

MEDICAID BUDGET STATE FISCAL YEAR 2010



Office of Vermont Health Access

Mission Statement

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

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

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The OVHA is responsible for the management of Medicaid, the State Children's Health Insurance Program (SCHIP) and other publicly funded health insurance programs. The OVHA is the largest insurer in Vermont in terms of dollars spent and the second largest in terms of covered lives.

As of 2009, the OVHA is also 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 costs of health care for all Vermonters.

**Office of Vermont Health Access**



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**FAST FACTS**

|                                                                                                                |                       |
|----------------------------------------------------------------------------------------------------------------|-----------------------|
| The Governor's Recommend for SFY 2010:                                                                         | <b>\$828,166,798.</b> |
| Number of covered lives in Vermont's publicly funded health insurance programs (excluding Healthy Vermonters): | <b>142,151</b>        |
| Number of children included in the above:                                                                      | <b>59,426</b>         |
| Number of OVHA employees:                                                                                      | <b>99</b>             |
| Rank in State of Vermont's programmatic expenditure:                                                           | <b>Largest</b>        |
| Rank as insurer in Vermont:                                                                                    | <b>Largest</b>        |
| Comparison in dollars spent:                                                                                   | <b>First</b>          |
| Comparison in number of covered lives:                                                                         | <b>Second</b>         |
| Percentage of Vermont's population receiving some or all of health care cost benefit:                          | <b>24%</b>            |
| Number of enrolled providers:                                                                                  | <b>11,007</b>         |
| Claims processed annually:                                                                                     | <b>8.9 million</b>    |
| Percentage of claims received electronically:                                                                  | <b>87%</b>            |
| Percentage of all claims processed within 30 days:                                                             | <b>98.3%</b>          |
| Average time from claim receipt to provider payment:                                                           | <b>9 days</b>         |
| Average number of calls to Member Services per month:                                                          | <b>32,000</b>         |
| Average number of calls handled by staff per day:                                                              | <b>1500</b>           |
| Average time to wait to speak with a live person:                                                              | <b>25 seconds</b>     |
| Calls answered by a live person within 2 minutes:                                                              | <b>97% of time</b>    |
| Expected 2010 health care expenditures for Vermont residents*:                                                 | <b>\$5.15 billion</b> |
| Vermont Medicaid's share of total health care expenditures*:                                                   | <b>25%</b>            |

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

## SECTION 1: CONTACT INFORMATION

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### Additional Resources

[www.hcr.vermont.gov](http://www.hcr.vermont.gov)

[www.vtmedicaid.com](http://www.vtmedicaid.com)

[www.greenmountaincare.org](http://www.greenmountaincare.org)

[www.vtccmp.com](http://www.vtccmp.com)

## SECTION 2: BUDGET CONSIDERATIONS

The Office of Vermont Health Access (OVHA) budget request includes an increase in program of \$26,870,669 and an increase in Administration of \$3,125,428. Please see pages 14-15 for budget reconciliation.

|                                                            |                             |
|------------------------------------------------------------|-----------------------------|
| <b>PROGRAM</b> .....                                       | <b>\$26,870,669 (gross)</b> |
| ~ State fund need before stimulus package enhanced funding | \$ 3,021,653                |

|                                                            |                             |
|------------------------------------------------------------|-----------------------------|
| <b>UPDATED TREND CHANGES</b> .....                         | <b>\$63,474,729 (gross)</b> |
| ~ State fund need before stimulus package enhanced funding | \$22,458,552                |

|                                           |                             |
|-------------------------------------------|-----------------------------|
| <b>Caseload and Trend Impact</b> .....    | <b>\$46,742,212 (gross)</b> |
| ~ State fund need before enhanced funding | \$ 15,947,275               |

Programs that are included in this section are: ABD, General, Global (VHAP), Optional (Underinsured), SCHIP, Choices for Care, and Pharmacy Programs. In 2009, the OVHA realigned its costs to the new Global Commitment reporting Medicaid eligibility groupings (MEGs) in order to comply with CMS reporting requirements. This process resulted in shifts in enrollment counts and expenditures by MEG from previous years, which subsequently resulted in cost shifts between individual appropriations.

The original SFY '09 appropriated funding did not include waterfall dollars earmarked for rate increases to providers **\$10,835,000**. These funds need to be included as base funds for SFY '10.

| Waterfall Funding Allocated    |                   |
|--------------------------------|-------------------|
| Dartmouth                      | 925,000           |
| Boston Children's Hospital     | 1,000,000         |
| In-State Hospitals             | 6,000,000         |
| Home Health Agencies           | 750,000           |
| ACCS                           | 660,000           |
| Long-Term Care Waiver Services | 1,500,000         |
| <b>TOTAL</b>                   | <b>10,835,000</b> |

The Dartmouth increase implemented in SFY '09 represented ½ year costs. The SFY '10 budget request includes funds to annualize this increase. Additionally, the increase provided to Boston Children's Hospital brought the reimbursement level to 70% of cost. A commitment was made to bring

them to 100% of cost in SFY '10. Therefore, an additional \$1.8 million is also being requested for this purpose. **\$2,725,000**

Rate increases are legislatively required for nursing homes. Therefore, these costs are included in normal caseload and trend anticipations - **\$4,142,000**. (However, please note that this is proposed below for elimination.)

**CASELOAD:** Caseload for these populations has grown from the appropriated total of 126,187 to 132,016, or a 4.62% growth rate. Please see enrollment charts demonstrating this growth. This equates to **\$28,042,271** in new caseload cost.

**TREND:** Historically trend has played a tremendous role in OVHA's budget. However, this year, there are many categories that have minimal changes ~ either positive or negative ~ that make up the **\$8,070,744** in the additional appropriation request. Included on Insert 1 is the Category of Service (COS) listing that shows historical spending patterns with relevant changes year over year.

**VPHARM TREND:** During SFY '09 Budget Adjustment, a request was made to reduce general fund in the state only appropriation due to the VPHARM expenditures coming in significantly less than originally anticipated. This annualizes that affect into SFY '10. **(\$7,072,804)**

**Catamount & ESIA Caseload and Trend Impact . . . \$14,460,494 (gross)**  
 ~ State fund need before enhanced funding \$ 4,239,254

The projected enrollment in the Catamount program has increased by an average of 1,443 individuals compared to the original appropriation and 3,111 as compared to budget adjustment estimates. These fiscal calculations also include an estimated increase in Catamount Health carrier premiums of 15% effective July 1, 2009.

Additionally, an income disregard was implemented after the SFY '09 budget was developed. This resulted in a shift between those who were previously eligible for Catamount funding only (over 200% FPL) to now qualifying for federal participation (under 200% FPL).

**Increase in Clawback Rates . . . . . \$2,272,023 (gross)**  
 ~ State fund need before enhanced funding \$2,272,023

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. As of this date, all beneficiaries of Vermont's publicly funded pharmacy programs who are also covered by

Medicare should receive their primary pharmacy benefit from Medicare. What in Medicaid is referred to as the state share is called the phased-down state contribution for Medicare. The state contribution design calls for states to annually pay a portion of what they would have paid in Medicaid “state share” in that year for the support of drug coverage of the Medicare beneficiaries who are or would be eligible for Medicaid drug coverage. This is referred to as “Clawback”. 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.

**TRANSFER TO DDAIL: INDIVID. SERVICE AGREEMENTS . . . . (\$ 700,000) (gross)**  
 ~ State fund need before enhanced funding (\$ 287,630)

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 for this purpose.

**TRANSFER TO DCF: VCHRYP PILOT PROGRAM . . . . . (\$ 371,943) (gross)**  
 ~ State fund need before enhanced funding (\$ 152,831)

The Vermont Coalition for Homeless and Runaway Youth Program (VCHRYP) has historically been funded by myriad departments within the Agency of Human Services. Department of Children and Families (DCF) will now be the sole payer. This represents the historical amount paid for by the OVHA.

**GOVERNOR’S RECOMMENDED POLICY INITIATIVES . . . . . (\$35,532,118) (gross)**  
 ~ State fund need before enhanced funding (\$18,996,439)

**Eliminate VPharm 1, 2, & 3 Programs . . . . . (\$ 8,664,421) (gross)**  
 ~ State fund need before enhanced funding (\$ 7,956,501)

This option would eliminate Vermont funded coverage under VPharm 1, 2, and 3 that is supplemental to Medicare Part D drug coverage. These programs pay for:

1. Medicare Part D beneficiary cost-sharing (i.e., costs that are not paid for by the Part D Prescription Drug Plans (PDPs)); this is referred to as the “Wrap”, which includes deductibles, coinsurance/copayments, and coverage in the “donut hole” (the period in a calendar year when there may be a gap in Part D before the catastrophic coverage applies).

Cost sharing is limited to the following drugs:

- a) VPharm1: All drugs covered by the federal Medicaid program.

- b) VPharm2: All maintenance drugs covered by the federal Medicaid program.
  - c) VPharm3: All maintenance drugs covered by Vermont's VScript Expanded program where manufacturers pay rebates to Vermont for the coverage of their drugs.
2. Cover certain drugs not covered by Medicare Part D. These are:
- barbiturates (used to treat seizure disorders or pain syndromes);
  - benzodiazepines (used to treat depression);
  - drugs used for anorexia, weight loss, or weight gain; fertility drugs; drugs used for cosmetic purposes or hair growth;
  - prescription vitamins and mineral products; and
  - over-the-counter drugs (e.g., cough and cold medicines, aspirin, etc.).

Program participation is based on income level and premium payments:

|         | <u>Enrollees</u><br><u>(SFY09)</u> | <u>Income Level</u>    | <u>Monthly Premium</u> |
|---------|------------------------------------|------------------------|------------------------|
| VPharm1 | 7,423                              | <= 150% FPL            | \$17 per person        |
| VPharm2 | 2,547                              | > 150% and <= 175% FPL | \$23 per person        |
| VPharm3 | 2,558                              | > 175% and <= 225% FPL | \$50 per person        |

**Eliminate PDP Premium Payments . . . . . (\$1,211,842) (gross)**  
 ~ State fund need before enhanced funding (\$ 497,946)

With the elimination of the VPharm programs, the State will no longer make premium payments and beneficiaries will pay their premiums directly to their PDPs for the Medicare Part D coverage.

NOTE: Currently, Healthy Vermonters is not available to those who have any insurance for drugs including Medicare Part D. Healthy Vermonters enables beneficiaries to purchase drugs at the Medicaid rate rather than at the usual and customary rate to the general public. Healthy Vermonters rules could be revised to include Medicare eligibles no longer eligible for VPharm. This would somewhat offset the impact on beneficiaries.

**Pharmacy ~ 90 Day Supply for Maintenance Drugs (\$ 1,289,345) (gross)**  
 ~ State fund need before enhanced funding (\$ 529,792)

Most maintenance medications are currently filled on a 30 day basis resulting in three (3) dispensing fees over a ninety day period. In some cases, these medications are filled much more frequently. In the case of maintenance compound drugs, as many as three (3) compounding fees may also apply in a ninety (90) day period. Currently dispensing fees are \$4.75 for each prescription filled by an in-state pharmacy and \$3.65 for each filled by an out-

of-state pharmacy. In the case of compound drugs, a compounding fee of \$15 applies for each prescription.

Under this proposal, effective July 1, 2009, payment for drugs in select maintenance drug classes would be limited to increments of ninety (90) day supplies in Medicaid, the Vermont Health Access Plan, VHAP Pharmacy, VScript, and VScript Expanded. Only one (1) dispensing fee will apply in a ninety (90) day period. In the case of maintenance compound drugs, only one (1) additional compounding fee will apply in a ninety (90) period. Applying this option will result in a reduction in the number of dispensing fees paid to pharmacies. For many beneficiaries, this provides the convenience of eliminating frequent trips to the drugstore and facilitates obtaining larger supplies of the drugs they take routinely.

This policy would only apply to drugs used as maintenance treatments for beneficiaries: it would not apply to drugs used to treat acute conditions, or on initial fills to provide an opportunity to trial a medication to assure that it is appropriate for the patient's medical needs and for maintenance use. This model is applied by many insurance companies using mail order services. Rather than using mail order as an approach, this continues to make these drugs available from local pharmacies but limits the payment of dispensing fees.

**Reduce Prescription Average Wholesale Price by .4% (\$400,000) (gross)**  
~ State fund need before enhanced funding (\$164,360)

In Medicaid, VHAP, VHAP Pharmacy, VScript, and VScript Expanded, the maximum reimbursement is established on a per claim basis. The amount is currently the lesser of:

- Average wholesale price (AWP) less 11.9% plus a dispensing fee,
- The Centers for Medicaid and Medicare Services established Federal Upper Limit (FUL) plus a dispensing fee,
- The MedMetrics managed Vermont Maximum Allowable Cost (MAC) amount plus a dispensing fee, or
- The pharmacy's usual and customary/submitted fee including a dispensing fee.

AWP is the most commonly used drug reimbursement basis for most brand name drugs. This is nationally recognized as a common reimbursement basis by both Medicaid programs and private insurers. In Vermont's publicly funded programs, 36.48% of prescriptions paid to pharmacies in the third quarter of calendar year 2008 were paid based on AWP. Under this proposal, effective July 1, 2009, the reduction to AWP will be 12.3% instead of the current 11.9%. See the 2009 Pharmacy Best Practices and Cost Control Report in Appendix 11 for more detailed information.

**Provider Reimbursement Decrease (4%) . . . . . (\$13,086,778) (gross)**  
 ~ State fund need before enhanced funding (\$ 5,377,358)

This proposal will change the reimbursement rate paid to providers for services (with the exception of those services that are federally or state mandated at a certain rate of reimbursement) effective with date of service March 15, 2009. One example of an exception is the state statutory requirement that the OVHA pay Evaluation and Management codes (E&M) at the Medicare 2006 rates. Please see page 73 for more specific information.

**Eliminate Nursing Home Inflation . . . . . (\$ 4,142,000) (gross)**  
 ~ State fund need before enhanced funding (\$1,701,948)

There is legislative directive to provide nursing homes with a cost of living rate increase annually. In SFY '10 this increase will not be provided; however, nursing homes will be exempted from the 4% provider rate reduction.

**Medicare Crossover Reimbursement . . . . . (\$ 2,343,809) (gross)**  
 ~ State fund need before enhanced funding (\$ 963,071)

Medicaid crossover claims are claims for individuals who are covered by both Medicare and Medicaid or dual eligibles. Medicaid is always the payer of last resort; therefore, Medicare would process the claim first as primary, and then Medicaid would process any balances as secondary. Medicare covered claims are subject to an annual deductible. Once that is met, Medicare will pay 80% up to the allowed amount with a couple of exceptions. This leaves non-covered services, deductible and co-insurance to be considered by Medicaid for payment.

Claims covered by Medicare that are presently submitted to Medicaid for consideration are paid without regard to Medicaid's fee schedule, paying both the deductible and co-insurance left after they are processed by Medicare. These claims are paid at a rate higher than individuals covered only by Medicaid for services when Medicare's fee schedule is higher than Medicaid. Please see page 83 for a more detailed description.

**PC+ Case Management Decrease (\$5.00 to \$2.50) . . (\$ 2,641,923) (gross)**  
 ~ State fund need before enhanced funding (\$ 1,085,566)

The OVHA currently pays primary care providers \$5.00 per member per month (pmpm) for managing care for beneficiaries enrolled in primary care plus (PC+). This decrease will reduce the rate of \$5.00 pmpm to \$2.50 pmpm. There are approximately 725 providers who will be affected by this change.

**Adult Dental Cap Decrease (\$495 to \$200) . . . . . (\$ 1,752,000) (gross)**  
 ~ State fund need before enhanced funding (\$ 719,897)

Currently the Adult Dental Cap is at \$495 and will be decreased to \$200 in April of 2009. There are an estimated 17,000 individuals who access dental benefits; and virtually all of these individuals reach the annual \$495 dental cap.

**REVENUE IMPLICATIONS . . . . . \$8,737,644 (gross)**

~ State fund need before enhanced funding \$6,212,032

**Premium Incr. for VHAP, Dr. Dynasaur, and SCHIP . . . . \$4,537,735 (gross)**

~ State fund need before enhanced funding \$1,798,748

The proposed SFY '10 premium structure simply returns beneficiary financial participation to the SFY '07 levels. 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. A depiction of the details is referenced on page 85.

**Addit. Hospital Tax Revenue Based on 5.5% Rate . . . . \$7,860,557 (gross)**

~ State fund need before enhanced funding \$7,860,557

Hospitals are taxed at 5.5% of total net patient revenues less bad debt percentage. Total expected tax is calculated annually based upon the most recently audited financial statement. This increase represents expected additional receipts beyond SFY '09 tax levels. Please note, however, that hospitals have been exempted from the 4% provider rate reduction. Please see page 88 for more detail.

**Loss of VPharm Premiums . . . . . (\$3,660,648) (gross)**

~ State fund need before enhanced funding (\$3,447,273)

VPharm beneficiaries are subject to premium payments based upon their income as a percent of federal poverty level. These premiums will be lost with the elimination of the programs.

**ADMINISTRATION . . . . . \$3,125,428 (gross)**

~ State fund need before stimulus package enhanced funding \$374,873

**PERSONAL SERVICES . . . . . (\$ 119,736) (gross)**

~ State fund need before enhanced funding (\$ 49,200)

**Payact and Related Fringe . . . . . \$275,487 (gross)**  
 ~ State fund need before enhanced funding \$113,198

**Annualize SFY '08 Positions and Exempt Reductions. (\$573,579) (gross)**  
 ~ State fund need before enhanced funding (\$235,684)

Through the 2 rounds of position rescissions that have occurred thus far, OVHA lost 18 positions ~ or roughly 16% of our overall workforce. While this amount is not insignificant, responsibilities have been reprioritized in order to manage to our mission. Please see page 68 for OVHA unit titles and responsibilities. Listed below are the respective divisions, titles, and pay grades that were eliminated:

| Unit                                     | Title                  | Pay Grade |
|------------------------------------------|------------------------|-----------|
| First Round of Position Reductions = 7   |                        |           |
| Program Integrity                        | Health Program         | 24        |
| COB                                      | Program Services Clerk | 15        |
| COB                                      | Program Services Clerk | 15        |
| COB                                      | COB Specialist         | 20        |
| Second Round of Position Reductions = 11 |                        |           |

**Healthcare Reform position costs . . . . . \$178,356 (gross)**  
 ~ State fund need before enhanced funding \$ 73,286

In December of SFY '09 the Healthcare Reform duties transferred from the Agency of Administration to the Office of Vermont Health Access.

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**OPERATING . . . . . (\$ 29,496) (gross)**  
 ~ State fund need before enhanced funding (\$ 12,120)

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 '10, it is anticipated that Vision costs for the OVHA will decrease by \$16,131 and DII costs by \$13,365.

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**GRANTS AND CONTRACTS . . . . . \$ 3,274,660 (gross)**  
 ~ State fund need before enhanced funding \$ 739,303

**The MOVE Initiative (one-time) . . . . . \$ 1,950,000 (gross)**  
 ~ State fund need before enhanced funding \$ 195,000

The Modernization of Vermont’s Enterprise ~ also known as MOVE, is a project to replace key Agency of Human Services information systems related to eligibility and claims processing:

- Phase One is the planning; procurement; design, development and implementation of a healthcare eligibility and enrollment system to replace the healthcare eligibility currently performed in the ACCESS system that is operated and maintained by the Department of Children and Families (DCF).
- Phase Two is the planning, procurement, and certification of a new Medicaid Management Information System (MMIS) that processes and manages the claims payments for Federal and State healthcare programs administered by the State of 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. Due to the complexity of Vermont’s healthcare program rules, automated systems utilizing new technology are essential to program administration.

The funds requested above begin the implementation of the MMIS replacement and will receive 90% matching funds from the federal government. Please see page 60 for additional information on this initiative.

**OVHA Contract Rescissions . . . . . \$ 1,400,000 (gross)**  
 ~ State fund need before enhanced funding \$ 575,260

The OVHA was allocated \$1.8 million in contract rescissions that are not feasible to absorb without severely impacting either providers through a slow-down of EDS processes or beneficiaries through a cut to our member services contractor. In an effort to address this contract rescission requirement, the OVHA is proposing to reduce our level of support to the Healthcare IT fund by \$400,000. Please see Insert 3 for more specific contract detail.

**Increase in the EDS Contract. . . . . \$ 102,660 (gross)**  
 ~ State fund need before enhanced funding \$ 42,183

The contract between the OVHA and EDS, our contractor responsible for claims processing, required a multi-year contract extension which began January 1, 2009. During the renegotiation process, significant attention was

given to minimizing cost increases. The amount requested represents a 1% increase over the SFY '09 appropriated level; and total anticipated expenditures are significantly less than the amounts spent in the previous 3 fiscal years.

**Grant Transfer** ..... **(\$ 178,000) (gross)**  
~ State fund need before enhanced funding (\$ 73,140)

There is an existing agreement between OVHA and VDH whereby we will transfer appropriation authority in order to support the Blueprint for Health Community Care Teams.

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**Revenue Corrections** ..... **\$ -0- (gross)**  
~ State fund need before enhanced funding (\$303,110)

Revenues needed to be reallocated between the myriad fund sources in order to allow for federal claiming for SCHIP administrative expenses. Additionally, a shift of Catamount admin costs from 100% Catamount funded to Global Commitment was necessary due to the impact of the revenue disregard on caseload.

---

|                                                                                                   |  |                    |
|---------------------------------------------------------------------------------------------------|--|--------------------|
| <b>FY10 Department Request - OVHA</b>                                                             |  | <b>Total</b>       |
| <b>OVHA Administration - As Passed FY09</b>                                                       |  | <b>35,954,075</b>  |
| <b>Rescissions:</b>                                                                               |  |                    |
| Round 2 position reduction                                                                        |  | (486,684)          |
| Logo reduction                                                                                    |  | -                  |
| Aug 08 Rescission items                                                                           |  | (1,447,720)        |
| 5% Exempt salary reduction                                                                        |  | (12,994)           |
| Personal Contractual Services                                                                     |  | (1,838,512)        |
| Liability Insurance reduction                                                                     |  | (4,905)            |
| Travel Reduction                                                                                  |  | (28,441)           |
| <b>Total After Rescission</b>                                                                     |  | <b>32,134,820</b>  |
| <b>FY09 After Rescission</b>                                                                      |  |                    |
| Adjustment of allocation within AHS of FY08 (Round 1) position reduction (AHS total 98 positions) |  | (232,509)          |
| Continue MITA/MOVE initiative                                                                     |  | 1,950,000          |
| Annualization of salary                                                                           |  | 128,415            |
| LTD change                                                                                        |  | 105                |
| Health insurance change                                                                           |  | 5,918              |
| Dental change                                                                                     |  | (1,909)            |
| Life insurance change                                                                             |  | 1,437              |
| Retirement change                                                                                 |  | 131,444            |
| FICA change                                                                                       |  | 10,292             |
| EAP change                                                                                        |  | (214)              |
| Annualization of 1/2 year '09 position reduction                                                  |  | (486,684)          |
| Annualization of 5% exempt salary reduction                                                       |  | (15,160)           |
| Reinstatement of Principal Assistant position                                                     |  | 160,774            |
| Contract reduction included in BAA                                                                |  | 1,800,000          |
| Transfer of 2 Healthcare Reform positions to OVHA from Agency of Admin                            |  | 178,356            |
| Increase in EDS contract                                                                          |  | 102,660            |
| Reduction in Healthcare IT Fund contribution                                                      |  | (400,000)          |
| Reduction in VISION allocation                                                                    |  | (16,131)           |
| Reduction in DII allocation                                                                       |  | (13,365)           |
| Blueprint grant - community care teams - Transfer funding to VDH - AHS net zero                   |  | (178,000)          |
| <b>FY10 Changes</b>                                                                               |  | <b>3,125,428</b>   |
| <b>FY10 Gov Recommended</b>                                                                       |  | <b>35,260,248</b>  |
| <b>Total Program - As Passed FY09</b>                                                             |  |                    |
| <b>Rescissions and other changes</b>                                                              |  | <b>755,675,972</b> |
| FY09 "Medicaid Waterfall"                                                                         |  | -                  |
| Aug 08 Rescission items                                                                           |  | 13,960,000         |
| Dec 08 Rescission items                                                                           |  | (3,125,000)        |
| <b>Total After Rescission</b>                                                                     |  | <b>(475,090)</b>   |
| <b>FY09 After Rescission</b>                                                                      |  | <b>766,035,882</b> |
| <b>Grants:</b>                                                                                    |  |                    |
| Traditional Medicaid program - caseload & trend                                                   |  | -                  |
| Change in Pharmacy Only Programs                                                                  |  | 38,860,710         |
| Increase in caseload & trend - CFC acute                                                          |  | (7,072,804)        |
| CFC home based caseload and nursing home inflation                                                |  | 3,963,084          |
| Change in CFC Buy-in                                                                              |  | 10,374,277         |
| Change in Non-Waiver Matched Buy In                                                               |  | 186,964            |
| Change in State Only Buy In                                                                       |  | 244,430            |
| SCHIP caseload & trend                                                                            |  | 136,049            |
| HIV and Civil Union caseload & trend                                                              |  | (17,284)           |
| To Capture Refugee in Proper Appropriation                                                        |  | (9,499)            |
| Caseload and Trend Impact                                                                         |  | 76,285             |
|                                                                                                   |  | 46,742,212         |

|                                                                                                                                                                                                                                                     |                     |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|
| Catamount/ESI caseload & trend < 200% FPL                                                                                                                                                                                                           | 17,350,602          |
| Catamount/ESI caseload & trend > 200% FPL                                                                                                                                                                                                           | (2,890,108)         |
| Caseload and Trend Impact                                                                                                                                                                                                                           | 14,460,494          |
| Increase in Clawback Rate                                                                                                                                                                                                                           | 2,272,023           |
| <b>SUBTOTAL TREND CHANGES</b>                                                                                                                                                                                                                       | <b>63,474,729</b>   |
| Transfer to DAILE for Individual Service Agreements - AHS net zero                                                                                                                                                                                  | (700,000)           |
| Transfer VCRYHP funding to DCF - AHS net zero                                                                                                                                                                                                       | (371,943)           |
| <b>SUBTOTAL COST NEUTRAL CHANGES</b>                                                                                                                                                                                                                | <b>(1,071,943)</b>  |
| GC Provider rate decreases of 4% will be realized. Rates to all providers will be adjusted to reflect this change with the exception of those that have been held harmless.                                                                         | (7,319,208)         |
| 4% rate decrease CFC Acute                                                                                                                                                                                                                          | (3,327,278)         |
| 4% rate decrease CFC Home Based Services                                                                                                                                                                                                            | (2,440,292)         |
| 4% Provider Rate Decreases                                                                                                                                                                                                                          | (13,086,778)        |
| Eliminate VPharm 1, VPharm 2, and VPharm3 - GC component                                                                                                                                                                                            | (1,201,697)         |
| The state of Vermont pays a premium charge for pharmacy beneficiaries. With the elimination of the pharmacy only programs, this prescription drug premium will no longer need to be paid and will result in additional savings.                     | (1,211,842)         |
| Eliminate VPharm 1, VPharm 2, and VPharm3 - GF component                                                                                                                                                                                            | (7,462,724)         |
| Eliminate VPharm 1, VPharm 2, and VPharm3                                                                                                                                                                                                           | (9,876,263)         |
| Reduce amount of dental benefit covered from \$495/year to \$200/year.                                                                                                                                                                              | (1,752,000)         |
| Pay Medicare cross-over claims at the Medicaid rate.                                                                                                                                                                                                | (2,343,809)         |
| To primary care physicians, the state of Vermont provides a set monthly management fee of \$5 per month per primary care plus recipient. This will reduce that monthly management fee from \$5 per person per month to \$2.50 per person per month. | (2,641,923)         |
| Pharmacy - 90 Day Supply for maintenance drugs                                                                                                                                                                                                      | (1,289,345)         |
| Reduce Average Wholesale Price by .4%                                                                                                                                                                                                               | (400,000)           |
| No CFC Nursing Home Inflation                                                                                                                                                                                                                       | (4,142,000)         |
| Subtotal All Other Policy Changes                                                                                                                                                                                                                   | (12,569,077)        |
| <b>SUBTOTAL ALL POLICY CHANGES</b>                                                                                                                                                                                                                  | <b>(35,532,118)</b> |
| <b>TOTAL ALL PROGRAM CHANGES</b>                                                                                                                                                                                                                    | <b>26,870,668</b>   |
| TOTAL FY09 OVHA Big Bill As Passed                                                                                                                                                                                                                  | 791,630,047         |
| TOTAL FY09 OVHA Reductions/Rescissions                                                                                                                                                                                                              | 6,540,655           |
| TOTAL FY10 OVHA Starting Point                                                                                                                                                                                                                      | 798,170,702         |
| TOTAL FY10 OVHA ups & downs                                                                                                                                                                                                                         | 29,996,096          |
| TOTAL FY10 OVHA Gov Recommended                                                                                                                                                                                                                     | 828,166,798         |

## SECTION 3: FEDERAL CHANGES

### Federal Stimulus Bills

At the time of the preparation of this document, the federal stimulus bills were still under development. While the details have not yet been finalized, it is clear that the bill will contain a number of provisions that are relevant to Vermont's Medicaid programs and OVHA's mission. These include:

- temporary increases to states' Federal Medical Assistance Percentage (FMAP);
- increases to states' Disproportionate Share Hospital (DSH) allotments;
- providing increase of full FMAP for program and administrative costs for certain people who are involuntarily terminated from employment;
- disregarding additional unemployment benefits from income calculation for Medicaid program eligibility;:
- providing Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit assistance to people involuntarily terminated from their jobs;
- providing an increase in Supplemental Security Income (SSI) payments to eligible individuals;
- funding for health information technology;
- funding for wellness and prevention activities;
- providing funds to train and support health care professionals; and
- moratoriums related to the Bush Administration's Centers for Medicare and Medicaid Services (CMS) regulatory initiatives.

