had in excess of 30 visits (less than 3%). The majority of these services are provided either by Independent Physical Therapists (52%) or within Hospital Outpatient Services (46%).

The five (5) most frequent diagnosis descriptions for beneficiaries that exceeded the 30 combined visit limit are listed below, along with the range or **maximum** number of visits recommended by each resource:

| <u>Diagnosis</u> | <u>APTA Guide to Best Practice*</u> | <u>Interqual Criteria*</u> |
|-------------------------|-------------------------------------|----------------------------|
| • Joint pain (shoulder) | 6-36 depending on diagnosis | max. 24 |
| • Cervicalgia | 6-36 depending on diagnosis | max. 32 |
| • Lumbago | 6-36 depending on diagnosis | max. 32 |
| • Rotator cuff sprain | 3-36 | max. 32 |
| • Backache NOS | 6-36 depending on diagnosis | max. 32 |

Many of these “diagnoses” do not specify the underlying condition but are instead a description of pain in a particular location. The pain may be caused by any one of a number of disorders and tissue types, and each of these may result in the need for a different amount of treatment. Given that it would be highly unusual for individuals to have the most severe condition, 30 appears to be a reasonable number of visits for the vast majority of individuals for these five (5) diagnoses as well as for most of the other diagnoses that were submitted for beneficiaries that exceed the proposed visit limitation.

**The American Physical Therapy Association Guide to Physical Therapy Best Practice and the McKesson Interqual Criteria are used to determine appropriate length of treatment per diagnosis. Both provide a range, dependent upon the severity of the condition and the needs of the individual client. Their methods of grouping diagnoses are different; every effort has been made to align them in the above Table. The Physical Therapy Best Practice guide was used because the top 5 diagnoses are commonly treated by Physical Therapists.*

Prior Authorization for Selected Radiology Services (\$2,000,000)

Private insurance carriers and other state Medicaid programs (e.g., Alabama, Colorado, Louisiana, Maine, Minnesota, Missouri, New Hampshire, Oklahoma, and Rhode Island) require prior authorization for high cost, high-volume outpatient elective radiology services to facilitate the use of more appropriate or lower cost tests where clinically applicable. Currently no prior authorizations are required by OVHA for these radiology services. Using evidenced-based guidelines and subject matter experts, OVHA proposes to require a prior authorization for:

- Computerized axial tomography scans (CT) and CT Angiography (CTA)
- Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiogram (MRA)
- Positron Emission Tomography (PET) and PET/CT

The following will NOT be subject to prior authorization:

- The above imaging procedures performed during an inpatient admission or emergency room visit
- All ultrasounds and mammograms

Prior Authorization Guidelines will be available on-line and also will be given to providers during the implementation of the program. In SFY '09, approximately 19,000 beneficiaries received these hi-tech imaging services, with a total annual cost of approximately \$9,540,000.

External radiology vendors provided presentations to OVHA clinical and operations staff on their radiology programs. Additionally, the OVHA Medical Director spoke to Medical Directors in other states that have implemented radiology programs to assess their overall satisfaction with the radiology programs. Overall, OVHA found that all of the radiology programs had high levels of satisfaction both pre and post implementation as reported by independent 3rd party evaluation companies (>95%). One of the program vendors that had extensive Medicaid experience had a 100% provider satisfaction rating and retention rating. Programs that had the highest provider satisfaction and retention rates shared the following qualities, and OVHA will incorporate these in our authorization process.:

1. Pre-Implementation Provider Training: Vendors and States established a communication plan that ensured understanding of the program design in order to overcome resistance in the provider community. The communication plans entailed: numerous mailings describing the program and face-to-face or web-directed educational seminars; quick reference guide covering the details of the program; web portal instructions and an overview of the prior authorization process. Additionally, vendors in collaboration with the State entity hosted meetings with key groups including the Medical Society, Hospital Association, and Radiological Society to help them feel comfortable with the program.

2. Quick and Easy Approval Process: All of the vendors offered providers the option of submitting requests through web portals, telephone for real-time responses, or via fax or mail.

- a. Web Portal: Provides significant functionality for providers to conduct nearly all of their interactions through a secure internet connection. Decisions are typically instantaneous.
- b. Telephone: Prior authorization submissions are received via telephone by intake coordinators that collect and record request information and either provide an approval or escalate the request to a nurse reviewer.
- c. Fax and Mail: Submissions received via fax occur through a designated 800 number or by mail.

3. Ongoing Provider Education: Vendors generally provide general ongoing education options for providers and targeted education tailored specifically to provider needs. Additionally Board certified specialists utilize the peer-to-peer discussions as the prime opportunity for education as well as discussing recent study findings and evidence based-rationales while explaining alternate options for treatment and diagnosis.

Reduce Drug Testing Lab Reimbursement Rates (\$110,000)

In SFY '09, approximately 7,991 beneficiaries received urine drug testing to test for the presence of illegal drugs, for a total Medicaid expenditure of \$6,253,667. The estimated cost of the supplies for this urine test is \$1.03 per unit. Vermont's current rates of Medicaid reimbursement are \$17.49 to independent laboratories, \$10.84 for outpatient laboratories, and \$10.49 for inpatient laboratories. New York Medicaid pays \$1.25, Massachusetts \$13.81, and New Hampshire \$15.22. All of these states have only one rate of reimbursement. This proposal would set on standard rate of reimbursement for Vermont at \$10.49.

Reduce # of Urine Drug Tests Allowed to 8/Month (\$450,000)

Currently there are no limitations in place on how many urine drug tests can be performed for a beneficiary in any given time period. For example, some Vermonters have these checks done daily. However, according to SAMSHA (Substance Abuse and Mental Health Services Administration) guidelines "...each new patient is asked to provide one random urine sample per week for the first six months and samples less frequently thereafter, based on treatment progress." In addition, SAMSHA's guideline for Opioid Treatment Programs (OTP) references the following regulation:

42 CFR § 8.12(f) (6) Drug abuse testing services. OTPs must provide adequate testing or analysis for drugs of abuse, including at least eight random drug abuse tests per year, per patient, in maintenance treatment, in accordance with generally accepted clinical practice. For patients in short-term detoxification treatment, the OTP shall perform at least one initial drug abuse test. For patients receiving long-term detoxification treatment, the program shall perform initial and monthly random tests on each patient.

As such, we are proposing to limit reimbursement of claims for urine tests provided by professionals, independent laboratories and outpatient hospitals to 8 tests per month for OVHA beneficiaries, which still far exceeds the SAMSHA regulation and guidelines. We have developed this proposal in collaboration with the Department of Health Division of Alcohol and Drug Abuse Programs (ADAP) to ensure this new policy is in compliance with their programs. By imposing this limit, the State of Vermont would see an annual savings of \$450,000.

Eligibility Determination Quality Control (\$2,563,780)

The Economic Services Division (ESD) of the Department for Children and Families (DCF) conducts all eligibility determinations regarding applications for state-supported financial and health care benefits. There are over 200 eligibility categories for health care programs alone, and as such, the eligibility determination process is very complex. This complexity is augmented by the extremely out-dated ACCESS system that is used for automated eligibility determinations.

The public must be confident that state-sponsored health care programs are providing support to those who are in need and are protected from abuse. Similarly, those who benefit from the system must know that accuracy and integrity are critical in these programs and that systems are in place to identify errors or abuses. As such, the ESD Quality Control/ /Fraud Unit *monitors* the accuracy and legitimacy of eligibility determinations to prevent inaccurate eligibility determinations before they are made; *detects* inaccurate determinations through the use of data matches, quality control reviews to ensure that program rules are being followed, and full and random audits; *deters* fraud through investigations, public reporting on high profile cases, and establishing and enforcing significant consequences for individuals committing intentional program violations; and *recovers* misspent dollars from all of the above activities.

DCF has conducted these functions to varying degrees over the years. Some are driven by state interest and commitment in program integrity. Some are driven by federal requirements. In recent years, the “Improper Payments Act” created extensive new requirements which the state has been required to attend to.

Until the fall of 2009, the QC/Fraud Unit had been staffed with a Program Manager, six staff dedicated to quality control (i.e., random sampling of eligibility across all programs), and five staff dedicated to fraud (i.e., running data matches looking for problems and pursuing concerns about individual situations). However, five staff members of this team retired during the fall of 2009; three of these were able to be filled and two were eliminated. Since these staff departed, enforcement activities particularly related to data matches have been suspended, and new requirements and opportunities from the federal government to complete intrastate matches, etc. are taking effect. We also believe that increased scrutiny will enable the state to identify beneficiaries who may be enrolled in the wrong program based on income or who may have access to Medicare but are not enrolled. For example, in the latter case, accurate eligibility determination would result in full reimbursement by OVHA instead of full Medicare payment for Low-In come Subsidy (LIS) eligibles, or partial cost sharing with Medicare.

Enhancing this capacity could result in substantial savings that can provide support to sustain our health care programs and ensure that Vermonters are getting access to the programs they are eligible for. As such, OVHA and DCF are jointly proposing

to add 2.3 FTEs from the Human Resources position pool to the DCF QC/Fraud Unit to focus on health care eligibility, with an estimated savings for SFY '11 of \$2,563,780. As we embark on expanded efforts, it is important to note that savings will not continue to expand each year. Once these efforts are in effect, fraud and abuse should diminish. Savings will come primarily from prevention and cost avoidance as opposed to recouping dollars from fraudulent actions. Specifically, these savings will be achieved in the following ways.

- Assuring beneficiaries are eligible for the correct healthcare program (e.g., people eligible for Medicare are enrolled in Medicare and/or in the appropriate Medicare program)
- Following-up on questionable income eligibility identified through the re-instituted DOL Wage Match
- Following-up on questionable income eligibility identified through the newly available National Database of New Hires W4 Match
- Following-up on the newly evadible PARIS (Public Assistance Reporting Information System) match for duplicate benefits in multiple states
- Increasing investigations regarding suspect eligibility information, such as unreported income and resources, family size, etc.

Reduce AWP on Drugs Historically Overfunded (\$3,389,429)

Reimbursement for pharmaceuticals must reflect the true costs of the drugs and not artificially inflated prices.

The U.S. District Court for the District of Massachusetts entered a Final Order and Judgment approving a class action settlement that involved two major publishers of drug pricing information, First Databank and Medispan, the most-widely used publishers of prescription drug prices in the United States. First Databank and Medispan were found to have conspired with McKesson Corp. to fraudulently increase the published price of a third of the most widely used brand-name prescription drugs by 5% since 2002, raising pharmacies' profits. This was accomplished through arbitrarily increasing the markups between what pharmacies pay wholesalers for prescription drugs (Wholesale Acquisition Cost or WAC) and what health insurers pay pharmacies, which is based on the Average Wholesale Price (AWP). This difference, or "spread," represents the pharmacy's profit. The lawsuits alleged, and the Court agreed, that McKesson colluded with these two publishers to inflate these prices in order to raise profits for pharmacies, many of which were McKesson customers. The lawsuit settlement calls for McKesson to pay \$350 million, and for First Databank and Medispan to reduce the AWP effective September 26, 2009, so the mark-up will be no greater than WAC plus 20%.

During the rule-making process in Summer and Fall 2009 regarding changes to the pharmacy programs approved during the 2009 Legislative Session, OVHA proposed to roll-back our reimbursement rate to reflect this illegally inflated pricing. However, because this was perceived as a provider rate change, the Legislative Committee on Administrative Rules did not believe it had the authority to consider this change. As such, OVHA made the pharmacies whole with respect to the lawsuit adjustment by changing the AWP on national drug codes impacted by the settlement. That is, Pharmacies are still getting reimbursed by OVHA at a rate that includes the inflated pricing.

The OVHA estimates that 18,860 national drug codes (NDCs) are affected. Of those, in SFY '09, 12,242 are prescription NDCs, with the remainder being for Over-the-Counter medicines and supplies not generally paid through the OVHA pharmacy benefit programs. Of the 12,242 prescription NDCs, OVHA had utilization for 2,020 (or 16.5%) during the 2nd calendar quarter of 2009; of all the Vermont Medicaid claims paid during the 2nd calendar quarter of 2009, 35% were processed using the AWP methodology. The remaining 65% were paid at MAC, FUL or U&C. Based on these data, if OVHA accepts the AWP reimbursement rate to reflect the intent of the lawsuit, the estimated savings to the Medicaid program for SFY'11 is \$3,389, 429.

Following is an illustration comparing Vermont's reimbursement prior to the court settlement and what it would be with the proposed AWP revision, compared with the reimbursement pharmacies receive through Vermont's commercial market. For ease of illustration, AWP was set to equal \$100. As can be seen, even with the

increase in OVHA's AWP discount to accomplish the 2% provider rate reduction in SFY '10, the Medicaid program reimbursement is higher than Vermont's commercial insurers. If the AWP adjustment is applied, OVHA is competitive with the commercial market.

As indicated by the Table below (which represents the most recent 6 months), two-thirds (66%) of the pharmacy reimbursement is made to Chain Pharmacies, while less than one-quarter (24.4%) is for Vermont Independent Pharmacies. Using this as a proxy, approximately 25% (\$847,357) of the impact of the \$3,389,429 gross savings due to the proposed AWP adjustment would be experienced by these Vermont Independent pharmacies, out of an estimated total annual payment of \$33.75 million.

| Pharmacy Type | Number of Pharmacies | Rx's | OVHA Paid | % of Total |
|------------------------------|----------------------|------------------|------------------------|----------------|
| Independent -In State | 42 | 332,339 | \$16,872,233.95 | 24.40% |
| Independent-Out of State | 15 | 752,277 | \$281,097.28 | 0.45% |
| Chain | 143 | 752,277 | \$45,479,164.59 | 65.77% |
| Franchise | 1 | 15,606 | \$694,516.32 | 1.00% |
| Alternate Dispensing Site | 9 | 14,783 | \$1,336,090.25 | 1.93% |
| Other | 17 | 12,893 | \$4,486,582.93 | 6.49% |
| Total | 227 | 1,880,175 | \$69,149,685.32 | 100.04% |

DATE RANGE: MOST RECENT 6 MONTHS

Following is a List of Independent Pharmacies:

- | | | |
|-------------------------------------|----------------------------------|-------------------------------|
| MCGREGORS MEDICINE-ON-TIME PHARMACY | AUSTINS DRUG STORE | DRAKES PHARMACY |
| RUTLAND PHARMACY | ENOSBURG PHARMACY | WOODSTOCK PHARMACY INC |
| THE PHARMACY INC | BARTON PHARMACY INC | EXTENDED CARE PHARMACY LLC |
| SPRINGFIELD PHARMACY | CORNER DRUG CO INC | MCGREGORS SOUTH HERO PHARMACY |
| THE HOTEL PHARMACY INC | WELLS RIVER PHARMACY | JACK RIXON PHARMACY |
| SWANTON REXALL | HARRYS DISCOUNT PHARMACY | NASSIFS PROFESSIONAL PHCY |
| GAUTHIERS PHARMACY INC | NORTHFIELD PHARMACY | LITTLES HSC PHARMACY |
| MESSENGER VALLEY PHARMACY | WILCOX LTC PHARMACY | MANCHESTER PHARMACY |
| NOTCH PHARMACY | LAKESIDE PHARMACY INC | THE DRUG STORE INC |
| WILCOX PHARMACY | GRANITE PHARMACY INC | HERITAGE DRUGS INC |
| BROWNS DRUG STORE | SHIRE APOTHECARY INC | GERI CARE |
| GREATER FALLS PHARMACY | THE PHARMACY NORTHSHIRE LLC | CORNERSTONE DRUG AND GIFT INC |
| MONTPELIER PHARMACY | CASTLETON HEALTH CENTER PHARMACY | LAPERLES PHARMACY |
| BEAUCHAMP AND OROURKE | GREEN MOUNTAIN PHARMACY | GLENNS PHARMACY INC |
| VERMONT FAMILY PHARMACY | FAIRFAX PHARMACY | HARBOR PHARMACY INC |
| VINCENTS DRUG AND VARIETY | LYNDONVILLE PHARMACY LLC | |

The OVHA cannot recommend continuing to reimburse pharmacies at the fraudulently inflated rate in effect since 2002. Vermont's position is consistent with the vast majority of other states, as indicated by a recent survey of state Medicaid programs conducted by the National Association of State Medicaid Directors. This survey indicated the majority of other states do not plan to adjust their AWP discount rate to counteract the effects of the lower AWP.

As Judge Saris articulated in the AWP/FDB Final Judgment:

... these pharmacies (both chain and independent) and PBMs, reimbursed on the basis of AWP, were unjustly enriched when drug prices were fraudulently inflated during the scheme, yet they have not been asked to disgorge their profits. None of the pharmacies protested the windfalls they received when prices were unilaterally inflated by five percent. Further, the pharmacies seem to have survived prior to the start of this fraudulent scheme, making it seem likely that they will survive after it has been undone.

OVHA cannot justify continuing to pay arbitrarily inflated prices to the pharmacies.

Example Represents a Brand Drug whose WAC = \$ 80

| OVHA - Prior to July 15, 2009 | OVHA - July 15, 2009 | OVHA - After 9/26/09 AWP Rollback | OVHA - After 11/06/09 Removal of Rollback |
|-------------------------------|----------------------|-----------------------------------|---|
| WAC | \$ 80.00 | WAC | \$ 80.00 |
| AWP = WAC x 1.25 | AWP = WAC x 1.25 | Rollback AWP = WAC x 1.20 | Unadjusted AWP = WAC x 1.25 |
| AWP | \$ 100.00 | RollbackAWP | \$ 96.00 |
| Discount off AWP | 11.90% | Discount off Rollback AWP | 14.20% |
| AWP - 11.9 % = | \$ 88.10 | Rollback AWP - 14.2 % = | \$ 82.37 |
| Dispensing Fee | \$ 4.75 | Dispensing Fee | \$ 4.75 |
| Total to Phmy = | \$ 92.85 | Total to Phmy = | \$ 87.12 |
| | | | WAC |
| | | | Unadjusted AWP |
| | | | Discount off Unadjusted AWP |
| | | | Unadjusted AWP - 14.2 % = |
| | | | Dispensing Fee |
| | | | Total to Phmy = |

| Estimated Commercial - Prior to 9/26/09 | Estimated Commercial - After 9/26/09 |
|---|--------------------------------------|
| WAC | \$ 80.00 |
| AWP = WAC x 1.25 | AWP = WAC x 1.25 |
| AWP | \$ 100.00 |
| Discount off AWP | 16.00% |
| AWP - 16 % = | \$ 84.00 |
| Dispensing Fee | \$ 2.25 |
| Total to Phmy = | \$ 86.25 |
| | WAC |
| | Unadjusted AWP |
| | Discount off Unadjusted AWP |
| | Unadjusted AWP - 17 % = |
| | Dispensing Fee |
| | Total to Phmy = |

Unadjusted AWP represents commercial payers keeping pharmacies whole (AWP not rolled back)

Expand Health Insurance Premium Program (HIPP) (\$795,000)

Currently there is a limited number (approximately 60) of traditional Medicaid beneficiaries for whom OVHA participates with their employer or private group health insurer (ESI) in order to enroll these individuals into the private healthcare available to them. Under this Health Insurance Premium Program (HIPP), OVHA determines whether it is more cost effective to pay the premium, all other cost cost-sharing, and wrap benefits for their ESI coverage as compared to enrolling them in Medicaid. We are proposing to extend this program to all beneficiaries currently enrolled in all Medicaid programs (other than VHAP and Dual Medicaid/Medicare eligible) that are employed more than 20.5 hours per week and have access to employer-based insurance (estimated at 116 beneficiaries for SFY '11 across all programs). We also are proposing to add one FTE to implement this expansion. Following are examples of how the cost effectiveness tests are applied:

Cost Effectiveness Tests

Example #1 - Individual Plan

Premium Amount \$ 121.53
 Coinsurance Amount (if any) \$ 750.00
 Deductible Max Amount \$ 300.00

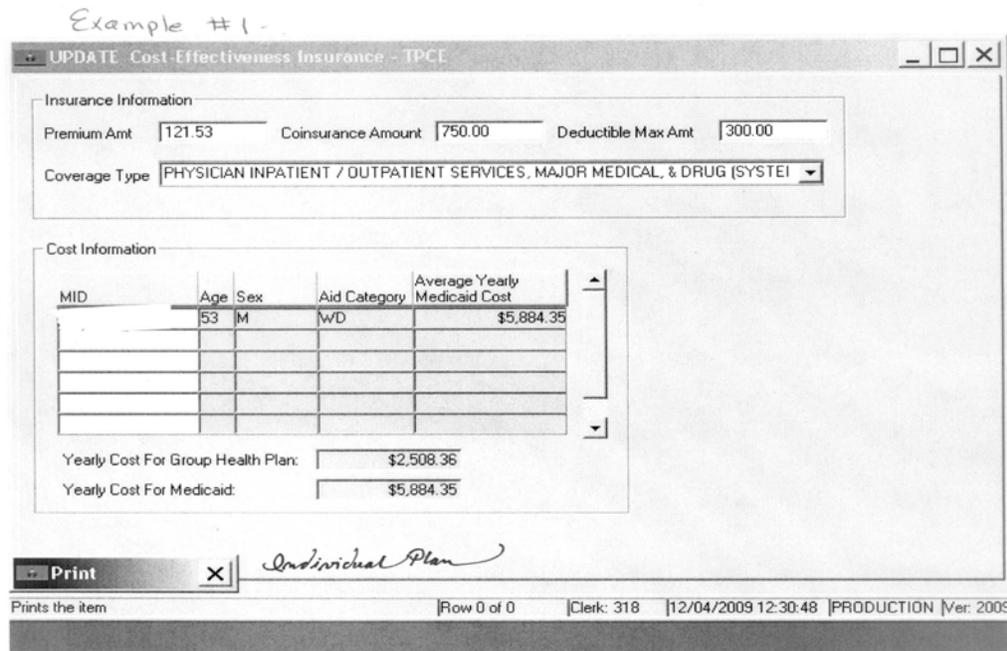
Yearly Cost for Group Health Plan: \$ 2,508.36

- Premium Amount x 12 (months in a year) + max out of pocket amount

Yearly Cost for Medicaid: \$ 5,884.35

- The Average Yearly Medicaid Cost is found by the claim types cost avoided by the cost avoidance criteria for the entered Coverage Types. It totals the average Medicaid cost for all recipients in the age grouping, sex, aid category grouping, for applicable claims types.
- The cost for Medicaid is **MORE** than the cost for the Health Plan, this is **COST EFFECTIVE**.

Example #1



Example #2 – Family Plan

| | |
|-----------------------------|-------------|
| Premium Amount | \$ 228.24 |
| Coinsurance Amount (if any) | \$ 1,500.00 |
| Deductible Max Amount | \$ 500.00 |

Yearly Cost for Group Health Plan: \$ 4,738.88

- Premium Amount x 12 (months in a year) + Max Out of Pocket Amount

Yearly Cost for Medicaid: \$13,604.76

- The Average Yearly Medicaid Cost if found by the claim types cost avoided by the cost avoidance criteria for the entered Coverage Types. It totals the average Medicaid cost for all recipients in the age grouping, sex, aid category grouping, for applicable claims types.
- The cost for Medicaid is **MORE** than the cost for the Health Plan, this is **COST EFFECTIVE**

Example #2

UPDATE Cost-Effectiveness Insurance - TPCL

Insurance Information

Premium Amt: Coinsurance Amount: Deductible Max Amt:

Coverage Type:

Cost Information

| MID | Age | Sex | Aid Category | Average Yearly Medicaid Cost |
|-----|-----|-----|--------------|------------------------------|
| | 11 | F | KC | \$2,077.79 |
| | 15 | F | C0 | \$3,801.47 |
| | 14 | F | C0 | \$2,077.79 |
| | 8 | M | C0 | \$3,569.92 |
| | 6 | F | C0 | \$2,077.79 |

Yearly Cost For Group Health Plan:

Yearly Cost For Medicaid:

Print *Family Plan*

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Example #3

| | |
|-----------------------------|-------------|
| Premium Amount | \$ 716.47 |
| Coinsurance Amount (if any) | \$ 1,560.00 |
| Deductible Max Amount | \$ 1,000.00 |

Yearly Cost for Group Health Plan: \$11,157.64

- Premium Amount x 12 (months in a year) + Max Out of Pocket Amount

Yearly Cost for Medicaid: \$ 2,172.25

- The Average Yearly Medicaid Cost is found by the claim types cost avoided by the cost avoidance criteria for the entered Coverage Types. It totals the average Medicaid cost for all recipients in the age grouping, sex, aid category grouping, for applicable claims types.
- The cost for Medicaid is **LESS** than the cost for the Health Plan, this is **NOT COST EFFECTIVE**.

Example #3

UPDATE Cost-Effectiveness Insurance - TPCE

Insurance Information

Premium Amt Coinsurance Amount Deductible Max Amt

Coverage Type

Cost Information

| MID | Age | Sex | Aid Category | Average Yearly Medicaid Cost |
|-----|-----|-----|--------------|------------------------------|
| | 1 | M | KC | \$2,172.25 |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Yearly Cost For Group Health Plan:

Yearly Cost For Medicaid:

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Example #4

| | |
|-----------------------------|------------|
| Premium Amount | \$ 451.03 |
| Coinsurance Amount (if any) | \$ 0.00 |
| Deductible Max Amount | \$1,000.00 |

Yearly Cost for Group Health Plan: \$6,412.36

- Premium Amount x 12 (months in a year) + Max Out of Pocket Amount

Yearly Cost for Medicaid \$3,737.37

- The Average Yearly Medicaid Cost is found by the claim types cost avoided by the cost avoidance criteria for the entered Coverage Types. It totals the average Medicaid cost for all recipients in the age grouping, sex, aid category grouping, for applicable claims types.
- The Cost for Medicaid is **LESS** than the cost for the Health Plan, this is **NOT COST EFFECTIVE**.

Example #4

UPDATE Cost-Effectiveness

Insurance Information

Premium Amt: 451.03 Coinsurance Amount: 0.00 Deductible Max Amt: 1,000.00

Coverage Type: PHYSICIAN INPATIENT / OUTPATIENT SERVICES, MAJOR MEDICAL, & DRUG (SYSTEMI)

Cost Information

| MID | Age | Sex | Aid Category | Average Yearly Medicaid Cost |
|-----|-----|-----|--------------|------------------------------|
| | 17 | M | AZ | \$3,737.37 |
| | | | | |
| | | | | |
| | | | | |

Yearly Cost For Group Health Plan: \$6,412.36

Yearly Cost For Medicaid: \$3,737.37

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Limit Emergency Room Services to 12 per Year (\$301,530)

The Emergency Medical Treatment and Labor Act (EMTALA) prevents limiting access to the emergency room (ER) – the ER is required by law to perform a screening exam (99281-99283) to rule out an emergency and then may either request permission to provide treatment or, if an emergency, must stabilize the patient before calling the provider or insurer. Both Rhode Island and New Hampshire Medicaid programs limit ER visits to 12 per year for situations where a Medicaid beneficiary is not admitted or transferred to another inpatient facility as a result of the emergency room visit. Under this proposal, OVHA will not reimburse for more than 12 emergency room visits per year in this same manner.

However, OVHA registered nurses and social workers in the Chronic Care Program are proactively beginning to reach out to the 180 beneficiaries and their selected primary care physicians that have been identified as having >12 non-emergent ER visits in SFY '09 to offer case management services. Additionally, on a quarterly basis the OVHA will monitor non-emergent ER use to identify beneficiaries that may exceed the 12 visit limit to initiate case management services. The OVHA Director of Chronic Care services has been actively meeting with leaders in the hospital association to identify greater opportunities for collaboration between the hospitals and the Chronic Care initiative in order to improve utilization and health outcomes for Medicaid beneficiaries. Currently all hospitals have either a care coordinator or disease manager assigned to their facility and processes to refer beneficiaries directly to the chronic care program staff. At some of the hospitals, OVHA receives daily inpatient and ER census sheets directly from the hospital and meets with hospital clinical staff on a frequent basis to discuss referrals, processes, and plans of care. The quarterly data queries that will be implemented in SFY 11 by the OVHA data-team to identify beneficiaries that may potentially exceed 12 ER visits a year will further OVHA's ability to proactively manage beneficiaries with chronic illness and high utilization of services. In addition, to the specific initiatives geared at reducing ER utilization, the OVHA Chronic Care staff continues to work on the ground in the communities with the primary care providers to facilitate access to a medical home and referrals to community and social support services. This will increase the quality of care for these beneficiaries and also limit any liability hospitals may incur due to unreimbursed emergency room visits by OVHA beneficiaries.