### State Children's Health Insurance Program (SCHIP)

Vermont's State Children's Health Insurance Program (SCHIP) started in 1998 and covers uninsured children between 225-300% of the Federal Poverty Level (FPL) and is part of the Dr Dynasaur program. The SCHIP program provides health care coverage to approximately 3,500 Vermont children in any given month and over 6,000 children during a year.

The Federal SCHIP program authorization expired in October 2007, and was extended until March 31, 2009 through The Medicare, Medicaid, and SCHIP Extension Act of 2007. In January 2009, both the U. S. House of Representatives and the U. S. Senate passed almost identical bills to reauthorize SCHIP for four and a half years. The expectation is that the House and Senate will resolve any minor differences and the President will sign it into law. Both bills provide funding for the Vermont program to continue intact, and allow for some room for growth in the future if state funds are available.

The most recent Department of Banking Insurance, Securities, and Health Care Administration 2008 Vermont Household Health Insurance Survey indicates that the uninsured rate for children has declined from 4.9% to 2.9% since 2005. The survey indicates that 3,869 Vermont children (ages 0-17) are uninsured, and that 3,000 of

these children might be eligible for our existing Dr. Dynasaur coverage (0-300% FPL). There may be as many as 600 of the 3,000 uninsured children that could be covered under SCHIP. With the newly authorized SCHIP funds, we are hopeful that the uninsured rate for Vermont children will continue to decline.

When SCHIP was first implemented there were concerns that substitution would occur, and states were required to have plans in place to prevent substitution. In August 2007, the Centers for Medicare and Medicaid Services (CMS) issued a State Health Official (SHO) letter reinterpreting SCHIP regulations as they relate to concerns of children giving up employer-sponsored coverage for publicly funded coverage. The August CMS letter required states covering children above 250% FPL to implement a number of strategies by August 2008. The most challenging of the strategies were: imposing a 12 month period without insurance prior to enrolling; imposing cost sharing in approximation to that of private coverage; and assurance that the number of children in the target population insured through private coverage has decreased over a period of five years. While the Vermont SCHIP program did increase premiums from \$40 to \$60 on July 1, 2008, it has not had to make any other changes to the program to meet the requirements of the August 17<sup>th</sup> SHO letter. The expectation is that the new Federal Administration will rescind the August 17<sup>th</sup> SHO letter.

## SECTION 4: OVERVIEW OF HEALTH CARE PROGRAMS



**Green Mountain Care** is the umbrella name for the state-sponsored family of low-cost and free health coverage programs for uninsured Vermonters. Offered by the state of Vermont and its partners, Green Mountain Care programs offer access to quality, comprehensive health care coverage at a reasonable cost. No or low co-payments and premiums keep out-of-pocket costs reasonable. The premium and co-pay charts are located on pages 86-87.

### **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 '10 for Catamount Health:

| Catamount Health             |          |               |
|------------------------------|----------|---------------|
| SFY                          | Caseload | Expenditures  |
| SFY '08 Actual               | 1,730    | \$ 7,995,183  |
| SFY '09 Appropriated         | 7,994    | \$ 36,101,229 |
| SFY '09 Budget Adjustment    | 6,302    | \$ 29,594,265 |
| SFY '10 Governor's Recommend | 9,277    | \$ 50,124,827 |

## Employer-Sponsored Insurance Premium Assistance

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

- The employee meets the eligibility criteria to enroll in Catamount Health or the Vermont Health Access Plan (VHAP);
- The employee's household income is under \$2,718 a month for one person;
- The employer's plan has comprehensive benefits; and
- The cost of providing premium assistance to enroll in an employer's plan is less than the cost of providing premium assistance to enroll in Catamount Health or the VHAP.

The following tables depict the caseload and expenditure information by SFY, including the Governor's Recommend for SFY '10 for Employer-Sponsored Insurance (ESI) Premium Assistance:

| Catamount ESI                |          |              |
|------------------------------|----------|--------------|
| SFY                          | Caseload | Expenditures |
| SFY '08 Actual               | 132      | \$ 168,977   |
| SFY '09 Appropriated         | 469      | \$ 658,636   |
| SFY '09 Budget Adjustment    | 493      | \$ 748,952   |
| SFY '10 Governor's Recommend | 630      | \$ 1,095,532 |

| VHAP ESI                     |          |              |
|------------------------------|----------|--------------|
| SFY                          | Caseload | Expenditures |
| SFY '08 Actual               | 276      | \$ 571,218   |
| SFY '09 Appropriated         | 1,169    | \$ 1,794,204 |
| SFY '09 Budget Adjustment    | 956      | \$ 1,982,422 |
| SFY '10 Governor's Recommend | 1,215    | \$ 2,850,534 |

## 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.

Adults without children can earn up to \$1,359 per month, and parents can make up to \$2,256 per month for a family of two, \$2,836 per month for a family of three, and \$3,415 per month for a family of four and still be eligible.

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 '10 for VHAP:

| VHAP                         |          |                |
|------------------------------|----------|----------------|
| SFY                          | Caseload | Expenditures   |
| SFY '07 Actual               | 22,404   | \$ 79,795,246  |
| SFY '08 Actual               | 24,771   | \$ 89,891,925  |
| SFY '09 Appropriated         | 23,513   | \$ 94,969,359  |
| SFY '09 Budget Adjustment    | 27,592   | \$ 110,833,046 |
| SFY '10 Governor's Recommend | 30,023   | \$ 119,758,901 |

## Dr. Dynasaur

Dr. Dynasaur 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.

### **State Children's Health Insurance Program (SCHIP)**

The general eligibility requirements for the State Children's Health Insurance Program (SCHIP) are: 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. A family of three can earn up to \$4,598 per month and a family of four can earn up to \$5,538 per month and still be eligible.

The following table depicts the caseload and expenditure information by SFY, including the Governor's Recommend for SFY '10 for the State Children's Health Insurance Program (SCHIP):

| <b>SCHIP</b>                 |                 |                     |
|------------------------------|-----------------|---------------------|
| <b>SFY</b>                   | <b>Caseload</b> | <b>Expenditures</b> |
| SFY '07 Actual               | 3,070           | \$ 4,189,850        |
| SFY '08 Actual               | 3,278           | \$ 4,462,004        |
| SFY '09 Appropriated         | 3,646           | \$ 5,540,466        |
| SFY '09 Budget Adjustment    | 3,398           | \$ 5,164,572        |
| SFY '10 Governor's Recommend | 3,559           | \$ 5,496,248        |

### **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. A family of three can earn up to \$4,598 per month and a family of four can earn up to \$5,538 per month and still be eligible.

The following table depicts the caseload and expenditure information by SFY, including the Governor's Recommend for SFY '09 for Uninsured Children:

| <b>Underinsured Children</b> |                 |                     |
|------------------------------|-----------------|---------------------|
| <b>SFY</b>                   | <b>Caseload</b> | <b>Expenditures</b> |
| SFY '07 Actual               | 1,186           | \$ 846,736          |
| SFY '08 Actual               | 1,138           | \$ 742,529          |
| SFY '09 Appropriated         | 1,297           | \$ 1,116,433        |
| SFY '09 Budget Adjustment    | 1,156           | \$ 842,837          |
| SFY '10 Governor's Recommend | 1,170           | \$ 894,887          |

### **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 '10 for BD and/or Medically Needy Children:

| <b>Blind or Disabled and/or Medically Needy Children</b> |                 |                     |
|----------------------------------------------------------|-----------------|---------------------|
| <b>SFY</b>                                               | <b>Caseload</b> | <b>Expenditures</b> |
| SFY '07 Actual                                           | 3,398           | \$ 28,299,312       |
| SFY '08 Actual                                           | 3,487           | \$ 27,775,036       |
| SFY '09 Appropriated                                     | 3,502           | \$ 32,750,206       |
| SFY '09 Budget Adjustment                                | 3,570           | \$ 32,042,833       |
| SFY '10 Governor's Recommend                             | 3,660           | \$ 33,942,009       |

### **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 '10 for General Children:

| <b>General Children</b>      |                 |                     |
|------------------------------|-----------------|---------------------|
| <b>SFY</b>                   | <b>Caseload</b> | <b>Expenditures</b> |
| SFY '07 Actual               | 51,187          | \$ 85,115,012       |
| SFY '08 Actual               | 50,664          | \$ 90,807,988       |
| SFY '09 Appropriated         | 54,972          | \$ 107,073,860      |
| SFY '09 Budget Adjustment    | 51,071          | \$ 104,257,972      |
| SFY '10 Governor's Recommend | 51,037          | \$ 105,463,098      |

### **Medicaid for Adults**

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

Medicaid 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, prescription medicines and dentist visits; and \$75 for an inpatient admission.

### **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 '10 for Dual Eligibles:

| <b>Dual Eligibles</b>        |                 |                     |
|------------------------------|-----------------|---------------------|
| <b>SFY</b>                   | <b>Caseload</b> | <b>Expenditures</b> |
| SFY '07 Actual               | 14,073          | \$ 37,371,558       |
| SFY '08 Actual               | 14,185          | \$ 35,614,807       |
| SFY '09 Appropriated         | 8,679           | \$ 41,994,267       |
| SFY '09 Budget Adjustment    | 14,453          | \$ 42,007,214       |
| SFY '10 Governor's Recommend | 14,681          | \$ 42,832,084       |

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

The general eligibility requirements for the ABD and/or Medically Needy Adults are: age 18 and older, categorized as aged, blind, or disabled (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 '10 for ABD and/or Medically Needy Adults:

| <b>Aged, Blind, &amp; Disabled (ABD) and/or Medically Need Adults</b> |                 |                     |
|-----------------------------------------------------------------------|-----------------|---------------------|
| <b>SFY</b>                                                            | <b>Caseload</b> | <b>Expenditures</b> |
| SFY '07 Actual                                                        | 11,330          | \$ 68,586,463       |
| SFY '08 Actual                                                        | 11,797          | \$ 72,515,067       |
| SFY '09 Appropriated                                                  | 16,338          | \$ 85,504,244       |
| SFY '09 Budget Adjustment                                             | 12,037          | \$ 83,212,076       |
| SFY '10 Governor's Recommend                                          | 12,400          | \$ 87,439,690       |

### **Choices for Care Waiver**

The general eligibility requirements for the Choices for Care Waiver are: Vermonters in nursing homes, home-based settings under home and community based services (HCBS) waiver programs, and enhanced residential care (ERC); subset of ABD and/or Medically Needy Adults.

The following table depicts the caseload and expenditure information by SFY, including the Governor's Recommend for SFY '10 for Choices for Care:

| Choices for Care Waiver and/or Medically Needy |          |                |
|------------------------------------------------|----------|----------------|
| SFY                                            | Caseload | Expenditures   |
| SFY '07 Actual                                 | 3,545    | \$ 169,555,756 |
| SFY '08 Actual                                 | 3,973    | \$ 189,742,595 |
| SFY '09 Appropriated                           | 4,841    | \$ 194,755,728 |
| SFY '09 Budget Adjustment                      | 4,841    | \$ 201,716,575 |
| SFY '10 Governor's Recommend                   | 4,938    | \$ 200,585,327 |

### 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 '10 for General Adults:

| General Adults               |          |               |
|------------------------------|----------|---------------|
| SFY                          | Caseload | Expenditures  |
| SFY '07 Actual               | 9,327    | \$ 41,239,463 |
| SFY '08 Actual               | 9,255    | \$ 43,797,118 |
| SFY '09 Appropriated         | 8,230    | \$ 51,642,224 |
| SFY '09 Budget Adjustment    | 9,291    | \$ 50,335,298 |
| SFY '10 Governor's Recommend | 9,333    | \$ 51,484,127 |

### 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** assists 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.

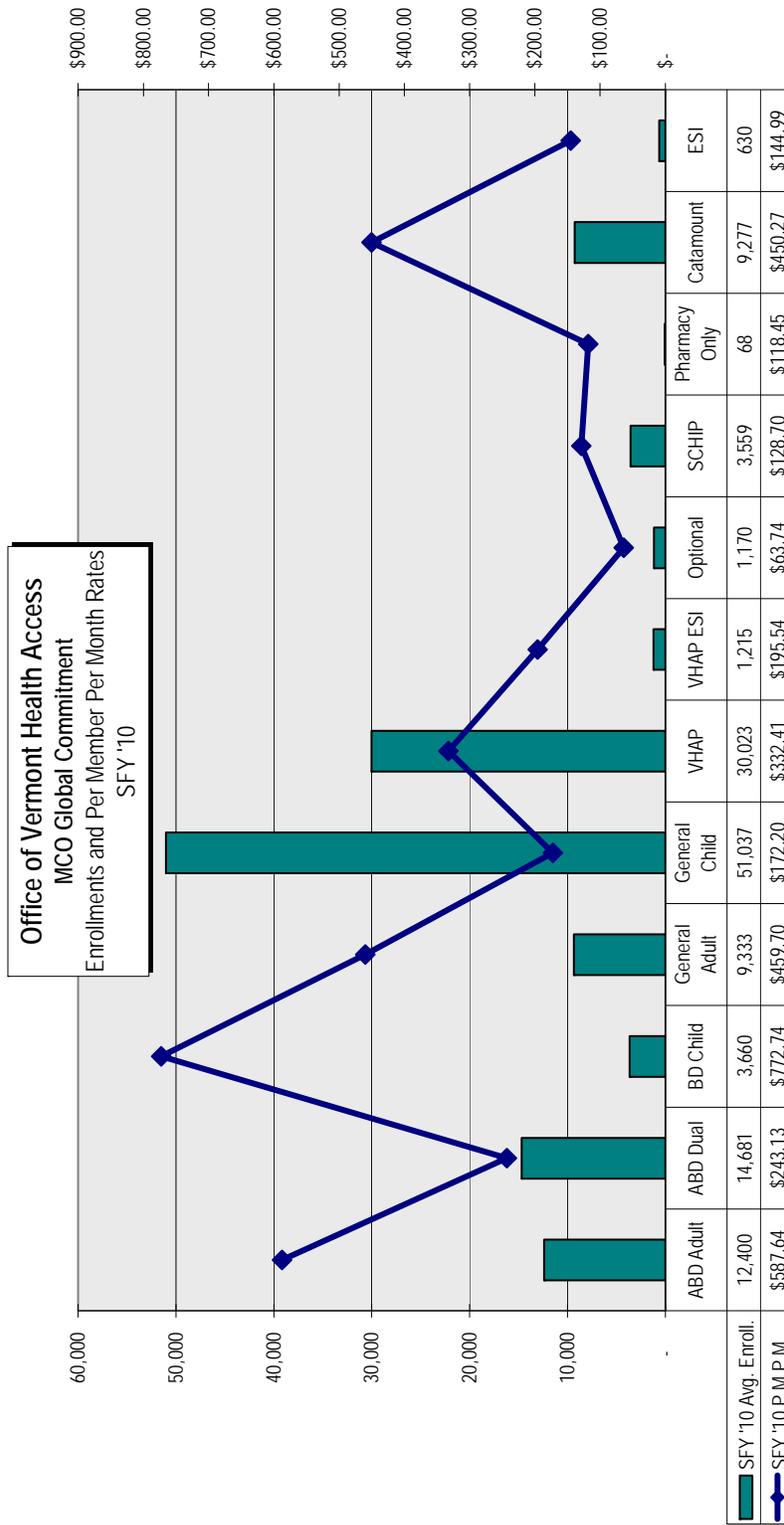
The following table depicts the caseload and expenditure information by SFY, including the Governor's Recommend for SFY '10 for the Pharmacy Programs:

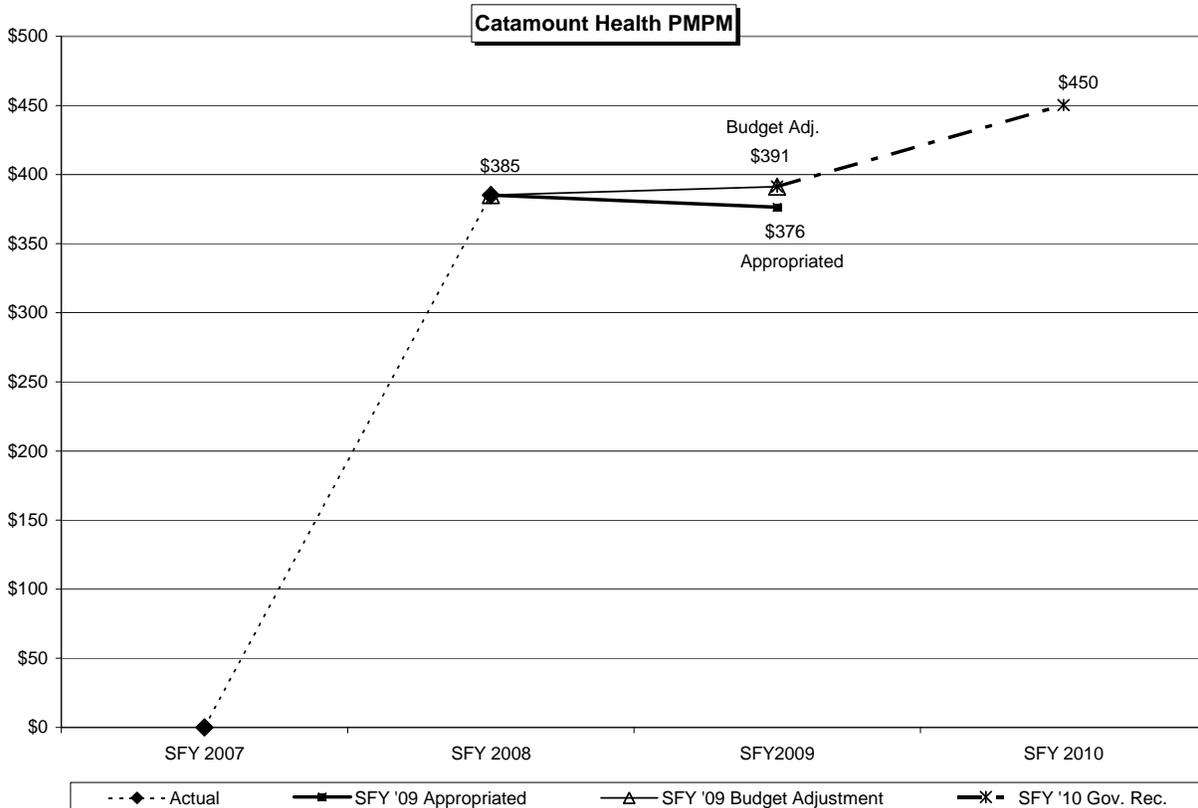
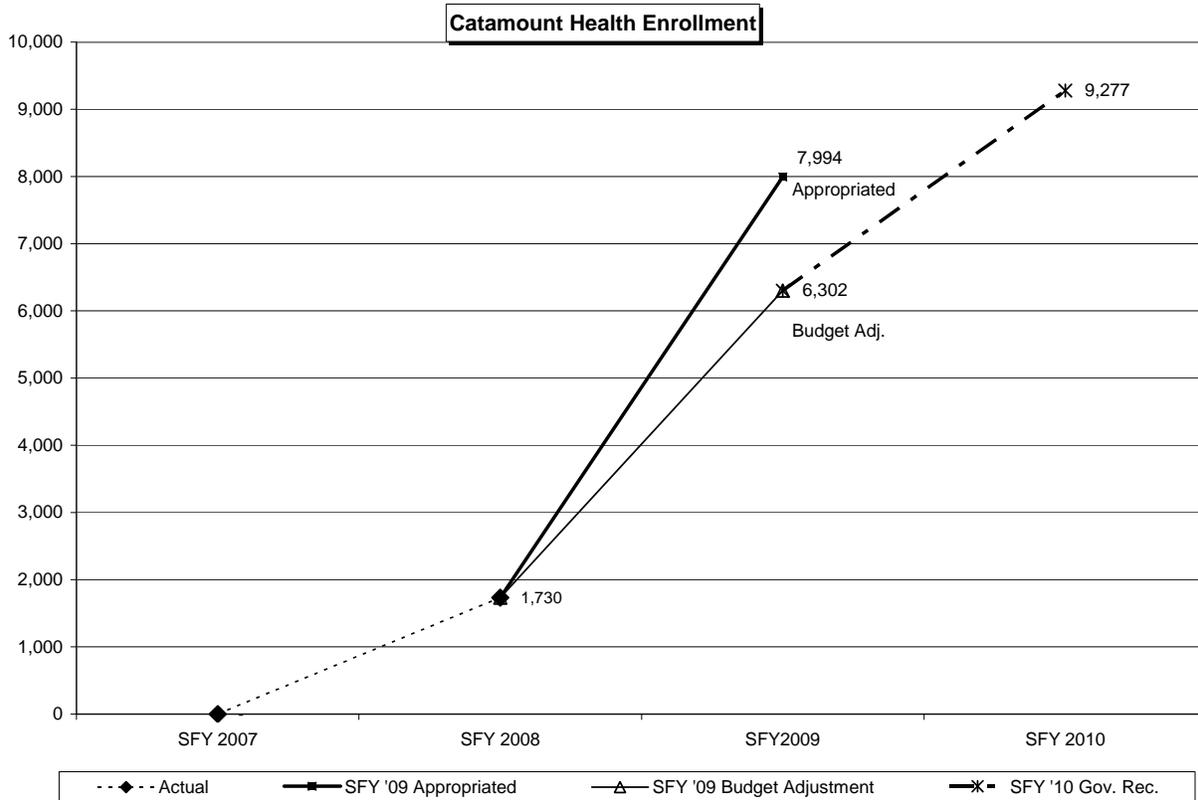
| Pharmacy Only Program        |          |               |
|------------------------------|----------|---------------|
| SFY                          | Caseload | Expenditures  |
| SFY '07 Actual               | 12,952   | \$ 8,585,791  |
| SFY '08 Actual               | 12,737   | \$ 7,318,162  |
| SFY '09 Appropriated         | 13,786   | \$ 16,223,405 |
| SFY '09 Budget Adjustment    | 9,488    | \$ 5,905,437  |
| SFY '10 Governor's Recommend | 68       | \$ 96,655     |

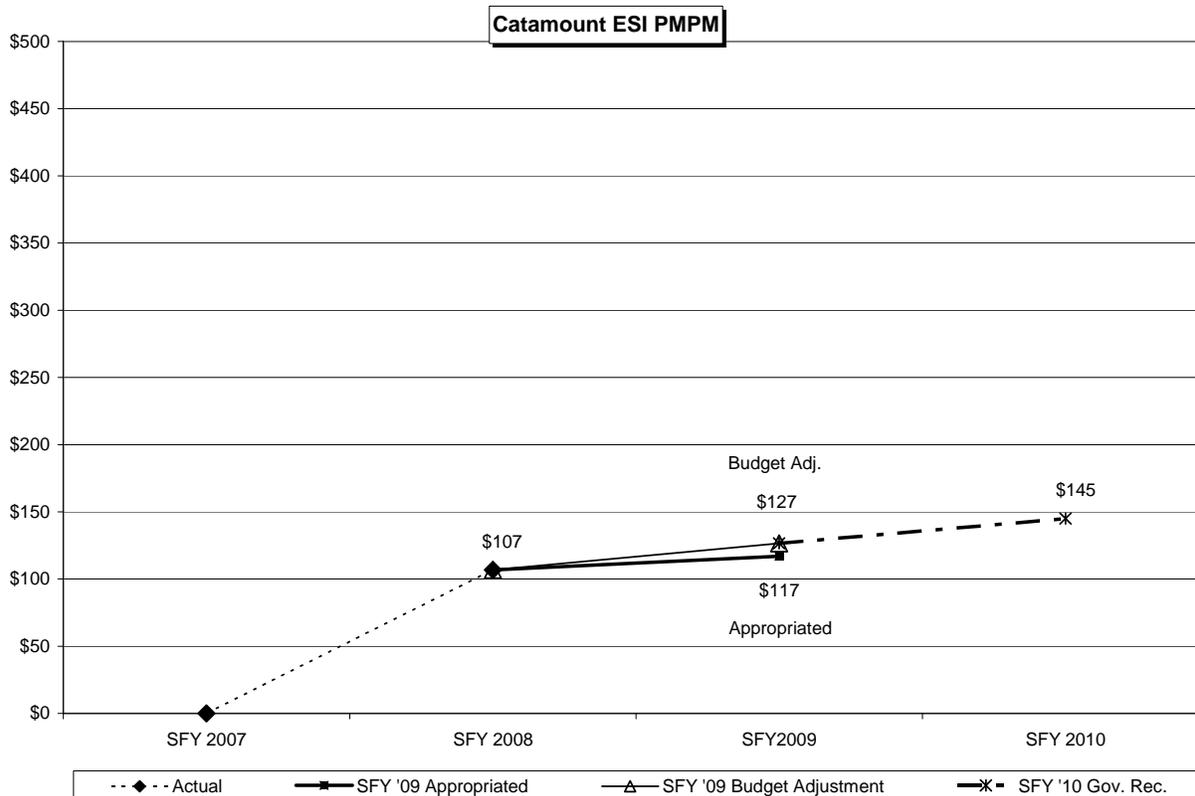
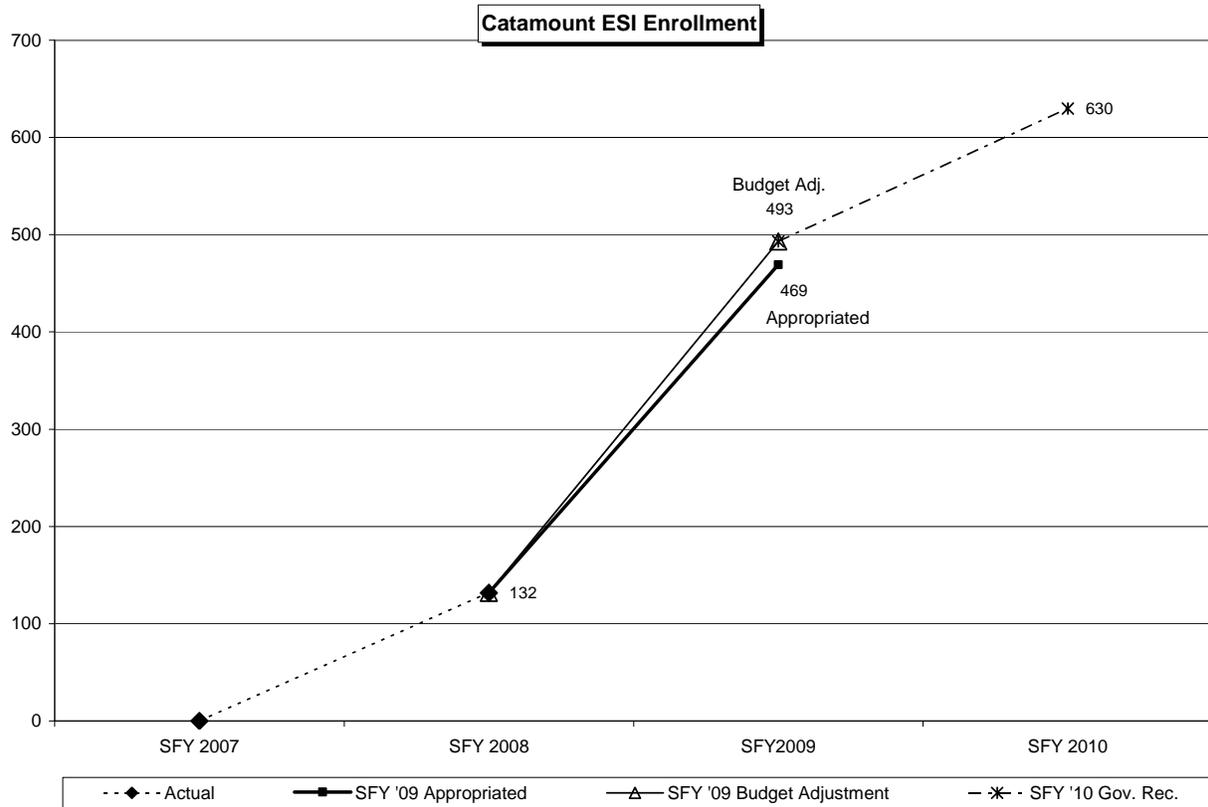
**Healthy Vermonters** provides a discount on short-term and long-term prescription medicines. There are no monthly premiums and eligibility is based on family income.

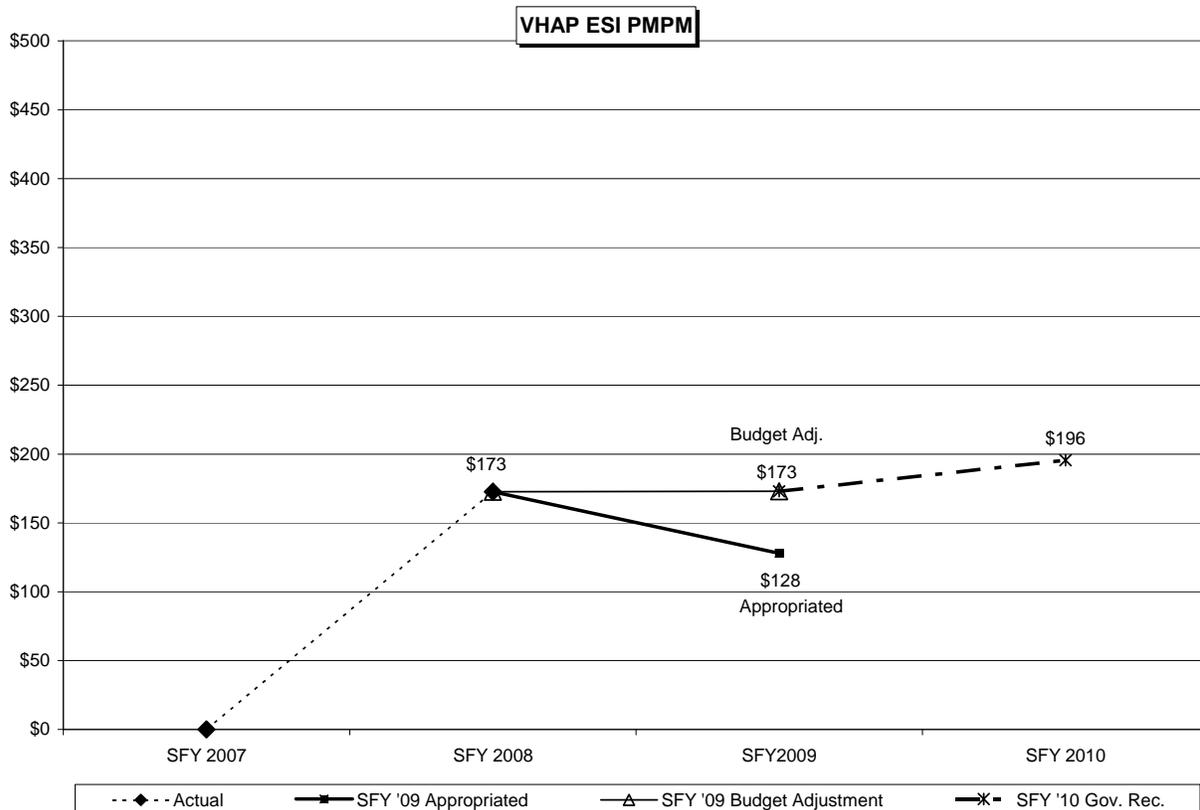
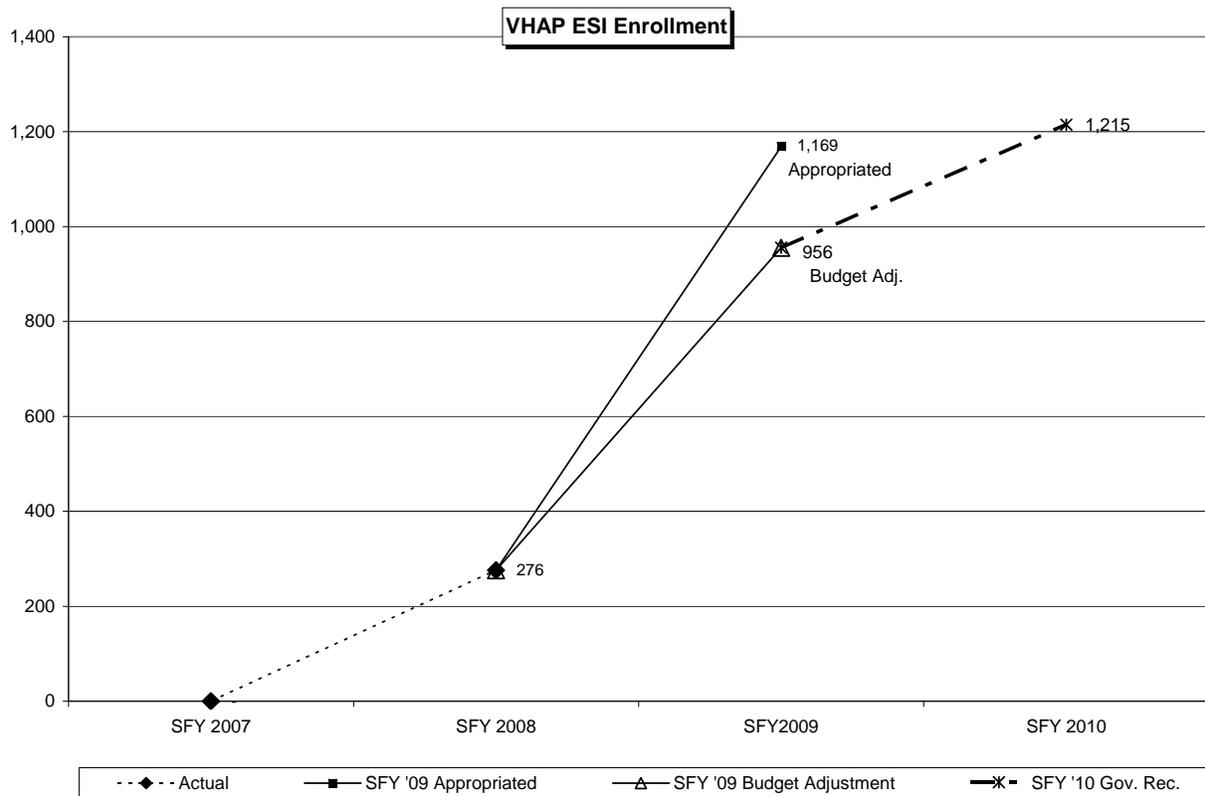
The following table depicts the caseload and expenditure information by SFY, including the Governor's Recommend for SFY '10 for the Healthy Vermonters Program:

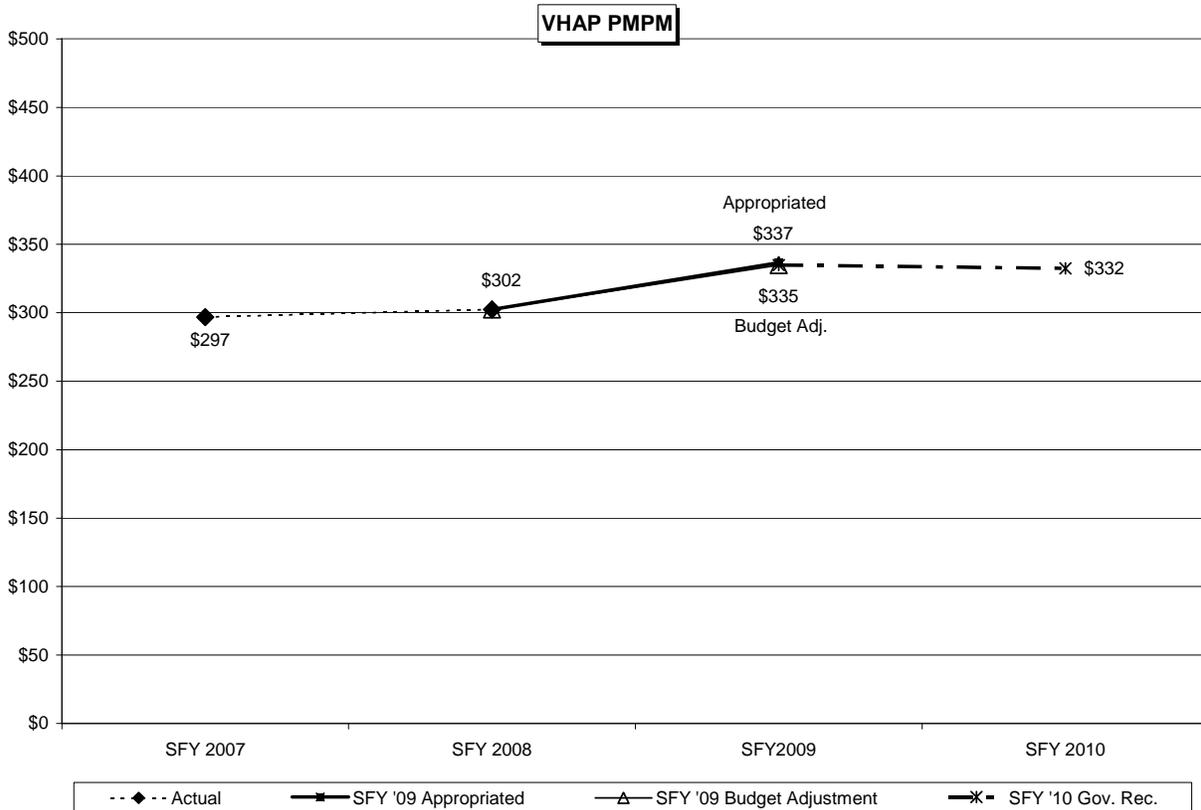
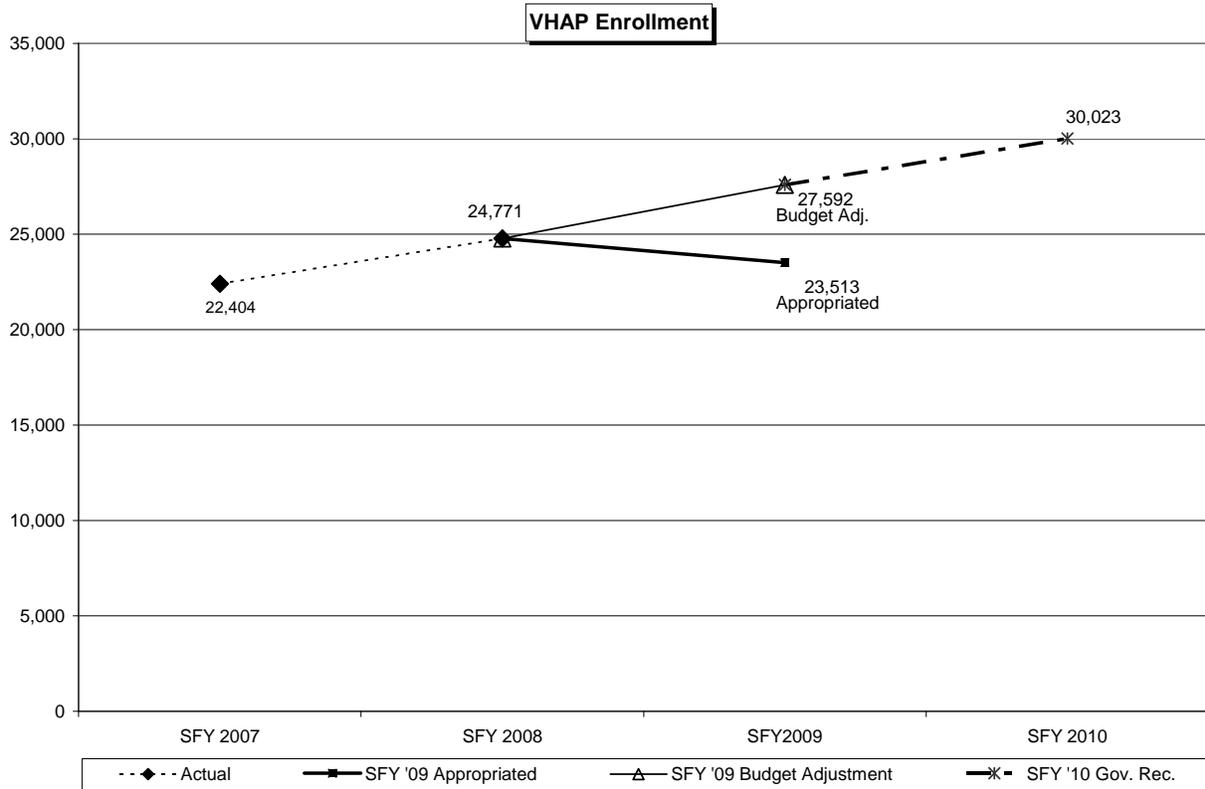
| Healthy Vermonters           |          |              |
|------------------------------|----------|--------------|
| SFY                          | Caseload | Expenditures |
| SFY '07 Actual               | 9,413    | N/A          |
| SFY '08 Actual               | 8,841    | N/A          |
| SFY '09 Appropriated         | 9,211    | N/A          |
| SFY '09 Budget Adjustment    | 9,211    | N/A          |
| SFY '10 Governor's Recommend | 9,211    | N/A          |

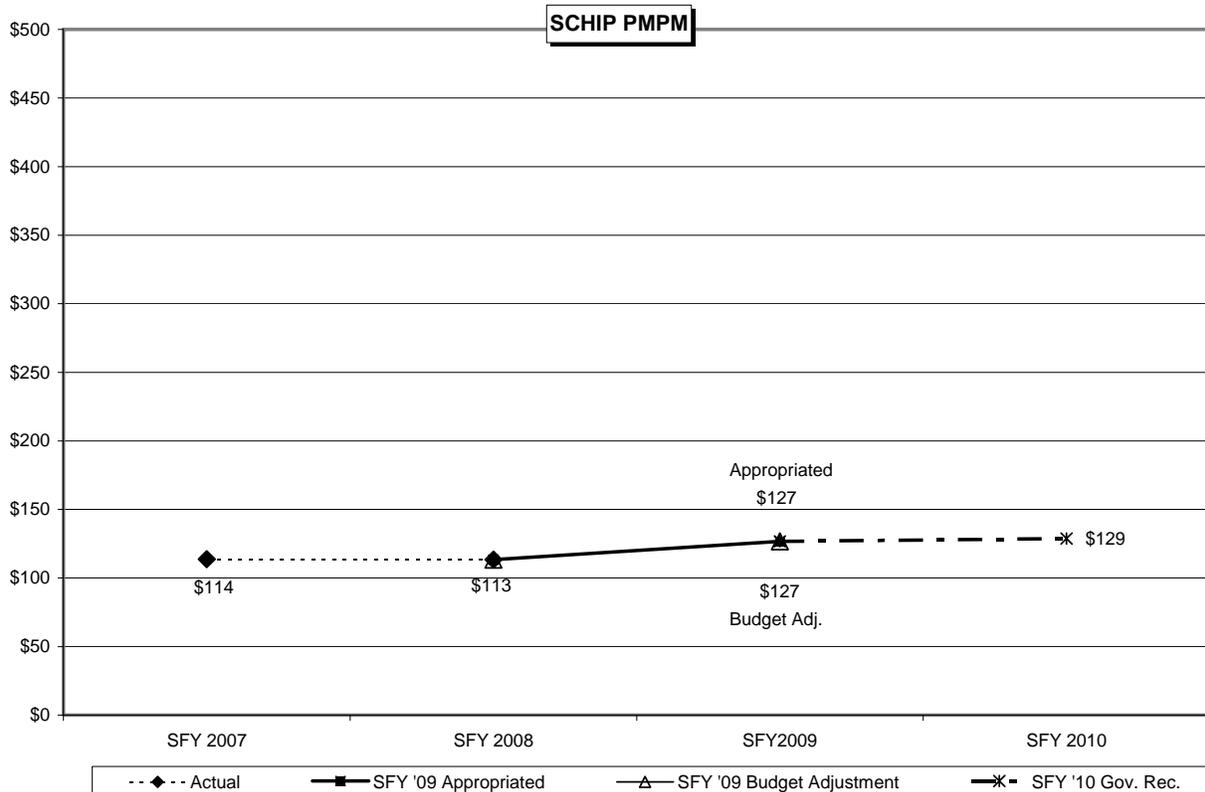
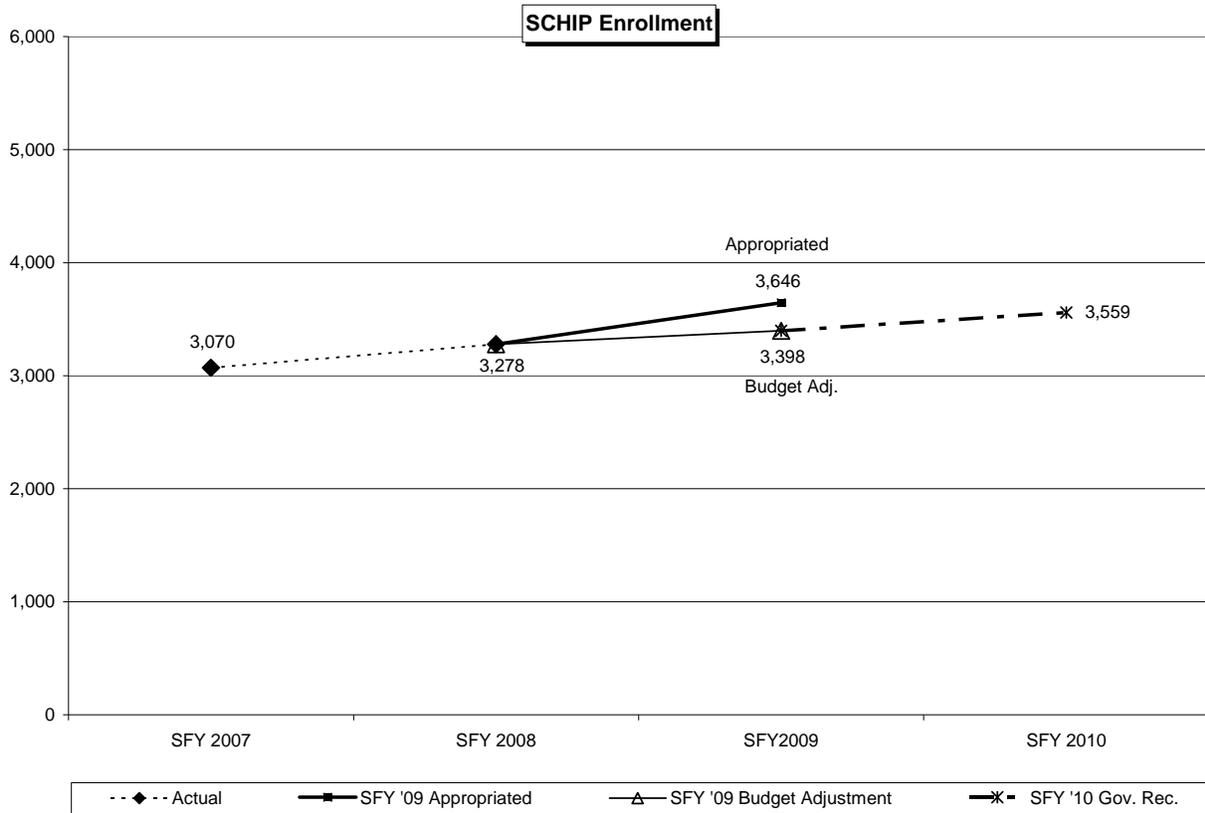
**Enrollments and Per Member Per Month Rates SFY 2010**


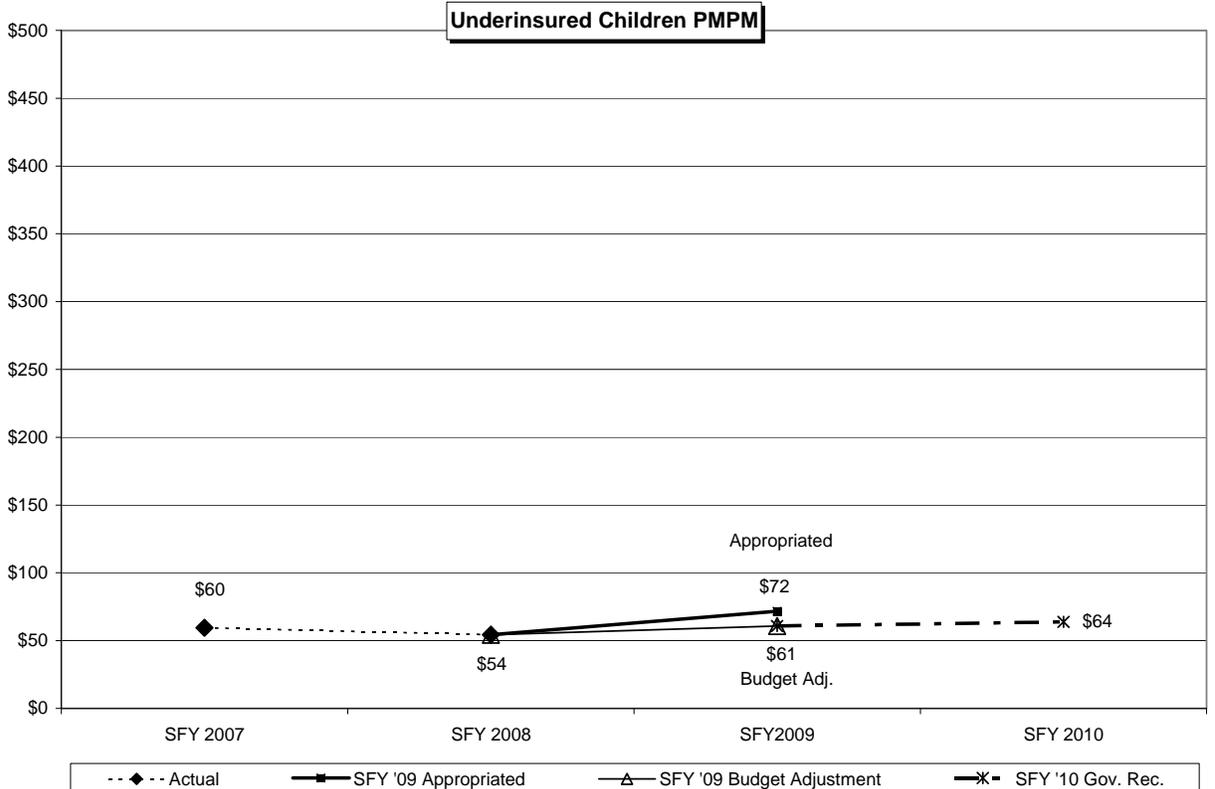
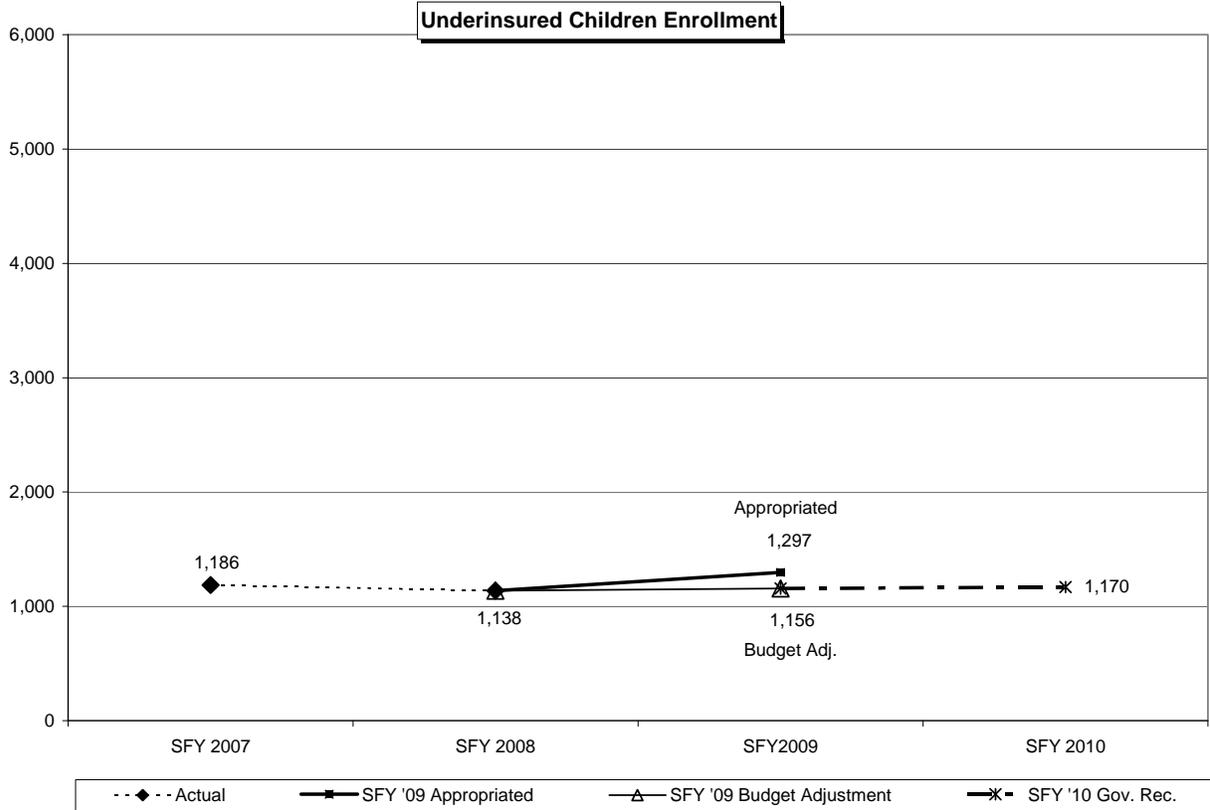