To provide more information about these beneficiaries, OVHA reviewed emergent and urgent ER claims data for two groups: beneficiaries who were not subsequently admitted who had 6-12 visits a year and who had greater than 12 visits a year. The top diagnoses were similar for those beneficiaries who had between 6-12 ER visits a year and for those who had greater than 12 visits a year. The top diagnoses in both groups included:

- Headache and Migraines (not intractable);
- Abdominal Pain- not specified;
- Lumbago and Backache-not specified; and
- Upper respiratory illness and infections.

The top chronic conditions that appeared to be associated with the aforementioned diagnosis included:

- Chronic pain,
- Asthma,
- Diabetes, and
- Depression

All of these conditions are currently managed under the OVHA Chronic Care program.

Additionally, OVHA ran an analysis to assess the hospitals most frequented by beneficiaries that had over 12 visits a year. 68% of the ER visits occurred at the following hospitals in descending order: Northwestern Medical Center (24%), Fletcher Allen Health Care (18.2%), Central Vermont Hospital (11.9%), Rutland Regional Medical Center (7.1%), and Southwestern Medical Center (6.9%).

Enhance Program Integrity Activity. (\$1,170,000)

Improper provider payments waste scarce health care resources. Two VT agencies, the Program Integrity Unit (PIU) of the Office of VT Health Access (OVHA) and the Medicaid Fraud and Residential Abuse Unit (MFRAU) of the Office of the Attorney General, are committed to combating provider fraud and abuse in the VT Medicaid program.

The OVHA PIU conducts audits and investigations as a result of program referrals, aberrant provider submissions/billing, and data mining. The PIU coordinates their efforts with the MFRAU.

The VT Attorney General's MFRAU is a state-run program, jointly funded by federal (75%) and state (25%) monies. The Unit became operational in February 1979 to investigate and prosecute healthcare providers who commit fraud against the Medicaid program and to also respond to complaints of abuse, neglect, and exploitation of vulnerable adults in Medicaid-funded facilities and programs. MFRAU is prohibited by federal regulation from data mining. MFRAU therefore relies heavily on the PIU and the Office of Inspector General fraud hotline for referral of provider fraud cases.

The PIU has several tools and compiles information from multiple sources to identify and combat fraud, waste and abuse in the VT Medicaid program:

- **Decision Support System (DSS)/Profiler**
The Decision Support System (DSS) is a tool that provides the framework for oversight of Medicaid services to ensure they are effective and efficient, adhere to policy, and meet standard of practice and billing compliance. Reports generated by the DSS allow the PIU staff to compare providers with their peers by unique case types. This is a valuable tool for detecting under and over utilization as well as outliers.
- **Medicaid Management Information System (MMIS) and Claim Check / Claim Review**
There are more than 700 various MMIS edits and audits in the MMIS system, which are designed to prevent errors in payment. These edits and audits are pre-payment and are used to analyze claims for clean claims submissions, proper billing, correct coding and adherence to VT Medicaid policy. In addition to the MMIS edits and audits, the OVHA also uses McKesson's ClaimCheck / ClaimReview (CC/CR) software. The CC/CR software is also a pre-payment auditing tool that reflects the American Medical Association guidelines, CMS, specialty society guidelines and industry standards. CC/CR uses a clinical knowledge base to create and ensure clinically valid edits.
- **Ingenix/HWT Post Payment Review**
The OVHA has also contracted with Ingenix to provide post-payment reviews of claims data. Ingenix has created a Program Integrity database consisting of 7 years of Medicaid medical, pharmacy and institutional data, as well as ancillary data sources. Ingenix employs a rules-based algorithmic process of data mining designed to identify specific claims that should not have been paid based upon

policy or accepted coding methodologies. The design of the claims data analysis and post payment review is structured to provide robust and efficient reports valuable to OVHA. These reports are designed utilizing an algorithmic approach to data mining focusing on provider types prioritized by OVHA, such as Physician, Pharmacy, Nurse Practitioner, DME and Hospice. The results of these algorithms can be used to identify aberrant billing patterns and outlier providers resulting in:

- a. Identification of subject providers for future audits
- b. Referrals to law enforcement, including the Attorney General's Medicaid Fraud and Residential Abuse Unit
- c. Direct recoupment of overpaid claims from providers
- d. Policy and payment system changes that will result in future savings
- e. Educational opportunities for OVHA and its providers

Ingenix also has algorithms designed to identify overpayments by all major provider types made as a result of inappropriate billing and coding combinations such as mutually exclusive and inclusive, unbundling and duplicative payments.

- **Training:** The PIU and MFRAU are planning a statewide fraud training for state agencies receiving and distributing Medicaid funds next spring. The purpose of this training will be to generate more referrals and educate other state employees and agencies regarding Medicaid fraud, waste and abuse. PIU staff will attend trainings provided by the Medicaid Integrity Institute that are federally funded. These trainings are essential for new staff and will improve the skills of more experienced staff.
- **Recipient Explanation of Benefits (REOMB) process:** Quarterly, EDS sends a list of billed services to a random sample of beneficiaries to verify that they actually received the services billed by providers.
- **Deficit Reduction Act/ Medicaid Integrity Program:** The Centers for Medicare & Medicaid Services, Medicaid Integrity Group (CMS-MIG), in accordance with the Deficit Reduction Act has engaged Medicaid Integrity Contractors (MICs) to audit VT Medicaid claims to identify overpayments to individuals or entities that received Federal funds. These MIC audits will begin as early as CYQ1 2010 and will be on-going monthly reviews in which the OVHA will work very closely with the MIC contractors. These audits have the potential to generate additional monetary recoveries in the coming several years by both the PIU and MFRAU; however, the PI unit staff resources will need to be redeployed in order to comply with additional CMS requirements. Thus, internal data mining efforts and the ability to receive outside referrals will be limited due to the need to respond to CMS.
- **Identification of Beneficiary Fraud, Waste and Abuse:** The PIU also focuses on identifying areas where there is high potential for beneficiary mis-use of provided benefits. Examples include identifying and terminating transportation for beneficiaries who are deemed ineligible for transport, or who receive transportation for an ineligible service; identifying beneficiaries who are 'doctor shopping' and or drug diverting and locking them into 1 doctor, 1 pharmacy for better care coordination as well as reducing inappropriate Medicaid spending; and proactive coordination with Primary Care Physicians, through the

Prescription Monitoring Program, for early identification and resolution. The PIU works closely with the OVHA Clinical Unit and the Chronic Care Initiative staff on cases where it appears there are excess and/or inappropriate service use to ensure beneficiaries are receiving needed services in the most clinically appropriate and effective manner.

A synopsis of OVHA's PI investigation process is as follows:

1. Intake Process – referrals are entered into the system administratively
 - a. Intake person calls to make sure it is not an open case for MFRAU (if it concerns a provider)
 - b. Intake person searches the SURS database to determine if it is an open case for the PI unit or if there is a history for the beneficiary or provider.
 - c. Cases are assigned at the weekly PI unit meetings
2. Preliminary Investigation – Assigned cases are investigated to determine if a full investigation is warranted
 - a. Check provider or beneficiary Medicaid enrollment status
 - b. Check excluded provider list
 - c. Initiate referral to MFRAU if provider fraud is suspected
 - d. Initiate referral to DCF, Economic Services Division if beneficiary enrollment fraud is suspected
 - e. Initiate referral to OVHA Clinical, Care Coordination or Transportation Unit if beneficiary service issue is involved
 - f. Assess if it is a provider education issue
 - g. Assess potential return and triage accordingly
 - h. Close case if full investigation is not warranted
3. Full Investigation – Full investigations are performed by appropriate PI unit staff
 - a. Nurse Case Manager investigates cases that are clinical in nature
 - b. Auditor investigates other cases and ones that involve other issues (e.g., transportation, coding)
 - c. Full investigations may include any or all of the following:
 - i. MMIS data queries
 - ii. Business Objects queries
 - iii. DSS Profiler queries
 - iv. Direct contact with provider and/or beneficiary
 - v. Records reviews
 - vi. Site visits
 - vii. Consultations/collaborations for technical advise (e.g., clinical, legal)
4. Case may include any or all of the following:
 - a. Recoupment of erroneous payment

- b. Curtail future erroneous billing
- c. Corrective Action Plan is developed by provider
- d. Sanctions on providers
- e. Review of future claims as deemed necessary
- f. Provider education is provided
- g. Beneficiary education is provided
- h. Work with other AHS departments on issues related to mental health, developmental services, children with special health needs, etc.

While the tools available to identify fraud, waste and abuse have grown, current OVHA staffing is not adequate to take advantage of these resources. The following table compares several states' PI unit staffing:

| State | Medicaid Beneficiaries | Medicaid Expenditures | PI Staffing (FTE) | Gross Savings | Gross Savings per FTE | Staff Cost (\$80k average) | Net Savings | Net Savings per FTE |
|---------------|------------------------|-----------------------|-------------------|---------------|-----------------------|----------------------------|---------------|---------------------|
| Nevada | 166,437 | \$1.2B | 13 | \$1,800,000 | \$138,462 | \$1,040,000.00 | \$760,000 | \$58,462 |
| Delaware | 105,800 | \$1B | 24 | \$5,300,000 | \$220,833 | \$1,920,000.00 | \$3,380,000 | \$140,833 |
| Connecticut | 400,000 | \$4.1B | 25 | \$14,300,000 | \$572,000 | \$2,000,000.00 | \$12,300,000 | \$492,000 |
| Maryland | 250,000 | \$2B | 14 | \$25,000,000 | \$1,785,714 | \$1,120,000.00 | \$23,880,000 | \$1,705,714 |
| Maine | 250,000 | \$3B | 12 | \$10,600,000 | \$883,333 | \$960,000.00 | \$9,640,000 | \$803,333 |
| Maryland | 829,981 | \$6B | 32 | \$24,000,000 | \$750,000 | \$2,560,000.00 | \$21,440,000 | \$670,000 |
| New Hampshire | 111,591 | \$1.22B | 8+1 admin | Not available | | Not Applicable | Not Available | Not Available |
| Wyoming | 88,000 | \$500M | 8 | \$2,500,000 | \$312,500 | \$640,000.00 | \$1,860,000 | \$232,500 |
| Utah | 270,000 | \$1.7B | 9 | \$3,600,000 | \$400,000 | \$720,000.00 | \$2,880,000 | \$320,000 |

*Nevada, Delaware, Connecticut and Maryland savings are from 2007. All other reported State savings are from 2008

With the current staffing, the PIU is only able to respond to referrals and not be proactive. In addition, not having a data person dedicated to the PI Unit limits the ability to look broadly across the spectrum of Medicaid claims to identify trends. As such, OVHA proposes to add three (3) additional staff members to the PI unit to maximize efforts to control fraud, waste and abuse in the Medicaid system, maximize recoupment from providers, and prevent beneficiary fraud, waste and abuse, for a total annual cost of \$240,000. As a result of this enhanced staffing, we estimate a savings of an additional \$930,000 (net) in SFY11 and we are confident that the addition of the requested staff will enable the PI Unit to more than double productivity after the first year.

Enhance Quality Control on Transportation Services (\$575,000)

Non-Emergency Medical Transportation (NEMT) is a service available to Medicaid and Dr. Dynasaur beneficiaries under certain conditions such as 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 (i.e., travel beyond 30 miles or out-of-state requires an out-of-area/state request). 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. In SFY '09, 11,169 beneficiaries received non-emergency medical transportation services for a total expenditure of \$11,694,573.

OVHA currently manages contracts with the following public transit providers to administer the OVHA's Non-Emergency Medical Transportation (NEMT) Program; they are also a provider of the transportation: Addison County Transit Resources (ACTR), Chittenden County Transportation Authority (CCTA), Connecticut River Transit (CRT), Green Mountain Community Network (GMCN), Green Mountain Transit Agency (GMTA), Marble Valley Regional Transit District (MVRTD), Rural Community Transportation (RCT), Special Services Transportation Agency (SSTA) and Stagecoach Transportation Services (STSI).

OVHA believes that \$500,000 (net) in savings can be gained in transportation services by implementing controls and optimizing efficiencies in areas such as reimbursement, utilization, and trip coordination, and by enhancing reliance on least costly mode of transportation, increasing the volunteer network, and management of high utilizers and no-show cases. We are requesting \$75,000 for a new position to focus on achieving these savings.

Tighten Eligibility for Children's Personal Care Services (\$1,000,000)

Detail testimony about these proposed reductions will be provided by the Department of Disabilities, Aging and Independent Living (DDAIL).

Reduce FQHC Reimbursement Rate (\$138,526)

Federally-funded Federally-Qualified Health Centers (FQHCs) must meet the following federal health center grant requirements and are required to report administrative, clinical and other information to the federal Bureau of Primary Health Care, HRSA:

- Not denying requested health care services, regardless of ability to pay;
- Not limiting the number of patients whose services are paid for by Medicare, Medicaid, or CHIP;
- Providing primary care health services for all life cycle ages (pediatric through geriatric);
- Providing on site or through arrangement basic lab, emergency care, radiological services, pharmacy, preventive health, preventive dental, transportation, case management, dental screening for children, after hours care, and hospital/speciality care services by referral at the same reduced, sliding scale cost for uninsured patients; and
- FQHCs must not be owned by or subsidiary to another organization, must be non-profit corporations with 501(c)3 tax exempt status from the IRS, and must be governed by a board of directors representative of the demographic and socio-economic status of their service area, at least 51% of whom must be patients of the health center.

Currently in Vermont, there are 8 Federally Qualified Health Centers (FQHCs) with 40 sites, a substantial increase since 2005 when there were 3 FQHCs with 11 sites. On average, in CY 2008, almost half of their patients had private insurance(43%), while a quarter (27%) had Medicaid coverage, 17% had Medicare and 12% were uninsured.

By Federal statute, FQHCs are reimbursed by Medicaid and Medicare in an all-inclusive rate based on reasonable costs that are subject to a maximum payment limit per patient visit. In a fee-for-service practice, revenue is estimated on the basis of procedures, such as office visits, lab tests and x-rays. In contrast, for FQHCs, revenue is estimated on an average cost per visit (up to a cap, if applicable) for each Medicaid (and Medicare) visit. FQHCs are paid for reasonable costs and submit cost reports annually to Medicare and Medicaid. The total of those allowed costs are divided by the total number of patient visits per year. The result is paid to FQHCs in an all inclusive Encounter Rate paid per patient visit. CMS sets a Federal Upper payment Limit (FUL) for Medicare reimbursement to FQHCs, which sets the ceiling for Medicaid reimbursement. (Medicare pays FQHCs 80% of the FUL.) States have the option to set rates that ensure their financial viability, up to a specified cap. In Vermont, that rate is up to 125% of the Medicare encounter payment.

Because of their safety net role and cost-based reimbursement structure, FQHCs were excluded from the 2% rate reduction approved in the SFY'10 Appropriations Bill experienced by most Medicaid providers. However, given current budget realities, we are proposing to impose a 1.3% reduction in their total Medicaid reimbursement beginning in SFY '11.

Adult Dental Cap Decrease (\$495 to \$200) (\$ 1,476,501)

Adult routine dental services are currently provided for beneficiaries ages 21 and older enrolled in Medicaid/Dr. Dynasaur (i.e., pregnant women) programs, with an annual cap of \$495. The services are preventive, diagnostic, or corrective procedures involving the oral cavity and teeth. Examples of allowable charges within this cap include an exam and cleaning, and endodontic limited to 3 teeth per lifetime. Crowns, bridges, orthodontia and periodontal services are not covered. The medical and surgical services (e.g., biopsies) of a dentist are not subject to the cap; these services are covered as hospital and/or physician services. However, tooth repair, replacement or other dental procedures, even if they are medically necessary part of surgery, are part of routine dental services and subject to the cap.

General Assistance for Emergency Dental

If a Vermont Medicaid/Dr. Dynasaur adult patient has exhausted or is close to exhausting their dental benefit (i.e., cap), they can obtain a General Assistance (GA) voucher for specific emergency dental treatments to relieve pain, bleeding and/or infection. GA vouchers are not for routine dental services and a GA voucher is not required to obtain the medical/surgical services of a dentist.

Given current fiscal realities, we are proposing to reduce the annual cap related to routine dental from \$495 to \$200. In SY 09, there were 13,213 adults who accessed dental benefits, and 6,682 of these would have been impacted by this proposed change in the cap. As such, the estimated savings for this proposal assumes that OVHA will experience a 10% increase in claims associated with the use of GA vouchers by adults for emergency dental treatment.

Changes in DDAIL Rates and Rules (\$4,333,224)

Detail testimony about these proposed reductions will be provided by the Department of Disabilities, Aging and Independent Living (DDAIL). In summary, savings will be achieved by: (1) modifying rules to change reimbursement for the Moderate Needs Group case management from 15 minute units to a monthly rate of \$50; (2) reducing the home health agency-directed Personal Care Attendant rate from \$26.15/hr to \$22/hr; (3) modifying rules to change reimbursement from 15 minute units to \$110 monthly rate for HB case management services; (4) modifying rules to tighten personal care variances and maintain variance in service hours for respite and companion services; (5) changing procedures in the Flexible Choices option to reduce authorized budgets and actual expenditures by 10% and eliminating annual carryover of unspent funds; (7) modifying regulations to reduce case management for Enhanced Residential Care participants to 3 hours/year; and (8) decreasing by 50% the case-mix weights for the following 4 resource utilization groups:

- Impaired Cognition A (IA1)
- Challenging Behavior A (BA1)
- Reduced Physical Functioning A2 (PA2)
- Reduced Physical Functioning A1 (PA1).

CATAMOUNT II (\$11,482,134)

The Catamount Health Plans, Catamount Health Assistance Program (CHAP) and Employer-Sponsored Insurance Assistance Programs (ESIA) that began in the fall of 2007 have been successful in providing insurance for over 12,000 uninsured Vermonters. The Governor and his Administration are strongly committed to continuing support for these important programs. However, given that there is a projected deficit of \$7.7 million in the Catamount Fund for SFY '11, we must find ways to make these programs more sustainable as we move toward federal health care reform. As such, we are proposing to change the generous cost sharing benefits in the existing Catamount Health Plans to a new Catamount II plan for all new CHAP enrollees as of July 1, 2010, and in which all current CHAP enrollees would be enrolled on their 12 month anniversary date.

CATAMOUNT II Design

- Existing Catamount benefits would remain unchanged, including waiver of cost sharing for preventive and chronic care services (e.g., asthma, diabetes, heart disease, major depression, chronic respiratory disease).
- Office visit co-pays will increase from \$10 to \$25
- Prescription co-pay changes:
 - Generic – unchanged at \$10
 - Tier 2 – increase from \$30 to \$35
 - Tier 3 – increase from \$50 to \$55
- Individual Annual Deductible increase from \$250 to \$1,200; this is in line with the most popular PPO plans in the association market, which is indicative of the entire market. For example, the most popular PPO deductible in 2009 for the BCBSVT BRS Association was \$1,000 which is being raised to \$1,500 in 2010 (representing 243 contracts).
- For the ESI cost effectiveness test, the ESI deductible will increase from \$500 to \$1,200. This change will result in some number of individuals moving from CHAP to ESI which would provide additional savings that are included in the projected savings.

| | <u>Single Premium</u> | <u>% Savings</u> | CHAP/ESI |
|--|-----------------------|------------------|----------|
| | <u>Savings*</u> | | |
| Current Program – Projected SFY'11 3 rd quarter | \$468 | | |
| \$1,200 Deductible, \$25 OV Co-pay, \$10/\$35/\$55 Rx mil | \$380 | 19% | \$3.85 |

Model Assumptions:

- Savings are for a full year beginning on July 1, 2010
- All CHAP enrollees move into the newly designed product on their 12 month anniversary date.
- Premium assistance amounts will be indexed to increases in the carrier Catamount Health Plan premium rates, per 33 V.S.A. § 1984(b), which will go into effect for CHAP enrollees with incomes above 200% FPL on April 1, 2010 (when the Plan premiums are increased by

MVP and BCBS-VT), and for those under 200% FPL on January 1, 2011 when the ARRA MOE expires. Note: The savings proposed by implementing Catamount II assume that CHAP beneficiaries' premiums remain the same as they would have been had the benefit package remained the same.

- The amounts used in the estimate for both premiums to the carriers and beneficiary premiums are average premiums that differ each month due to the rollout (staggered implementation as beneficiaries reach their anniversary dates), so each month the average premium reflects that some people are still on at the higher rate and some people are shifting to the lower rate.

Catamount and ESIA Beneficiary Premium Schedule

| | SFY '10 | | | SFY '11 | | | |
|----------|-----------|-----------------|-----------------|----------------|----------------|----------------|----------------|
| | Base Rate | new rate 1/1/10 | new rate 4/1/10 | new rate 1Q 11 | new rate 2Q 11 | new rate 3Q 11 | new rate 4Q 11 |
| 150-175% | \$ 60.00 | \$ 60.00 | \$ 60.00 | \$ 60.00 | \$ 60.00 | \$ 71.00 | \$ 73.00 |
| 175-200% | \$ 60.00 | \$ 60.00 | \$ 60.00 | \$ 60.00 | \$ 60.00 | \$ 71.00 | \$ 73.00 |
| 200-225% | \$ 110.00 | \$ 122.00 | \$ 124.34 | \$ 127.00 | \$ 129.00 | \$ 132.00 | \$ 134.00 |
| 226-250% | \$ 135.00 | \$ 149.00 | \$ 152.34 | \$ 155.00 | \$ 158.00 | \$ 161.00 | \$ 165.00 |
| 251-275% | \$ 160.00 | \$ 177.00 | \$ 180.34 | \$ 184.00 | \$ 188.00 | \$ 191.00 | \$ 195.00 |
| 276-300% | \$ 185.00 | \$ 205.00 | \$ 208.34 | \$ 213.00 | \$ 217.00 | \$ 221.00 | \$ 225.00 |

Office of Vermont Health Access

 SFY '11 Catamount Health and Employer Sponsored Insurance Assistance Balance Sheet
 CATAMOUNT STEADY STATE

| | TOTAL | |
|--|----------------------|-----------------------|
| | GROSS | NET* |
| <i>* Net = State share including ARRA</i> | | |
| Total Program Expenditures | | |
| Catamount Health | \$ 63,500,357 | \$ 23,813,515 |
| Employer Sponsored Insurance Assistance | \$ 2,940,600 | \$ 1,109,228 |
| Revenue Offset | \$ (1,089,507) | \$ (422,696) |
| Total Direct Program Costs | \$ 65,351,450 | \$ 24,500,047 |
| OVHA Administrative Costs | \$ 1,464,515 | \$ 545,707 |
| DCF Administrative Costs | \$ 1,232,510 | \$ 535,288 |
| Total Direct Program Costs | \$ 2,697,025 | \$ 1,080,995 |
| Total Gross Program Spending ~ Direct and Admin | \$ 68,048,475 | \$ 25,581,042 |
| Catamount Fund Need ~ Direct and Admin | | \$ 25,581,042 |
| Additional Expenditures | | |
| Immunizations Program | \$ 2,500,000 | \$ 2,500,000 |
| VT Dept. of Labor Admin Costs Assoc. With Employer Assess. | \$ 394,072 | \$ 394,072 |
| Marketing and Outreach | \$ 500,000 | \$ 206,350 |
| Blueprint | \$ 1,846,713 | \$ 1,846,713 |
| Total | \$ 5,240,785 | \$ 4,947,135 |
| Catamount Fund Need ~ Additional Expenditures | | \$ 4,947,135 |
| Catamount Fund Need ~ Total All Expenditures | | \$ 30,528,177 |
| Total Revenues | | |
| Catamount Health Premiums | \$ 12,402,619 | \$ 4,788,150 |
| Total Premiums | \$ 12,402,619 | \$ 4,788,150 |
| Federal Participation | | \$ 7,614,469 |
| Cigarette Tax | \$ 9,408,500 | |
| Floor Stock | \$ - | |
| Interest | \$ - | |
| Employer Assessment | \$ 7,600,000 | |
| Reserve Account Funding (GF Transfer) | \$ - | |
| Total Other Revenue | \$ 17,008,500 | |
| Catamount Fund Revenues | \$ 21,796,650 | |
| Catamount Fund Balance ~ Revenues Less Expenses | | |
| SFY '09 Catamount Fund Carryforward | | \$ 1,021,478 |
| Funds transferred out of Catamount Fund | | \$ - |
| Fund Balance | | \$ (7,710,049) |

*NOTE: Due to the Joint Fiscal Committee's decision to rescind funding associated with the Catamount expansion; the related costs for such have been removed from this balance sheet.

Office of Vermont Health Access

 SFY '11 Catamount Health and Employer Sponsored Insurance Assistance Balance Sheet
 CATAMOUNT II

| | TOTAL | |
|--|----------------------|-----------------------|
| | GROSS | NET* |
| <i>* Net = State share including ARRA</i> | | |
| Total Program Expenditures | | |
| Catamount Health | \$ 49,482,634 | \$ 18,398,346 |
| Employer Sponsored Insurance Assistance | \$ 7,226,334 | \$ 2,690,875 |
| Revenue Offset | \$ (2,839,652) | \$ (1,081,321) |
| Total Direct Program Costs | \$ 53,869,316 | \$ 20,007,900 |
| OVHA Administrative Costs | \$ 1,464,515 | \$ 545,707 |
| DCF Administrative Costs | \$ 1,232,510 | \$ 535,288 |
| Total Direct Program Costs | \$ 2,697,025 | \$ 1,080,995 |
| Total Gross Program Spending ~ Direct and Admin | \$ 56,566,341 | \$ 21,088,895 |
| Catamount Fund Need ~ Direct and Admin | | \$ 21,088,895 |
| Additional Expenditures | | |
| Immunizations Program | \$ 2,500,000 | \$ 2,500,000 |
| VT Dept. of Labor Admin Costs Assoc. With Employer Assess. | \$ 394,072 | \$ 394,072 |
| Marketing and Outreach | \$ 500,000 | \$ 206,350 |
| Blueprint | \$ 1,846,713 | \$ 1,846,713 |
| Total | \$ 5,240,785 | \$ 4,947,135 |
| Catamount Fund Need ~ Additional Expenditures | | \$ 4,947,135 |
| Catamount Fund Need ~ Total All Expenditures | | \$ 26,036,030 |
| Total Revenues | | |
| Catamount Health Premiums | \$ 10,852,292 | \$ 4,147,691 |
| Total Premiums | \$ 10,852,292 | \$ 4,147,691 |
| Federal Participation | | \$ 6,704,601 |
| Cigarette Tax | \$ 9,408,500 | |
| Floor Stock | \$ - | |
| Interest | \$ - | |
| Employer Assessment | \$ 7,600,000 | |
| Reserve Account Funding (GF Transfer) | \$ - | |
| Total Other Revenue | \$ 17,008,500 | |
| Catamount Fund Revenues | \$ 21,156,191 | |
| Catamount Fund Balance ~ Revenues Less Expenses | | |
| SFY '09 Catamount Fund Carryforward | | \$ 1,021,478 |
| Funds transferred out of Catamount Fund | | \$ - |
| Fund Balance | | \$ (3,858,361) |

*NOTE: Due to the Joint Fiscal Committee's decision to rescind funding associated with the Catamount expansion; the related costs for such have been removed from this balance sheet.

Office of Vermont Health Access

 SFY '11 Catamount Health and Employer Sponsored Insurance Assistance Balance Sheet
 CHANGE FROM CATAMOUNT STEADY STATE TO CATAMOUNT II

| | TOTAL | |
|--|------------------------|-----------------------|
| | GROSS | NET* |
| <i>* Net = State share including ARRA</i> | | |
| Total Program Expenditures | | |
| Catamount Health | \$ (14,017,723) | \$ (5,415,169) |
| Employer Sponsored Insurance Assistance | \$ 4,285,733 | \$ 1,581,647 |
| Revenue Offset | \$ (1,750,145) | \$ (658,626) |
| Total Direct Program Costs | \$ (11,482,134) | \$ (4,492,147) |
| OVHA Administrative Costs | \$ - | \$ - |
| DCF Administrative Costs | \$ - | \$ - |
| Total Direct Program Costs | \$ - | \$ - |
| Total Gross Program Spending ~ Direct and Admin | \$ (11,482,134) | \$ (4,492,147) |
| Catamount Fund Need ~ Direct and Admin | | \$ (4,492,147) |
| Additional Expenditures | | |
| Immunizations Program | \$ - | \$ - |
| VT Dept. of Labor Admin Costs Assoc. With Employer Assess. | \$ - | \$ - |
| Marketing and Outreach | \$ - | \$ - |
| Blueprint | \$ - | \$ - |
| Total | \$ - | \$ - |
| Catamount Fund Need ~ Additional Expenditures | | \$ - |
| Catamount Fund Need ~ Total All Expenditures | | \$ (4,492,147) |
| Total Revenues | | |
| Catamount Health Premiums | \$ (1,550,327) | \$ (640,460) |
| Total Premiums | \$ (1,550,327) | \$ (640,460) |
| Federal Participation | | \$ (909,868) |
| Cigarette Tax | \$ - | |
| Floor Stock | \$ - | |
| Interest | \$ - | |
| Employer Assessment | \$ - | |
| Reserve Account Funding (GF Transfer) | \$ - | |
| Total Other Revenue | \$ - | |
| Catamount Fund Revenues | \$ (640,460) | |
| Catamount Fund Balance ~ Revenues Less Expenses | | |
| SFY '09 Catamount Fund Carryforward | | \$ - |
| Funds transferred out of Catamount Fund | | \$ - |
| Net Difference btwn Catamount Steady State and Catamount II | | \$ 3,851,688 |

*NOTE: Due to the Joint Fiscal Committee's decision to rescind funding associated with the Catamount expansion; the related costs for such have been removed from this balance sheet.

REVENUE IMPLICATIONS \$8,951,019

**Premium Increases for
 VHAP, Dr. Dynasaur, SCHIP, and Pharmacy Only \$1,739,263**

The SFY '11 premium structure proposes modest increases to beneficiaries in the higher FPL categories for an additional \$1,739,263 in revenues for the State Health Care Resource Fund managed by AHS. The premium levels do not apply to beneficiaries with very low incomes or traditional eligibility premiums (e.g. Aged, Blind, and Disabled). Children in households with incomes below 185% FPL and VHAP beneficiaries with incomes below 50% FPL (37% of total VHAP enrollment) will continue to be eligible without a monthly premium. These premiums cannot be increased for beneficiaries covered under the Global Commitment Waiver as of July 1, 2008 until January 1, 2011 due to Maintenance of Effort (MOE) requirements under ARRA.

Premiums

| Program | % FPL | '11 Gov. Rec. Enroll | '10 Premium | '11 Premium Revenue (no chgs.) | '11 Proposed Premiums | '11 Proposed Premium Revenue | Value of Increase |
|-----------------------------|----------|----------------------|-------------|--------------------------------|-----------------------|------------------------------|-------------------|
| Dr. Dynasaur | 0-185% | 54,810 | \$ - | \$ - | \$ - | \$ - | \$ - |
| Dr. Dynasaur | 185-225% | 4,592 | \$ 15.00 | \$ 516,644 | \$ 30.00 | \$ 774,966 | \$ 258,322 |
| Dr. D with ins. | 225-300% | 1,282 | \$ 20.00 | \$ 192,350 | \$ 40.00 | \$ 288,525 | \$ 96,175 |
| Dr. D without ins. | 225-300% | 3,966 | \$ 60.00 | \$ 1,784,758 | \$ 80.00 | \$ 2,082,218 | \$ 297,460 |
| Dr. D Total | | 64,651 | | \$ 2,493,752 | | \$ 3,145,709 | \$ 651,957 |
| VHAP | 0-50% | 12,966 | \$ - | \$ - | \$ - | \$ - | \$ - |
| VHAP | 50-75% | 4,644 | \$ 7.00 | \$ 390,081 | \$ 12.00 | \$ 529,395 | \$ 139,315 |
| VHAP | 75-100% | 5,382 | \$ 25.00 | \$ 1,614,731 | \$ 42.00 | \$ 2,163,739 | \$ 549,008 |
| VHAP | 100-150% | 12,380 | \$ 33.00 | \$ 4,902,593 | \$ 55.00 | \$ 6,536,791 | \$ 1,634,198 |
| VHAP | 150-185% | 3,053 | \$ 49.00 | \$ 1,795,262 | \$ 82.00 | \$ 2,399,789 | \$ 604,527 |
| VHAP Total | | 38,426 | | \$ 8,702,667 | | \$ 11,629,714 | \$ 2,927,048 |
| VPharm 1 & VHAP Pharmacy | 0-150% | 7,469 | \$ 15.00 | \$ 1,344,427 | \$ 20.00 | \$ 1,568,498 | \$ 224,071 |
| VPharm 2 & VScript | 150-175% | 2,659 | \$ 20.00 | \$ 638,248 | \$ 25.00 | \$ 718,029 | \$ 79,781 |
| VPharm 3 & VScript Expanded | 175-225% | 2,451 | \$ 50.00 | \$ 1,470,781 | \$ 60.00 | \$ 1,617,859 | \$ 147,078 |
| Pharmacy Total | | 12,580 | | \$ 3,453,456 | | \$ 3,904,386 | \$ 450,930 |
| Federal | | | 58.03% | \$ 7,872,529 | | \$ 10,163,201 | \$ 2,290,672 |
| ARRA | | | 6.30% | \$ 624,162 | | \$ 835,685 | |
| GF | | | 35.67% | \$ 6,153,184 | | \$ 7,680,924 | \$ 1,739,263 |
| Total | | | | \$ 14,649,875 | | \$ 18,679,810 | \$ 4,029,935 |

*for a family of three for children's programs and a family of two for adult programs

Vermont Medicaid Premium History Through SFY '11

| | | SFY |
|---------------------------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|-------------------|
| | | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
| Program | % FPL | Premiums | Proposed Premiums |
| Dr. Dynasaur | 0-185% | None |
| Dr. Dynasaur | 185-225% | \$10* | \$20* | \$25* | \$25* | \$30* | \$30* | \$15* | \$15* | \$15* | \$30* |
| Dr. D <i>with ins.</i> | 225-300% | \$12* | \$24* | \$35* | \$35* | \$40* | \$40* | \$20* | \$20* | \$20* | \$40* |
| Dr. D <i>without ins.</i> | 225-300% | \$25* | \$50* | \$70* | \$70* | \$80* | \$80* | \$40* | \$60* | \$60* | \$80* |
| VHAP | 0-50% | None |
| VHAP | 50-75% | \$10** | \$10** | \$10*** | \$10*** | \$11*** | \$11*** | \$7*** | \$7*** | \$7*** | \$12*** |
| VHAP | 75-100% | \$15** | \$15** | \$35*** | \$35*** | \$39*** | \$39*** | \$25*** | \$25*** | \$25*** | \$42*** |
| VHAP | 100-150% | \$20** | \$40** | \$45*** | \$45*** | \$50*** | \$50*** | \$33*** | \$33*** | \$33*** | \$55*** |
| VHAP | 150-185% | \$25** | \$50** | \$65*** | \$65*** | \$75*** | \$75*** | \$49*** | \$49*** | \$49*** | \$82*** |
| VHAP Pharmacy | 0-150% | N/A | N/A | \$13*** | \$13*** | \$13*** | \$15*** | \$15*** | \$15*** | \$15*** | \$20*** |
| VScript | 150-175% | N/A | N/A | \$17*** | \$17*** | \$17*** | \$20*** | \$20*** | \$20*** | \$20*** | \$25*** |
| VScript Expanded | 175-225% | N/A | N/A | \$35*** | \$35*** | \$35*** | \$42*** | \$42*** | \$50*** | \$50*** | \$60*** |
| Effective 1/1/2006 | | | | | | | | | | | |
| Vpharm 1 | 0-150% | N/A | N/A | N/A | N/A | \$13*** | \$15*** | \$15*** | \$15*** | \$15*** | \$20*** |
| Vpharm 2 | 150-175% | N/A | N/A | N/A | N/A | \$17*** | \$20*** | \$20*** | \$20*** | \$20*** | \$25*** |
| Vpharm 3 | 175-225% | N/A | N/A | N/A | N/A | \$35*** | \$42*** | \$42*** | \$50*** | \$50*** | \$60*** |

* Per family per month

** Per individual for 6 months

*** Per individual per month

**** Implementation of Pharmacy Premiums 1/1/2004 replacing cost sharing

Additional Hospital Tax Revenue Based on 5.5% Rate \$7,325,812

Per Vermont State Statute, Title 33 § 1953 (a) (1), hospitals are subject to an annual assessment at the rate of 5.5% of their net patient revenues less chronic, skilled, and swing bed revenues. Also, per the same section of the statute, the “annual assessment shall be based on data from a hospital’s third most recent full fiscal year.” To calculate the SFY2011 provider assessments, the OVHA used net patient revenues (minus chronic, skilled, and swing bed revenues) from the hospitals 2007 financial statements as provided by BISCHA. This 5.5% assessment will yield \$7,325,812 in additional state revenue beyond the SFY ’10 appropriated levels for this funding source. These funds are deposited into the State Health Care Resource Fund managed by AHS.

Provider Assessments - SFY '08 Actual thru SFY '11 Gov. Rec.

| | FY08 Actual | FY09 Actual | FY10 As Passed | FY10 BAA | FY11 Gov. Rec. | |
|-------------------------|-------------------|-------------------|-------------------|-------------------|--------------------|---|
| General Hospitals | 61,686,261 | 66,413,401 | 74,396,881 | 72,285,982 | 81,722,693 | → 7,325,812 Increase Over Appropriated |
| Psych. Hospitals | 876,955 | 885,672 | 848,818 | 848,590 | 858,760 | |
| Nursing Homes | 14,559,205 | 13,004,774 | 13,816,171 | 13,536,996 | 13,060,927 | → 9,436,711 Increase Over Actual SFY 10 Tax Basis |
| Home Health | 4,426,736 | 3,864,347 | 4,062,099 | 4,101,901 | 4,088,575 | |
| ICF-MR | 61,104 | 62,059 | 61,666 | 66,002 | 66,002 | |
| Pharmacy - \$.10/script | 603,986 | 835,186 | 800,000 | 800,000 | 800,000 | |
| - | <u>82,214,247</u> | <u>85,065,439</u> | <u>93,985,635</u> | <u>91,639,471</u> | <u>100,596,957</u> | |

Note: Nursing home tax revenues are lower due a decline in the number of licensed bed days. The Home Health Agency tax was reduced slightly last year in the fee bill from 18.45% to 17.69% (Act No.47, An Act Relating to Executive Branch fees).

POLICY CHANGES \$ 0

- During the SFY '10 legislative session, statutory reference that was created to exempt "health insurer are defined by section 9402 of this title, or any insurance company regulated under Title 8" did not specifically encompass Vermont's publicly funded health care programs. Legislative intent was to exempt them. As such, our proposal is as follows:

18 VSA § 4474c(b) is amended to read:

(b) This chapter shall not be construed to require that coverage or reimbursement for the use of marijuana for symptom relief be provided by:

- (1) a health insurer as defined by section 9409 of this title, or any insurance company regulated under Title 8;
- (2) Medicaid, Vermont health access plan, and any other public health care assistance program;
- (3) an employer; or
- ~~(3)~~ (4) for purposes of workers' compensation, an employer as defined in subdivision 601 (3) of Title 21.

- Language was included in Act 61 of 2009 requiring an expansion to the Catamount program. The potential expansions included: 1) allowing Catamount enrollment without a 12-month waiting period for self-employed individuals who lost their individual coverage as a result of a business closure; and 2) allowing depreciation as a part of the income calculations that determine Catamount eligibility. The Joint Fiscal Committee rescinded the appropriation for these two expansions on 8/18/09.

As such, OVHA proposes to repeal 8 VSA 4080f(a)(9)(II)(aa) and (bb) regarding self-employment and to rescind Sec. 22 and 23 from Act 61, containing the provision on allowing depreciation when determining countable income for eligibility (Sec. 22) and a related reporting activity (Sec. 23).

OVHA also proposes to rescind Sec. 43 from Act 61, containing the adjustments to spending authority for Global Commitment relative to the Catamount Health assistance program expansion and associated immunization program funding changes.

Specifically, repealing the following language is proposed:

8 VSA 4080f(a)(9)(II)

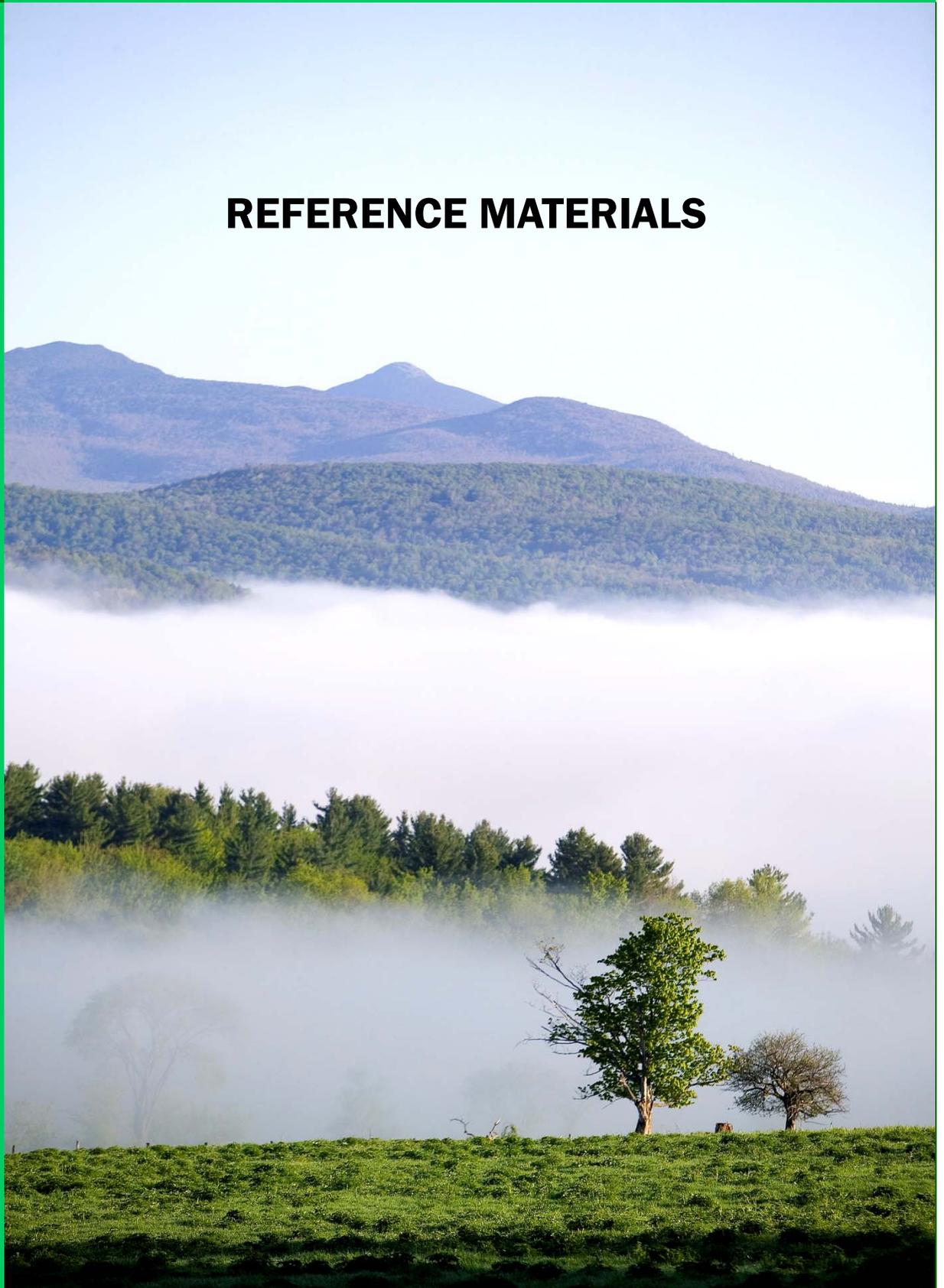
"(aa) A self-employed individual who was insured through the nongroup market whose insurance coverage ended as the direct result of either the termination of a business entity owned by the individual or the individual's inability to continue in his or her line of work, if the individual produces satisfactory evidence to the office of Vermont health access of the business termination or certifies by

affidavit to the office of Vermont health access that he or she is not employed and is no longer seeking employment in the same line of work;

(bb) Subdivision (aa) of this subdivision (II) shall take effect upon issuance by the Centers for Medicare and Medicaid Services of approval of an amendment to the Global Commitment for Health Medicaid Section 1115 Waiver allowing for a self-employment exception to the Catamount Health waiting period;"

OFFICE of VERMONT HEALTH ACCESS

REFERENCE MATERIALS



Overview of Green Mountain Care Programs as of 1/11/10
Created by the Office of Health Care Ombudsman
1-800-917-7787

| PROGRAM | WHO IS ELIGIBLE | BENEFITS | COST-SHARING |
|---|--|--|---|
| Medicaid¹ PIL² Medicaid Working Disabled 250% FPL³ | <ul style="list-style-type: none"> • Aged, blind, disabled • Parents or caretaker relatives of a dependent child • Children up to age 21 <ul style="list-style-type: none"> • Disabled working adults | <ul style="list-style-type: none"> • Covers: physical and mental health, dental (\$495 cap/yr), prescriptions, chiro (limited). • Not covered: dentures, eyeglasses. • Covers excluded classes of Medicare Part D drugs for dual-eligible individuals. • <21 same as Dr. Dynasaur | <ul style="list-style-type: none"> • No program fee. Some co-pays age 18-21. • \$1/\$2/\$3 prescription co-pay if no Medicare Part D coverage. • \$1.10 -\$6.30 co-pays if have Part D. Medicare Part D is primary prescription coverage for Medicaid/Medicare recipients. • \$3 dental co-pay • \$3/outpatient hospital visit • \$75/inpatient admission |
| Dr. Dynasaur 200% FPL | Pregnant women | <ul style="list-style-type: none"> • Same as Medicaid. | <ul style="list-style-type: none"> • Up to 185% FPL: No fee • Up to 200% FPL: \$15/family/month • \$1/\$2/\$3 prescription co-pays. |
| Dr. Dynasaur 300% FPL | Children up to age 18 | <ul style="list-style-type: none"> • Same as Medicaid but covers eyeglasses, full dental, & additional benefits. | <ul style="list-style-type: none"> • Up to 185% FPL: no fee • Up to 225% FPL: \$15/family/month • Up to 300% FPL: \$20/family/month (\$60/family/month without other insurance) • \$1/\$2/\$3 prescription copays. |
| VHAP (Vermont Health Access Plan) 150% FPL -or- VHAP-ESIA (Employer Sponsored Insurance Assistance) | Uninsured adults Uninsured adults with access to approved ESI | <ul style="list-style-type: none"> • Same as Medicaid except: no dental or transportation. • Covered by employer sponsored insurance; VHAP wraps coverage as secondary | <ul style="list-style-type: none"> • Up to 50%FPL: \$0 • Up to 75% FPL: \$7/person/ month • Up to 100% FPL: \$25/person/ month • Up to 150% FPL: \$33/ person/ month • Only costsharing is: \$25 ER visit/ \$60 if not medically necessary ; \$1/\$2 script copay. |
| VHAP -or- VHAP-ESIA 185% FPL | Uninsured adults with dependent children (with or w/o access to ESI) | <ul style="list-style-type: none"> • Same as directly above | <ul style="list-style-type: none"> • \$49/person/month, otherwise same as VHAP without dependent children. |
| Catamount-ESIA (Employer Sponsored Insurance Assistance) 150%-300% FPL | Uninsured adults (some exceptions) w/access to approved ESI | <ul style="list-style-type: none"> • Covered by employer sponsored insurance; provides premium assistance | <ul style="list-style-type: none"> • Wrap-around benefits for chronic care as per Blueprint • Cost sharing according to ESI • Premiums \$60-\$205 per person |
| CHAP (Catamount Health Premium Assistance Program) 150%-300% FPL | Uninsured adults (some exceptions) WITHOUT access to approved ESI | Covered by: BCBS Catamount Blue -OR- MVP Catamount Choice | <ul style="list-style-type: none"> • Cost sharing according to plan • Premiums \$60-\$205 per person |
| Catamount Health (no state assistance) | Same as directly above income over 300% FPL | Covered by BCBS or MVP plans above | <ul style="list-style-type: none"> • Cost sharing according to plan • Full premium costs; family plans available |
| VHAP Pharmacy 150% FPL | Aged or disabled, not eligible for Medicare Part A or B, and has no other insurance that covers any portion of prescription cost | <ul style="list-style-type: none"> • Same prescriptions covered by Medicaid • Diabetic supplies • Eye exams | <ul style="list-style-type: none"> • \$15/person/month • \$1/\$2 prescription copays. |
| VScript 175% FPL VScript Expanded 225% FPL | Same as directly above Same as directly above | <ul style="list-style-type: none"> • Maintenance medication • Diabetic supplies <ul style="list-style-type: none"> • Maintenance medication • Diabetic supplies | <ul style="list-style-type: none"> • \$20/person/month;\$1/\$2 script copays. • \$50/person/month; \$1/\$2 script copays. • Manufacturer has to sign supplemental rebate agreement with the state. |

¹ Medicaid is the only program with resource limits: \$2000/individual; \$3000/couple. Long Term Care Medicaid (nursing home care; waiver services) is not included in this chart.

² PIL: Protected Income Limit. Note: Medicaid income limit for age 18 in households ≥ 2 is 100% of FPL.

³ FPL: Federal Poverty Level

| | | | |
|--|---|--|---|
| VPharm1 150% FPL | Medicare Part D beneficiaries | • Covers Medicare Part D cost-sharing + excluded classes of Part D meds. | • \$15/person/month premium paid to State. • \$1/\$2 prescription copays. *Must apply for the low income subsidy* |
| VPharm2 175% FPL | Medicare Part D beneficiaries | • Covers Part D cost-sharing + excluded classes of Part D meds for maintenance meds. | • \$20/person/month premium paid to State. • \$1/\$2 script copays for maintenance meds. • Part D cost-sharing for acute medications. |
| VPharm3 225% FPL | Medicare Part D beneficiaries | • Same as directly above. | • \$50/person/month premium paid to State. • \$1/\$2 script copays for maintenance meds. • Part D cost-sharing for acute medications. |
| Healthy Vermonters 350% FPL Healthy Vermonters 400% FPL | • Anyone who has no/has exhausted script coverage • Aged or disabled, has no/has exhausted prescription coverage | • Discount on medications • Discount on medications. | • Beneficiary pays the Medicaid rate for all prescriptions. • Beneficiary pays the Medicaid rate for all prescriptions. Medicare Part D is primary. HV is secondary. |

| Coverage Groups | Premium | FPL ³ | household size | | | |
|--|--|------------------|----------------|-----------------------|------------------------|------------------------|
| | | | 1 | 2 | 3 | 4 |
| Medicaid PIL outside Chittenden Cty | | NA | \$916.00 | \$916.00 ² | \$1100.00 ² | \$1250.00 ² |
| Medicaid PIL inside Chittenden Cty | | NA | \$991.00 | \$991.00 ² | \$1175.00 ² | \$1316.00 ² |
| VHAP-ESIA or VHAP (if no ESI) | | 0% - 185% | | | | |
| ≤50% | No fee | 50% | \$453.00 | \$610.00 | \$767.00 | \$923.00 |
| >50% but ≤75% | \$7/person/month | 75% | \$680.00 | \$915.00 | \$1150.00 | \$1385.00 |
| >75% but ≤100% | \$25/person/month | 100% | \$906.00 | \$1220.00 | \$1533.00 | \$1846.00 |
| >100% but ≤150% | \$33/person/month | 150% | \$1359.00 | \$1829.00 | \$2299.00 | \$2769.00 |
| >150% but ≤185%* | \$49/person/month | 185% | \$1676.00 | \$2256.00 | \$2836.00 | \$3415.00 |
| *families with dependent children only | | | | | | |
| VHAP Pharmacy | \$15/person/month | 150% | \$1359.00 | \$1829.00 | \$2299.00 | \$2769.00 |
| VScript | \$20/person/month | 175% | \$1586.00 | \$2134.00 | \$2682.00 | \$3231.00 |
| VScript Expanded | \$50/person/month | 225% | \$2039.00 | \$2744.00 | \$3449.00 | \$4154.00 |
| VPharm | \$15/person/month | 150% | \$1359.00 | \$1829.00 | \$2299.00 | \$2769.00 |
| VPharm | \$20/person/month | 175% | \$1586.00 | \$2134.00 | \$2682.00 | \$3231.00 |
| VPharm | \$50/person/month | 225% | \$2039.00 | \$2744.00 | \$3449.00 | \$4154.00 |
| Dr. Dinosaur (kids up to 18) | No Fee | 185% | \$1676.00 | \$2256.00 | \$2836.00 | \$3415.00 |
| Dr. Dinosaur (pregnant women & kids up to 18) | \$15/family/month | 200% | \$1812.00 | \$2439.00 | \$3065.00 | \$3692.00 |
| Dr. Dy. (kids up to 18) | \$15/family/month | 225% | \$2039.00 | \$2744.00 | \$3449.00 | \$4154.00 |
| Dr. Dinosaur (kids up to 18) | • \$20/family/month • \$60/family uninsured | 300% | \$2718.00 | \$3658.00 | \$4598.00 | \$5538.00 |
| Catamount-ESIA or CHAP (if no ESI) | | 150%-300% | | | | |
| >150% but ≤200% | \$60 per person | 200% | \$1812.00 | \$2439.00 | \$3065.00 | \$3692.00 |
| >200% but ≤225% | \$110 or \$122* pp | 225% | \$2039.00 | \$2744.00 | \$3449.00 | \$4154.00 |
| >225% but ≤250% | \$135 or \$149* pp | 250% | \$2265.00 | \$3048.00 | \$3832.00 | \$4615.00 |
| >250% but ≤275% | \$160 or \$177* pp | 275% | \$2492.00 | \$3353.00 | \$4215.00 | \$5077.00 |
| >275% but ≤300% | \$185 or \$205* pp | 300% | \$2718.00 | \$3658.00 | \$4598.00 | \$5538.00 |
| * CHAP increases effective policy anniversary date. *All Catamount ESIA increases effective 1/1/10. | | | | | | |
| Catamount Health (no premium assistance) | | >300% | >\$2718.00 | >\$3658.00 | >\$4598.00 | >\$5538.00 |
| Healthy Vermonters (any age) | | 350% | \$3171.00 | \$4268.00 | \$5364.00 | \$6461.00 |
| Healthy Vermonters (aged, disabled) | | 400% | \$3624.00 | \$4877.00 | \$6130.00 | \$7384.00 |