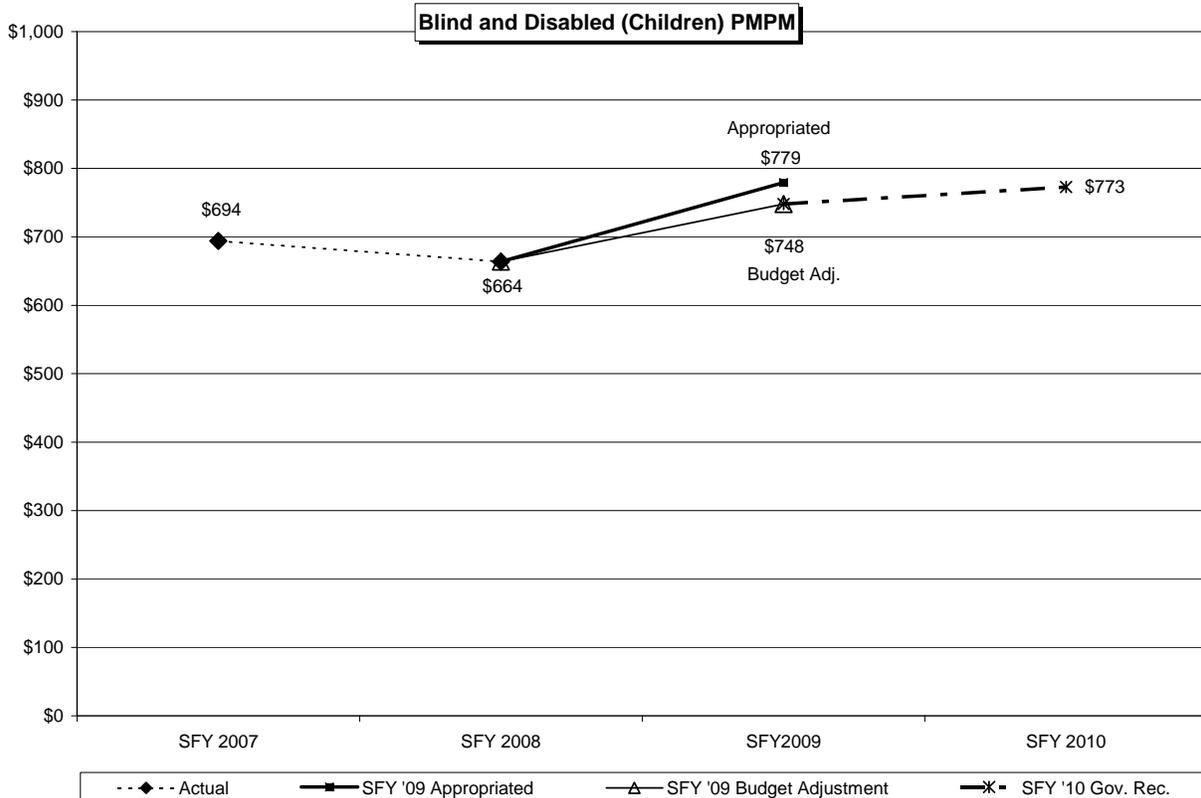
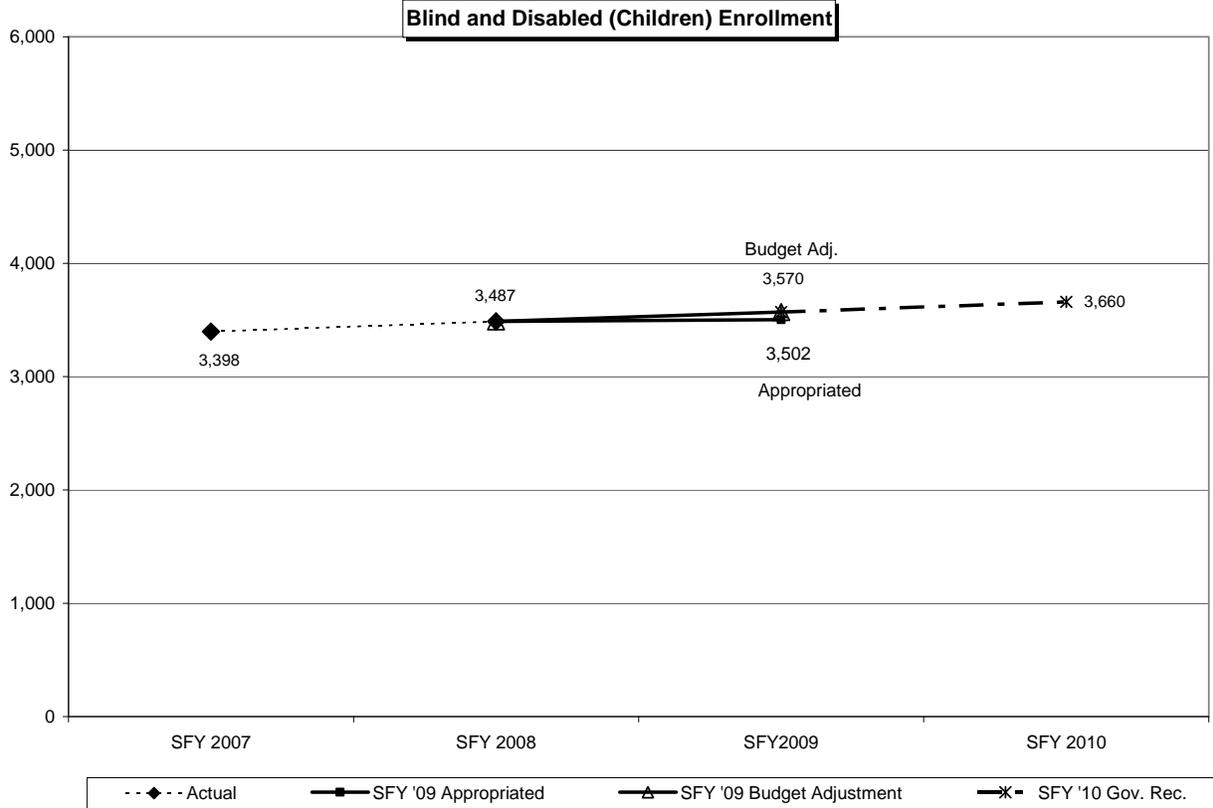


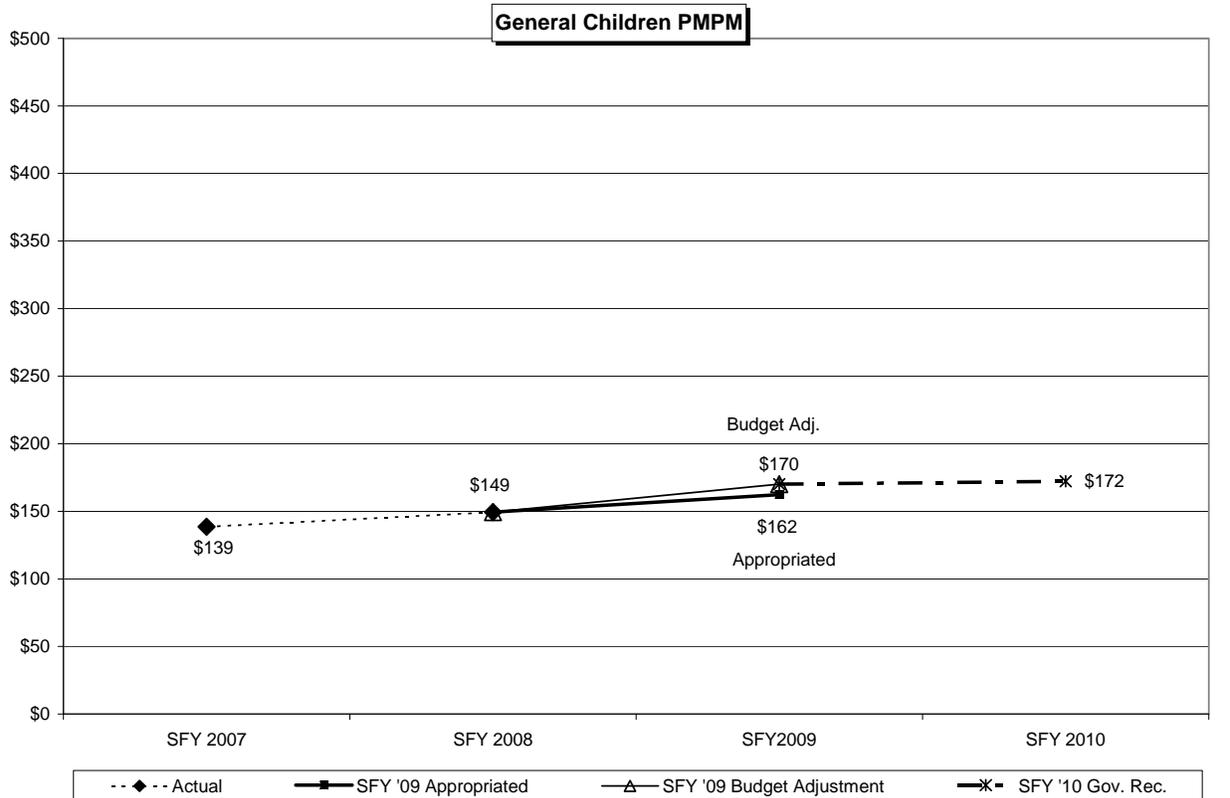
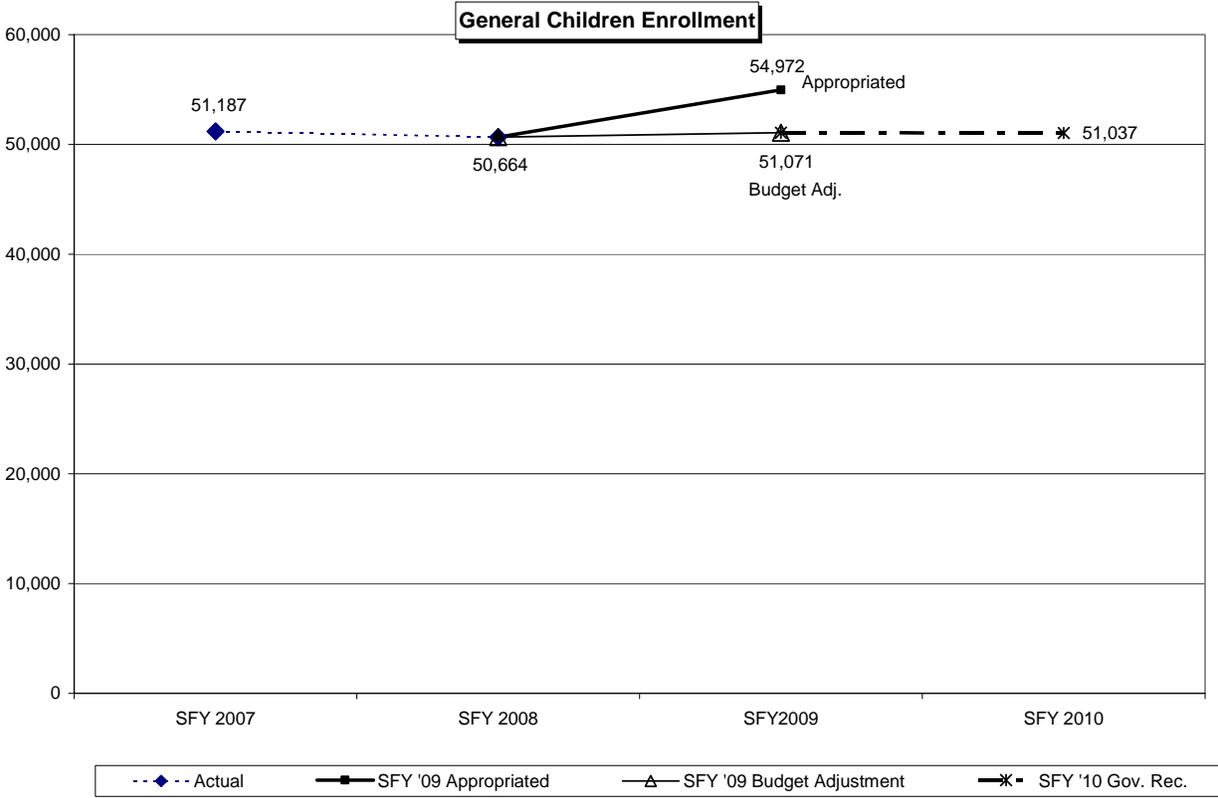


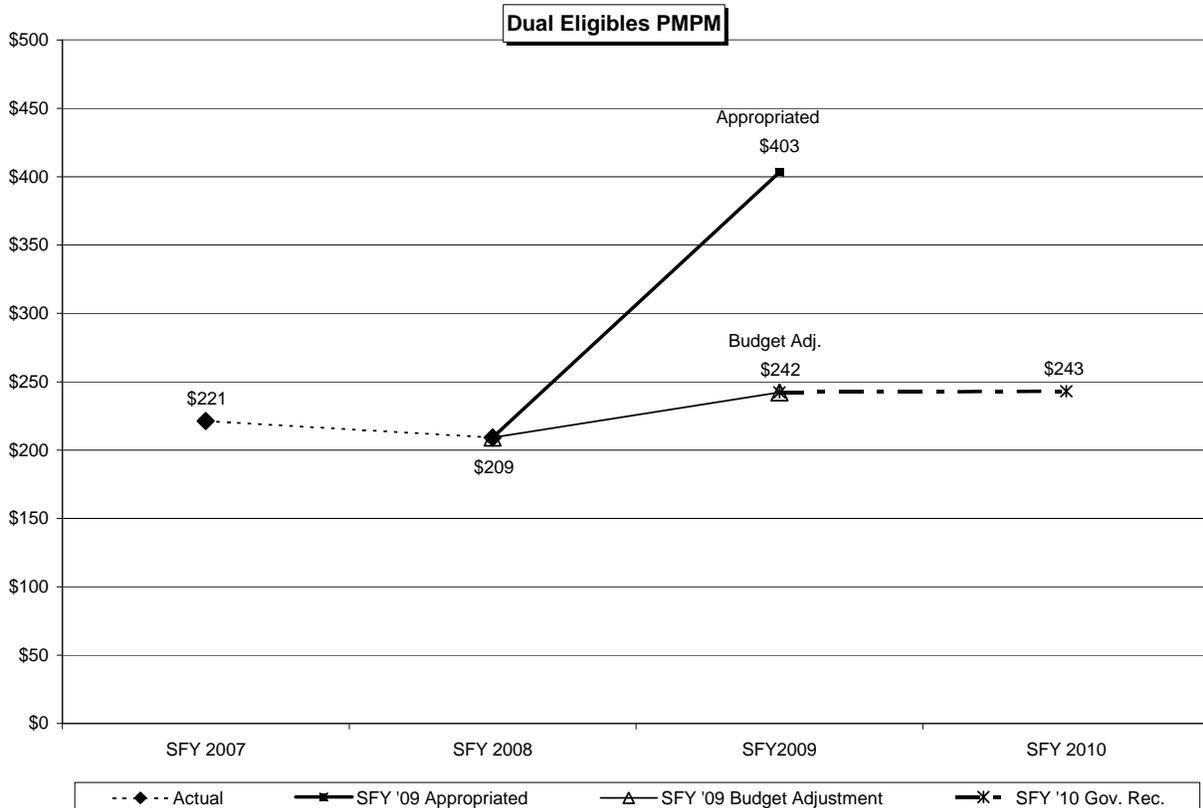
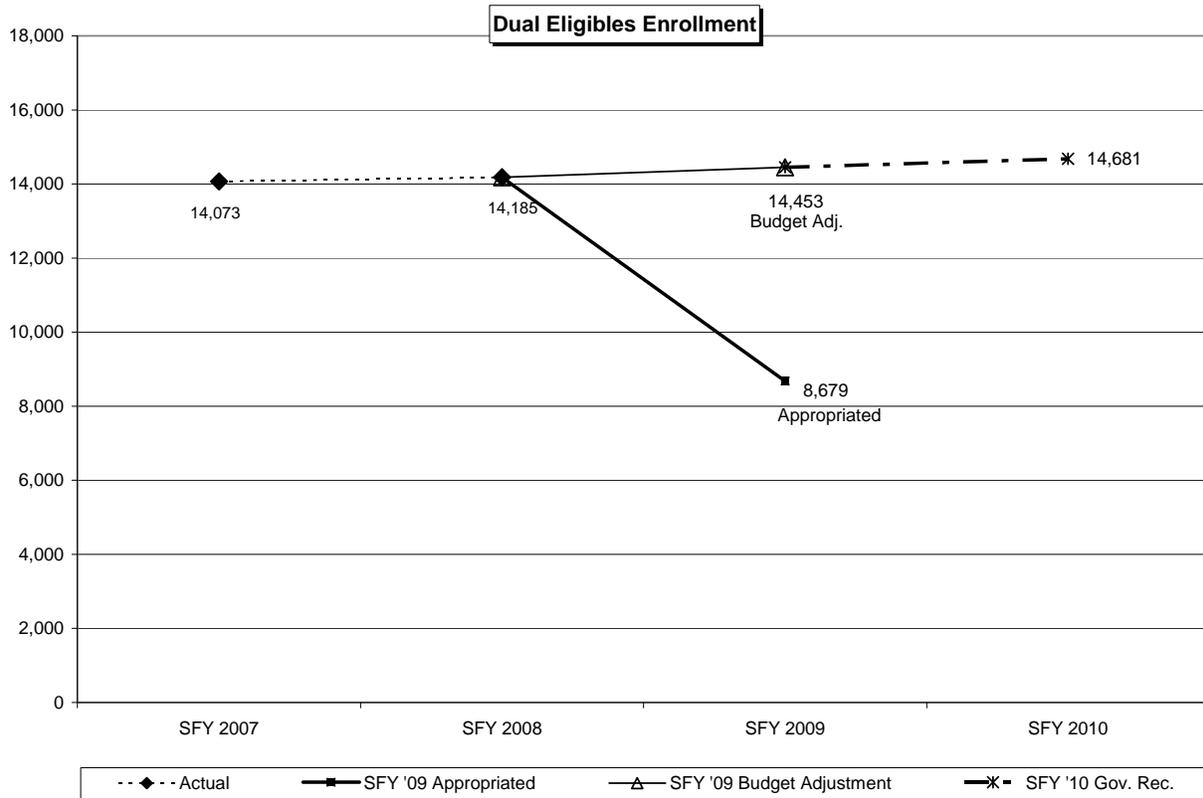


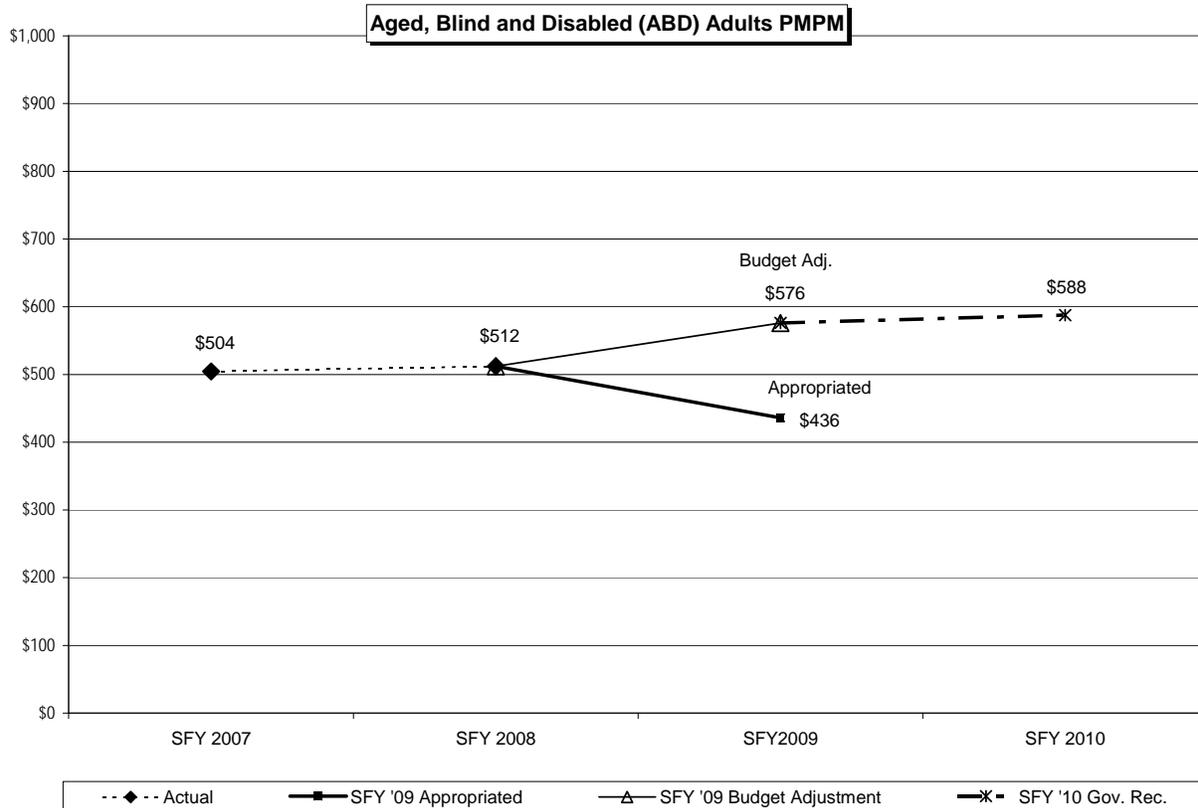
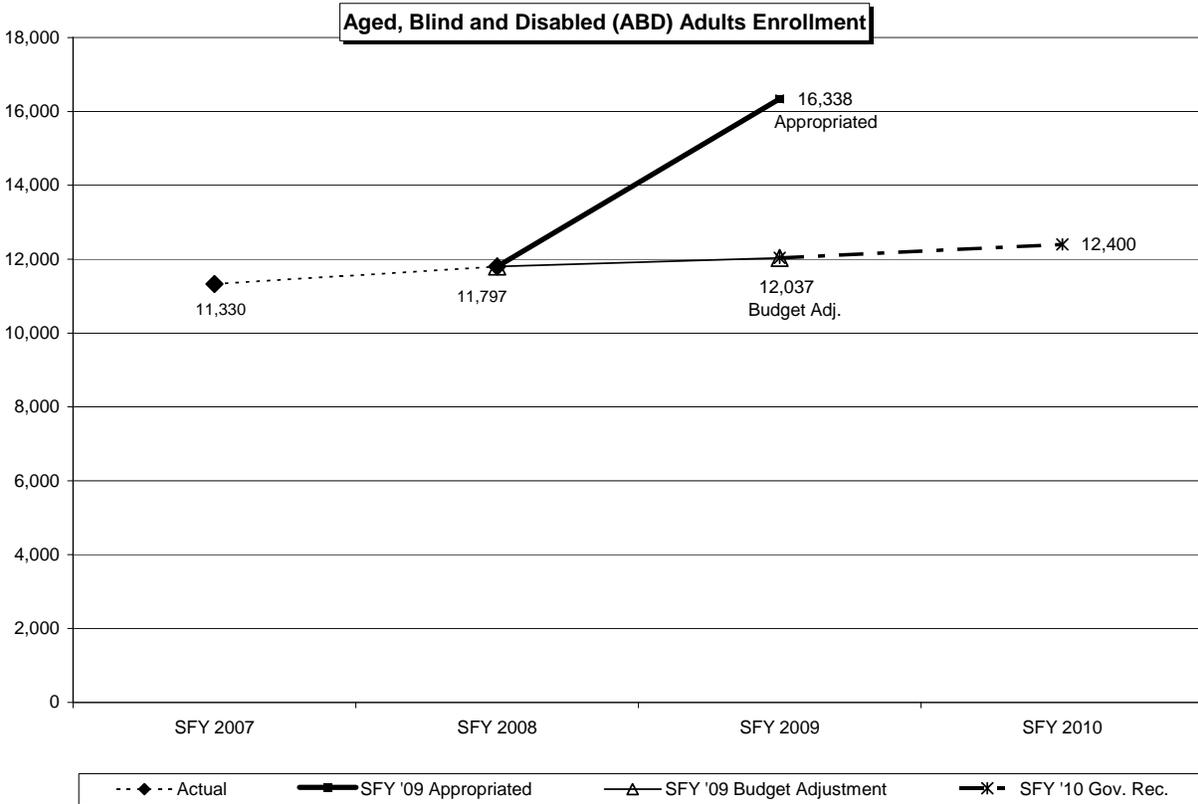


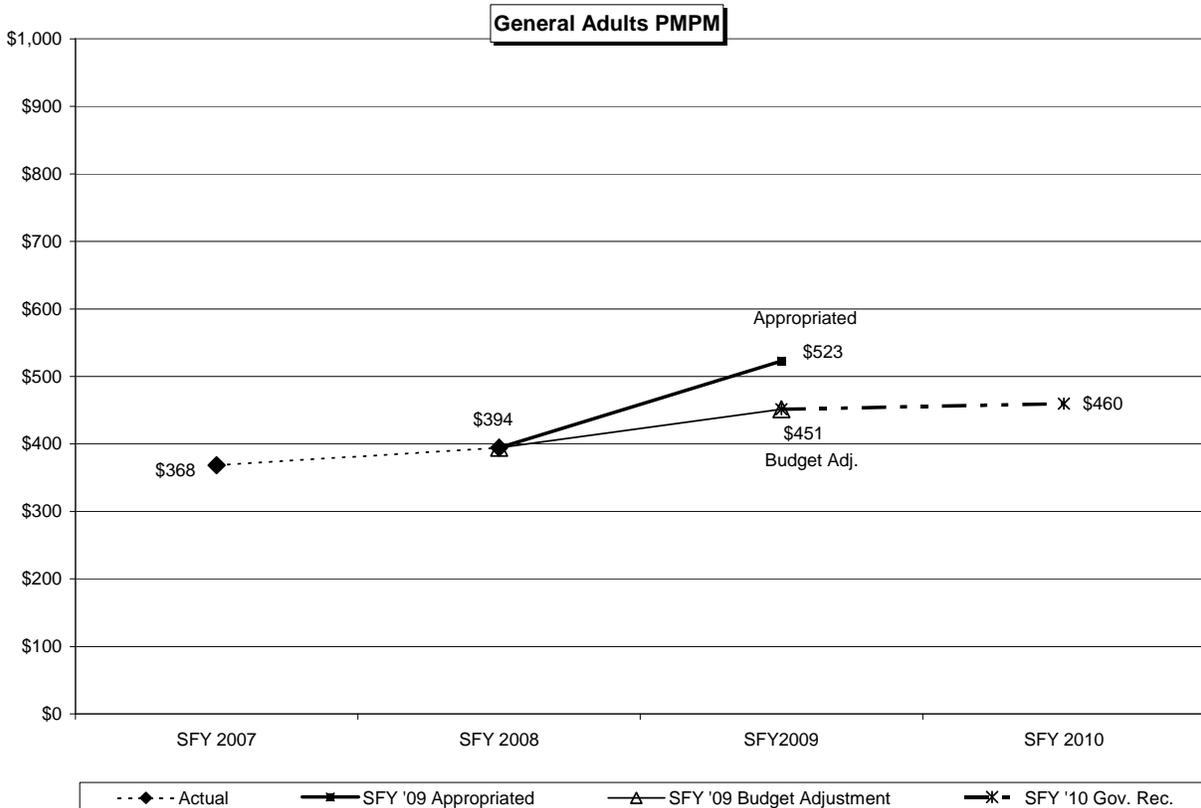
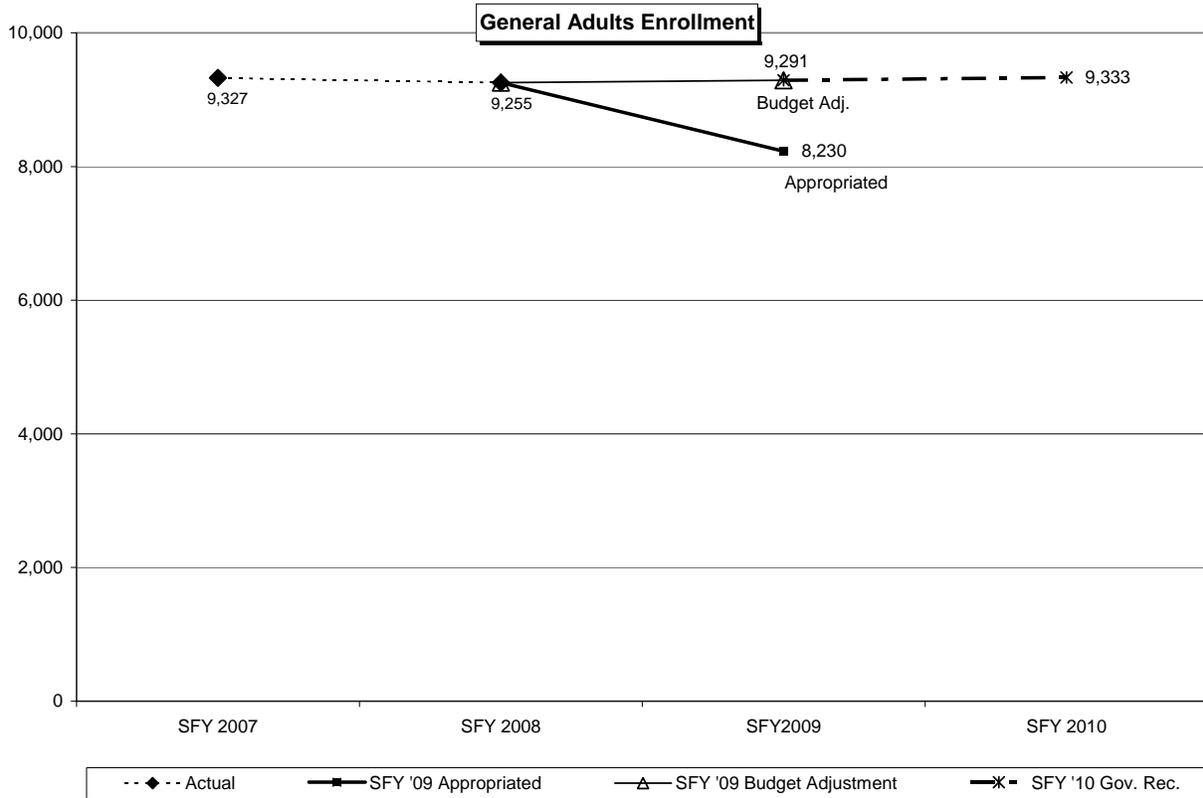