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

Federal Poverty Level (FPL) Guidelines
January 1, 2009 to February 28, 2010

| Monthly | | Household Size | | | | | | | |
|-----------------------|-------------|-----------------------|----------|----------|----------|----------|----------|----------|----------|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| Percent of FPL | 50% | 453 | 610 | 767 | 923 | 1,080 | 1,237 | 1,393 | 1,550 |
| | 75% | 680 | 915 | 1,150 | 1,385 | 1,620 | 1,855 | 2,090 | 2,325 |
| | 100% | 906 | 1,220 | 1,533 | 1,846 | 2,160 | 2,473 | 2,786 | 3,100 |
| | 120% | 1,087 | 1,463 | 1,839 | 2,215 | 2,591 | 2,967 | 3,343 | 3,719 |
| | 125% | 1,133 | 1,524 | 1,916 | 2,308 | 2,699 | 3,091 | 3,483 | 3,874 |
| | 130% | 1,178 | 1,585 | 1,993 | 2,400 | 2,807 | 3,215 | 3,622 | 4,029 |
| | 133% | 1,205 | 1,622 | 2,039 | 2,455 | 2,872 | 3,289 | 3,706 | 4,122 |
| | 135% | 1,223 | 1,646 | 2,069 | 2,492 | 2,915 | 3,338 | 3,761 | 4,184 |
| | 150% | 1,359 | 1,829 | 2,299 | 2,769 | 3,239 | 3,709 | 4,179 | 4,649 |
| | 175% | 1,586 | 2,134 | 2,682 | 3,231 | 3,779 | 4,327 | 4,876 | 5,424 |
| | 185% | 1,676 | 2,256 | 2,836 | 3,415 | 3,995 | 4,575 | 5,154 | 5,734 |
| | 200% | 1,812 | 2,439 | 3,065 | 3,692 | 4,319 | 4,945 | 5,572 | 6,199 |
| | 225% | 2,039 | 2,744 | 3,449 | 4,154 | 4,859 | 5,564 | 6,269 | 6,974 |
| | 250% | 2,265 | 3,048 | 3,832 | 4,615 | 5,398 | 6,182 | 6,965 | 7,748 |
| | 275% | 2,492 | 3,353 | 4,215 | 5,077 | 5,938 | 6,800 | 7,662 | 8,523 |
| | 300% | 2,718 | 3,658 | 4,598 | 5,538 | 6,478 | 7,418 | 8,358 | 9,298 |
| 350% | 3,171 | 4,268 | 5,364 | 6,461 | 7,558 | 8,654 | 9,751 | 10,848 | |
| 400% | 3,624 | 4,877 | 6,130 | 7,384 | 8,637 | 9,890 | 11,144 | 12,397 | |

| Annual | | Household Size | | | | | | | |
|-----------------------|-------------|-----------------------|----------|----------|----------|----------|----------|----------|----------|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| Percent of FPL | 50% | 5,435 | 7,315 | 9,195 | 11,075 | 12,955 | 14,835 | 16,715 | 18,595 |
| | 75% | 8,153 | 10,973 | 13,793 | 16,613 | 19,433 | 22,253 | 25,073 | 27,893 |
| | 100% | 10,870 | 14,630 | 18,390 | 22,150 | 25,910 | 29,670 | 33,430 | 37,190 |
| | 120% | 13,044 | 17,556 | 22,068 | 26,580 | 31,092 | 35,604 | 40,116 | 44,628 |
| | 125% | 13,588 | 18,288 | 22,988 | 27,688 | 32,388 | 37,088 | 41,788 | 46,488 |
| | 130% | 14,131 | 19,019 | 23,907 | 28,795 | 33,683 | 38,571 | 43,459 | 48,347 |
| | 133% | 14,457 | 19,458 | 24,459 | 29,460 | 34,460 | 39,461 | 44,462 | 49,463 |
| | 135% | 14,675 | 19,751 | 24,827 | 29,903 | 34,979 | 40,055 | 45,131 | 50,207 |
| | 150% | 16,305 | 21,945 | 27,585 | 33,225 | 38,865 | 44,505 | 50,145 | 55,785 |
| | 175% | 19,023 | 25,603 | 32,183 | 38,763 | 45,343 | 51,923 | 58,503 | 65,083 |
| | 185% | 20,110 | 27,066 | 34,022 | 40,978 | 47,934 | 54,890 | 61,846 | 68,802 |
| | 200% | 21,740 | 29,260 | 36,780 | 44,300 | 51,820 | 59,340 | 66,860 | 74,380 |
| | 225% | 24,458 | 32,918 | 41,378 | 49,838 | 58,298 | 66,758 | 75,218 | 83,678 |
| | 250% | 27,175 | 36,575 | 45,975 | 55,375 | 64,775 | 74,175 | 83,575 | 92,975 |
| | 275% | 29,893 | 40,233 | 50,573 | 60,913 | 71,253 | 81,593 | 91,933 | 102,273 |
| | 300% | 32,610 | 43,890 | 55,170 | 66,450 | 77,730 | 89,010 | 100,290 | 111,570 |
| 350% | 38,045 | 51,205 | 64,365 | 77,525 | 90,685 | 103,845 | 117,005 | 130,165 | |
| 400% | 43,480 | 58,520 | 73,560 | 88,600 | 103,640 | 118,680 | 133,720 | 148,760 | |

FEDERAL MATCH RATES

FEDERAL MATCH RATES

FFIS projs + JFO/Admin consensus ARRA - December 14, 2009

Title XIX / Medicaid (program) & Title IV-E / Foster Care (program):

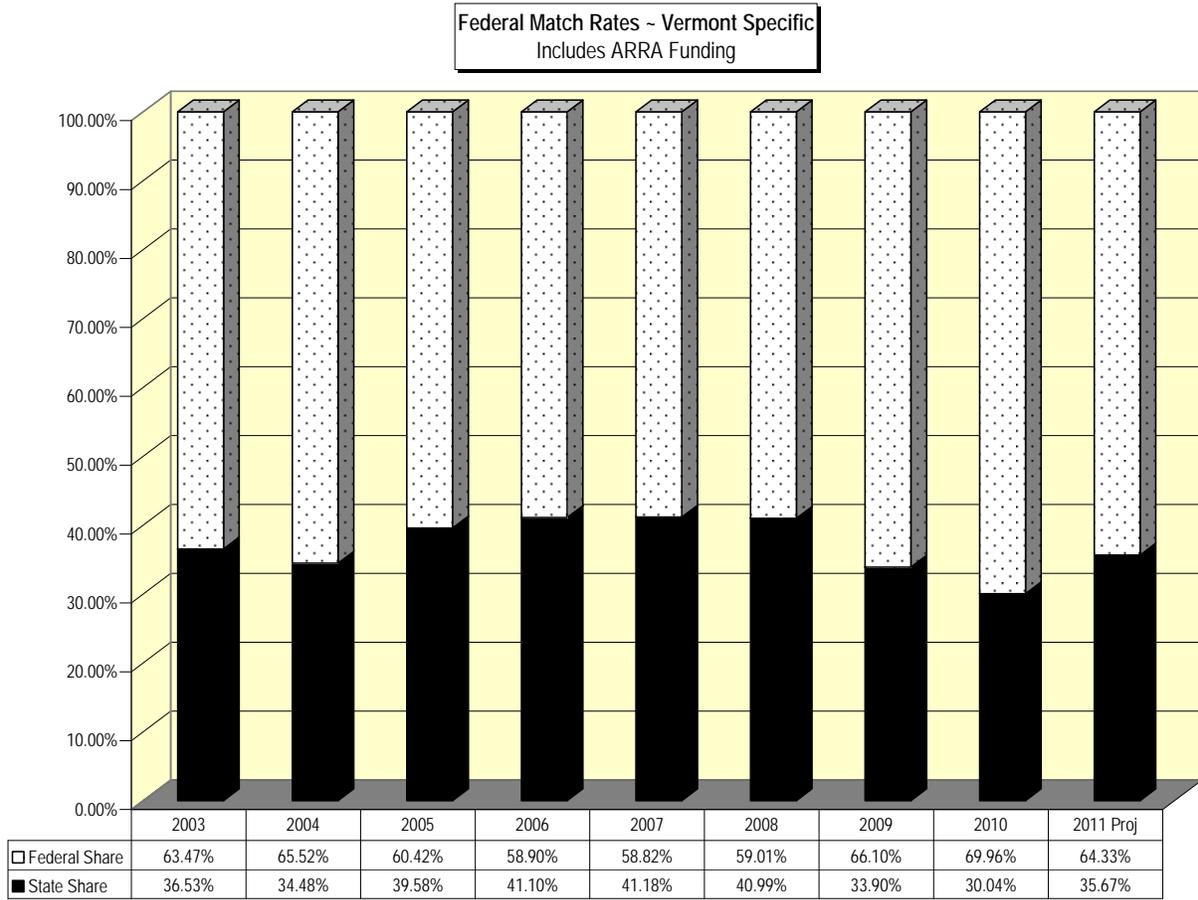
| Federal Fiscal Year | | | | | | | State Fiscal Year | | | | | | |
|---------------------|--|----------|---------------------------------|------------------------------|---------------------|-------------|-------------------|---------------------------|-----------|---------------------------------|------------------------------|---------------------|-------------|
| FFY | From | To | Federal Share w/o hold harmless | ARRA including hold harmless | Total Federal Share | State Share | SFY | From | To | Federal Share w/o hold harmless | ARRA including hold harmless | Total Federal Share | State Share |
| | 07/01/73 | 06/30/75 | 65.38% | | | 34.62% | | | | | | | |
| | 07/01/75 | 09/30/77 | 69.82% | | | 30.18% | | | | | | | |
| | 10/01/77 | 09/30/79 | 68.02% | | | 31.98% | | | | | | | |
| | 10/01/79 | 09/30/81 | 68.40% | | | 31.60% | | | | | | | |
| | 10/01/81 | 09/30/83 | 68.54% | | | 31.46% | | | | | | | |
| | 10/01/83 | 09/30/85 | 69.37% | | | 30.63% | | | 1986 | 67.64% | 32.36% | | |
| | 10/01/85 | 09/30/86 | 67.06% | | | 32.94% | | | 1987 | 67.29% | 32.71% | | |
| | 10/01/86 | 09/30/87 | 67.37% | | | 32.63% | | | 1988 | 66.52% | 33.49% | | |
| | 10/01/87 | 09/30/88 | 66.23% | | | 33.77% | | | 1989 | 64.50% | 35.50% | | |
| | 10/01/88 | 09/30/89 | 63.92% | | | 36.08% | | | | | | | |
| 1990 | 10/01/89 | 09/30/90 | 62.77% | | | 37.23% | 1990 | 7/1/1989 | 6/30/1990 | 63.06% | 36.94% | | |
| 1991 | 10/01/90 | 09/30/91 | 61.97% | | | 38.03% | 1991 | 7/1/1990 | 6/30/1991 | 62.17% | 37.83% | | |
| 1992 | 10/01/91 | 09/30/92 | 61.37% | | | 38.63% | 1992 | 7/1/1991 | 6/30/1992 | 61.52% | 38.48% | | |
| 1993 | 10/01/92 | 09/30/93 | 59.88% | | | 40.12% | 1993 | 7/1/1992 | 6/30/1993 | 60.25% | 39.75% | | |
| 1994 | 10/01/93 | 09/30/94 | 59.55% | | | 40.45% | 1994 | 7/1/1993 | 6/30/1994 | 59.63% | 40.37% | | |
| 1995 | 10/01/94 | 09/30/95 | 60.82% | | | 39.18% | 1995 | 7/1/1994 | 6/30/1995 | 60.50% | 39.50% | | |
| 1996 | 10/01/95 | 09/30/96 | 60.87% | | | 39.13% | 1996 | 7/1/1995 | 6/30/1996 | 60.86% | 39.14% | | |
| 1997 | 10/01/96 | 09/30/97 | 61.05% | | | 38.95% | 1997 | 7/1/1996 | 6/30/1997 | 61.01% | 38.99% | | |
| 1998 | 10/01/97 | 09/30/98 | 62.18% | | | 37.82% | 1998 | 7/1/1997 | 6/30/1998 | 61.90% | 38.10% | | |
| 1999 | 10/01/98 | 09/30/99 | 61.97% | | | 38.03% | 1999 | 7/1/1998 | 6/30/1999 | 62.02% | 37.98% | | |
| 2000 | 10/01/99 | 09/30/00 | 62.24% | | | 37.76% | 2000 | 7/1/1999 | 6/30/2000 | 62.17% | 37.83% | | |
| 2001 | 10/01/00 | 09/30/01 | 62.40% | | | 37.60% | 2001 | 7/1/2000 | 6/30/2001 | 62.36% | 37.64% | | |
| 2002 | 10/01/01 | 09/30/02 | 63.06% | | | 36.94% | 2002 | 7/1/2001 | 6/30/2002 | 62.90% | 37.10% | | |
| 2003 | 10/01/02 | 09/30/03 | 62.41% | | | 37.59% | 2003 | 7/1/2002 | 6/30/2003 | 62.57% | 37.43% | | |
| fiscal relief | 04/01/03 | 09/30/03 | 66.01% | | | 33.99% | | | | fiscal relief - Title XIX only: | 63.47% | 36.53% | |
| | Per TRRA...applies only to Title XIX (excluding DSH pymts) | | | | | | | | | | no adj for DSH | | |
| 2004 | 10/01/03 | 09/30/04 | 61.34% | | | 38.66% | 2004 | 7/1/2003 | 6/30/2004 | 61.61% | 38.39% | | |
| fiscal relief | 10/01/03 | 06/30/04 | 65.36% | | | 34.64% | | | | fiscal relief - Title XIX only: | 65.52% | 34.48% | |
| | Per TRRA...applies only to Title XIX (excluding DSH pymts) | | | | | | | | | | no adj for DSH | | |
| 2005 | 10/01/04 | 09/30/05 | 60.11% | n/a | 60.11% | 39.89% | 2005 | 7/1/2004 | 6/30/2005 | 60.42% | n/a | 60.42% | 39.58% |
| 2006 | 10/01/05 | 09/30/06 | 58.49% | n/a | 58.49% | 41.51% | 2006 | 7/1/2005 | 6/30/2006 | 58.90% | n/a | 58.90% | 41.10% |
| 2007 | 10/01/06 | 09/30/07 | 58.93% | n/a | 58.93% | 41.07% | 2007 | 7/1/2006 | 6/30/2007 | 58.82% | n/a | 58.82% | 41.18% |
| 2008 | 10/01/07 | 09/30/08 | 59.03% | n/a | 59.03% | 40.97% | 2008 | 7/1/2007 | 6/30/2008 | 59.01% | n/a | 59.01% | 40.99% |
| 2009 | 10/01/08 | 09/30/09 | | | | | 2009 | 7/1/2008 | 6/30/2009 | | | | |
| | Non-ARRA | | 59.45% | n/a | 59.45% | 40.55% | | Non-ARRA | | 59.35% | n/a | 59.35% | 40.65% |
| | ARRA-increased | | 59.45% | 9.38% | 68.83% | 31.17% | | ARRA-increased | | 59.35% | 6.76% | 66.10% | 33.90% |
| 2010 | 10/01/09 | 09/30/10 | | | | | 2010 | 7/1/2009 | 6/30/2010 | | | | |
| | Non-ARRA | | 58.73% | n/a | 58.73% | 41.27% | | Non-ARRA | | 58.91% | n/a | 58.91% | 41.09% |
| | ARRA-increase - consensus | | 58.73% | 11.23% | 69.96% | 30.04% | | ARRA-increase - consensus | | 58.91% | 11.05% | 69.96% | 30.04% |
| 2011 Proj. | 10/01/10 | 09/30/11 | | | | | 2011 Proj. | 7/1/2010 | 6/30/2011 | | | | |
| | Non-ARRA | | 58.71% | n/a | 58.71% | 41.29% | | Non-ARRA | | 58.72% | n/a | 58.72% | 41.28% |
| | ARRA-increase - consensus | | 58.71% | 2.81% | 61.52% | 38.48% | | ARRA-increase - consensus | | 58.72% | 5.62% | 64.33% | 35.67% |

Note: ARRA FFY10 reflect JFO/Admin consensus based on monthly projections of unemployment. ARRA FFY11 reflects 3 months of consensus INCREASED estimate and 9 months of FFIS base estimate.

Note: ARRA SFY10 reflect JFO/Admin consensus based on monthly projections of unemployment. ARRA SFY11 reflects July to December at consensus INCREASED rate; January to June at FFIS base estimate.

Title XXI / SCHIP (program & admin) enhanced FMAP:

| Federal Fiscal Year | | | | | State Fiscal Year | | | | |
|---------------------|----------|----------|---------------|-------------|-------------------|----------|-----------|---------------|-------------|
| FFY | From | To | Federal Share | State Share | SFY | From | To | Federal Share | State Share |
| 2005 | 10/01/04 | 09/30/05 | 72.08% | 27.92% | 2005 | 7/1/2004 | 6/30/2005 | 72.30% | 27.71% |
| 2006 | 10/01/05 | 09/30/06 | 70.94% | 29.06% | 2006 | 7/1/2005 | 6/30/2006 | 71.23% | 28.78% |
| 2007 | 10/01/06 | 09/30/07 | 71.25% | 28.75% | 2007 | 7/1/2006 | 6/30/2007 | 71.17% | 28.83% |
| 2008 | 10/01/07 | 09/30/08 | 71.32% | 28.68% | 2008 | 7/1/2007 | 6/30/2008 | 71.30% | 28.70% |
| 2009 | 10/01/08 | 09/30/09 | 71.62% | 28.38% | 2009 | 7/1/2008 | 6/30/2009 | 71.55% | 28.46% |
| 2010 | 10/01/09 | 09/30/10 | 71.11% | 28.89% | 2010 | 7/1/2009 | 6/30/2010 | 71.24% | 28.76% |
| 2011 Proj. | 10/01/10 | 09/30/11 | 71.10% | 28.90% | 2011 Proj. | 7/1/2010 | 6/30/2011 | 71.10% | 28.90% |

FEDERAL MATCH RATES – VERMONT SPECIFIC


MCO INVESTMENT EXPENDITURES

| Department | Investment Description | SFY06 Actuals - | | | | |
|------------|--|-----------------|---------------|---------------|---------------|---------------|
| | | 3/4 SFY | SFY07 Actuals | SFY08 Actuals | SFY09 Actuals | SFY10 BAA |
| DOE | School Health Services | \$ 6,397,319 | \$ 8,956,247 | \$ 8,956,247 | \$ 8,956,247 | \$ 8,956,247 |
| AOA | Blueprint Director | \$ - | \$ - | \$ 70,000 | \$ 68,879 | \$ 188,393 |
| BISHCA | Health Care Administration | \$ 983,637 | \$ 914,629 | \$ 1,340,728 | \$ 1,871,651 | \$ 1,898,824 |
| DII | Vermont Information Technology Leaders | \$ 266,000 | \$ 105,000 | \$ 105,000 | \$ 339,500 | \$ - |
| VVH | Vermont Veterans Home | \$ 747,000 | \$ 913,047 | \$ 913,047 | \$ 881,043 | \$ 837,225 |
| VSC | Health Professional Training | \$ 283,154 | \$ 391,698 | \$ 405,407 | \$ 405,407 | \$ 405,407 |
| UVM | Vermont Physician Training | \$ 2,798,070 | \$ 3,870,682 | \$ 4,006,152 | \$ 4,006,156 | \$ 4,006,156 |
| AHSCO | 2-1-1 Grant | \$ - | \$ - | \$ - | \$ 415,000 | \$ 415,000 |
| VDH | Emergency Medical Services | \$ 174,482 | \$ 436,642 | \$ 626,728 | \$ 427,056 | \$ 411,739 |
| VDH | AIDS Services/HIV Case Management | \$ 152,945 | \$ - | \$ - | \$ - | \$ - |
| VDH | TB Medical Services | \$ 27,052 | \$ 29,129 | \$ 15,872 | \$ 28,359 | \$ 27,342 |
| VDH | Epidemiology | \$ 326,708 | \$ 427,075 | \$ 416,932 | \$ 204,646 | \$ 197,306 |
| VDH | Health Research and Statistics | \$ 276,673 | \$ 403,244 | \$ 404,431 | \$ 217,178 | \$ 209,389 |
| VDH | Health Laboratory | \$ 1,369,982 | \$ 1,908,982 | \$ 2,012,252 | \$ 1,522,578 | \$ 1,467,970 |
| VDH | Tobacco Cessation: Community Coalitions | \$ 938,056 | \$ 1,647,129 | \$ 1,144,713 | \$ 1,016,685 | \$ 980,221 |
| VDH | Slatewide Tobacco Cessation | \$ - | \$ - | \$ - | \$ 22,492 | \$ 21,685 |
| VDH | Family Planning | \$ 365,320 | \$ 122,961 | \$ 169,392 | \$ 300,876 | \$ 290,085 |
| VDH | Physician/Dentist Loan Repayment Program | \$ 810,716 | \$ 439,140 | \$ 930,000 | \$ 1,516,361 | \$ 1,461,976 |
| VDH | Renal Disease | \$ 15,000 | \$ 7,601 | \$ 16,115 | \$ 15,095 | \$ 14,554 |
| VDH | Newborn Screening | \$ 74,899 | \$ 166,795 | \$ 136,577 | \$ - | \$ - |
| VDH | WIC Coverage | \$ 161,804 | \$ 1,165,699 | \$ 562,446 | \$ 295,375 | \$ 284,781 |
| VDH | Vermont Blueprint for Health | \$ 92,049 | \$ 1,975,940 | \$ 753,087 | \$ 1,395,135 | \$ 1,345,097 |
| VDH | Area Health Education Centers (AHEC) | \$ - | \$ 35,000 | \$ 310,000 | \$ 565,000 | \$ 544,736 |
| VDH | Community Clinics | \$ - | \$ - | \$ - | \$ 640,000 | \$ 617,046 |
| VDH | FOHC Lookalike | \$ - | \$ - | \$ 30,000 | \$ 105,650 | \$ 101,861 |
| VDH | Patient Safety - Adverse Events | \$ - | \$ - | \$ 190,143 | \$ 100,509 | \$ 96,904 |
| VDH | Coalition of Health Activity Movement Prevention Program (CHAMPPS) | \$ - | \$ 100,000 | \$ 291,298 | \$ 486,466 | \$ 469,019 |
| VDH | Substance Abuse Treatment | \$ 1,466,732 | \$ 2,514,963 | \$ 2,744,787 | \$ 2,997,668 | \$ 2,890,154 |
| VDH | Recovery Centers | \$ 171,153 | \$ 287,374 | \$ 329,215 | \$ 713,576 | \$ 687,983 |
| VDH | Immunization | \$ - | \$ - | \$ - | \$ 726,264 | \$ 700,216 |
| VDH | DMH Investment Cost in CAP | \$ - | \$ - | \$ - | \$ 64,843 | \$ - |
| DMH | Special Payments for Treatment Plan Services | \$ 101,230 | \$ 131,309 | \$ 113,314 | \$ 164,356 | \$ 167,293 |
| DMH | MH Outpatient Services for Adults | \$ 775,899 | \$ 1,393,395 | \$ 1,293,044 | \$ 1,320,521 | \$ 1,344,114 |
| DMH | Mental Health Elder Care | \$ 38,563 | \$ 37,682 | \$ 38,970 | \$ - | \$ - |
| DMH | Mental Health Consumer Support Programs | \$ 451,606 | \$ 546,987 | \$ 673,160 | \$ 707,976 | \$ 720,625 |
| DMH | Mental Health CRT Community Support Services | \$ 2,318,668 | \$ 602,186 | \$ 807,539 | \$ 1,124,728 | \$ 1,144,823 |
| DMH | Mental Health Children's Community Services | \$ 1,561,396 | \$ 3,066,774 | \$ 3,341,602 | \$ 3,597,662 | \$ 3,661,941 |
| DMH | Emergency Mental Health for Children and Adults | \$ 1,885,014 | \$ 1,988,548 | \$ 2,016,348 | \$ 2,165,648 | \$ 2,204,341 |
| DMH | Respite Services for Youth with SED and their Families | \$ 385,581 | \$ 485,586 | \$ 502,237 | \$ 412,920 | \$ 420,298 |
| DMH | CRT Staff Secure Transportation | \$ - | \$ - | \$ 52,242 | \$ - | \$ - |
| DMH | Recovery Housing | \$ - | \$ - | \$ 235,267 | \$ - | \$ - |
| DMH | Transportation - Children in Involuntary Care | \$ 4,768 | \$ 1,075 | \$ - | \$ - | \$ - |
| DMH | VSH Medical Records | \$ - | \$ - | \$ - | \$ - | \$ 314,000 |
| OVHA | HIT Admin (formerly DII-VITL) | \$ - | \$ - | \$ - | \$ - | \$ 339,500 |
| OVHA | Buy-In | \$ 4,594 | \$ 314,376 | \$ 419,951 | \$ 248,537 | \$ 554,485 |
| OVHA | Vscript Expanded | \$ 1,695,246 | \$ - | \$ - | \$ - | \$ - |
| OVHA | HIV Drug Coverage | \$ 31,172 | \$ 42,347 | \$ 44,524 | \$ 48,711 | \$ 47,578 |
| OVHA | Civil Union | \$ 373,175 | \$ 543,986 | \$ 671,941 | \$ 556,811 | \$ 722,933 |
| OVHA | Vpharm | \$ - | \$ - | \$ - | \$ 278,934 | \$ 183,381 |
| OVHA | Hospital Safety Net Services | \$ - | \$ - | \$ 281,973 | \$ - | \$ - |
| DCF | Family Infant Toddler Program | \$ - | \$ 199,064 | \$ 326,424 | \$ 335,235 | \$ 2,244,268 |
| DCF | Medical Services | \$ 69,893 | \$ 91,569 | \$ 120,494 | \$ 65,278 | \$ 67,249 |
| DCF | Residential Care for Youth/Substitute Care | \$ 9,181,386 | \$ 10,536,996 | \$ 10,110,441 | \$ 9,392,213 | \$ 9,675,785 |
| DCF | AABD Admin | \$ 988,557 | \$ - | \$ - | \$ - | \$ - |
| DCF | AABD | \$ 2,415,100 | \$ - | \$ - | \$ - | \$ - |
| DCF | Aid to the Aged, Blind and Disabled CCL Level III | \$ 96,000 | \$ 2,617,350 | \$ 2,615,023 | \$ 2,591,613 | \$ 2,591,613 |
| DCF | Aid to the Aged, Blind and Disabled Res Care Level III | \$ - | \$ 143,975 | \$ 170,117 | \$ 172,173 | \$ 172,173 |
| DCF | Aid to the Aged, Blind and Disabled Res Care Level IV | \$ 210,989 | \$ 312,815 | \$ 349,887 | \$ 366,161 | \$ 366,161 |
| DCF | Essential Person Program | \$ 542,382 | \$ 675,860 | \$ 614,974 | \$ 620,052 | \$ 620,052 |
| DCF | GA Medical Expenses | \$ 254,154 | \$ 339,928 | \$ 298,207 | \$ 380,000 | \$ 440,000 |
| DCF | CUPS/Early Childhood Mental Health | \$ - | \$ - | \$ 52,825 | \$ 499,143 | \$ 264,000 |
| DCF | VCRHYP/Vermont Coalition for Runaway and Homeless Youth Program | \$ - | \$ - | \$ 1,764,400 | \$ - | \$ - |
| DCF | HBKF/Healthy Babies, Kids & Families | \$ - | \$ - | \$ 318,321 | \$ 63,921 | \$ 31,738 |
| DCF | CCCSA/Community Child Care Support Agency | \$ - | \$ - | \$ - | \$ - | \$ 673,700 |
| DCF | Catamount Administrative Services | \$ - | \$ - | \$ - | \$ 339,894 | \$ - |
| DCF | Therapeutic Child Care | \$ - | \$ - | \$ - | \$ 978,886 | \$ 940,000 |
| DCF | Lund Home | \$ - | \$ - | \$ - | \$ 325,516 | \$ 374,400 |
| DDAIL | Elder Coping with MMA | \$ 441,234 | \$ - | \$ - | \$ - | \$ - |
| DDAIL | Mobility Training/Other Svcs - Elderly Visually Impaired | \$ 187,500 | \$ 250,000 | \$ 250,000 | \$ 250,000 | \$ 245,000 |
| DDAIL | DS Special Payments for Medical Services | \$ 394,055 | \$ 192,111 | \$ 880,797 | \$ 522,058 | \$ 287,224 |
| DDAIL | Flexible Family/Respite Funding | \$ 1,086,291 | \$ 1,135,213 | \$ 1,341,698 | \$ 1,364,896 | \$ 750,935 |
| DDAIL | Quality Review of Home Health Agencies | \$ - | \$ 77,467 | \$ 186,664 | \$ 126,306 | \$ 432,938 |
| DOC | Intensive Substance Abuse Program (ISAP) | \$ 382,230 | \$ 299,602 | \$ 310,610 | \$ 200,000 | \$ 200,000 |
| DOC | Intensive Sexual Abuse Program | \$ 72,439 | \$ 46,078 | \$ 85,542 | \$ 88,523 | \$ 88,523 |
| DOC | Intensive Domestic Violence Program | \$ 109,692 | \$ 134,663 | \$ 230,353 | \$ 229,166 | \$ 229,166 |
| DOC | Women's Health Program (Tapestry) | \$ 460,130 | \$ 487,344 | \$ 487,231 | \$ 527,956 | \$ 527,956 |
| DOC | Community Rehabilitative Care | \$ 1,038,114 | \$ 1,982,456 | \$ 2,031,408 | \$ 1,997,499 | \$ 1,997,499 |
| DOC | Return House | \$ - | \$ - | \$ - | \$ 51,000 | \$ 51,000 |
| | | \$ 45,455,809 | \$ 55,495,719 | \$ 59,918,097 | \$ 62,419,988 | \$ 64,624,007 |



PALLIATIVE CARE FOR CHILDREN

Report to:

**Senate Appropriations Committee
Senate Health and Welfare Committee
House Appropriations Committee
House Human Services Committee**

**Office of Vermont Health Access
Agency of Human Services**

November 16, 2009

Executive Summary

Act 25 (H.435), passed by the Vermont legislature in 2009, requires the Agency of Human Services to submit a report to the House Appropriations and Human Services Committees and the Senate Appropriations and Health and Welfare Committees on the programmatic and cost implications of a Medicaid and State Children's Health Insurance Program (SCHIP) waiver amendment allowing Vermont to provide concurrent palliative and curative care to Medicaid- and SCHIP-eligible children who have life-limiting illnesses. The full text of Section 7 of Act 25 is included as Attachment 1.

The Office of Vermont Health Access (OVHA), which is submitting this report on behalf of the Agency, estimates that Vermont could provide additional palliative care services to 29 to 170 Medicaid children with life-limiting illnesses for a cost of between \$160,000 and \$1 million per year in state funds. Based on the number of children served in other states' palliative care programs, the cost would likely be closer to \$160,000 than to \$1 million.

Introduction

Over the last decade there has been growing concern that children with life-limiting illnesses do not always receive the care they need to alleviate physical and psychosocial pain. Under Centers for Medicare and Medicaid (CMS) rules, hospice services, which were originally designed for adults, are available to children only if they have a life expectancy of six months or less and their parents agree to forego any potentially curative treatments. Children and their families often need hospice-like services at an earlier stage of their illness, and many parents are reluctant to terminate curative treatments. Nationally, child health organizations, providers, and advocates are attempting to define a pediatric palliative care model that will enhance the quality of life for both the terminally ill child and the family.

Palliative vs. Curative Care

Hospice is a model of care that focuses on relieving symptoms and supporting patients with a life expectancy of six months or less. Medicare and Medicaid pay for hospice services for children, but federal regulations allow hospice services to be reimbursed only when there is an expectation that the patient will die within the next six months, and only if the child's parents have signed a statement agreeing to forego further curative treatment. Typically adults with a terminal illness experience a precipitous decline just before the end of life, whereas many children with life-limiting illnesses experience a gradual but inevitable decline, thus making it very difficult, if not impossible, to determine whether they are within six months of death.

Palliative care is patient- and family-centered care that seeks to enhance quality of life by providing treatments that focus on the relief of symptoms, such as pain, and conditions, such as loneliness or fear, that cause distress and detract from the child's quality of life. It also seeks to ensure that bereaved families are able to remain functional and intact.

Curative care is intended to eliminate the disease and promote recovery or prolong the life of the patient. However, the term "curative care" is not accurate for many children with severe malignancies or developmental or genetic diseases where survival to adulthood is often unlikely. The continuation of disease-modifying efforts for children with life-limiting diseases is usually life-prolonging rather than curative and may, in fact, provide palliative care rather than curative treatment. In adults, the election of hospice accompanies the medical decision that further disease-treating efforts will not substantially alter the natural course of the disease. In children, the continuation of disease-treating efforts may be seen as providing the child and family with additional improved quality of life.

Services currently available to Medicaid and SCHIP children in Vermont

"Dr. Dynasaur" is the name that most Vermonters recognize as Vermont's Medicaid and SCHIP program. Dr. Dynasaur children currently have access to many types of curative and palliative care services, such as

- physician visits
- inpatient and outpatient care
- medications for pain and symptom control
- medical equipment and supplies
- rehabilitative therapies (PT, OT, speech, inhalation)
- counseling and group therapy
- nurse practitioner services
- home health services, and
- personal care services.

Children also have access to hospice services. However, federal Medicare and Medicaid regulations require that children's life expectancy be six months or less in order to qualify for hospice services. The parents of the child must sign a statement that waives all other Medicaid services, except the services of a designated family physician, ambulance service, and services unrelated to the terminal illness. Hospice services are reimbursed on a per diem basis and are available for a maximum of 210 days.

Additional services under a waiver amendment

If Vermont requested an amendment to its Global Commitment waiver, and the amendment was approved by the Centers for Medicare and Medicaid (CMS), to allow concurrent curative and palliative care for children, children with life-limiting illnesses would be eligible to receive some services that they can receive now only if they are in hospice.

These services could include:

- care coordination
- respite care for the child's parents or caregivers
- expressive therapies such as art, music, and play therapies
- training for family members on palliative care principles and care needs, and bereavement counseling for family members.

These additional services could be provided to a child and the child's family as needed, subject to defined limits, for the duration of the child's illness.

There are many other services that families of terminally ill children need that cannot, unfortunately, be provided using Medicaid funds. Based on information received by OVHA from families and community organizations supporting families, these services could include:

- home adaptations and cleaning
- heating and air conditioning
- help with mortgage/rent and utilities
- vehicle repairs
- acupuncture and massage therapy
- help with funeral expenses, and
- travel expenses for families whose children are being treated away from their home community.

OVHA wishes to recognize and commend the excellent work community organizations and private foundations are doing to meet families' needs in these areas in spite of limited resources.

Waiver amendment process

The Social Security Act authorizes multiple waiver and demonstration authorities to allow states flexibility in operating Medicaid programs. Each authority has a distinct purpose, and distinct requirements.

Section 1115 Research & Demonstration Projects: This section provides the Secretary of Health and Human Services broad authority to approve projects that test policy innovations likely to further the objectives of the Medicaid program.

Section 1915(b) Managed Care/Freedom of Choice Waivers: This section provides the Secretary authority to grant waivers that allow states to implement managed care delivery systems, or otherwise limit individuals' choice of provider under Medicaid.

Section 1915(c) Home and Community-Based Services Waivers: This section provides the Secretary authority to waive Medicaid provisions in order to allow long-term care services to be delivered in community settings. This program is the Medicaid alternative to providing comprehensive long-term services in institutional settings.

Vermont is unique among states in its Section 1115 Global Commitment waiver that encompasses most Medicaid services offered in the state. After consultation with CMS central office staff in Baltimore, OVHA concluded that, were a decision made to move forward on a palliative care program, Vermont would most likely request an amendment to incorporate a pediatric palliative care program as part of its existing 1115 waiver, rather than request a separate waiver.

However, there is a potential problem with children covered by the federal State Children's Health Insurance Program (SCHIP). In Vermont, these are children on Dr. Dynasaur who have family incomes between 225% and 300 % FPL and who have no private insurance. SCHIP children are not covered by the 1115 Global Commitment waiver; rather, they are covered under the SCHIP state plan. Since there is no waiver authority under SCHIP, and since palliative care is not a state plan service under SCHIP, it is possible that palliative care services to SCHIP children would have to be paid for with state funds. However, if the legislature's decision is to move forward on a waiver amendment request, the administration would work with CMS to determine if there is a way to include SCHIP children in the federally-funded palliative care program. SCHIP children have not been included in other states' palliative care programs, except for Washington's program, which is not operating under a waiver.

There was pending federal legislation that, if passed, would have allowed Vermont to implement a palliative care program without a waiver amendment. H.R. 722, the ChiPACC (Children's program of all-inclusive coordinated care) Act of 2009, aka the "Mattie and Melinda bill," was co-sponsored by Representative James Moran of Virginia and Representative C.W. Young of Florida in January of 2009. It was in the House Energy and Commerce Committee when discussion began on the broader health care reform plan. Section 1632 of the Senate health care reform bill would allow states to provide hospice care to a child without requiring the child to give up rights to services related to treatment of the child's condition. There is no comparable provision in the House bills.

Pediatric palliative care programs in other states

Although there have been numerous pediatric palliative care programs in place for many years as collaborations between children's hospitals and hospice agencies, there are only a few states that have implemented programs utilizing federal Medicaid funds.

The Children's Hospice International Program for All-Inclusive Care for Children and Their Families (CHI PACC®) was developed by Children's Hospice International (CHI) in coordination with the Centers for Medicare and Medicaid (CMS). The CHI PACC® model eliminates the requirement that patients decline further curative treatments and have a prognosis of death within six months.

The U.S. Congress appropriated funds for FY 2000-2003 to enable CHI, through the Department of Health and Human Services, to conduct state demonstration model programs of the CHI PACC® model. Organizations (some of which were private hospitals or hospice associations) in six states were included in the demonstration:

Colorado, Florida, Kentucky, New York, Utah, and Virginia. The intent was that states would apply for a CMS waiver to continue the programs. To date, only Florida and Colorado have applied for waivers.

Below are descriptions of operating programs in states using federal Medicaid funds:

Florida's Partners in Care: Together for Kids

In 2005 Florida amended an existing 1915(b) waiver to create the first publicly financed program in the nation to support concurrent pediatric palliative and curative care. Partners in Care: Together for Kids (PIC) is administered by Florida's Title V program for children with special health needs (CSHN). To be eligible, children must be under age 21 and enrolled in CSHN, have an illness that puts them at risk of death before age 21, and be certified by a nurse case manager. The program began in seven pilot sites, and as of January 2008 there were nine sites serving a total of 468 children. Any hospice program approved by the state may participate if staff completes modules in a nationally-recognized palliative care curriculum within 24 months from start-up. According to a 2008 report produced by the University of Florida's Institute for Child Health Policy, 85% of parents were satisfied with the program.

Colorado's Hopeful Program

Colorado implemented its palliative care program in January of 2008 after approval of its 1915(c) waiver request by CMS in 2007. The Hopeful program, administered by Colorado's Medicaid agency, operates statewide and serves a maximum of 200 children under the age of 19 each year. To participate, children must be Medicaid eligible, have an illness that will result in probable death before adulthood, be at risk of hospitalization within one month, and be certified by a case manager. As of September of 2009 there were 85 children in the program. An additional 24 children were served prior to leaving the program for various reasons, such as death, reaching the age of 19, moving to traditional hospice services, moving to a group home, or moving out of state.

California's Pediatric Palliative Care Program

California's 1915(c) waiver, which was approved in December of 2008, will result in the implementation of pilot programs in five counties in its first year (beginning April 2009) and 11 counties in year two. They are expecting 300 children to be served in the first year and 800 in the second year. To be eligible, children must be from families with income below 100% of the federal poverty level, be under age 21, have been diagnosed with specific life-limiting conditions, be at risk of hospitalization, and certified by a nurse case manager or physician.

Washington State's Pediatric Palliative Care Program

Washington State did not request a waiver, but rather broadly interpreted the federal Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program to include certain palliative care benefits. To be eligible, children must be eligible for Medicaid, under the age of 21, and have a life-limiting medical condition with complex needs that requires case management and coordination of medical services. A limitation of the EPSDT approach is that services are not available to the child's family.

Although not programs that use federal Medicaid funds, a description of other New England programs is included here:

Massachusetts' Pediatric Initiative

Massachusetts' Health Care Reform Law included a pediatric initiative with a one-time appropriation of \$800,000 in state funds to pay for hospice services for children. Grants of \$55,000 each were awarded by the Department of Public Health to 10 hospice agencies for training, development, and implementation of an integrated pediatric palliative care program. The state sees itself as the "payer of last resort." Any costs for services not underwritten by the appropriation or reimbursed by private insurance become the responsibility of the hospice. Children under the age of 19 are eligible if they are determined by a physician to have a life-limiting illness.

Maine's Jason Program

The Jason Program, which began operation in November 2007, operates as a medical practice with an independent physician, full-time nurse and social worker, and part-time child life specialist and spiritual counselor. The program approaches care using a chronic care model along with palliative care. The Jason Program is a private enterprise, but obtained initial funding through Maine Medicaid program grant carved out of state-only funds and a gift from a local philanthropist.

A side-by-side comparison of programs in Colorado, Florida, and California is included as Attachment 2.

Analysis of Vermont Claims Data for Children with Life-limiting Illnesses

OVHA had hoped to obtain cost/savings data from other states that have pediatric palliative care programs already in place. In submitting their waiver requests, Florida, Colorado, and California predicted that new costs for palliative services would be more than offset by savings in acute services. For example, better coordination of treatment and good case management should reduce the number of emergency room visits, shorten hospital stays, or avoid hospital stays by providing services in the child's home. In fact, Colorado's and California's 1915(c) waiver requests are based on the assumption that children eligible for waiver services would be hospitalized were it not for the availability of the services provided under the waiver.

At the time this report was developed, however, there were no cost/savings data available based on actual program experience in these three programs. Because Florida's pediatric palliative care program is only one component of its 1915(b) waiver, it cannot stratify cost/savings data by program. Colorado will begin working on its first evaluative report to CMS later this fall, and California's program has been up and running for only a few months.

There has been some research on the cost savings associated with hospice and palliative care. Some studies have found that hospice care reduced Medicare spending by

significant amounts; however, these studies primarily involved adults who were in their last few months of life and so may or may not have relevance to a pediatric palliative care program that provides services to children at earlier stages of illness.

To analyze the potential costs of pediatric palliative care waiver services in Vermont, OVHA obtained a list from Children’s Hospice International of diagnosis codes for life-limiting illnesses and matched the list against its claims database for the period of SFY 2008 (July 1, 2007, through June 30, 2008). This match revealed 170 children on Medicaid and SCHIP with claims with one or more of these diagnosis codes.

The following chart shows the age and gender of these children:

| Children with life-limiting illnesses | | | |
|---|------------|-----------|--------------|
| | M | F | Total |
| Age | | | |
| 0 to 5 | 8 | 7 | 15 |
| 6 to 12 | 39 | 25 | 64 |
| 13 to 17 | 29 | 16 | 45 |
| 18 to 20 | 16 | 13 | 29 |
| 21+ * | 11 | 6 | 17 |
| Total | 103 | 67 | 170 |
| *These children were included because they were under 21 on the date of service for the claims included in this analysis. | | | |

Leukemia and other forms of cancer accounted for the majority of the illnesses diagnosed. The following is a chart showing the illnesses diagnosed and the number of children diagnosed with each one:

| Diseases and Conditions by Number Of Children | |
|---|---------------------------|
| Disease | Number of children |
| Leukemia | 43 |
| Other cancers | 65 |
| Muscular Dystrophy | 23 |
| Chronic liver disease | 14 |
| Other* | 25 |
| Total | 170 |
| *Includes cerebral palsy, Werdnig-Hoffmann disease, Patau's Syndrome, congenital heart disease, aplastic anemia, Fragile X Syndrome | |

Total Vermont Medicaid expenditures on claims for these 170 children were \$4,551,636.99 for SFY08, a total of 18,968 individual services. Per-child expenditures averaged \$26,774.34; however, per-child expenditures varied widely from a low of \$83.58 to a high of \$355,822.63, with approximately half of the children having claims of less than \$10,000. Forty-three of the 170 children had at least some claims paid by private insurance or Medicare.

The following table shows the number of children in various Medicaid claims expenditure ranges:

| Claims Cost Ranges | | | | |
|---------------------------|------------------------|-----------------------|----------------------|-------------------|
| Cost range | Number children | Total Amt Paid | % of Children | % of Costs |
| \$0 to \$1000 | 17 | \$8,247.31 | 10.00% | 0.18% |
| \$1001 to \$10,000 | 69 | \$302,270.51 | 40.59% | 6.64% |
| \$10,001 to \$20,000 | 20 | \$291,551.21 | 11.76% | 6.41% |
| \$20,001 to \$30,000 | 18 | \$431,074.58 | 10.59% | 9.47% |
| \$30,001 to \$40,000 | 11 | \$386,937.56 | 6.47% | 8.50% |
| \$40,001 to \$50,000 | 7 | \$313,315.82 | 4.12% | 6.88% |
| \$50,001 to \$100,000 | 19 | \$1,281,955.48 | 11.18% | 28.16% |
| \$100,000+ | 9 | \$1,536,284.52 | 5.29% | 33.75% |
| Total | 170 | \$4,551,636.99 | 100% | 100% |

The 170 children live in towns across the state. The following table shows the percentage of children in each region of the state:

| Region | Percentage of children |
|---------------|-------------------------------|
| Northeast | 10% |
| Northwest | 33% |
| Central | 20% |
| Southeast | 17% |
| Southwest | 20% |
| Total | 100% |

The children were receiving Medicaid through a variety of program components, including Reach Up, disabled child, Dr. Dynasaur, foster child, Katie Beckett, and VHAP. The largest categories were children receiving SSI disability benefits, Dr. Dynasaur, and Katie Beckett (Katie Beckett is a Medicaid component that allows the parents' income to be disregarded if the child meets certain disability criteria).

Financial impact of a waiver amendment

The provision of concurrent palliative care and curative care to Medicaid children could cost as much as \$1 million per year in state dollars, or as little as \$160,000 per year based on current rates for services (this cost may be approximately 4.2% higher for each subsequent year based on the Bureau of Labor Statistics Consumer Price Index five-year average for the Medical Care category). Attachments 3 and 4 show how the high- and low-cost estimates were derived. The high-cost estimate was based on an assumption that all 170 children with life-limiting illnesses would receive palliative care services during a given year, whereas the low-cost estimate assumes that only the highest-need children would receive services. The actual cost of the program would probably be closer to the lower-cost estimate for a number of reasons:

- Although all of the 170 children had at least one life-limiting diagnosis, many of the children had very few claims submitted under that diagnosis code, indicating that the illness was probably in an early stage or in remission, in which case palliative services may not yet be necessary.
- It is likely that there would not be an expectation of death before age 21 for at least some of the 170 children, in which case they would not qualify for hospice-like services under this program.
- Other states that have implemented similar programs are serving a relatively small number of children. For example, Florida has 468 children in its palliative care program out of a population of Medicaid children of 1,095,400 (as of 2008), or .04%. Colorado has 85 children out of a population of 232,500, or .037%. The 29 children in the low-cost estimate would represent .05% of Vermont's Medicaid children enrolled in 2008.
- Some of the children are receiving services through other state programs, such as Developmental Disability Services and Children's Personal Care Services, both programs administered by the Department of Disabilities, Aging, and Independent Living (DAIL). To the extent that other programs are providing case management, care coordination, home supports, respite care, crisis services, and other types of services, these same services would not be add-ons to the palliative care program. Both the high- and low-cost estimates do subtract personal care services from the additional costs, since the provision of personal care services would reduce the added cost for respite care.

Based on the advice of clinicians, OVHA has included in its cost analysis an estimate of inpatient and outpatient savings based on an assumption that some emergency room and hospital readmissions could be avoided through effective case management.

Conclusions

Although other states have projected cost neutrality for their palliative care programs, no state has yet been able to prove cost neutrality using actual program experience. Based on actual claims data for SFY 08 for children with life-limiting illnesses, OVHA estimates that a palliative care program in Vermont could cost as little as \$160,000 per year in state funds, provided that additional palliative care services are provided only to children in advanced stages of illness.

OVHA wishes to thank the following people who provided information and guidance in developing this report:

Ann Armstrong-Dailey, Children's Hospice International
Patricia Berry, Vermont Child Health Improvement Program (VCHIP), UVM
Dr. Zail Berry, UVM College of Medicine
Stephen Brooks, Children with Special Health Needs, VT Department of Health
Melissa Harris, Centers for Medicare and Medicaid Services (CMS)
Thomas Hennessy, CMS
Brendan Hogan, VT Department of Disabilities, Aging, and Independent Living (DAIL)
Edward Hutton, CMS
Dr. Robert Macauley, Pediatric Palliative Care Team, Fletcher Allen Health Care
Linda MacDonald, Agency for Health Care Administration, State of Florida
Ellen Malone, DAIL
Christine Marcellino, Children's Specialty Center
Angel Means, Visiting Nurses Association
David O'Vitt, DAIL
Judy Peterson, Central Vermont Home Health and Hospice
Dawn Phillibert, VT Department of Health
Diana Pierce, Central Vermont Home Health and Hospice
Barbara Segal, Palliative Care Service, Fletcher Allen Health Care
Dr. Judy Shaw, VCHIP, UVM
Carrie Smith, CMS
Mark Sustic & Deborah Travis, RN, Tom Sustic Fund
Elizabeth Svedek, Health Care Policy and Financing, State of Colorado
Dr. Donald Swartz, VT Department of Health
Chong Tieng, CMS
Dr. Richard Wasserman, VCHIP, UVM
Scott Wittman, Pacific Health Policy Group
Kay Van Woert, Vermont Family Network/Family Voices of Vermont
Office of Vermont Health Access staff members

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Attachment 1

Section 7 of Act 25, An Act Relating to Palliative Care

- (a) No later than October 1, 2009, the secretary of human services shall submit to the house committees on appropriations and on human services and the senate committees on appropriations and on health and welfare a report on the programmatic and cost implications of a Medicaid and a State Children's Health Insurance Program (SCHIP) waiver amendment allowing Vermont to provide its Medicaid- and SCHIP-eligible children who have life-limiting illnesses with concurrent palliative services and curative care.
- (b) For purposes of this section:
 - (1) "Life-limiting illness" means a medical condition that, in the opinion of the child's treating health care provider, has a prognosis of death that is highly probable before the child reaches adulthood.
 - (2) "Palliative services" means personal care, respite care, hospice-like services, and counseling.

Attachment 2

COMPARISON OF PEDIATRIC PALLIATIVE CARE PROGRAM IN THREE STATES

| | Colorado | Florida | California |
|-----------------------------|--|--|--|
| Implementation date | January 1, 2008 | January 1, 2005 | April 1, 2009 |
| Name of program | Hopeful (Pediatric Hospice waiver) | FL Partners in Care: Together for Kids | CA Pediatric Palliative Care |
| Waiver type | 1915c HCBS | 1915b managed care | 1915c HCBS |
| Regions | Statewide | 7 sites to start, 9 sites in 2008 | 5 counties in Yr 1, 11 in Yr 2 |
| Age | Up to age 19 | Up to age 21 | Up to age 21 |
| Number served | Up to 200 per year, currently 85 | Up to 1000/yr, 251 in 2007, 468 in 2008 | 300 Yr 1, 801 Yr 2, 1802 Yr 3 |
| Agency | Dept. of HC Policy & Financing (Medicaid agency) | Children's Medical Services Network Title V - CSHN | Medi-Cal (Medicaid agency) CA Children's Services |
| Eligibility criteria | Medicaid-eligible Probable death before adulthood At risk of hospitalization within 1 mo. Certification by case manager At least one benefit per month | Enrolled in CSHN At risk of death prior to age 21 Certification by nurse case manager | 100% FPL (Medi-Cal eligible) Diagnosed with specified conditions At risk of hospitalization Certification by nurse case mgr or phys |
| Covered services | In-home respite care (30 days/year) Personal care Nursing or home health aide Individual/family counseling (98 hrs/yr) Expressive therapies (39 hrs/yr) Palliative/supportive care (per diem) Hospice-like services such as: PT/OT Speech pathology Alternative therapies Dietary counseling Case management (admin, not benefit) | Provided by 7 hospice agencies: Art, music, play therapies Pain and symptom control In-home nursing In-home personal care (up to 6 hrs/day) Respite care (7 days/yr) Individual/group counseling | Care coordination (fixed fee 4-12 hrs/mo) Respite care (in and out of home) (30 days/yr) Family counseling (52 hrs/yr) Expressive therapies (30 hrs/90 days) Family training on palliative care (100 hrs/yr) |

Attachment 3: ADDITIONAL PALLIATIVE CARE COSTS--HIGH ESTIMATE

| COSTS | | | | | | |
|--|--------------------------|-------------------------|-------------|------------------------|-----------------|-----------------------|
| Type of service | Max units/child | # Children ⁴ | Units/child | Cost/unit ⁵ | Gross cost/year | |
| Family training/counseling | 98 hours ¹ | | | | | |
| High need | | 35 | 98 | \$70.56 | | \$242,020.80 |
| Medium need | | 49 | 49 | \$70.56 | | \$169,414.56 |
| Low need | | 86 | 24 | \$70.56 | | \$145,635.84 |
| In-home respite care | 720 hours ¹ | | | | | |
| Skilled | High need | 35 | 720 | \$40.68 | | \$1,025,136.00 |
| Unskilled | Medium need | 49 | 360 | \$23.08 | | \$407,131.20 |
| | Low need | 86 | 180 | \$23.08 | | \$357,278.40 |
| Expressive therapy | 39 hours ¹ | | | | | |
| | High need | 35 | 39 | \$46.96 | | \$64,100.40 |
| | Medium need | 49 | 20 | \$46.96 | | \$46,020.80 |
| | Low need | 86 | 10 | \$46.96 | | \$40,385.60 |
| Bereavement counseling | 26 hours ² | 5 | 26 | \$70.56 | | \$9,172.80 |
| Care coordination/case mgt. | 2 positions ³ | | 2 | \$77,625.00 | | \$155,250.00 |
| GROSS COSTS | | | | | | \$2,661,546.40 |
| Minus personal care⁶ | | | | | | \$473,314.83 |
| ADJUSTED COSTS | | | | | | \$2,188,231.57 |
| SAVINGS⁷ | | | | | | |
| Type of service | Claims cost | Reduction | | Gross savings | | |
| Inpatient claims | \$942,920.53 | 20% | | \$188,584.11 | | |
| Outpatient claims | \$387,319.55 | 10% | | \$38,731.96 | | |
| GROSS SAVINGS | | | | | | \$227,316.06 |
| NET COSTS | | | | | | \$2,434,230.34 |
| STATE SHARE⁸ | | | | | | \$1,005,093.71 |

¹Maximum units are based on Colorado's program.

²Payment would occur at time of child's death; sessions could be spread over a 12-month period following child's death.

³Estimate of # positions is based on a ratio of 1:25, with assumption that not all 170 children would need CM, and some were already receiving CM services.

⁴High/medium/low need categories are based on cost; if program became operational, a clinical evaluation would determine each child's needs.

High need = \$40,000+, medium need = \$10,000-\$40,000, low need = less than \$10,000.

⁵Cost per unit is based on current allowable Medicaid reimbursement rates for same or similar services.

⁶46 of the 170 children were receiving personal care services equivalent to respite care, so these would not be additional costs.

⁷Savings estimates are based on the assumption that some inpatient and emergency room claims can be avoided with effective case management.

Attachment 3 Costs and savings have not been adjusted for medical inflation, assuming a potential implementation date of SFY 11.