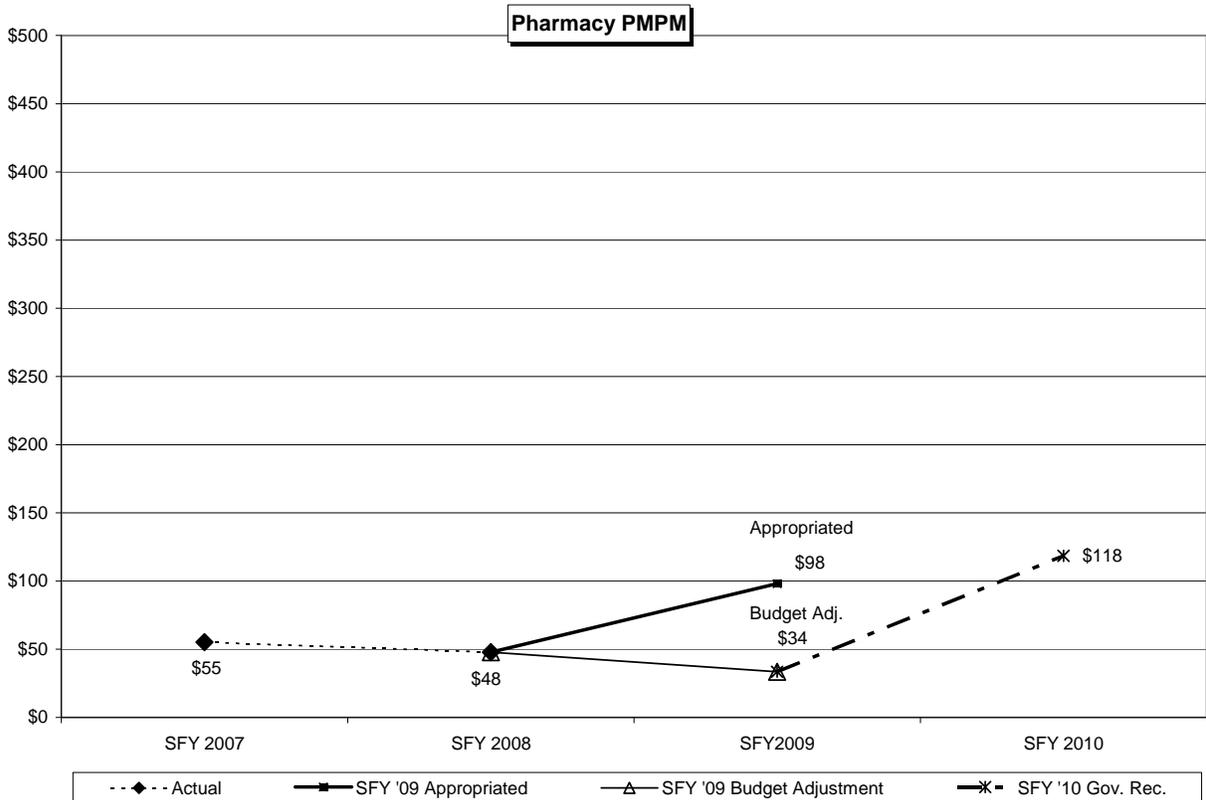
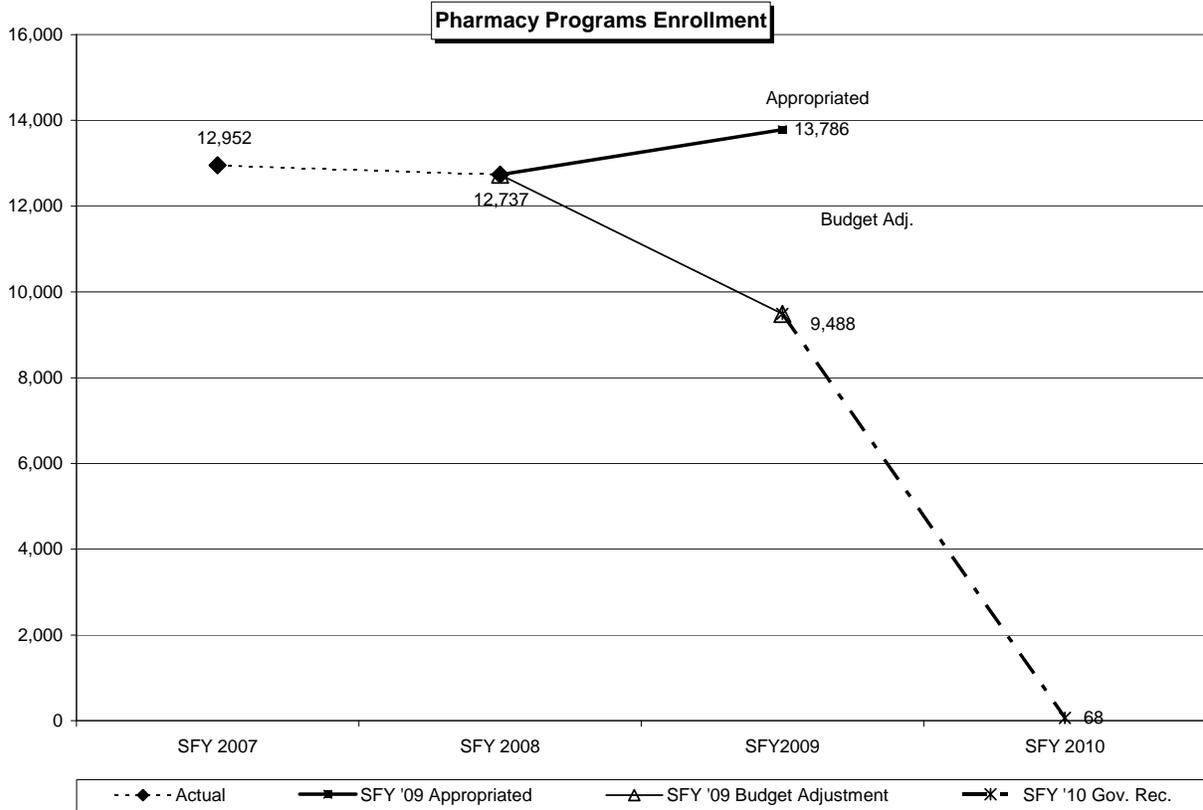












## SECTION 5: OVERVIEW OF HEALTH CARE REFORM

As of 2009, OVHA is also the home of state oversight and coordination of Vermont's expansive health care reform initiatives. Starting with Acts 190 and 191 (Acts Relating to Health Care Affordability for Vermonters) and augmented by Acts 70 and 71 in 2007 and Acts 203 and 204 in 2008, the legislation is designed to simultaneously achieve the following three goals:

- ❖ *Increase access to affordable health insurance for all Vermonters*
- ❖ *Improve quality of care across the lifespan*
- ❖ *Contain health care costs*

Entering 2009 with over 60 active (or completed) reform initiatives, projects and programs, Vermont can be proud of the work done to date to improve, refine, and transform the health care delivery system, improve quality of care, expand access to coverage, and improve system performance.

Vermont is making steady strides in covering its uninsured. Between November 2007 and December 2008, over 11,500 more Vermonters enrolled in health care programs offered through Green Mountain Care, the state's family of comprehensive health coverage programs for the uninsured. As of December 2008, Vermont's uninsured rate has fallen from 9.8% of those living without health insurance to 7.6%.

We have also been successful in other aspects of our state's comprehensive health care reform efforts:

- Starting in July 2008, we launched the Blueprint multi-payer Integrated Medical Home Pilots in three areas of the state and continued the successes of the statewide Healthy Living self-management classes for people with chronic conditions.
- We are collaborating with Maine, New Hampshire, Massachusetts and Rhode Island, with support from the Milbank Foundation, to develop a New England wide medical home pilot initiative.
- During 2008, we implemented a Health Information Technology Fee to support health care information technology for primary care providers and to further our statewide health information exchange network.
- In addition, we also implemented a 340B Pharmacy program to decrease the pharmaceutical cost for FQHC patients; made significant progress on public health and prevention efforts related to promoting healthy weight for Vermonters; promulgated rules to allow Vermont health insurance carriers to offer cost-sharing discounts for enrollee adherence to health promotion and disease prevention programs, as well as rules to facilitate the availability of transparent price and quality information for health care consumers; begun implementation of a multi-payer claims database to facilitate understanding of our health care utilization, expenditures, and performance across all payers and services; and

implemented an outreach tracking tool to further assist our Green Mountain Care enrollment efforts.

- We also are participating in two external two-year evaluations regarding the success of our efforts to improve access and affordability for health care coverage.

OVHA has responsibility for assuring that Vermont's comprehensive health care reform initiatives are coordinated across state government and with other public and private partners, fostering a collaborative, inclusive approach to the implementation of health care reform to ensure its consistency and effectiveness. OVHA's collaboration partners within state government include the Departments of Health, Mental Health, Children & Families, Aging and Independent Living, Information and Innovation, Labor, Human Resources and Health Care Administration, as well as the Vermont General Assembly. External collaborators include such entities as private insurance carriers, health care advocacy organizations, health care providers and hospitals, Vermont Information Technology Leaders, University of Vermont Medical School, the business community and many others.

For detailed information on current and past health care reform initiatives, with links to a wide variety of reports and program implementation information, see <http://hcr.vermont.gov>.

## SECTION 6: STATUS UPDATE OF KEY ACTIVITIES

### Green Mountain Care

**Fast Facts:**

- In 2005 over 61,000 (9.8%) of Vermonters were uninsured, half of whom qualified for existing state-sponsored health insurance programs.
- Results of the 2008 BISHCA survey show that the number of uninsured has decreased to 47,286, a 2.21% decline since 2005
- Act 191 goal: Achieve 96% coverage by 2010.
- Catamount Health is offered by BCBS of Vermont and MVP Health Care.
- <http://www.GreenMountainCare.org> is the Green Mountain Care website.
- 1-800-250-8427 is the number for Health Access Member Services for Green Mountain Care.

Act 191 created the private insurance product, Catamount Health, which became available on October 1, 2007 through Blue Cross Blue Shield of Vermont and MVP Health Care. Also created by Act 191 were premium assistance programs to assist uninsured Vermonters with income up to 300 percent of the federal poverty level (FPL) in paying the premiums for Catamount Health or their employer-sponsored insurance (ESI) plans.

Because half of the 61,000 Vermonters who did not have health insurance in 2005 qualified for existing state-sponsored health insurance programs, one overarching brand (Green Mountain Care) was developed to

attract Vermonters to the full range of coverage options, including Catamount Health and the new premium assistance programs, as well as existing health care programs such as VHAP and Dr. Dynasaur. Focus group research provided the name “Green Mountain Care” and the tag line, “A Healthier State of Living.”

The website, <http://www.GreenMountainCare.org>, hosts a high-level screening tool, and allows Vermonters to determine which programs they may be eligible for and enables the download of the appropriate application. The 1-800 number at Health Access Member Services (i.e., Maximus) for Green Mountain Care is found throughout the website and screening tool to allow for phone inquiries.

### **Enrollment**

As of the end of December 2008, over 8,600 individuals had enrolled in the new premium assistance programs (Catamount Health and ESI). In addition, enrollment in existing programs such as Medicaid, VHAP, and Dr. Dynasaur has increased since the implementation of the new premium assistance programs. Overall, there are 11,762 more people enrolled in health care assistance in December 2008 than were enrolled in October of 2007, a 10 percent increase.

Preliminary results of the 2008 BISHCA Household Health Insurance Survey were released in December. These results show that the number of uninsured Vermonters

has declined by 2.21 percent since 2005, a very positive outcome, especially in light of the challenging economic conditions Vermont is experiencing.

Monthly enrollment reports, including information on income range, age, gender, and county of residence for Vermonters enrolled in the various programs are available on the OVHA website at <http://ovha.vermont.gov/budget-legislative/2008-legislative-reports>

### **Marketing**

The Green Mountain Care advertising campaign began November 2007. During a three-month period, the state advertised for six weeks, and then conducted a survey. The survey showed that nearly half of Vermonters were aware of Green Mountain Care. By bringing existing programs under Green Mountain Care – namely Medicaid, Dr. Dynasaur, Catamount Health, and VHAP – they also became better known.

Additionally, more than two-thirds of Vermonters (69 percent) recall seeing the Green Mountain Care ad and the ad caused 1-in-5 Vermonters to take some kind of action step: call the 1-800 number, visit the Web site, or tell a friend about the program. Also, a majority (58 percent) reported they were interested in Green Mountain Care.

Most Vermonters reported that they strongly support the idea of Green Mountain Care. Knowing the state is offering such a program makes three-quarters of Vermonters (77 percent) feel more favorably toward the state.

Marketing efforts included rebranding existing materials used by the Department of Children and Families and the Department of Health under Green Mountain Care. An important aspect of outreach, also included forging a partnership with the Vermont Department of Labor to meet with over 800 laid-off employees about Green Mountain Care benefits. The OVHA and DOL also coordinated a mailing to over 22,000 employers in Vermont and teamed up with the Vermont Human Resource Association to reach over 100 employers in a program titled: “Where Government and Human Resources Intersect.” The OVHA also worked with state and private colleges to launch a spring campaign to reach close to 10,000 college seniors, faculty and parents about health care options upon graduation.

During the fall of 2008, OVHA utilized two Green Mountain Care ambassadors in the Burlington area to provide information at job fairs and fall festivals. They maintained a weekly presence at a downtown grocery store and canvassed Burlington and Winooski businesses, hotels and pharmacies.

In all of the above efforts, the OVHA partners with many community stakeholders to maximize limited resources and ensure that our outreach is coordinated.

## ***Application Tracking***

Act 71, passed in 2007, requires a proactive outreach system that uses web-based tools and an inquiry tracking system establishing a case file for potential applicants at the first point of contact. In 2008 OVHA IT staff built a web-based tracking tool that can be accessed by health care providers and community organizations throughout the state that regularly come into contact with uninsured Vermonters. When identifying data on an uninsured person are entered on the website, OVHA's Member Services Unit will follow up with a phone call and an offer to assist with the application process. Through a grant agreement with Bi-State Primary Care Association, OVHA is funding an outreach specialist position to provide applicants who need it with a higher level of assistance than has previously been available. The outreach specialist is also training providers and other stakeholders on the tracking tool and the application process for Green Mountain Care.

## ***Changes to Green Mountain Care in 2008***

OVHA, the Department for Children and Families (DCF), and BISHCA worked together to implement several changes to the premium assistance programs required by the SFY09 budget act and Act 201 (H.887). They are as follows:

- Beneficiary premiums for Catamount Health and ESI premium assistance programs were increased in July 2008 for the August coverage month; however, a new \$400 earned income disregard helped mitigate the impact of the premium increase for most families by effectively lowering the income level used to compute the amount of the premium.
- A new exception to the 12-month waiting period was added in VHAP and the premium assistance programs for individuals who lost private insurance coverage as a result of domestic violence.
- An exception to the 12-month waiting period was added for full-premium Catamount Health for individuals enrolled in a private insurance policy with a deductible of \$10,000 or more.
- OVHA will submit a waiver amendment request to CMS in February 2009 to implement the domestic violence exception to the waiting period and to seek federal financial participation for premium assistance beneficiaries with incomes between 200 and 300 percent FPL.

Office of Vermont Health Access  
SFY '09 Catamount Health Actual Revenue and Expense Tracking  
Thursday, January 15, 2009

|                                                            | SFY '09 Revised Appropriated |                   | Consensus Estimates for SFY to Date |                   | Actuals thru 12/31/08 |                   |
|------------------------------------------------------------|------------------------------|-------------------|-------------------------------------|-------------------|-----------------------|-------------------|
|                                                            | <=200%                       | >200%             | <=200%                              | >200%             | <=200%                | >200%             |
| <b>TOTAL PROGRAM EXPENDITURES</b>                          | <b>20,817,250</b>            | <b>8,911,418</b>  | <b>9,129,487</b>                    | <b>3,890,434</b>  | <b>9,041,402</b>      | <b>4,485,657</b>  |
| Catamount Health                                           | 20,817,250                   | 8,911,418         | 9,129,487                           | 3,890,434         | 9,041,402             | 4,485,657         |
| Catamount Eligible Employer-Sponsored Insurance            | 803,144                      | 406,981           | 341,278                             | 172,937           | 314,428               | 163,417           |
| Subtotal New Program Spending                              | 21,620,395                   | 9,318,399         | 9,470,765                           | 4,063,371         | 9,355,830             | 4,649,075         |
| Catamount and ESI Administrative Costs                     | 1,658,945                    | 1,297,834         | 829,473                             | 648,917           | 829,473               | 648,917           |
| <b>TOTAL GROSS PROGRAM SPENDING</b>                        | <b>23,279,340</b>            | <b>10,616,233</b> | <b>10,300,238</b>                   | <b>4,712,288</b>  | <b>10,185,303</b>     | <b>5,297,992</b>  |
| <b>TOTAL STATE PROGRAM SPENDING</b>                        | <b>9,463,052</b>             | <b>10,616,233</b> | <b>4,187,047</b>                    | <b>4,712,288</b>  | <b>4,140,326</b>      | <b>5,297,992</b>  |
| <b>TOTAL OTHER EXPENDITURES</b>                            | <b>203,250</b>               | <b>4,740,785</b>  | <b>101,625</b>                      | <b>2,370,393</b>  | <b>101,625</b>        | <b>2,370,393</b>  |
| Immunizations Program                                      | -                            | 2,500,000         | -                                   | 1,250,000         | -                     | 1,250,000         |
| VT Dept. of Labor Admin Costs Assoc. With Employer Assess. | -                            | 394,072           | -                                   | 197,036           | -                     | 197,036           |
| Marketing and Outreach                                     | 500,000                      | -                 | 250,000                             | -                 | 250,000               | -                 |
| Blueprint                                                  | -                            | 1,846,713         | -                                   | 923,357           | -                     | 923,357           |
| <b>TOTAL OTHER SPENDING</b>                                | <b>500,000</b>               | <b>4,740,785</b>  | <b>250,000</b>                      | <b>2,370,393</b>  | <b>250,000</b>        | <b>2,370,393</b>  |
| <b>TOTAL STATE OTHER SPENDING</b>                          | <b>203,250</b>               | <b>4,740,785</b>  | <b>101,625</b>                      | <b>2,370,393</b>  | <b>101,625</b>        | <b>2,370,393</b>  |
| <b>TOTAL ALL STATE SPENDING</b>                            | <b>9,666,302</b>             | <b>15,357,018</b> | <b>4,288,672</b>                    | <b>7,082,681</b>  | <b>4,241,951</b>      | <b>7,668,384</b>  |
| <b>TOTAL REVENUES</b>                                      | <b>19,870,877</b>            | <b>3,242,079</b>  | <b>6,308,880</b>                    | <b>1,410,027</b>  | <b>576,193</b>        | <b>1,121,272</b>  |
| Catamount Health Premiums                                  | 6,272,109                    | 2,972,223         | 1,447,203                           | 1,295,358         | 1,319,705             | 1,039,412         |
| Catamount Eligible Employer-Sponsored Insurance Premiums   | 246,580                      | 269,856           | 104,779                             | 114,669           | 97,743                | 81,860            |
| Subtotal Premiums                                          | 3,546,466                    | 3,242,079         | 1,551,981                           | 1,410,027         | 1,417,448             | 1,121,272         |
| Federal Share of Premiums                                  | (2,104,828)                  | -                 | (921,101)                           | -                 | (841,255)             | -                 |
| <b>TOTAL STATE PREMIUM SHARE</b>                           | <b>1,441,638</b>             | <b>3,242,079</b>  | <b>630,880</b>                      | <b>1,410,027</b>  | <b>576,193</b>        | <b>1,121,272</b>  |
| Cigarette Tax Increase (\$.60 / \$.80)                     | 9,207,000                    | -                 | -                                   | -                 | -                     | -                 |
| Floor Stock                                                | 500,000                      | -                 | -                                   | -                 | -                     | -                 |
| Employer Assessment                                        | 5,480,159                    | -                 | -                                   | -                 | -                     | -                 |
| Interest                                                   | -                            | -                 | -                                   | -                 | -                     | -                 |
| <b>TOTAL OTHER REVENUE</b>                                 | <b>15,187,159</b>            | <b>-</b>          | <b>4,603,500</b>                    | <b>250,000</b>    | <b>2,740,080</b>      | <b>3,169,000</b>  |
| <b>TOTAL STATE REVENUE</b>                                 | <b>1,441,638</b>             | <b>3,242,079</b>  | <b>630,880</b>                      | <b>1,410,027</b>  | <b>576,193</b>        | <b>1,121,272</b>  |
| State-Only Balance                                         | (5,152,443)                  | -                 | -                                   | -                 | -                     | -                 |
| Carryforward                                               | 9,820,186                    | -                 | -                                   | -                 | -                     | -                 |
| <b>(DEFICIT)/SURPLUS</b>                                   | <b>4,667,743</b>             | <b>-</b>          | <b>8,083,320</b>                    | <b>-</b>          | <b>8,083,320</b>      | <b>-</b>          |
| Reserve Account Funding                                    | -                            | -                 | -                                   | -                 | -                     | -                 |
| <b>REVISED (DEFICIT)/SURPLUS WITH RESERVE FUNDING</b>      | <b>4,667,743</b>             | <b>-</b>          | <b>8,083,320</b>                    | <b>-</b>          | <b>8,083,320</b>      | <b>-</b>          |
| <b>TOTAL STATE REVENUE</b>                                 | <b>10,334,339</b>            | <b>10,334,339</b> | <b>10,334,339</b>                   | <b>10,334,339</b> | <b>10,334,339</b>     | <b>10,334,339</b> |
| <b>% of SFY to-Date</b>                                    | <b>100.00%</b>               | <b>100.00%</b>    | <b>100.00%</b>                      | <b>100.00%</b>    | <b>100.00%</b>        | <b>100.00%</b>    |

NOTE: The total program expenditures include both claims and premium costs

## Chronic Care Initiative

**Mission:**

- Identify and assist Medicaid beneficiaries with chronic health conditions in accessing clinically appropriate health care information and services;
- Coordinate the efficient delivery of health care to this population by attempting to remove barriers, bridge gaps, and avoid duplication of services; and
- Educate, encourage and empower this population to eventually self-manage their chronic conditions.

The OVHA's Chronic Care Initiative (CCI) is a system redesign to improve the health outcomes of Medicaid beneficiaries through addressing the increasing prevalence of chronic illness for the Medicaid population. The CCI exemplifies the Chronic Care Model in action

and emphasizes evidence-based, planned, integrated and collaborative care for beneficiaries who exhibit high-prevalence chronic disease states, high-expense utilization, high medication utilization, and/or high emergency room and inpatient utilization.

Ultimately, the CCI aims to improve health outcomes by supporting better self-care and lowering health care expenditures through appropriate utilization of health care services. It is designed to take a holistic approach by evaluating both the physical and behavioral conditions, as well as the socioeconomic issues, that are often barriers to health improvement. The CCI partners with providers, hospitals, community agencies and other Agency of Human Services (AHS) departments to support a patient-focused model of care committed to healthcare systems improvement, efficient coordination of services, and enhanced patient self-management skills. The OVHA CCI supports and aligns with other State health care reform efforts, including the Blueprint for Health.

### **Method**

The CCI focuses on high risk Medicaid beneficiaries identified as having one or more specified chronic health condition who are eligible for Medicaid, and who are not eligible for Medicare. Those specifically targeted for enrollment in the CCI programs have at least one chronic condition including, but not limited to, the following: Arthritis, Asthma, Chronic Obstructive Pulmonary Disease (COPD), Chronic Renal Failure, Congestive Heart Failure (CHF), Depression, Diabetes, Hyperlipidemia, Hypertension, Ischemic Heart Disease, and Low Back Pain. The OVHA estimates there are approximately 26,000 beneficiaries with at least one of these diagnoses. Especially among beneficiaries at highest risk, these conditions and their management are often complicated by the co-occurring conditions of mental health and substance abuse, as well as challenges due to financial insecurity such as food security, availability of safe and affordable housing, and availability of transportation.

State staff at OVHA started providing services at the local level in some areas of the state in 2006. When the new partnership with contracted staff at APS Healthcare was initiated in July 2007, services expanded to provide some level of chronic care intervention to over 25,000 beneficiaries throughout the state with one or more of the eleven chronic conditions. Based upon the level of need as determined through

predictive modeling and clinical assessment, OVHA has implemented a tiered intervention protocol with services along a continuum from printed education and self-management information to telephonic health coaching and disease management services, to intensive face-to-face care coordination services. All beneficiaries determined to be at lower risk are provided with printed educational and self-management materials. APS provides predominantly telephonic health education and coaching services to individuals who are at moderate to high risk, and the OVHA Care Coordination field staff provides intensive case management to assist with the coordination of medical and social services for Vermont's most costly and medically complex Medicaid beneficiaries. The CCI is designed to enable seamless transition between service tiers as a beneficiary's needs change.

This unique and sophisticated model includes hospital-based nurses, community-based nurse case managers and medical social workers, as well as centrally located nursing and disease management staff, all with access to the same vertically and horizontally integrated chronic care management computer system, APS CareConnection®. In addition to being a case tracking system and repository for information on every beneficiary served, the APS CareConnection® system enables secure communications among staff regarding co-managed beneficiaries, and also is accessible by primary care providers as a means to be informed about a patient's plan of care (POC) and related activities.

### ***Implementation***

The OVHA began providing face-to-face intensive care coordination in 2006 to high risk, medically complex beneficiaries, and progressed to a statewide field presence in early 2008. The OVHA staff is now fully embedded in the local communities, has strong relationships with local providers and hospital partners, and is co-located within the AHS district offices. This holistic approach facilitates addressing socioeconomic health indicators along with identified health needs for this population, thereby helping ensure sustainable changes.

The OVHA considerably expanded operations to provide a full spectrum of care coordination and disease management services beginning in July 2007 when contracted services with APS Healthcare began. APS' activities during the first year included securing office space and related computer and telephonic installations in Williston, Vermont, hiring and training staff, establishing local relationships, and, in general, making connections with the broad array of individuals and organizations involved in Vermont's health care system. OVHA and APS outreach efforts for the CCI have included, among others, the Medicaid beneficiaries themselves, their individual physicians, AHS district offices, community agencies, and Vermont Blueprint for Health partners.

Implementation challenges included a delay until April 2008 in hiring a Vermont APS Executive Director, developing data file formats and transfer protocols, and staff learning to use APS CareConnection®. In addition, APS CareConnection® required

functionality enhancements for it to be of maximum usefulness to all staff and to be capable of reporting clinical outcome measures. Identifying needed functionality improvements and developing and implementing system enhancements occurred throughout the year. Finally, statewide coverage by care coordination teams did not occur until mid-way through 2008.

APS primarily provides disease management intervention services. The focus is to assist beneficiaries in understanding the health risks of their condition, engage them in changing their own behavior, and facilitate their effective communication with their primary care provider. The intention ultimately is to support the person in taking charge of their own health care. Three RN Health Coaches and three Disease Management Coordinators are stationed at APS' Williston office. In addition, five community RN Health Coaches are stationed throughout the state: three are in hospitals, one is in a community action agency, and one is in the southeastern part of the state but not currently hosted by a medical facility. The work of the APS RN Health Coaches and Disease Management Coordinators is supported by one Social Worker who assists with valuable linkages for beneficiaries with other community resources.

Both OVHA care coordinators and APS health coaches provide education and coaching to empower beneficiaries to become better self-managers of their chronic conditions. While APS primarily provides disease management services via telephone, the OVHA care coordination staff provides intensive face-to-face outreach and support to the highest risk beneficiaries, facilitating a medical home and effective communication among service providers, supporting the primary care provider in achieving the clinical plan of care, and working to eliminate failure by beneficiaries to keep scheduled medical appointments by addressing issues such as lack of transportation. The OVHA staff is comprised of on-site RN care coordinators and medical social workers located in eight AHS districts who provide a statewide presence. Co-location with AHS assures resource linkages for this highly vulnerable population. Staff assignment by region is shown in the map on page 54.

### ***Assessment and Intervention***

Beneficiaries with at least one of the eleven chronic conditions are identified using Adjusted Clinical Group predictive modeling provided by the Center for Health Policy and Research (CHPR), a part of the University of Massachusetts Medical School. Targeting predicted high opportunity (cost) beneficiaries enables allocation of resources where there is the greatest cost savings opportunity.