Attachment 4 ADDITIONAL PALLIATIVE CARE COSTS--LOW ESTIMATE

COSTS

| Type of service | Max units/child | # Children | Units/child | Cost/unit ⁴ | Gross cost/year |
|-----------------------------------|--------------------------|------------|-------------|------------------------|---------------------|
| Family training/counseling | 98 hours ¹ | 29 | 98 | \$70.56 | \$200,531.52 |
| In-home respite care ⁵ | 720 hours ¹ | 5 | 720 | \$40.68 | \$146,448.00 |
| Expressive therapy | 39 hours ¹ | 29 | 39 | \$46.96 | \$53,111.76 |
| Bereavement counseling | 26 hours ² | 3 | 26 | \$70.56 | \$5,503.68 |
| Care coordination/case mgt. | 1 positions ³ | | 1 | \$77,625.00 | \$77,625.00 |
| GROSS COSTS | | | | | \$483,219.96 |

SAVINGS⁶

| Type of service | Claims cost | Reduction | Gross savings |
|-------------------|--------------|-----------|---------------|
| Inpatient claims | \$708,726.49 | 20% | \$141,745.30 |
| Outpatient claims | \$191,233.88 | 10% | \$19,123.39 |

GROSS SAVINGS **\$160,868.69**

NET COSTS **\$322,351.27**

STATE SHARE **\$133,098.84**

¹Maximum units are based on Colorado's program.

²Payment would occur at time of child's death; sessions could be spread over a 12-month period following child's death.

³Estimate of # positions is based on a ratio of 1:25, with the assumption that not all 170 children will need CM, and some children were already receiving services.

⁴Cost per unit is based on current allowable Medicaid reimbursement rates for same or similar services.

⁵Only 5 of the 29 children were not receiving personal care.

⁶Savings estimates are based on the assumption that some inpatient and emergency room claims can be avoided with effective case management.

Costs and savings have not been adjusted for medical inflation, assuming a potential program implementation date of SFY11.

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THE FINANCIAL IMPACT OF ALLOWING DEPRECIATION AS A BUSINESS EXPENSE WHEN DETERMINING ELIGIBILITY FOR HEALTH CARE PROGRAMS

A Report from the Office of Vermont Health Access to the
Senate Appropriations Committee
House Appropriations Committee
Senate Health & Welfare Committee
House Health Care Committee

January 15, 2010

Summary

Section 23 of Act 61, passed during the 2008/2009 legislative session, states the following:

No later than January 15, 2010, the office of Vermont health access shall report to the house committees on appropriations and on health care and the senate committees on appropriations and on health and welfare on the financial impact of modifying the income eligibility rules to allow depreciation as a business expense effective upon approval of the waiver amendment pursuant to Sec. 22(a)(2) of this act. The report shall include an analysis of estimated increases in enrollment, impacts on the premium amounts paid by the enrollees, and increases in federal funds due to the rule change.

The analysis described in this report found that allowing depreciation as a deduction from self-employment income when determining eligibility for health care assistance programs would most likely cost approximately \$81,000 in state funds for the last five months of SFY10 (assuming a February 1, 2010, implementation date) and \$266,400 in SFY11, assuming that the policy change would be phased in for active cases over a 12-month period beginning on February 1, 2010. If the policy change were implemented at a single point in time, rather than phased in as beneficiaries reach their 12-month review, the cost in SFY11 would be \$281,700; however, it would be administratively very difficult to implement this change for all beneficiaries at the same time.

It is likely that the cost of this policy change is understated, since it was not possible to include in the estimated cost the impact of individuals who may have been denied coverage in the past, but who subsequently learn that depreciation is now an allowable expense, and therefore reapply for benefits.

Due to the fact that the Centers for Medicare and Medicaid (CMS) have not yet approved Vermont's request for a waiver amendment to allow depreciation as a business expense deduction, it is highly unlikely that implementation can occur on February 1. CMS has indicated that it will not consider the waiver amendment request until and unless the Vermont legislature restores funding for this policy change.

OVHA worked closely with Joint Fiscal Office to develop the cost estimates based on the results of the case reviews described in the methodology section of this report.

The types of businesses owned by the beneficiaries in the active cases sample were quite diverse. Of the people who would change categories if depreciation were allowed, almost half were in the construction business (carpenters and painters). Other lines of work included rental property, sandwich shop, hair salon, massage, house cleaning, flea market sales, upholstery, and child/adult day care. There was only one farmer in the sample. Monthly depreciation deductions in the sample as a whole ranged from \$0 to \$2347.50. Approximately 14% of the depreciation amounts exceeded \$1000 per month.

Background

The Internal Revenue Service defines "depreciation" in its Schedule C instructions as "the annual deduction allowed to recover the cost or other basis of business or investment property having a useful life substantially beyond the tax year."

The majority of the assistance programs administered by the Department for Children and Families' Economic Services Division (DCF/ESD) do not allow depreciation as a business expense when calculating income for purposes of determining eligibility. These programs include Reach Up, 3SquaresVT (formerly food stamps), fuel assistance, and most health care programs, including Medicaid, VHAP, and Catamount and ESIA premium assistance. Dr. Dynasaur is the only program that allows depreciation as a business expense. The policy decision to allow depreciation as a business expense for Dr. Dynasaur was made at the time Dr. Dynasaur was implemented to align the eligibility determination process with the Department of Health's Women, Infants, and Children program.

Federal regulations for 3SquaresVT prohibit the use of depreciation as a business expense when determining eligibility. Federal regulations for other programs are silent on this issue.

When DCF/ESD eligibility workers (called "Benefit Program Specialists" or "BPSs") receive an application from a self-employed person, they request the person to submit the most recently filed tax return, which will include an IRS Schedule C, the Profit or Loss from Business form. When computing countable income for the eligibility determination process, a BPS will use the net income from Schedule C (which allows deductions from gross income for advertising, labor costs, insurance, office costs, supplies, travel, meals, and other business expenses); however, the BPS will add the depreciation cost to net income to reach the countable income amount.

Methodology used to develop the cost estimate

DCF/ESD searched the eligibility database to find all self-employed VHAP, premium assistance, and Healthy Vermonters beneficiaries with active cases for the four-month period of February through May of 2008. Medicaid beneficiaries were not included in the pool of potentially affected beneficiaries since they are already below 100% of the Federal Poverty Level (FPL) and would therefore not become eligible for a different category of health care assistance were depreciation allowed as a business expense. Dr. Dynasaur children were not included because depreciation is already an allowable business expense deduction in that program. In addition, a list was produced of self-employed VHAP, Medicaid, and premium assistance beneficiaries whose coverage ended during the four-month sample period because their income exceeded 300% FPL.

The self-employed population for the four-month period included 6393 active VHAP and premium assistance cases, 100 Healthy Vermonter cases, and 99 closed cases. From these three pools random samples were chosen to produce a cost estimate with a 95% confidence level and a 10% margin of error. A DCF/ESD central office eligibility expert then manually recomputed eligibility for all cases in the sample and recorded the results, which were then extrapolated to the entire population.

Results of sample evaluation

For approximately one third of the cases active in VHAP or the premium assistance programs, allowing depreciation as a business expense would either change their health care category (for example, a person on Catamount Health premium assistance would qualify for VHAP), or reduce their monthly premium (for example, someone on VHAP would have a premium of \$7 instead of \$49). In some cases the loss of premium revenue was more than offset by savings in the per-member-per-month (PMPM) cost, since the Catamount Health PMPM is higher than the VHAP PMPM.

In the sample of Healthy Vermonters cases, approximately 45% would become eligible for either premium assistance or VHAP if depreciation were allowed as a business expense. Since Healthy Vermonters is a pharmacy discount program that requires no state program costs, any shift from Healthy Vermonters to other assistance categories would be a new cost.

In the sample of closed cases approximately 50% would have remained eligible for a component of health care assistance had depreciation been an allowed business expense deduction. Specific data on cases with self-employment income that were denied over the five-month sample period could not be obtained, so an estimate of the cost of denials was derived by evaluating the total number of health care denials vs. closures over a several-month period. It was found that there was an average of 3.3 times as many closures as denials; therefore, the estimated cost of the closures in the sample was divided by 3.3 to determine an estimated denial cost.

Below is a breakdown of the costs for each category:

Active cases

| | SFY 10 | SFY 11 |
|-------|---------------|---------------|
| Gross | \$37,530.13 | \$216,533.04 |
| Net | \$15,421.13 | \$89,384.84 |

Healthy Vermonters

| | SFY 10 | SFY 11 |
|-------|---------------|---------------|
| Gross | \$78,235.90 | \$211,272.90 |
| Net | \$32,147.13 | \$87,213.45 |

Closed cases

| | SFY 10 | SFY 11 |
|-------|---------------|---------------|
| Gross | \$62,451.20 | \$166,998.18 |
| Net | \$25,661.20 | \$68,936.85 |

Denied cases

| | SFY 10 | SFY 11 |
|-------|---------------|---------------|
| Gross | \$18,924.61 | \$50,605.51 |
| Net | \$7,776.12 | \$20,889.95 |

TOTAL

| | SFY 10 | SFY 11 |
|-------|---------------|---------------|
| Gross | \$197,141.84 | \$645,409.63 |
| Net | \$81,005.58 | \$266,425.10 |

ACRONYMS

| | |
|---|---|
| AAA..... Area Agency on Aging | CC.....Committed Child |
| AABD Aid to the Aged, Blind & Disabled | CCMP.....Chronic Care Management Program |
| AAG..... Assistant Attorney General | CCTA..... Chittenden County Transportation Authority |
| AAP American Academy of Pediatrics | CD.....Compact Disk |
| ABAWD Able-Bodied Adults without Dependents | CF.....Crisis Fuel |
| ABD.....Aged, Blind and Disabled | CFR.....Code of Federal Regulations |
| ACCESS.....The computer software system used by DCF and OVHA to track program eligibility information | CHAP..... Catamount Health Assistance Program |
| ACF..... Administration for Children & Families | CHF..... Congestive Heart Failure |
| ADA..... American Dental Association | CHIPRA.....Children’s Health Insurance Program Re-authorization Act of 2009 |
| ADAP.....Alcohol and Drug Abuse Programs | CHPR Center for Health Policy and Research |
| ADO.....St. Albans District Office | CIO Chief Information Office |
| AEP Annual Enrollment Period | CM.....Case Management |
| AGA..... Adult General Assessment | CMN.....Certification of Medical Necessity |
| AHCPR.....Agency for Health Care Policy & Research | CMS..... Centers for Medicare & Medicaid Services (formerly HCFA) |
| AHEC..... Area Health Education Center | CMSO..... Center for Medicaid & State Operations |
| AHRQ Agency for Healthcare Research & Quality | COA.....Council on Aging |
| AHS..... Agency of Human Services | COBCoordination of Benefits |
| AIM®.....Advanced Information Management system (see MMIS) | COB-MAT.....Coordination of Office Based Medication Assisted Therapy |
| AIRS.....Automated Information and Referral System | CON.....Certificate of Need |
| ALS Advanced Life Support | COPDChronic Obstructive Pulmonary Disease |
| AMA American Medical Association | COPS.....Computer Operations and Problem Solving |
| AMAP..... Aids Medication Assistance Program | COS Categories of Service |
| ANFC.....Aid to Needy Families with Children | CPH.....Community Public Health (of the VDH) |
| AOA..... Agency of Administration | CPT.....Common Procedural Terminology |
| APA Administrative Procedures Act | CPTOD. Capitated Program for the Treatment of Opiate Dependency |
| APC..... Ambulatory Payment Classification | CRT.....Community Rehabilitation & Treatment |
| APD Advance Planning Document | CSD.....Computer Services Division |
| APS.....APS Healthcare | CSME..... Coverage & Services Management Enhancement |
| ASD..... Administrative Services Division | CSR.....Customer Service Request |
| AWP..... Average Wholesale Price | CY.....Calendar Year |
| BAFO Best & Final Offer | DAD..... Department of Aging & Disabilities (see DAIL) |
| BC/BS Blue Cross/Blue Shield | DAIL.....Department of Disabilities, Aging and Independent Living |
| BCCT.....Breast and Cervical Cancer Treatment Program | DCF.....Department for Children and Families |
| BD Blind & Disabled | DDI.....Design, Development & Implementation |
| BDO Burlington District Office | DDMHS.....Department of Developmental & Mental Health Services |
| BISHCA.....Banking, Insurance, Securities, & Health Care Administration (Department of) | DDS.....Disability Determination Services (part of DCF) |
| BPS..... Benefits Programs Specialist | DHHS..... Department of Health & Human Services (United States) |
| BROC.....Bennington-Rutland Opportunity Council | |
| CAHPS.....Consumer Assessment of Health Plans Survey | |
| CAP.....Community Action Program | |

| | | | |
|------------|---|--------------|--|
| DII..... | Department of Information & Innovation | FFS..... | Fee for Service |
| DIS | Detailed Implementation Schedule | FFY..... | Federal Fiscal Year |
| DME..... | Durable Medical Equipment | FH..... | Fair Hearing |
| DMC | Disease Management Coordinators | FICA..... | Federal Insurance Contribution Act |
| DMH..... | Department of Mental Health | FMAP..... | Federal Medical Assistance Percentage |
| DO..... | District Office | FPL. | Federal Poverty Level |
| DOA..... | Date of Application | FQHC..... | Federally Qualified Health Centers |
| DOB | Date of Birth | FUL..... | Federal Upper Limit (for pricing & payment of drug claims) |
| DOC..... | Department of Corrections | GA | General Assistance |
| DOE | Department of Education | GAO | General Accounting Office |
| DOH | Department of Health (see VDH) | GC..... | Global Commitment |
| DOS..... | Date of Service | GCR..... | Global Clinical Record (application of the MMIS) |
| DR..... | Desk Review | GF..... | General Fund |
| DRA | Deficit Reduction Act | GMC..... | Green Mountain Care |
| DR. D..... | Dr. Dinosaur Program | HAEU..... | Health Access Eligibility Unit |
| DRG | Diagnosis Related Grouping | HATF..... | Health Access Trust Fund |
| DSH..... | Disproportionate Share Hospital | HCBS..... | Home and Community Based Services |
| DSW..... | Department of Social Welfare (see PATH) | HCFA..... | Health Care Finance Administration (now CMS) |
| DUR | Drug Utilization Review (Board) | HCPCS..... | HCFA Common Procedure Coding System |
| EA | Emergency Assistance | HDO..... | Hartford District Office |
| EAC..... | Estimated Acquisition Cost | HEDIS..... | Healthcare Effectiveness Data & Information Set |
| EBT..... | Electronic Benefit Transfer | HHA..... | Home Health Agency |
| ECS..... | Electronic Claims Submission | HHS..... | Health and Human Services (U.S. Department of) |
| EDI..... | Electronic Data Interchange | HIE..... | Health Information Exchange |
| EDS | Electronic Data Systems Corporation, now HP Enterprise Services | HIFA..... | Health Insurance Flexibility and Accountability |
| EFT | Electronic Funds Transfer | HIPAA..... | Health Insurance Portability & Accountability Act |
| EGA | Estimated Gestational Age | HIT..... | Health Information Technology |
| EHR..... | Electronic Health Record | HP..... | HP Enterprise Services, formerly EDS |
| EOMB..... | Explanation of Medicare (or Medicaid) Benefits | HPIU | Health Programs Integration Unit |
| EP..... | Essential Person | HRA..... | Health Risk Assessment |
| EPSDT..... | Early & Periodic Screening, Diagnosis & Treatment | HRSA..... | Health Resources and Services Administration |
| EQR..... | External Quality Review | HSB..... | Human Services Board |
| ER..... | Emergency Room | HVP..... | Healthy Vermonters Program |
| ERA..... | Electronic Remittance Advice | IAPD..... | Implementation Advance Planning Document |
| ERC..... | Enhanced Residential Care | IBNR..... | Incurred But Not Reported |
| ESD..... | Economic Services Division (of the DCF) | IC | Individual Consideration |
| ESI..... | Employer Sponsored Insurance | ICD | International Classification of Diseases |
| ESRD..... | End Stage Renal Disease | ICF/MR..... | Intermediate Care Facility for the Mentally Retarded |
| EST | Eastern Standard Time | ICN..... | Internal Control Number |
| EVAH..... | Enhanced VT Ad Hoc (query & reporting system) | ICU | Intensive Care Unit |
| EVS..... | Eligibility Verification System | ID | Identification |
| FA..... | Fiscal Agent | IEP..... | Individual Education Plan |
| FADS..... | Fraud Abuse & Detection System | | |
| FDA..... | Food & Drug Administration | | |
| FEIN..... | Federal Employer's Identification Number | | |
| FFP | Federal Financial Participation | | |

| | | | |
|-------------|---|--------------|---|
| IEVS..... | Income Eligibility Verification System | NDO..... | Newport District Office |
| IGA..... | Intergovernmental Agreements | NEKCA..... | Northeast Kingdom Community Action |
| IHI..... | Institute for Healthcare Improvement | NEMT | Non-Emergency Medical Transportation |
| IRS..... | Internal Revenue Service | NGA..... | National Governors Association |
| IT..... | Information Technology | NPA..... | Non-Public Assistance |
| ITF..... | Integrated Test Facility | NPF..... | National Provider File |
| IVS..... | Intervention Services | NPI..... | National Provider Identifier |
| JCL..... | Job Control Language | OADAP..... | Office of Alcohol & Drug Abuse Programs |
| JDO..... | St. Johnsbury District Office | OASDI..... | Old Age, Survivors, Disability Insurance |
| LAMP..... | Legal Aid Medicaid Project | OCS..... | Office of Child Support |
| LAN..... | Local Area Network | ODAP..... | Office of Drug & Alcohol Prevention |
| LC..... | Legislative Council | OEO..... | Office of Economic Opportunity |
| LDO..... | Brattleboro District Office | OHRA..... | Oral Health Risk Assessment |
| LECC..... | Legally Exempt Child Care | OPS..... | Operations |
| LIHEAP..... | Low-Income Home Energy Assistance Program | OPPS..... | Outpatient Prospective Payment System |
| LIS..... | Low-Income Subsidy | OTC..... | Over the Counter |
| LIT..... | Local Interagency Team | OVHA..... | Office of Vermont Health Access |
| LTC..... | Long-Term Care | PA..... | Prior Authorization or Public Assistance |
| LUPA..... | Low Utilization Payment Adjustment | PACE..... | Program for All-Inclusive Care for the Elderly |
| MA..... | Medicare Advantage – Medicare Part C in VT | PARIS..... | Public Assistance Reporting Information System |
| MAB..... | Medicaid Advisory Board | PATH..... | Department of Prevention, Assistance, Transition, & Health Access (now DCF) |
| MAC..... | Maximum Acquisition Cost | PBA/PBM... | Pharmacy Benefits Administrator/Pharmacy Benefits Manager |
| MAC..... | Maximum Allowable Cost (refers to drug pricing) | PC Plus..... | VT Primary Care Plus |
| MARS..... | Management & Administrative Reporting | PC..... | Personal Computer |
| MAT..... | Medication Assisted Therapy | PCCM..... | Primary Care Case Management |
| MCO..... | Managed Care Organization | PCP..... | Primary Care Provider |
| MCP..... | Managed Care Plan | PDF..... | Portable Document File |
| MDB..... | Medicare Database | PDL..... | Preferred Drug List |
| MDO..... | Barre District Office | PDP..... | Prescription Drug Plan |
| MEQC..... | Medicaid Eligibility Quality Control | PDSA..... | Plan Do Study Act |
| MFRAU..... | Medicaid Fraud & Residential Abuse Unit | PEP..... | Proposal Evaluation Plan or Principal Earner Parent |
| MID..... | Beneficiary Medicaid Identification Number | PERM..... | Payment Error Rate Measurement |
| MIS..... | Management Information System | PES..... | Provider Electronic Solutions |
| MITA..... | Medicaid Information Technology Architecture | PHO..... | Physician Hospital Organization |
| MMA..... | Medicare Modernization Act | PI..... | Program Integrity |
| MMIS..... | Medicaid Management Information System | PIL..... | Protected Income Level |
| MNF..... | Medical Necessity Form | PIRL..... | Plan Information Request Letter |
| MOE..... | Maintenance of Effort | PMPM..... | Per Member Per Month |
| MOVE..... | Modernization of Vermont’s Enterprise | PNMI..... | Private Non-Medical Institution |
| MSIS..... | Medicaid Statistical Information | POC..... | Plan of Care |
| MSP..... | Medicare Savings Programs | POS..... | Point of Sale or Point of Service |
| MVP..... | Mohawk Valley Physicians | PP&D..... | Policy, Procedures and Development (Interpretive Rule Memo) |
| NCBD..... | National CAHPS Benchmarking Database | PPR..... | Planning, Policy and Regulation |
| NDC..... | National Drug Code | PRO..... | Peer Review Organization |

| | | | |
|-------------|---|--------------|---|
| PRWORA..... | Personal Responsibility & Work Opportunity Reconciliation Act | UC..... | Unemployment Compensation |
| PSE..... | Post-Secondary Education | UCR..... | Usual & Customary Rate |
| QC..... | Quality Control | UI..... | Unemployment Insurance |
| QI..... | Qualified Individual | UIB..... | Unemployment Insurance Benefits |
| QIAC..... | Quality Improvement Advisory Committee | UM..... | Utilization Management |
| QMB..... | Qualified Medicare Beneficiary | UR..... | Utilization Review |
| QWDI..... | Qualified Working Disabled Individual | UVM..... | University of Vermont |
| RA..... | Remittance Advice | VA..... | Veterans Administration |
| RBC..... | Risk Based Capital | VAB..... | VT Association for the Blind |
| RBUC..... | Reported But Unpaid Claims | VAHHA..... | VT Assembly of Home Health Agencies |
| RDO..... | Rutland District Office | VAHHS..... | VT Association of Hospital & Health Systems |
| REVS..... | Recipient Eligibility Verification System | VCCI..... | VT Chronic Care Initiative |
| RFI..... | Requests for Information | VDH..... | VT Department of Health |
| RFP..... | Requests for Proposals | VDHA..... | VT Dental Hygienists Association |
| RN..... | Registered Nurse | VDO..... | Morrisville District Office |
| RO..... | Regional Office | VHAP... .. | VT Health Access Plan |
| RR..... | Railroad Retirement | VHAP-Rx..... | VT Health Access Plan Pharmacy Program |
| RU..... | Reach Up program | VIP..... | VT Independence Project |
| RVU..... | Relative Value Units | VISION..... | VT's Integrated Solution for Information and Organizational Needs (the statewide accounting system) |
| SAMHSA... | Substance Abuse and Mental Health Services Administration | VIT..... | VT Interactive Television |
| SAS..... | Statement on Auditing Standards | VITL..... | VT Information Technology Leaders |
| SCHIP..... | State Children's Health Insurance Program | VLA..... | VT Legal Aid |
| SDO..... | Springfield District Office | VMS..... | VT Medical Society |
| SDX..... | State Data Exchange System | VNA..... | Visiting Nurses Association |
| SE..... | Systems Engineer | VPHARM..... | VT Pharmacy Program |
| SEP..... | Special Enrollment Periods | VPQHC..... | VT Program for Quality in Health Care |
| SF..... | Supplemental Fuel | VPTA..... | Vermont Public Transportation Agency |
| SFY..... | State Fiscal Year | VR..... | Vocational Rehabilitation |
| SLMB..... | Specified Low-Income Medicare Beneficiary | VRS..... | Voice Response System |
| SMM..... | State Medicaid Manual | VSA..... | VT Statutes Annotated |
| SNF..... | Skilled Nursing Facility | VSAC..... | VT Student Assistance Corporation |
| SPA..... | State Plan Amendment | VScript..... | VT Pharmacy Assistance Program |
| SPAP..... | State Pharmacy Assistance Program | VSDS..... | VT State Dental Society |
| SRS..... | Social & Rehabilitative Services (Department of) | VSEA..... | VT State Employees Association |
| SSA..... | Social Security Administration or State Self Assessment | VSECU..... | VT State Employees Credit Union |
| SSI..... | Supplemental Security Income | VSH..... | VT State Hospital |
| SSN..... | Social Security Number | VSHA..... | VT State Housing Authority |
| SUR..... | Surveillance & Utilization Review | VT..... | State of Vermont |
| TAD..... | Turnaround Documents | VTD..... | VT Part D as Primary |
| TANF..... | Temporary Assistance for Needy Families (Reach Up in VT) | VTM..... | VT Medicaid as Primary |
| TBI..... | Traumatic Brain Injury | VUL..... | VT Upper Limit |
| TDO..... | Bennington District Office | WAM..... | Welfare Assistance Manual |
| TM..... | Transitional Medicaid | WIC..... | Women, Infants & Children |
| TPA..... | Third Party Administrator | WTW..... | Welfare to Work |
| TPL..... | Third Party Liability | YDO..... | Middlebury District Office |
| | | ZDO..... | State Office/Central Office (Waterbury) |