All beneficiaries identified by CHPR are sent an introductory mailing with a brief overview of the CCI. Through September 30, 2008, APS staff attempted to contact all beneficiaries identified by CHPR to explain the services available to them through the CCI and to administer an SF-8, a nationally standardized eight question survey that scores the general recent state of the beneficiary's health. Except for the highest risk individuals who always were and continue to be referred directly for care coordination services, those who scored above a predetermined score on the SF-8 were referred to

APS staff to be considered for telephonic health coach services. Beneficiaries who agreed to participate received more intensive evaluation using either an Adult General Assessment (AGA) or Pediatric General Assessment (PGA), depending on their age. Beneficiaries who scored below a predetermined score on the SF-8 received quarterly newsletters, disease specific materials, continuous access to web-based education and behavior change tools, and the ability to call and speak with a nurse, as needed.

Vermont's state budget rescission for State Fiscal Year 2009 included elimination of approximately 25% of the funds budgeted for the APS Healthcare contract. As a result, SF-8 administration was discontinued effective October 1, 2008. As a consequence of eliminating the SF-8 function, APS and OVHA clinical field staff now are re-tooling their approach for initial outreach. Concurrent with the APS funding reduction, the OVHA Care Coordination staffing model was adjusted by eliminating medical social worker positions in 2 districts, St. Albans and Bennington. Medical social worker coverage has since been redesigned to assure these consultation services remain available throughout the state.

Using general assessments, disease-specific assessments, and clinical judgment, OVHA Care Coordination teams or APS nurse health coaches determine the beneficiary's needs and develop a customized plan of care (POC) in collaboration with the beneficiary and the primary care provider. In addition to interventions offered by both APS and OVHA staff (such as health education, referrals, coaching and support based on disease specific best practice guidelines aimed at improving beneficiary self-management of their chronic conditions), OVHA care coordination interventions may also include any of the following services:

- Facilitating access to a medical home, development of a holistic POC, and coordination among existing medical service providers, including mental health and substance abuse resources, as indicated;
- Facilitating transportation requirements to medical care provider(s) appointments for proactive, evidence-based care delivery;
- Coaching, education and/or referrals based on health literacy requirements;
- Facilitating referral to community and social support services to assure stability in safe and affordable housing, employment, financial support for prescription medications and/or food security needs.

### ***Providers as a Key Component of Care Coordination Services***

The CCI also provides ongoing outreach, education and support to the primary care providers (PCPs) of participating beneficiaries. PCPs are notified whenever one of their patients decides to participate in care coordination or disease management services, as well as when their patients are selected but can't be reached or decline services. In addition, they are involved with developing their patient's care management Plan of Care (POC) and are provided periodic updates on patients' progress in completing goals established through the POC. Recognizing the value of CCI, several physicians' offices have offered to assist with contacting difficult to reach eligible beneficiaries and

to encourage them to participate in services offered through the CCI. Physicians have 24-hour access to APS CareConnection® to monitor implementation and progress of their patients' Plan of Care (POC). Written instructions for using the system are provided and an Outreach Coordinator from APS provides on-site information and training for providers and their office staff. Approximately ¾ of health system outreach during the past year involved these provider office site visits.

To further encourage PCP engagement with the highest risk beneficiaries, OVHA pays a PCP an enhanced capitated payment rate of \$15 per month for a care coordination participant. To emphasize the importance of developing a case management POC with the primary care provider, the OVHA also reimburses the provider \$55 for meeting with Care Coordination teams when one of their patients is enrolled in care coordination services. Providers are also reimbursed \$55 for a "discharge" meeting to emphasize the importance of a smooth transition to a less intense level of service. The combination of incentive payments for meetings and an enhanced case management fee provides primary care providers with an attractive financial incentive for collaborating with their patients' care coordination team.

CCI efforts are fully aligned with Blueprint goals and objectives to foster adherence to clinical best practices for chronic conditions in partnership with the primary care provider (PCP), through local collaboration with Blueprint leadership and participating PCPs to engage Medicaid beneficiaries and assure a medical home. The CCI addresses the unique characteristics of Medicaid beneficiaries and the challenges they face in participating fully within the Blueprint. Many beneficiaries need additional support to become the "...informed, activated patient" that the model describes. CCI provides this additional support through the essential components of disease management programs, such as patient education, outreach, team-based care, cross-consortium coordination, and care management. With the advent of the new Blueprint Community Care Team (CCT) pilots, OVHA staff participate in CCT meetings and work directly with CCT staff and providers to assure the highest risk Medicaid beneficiaries have a PCP, that efforts are not redundant, and gaps in service are filled for those not eligible for CCI but in need of case management support (e.g., dual insured, on various waivers, or receive other CMS covered case management services).

The OVHA also assures alignment with the Blueprint at the state level through leadership collaboration. For example, the OVHA Associate Medical Director serves on key Blueprint provider practice workgroups and on the Blueprint Evaluation Committee. In addition, the OVHA has requested access to the Blueprint DocSite system to support local CCI engagement with the PCP. CCI also is a partner in the Vermont "Triple Aim," a collaborative effort of the Blueprint and the Institute for Healthcare Improvement (IHI) that seeks to improve the health of the population, the individual's experience of care, and the per capita cost, all goals consistent with the OVHA's CCI.

## ***Agency, Stakeholder, and Healthcare System Collaboration***

The Agency of Human Services (AHS) reorganization recognized the need for coordination of services at the community level. Consistent with this philosophy, OVHA Care Coordination teams are located primarily at the local AHS district offices to provide care coordination services as an important part of the AHS support network. CCI staff works closely with the AHS district field service directors on common beneficiaries and is instrumental in identifying service gaps and barriers critical to successful and effective resolution. In addition, CCI field teams collaborate with VDH partners in the office of Local Public Health and other internal and external partners developing local community plans for improving chronic illness care.

Similarly, three APS nurse health coaches are located within hospitals and one is located within a community action agency. These arrangements facilitate CCI staff relationships with primary care providers, other health care professionals, and additional community resources.

CCI has engaged in outreach and collaboration with other internal and external agencies, stakeholders, providers and healthcare system entities statewide since its inception. These efforts have included, but are not limited to, other AHS departments and divisions and other agencies (e.g., Department for Children and Families, Department of Disabilities, Aging and Independent Living, Vermont Department of Health including Children with Special Healthcare Needs, Department of Mental Health, Department of Corrections, the Blueprint for Health, Department of Labor); regional mental health services and substance abuse treatment providers; homeless shelters; hospitals and provider practices; the University of Vermont School of Medicine, Area Health Education Centers; and other healthcare-related associations (e.g., Vermont State Nurses Association, Visiting Nurses Association, etc.). Outreach was conducted in all 14 counties and all 13 hospital service areas in the state.

OVHA CCI staff provided several presentations to participating Blueprint communities and conducted regular local outreach with PCPs, specialty providers and other community service partners engaged with care coordination efforts. In addition, APS staff provided the following outreach visits to healthcare system entities: 17 to hospitals, 60 to hospital affiliates, 57 to private physician family practices, 11 to internal medicine practices, 26 to pediatricians, 64 to Federally Qualified Health Centers (FQHCs) and Regional Health Centers (RHCs), 16 to Vermont health organizations (e.g., Vermont Assembly of Home Health Agencies, Vermont Association of Hospitals and Health Systems), and three to Vermont chapters of national health organizations (the American Diabetes Association, the American Heart Association, and the American Lung Association). In addition, seven meetings occurred with other AHS departments and CCI staff participated in nine conferences.

## **2008 Key Achievements**

- 1) Emergency room use declined by 7.2% and inpatient admissions declined by 8.3% during the first year of full CCI implementation.
- 2) 35,200 introductory letters were sent to beneficiaries describing the CCI and providing contact information. 41,000 follow-up letters also were sent. Member brochures with detailed information about the CCI and tips for beneficiaries on working effectively with their PCP were sent to 15,200 members. Quarterly newsletters with healthy living tips and disease specific information were sent to all beneficiaries during the first year. A total of 91,600 were sent. As a result of the state budget rescission, quarterly newsletters have been discontinued.
- 3) Over 24,000 SF-8 health assessments were completed with beneficiaries before this function was eliminated effective October 1, 2008, due to the state budget rescission.
- 4) Over 5,200 general and disease-specific assessments have been completed, and APS staff worked with beneficiaries to establish over 1,400 disease management Plans of Care. OVHA staff provided care coordination services to over 1,000 beneficiaries.
- 5) The OVHA's care coordination services expanded to include state-wide coverage in January 2008 with nurses and medical social workers co-located in eight (8) AHS district offices.
- 6) Ongoing training and skill development were provided to Care Coordination staff on topics including the model for improvement, clinical best practices for chronic conditions, motivational interviewing including specific strategies for engaging those with substance abuse problems, challenges for beneficiaries with co-occurring conditions of mental health and substance abuse, techniques for coaching on self-management, the readiness for change model, de-escalation techniques, and Bridges out of Poverty. Both OVHA and APS staff attended Medicaid Boot Camp. APS staff provided regular skills training, often through Webinars, on CareConnection® features and documentation procedures.
- 7) Operating policies and procedures have been developed for program standardization statewide and to assure seamless operation and consistency of OVHA and APS Healthcare staff.
- 8) The APS CareConnection® data management and tracking system has been upgraded to provide the functionality required for program implementation, management, monitoring and evaluation based on process and clinical outcomes.
- 9) Evidence-based Clinical Guidelines, Touch Levels, and Action Plans were developed and are in place for all 11 chronic conditions to guide CCI staff interventions. Clinical content for diabetes and asthma were coordinated with Blueprint staff to ensure consistent information is provided to the various medical audiences throughout the State. Beneficiary educational materials and Action Plans are developed and/or selected in tandem with APS Healthcare and VDH partners working on chronic disease initiatives to assure standardized approaches to consumer education.

- 10) A consumer experience of care survey was administered by WB&A Market Research in the fall of 2008 to evaluate beneficiaries' satisfaction with the program and their perception of its impact on their overall health. Overwhelmingly, consumers rated their satisfaction with the program as very high (90% said they would recommend the program to a friend or relative), and felt they were provided with the help they needed to manage their care (90% said their care coordinator or health coach gave them the help they needed to make changes to manage their current health). Most importantly, consumers who said they needed and received help agreed they have been able to maintain the changes they made while in the program (84% agreed they have been able to maintain the lifestyle changes they made for their health).
- 11) The OVHA became a member of the Institute for Healthcare Improvement (IHI) 'Triple Aim' team, lead by the Blueprint. IHI is an internationally recognized leader in healthcare quality improvement.
- 12) The OVHA published an article in the Vermont Nurse Connection (VNC) on the CCI. The VNC is the official newsletter for the Vermont State Nurses Association and is disseminated to all registered as well as licensed practical nurses in the state.

### **SFY '09 and SFY '10 Plans**

As previously noted, program changes were implemented in SFY '08 to respond to state fiscal challenges. Key changes and goals include the following:

- 1) Quarterly newsletters have been replaced with a general *Healthy Living Action Plan* will be included with the introductory letter regarding CCI that is sent to every beneficiary with a chronic condition.
- 2) CCI has refocused efforts predominantly on the very high and high risk beneficiaries, in particular those who will benefit from face-to-face intensive care coordination services and telephonic health coaching. Medium and low risk individuals will be contacted twice each year via Interactive Voice Recognition software. If they express interest in speaking directly with a CCI staff member, they will immediately be transferred to an RN Health Coach or Disease Management Coordinator.
- 3) CCI will provide health coaching and/or care coordination intervention services to 4,000 beneficiaries during SFY'09 and another 4,000 in SFY '10.
- 4) CCI will achieve a minimum savings of \$7,109,827.00 during SFY'09.
- 5) Medicaid beneficiaries taking Buprenorphine will be enrolled in the high risk level of the CCI.
- 6) CHPR will conduct Medical Record Reviews during SFY Q3 on beneficiary charts to collect data on HEDIS quality metrics that are not available through administrative (claims) information.
- 7) Clinical outcome measures will be tracked and reported through APS CareConnection®.

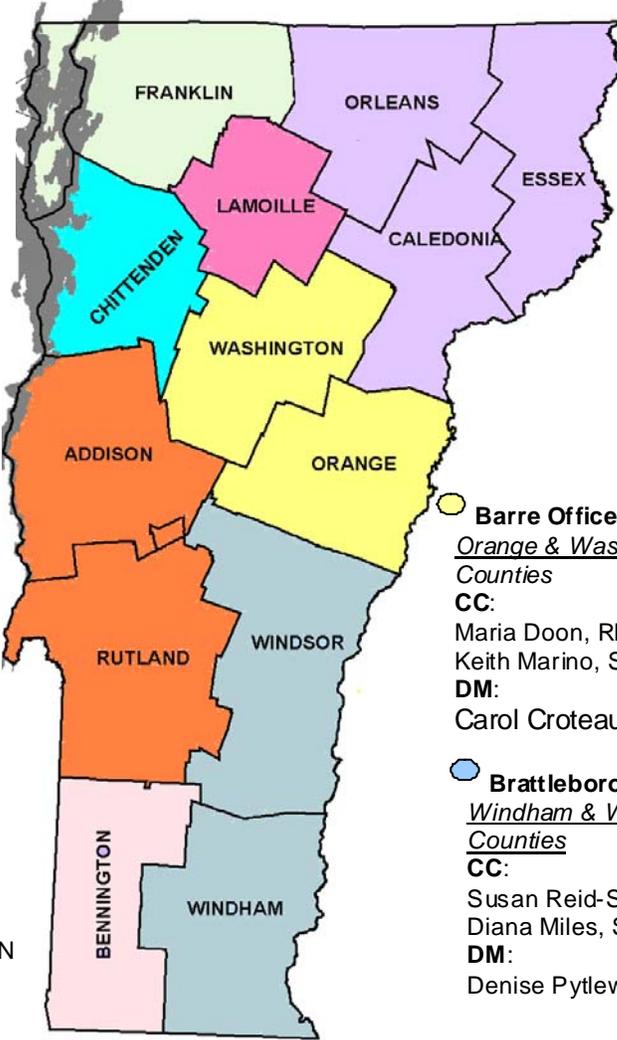
- 8) OVHA and APS CCI staff will participate in the same trainings to the extent possible, to achieve efficiencies and ensure consistent approaches, understanding, and protocols throughout the initiative.
- 9) Collaboration and coordination with the Blueprint for Health and other AHS partnerships will be increased.
- 10) Provider outreach and engagement will be strengthened. The CCI will identify and focus efforts on practices serving high numbers of high risk beneficiaries and, to the extent possible, will facilitate the medical home model for improving care and outcomes. Incentives for providers to collaborate with CCI include enhanced reimbursements, fewer missed appointments, coordination of services to help achieve the clinical POC, and improved patient outcomes.

## CHRONIC CARE INITIATIVE

### Chronic Care Teams

#### Care Coordination (CC) Disease Management (DM)

Teams consist of Registered Nurses (RN) and Social Workers (SW).



**St Albans Office**  
Franklin & Grand Isle Counties  
**CC:**  
 Angie White, RN  
 Mark Nash, SW  
**DM:**  
 Rosemaryl Harple, RN  
 Sonya Brown, SW

**St Johnsbury Office**  
Caledonia, Essex & Orleans Counties  
**CC:**  
 Heather Bollman, RN  
 Melody Neun, SW  
**DM:**  
 Nadine McCue, RN

**Burlington Office**  
Chittenden County  
**CC:**  
 Maura Crandall, RN  
 Katie Wells, RN  
 Ann Marie Miles, SW  
**DM:**  
 Karen Ploof, RN

**Morrisville Office**  
Lamoille County  
**CC:**  
 Angie White, RN  
 Mark Nash, SW  
**DM:**  
 Nadine McCue, RN

**Rutland Office**  
Addison & Rutland Counties  
**CC:**  
 Janice McCann, RN  
 Mark Gagnon, SW  
**DM:**  
 Sharon Lykins-Brown, RN  
 Carol Croteau, RN

**Barre Office**  
Orange & Washington Counties  
**CC:**  
 Maria Doon, RN  
 Keith Marino, SW  
**DM:**  
 Carol Croteau, RN

**Bennington Office**  
Bennington County  
**CC:**  
 Christine Bongartz, RN  
 Diana Miles, SW  
**DM:**  
 Sharon Lykins-Brown, RN

**Brattleboro Office**  
Windham & Windsor Counties  
**CC:**  
 Susan Reid-Smith, RN  
 Diana Miles, SW  
**DM:**  
 Denise Pytlewski, RN

- Georgette Coleman, Regional Supervisor for Northern Vermont (Barre Office)
- Janice McCann, Regional Supervisor for Southern Vermont (Rutland Office)
- Eileen Girling, Field Director (Williston Office)
- Eileen Lauer, Health Services Manager, APS Healthcare (Williston location)

## Buprenorphine Program

**Mission:**

Increase access to effective treatment for opiate dependency.

Many physicians limit the number of opiate dependent patients because of the challenging nature of caring for this population (i.e., missed appointments, diversion, time spent by office

staff). The end result is that most physicians see far fewer patients than they could. The Office of Vermont Health Access (OVHA), in cooperation with the Vermont Department of Health (VDH) Alcohol & Drug Abuse Program (ADAP), the Department of Corrections (DOC), and the commercial insurers, aims to increase access for patients to Buprenorphine services, increase the number of physicians in Vermont licensed to prescribe Buprenorphine and to support practices caring for the opiate dependent population.

### Methodology

In 2006, the OVHA was appropriated \$500,000 by the legislature to implement the Buprenorphine Program. Throughout SFY '08, the OVHA, in collaboration with ADAP, utilized these funds to maintain the capitated payment program which increased reimbursement to physicians in a step-wise manner depending on the number of patients treated by a physician who was enrolled in the program.

The Capitated Payment Methodology is depicted below:

| Level | Complexity Assessment  | Rated Capitation Payment |   |              |   |
|-------|------------------------|--------------------------|---|--------------|---|
| III.  | Induction              | \$348.97                 | + | <b>BONUS</b> | = |
| II.   | Stabilization/Transfer | \$236.32                 |   |              |   |
| I.    | Maintenance Only       | \$101.28                 |   |              |   |

**Final Capitated Rate (depends on the number of patients per level, per provider)**

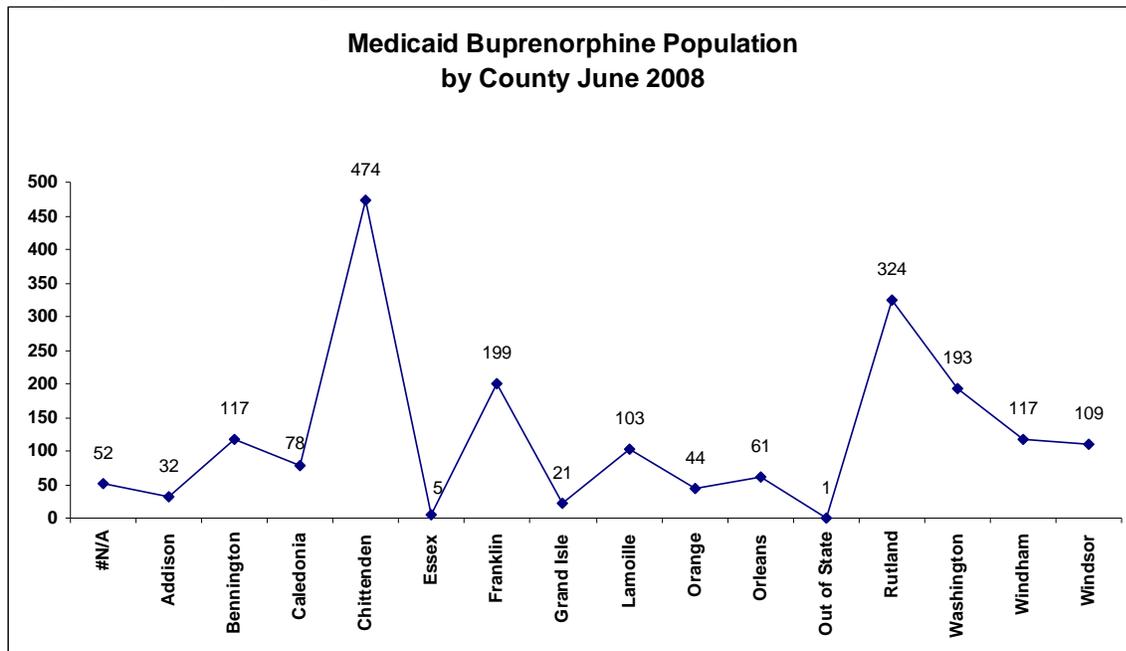
In SFY '08, the Buprenorphine Program paid a total of \$396,589.54 of the \$500,000 appropriation to 34 enrolled providers who treated approximately 420 patients. In SFY '09, the OVHA received an additional appropriation of \$500,000 for the Buprenorphine Program and as of the close of the 2<sup>nd</sup> quarter of SFY '09, the program has paid \$216,720.81 to 34 providers who treated approximately 386 patients.

In November 2007, the funding for VDH/ADAP was reduced which resulted in the cancellation of the Coordination of Office Based Medication Assisted Therapy (COB-MAT) program. Despite this setback, OVHA and ADAP continued to collaborate to ensure that providers who were enrolled in OVHA's capitated plan continued to receive support in the management of patients being treated with Buprenorphine for opioid dependence.

In 2009, OVHA will enroll all patients under the care of providers who are capitated program participants into case management services, which will be provided by OVHA's Care Coordination Program. The goal is to provide an optimum environment for Medicaid beneficiaries to receive treatment for opiate addiction while also providing support to the medical offices that care for this challenging population.

ADAP will provide OVHA Care Coordination staff with training focused on best practices for substance abuse treatment which include: motivational interviewing, ongoing reevaluation of the patient status and the treatment efficacy, minimization of risk of diversion etc. A data base will be established so that in addition to "routine" information gathering, the OVHA Care Coordinators will have a Buprenorphine treatment map to follow with the patient and all providers involved. This information will not only serve as a real time clinical/treatment guide, but will also demonstrate the efficacy of the programs.

Also, the additional funding that was ultimately allocated to ADAP will be distributed as follows: funding for one FTE for counseling services at the Evergreen Center in Rutland, VT and one FTE at the Howard Center in Burlington, VT. The counseling staff assigned to this project will be dedicated to the treatment of Buprenorphine patients receiving medication in those two areas. They will interface directly with the OVHA Care Coordinators and with the Medical Director of ADAP. Additionally, a half time FTE social work/care coordinator will be funded for the Comprehensive Obstetric Services Clinic (high risk pregnancy management) and a lump sum will be allocated to Dr. Tom Simpatico's research team at the University of Vermont whose charge is to demonstrate program efficacy through the use of the data collected by the OVHA Care Coordinators.



## Dental Dozen

In early 2007, the State of Vermont and the Office of Vermont Health Access (OVHA) announced a comprehensive program for State Fiscal Year (SFY) 08 and beyond -- the Dental Dozen --12 targeted initiatives to improve oral health for all Vermonters. Together, they provide for a statewide commitment and promote a cultural transformation by reinforcing the importance of oral health, and represent a comprehensive, balanced approach that impacts beneficiaries, and current and future providers. The Dental Dozen recognizes oral health as a fundamental component of overall health and moves toward creating parity between oral health and other health care services.

All initiatives are underway; the OVHA will focus on sustaining momentum on each initiative, gather data/measure results where appropriate, and take further steps to improve oral health access wherever possible.

Initiative #1: Ensure Oral Health Exams for School-age Children - The Vermont Department of Health (VDH), the Office of Vermont Health Access (OVHA) and the Department of Education (DOE) collaborated to reinforce the importance of oral health exams and encourage preventive care. Brochures were provided to schools for distribution in October, 2008 to educate parents and children on the importance of fluoride, sealants and regular checkups.

Initiative #2: Dental Reimbursement Rates - The OVHA committed to increase Medicaid reimbursement rates to stabilize the current provider network, encourage new dentists to enroll as Medicaid providers and encourage enrolled dentists to see more Medicaid beneficiaries. Rates were increased by \$637,862 in SFY 2008 and by \$1,412,441 for SFY 2009. Reimbursement rates for SFY 2010 are level funded; however, the proposed 4% provider reimbursement decrease does not apply to dental.

Initiative #3: Reimburse Primary Care Physicians for Oral Health Risk Assessments - The OVHA reimburses Primary Care Providers (PCPs) for performing Oral Health Risk Assessments (OHRAs) to promote preventive care and increase access for children from ages 0-3. An action plan has been developed to educate/train physicians on performing OHRA's, including online web links.

Initiative #4: Place Dental Hygienists in Each of the 12 District Health Offices – A successful pilot project resulted in the start of placement of part-time dental hygienists in District Health Offices. Current funding now covers one half-time dental hygienist in the Newport District Office.

Initiative #5: Selection/Assignment of a Dental Home for Children - The OVHA introduced the capability to select/assign a primary dentist for a child, allowing for the same continuity of care as assigning a Primary Care Physician (PCP) for health improvement; most new beneficiaries select a dental home, emphasizing the

importance of keeping oral health care on par with regular physicals and health checkups.

Initiative #6: Enhance Outreach - The OVHA and VDH conducted outreach and awareness activities to support understanding of the Dental Dozen and help ensure the success of the initiatives. In SFY 2010, work will continue to promote benefits available to dental providers, highlight incentives designed to bring and keep more dentists in Vermont and continue outreach with schools, parents and children. A retired Vermont dentist, with grant assistance, is helping recruit and retain more dentists.

Initiative #7: Codes for Missed Appointments/Late Cancellations – The OVHA introduced a code to report missed appointments and late cancellations. The OVHA continues to evaluate this data and explore processes to reduce missed appointments and late cancellations in the future.

Initiative #8: Automation of the Medicaid Cap Information for Adult Benefits - The OVHA introduced a system upgrade to allow enrolled dentists to access Medicaid cap information for adult benefits automatically.

Initiative #9: Loan Repayment Program – Vermont awards loan repayment incentives to dentists in return for a commitment to practice in Vermont and serve low income populations (included in VDH budget).

Initiative #10: Scholarships - Scholarships, administered through the Vermont Student Assistance Corporation (VSAC), are awarded to encourage new dentists to practice in Vermont. The combined allocation of \$40,000 for SFY 2008/09 will be distributed for the 2008-2009 academic year. Scholarships are included in the VDH budget.

Initiative #11: Access Grants – Grants are awarded as an incentive for dentists to expand access to Medicaid beneficiaries (included in the VDH budget).

Initiative #12: Supplemental Payment Program – The OVHA allocates \$290,000 to recognize and reward dentists serving high volumes of Medicaid beneficiaries.

## **Non-Emergency Medical Transportation (NEMT)**

For many years, the OVHA has contracted with the Vermont Public Transportation Authority (VPTA) to provide transportation services for Medicaid beneficiaries. Under the VPTA arrangement, VPTA was considered the “contractor” and the brokers were considered the “subcontractors.” VPTA discontinued its Medicaid operation as of December 31, 2008. As such, in January 1, 2009, the Office of Vermont Health Access (OVHA) entered into multiple sole source contracts with Vermont public transit brokers to provide non-emergency medical transportation (NEMT) services for beneficiaries enrolled in traditional and Primary Care Plus (PCPlus) Medicaid and the Dr. Dinosaur programs. The brokers may also secure transportation, upon request/authorization, for

the Reach-Up Program, Disability Determination Services and for the Ladies First Program. In order to ensure statewide access to NEMT, the OVHA has contracts with the following brokers:

- Addison County Transit Resources (ACTR)
- Connecticut River Transit, Inc. (CRT)
- Green Mountain Community Network (GMCN)
- Green Mountain Transit Agency (GMTA)
- Marble Valley Regional Transit District (MVRTD)
- Rural Community Transit (RCT)
- Special Services Transportation Agency (SSTA)
- Stagecoach Transportation Services, Inc. (STS)

These contracts allowed for a seamless transition from the VPTA model to the direct broker model and were transparent to beneficiaries. The OVHA also contracts with the Chittenden County Transportation Authority (CCTA) to operate the Medicaid Bus Pass Program.

### Coordination of Benefits (COB)

The continuing fiscal challenges of government healthcare programs require that OVHA as a public insurer work very hard to coordinate benefits to ensure that other parties pay their portion of healthcare costs, which minimizes the financial burden on taxpayers. State healthcare programs are required to pay for a service only if private insurers and Medicare are not. There are two approaches used to coordinate benefits with other payers:

- Retroactive: Pay and Chase

After a claim is paid, attempts are made to collect from the liable third party because the liable party was not known at the time of adjudication.

- Proactive: Cost Avoidance

During adjudication of the claim, the provider is required to prove payment or denial from the liable third party. During this process the liable third party is known at the time of adjudication.