Mandatory & Optional Coverage Groups & Services

| Medicaid Eligibility Group | Description of Population | | | Mandatory Services | Optional Services |
|--|---|-------------|---|--|---|
| Mandatory Population | | | | | |
| <ul style="list-style-type: none"> • ANFC Children • ANFC Adults | Traditional Medicaid: mandatory groups under Title XIX of Social Security Act | 0%-100% FPL | Children <ul style="list-style-type: none"> • Children who meet §1931 criteria (1996 ANFC financial test) • Children receiving Reach Up • Newborns up to 12 months • Children ages 1 through 5 • Children 6 or older, born after 9/30/83 • Children under 19, born after 9/30/83 • Transitional Medicaid (first 12 months) Pregnant Women Parents & Caretaker Relatives | Inpatient hospital (excl. inpatient svcs. in IMDs) Outpatient hospital including FQHCs Other laboratory and x-ray Certified pediatric and family nurse practitioners Nursing facility svcs. for beneficiaries age 21+ EPSDT for children under age 21 Family planning services and supplies Physicians' services Medical and surgical services of a dentist Home health svcs. for those entitled to nursing facility svcs. Home health aides | Podiatrists Optometrists Psychologists Physician Directed Clinic Services Home Health Audiology Therapy Dental Physical Therapy Occupational Therapy Speech & Language Therapy Prescribed Drugs Prosthetic Devices Screening Services Preventive Services Mental Health Stabilization Rehab Mental Health Other Inpatient Hosp., NH, ICF/MR Inpatient Psych. For under 21 Personal Care Services Targeted Case Mgmt. Primary Care Case Mgmt. Hospice Care Respiratory Care for Ventilator Dependent PACE Transportation Nursing Facility for Under 21 Emergency Hospital for Non-MCare Particip. Eyeglasses Orthotics ADAP Dialysis Ambulance HCBS (Children's Waiver?? DS Waiver??) |
| <ul style="list-style-type: none"> • ABD Adults • ABD Duals • BD Children | Traditional Medicaid: Mandatory Groups (SSI-Related) | | <ul style="list-style-type: none"> • SSI cash recipients • Individuals receiving state supplemental payments (AABD) • Disabled children eligible under §4913 • Disabled adult children • Individuals determined eligible under the Pickle amendment • Disabled widows and widowers • Early widows and widowers • Essential spouses eligible in December 1973 • Institutionalized individuals eligible in 1973 • Disabled individuals eligible in 1973 | Intermittent or part-time nursing services provided by home health agency or by a registered nurse when there is no home health agency in the area Medical supplies and appliances for use in the home Nurse mid-wife services Pregnancy related services Prenatal and delivery services RHCs and FQHCs Post partum services for those under age 18 who are entitled to institutional and ambulatory services | |

| Medicaid Eligibility Group | Description of Population | | | Mandatory Services | Optional Services |
|--|--|----------------|--|---|---|
| Optional Population | | | | | |
| <ul style="list-style-type: none"> • ANFC Children • ANFC Adults | Traditional Medicaid: optional groups under Title XIX of Social Security Act | up to 185% FPL | <ul style="list-style-type: none"> • Transitional Medicaid (month 12-36) up to 185% FPL • Children under age 21 (PIL) • Individuals receiving child care services • Special needs adoption under 21 • Committed Children - SRS adoption assistance • Committed Children - SRS foster care • ANFC-related medically needy (PIL) • Pregnant women to 200% FPL • Caretaker relatives up to 150% FPL | | Podiatrists Optometrists Psychologists Physician Directed Clinic Services Home Health Audiology Therapy Dental Physical Therapy Occupational Therapy Speech & Language Therapy Prescribed Drugs Prosthetic Devices Screening Services Preventive Services Mental Health Stabilization Rehab Mental Health Other Inpatient Hosp., NH, ICF/MR Inpatient Psych. For under 21 Personal Care Services Targeted Case Mgmt. Primary Care Case Mgmt. Hospice Care Respiratory Care for Ventilator Dependent PACE Transportation Nursing Facility for Under 21 Emergency Hospital for Non-MCare Particip. Eyeglasses Orthotics ADAP Dialysis Ambulance HCBS (Children's Waiver?? DS Waiver??) |
| <ul style="list-style-type: none"> • VHAP • Underinsured Children • VPharm1 • VPharm2 • VPharm3 • VHAP Pharmacy • VScript • VScript Expanded • Healthy Vermonters | VHAP: expansion groups under §1115 of Social Security Act | up to 225% FPL | <ul style="list-style-type: none"> • Children with other insurance over 225% FPL • Premiums for pregnant women between 185% - 200% FPL • Parents & caretaker relatives between 150%-185% FPL • Health insurance coverage for single adults up to 150% FPL who are ineligible for Medicare and Medicaid • Traumatic Brain Injury • Kids Mental Health • Developmentally Disabled • Pharmacy groups - (VPharm 1, 2, & 3) • VHAP Pharmacy • VScript • VScript expanded • Healthy Vermonters • Health insurance coverage for CRT enrolled adults whose earnings place them over 150% FPL and are ineligible for Medicaid | Inpatient hospital (excl. inpatient svcs. in IMDs) Outpatient hospital including FQHCs Other laboratory and x-ray Certified pediatric and family nurse practitioners Nursing facility svcs. for beneficiaries age 21+ EPSDT for children under age 21 Family planning services and supplies Physicians' services Medical and surgical services of a dentist Home health svcs. for those entitled to nursing facility svcs. Intermittent or part-time nursing services provided by home health agency or by a registered nurse when there is no home health agency in the area Home health aides Medical supplies and appliances for use in the home Pregnancy related services Prenatal and delivery services Post partum services for those under age 18 who are entitled to institutional and ambulatory services Nurse mid-wife services RHCs and FQHCs | |
| <ul style="list-style-type: none"> • Catamount Health • Employer-Sponsored Insurance | Premium Assistance Coverage Groups: under §1115 of Social Security Act | up to 300% FPL | <ul style="list-style-type: none"> • CHAP (0-300% FPL) - premium assistance for those without access to ESI • ESIA (0-300% FPL) - premium assistance for those with access to employer sponsored insurance • VHAP + ESIA (0-150/185% FPL) | | |
| <ul style="list-style-type: none"> • Choices for Care Waiver Enrollees • Qualified Individuals (Qis) • ABD Adults (working) • Ladies First | Traditional Medicaid: optional groups (SSI Related) | | <ul style="list-style-type: none"> • Hospice care • Working Disabled • Individuals eligible for but not receiving SSI or AABD cash benefits • Breast & Cervical Cancer • Disabled Children in Home Care (Katie Beckett) • Special needs adoption under 21 • Choices for Care - home based special income group • Choices for Care - long-term care medically needy • SSI-related medically needy - community Medicaid • Earnings too high to receive SSI cash (§1619(a)(b)) • Qualified Medicare Beneficiaries (QMB) • Qualified Disabled Working Individuals (QDWI) • Specified Low-Income Medicare Beneficiaries (SLMB) • Qualified Individuals (QI-1) | | |
| <ul style="list-style-type: none"> • Civil Union • HIV | | | <ul style="list-style-type: none"> • Qualify for Services through MCO Investments • Qualify for Services through MCO Investments | | |
| <ul style="list-style-type: none"> • SCHIP | SCHIP: under Title XXI of Social Security Act | up to 300% FPL | <ul style="list-style-type: none"> • Children without other insurance | | |

Program Cost Comparison SFY 2007 through SFY 2011 Governor's Recommend

Revised 02/04/2010- Choices for Care enrollment counts & PMPM)

State of Vermont
Agency of Human Services
Office of Vermont Health Access
Medicaid Budget SFY 2011

| PROGRAM EXPENDITURES | | | | | | | | | | | | | | | | | | |
|--|-----------------|-----------------------|--------------------|-----------------|-----------------------|--------------------|-----------------|-----------------------|--------------------|----------------------|-----------------------|--------------------|----------------|-----------------------|--------------------|-------------------|-----------------------|--------------------|
| Adults | SFY '07 Actuals | | | SFY '08 Actuals | | | SFY '09 Actuals | | | SFY '10 Appropriated | | | SFY '10 BAA | | | SFY '11 Gov. Rec. | | |
| | Enrollment | Expenses | PMPM | Enrollment | Expenses | PMPM | Enrollment | Expenses | PMPM | Enrollment | Expenses | PMPM | Enrollment | Expenses | PMPM | Enrollment | Expenses | PMPM |
| Aged, Blind, or Disabled (ABD)/Medically Needy | 11,330 | \$ 68,586,463 | \$ 504.46 | 11,797 | \$ 72,515,067 | \$ 512.24 | 12,550 | \$ 82,398,879 | \$ 547.15 | 12,400 | \$ 87,391,435 | \$ 587.32 | 13,184 | \$ 80,842,468 | \$ 510.97 | 13,866 | \$ 88,506,243 | \$ 531.93 |
| Dual Eligibles | 14,073 | \$ 37,371,558 | \$ 221.30 | 14,185 | \$ 35,614,807 | \$ 209.23 | 14,753 | \$ 38,596,281 | \$ 218.02 | 14,681 | \$ 42,783,829 | \$ 242.85 | 15,111 | \$ 42,040,322 | \$ 231.85 | 15,536 | \$ 43,787,312 | \$ 234.88 |
| General | 9,327 | \$ 41,239,463 | \$ 368.44 | 9,255 | \$ 43,797,118 | \$ 394.36 | 9,847 | \$ 53,060,215 | \$ 449.06 | 9,333 | \$ 51,435,872 | \$ 459.27 | 10,297 | \$ 55,295,379 | \$ 447.51 | 10,786 | \$ 59,173,662 | \$ 457.17 |
| VHAP | 22,404 | \$ 79,795,246 | \$ 296.80 | 24,771 | \$ 89,891,925 | \$ 302.40 | 28,224 | \$ 111,730,898 | \$ 329.89 | 30,023 | \$ 118,932,948 | \$ 330.12 | 32,429 | \$ 122,905,750 | \$ 315.83 | 36,862 | \$ 148,458,099 | \$ 335.62 |
| VHAP ESI | - | \$ - | \$ - | 276 | \$ 571,218 | \$ 172.63 | 821 | \$ 1,525,747 | \$ 154.95 | 1,215 | \$ 3,146,430 | \$ 215.84 | 1,195 | \$ 2,389,512 | \$ 166.61 | 1,564 | \$ 4,172,221 | \$ 222.30 |
| Catamount | - | \$ - | \$ - | 1,730 | \$ 7,995,765 | \$ 385.12 | 6,350 | \$ 30,293,232 | \$ 397.55 | 9,277 | \$ 50,124,827 | \$ 450.27 | 9,081 | \$ 44,329,429 | \$ 406.79 | 10,379 | \$ 49,765,094 | \$ 399.57 |
| ESIA | - | \$ - | \$ - | 132 | \$ 168,977 | \$ 106.81 | 478 | \$ 688,592 | \$ 120.17 | 630 | \$ 1,095,532 | \$ 144.99 | 710 | \$ 1,247,392 | \$ 146.50 | 2,413 | \$ 4,512,365 | \$ 155.82 |
| Subtotal Adults | 57,134 | \$ 226,992,729 | \$ 331.08 | 62,146 | \$ 250,554,876 | \$ 335.98 | 73,021 | \$ 318,293,843 | \$ 363.24 | 77,558 | \$ 354,910,872 | \$ 381.34 | 82,007 | \$ 349,050,253 | \$ 354.69 | 91,406 | \$ 398,374,998 | \$ 363.19 |
| Children | | | | | | | | | | | | | | | | | | |
| Blind or Disabled (BD)/Medically Needy | 3,398 | \$ 28,299,312 | \$ 693.95 | 3,487 | \$ 27,775,036 | \$ 663.78 | 3,605 | \$ 31,686,636 | \$ 732.47 | 3,660 | \$ 33,942,009 | \$ 772.74 | 3,680 | \$ 31,709,593 | \$ 718.12 | 3,771 | \$ 33,052,202 | \$ 730.34 |
| General | 51,187 | \$ 85,115,012 | \$ 138.57 | 50,664 | \$ 90,807,988 | \$ 149.36 | 52,224 | \$ 100,299,806 | \$ 160.05 | 51,037 | \$ 105,463,098 | \$ 172.20 | 53,863 | \$ 103,396,604 | \$ 159.97 | 55,631 | \$ 111,652,406 | \$ 167.25 |
| Underinsured | 1,186 | \$ 846,736 | \$ 59.51 | 1,138 | \$ 742,529 | \$ 54.39 | 1,212 | \$ 721,162 | \$ 49.61 | 1,170 | \$ 894,887 | \$ 63.74 | 1,248 | \$ 696,455 | \$ 46.50 | 1,282 | \$ 755,915 | \$ 49.12 |
| SCHIP (Uninsured) | 3,070 | \$ 4,189,850 | \$ 113.73 | 3,278 | \$ 4,462,004 | \$ 113.42 | 3,412 | \$ 5,386,841 | \$ 131.56 | 3,559 | \$ 5,523,528 | \$ 129.34 | 3,721 | \$ 5,648,299 | \$ 126.50 | 3,966 | \$ 6,421,696 | \$ 134.93 |
| Subtotal Children | 58,841 | \$ 118,450,910 | \$ 167.76 | 58,567 | \$ 123,787,557 | \$ 176.13 | 60,452 | \$ 138,094,446 | \$ 190.36 | 59,426 | \$ 145,823,521 | \$ 204.49 | 62,512 | \$ 141,450,951 | \$ 188.57 | 64,651 | \$ 151,882,219 | \$ 195.77 |
| Pharmacy Only Programs | 12,952 | \$ 9,285,897 | \$ 55.24 | 12,737 | \$ 8,052,596 | \$ 47.88 | 12,456 | \$ 7,535,743 | \$ 50.42 | 12,498 | \$ 6,513,896 | \$ 43.43 | 12,659 | \$ 1,399,166 | \$ 9.21 | 12,580 | \$ 5,637,397 | \$ 37.34 |
| Choices for Care | | | | | | | | | | | | | | | | | | |
| Nursing Home, Home & Community Based, ERC | 3,545 | \$ 148,714,078 | \$ 3,496.19 | 3,973 | \$ 166,375,075 | \$ 3,489.85 | 4,010 | \$ 172,372,731 | \$ 3,582.14 | 4,010 | \$ 173,314,853 | \$ 3,601.72 | 4,010 | \$ 174,214,875 | \$ 3,620.43 | 4,010 | \$ 175,487,571 | \$ 3,646.87 |
| Acute-Care Services - OVHA | 3,545 | \$ 18,015,671 | \$ 423.54 | 3,973 | \$ 20,041,562 | \$ 420.39 | 4,010 | \$ 22,925,258 | \$ 476.42 | 4,010 | \$ 26,041,957 | \$ 541.19 | 4,010 | \$ 21,856,882 | \$ 454.22 | 4,010 | \$ 24,238,964 | \$ 503.72 |
| Acute-Care Services - Other Depts. | 3,545 | \$ 627,528 | \$ 14.75 | 3,973 | \$ 1,097,788 | \$ 23.03 | 4,010 | \$ 284,592 | \$ 5.91 | 4,010 | \$ 1,268,632 | \$ 26.36 | 4,010 | \$ 287,519 | \$ 5.98 | 4,010 | \$ 300,140 | \$ 6.24 |
| Buy-In | - | \$ 2,198,479 | \$ - | - | \$ 2,228,171 | \$ - | - | \$ 2,371,707 | \$ - | - | \$ 2,679,815 | \$ - | - | \$ 2,875,797 | \$ - | - | \$ 3,071,780 | \$ - |
| Subtotal Choices for Care* | 3,545 | \$ 169,555,756 | \$ 3,986.17 | 3,973 | \$ 189,742,595 | \$ 3,980.00 | 4,010 | \$ 197,954,288 | \$ 4,113.76 | 4,010 | \$ 203,305,257 | \$ 4,224.96 | 4,010 | \$ 199,235,074 | \$ 4,140.38 | 4,010 | \$ 203,098,454 | \$ 4,220.67 |
| Subtotal Direct Services | 132,472 | \$ 524,285,291 | \$ 329.81 | 137,422 | \$ 572,137,623 | \$ 346.95 | 149,940 | \$ 661,878,320 | \$ 367.86 | 153,492 | \$ 710,553,546 | \$ 385.77 | 161,188 | \$ 691,135,443 | \$ 357.31 | 172,646 | \$ 758,993,068 | \$ 366.35 |
| Miscellaneous Program | | | | | | | | | | | | | | | | | | |
| GC to CFC Funding Reallocation | - | \$ (627,528) | \$ - | - | \$ (1,097,788) | \$ - | - | \$ (284,592) | \$ - | - | \$ (1,268,632) | \$ - | - | \$ (287,519) | \$ - | - | \$ (300,140) | \$ - |
| Refugee | 22 | \$ 93,315 | \$ 357.53 | 17 | \$ 68,304 | \$ 334.83 | 47 | \$ 222,863 | \$ 395.15 | 162 | \$ 75,939 | \$ 39.07 | 48 | \$ 230,678 | \$ 402.43 | 53 | \$ 271,411 | \$ 427.13 |
| HIV and Civil Unions | 220 | \$ 1,055,504 | \$ 399.21 | 295 | \$ 1,054,678 | \$ 297.48 | 314 | \$ 884,456 | \$ 234.54 | 299 | \$ 993,560 | \$ 277.12 | 350 | \$ 953,892 | \$ 226.81 | 388 | \$ 1,117,244 | \$ 240.04 |
| DSH | - | \$ 59,377,729 | \$ - | - | \$ 49,003,898 | \$ - | - | \$ 35,648,781 | \$ - | - | \$ 37,448,781 | \$ - | - | \$ 37,448,781 | \$ - | - | \$ 37,448,781 | \$ - |
| Clawback | - | \$ 19,142,150 | \$ - | - | \$ 20,339,254 | \$ - | - | \$ 20,779,093 | \$ - | - | \$ 23,113,134 | \$ - | - | \$ 23,113,134 | \$ - | - | \$ 24,414,748 | \$ - |
| Buy-In - GC | - | \$ 21,744,731 | \$ - | - | \$ 21,063,422 | \$ - | - | \$ 21,306,607 | \$ - | - | \$ 25,016,468 | \$ - | - | \$ 26,846,000 | \$ - | - | \$ 28,675,532 | \$ - |
| Buy-In - State Only (MCO Invest.) | - | \$ 314,376 | \$ - | - | \$ 419,951 | \$ - | - | \$ 248,537 | \$ - | - | \$ 516,704 | \$ - | - | \$ 554,485 | \$ - | - | \$ 592,264 | \$ - |
| Buy-In - Federal Only | - | \$ 2,489,407 | \$ - | - | \$ 3,123,135 | \$ - | - | \$ 2,730,326 | \$ - | - | \$ 3,503,500 | \$ - | - | \$ 3,759,721 | \$ - | - | \$ 4,015,941 | \$ - |
| Legal Aid | - | \$ 564,937 | \$ - | - | \$ 476,832 | \$ - | - | \$ 547,983 | \$ - | - | \$ 506,142 | \$ - | - | \$ 547,983 | \$ - | - | \$ 547,983 | \$ - |
| Misc. Pymts. | - | \$ 2,470,780 | \$ - | - | \$ 2,237,253 | \$ - | - | \$ 2,788,183 | \$ - | - | \$ 4,443,598 | \$ - | - | \$ 3,495,288 | \$ - | - | \$ 4,981,021 | \$ - |
| Healthy Vermonters Program | 9,413 | \$ - | n/a | 5,781 | \$ - | n/a | 4,843 | \$ - | n/a | 9,211 | \$ - | n/a | 4,782 | \$ - | n/a | 4,676 | \$ - | n/a |
| Subtotal Miscellaneous Program | 9,655 | \$ 106,625,402 | | 6,094 | \$ 96,688,940 | | 5,204 | \$ 84,872,236 | | 9,672 | \$ 94,349,196 | | 5,180 | \$ 96,662,443 | | 5,117 | \$ 101,764,785 | |
| TOTAL PROGRAM EXPENDITURES | 142,127 | \$ 630,910,693 | | 143,516 | \$ 668,826,564 | | 155,144 | \$ 746,750,556 | | 163,163 | \$ 804,902,742 | | 166,368 | \$ 787,797,886 | | 177,763 | \$ 860,757,857 | |

| ADMINISTRATIVE EXPENDITURES | | | | | | | | | | | | | | | | | | |
|--------------------------------------|-----------------|-----------------------|-------------|-----------------|-----------------------|-------------|-----------------|-----------------------|-------------|----------------------|-----------------------|-------------|---------------------------------------|-----------------------|-------------|-------------------|-----------------------|-------------|
| Contract | SFY '07 Actuals | | | SFY '08 Actuals | | | SFY '09 Actuals | | | SFY '10 Appropriated | | | SFY '10 BAA | | | SFY '11 Gov. Rec. | | |
| | Expenses | | | Expenses | | | Expenses | | | Expenses | | | Expenses | | | Expenses | | |
| Claims Processing | - | \$ 9,928,717 | \$ - | - | \$ 9,938,968 | \$ - | - | \$ 9,433,393 | \$ - | - | \$ 9,535,000 | \$ - | - | \$ 9,685,000 | \$ - | - | \$ 10,695,522 | \$ - |
| Member Services | - | \$ 2,808,807 | \$ - | - | \$ 2,913,852 | \$ - | - | \$ 3,117,187 | \$ - | - | \$ 2,913,852 | \$ - | - | \$ 2,947,800 | \$ - | - | \$ 2,913,852 | \$ - |
| Pharmacy Benefits Manager | - | \$ 2,112,158 | \$ - | - | \$ 2,704,233 | \$ - | - | \$ 2,538,847 | \$ - | - | \$ 2,964,993 | \$ - | - | \$ 2,964,993 | \$ - | - | \$ 2,964,993 | \$ - |
| Chronic Care Initiative | - | \$ 1,257,191 | \$ - | - | \$ 3,562,406 | \$ - | - | \$ 4,249,583 | \$ - | - | \$ 5,035,184 | \$ - | - | \$ 5,034,497 | \$ - | - | \$ 4,749,294 | \$ - |
| Catamount Outreach | - | \$ 664,427 | \$ - | - | \$ 1,697,182 | \$ - | - | \$ 500,000 | \$ - | - | \$ 500,000 | \$ - | - | \$ 392,000 | \$ - | - | \$ 500,000 | \$ - |
| Miscellaneous | - | \$ 2,970,277 | \$ - | - | \$ 1,892,349 | \$ - | - | \$ 2,179,530 | \$ - | - | \$ 4,724,851 | \$ - | - | \$ 3,949,589 | \$ - | - | \$ 3,053,723 | \$ - |
| Health Information Technology | - | \$ - | \$ - | - | \$ - | \$ - | - | \$ - | \$ - | - | \$ - | \$ - | - | \$ 3,587,101 | \$ - | - | \$ 3,655,674 | \$ - |
| MITA/MOVE | - | \$ - | \$ - | - | \$ 1,184,745 | \$ - | - | \$ 926,779 | \$ - | - | \$ 1,950,000 | \$ - | - | \$ 1,950,000 | \$ - | - | \$ 13,100,000 | \$ - |
| Operating/Personnel Services | - | \$ 5,509,561 | \$ - | - | \$ 7,152,358 | \$ - | - | \$ 7,067,735 | \$ - | - | \$ 8,036,369 | \$ - | - | \$ 7,203,038 | \$ - | - | \$ 8,170,601 | \$ - |
| Total Administrative Expenses | | \$ 25,251,238 | | | \$ 31,046,091 | | | \$ 30,013,053 | | | \$ 35,660,249 | | | \$ 37,714,018 | | | \$ 49,803,659 | |
| TOTAL ALL EXPENDITURES | 142,252 | \$ 656,161,931 | | 146,717 | \$ 699,872,655 | | 155,144 | \$ 776,763,609 | | | \$ 840,562,990 | | | \$ 825,511,904 | | | \$ 910,561,516 | |
| | | | | | | | | | | | | | 53rd week | 12,083,044 | | | 5,835,000 | |
| | | | | | | | | | | | | | total trend, etc. including 53rd week | 837,594,948 | | | 916,396,516 | |

*

INSERT 2A - Program Expenditures SFY 2010 & SFY 2011 Governor's Recommend w/ Funding Description

State of Vermont
Agency of Human Services
Office of Vermont Health Access
Medicaid Budget SFY 2011

| PROGRAM EXPENDITURES | | | | | | | |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|---|
| | SFY '10 Appropriated | | SFY '10 BAA | | SFY '11 Gov. Rec. | | SFY '11 Funding Description |
| | Gross Expenses | State Funds | Gross Expenses | State Funds | Gross Expenses | State Funds | |
| Adults | | | | | | | |
| Aged, Blind, or Disabled (ABD)/Medically Needy | \$ 87,391,435 | \$ 26,252,387 | \$ 80,842,468 | \$ 24,285,078 | \$ 88,506,243 | \$ 31,570,177 | Global Commitment funded - g.f. @ 35.67%, traditional federal @ 58.72%, and ARRA @ 5.61% |
| Dual Eligibles | \$ 42,783,829 | \$ 12,852,262 | \$ 42,040,322 | \$ 12,628,913 | \$ 43,787,312 | \$ 15,618,934 | Global Commitment funded - g.f. @ 35.67%, traditional federal @ 58.72%, and ARRA @ 5.61% |
| General | \$ 51,435,872 | \$ 15,451,336 | \$ 55,295,379 | \$ 16,610,732 | \$ 59,173,662 | \$ 21,107,245 | Global Commitment funded - g.f. @ 35.67%, traditional federal @ 58.72%, and ARRA @ 5.61% |
| VHAP | \$ 118,932,948 | \$ 35,727,458 | \$ 122,905,750 | \$ 36,920,887 | \$ 148,458,099 | \$ 52,955,004 | Global Commitment funded - g.f. @ 35.67%, traditional federal @ 58.72%, and ARRA @ 5.61% |
| VHAP ESI | \$ 3,146,430 | \$ 945,187 | \$ 2,389,512 | \$ 717,809 | \$ 4,172,221 | \$ 1,488,231 | Global Commitment funded - g.f. @ 35.67%, traditional federal @ 58.72%, and ARRA @ 5.61% |
| Catamount | \$ 50,124,827 | \$ 19,160,622 | \$ 44,329,429 | \$ 17,874,818 | \$ 49,765,094 | \$ 18,500,332 | Global Commitment funded - g.f. @ 35.67%, traditional federal @ 58.72%, and ARRA @ 5.61% (ARRA not available for expansion population so g.f. = 41.28%) |
| ESIA | \$ 1,095,532 | \$ 423,017 | \$ 1,247,392 | \$ 450,919 | \$ 4,512,365 | \$ 1,657,540 | |
| Subtotal Adults | \$ 354,910,872 | \$ 110,812,269 | \$ 349,050,253 | \$ 109,489,156 | \$ 398,374,998 | \$ 142,897,464 | |
| Children | | | | | | | |
| Blind or Disabled (BD)/Medically Needy | \$ 33,942,009 | \$ 10,196,179 | \$ 31,709,593 | \$ 9,525,562 | \$ 33,052,202 | \$ 11,789,720 | Global Commitment funded - g.f. @ 35.67%, traditional federal @ 58.72%, and ARRA @ 5.61% |
| General | \$ 105,463,098 | \$ 31,681,115 | \$ 103,396,604 | \$ 31,060,340 | \$ 111,652,406 | \$ 39,826,413 | Global Commitment funded - g.f. @ 35.67%, traditional federal @ 58.72%, and ARRA @ 5.61% |
| Underinsured | \$ 894,887 | \$ 268,824 | \$ 696,455 | \$ 209,215 | \$ 755,915 | \$ 269,635 | Global Commitment funded - g.f. @ 35.67%, traditional federal @ 58.72%, and ARRA @ 5.61% |
| SCHIP (Uninsured) | \$ 5,523,528 | \$ 1,588,567 | \$ 5,648,299 | \$ 1,624,451 | \$ 6,421,696 | \$ 1,855,870 | Title XXI - g.f. @ 28.9% and federal @ 71.10% |
| Subtotal Children | \$ 145,823,521 | \$ 43,734,685 | \$ 141,450,951 | \$ 42,419,567 | \$ 151,882,219 | \$ 53,741,639 | |
| Pharmacy Only Programs | \$ 6,513,896 | \$ 5,512,648 | \$ 1,399,166 | \$ 614,212 | \$ 5,637,397 | \$ 4,904,228 | 100% g.f. for +/- 80% of program; balance is Global Commitment as described above |
| Choices for Care | | | | | | | |
| Nursing Home, Home & Community Based, ERC | \$ 173,314,853 | \$ 52,063,782 | \$ 174,214,875 | \$ 52,334,149 | \$ 175,487,571 | \$ 62,596,417 | 35.67% g.f., 58.72% traditional federal, and 5.61% ARRA |
| Acute-Care Services - OVHA | \$ 26,041,957 | \$ 7,823,004 | \$ 21,856,882 | \$ 6,565,807 | \$ 24,238,964 | \$ 8,646,038 | 35.67% g.f., 58.72% traditional federal, and 5.61% ARRA |
| Acute-Care Services - Other Depts. | \$ 1,268,632 | \$ 381,097 | \$ 287,519 | \$ 86,371 | \$ 300,140 | \$ 107,060 | 35.67% g.f., 58.72% traditional federal, and 5.61% ARRA |
| Buy-In | \$ 2,679,815 | \$ 805,016 | \$ 2,875,797 | \$ 863,890 | \$ 3,071,780 | \$ 1,095,704 | 35.67% g.f., 58.72% traditional federal, and 5.61% ARRA |
| Subtotal Choices for Care* | \$ 203,305,257 | \$ 61,072,899 | \$ 199,235,074 | \$ 59,850,216 | \$ 203,098,454 | \$ 72,445,219 | |
| Subtotal Direct Services | \$ 710,553,546 | \$ 221,132,501 | \$ 691,135,443 | \$ 212,373,151 | \$ 758,993,068 | \$ 273,988,549 | |
| Miscellaneous Program | | | | | | | |
| GC to CFC Funding Reallocation | \$ (1,268,632) | \$ (381,097) | \$ (287,519) | \$ (86,371) | \$ (300,140) | \$ (107,060) | Global Commitment funded - g.f. @ 35.67%, traditional federal @ 58.72%, and ARRA @ 5.61% |
| Refugee | \$ 75,939 | \$ - | \$ 230,678 | \$ - | \$ 271,411 | \$ - | 100% federally reimbursed |
| HIV and Civil Unions | \$ 993,560 | \$ 298,465 | \$ 953,892 | \$ 286,549 | \$ 1,117,244 | \$ 398,521 | MCO Investments - 35.67% g.f., 58.72% traditional federal, and 5.61% ARRA |
| DSH | \$ 37,448,781 | \$ 15,387,704 | \$ 37,448,781 | \$ 15,387,704 | \$ 37,448,781 | \$ 15,458,857 | 41.28% g.f. and 58.72% federal |
| Clawback | \$ 23,113,134 | \$ 23,113,134 | \$ 23,113,134 | \$ 23,113,134 | \$ 24,414,748 | \$ 24,414,748 | 100% g.f. |
| Buy-In - GC | \$ 25,016,468 | \$ 7,514,947 | \$ 26,846,000 | \$ 8,064,538 | \$ 28,675,532 | \$ 8,765,250 | Global Commitment funded - g.f. @ 35.67%, traditional federal @ 58.72%, and ARRA @ 5.61% |
| Buy-In - State Only (MCO Invest.) | \$ 516,704 | \$ 155,218 | \$ 554,485 | \$ 166,567 | \$ 592,264 | \$ 181,037 | MCO Investments - 35.67% g.f., 58.72% traditional federal, and 5.61% ARRA |
| Buy-In - Federal Only | \$ 3,503,500 | \$ - | \$ 3,759,721 | \$ - | \$ 4,015,941 | \$ - | 100% federally reimbursed |
| Legal Aid | \$ 506,142 | \$ 152,045 | \$ 547,983 | \$ 164,614 | \$ 547,983 | \$ 167,502 | Global Commitment funded - g.f. @ 35.67%, traditional federal @ 58.72%, and ARRA @ 5.61% |
| Misc. Pymts. | \$ 4,443,598 | \$ 1,334,857 | \$ 3,495,288 | \$ 1,049,985 | \$ 4,981,021 | \$ 1,522,549 | Global Commitment funded - g.f. @ 35.67%, traditional federal @ 58.72%, and ARRA @ 5.61% |
| Healthy Vermonters Program | \$ - | \$ - | \$ - | \$ - | \$ - | \$ - | |
| Subtotal Miscellaneous Program | \$ 94,349,196 | \$ 47,575,274 | \$ 96,662,443 | \$ 48,146,721 | \$ 101,764,785 | \$ 50,801,403 | |
| TOTAL PROGRAM EXPENDITURES | \$ 804,902,742 | \$ 268,707,775 | \$ 787,797,886 | \$ 260,519,872 | \$ 860,757,857 | \$ 324,789,952 | |