The Retroactive Pay and Chase process produces real dollar collections while the cost-avoided dollars represent claims payments not expended because another payer paid as primary.

|                                                     | SFY '06<br>Actual | SFY '07<br>Actual | SFY '08<br>Approp. | SFY '08 BAA    | SFY '09 Gov.<br>Rec.* | '07 Act-'08 BAA<br>% Chg. | 08 BAA-'09 Gov.<br>Req. Chg. |
|-----------------------------------------------------|-------------------|-------------------|--------------------|----------------|-----------------------|---------------------------|------------------------------|
| Third Party Liability and Program                   |                   |                   |                    |                |                       |                           |                              |
| Integrity Collections                               | \$ (6,620,029)    | \$ (5,449,974)    | \$ (4,311,258)     | \$ (7,311,258) | \$ (10,576,326)       | 34.2%                     | 44.7%                        |
| *includes \$2,460,025 in Program Integrity Activity |                   |                   |                    |                |                       |                           |                              |

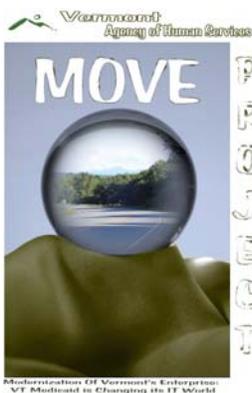
The Proactive Cost Avoidance efforts of the OVHA Coordination of Benefits Unit to identify and maintain third party payer requirements yielded an estimated \$187 million dollars annually in cost avoidance for individuals with other insurance (Medicare and private insurance) in SFY '08, as measured by EDS and reported to CMS.

The Deficit Reduction Act (DRA) passed in 2005 further enhances the ability for state Medicaid agencies to adjudicate claims as payer of last resort; increasing the ability to cost avoid dollars. This provision provided the authority to collect additional eligibility and coverage information from private health insurers in order to better identify primary payers who are responsible for payment prior to Medicaid. A provision of the DRA also mandated that states pass legislation which will require private health insurers to cooperate in this effort by providing Medicaid agencies with information. In 2007 language was added to 33 VSA 1908 (d) stating the following: At the agency's request, an insurer shall provide the agency with the information necessary to determine whether an applicant or recipient of Medicaid under this subchapter is or was covered by the insurer and the nature of the coverage, including the member, subscriber, or policyholder information necessary to determine third party liability and other information required under section 9410(h) of Title 18. The agency may require the insurer to provide the information electronically. The COB Unit is currently working with the three largest insurers in order to operationalize this mandate.

## Information Technology

A major challenge and opportunity for the OVHA is to create a comprehensive vision for Medicaid health information technology (IT) and health information exchange. Each project and technology system must be part of a cohesive system of care. The OVHA must be forward thinking, but must also proceed prudently, making good investment decisions and ensuring that beneficiaries' health information is secure and accessed appropriately.

### ***MOVE Project (Modernization of Vermont's Enterprise)***



The MOVE Project, the Modernization of Vermont's (Medicaid) Enterprise, is on a track to update and upgrade system support for the Medicaid program. Vermont has been working towards implementing a health care eligibility and enrollment system, called the Vermont Integrated Eligibility Workflow System (VIEWS) and the implementation of a new claims processing/payment system (Medicaid Management Information System – MMIS), to be completed within the next several years.

The MOVE Project has two main phases:

- *Phase One* is the planning; procurement; design, development and implementation (DDI) of a healthcare eligibility and enrollment system called Vermont's Integrated Eligibility Workflow System (VIEWS). This system will

replace the healthcare eligibility currently performed in the ACCESS system that is operated and maintained by the Department of Children and Families (DCF).

- *Phase Two* is the planning; procurement; DDI; and certification of a new Medicaid Management Information System (MMIS). This system will replace the current MMIS that is operated and maintained by Electronic Data Systems (EDS).

ACCESS is the current eligibility determination and enrollment system for administering financial and healthcare assistance programs for the State of Vermont. ACCESS is used throughout the Agency of Human Services and is maintained by state employees in the Department for Children and Families (DCF) and operated on the state mainframe in the Department for Information and Innovation (DII) data center. It has been operational since 1983. The MMIS is the system responsible for processing and managing the claims payments for Federal and State healthcare programs administered by the State of Vermont. The MMIS for Vermont, operated through a fiscal agent contract with EDS, was last certified by CMS in 1993.

Transmission of case information from our current ACCESS eligibility determination system 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. In addition, the Centers for Medicare and Medicaid Services (CMS) requires that states replace their MMIS every 5 to 7 years to ensure accurate claims processing; Vermont is significantly beyond this required timeframe.

Contemporary eligibility and claims processing systems that leverage the benefits that newer technologies afford, such as greater flexibility and responsiveness, will better serve the needs of Vermont's public health care programs. Due to the complexity of Vermont's health care program rules, automated systems utilizing new technology are essential to program administration. These two new systems will be modern, flexible, responsive and interoperable so that key program implementation drivers are the health care vision, optimal customer service, and program needs, and not the constraints of the supporting technology. This objective is the foundation for the MOVE Project, which is charged with turning the goals into reality.

### ***MOVE Work To-Date and Planned for SFY 2010***

The OVHA and its AHS partners put forth significant effort during SFY 2008 and 2009 to develop requirements for the new health care eligibility system, VIEWS. The VIEWS requirements were created through a collaborative AHS-wide effort, and were designed to provide easier access and online services to beneficiaries, to support improved operations and administration, and to allow faster program implementations. A draft Implementation Advance Planning Document (IAPD) and a draft Request for Proposals for a vendor to implement VIEWS have been submitted to CMS for their review and approval; this will enable the State to receive approximately 50% federal match on this project. The cost of implementing VIEWS is estimated at \$26.4 million (gross) for the system implementation vendor and \$1.98 million (gross) for IV&V services over as three

year period. The request in the SFY '10 Capital Bill will support the implementation of this project for 2010. (Please note that the funds in the table below are estimates for contractual costs only and are based on average estimated costs for vendor services by other states; actual vendor and other operational costs will not be known until contracts are negotiated and signed.) The Agency of Human Services will pursue sources to support the remaining costs for SFY '11 and SFY '12. Even if these additional funds do not come to fruition, the following tasks that will be accomplished in SFY '10 will still be able to be utilized, thereby not wasting the SFY '10 investment:

- 1) Validation of Requirements – modifying and finalizing all drafted functional and technical requirements
- 2) Architectural definition – defining the configuration of the State's IT structure along with a detailed plan for new system integration
- 3) General and detailed system design – finalizing the specific details of the new system
- 4) Depending on bids and vendor selection, we may also purchase certain system components based on Service Oriented Architecture (SOA)
- 5) Some initial costs may be associated with certain licenses that can be carried forward for future uses

To position the State for the MMIS procurement, CMS requires each state to complete a Medicaid Information Technology Architecture (MITA) State Self-Assessment (SSA) for submission with a funding request. The MITA SSA establishes a vision and framework for future Medicaid Management Information Systems (MMIS) development. OVHA has completed the MITA SSA and it has been approved by CMS. As such, CMS has approved funding at 90% FFP to procure a Technical Assistance (TA) vendor to work with the State to develop requirements for the new MMIS and fiscal agent services, complete the CMS required Implementation Advance Planning Document (IAPD) and complete the Request for Proposals (RFP).

The OVHA intends to sign a contract with the system implementation vendor during the last quarter of calendar 2010. Representatives from all AHS departments will participate in planning and implementing the new MMIS. The OVHA also will procure consulting services to perform Independent Verification and Validation (IV&V) functions to ensure that the system procured meets the requirements of the RFP and contract in every detail. The MMIS project will take four calendar years to complete (1/1/2010 – 12/31/2013) for an estimated cost of \$88 million, of which 90% will be supported through federal funds.

### **MOVE Procurement Timeline**

| Task                                    | Anticipated Completion | SFY Budget |
|-----------------------------------------|------------------------|------------|
| 1. MMIS Technical Assistance RFP        | June 2009              | 2010       |
| 2. VIEWS RFP                            | June 2009              | 2010-2012  |
| 3. MMIS Requirements                    | January 2010           | 2010       |
| 4. MMIS Federal Funding Request and RFP | June 2010              | 2010       |
| 5. MMIS Procurement                     | December 2010          | 2011       |
| 6. MMIS Implementation                  | December 2012          | 2011-2013  |

### **MOVE Required Contracts and Estimated Costs by SFY in millions \***

| Contract Charge                          | SFY        |           |           |           |             |                |
|------------------------------------------|------------|-----------|-----------|-----------|-------------|----------------|
|                                          | 2010       | 2011      | 2012      | 2013      | Split Total | Contract Total |
| <b>VIEWS</b> Contract                    | \$ 1.34 F  | \$ 6.43 F | \$ 5.18 F |           | \$ 13.0 F   | \$ 26.37       |
|                                          | \$ 1.38 S  | \$ 6.65 S | \$ 5.35 S |           | \$ 13.37 S  |                |
| <b>VIEWS</b> IV&V                        | \$ .2 F    | \$ .49 F  | \$ .48 F  |           | \$ 1.2 F    | \$ 2.0         |
|                                          | \$ .14 S   | \$ .33 S  | \$ .33 S  |           | \$ .8 S     |                |
| <b>VIEWS</b> Total Federal               | \$ 1.54    | \$ 6.92   | \$ 5.66   |           | \$ 14.2     |                |
| <b>VIEWS</b> Total State                 | \$ 1.52    | \$ 6.98   | \$ 5.68   |           | \$ 14.17    |                |
| <b>VIEWS</b> Grand Total                 | \$ 3.06    | \$ 13.9   | \$ 11.34  |           | \$ 28.37    |                |
| <b>MMIS</b>                              |            |           |           |           |             |                |
| <b>MMIS</b> Technical Assistance Support | \$ 1.755 F | \$ .945 F |           |           | \$ 2.7 F    | \$ 3.0         |
|                                          | \$ .195 S  | \$ .105 S |           |           | \$ .3 S     |                |
| <b>MMIS</b> Vendor                       |            | \$ 9.0 F  | \$ 31.5 F | \$ 31.5 F | \$ 72.0 F   | \$ 80.0        |
|                                          |            | \$ 1.0 S  | \$ 3.5 S  | \$ 3.5 S  | \$ 8.0 S    |                |
| <b>MMIS</b> IV&V                         |            | \$ .9 F   | \$ 1.8 F  | \$ 1.8 F  | \$ 4.5 F    | \$ 5.0         |
|                                          |            | \$ .1 S   | \$ .2 S   | \$ .2 S   | \$ .5 S     |                |
| <b>MMIS</b> Total Federal                | \$ 1.755   | \$ 10.845 | \$ 33.3   | \$ 33.3   | \$ 79.2     |                |
| <b>MMIS</b> Total State                  | \$ .195    | \$ 1.205  | \$ 3.7    | \$ 3.7    | \$ 8.8      |                |
| <b>MMIS</b> Grand Total                  | \$ 1.95    | \$ 12.05  | \$ 37.0   | \$ 37.0   | \$ 88.0     |                |
| <b>Total</b>                             |            |           |           |           |             |                |
| Total Federal                            | \$ 3.3     | \$ 17.77  | \$ 38.96  | \$ 33.33  | \$ 93.4     | \$ 116.37      |
| Total State                              | \$ 1.72    | \$ 8.19   | \$ 9.38   | \$ 3.7    | \$ 22.97    |                |
| Total                                    | \$ 5.02    | \$ 25.96  | \$ 48.34  | \$ 37.0   | \$ 116.37   |                |

\* The funds in the table above are estimates for contractual costs only and are based on average estimated costs for vendor services by other states; actual vendor and other operational costs will not be known until contracts are negotiated and signed.

## SECTION 7: OVERVIEW OF OVHA

### Global Commitment/Managed Care Organization (MCO)

Global Commitment for Health is a Medicaid 1115 demonstration waiver that allows the Office of Vermont Health Access (OVHA) to become a public managed care organization (MCO) with an active role in improving the quality of health services for beneficiaries served by Medicaid. OVHA as public MCO is under contract with the state's Medicaid agency – the Agency of Human Services (AHS) – to provide all Medicaid services. OVHA subcontracts with the other departments in state government – e.g., DAIL, VDH, DCF, and DOE – to provide or pay for services for the populations served by the various specialty programs under Medicaid. These contracts are based on the Medicaid programs existing prior to the waiver, and the legislature appropriates each portion of the premium to be paid to OVHA and to the other Departments. As such, Global Commitment has not substantially changed authority for policy decisions on the part of OVHA and the subcontracting Departments. However, the waiver does afford greater opportunity and incentive for different service systems to collaborate more closely on service integration. In addition, the Legislature has retained approval authority over many elements of Global Commitment, especially eligibility and benefits.

Adopting a public MCO approach also affords Vermont more flexibility in how it uses Medicaid resources. The state has fewer restrictions on the use of federal match dollars because the match applies not to individual fee-for-service payments (paid claims) as before, but to a single MCO premium that AHS determines at the start of the fiscal year and pays monthly to OVHA. The premium includes *all* Medicaid spending except the Choices for Care waiver, some administrative costs, disproportionate share spending, and SCHIP. The primary federal condition is that AHS establish the premium amount within an actuarially set premium range determined and certified each year by an independent actuary based on historical spending and current trends. This all-inclusive premium is matched with the federal share, which is about 60% of Vermont's Medicaid spending.

Because of Global Commitment, the format of the Medicaid budget has been adjusted to be better aligned with the waiver. Previously, the Medicaid budget tracked spending only from OVHA. Under the new approach, the budget includes all spending under Global Commitment. This, in turn, required a change in financial reporting and budgeting that has resulted in a more integrated statewide perspective on Medicaid spending and revenues. The impact is a greater understanding of the multiple components that comprise the Medicaid budget and each component's fiscal impact.

A key benefit of Global Commitment is the flexibility to use federal Medicaid matching funds on non-Medicaid health programs under specified conditions. Consistent with federal Medicaid MCO rules, and similar to private MCO practices, the waiver provides flexibility to use federal Medicaid funds to support health improvement programs serving Medicaid beneficiaries and uninsured individuals. Under the waiver, any MCO premium

dollars that remain after payments for Medicaid services can be used for the following health-related purposes:

- Increase access to quality health care for the Medicaid beneficiaries and uninsured individuals (e.g., school nurses, immunization programs)
- Fund preventive and public health programs that improve outcomes and quality of life for Medicaid beneficiaries (e.g., smoking cessation, alcohol and drug abuse prevention)
- Reduce the rate of uninsured (e.g., Catamount Health)
- Support public-private partnerships in health care (e.g., Blueprint for Health).

Because each MCO premium dollar has a 60% federal match, budget “savings” result when these funds are available to support health improvement programs that previously were state-only funded. The summary MCO Investment list for State Fiscal Years (SFY) 2008 (Actuals) and SFY 2009 (Budget Adjustment) is on page 67.

### ***Grievance and Appeals***

As a Managed Care Organization (MCO) under the federally approved Global Commitment to Health Waiver, the MCO must have an internal appeal process for resolving service disagreements between beneficiaries and the Office of Vermont Health Access (OVHA), other Agency of Human Services (AHS) departments in the MCO, or contractors as required by federal rules. The OVHA and the AHS promulgated rules, effective July 1, 2007, that outline the new internal OVHA appeal process. These rules apply to all Medicaid-funded services except Choices for Care. The latest legislative report on this process was due in January 2009 and is included in Appendix 9.

Since this process began through September 30, 2008, 67% of the MCO appeals have been upheld, 18% reversed, and 12% approved. (Three percent were requested by an unauthorized representative.) This data demonstrates that appeals are being heard in an objective manner, as the rules mandate. In addition, new information is sometimes introduced as part of the appeals process, leading to a modified outcome on a much faster track (59 days at the most but generally within 45 days) than a fair hearing, which can take many months. In OVHA, we have seen a resulting steady increase in the number of appeals and a corresponding decrease in fair hearings requested.

### ***Next Steps:***

The Agency of Human Services (AHS) and the Office of Vermont Health Access (OVHA) continue to work with the Centers for Medicare and Medicaid Services (CMS) to address outstanding issues related to the Global Commitment to Health Demonstration Waiver. Current and pending policy issues include:

- 1) Enrollment of Catamount-eligible individuals with incomes between 200 and 300 percent of the Federal Poverty Level (FPL) into the Waiver.

- 2) Continued review and discussion of items included as “MCO Investments” and development of empirical data and analysis to support inclusion of items on the MCO Investment list.

The initial, five-year term for the Global Commitment to Health Demonstration Waiver will end on September 30, 2010. Pursuant to the Global Commitment Special Terms and Conditions, the AHS Secretary must submit a written request to extend the Waiver at least one year prior to the end of the approval period, meaning the extension request must be submitted no later than September 30, 2009. While federal law provides for a “streamlined” extension process, this process does limit the State’s ability to modify the existing program design and requires the State to accept federally-determined inflation rates for the three-year extension period. Over the spring and summer of 2009, the State will need to identify funding requirements for the three-year extension period and assess whether proposed federal trend rates allow for sufficient federal spending authority. The State also will need to evaluate whether any modifications to the program’s design are necessary to enhance the effectiveness of the program or meet Legislative objectives.

**MCO Investment Expenditures**

| Department | Investment Description                                             | SFY08 Actuals | SFY09 BAA     |
|------------|--------------------------------------------------------------------|---------------|---------------|
| DOE        | School Health Services                                             | \$ 8,956,247  | \$ 8,956,247  |
| AOA        | Blueprint Director                                                 | \$ 70,000     | \$ 68,879     |
| BISHCA     | Health Care Administration                                         | \$ 1,340,728  | \$ 1,897,427  |
| DII        | Vermont Information Technology Leaders                             | \$ 105,000    | \$ 339,500    |
| VVH        | Vermont Veterans Home                                              | \$ 913,047    | \$ 881,043    |
| VSC        | Health Professional Training                                       | \$ 405,407    | \$ 405,407    |
| UVM        | Vermont Physician Training                                         | \$ 4,006,152  | \$ 4,006,156  |
| AHSCO      | 2-1-1 Grant                                                        | \$ -          | \$ 415,000    |
| VDH        | Emergency Medical Services                                         | \$ 626,728    | \$ 708,147    |
| VDH        | AIDS Services/HIV Case Management                                  | \$ -          | \$ -          |
| VDH        | TB Medical Services                                                | \$ 15,872     | \$ 15,872     |
| VDH        | Epidemiology                                                       | \$ 416,932    | \$ 498,351    |
| VDH        | Health Research and Statistics                                     | \$ 404,431    | \$ 485,850    |
| VDH        | Health Laboratory                                                  | \$ 2,012,252  | \$ 2,093,671  |
| VDH        | Tobacco Cessation                                                  | \$ 1,144,713  | \$ 1,226,132  |
| VDH        | Family Planning                                                    | \$ 169,392    | \$ 250,811    |
| VDH        | Physician/Dentist Loan Repayment Program                           | \$ 930,000    | \$ 930,000    |
| VDH        | Renal Disease                                                      | \$ 16,115     | \$ 97,534     |
| VDH        | Newborn Screening                                                  | \$ 136,577    | \$ 217,996    |
| VDH        | WIC Coverage                                                       | \$ 562,446    | \$ 643,865    |
| VDH        | Vermont Blueprint for Health                                       | \$ 753,087    | \$ 915,925    |
| VDH        | Area Health Education Centers (AHEC)                               | \$ 310,000    | \$ 310,000    |
| VDH        | FOHC Lookalike                                                     | \$ 30,000     | \$ 111,419    |
| VDH        | Patient Safety - Adverse Events                                    | \$ 190,143    | \$ 271,562    |
| VDH        | Coalition of Health Activity Movement Prevention Program (CHAMPPS) | \$ 291,298    | \$ 372,717    |
| VDH        | Substance Abuse Treatment                                          | \$ 2,744,787  | \$ 2,988,768  |
| VDH        | Recovery Centers                                                   | \$ 329,215    | \$ 410,634    |
| DMH        | Special Payments for Medical Services                              | \$ 113,314    | \$ 158,926    |
| DMH        | MH Outpatient Services for Adults                                  | \$ 1,293,044  | \$ 1,338,656  |
| DMH        | Mental Health Elder Care                                           | \$ 38,970     | \$ 84,582     |
| DMH        | Mental Health Consumer Support Programs                            | \$ 673,160    | \$ 718,772    |
| DMH        | Mental Health CRT Community Support Services                       | \$ 807,539    | \$ 853,151    |
| DMH        | Mental Health Children's Community Services                        | \$ 3,341,602  | \$ 3,387,214  |
| DMH        | Emergency Mental Health for Children and Adults                    | \$ 2,016,348  | \$ 2,061,960  |
| DMH        | Respite Services for Youth with SED and their Families             | \$ 502,237    | \$ 547,849    |
| DMH        | CRT Staff Secure Transportation                                    | \$ 52,242     | \$ 97,854     |
| DMH        | Recovery Housing                                                   | \$ 235,267    | \$ 280,879    |
| DMH        | Transportation - Children in Involuntary Care                      | \$ -          | \$ -          |
| DMH-VSH    | VSH Records                                                        | \$ -          | \$ 450,000    |
| OVHA       | Buy-In                                                             | \$ 419,951    | \$ 480,052    |
| OVHA       | Vscript Expanded                                                   | \$ -          | \$ -          |
| OVHA       | HIV Drug Coverage                                                  | \$ 44,524     | \$ 104,625    |
| OVHA       | Civil Union                                                        | \$ 671,941    | \$ 732,042    |
| OVHA       | Hospital Safety Net Services                                       | \$ 281,973    | \$ -          |
| DCF        | Family Infant Toddler Program                                      | \$ 326,424    | \$ 952,541    |
| DCF        | Medical Services                                                   | \$ 120,494    | \$ 1,050,917  |
| DCF        | Residential Care for Youth/Substitute Care                         | \$ 10,110,441 | \$ 10,110,441 |
| DCF        | AABD Admin                                                         | \$ -          | \$ -          |
| DCF        | AABD                                                               | \$ -          | \$ -          |
| DCF        | Aid to the Aged, Blind and Disabled CCL Level III                  | \$ 2,615,023  | \$ 2,615,023  |
| DCF        | Aid to the Aged, Blind and Disabled Res Care Level III             | \$ 170,117    | \$ 170,117    |
| DCF        | Aid to the Aged, Blind and Disabled Res Care Level IV              | \$ 349,887    | \$ 349,887    |
| DCF        | Essential Person Program                                           | \$ 614,974    | \$ 614,974    |
| DCF        | GA Medical Expenses                                                | \$ 298,207    | \$ 340,000    |
| DCF        | CUPS                                                               | \$ 52,825     | \$ 678,942    |
| DCF        | VCRHYP                                                             | \$ 1,764,400  | \$ -          |
| DCF        | HBKF                                                               | \$ 318,321    | \$ 944,438    |
| DCF        | CDD Therapeutic Child Care                                         | \$ -          | \$ 940,000    |
| DCF        | Lund Home                                                          | \$ -          | \$ 390,000    |
| DDAIL      | Elder Coping with MMA                                              | \$ -          | \$ -          |
| DDAIL      | Mobility Training/Other Svcs.-Elderly Visually Impaired            | \$ 250,000    | \$ 250,000    |
| DDAIL      | DS Special Payments for Medical Services                           | \$ 880,797    | \$ 200,000    |
| DDAIL      | Flexible Family/Respite Funding                                    | \$ 1,341,698  | \$ 1,088,159  |
| DDAIL      | Quality Review of Home Health Agencies                             | \$ 186,664    | \$ 432,938    |
| DDAIL      | Registry                                                           | \$ -          | \$ 60,000     |
| DOC        | Intensive Substance Abuse Program (ISAP)                           | \$ 310,610    | \$ 300,410    |
| DOC        | Intensive Sexual Abuse Program                                     | \$ 85,542     | \$ 75,342     |
| DOC        | Intensive Domestic Violence Program                                | \$ 230,353    | \$ 220,153    |
| DOC        | Women's Health Program (Tapestry)                                  | \$ 487,231    | \$ 477,031    |
| DOC        | Community Rehabilitative Care                                      | \$ 2,031,408  | \$ 2,021,208  |
|            |                                                                    | \$ 59,918,097 | \$ 65,097,996 |

## **OVHA Unit Responsibilities**

The Office of Vermont Health Access (OVHA) assists beneficiaries in accessing clinically appropriate health services, administers Vermont's public health care insurance programs efficiently and effectively, and collaborates with other health care system entities in bringing evidence-based practices to beneficiaries. As of 2009, the OVHA is also home to state oversight of Health Care Reform initiatives.

The following list of OVHA units includes major areas of responsibility and is not intended to provide an all-inclusive listing of responsibilities.