| ADMINISTRATIVE EXPENDITURES | | | | | | | |
|--------------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|---|
| | SFY '10 Appropriated | | SFY '10 BAA | | SFY '11 Gov. Rec. | | |
| | Gross Expenses | State Funds | Gross Expenses | State Funds | Gross Expenses | State Funds | |
| Contract | | | | | | | |
| Claims Processing | \$ 9,535,000 | \$ 2,864,314 | \$ 9,685,000 | \$ 2,909,374 | \$ 10,695,522 | \$ 3,815,093 | Most admin. expenses are funded with: Global Commitment funds - g.f. @ 35.67%, traditional federal @ 58.72%, and ARRA @ 5.61%(ARRA not available for expansion population administration so g.f. = 41.28%) and Title XXI funds (28.90% g.f. and 71.10%) |
| Member Services | \$ 2,913,852 | \$ 875,321 | \$ 2,947,800 | \$ 885,519 | \$ 2,913,852 | \$ 1,039,371 | |
| Pharmacy Benefits Manager | \$ 2,964,993 | \$ 890,684 | \$ 2,964,993 | \$ 890,684 | \$ 2,964,993 | \$ 1,057,613 | |
| Chronic Care Initiative | \$ 5,035,184 | \$ 1,512,569 | \$ 5,034,497 | \$ 1,512,363 | \$ 4,749,294 | \$ 1,694,073 | |
| Catamount Outreach | \$ 500,000 | \$ 150,200 | \$ 392,000 | \$ 117,757 | \$ 500,000 | \$ 178,350 | |
| Miscellaneous | \$ 4,724,851 | \$ 1,419,345 | \$ 3,949,589 | \$ 1,186,457 | \$ 3,053,723 | \$ 1,089,263 | |
| Health Information Technology | \$ - | \$ - | \$ 3,587,101 | \$ - | \$ 3,655,674 | \$ - | |
| MITA/MOVE | \$ 1,950,000 | \$ 195,000 | \$ 1,950,000 | \$ 195,000 | \$ 13,100,000 | \$ 1,310,000 | |
| Operating/Personnel Services | \$ 8,036,369 | \$ 2,414,125 | \$ 7,203,038 | \$ 2,163,793 | \$ 8,170,601 | \$ 2,454,449 | |
| Total Administrative Expenses | \$ 35,660,249 | \$ 10,321,559 | \$ 37,714,018 | \$ 9,860,946 | \$ 49,803,659 | \$ 12,638,211 | |
| TOTAL ALL EXPENDITURES | \$ 840,562,990 | \$ 279,029,334 | \$ 825,511,904 | \$ 270,380,818 | \$ 910,561,516 | \$ 337,428,164 | |
| | | | 12,083,044 | 3,629,746 | 5,835,000 | 2,081,345 | |
| | | | 837,594,948 | 274,010,565 | 916,396,516 | 339,509,508 | |

*

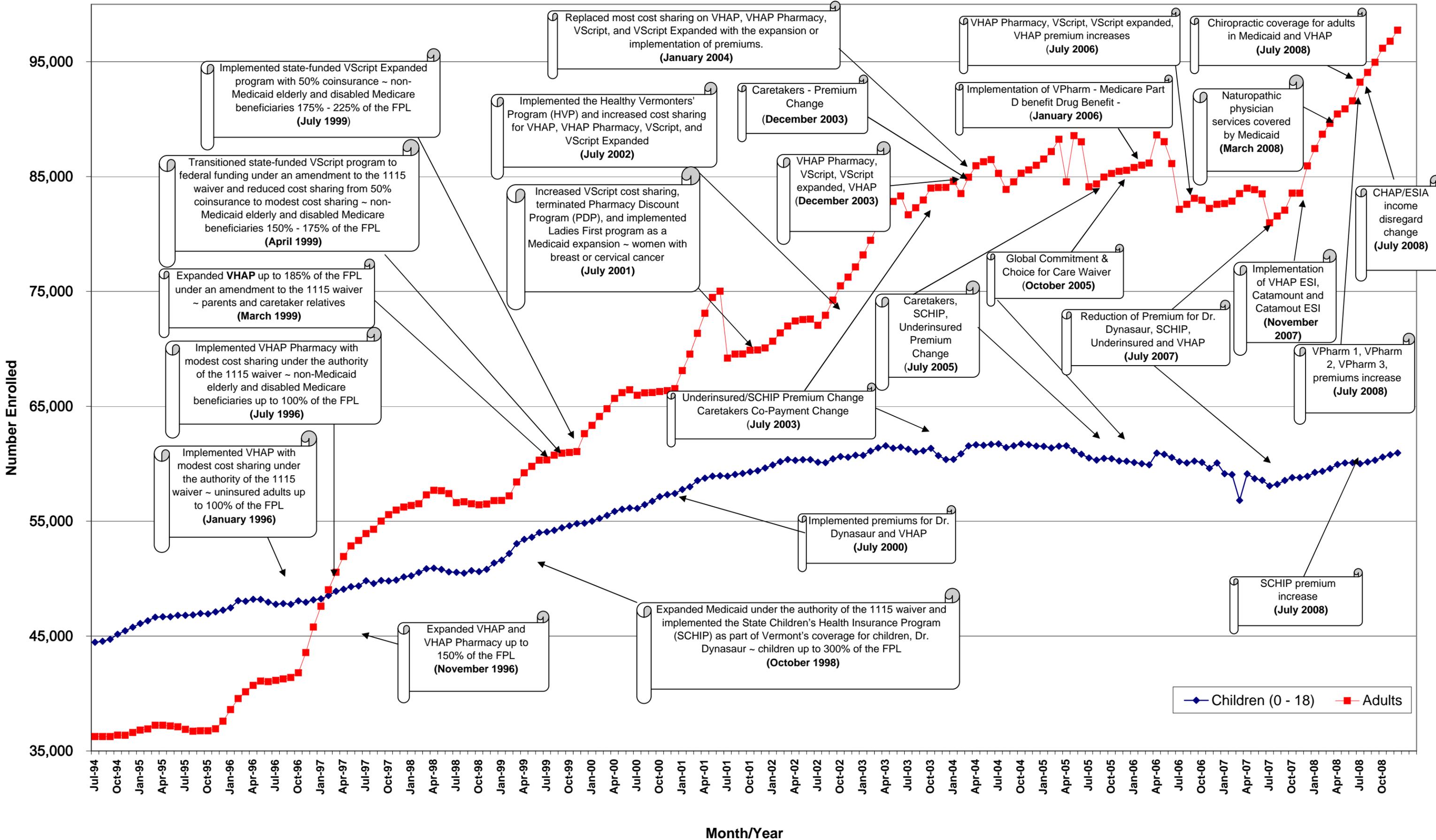
Categories of Service (COS)

State of Vermont
 Agency of Human Services
 Office of Vermont Health Access
 Medicaid Budget SFY 2011

| COS | Description of Service | Actual SFY '03 | 2002-2003 % Change | Actual SFY '04 | 2003-2004 % Change | Actual SFY '05 | 2004-2005 % Change | Actual SFY '06 | 2005-2006 % Change | Actual SFY '07 | 2006-2007 % Change | Actual SFY '08 | 2007-2008 % Change | Actual SFY '09 | 2008 Act-2009 Est. % Change | Approp. SFY '10 | 2009 Act.-2010 Approp. % | BAA SFY '10 | 2009 Act.-2010 BAA % Change | Gov. Rec. SFY '11 | 2010 BAA-2011 SS % Change |
|---------|------------------------------------|----------------|--------------------|----------------|--------------------|----------------|--------------------|----------------|--------------------|----------------|--------------------|----------------|--------------------|----------------|-----------------------------|-----------------|--------------------------|-------------|-----------------------------|-------------------|---------------------------|
| 01-00 | Inpatient | 40,929,353 | 6.8% | 55,423,636 | 35.4% | 59,916,830 | 8.1% | 59,404,188 | -0.9% | 57,668,408 | -2.9% | 64,635,263 | 12.1% | 86,235,838 | 33.4% | 88,216,968 | 2.3% | 97,563,269 | 13.1% | 101,759,643 | 4.3% |
| 02-00 | Outpatient | 43,429,952 | 6.8% | 51,810,009 | 19.3% | 59,256,286 | 14.4% | 64,519,817 | 8.9% | 62,005,623 | -3.9% | 67,819,155 | 9.4% | 73,572,880 | 8.5% | 80,823,904 | 9.9% | 81,323,558 | 10.5% | 88,987,277 | 9.4% |
| 03-00 | Physician | 47,157,888 | 6.4% | 51,268,594 | 8.7% | 61,369,027 | 19.7% | 58,623,126 | -4.5% | 61,235,508 | 4.5% | 68,710,405 | 12.2% | 77,883,797 | 13.4% | 80,371,477 | 3.2% | 87,327,788 | 12.1% | 96,784,364 | 10.8% |
| 04-00 | Pharmacy | 125,291,458 | 8.2% | 152,886,158 | 22.0% | 191,397,999 | 25.2% | 167,532,601 | -12.5% | 109,065,993 | -34.9% | 112,406,224 | 3.1% | 125,709,817 | 11.8% | 124,720,305 | -0.8% | 134,165,876 | 6.7% | 140,889,206 | 5.0% |
| 05-00 | Nursing Home | 95,547,013 | 1.2% | 102,673,295 | 7.5% | 105,538,644 | 2.8% | 104,487,943 | -1.0% | 109,236,612 | 4.5% | 115,642,835 | 5.9% | 119,361,580 | 3.2% | 117,947,659 | -1.2% | 116,073,123 | -2.8% | 117,194,372 | 1.0% |
| 07-00 | Mental Health Facility | 88,376 | -66.8% | 346,914 | 292.5% | (216,883) | -162.5% | 66,065 | -130.5% | 200,938 | 204.2% | 242,458 | 20.7% | 137,992 | -43.1% | 248,460 | 80.1% | 248,460 | 0.0% | 248,460 | 0.0% |
| 08-00 | Dental | 13,651,738 | -7.7% | 14,090,596 | 3.2% | 15,938,630 | 13.1% | 14,739,118 | -7.5% | 15,125,710 | 2.6% | 15,980,470 | 5.7% | 19,319,401 | 20.9% | 21,507,700 | 11.3% | 22,165,962 | 14.7% | 23,032,365 | 3.9% |
| 09-01 | MH Clinic | 47,771 | -221.6% | 18,420 | -61.4% | 37,525 | 103.7% | 44,333 | 18.1% | 133,264 | 200.6% | 55,163 | -58.6% | 14,754 | -73.3% | 51,397 | 248.4% | 51,397 | 248.4% | 51,397 | 0.0% |
| 10-00 | Independent Laboratory | 2,200,561 | 27.1% | 1,981,035 | -10.0% | 3,394,475 | 71.3% | 2,263,320 | -33.3% | 2,934,505 | 29.7% | 3,467,612 | 18.2% | 5,945,785 | 71.5% | 4,864,983 | -18.2% | 7,539,863 | 26.8% | 8,427,926 | 11.8% |
| 11-00 | Home Health | 7,972,483 | 2.6% | 7,651,902 | -4.0% | 7,633,288 | -0.2% | 7,798,335 | 2.2% | 5,668,194 | -27.3% | 6,313,071 | 11.4% | 6,576,435 | 4.2% | 7,469,575 | 13.6% | 7,053,492 | 7.3% | 7,413,985 | 5.1% |
| 12-00 | RHC & FQHC | 8,414,816 | 9.4% | 10,121,951 | 20.3% | 10,830,725 | 7.0% | 10,946,861 | 1.1% | 12,064,368 | 10.2% | 14,434,537 | 19.6% | 16,381,379 | 13.5% | 19,127,472 | 16.8% | 19,388,703 | 18.4% | 22,636,725 | 16.8% |
| 13-00 | Hospice | 353,237 | -5.3% | 524,835 | 48.6% | 576,137 | 9.8% | 550,093 | -4.5% | 942,007 | 71.2% | 1,321,956 | 40.3% | 1,330,036 | 0.6% | 1,719,329 | 29.3% | 1,632,495 | 22.7% | 1,929,200 | 18.2% |
| 15-00 | Chiropractor | 154,279 | -51.2% | 88,164 | -42.9% | 84,868 | -3.7% | 55,125 | -35.0% | 48,784 | -11.5% | 50,357 | 3.2% | 964,128 | 1814.6% | 735,000 | -23.8% | 735,000 | -23.8% | 787,311 | 7.1% |
| 16-00 | Nurse Practitioners | 364,337 | -7.8% | 598,020 | 64.1% | 617,187 | 3.2% | 541,354 | -12.3% | 566,198 | 4.6% | 507,683 | -10.3% | 509,254 | 0.3% | 572,795 | 12.5% | 574,694 | 12.9% | 656,718 | 14.3% |
| 17-00 | Skilled Nursing | 4,174,255 | -4.3% | 4,656,432 | 11.6% | 4,755,608 | 2.1% | 4,631,221 | -2.6% | 4,135,104 | -10.7% | 2,903,558 | -29.8% | 3,230,347 | 11.3% | 3,213,236 | -0.5% | 3,365,417 | 4.2% | 3,550,320 | 5.5% |
| 18-00 | Podiatrist | 132,681 | 11.0% | 161,904 | 22.0% | 211,724 | 30.8% | 211,990 | 0.1% | 218,769 | 3.2% | 238,065 | 8.8% | 246,648 | 3.6% | 281,274 | 14.0% | 285,423 | 15.7% | 334,456 | 17.2% |
| 19-00 | Psychologist | 6,696,605 | 27.0% | 7,653,452 | 14.3% | 11,105,331 | 45.1% | 12,321,970 | 11.0% | 12,780,061 | 3.7% | 13,650,779 | 6.8% | 15,078,858 | 10.5% | 15,299,971 | 1.5% | 16,281,591 | 8.0% | 17,457,891 | 7.2% |
| 20-00 | Optometrist | 669,818 | -27.7% | 706,214 | 5.4% | 821,836 | 16.4% | 786,030 | -4.4% | 814,027 | 3.6% | 873,743 | 7.3% | 970,695 | 11.1% | 945,145 | -2.6% | 1,053,695 | 8.6% | 1,146,733 | 8.8% |
| 21-00 | Optician | 244,641 | -47.7% | 151,077 | -38.2% | 187,424 | 24.1% | 202,259 | 7.9% | 225,809 | 11.6% | 237,305 | 5.1% | 262,905 | 10.8% | 269,552 | 2.5% | 281,985 | 7.3% | 295,804 | 4.9% |
| 22-00 | Transportation | 5,339,085 | 16.9% | 6,287,195 | 17.8% | 6,722,540 | 6.9% | 9,424,484 | 40.2% | 9,900,218 | 5.0% | 10,663,296 | 7.7% | 11,694,573 | 9.7% | 12,193,527 | 4.3% | 12,635,938 | 8.0% | 12,675,143 | 0.3% |
| 23-00 | OT/PT/ST Services | 600,657 | 41.0% | 939,926 | 56.5% | 1,481,146 | 57.6% | 1,469,402 | -0.8% | 1,516,267 | 3.2% | 1,630,481 | 7.5% | 2,322,326 | 42.4% | 2,179,098 | -6.2% | 2,875,954 | 23.8% | 3,519,006 | 22.4% |
| 24-00 | Prosthetic/Ortho | 1,667,329 | 26.6% | 1,767,709 | 6.0% | 1,732,815 | -2.0% | 1,644,408 | -5.1% | 1,522,775 | -7.4% | 1,784,140 | 17.2% | 1,881,035 | 5.4% | 2,348,755 | 24.9% | 2,084,440 | 10.8% | 2,306,696 | 10.7% |
| 25-00 | Medical Supplies & DME (26-00) | 4,658,025 | 20.0% | 5,469,602 | 17.4% | 6,178,377 | 13.0% | 7,019,503 | 13.6% | 6,825,297 | -2.8% | 6,827,517 | 0.0% | 8,009,175 | 17.3% | 7,275,113 | -9.2% | 8,638,821 | 7.9% | 9,207,795 | 6.6% |
| 27-00 | H&CB Services | 23,228,773 | 20.5% | 27,058,997 | 16.5% | 32,160,154 | 18.9% | 32,834,665 | 2.1% | 36,078,707 | 9.9% | 44,727,273 | 24.0% | 46,321,622 | 3.6% | 48,774,675 | 5.3% | 49,674,070 | 7.2% | 49,869,850 | 0.4% |
| 27-02 | H&CB Mental Health Services | 951,432 | 424.1% | 1,138,960 | 19.7% | 1,157,853 | 1.7% | 810,643 | -30.0% | 534,055 | -34.1% | 594,391 | 11.3% | 575,154 | -3.2% | 667,937 | 16.1% | 595,990 | 3.6% | 608,162 | 2.0% |
| 27-03 | H&CB Mental Retardation | 15,389 | -20.2% | 24,184 | 57.2% | - | -100.0% | 16,486 | 0.0% | 34,556 | 109.6% | 20,846 | -39.7% | - | -100.0% | 51,313 | 0.0% | 24,064 | 0.0% | 26,562 | 10.4% |
| 27-13 | TBI Services | (14,251) | -100.7% | (60) | -99.6% | - | -100.0% | - | 0.0% | - | 0.0% | - | 0.0% | - | 0.0% | - | 0.0% | - | 0.0% | - | 0.0% |
| 27-17 | Enhanced Resident Care | 2,156,820 | 21.8% | 2,429,162 | 12.6% | 2,723,956 | 12.1% | 3,365,075 | 23.5% | 4,775,636 | 41.9% | 6,896,341 | 44.4% | 5,731,482 | -16.9% | 7,803,435 | 36.2% | 7,655,449 | 33.6% | 7,655,491 | 0.0% |
| 29-00 | Personal Care Services | 8,165,126 | 42.9% | 10,615,921 | 30.0% | 13,131,328 | 23.7% | 16,411,319 | 25.0% | 16,832,388 | 2.6% | 16,839,209 | 0.0% | 19,276,508 | 14.5% | 20,907,852 | 8.5% | 20,523,685 | 6.5% | 20,267,855 | -1.2% |
| 30-00 | Target Case Management | (6) | -100.1% | 1,658 | -27411.2% | 8,196 | 394.4% | 2,768 | -66.2% | 2,770 | 0.1% | 1,914 | -30.9% | 41,580 | 2072.2% | 2,491 | -94.0% | 2,491 | -94.0% | 2,604 | 4.5% |
| 33-04 | Assistive Community Care Services | 5,216,479 | 17.1% | 6,487,940 | 24.4% | 7,696,713 | 18.6% | 8,252,128 | 7.2% | 9,825,397 | 19.1% | 11,046,374 | 12.4% | 11,691,935 | 5.8% | 13,183,825 | 12.8% | 12,697,393 | 8.6% | 13,298,940 | 4.7% |
| 34-01 | Day Treatment (MHS) | 39,432 | -26.1% | 80,050 | 103.0% | 56,415 | -29.5% | 65,710 | 16.5% | 75,895 | 15.5% | 58,122 | -23.4% | 86,781 | 49.3% | 69,316 | -20.1% | 96,673 | 11.4% | 115,685 | 19.7% |
| 35-07 | ADAP Families in Recovery | 53,936 | 0.0% | 122,782 | 127.6% | 303,097 | 146.9% | 12,290 | -95.9% | 33,820 | 175.2% | 79,764 | 135.8% | 19,425 | -75.6% | 87,043 | 348.1% | 87,043 | 348.1% | 95,145 | 9.3% |
| 37-01 | Rehabilitation/D&P Dept. of Health | 30,022 | -63.1% | 543,437 | 1710.2% | 3,736,272 | 587.5% | 3,363,147 | -10.0% | 4,720,375 | 40.4% | 3,713,914 | -21.3% | 3,850,941 | 3.7% | 4,160,291 | 8.0% | 4,203,399 | 9.2% | 4,490,906 | 6.8% |
| 38-01 | Capitation Fee Health Plans | - | 0.0% | - | 0.0% | - | 0.0% | - | 0.0% | - | 0.0% | - | 0.0% | - | 0.0% | - | 0.0% | - | 0.0% | - | 0.0% |
| 38-01 | Health Care Risk Pool | - | -100.0% | - | 0.0% | - | 0.0% | - | 0.0% | - | 0.0% | - | 0.0% | - | 0.0% | - | 0.0% | - | 0.0% | - | 0.0% |
| 38-03 | PC+ Case Management Fees | 4,976,410 | 4.6% | 5,075,010 | 2.0% | 5,127,135 | 1.0% | 5,521,200 | 7.7% | 4,475,263 | -18.9% | 5,084,590 | 13.6% | 5,326,311 | 4.8% | 5,404,870 | 1.5% | 5,788,475 | 8.7% | 6,350,676 | 9.7% |
| 05 & 38 | Pace Capitation | - | - | - | - | - | - | - | - | - | - | - | - | - | - | 1,000,000 | - | 1,442,234 | -47.0% | 3,400,278 | 135.8% |
| 40-00 | Ambulance | 1,664,640 | 17.9% | 1,972,634 | 18.5% | 2,348,739 | 19.1% | 2,508,296 | 6.8% | 2,287,713 | -8.8% | 2,514,402 | 9.9% | 3,144,232 | 25.0% | 3,555,663 | 13.1% | 3,666,959 | 16.6% | 4,238,728 | 15.6% |
| 41-00 | Dialysis | 206,113 | 110.0% | 294,592 | 42.9% | 391,569 | 32.9% | 505,642 | 29.1% | 692,408 | 36.9% | 569,685 | -17.7% | 3,012,489 | 428.8% | 916,313 | -69.6% | 3,186,732 | 5.8% | 3,293,318 | 3.3% |
| 42-00 | ASC | 46,492 | 102.7% | 9,899 | -78.7% | 6,277 | -36.6% | 5,084 | -19.0% | 6,097 | 20.7% | 8,563 | 40.4% | 6,871 | -19.8% | 9,058 | 5.8% | 9,608 | 6.1% | 9,608 | 0.0% |
| 43-00 | Outpatient Rehab | 183,367 | 4.5% | 240,341 | 31.1% | 298,602 | 24.2% | 290,361 | -2.8% | 203,595 | -29.9% | 158,647 | -22.1% | 5,826 | -96.3% | 174,285 | 2891.4% | 174,285 | 2891.4% | 174,285 | 0.0% |
| 39-06 | PDP Premium Payments | - | 0.0% | - | 0.0% | - | 0.0% | 2,287,779 | 0.0% | 2,421,626 | 5.9% | 1,888,168 | -22.0% | 1,829,725 | -3.1% | 1,211,842 | -33.8% | 1,927,714 | 5.4% | 2,064,912 | 7.1% |
| 39-10 | New Premium Payments | - | 0.0% | - | 0.0% | - | 0.0% | - | 0.0% | - | 0.0% | 8,593,929 | 0.0% | 32,210,646 | 274.8% | 53,969,635 | 67.6% | 47,648,152 | 47.9% | 57,936,476 | 21.6% |
| 45-00 | Miscellaneous | 64,270 | -177.0% | 219,599 | 241.7% | 2,624,357 | 1095.1% | 1,296,427 | -50.6% | 1,173,211 | -9.5% | 294,974 | -74.9% | 49,398 | -83.3% | 165,130 | 234.3% | 165,130 | 234.3% | 165,130 | 0.0% |
| | Total | 456,770,799 | 6.8% | 533,592,148 | 16.8% | 621,342,200 | 16.4% | 606,832,565 | -2.3% | 559,005,383 | -7.9% | 613,484,713 | 9.7% | 713,542,478 | 16.3% | 754,495,480 | 5.7% | 782,915,939 | 9.7% | 835,357,405 | 6.7% |
| | Total w/o Catamount | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| | Other Expenditures | - | 0.0% | - | 0.0% | - | 0.0% | - | 0.0% | - | 0.0% | - | 0.0% | - | 0.0% | - | 0.0% | - | 0.0% | - | 0.0% |
| | DSH | 28,868,690 | 8.9% | 29,259,141 | 1.4% | 34,793,164 | 18.9% | 35,205,323 | 1.2% | 59,377,729 | 68.7% | 49,003,898 | -17.5% | 35,648,781 | -27.3% | 37,448,781 | 5.0% | 37,448,781 | 5.0% | 37,448,781 | 0.0% |
| | Clawback | - | 0.0% | - | 0.0% | - | 0.0% | 6,888,177 | 0.0% | 19,142,150 | 177.9% | 20,339,254 | 6.3% | 20,779,093 | 2.2% | 23,113,134 | 11.2% | 23,113,134 | 11.2% | 24,414,748 | 5.6% |
| | Insurance Premium Payouts | 168,124 | -6.4% | 237,224 | 41.1% | 283,304 | 19.4% | 233,567 | -17.6% | 66,307 | -71.6% | (31,616) | -147.7% | 150,307 | -575.4% | - | -100.0% | 160,844 | 7.0% | 172,291 | 7.1% |
| | HIV Insurance Fund F | 55,638 | 42.0% | 46,108 | -17.1% | 46,738 | 1.4% | 40,936 | -12.4% | 49 | | | | | | | | | | | |

History of Program Expansions July 1994 – December 2008

State of Vermont
Agency of Human Services
Office of Vermont Health Access
Medicaid Budget State Fiscal Year 2011



OFFICE of VERMONT HEALTH ACCESS

MISSION

The Office of Vermont Health Access (OVHA) strives to:

- Provide leadership across all Vermont stakeholders to improve access, quality and cost effectiveness of health care in the state.
- Assist Medicaid beneficiaries in accessing clinically appropriate health services.
- Collaborate with other health care system entities in bringing evidence-based practices to Vermont Medicaid beneficiaries.
- Administer Vermont's public health insurance system efficiently and effectively.

OVERVIEW

The Office of Vermont Health Access (OVHA) is the state office responsible for the management of Medicaid, the State Children's Health Insurance Program (SCHIP), and other publicly funded health insurance programs in Vermont. The OVHA is the largest insurer in Vermont in terms of dollars spent and the second largest insurer in terms of covered lives. As of 2009, the OVHA also is the home of state oversight and coordination of Vermont's expansive Health Care Reform initiatives which are designed to increase access, improve quality, and contain the cost of health care for all Vermonters. The OVHA also now has responsibility for Vermont's health information technology strategic planning, coordination and oversight.