### ***Clinical Unit***

The Clinical Unit is responsible for:

- Blueprint for Health Clinical Liaison
- Care Coordination Program (CCP)
- Chronic Care Initiative, which now includes the Chronic Care Management Program (CCMP) , the Care Coordination Program (CCP) and the Buprenorphine Program
- Clinical Quality Improvement
- Prior Authorizations (PAs)
- Contract Administration (examples): APS Healthcare
- Denied Claims Appeals
- Annual Review of New Procedure Codes
- Drug Utilization Review (DUR) Board (*in conjunction with the Pharmacy Unit*)
- Fair Hearings (*in conjunction with the Policy Unit*)
- Medicaid M108 Exceptions (*in conjunction with the Policy Unit*)
- Correct Coding (*in conjunction with Program Integrity Unit*)

### ***Communications Unit***

The Communications Unit is responsible for:

- Health Insurance Portability and Accountability Act (HIPAA) - Privacy
- Legislative Activities
- Managing the Transportation Benefit
- Dental Dozen
- Medicaid Advisory Board (MAB)
- Media Relations
- Provider Network Adequacy
- Provider Relations
- Website
- Contract Administration (examples): Chadwick Optical, Vermont State Dental Clinic, Vermont's Transportation Brokers

### ***Coordination of Benefits (COB) Unit***

The Coordination of Benefits (COB) Unit is responsible for:

- Catamount Health and Employer Sponsored Insurance Beneficiary Assistance
- Medicare Part D Casework
- Estate Recovery
- Absent Parent Medical Support Recovery
- Casualty Recovery
- Patient Liability Recovery
- Medicare Recovery
- Medicare Prescription Recovery
- Special Needs and Trust Recovery

### ***Fiscal Operations Unit***

The Fiscal Operations Unit is responsible for:

- Global Commitment Financial Development and Implementation
- Budgeting and Budget Monitoring
- Cost Allocation Processing
- Accounts Payable/Receivable
- Contracts and Grants Monitoring
- Federal Reporting
- Asset Management
- Audit Coordination
- Building Maintenance Needs (Cleaning, Repair, Coordination of Space)
- Coordination of Personnel Needs (Benefits, Expenses, New-Hire Logistics, Payroll, Reclassification)
- General Office Needs (Coordination of Mailings, Public Records, Shredding/Recycling, Supply Purchasing, Telecommunications)

### ***Health Care Reform Unit***

The Health Care Reform Unit is responsible for:

- Coordinating the implementation of Vermont's comprehensive health care reform activities across state government and other stakeholders
- Representing the Governor and his administration on health care reform policy and initiatives within Vermont and at the national level
- Maintaining the state's health care reform website

### ***Health Programs Integration Unit (HPIU)***

The Health Programs Integration Unit (HPIU) is responsible for:

- Coordinating health care initiatives with BISHCA, DCF, DDAIL, VDH, DMH, Blueprint for Health

- Representing OVHA at the Long Term Care Partnership & Governor's Committee on Healthy Aging
- Monitoring Inter-Governmental Agreements (IGA)
- Monitoring Memorandums of Understanding (MOU)
- Facilitating OVHA Quality Council
- State Children's Health Insurance Program (SCHIP)
- Coordination for meeting the MCO External Quality Review Standards

### ***Information Technology (IT) Unit***

The Information Technology (IT) Unit is responsible for:

- Catamount Outreach Tracking System
- IT Project Planning and Implementation
- Medicaid Management Information System (MMIS) Technical Oversight
- Modernization of Vermont's Enterprise (MOVE)
- Operational Health Care Database Reconciliation
- Systems Development, Operations, User Support and Maintenance
- User Account Management and Related Technical System Security

### ***Pharmacy Unit***

The Pharmacy Unit is responsible for:

- Administering the pharmaceutical benefit
- Administering the pharmacy programs
- Drug Utilization Review (DUR) Board (*in conjunction with the Clinical Unit*)
- Preferred Drug List (PDL)
- Pharmacy Benefits Management (PBM)
- Policy Collaboration
- Contract Administration (examples): MedMetrics Health Partners

### ***Policy Unit***

The Policy Unit is responsible for:

- Rules and Procedures for all health care programs related to coverage, delivery, reimbursement
- Medicaid State Plan Amendments and Research (coverage, delivery and reimbursement)
- On-Line Rules and State Plan Project
- Fair Hearing Process (*in conjunction with the Clinical Unit*)
- Grievance and Appeals (overall MCO coordination and related to OVHA situations)
- Medicaid M108 Exceptions (*in conjunction with the Clinical Unit*)
- Forms Management
- Administrative Procedures Act Compliance

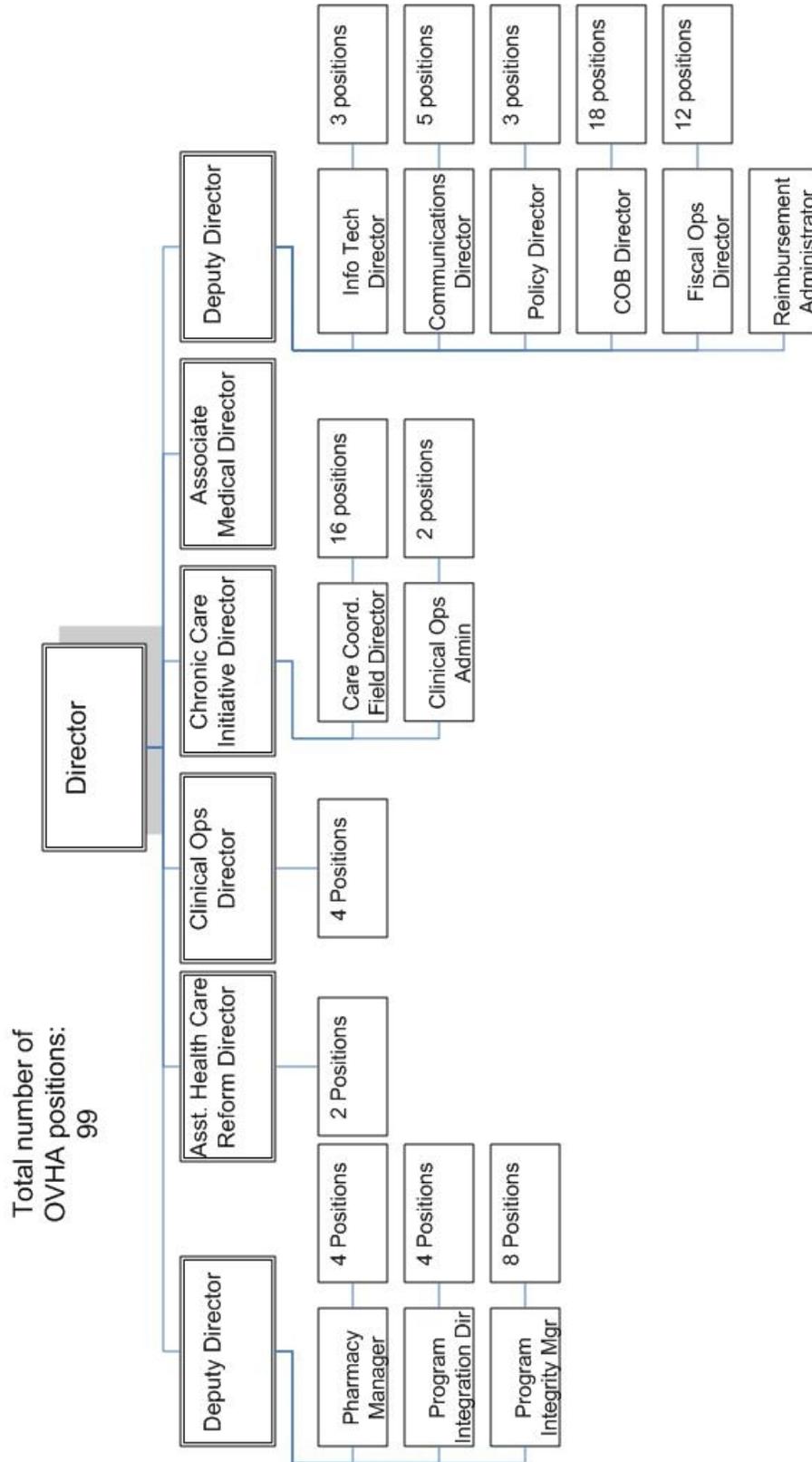
- Public Records Requests
- Contract Administration (examples): Member Services, Ombudsman
- Responding to consumer complaints

### ***Program Integrity (PI) Unit***

The Program Integrity (PI) Unit is responsible for:

- Rate Setting
- Billing Accuracy
- Claims Check & Correct Coding
- Budget/Budget Projections & Utilization Analysis
- Enrollment Reporting
- Healthcare Effectiveness Data & Information Set (HEDIS) Analysis
- All other Data Collection and Analysis
- Disproportionate Share Hospital (DSH) Provider Assessment
- Fraud, Abuse, Waste Detection
- Lock-in for Drug Diversion
- Payment Error Rate Measurement (PERM)
- Provider Demographics (Mapping)
- Timely Filing & Denied Claims Appeals

## Organization Chart



## SECTION 8: SUPPLEMENTAL INFORMATION FOR BUDGET CONSIDERATION

### Proposal to Reduce OVHA Reimbursement Rates to Providers by 4% January 30, 2009

Medicaid rates paid to providers by the Office of Vermont Health Access are proposed to be decreased by 4%, effective with date of service on March 15, 2009 (to achieve a 3 month savings in SFY '09) and continuing for all four quarters of SFY '10. Some provider types or billing codes are exempt from this proposed decrease due to federal or state mandated reimbursement rates. These include:

**Nursing Homes** – Nursing Homes are not getting their mandatory inflationary increase in SFY '10.

**Hospitals** – The 5.5 % rate for the hospital provider tax will remain intact for SFY '10; as such, hospitals will experience an increase in their provider tax payments because it is linked to their revenues which have increased.

**Physicians** - Rates will be maintained at the Medicare 2006 rate for Evaluation and Management Services per SFY '07 legislation.

**Hospice** – Per federal requirements, payments each year change to the Medicare level of Reimbursement.

**FQHC/RHC** – Per federal requirements, these providers are cost settled for their encounter rate and all related services; therefore a rate decrease would not have an overall impact.

**Dental** – The \$2 million rate increase intended for SFY '10 in the Dental Dozen Initiative will not be implemented.

Also, please note that reimbursements to providers contained in other department's appropriations are not included in this proposed 4% decrease (e.g., Department of Mental Health contract with Designated Agencies for core mental health services).

**Category of Service Description List - 4% Rate Decrease Impact**

| Category of Service                          | SFY '09 Budget Adjustment | SFY '09 4% Decrease (3 months) | SFY '10 Projected | SFY '10 4% Decrease |
|----------------------------------------------|---------------------------|--------------------------------|-------------------|---------------------|
| ADAP Families in Recovery                    | 84,590                    | 846                            | 89,707            | 3,588               |
| Ambulance                                    | 3,833,844                 | 38,338                         | 4,549,865         | 181,995             |
| Ambulatory Surgical Care                     | 6,603                     | 66                             | 7,082             | 283                 |
| Assistive Community Care Services            | 12,745,815                | 127,458                        | 14,102,675        | 564,107             |
| Case Management                              | 2,220                     | 22                             | 2,568             | 103                 |
| Chiropractor                                 | 950,181                   | 9,502                          | -                 | -                   |
| Day Treatment (MHS)                          | 65,143                    | 651                            | 71,437            | 2,857               |
| Dialysis                                     | 733,400                   | 7,334                          | 953,378           | 38,135              |
| Enhanced Resident Care                       | 7,319,142                 | 73,191                         | 7,799,977         | 311,999             |
| H&CB Mental Health Services                  | 641,424                   | 6,414                          | 688,381           | 27,535              |
| H&CB Mental Retardation                      | 48,021                    | 480                            | 52,884            | 2,115               |
| H&CB Services                                | 47,969,909                | 479,699                        | 53,255,103        | 2,130,204           |
| Home Health                                  | 7,698,023                 | 76,980                         | 8,537,329         | 341,493             |
| Independent Laboratory                       | 4,186,612                 | 41,866                         | 5,014,005         | 200,560             |
| Medical Supplies & Durable Medical Equipment | 7,362,915                 | 73,629                         | 8,193,692         | 327,748             |
| Mental Health Clinic                         | 56,266                    | 563                            | 58,011            | 2,320               |
| Mental Health Facility                       | 247,134                   | 2,471                          | 254,324           | 10,173              |
| Miscellaneous                                | 212,106                   | 2,121                          | 166,772           | 6,671               |
| Nurse Practitioners                          | 550,174                   | 5,502                          | 585,900           | 23,436              |
| Optician                                     | 257,947                   | 2,579                          | 275,357           | 11,014              |
| Optometrist                                  | 936,628                   | 9,366                          | 986,117           | 39,445              |
| Outpatient Rehab                             | 168,576                   | 1,686                          | 177,961           | 7,118               |
| Personal Care Services                       | 19,051,084                | 190,511                        | 21,547,822        | 861,913             |
| Pharmacy                                     | 115,179,040               | 1,140,306                      | 123,241,398       | 4,929,656           |
| Physician                                    | 75,188,109                | 375,941                        | 81,761,262        | 1,635,225           |
| Podiatrist                                   | 271,422                   | 2,714                          | 289,789           | 11,592              |
| Prosthetic and Orthotics                     | 2,079,040                 | 20,790                         | 2,420,658         | 96,826              |
| Psychologist                                 | 14,666,048                | 146,660                        | 15,662,549        | 626,502             |
| Rehabilitation/Children's Services           | 4,349,579                 | 43,496                         | 5,010,502         | 200,420             |
| Skilled Nursing                              | 3,155,003                 | 31,550                         | 3,358,005         | 134,320             |
| Therapy Services                             | 2,061,133                 | 20,611                         | 2,232,734         | 89,309              |
| Transportation                               | 11,710,007                | 117,100                        | 12,996,618        | 519,865             |
| Subtotal of affected providers               | 343,787,138               | 3,050,446                      | 374,343,864       | 13,338,529          |
| Third Party Liability                        | (6,018,369)               | (60,184)                       | (6,293,791)       | (251,752)           |
| Subtotal of excluded providers               | 361,438,177               | -                              | 398,121,215       | -                   |
| Total                                        | 699,206,946               | 2,990,262                      | 766,171,287       | 13,086,777          |

**ADAP Families in Recovery**

Description: ADAP Facility billing for Alcohol and/or Drug Services, Acute Detoxification, Behavioral Health, Short Term Residential

Providers: Maple Leaf Farm Assoc  
Valley Vista

**Ambulance**

Description: Ambulance Emergency and Non-Emergency services

Providers: 110+- Ambulance/Rescue Squads

**Ambulatory Surgical Care**

Description: Ambulatory Surgical Care Centers; currently minimal surgical services in Vermont

Providers: Albany Memorial Hospital  
Cincinnati Eye Institute Ambulatory  
Dunning Street Ambulatory Care

**Assistive Community Care Services (ACCS)**

Description: Non-Medical Residential Care Facility billing for assistive community care services, case management

Providers: 92+- ACCS Providers

**Case Management**

Description: OBGYN billing for prenatal care, at-risk assessment

Providers: 45+- Providers / Groups

**Chiropractic**

Description: Manipulation by chiropractic physician

Providers: Licensed Chiropractors

**Day Treatment (MHS)**

Description: Mental Health Clinic billing for Day Hospital Services

Providers: Day Hospital Services

**Dialysis**

Description: Freestanding Dialysis Providers billing for Dialysis and Associated Services

Providers: Bio Medical Application of NH  
BMA Yankee Family Dialysis  
Fletcher Allen Health Care  
Monadnock Dialysis Center  
Southwestern Vermont Renal Center

**Enhanced Residential Care**

Description: Home Based Waiver Services  
Waiver Case Management Services by Home Health Nurse  
Enhanced Residential Care Rate (Tiers 1, 2, 3)

Providers: 45+- Homes/Groups

**Home & Community Based Mental Health Services**

Description: Behavioral Health Long Term Residential and Individual Therapy

Providers: Matrix Health Systems  
NFI Vermont  
Vermont Catholic Charities

**Home & Community Based Mental Retardation**

Description: Community Based Wrap Services

Providers: Howard Center  
United Counseling Services Inc

**Home & Community Based Services**

Description: Wide Range of H&CB Services predominantly under the Long-term Care Waiver

Providers: 65+ provider organizations and 3,300 individual caregivers through Choices for Care, Attendant Services Program Medicaid-PDAC, and Children's Personal Care services  
Addison County Home Health Hospice Inc  
Area Agency On Aging, For NE  
Area Resource For Individualized Services  
Bennington Project Independence Inc  
Care Partners Adult Day Center

Carlos G Otis Health Care Center Inc  
Cathedral Square Corp ERC ALR  
Central Vermont Council On Aging Inc  
Champlain Valley  
Champlain Vocational Services Inc  
Coasev Waiver  
Central VT Home Health Hospice  
Elderly Services Inc  
Franklin County HHA  
Gifford Med Center DBA Randolph Area ADS  
Green Mountain Adult Day Services  
GTL Incorporated  
His Independence Project Inc  
Howard Center  
Lakeview Neuro Rehabilitation Center  
Lamoille Home Health Agency  
Lifeline Systems Inc, DBA The Lifeline FND  
Manchester Health Services Inc  
Matrix Health Systems  
NFI Vermont Inc  
Northern Counties Health Care  
Northwestern Counseling CFC  
OEVNA Waiver  
Our Lady Of The Meadows Respite  
Out And About Waiver  
Oxbow Senior Independence Program Waiver  
Pride Inc  
Professional Nursing Service  
Project Independence  
Riverbend RCH Respite  
Riverside Life Enrichment Center  
Rutland Area VNA and Hospice  
Rutland Community Programs Inc-Interage  
Rutland Regional Medical Center Lifeline  
Southwestern VT Health Care Aux Pers  
Springfield Hospital Ispr Adult Day Care  
Sterling Area Services Inc  
SVCOA Waiver  
The Gathering Place Adult Day Service Waiver  
The Meadows At East Mountain ALR  
The Meeting Place Day Health Rehab  
United Counseling Service CFC  
United Counseling Service Inc  
Upper Valley Services Inc  
Vermont Catholic Charities  
Vernon Hall Rr ALR

Visiting Nurse Assoc + Hospice Of VT + N H  
Visiting Nurse Assoc Of Chittenden And  
VNA + Hospice Of SVHC  
VT Senior Companion Program  
West River Valley Assisted Living Residence

### **Home Health**

Description: Home Health Agency billing for Physical Therapy, Occupational Therapy, Speech Therapy, Medical/Surgical Supplies, Skilled Nursing, and Home Health & Homemaker Services

Provider: Addison County Home Health & Hospice  
Central Vermont Home Health & Hospice  
Franklin County Home Health  
Lamoille Home Health & Hospice  
Manchester Health Services  
Northern Counties Health Care  
Orleans, Essex VNA & Hospice  
Professional Nursing Services  
Rutland Area VNA & Hospice  
Visiting Nurse & Hospice of VT & NH  
Visiting Nurse Association of Chittenden, Grand Isle Counties (Colchester)  
Visiting Nurse Association & Hospice of SVHC

### **Independent Labs**

Description: Independent Lab Services billing for Laboratory Tests (CPT 8xxxx)

Provider: 26+- Laboratories/Groups

### **Medical Supplies & Durable Medical Equipment**

Description: DME Suppliers billing for wheelchairs, walkers, canes, shower seats, etc., and wound care etc.

Providers: 200+- Providers/Suppliers

### **Mental Health Clinic**

Description: Mental Health Clinic and DMH Case Rates for Crossover Claims

Provider: Clara Martin Center (Randolph)  
Counseling Services of Addison County (Middlebury)  
DMH  
Health Care and Rehabilitation Services (Springfield)  
Howard Center for Human Services (Burlington)  
Northeast Kingdom Human Services (Newport)

North Western Counseling and Support Services (St. Albans)  
United Counseling Services (Bennington)  
Washington County Mental Health Services (Montpelier)

### **Mental Health Facility**

Description: Free Standing Psychiatric Facility (Adults and Children) billing for Inpatient Mental Health Services, Outpatient Clinical Services

Provider: Brattleboro Retreat

### **Miscellaneous**

Description: Services that don't meet a specific category at time of processing

### **Nurse Practitioners (excluding Evaluation and Management Services)**

Description: Nurse Practitioner billing for Primary Care, Anesthesia, Psychiatric Services, Immunizations etc.

Provider: 34+- Practitioners and/or group

### **Optician**

Description: Optician and Sole Source Eyeglass Lab billing for Eyeglass related services

Provider: Chadwick Optical Inc  
Ethan Allen Optical  
Lakes Region Opticians  
Optics LTD  
Pro Optical  
Rutland Optical Inc

### **Optometrist (excludes Evaluation and Management Services)**

Description: Optometrist billing for Ophthalmological Services. (E & M, Office Visits, Office and Other Outpatient Services, Emergency Department Services, Preventative Medicine Services)

Provider: 56+- Practitioners and/or group

**Outpatient Rehabilitation Services**

Description: Outpatient Rehabilitation Services billing for Physical Therapy

Providers: Associates in PT/OT

**Personal Care Services**

Description: Personal Care Aide/Assistant and Independent Billing High Tech Nurses  
Personal Care Services  
Billing for Home Assessments, Contracted Home Health Agency Services,  
Nursing Services

Providers: 45+- Homes/Groups; includes \$198,000 across 11 Designated Agencies

**Pharmacy**

Description: Prescription Drugs purchased through a pharmacy

Provider: Pharmacies

**Physicians (excluding Evaluation and Management Services)**

Description: Physician and Naturopathic Physician billing for a wide range of services from Primary Care, Surgeries, Deliveries to Immunizations (excludes: CPT 99xxx (E & M, Office Visits, Office and Other Outpatient Services, Emergency Department Services, Preventative Medicine Services))

Provider: 770+- Individual Providers and/or group

**Podiatrist (excluding Evaluation and Management Services)**

Description: Podiatrist billing for services related to the treatment and care of feet. (E & M, Office Visits, Office and Other Outpatient Services, Emergency Department Services, Preventative Medicine Services)

Provider: 15+- Podiatrists

**Prosthetics and Orthotics**

Description: DME Suppliers, Pharmacies and Prosthetics/Orthotics Suppliers billing for Prosthetic and Orthotic related Services and Supplies

Providers: 62+- Providers/Suppliers

**Psychologists**

Description: Master Level Licensed Psychologist, Counselor, and/or Social Worker; Doctorate Psychologist; Mental Health/Developmental Services Clinic – VHAP; and Certified Adolescent ADAP Counselor billing for Counseling Services.

Provider: 700+- Counseling Service Providers; includes ~\$4,473,000 across 11 Designated Agencies

**Rehabilitation/Children's Services**

Description: Children's Medical Services for Healthy Babies, Kids and Families and High Risk Programs (Development of Cognitive Skills, Contracted Home Health Agency Services, Case Management, Parent Education, and Sign Language & Interpretive Services

Providers: Addison County Home Health + Hospice Inc  
Addison County Parent/Child Center  
Central VT Home Health + Hospice  
Family Center of Washington County  
Fletcher Allen Health Care  
Franklin County HHA  
Health South Rehab Hospital Of Concord NH  
Lamoille Family Center PCC  
Lamoille Home Health Agency  
Lund Family Center Health Babies  
Manchester Health Services Inc  
Milton Family Community Center Parent Child Center  
No Counseling + Support Services Inc Healthy Babies  
Northeast Kingdom Human Services Inc HBKF  
Northeast Kingdom Learning Services Inc FIT  
Northern Counties Health Care Inc Healthy Babies  
Northwestern Counseling +Support Services Inc - FIT  
OEVNA Healthy Babies  
Orange County Parent Child Center HBr+F  
Orleans/Northern Essex Family Infant/Toddler Program  
Parent to Parent of Vermont  
Rome Memorial Hospital  
Rutland Area VNA And Hospice Healthy Babies  
Rutland County Parent/Child Center  
Southwestern VT Medical Center Fit  
Springfield Area Parent Child Center  
Sunrise Family Resource Center, Inc  
The Family Place  
Vermont Assoc For The Blind + Visually Impaired  
Vermont Parent Infant Program

Visiting Nurse Assoc + Hospice Of VT + N H Inc  
Visiting Nurse Assoc Chittenden/Grand Isle Counties  
VNA + Hospice Of SVHC Healthy Babies  
Washington County Youth Service Bureau/ B +G CI  
Winston L Prouty Center Fit  
Winston L Prouty Center Healthy Babies

### **Skilled Nursing**

Description: Skilled nursing professionals billing for skilled nursing services, nursing assessment and evaluation, home health aid, and case management

Provider: Addison County Home Health & Hospice  
Central Vermont Home Health & Hospice  
Franklin County Home Health  
Lamoille Home Health & Hospice  
Northern Counties Health Care  
Professional Nursing Services  
Rutland Area VNA & Hospice  
Visiting Nurse & Hospice of VT & NH  
Visiting Nurse Association of Chittenden, Grand Isle Counties (Colchester)  
Visiting Nurse Association & Hospice of SVHC

### **Therapy Services**

Description: Licensed Therapist (PT, OT ST (once enrolled)) and Audiologist billing for Physical Therapy Services, Occupational Therapy Services, and Audiology Services

Provider: 100+- Practitioners and/or groups

### **Transportation**

Description: Non-Emergency Medical Transportation (Administration and Services Reimbursement), Providers/Brokers and their subcontractors, Taxis, Volunteers, Bus Pass Program, etc.

Provider: Addison County Transit Resources  
Chittenden County Transportation Authority  
Connecticut River Transit Inc  
Green Mountain Community Network  
Green Mountain Transit Agency  
Marble Valley Regional Transit District  
Rural Community Transportation Inc  
Special Services Transportation Agency  
Stagecoach Transportation Services Inc

## Medicare Crossover Reimbursement Consistent Payment Policy Proposal

### Problem Statement

- When claims cross over from Medicare to Medicaid for a Dual Eligible (a beneficiary covered by both Medicare and Medicaid), Medicaid currently pays the full co-insurance and deductible *without regard to the Medicaid allowed amount*.

### What is a Medicare Crossover?

- Claims are processed by Medicare as the primary insurer.
- Medicare pays claims on covered services, subject to a deductible and a 20% co-insurance.
- Balance after Medicare processing is submitted to Vermont Medicaid for payment of coinsurance and deductible.

### Consistent Payment Policy Proposal

- Configure the EDS System so that the claims are not reimbursed at a rate greater than the Medicaid Allowed amount for the service.
- Pay the coinsurance and/or deductible as calculated by Medicare up to the Medicaid allowed amount for the service or the Medicare allowed amount, whichever is less.
- Ensures consistent payment policy for all services provided, regardless of primary coverage.

| Scenario                                                                                                                          | Medicare Allowed | Medicare Payment | Medicare Coinsurance | Medicaid Allowed | Medicaid Payment | Total Reimbursement to Provider |
|-----------------------------------------------------------------------------------------------------------------------------------|------------------|------------------|----------------------|------------------|------------------|---------------------------------|
| <b>Current Payment for Medicare Crossover</b>                                                                                     | \$ 100.00        | \$ 80.00         | \$ 20.00             | \$ 75.00         | \$ 20.00         | \$ 100.00                       |
| <b>Proposed Payment for Medicare Crossover</b>                                                                                    |                  |                  |                      |                  |                  |                                 |
| 1. <i>Medicare Allowed &gt; Medicaid Allowed</i><br><i>Medicaid Pays difference between Medicare Payment and Medicaid Allowed</i> | \$ 100.00        | \$ 80.00         | \$ 20.00             | \$ 75.00         | \$ -             | \$ 80.00                        |
| 2. <i>Medicare Allowed &lt; Medicaid Allowed</i><br><i>Medicaid Pays difference between Medicare Payment and Medicare Allowed</i> | \$ 100.00        | \$ 80.00         | \$ 20.00             | \$ 120.00        | \$ 20.00         | \$ 100.00                       |
| <b>Current Payment for all other Beneficiaries</b>                                                                                |                  | N/A              | N/A                  | \$ 75.00         | \$ 75.00         | \$ 75.00                        |

In the example above depicted for the “Current Payment for Medicare Crossover,” the Medicaid payment results in a total reimbursement to the provider that exceeds the Medicaid allowed amount by \$25.

In the proposed scenario #1 example above, the Medicare allowable reimbursement is *less than* the Medicaid allowable reimbursement for a claim. Medicaid will not provide reimbursement resulting in payment that exceeds the Medicaid allowable.

In the proposed scenario #2 example above, the Medicaid allowable reimbursement is *greater than* the Medicare allowable amount. The difference is reimbursed, however, *not* to exceed the Medicare allowable.

**Premium Increases for VHAP, Dr. Dynasaur & SCHIP**
**Premium Increase Impact ~ SFY '10**

| Program                     | % FPL    | '09 Actual Premium | '10 Gov. Rec. Premium | '10 Enrollment | '10 Gov. Rec. | Premium Increase |
|-----------------------------|----------|--------------------|-----------------------|----------------|---------------|------------------|
| Dr. Dynasaur                | 185-225% | \$ 15.00           | \$ 30.00              | 4,213          | \$ 947,964    | \$ 473,982       |
| Dr. D <i>with ins.</i>      | 225-300% | \$ 20.00           | \$ 40.00              | 1,170          | \$ 350,967    | \$ 175,484       |
| Dr. D <i>without ins.</i>   | 225-300% | \$ 60.00           | \$ 80.00              | 3,559          | \$ 2,135,307  | \$ 533,827       |
| Dr. D Total                 |          |                    |                       | 8,942          | \$ 3,434,238  | \$ 1,183,292     |
| <hr/>                       |          |                    |                       |                |               |                  |
| VHAP                        | 50-75%   | \$ 7.00            | \$ 11.00              | 3,238          | 427,368       | \$ 155,407       |
| VHAP                        | 75-100%  | \$ 25.00           | \$ 39.00              | 3,815          | 1,785,293     | \$ 640,875       |
| VHAP                        | 100-150% | \$ 33.00           | \$ 50.00              | 8,892          | 5,334,966     | \$ 1,813,888     |
| VHAP                        | 150-185% | \$ 49.00           | \$ 75.00              | 2,385          | 2,146,942     | \$ 744,273       |
| VHAP Total                  |          |                    |                       | 30,023         | \$ 9,694,569  | \$ 3,354,443     |
| <hr/>                       |          |                    |                       |                |               |                  |
| VPharm 1 & VHAP Pharmacy    | 0-150%   | \$ 17.00           | \$ 17.00              | 10             | 1,948         | \$ -             |
| VPharm 2 & VScript          | 150-175% | \$ 23.00           | \$ 23.00              | 42             | 11,716        | \$ -             |
| VPharm 3 & VScript Expanded | 175-225% | \$ 50.00           | \$ 50.00              | 16             | 9,600         | \$ -             |
| Pharmacy Total              |          |                    |                       | 68             | \$ 23,264     | \$ -             |
| <hr/>                       |          |                    |                       |                |               |                  |
| Catamount Health            | 0-150%   | \$ 60.00           | \$ 69.00              | 1,548          | 1,281,950     | \$ -             |
| Catamount Health            | 150-175% | \$ 60.00           | \$ 69.00              | 2,202          | 1,822,894     | \$ -             |
| Catamount Health            | 175-200% | \$ 65.00           | \$ 74.75              | 3,001          | 2,692,038     | \$ -             |
| Catamount Health            | 200-225% | \$ 110.00          | \$ 126.50             | 1,383          | 2,099,077     | \$ -             |
| Catamount Health            | 226-250% | \$ 135.00          | \$ 155.25             | 1,027          | 1,913,382     | \$ -             |
| Catamount Health            | 251-275% | \$ 160.00          | \$ 184.00             | 425            | 938,953       | \$ -             |
| Catamount Health            | 276-300% | \$ 185.00          | \$ 212.75             | 320            | 817,956       | \$ -             |
| Catamount Total             |          |                    |                       | 9,906          | \$ 11,566,249 | \$ -             |
| <hr/>                       |          |                    |                       |                |               |                  |
| Federal                     |          |                    |                       |                | \$ 11,414,365 | \$ 2,738,987     |
| GF                          |          |                    |                       |                | \$ 13,303,955 | \$ 1,798,748     |
| Total                       |          |                    |                       |                | \$ 24,718,321 | \$ 4,537,735     |

### Vermont Medicaid Premium History Through SFY 2010

| Program            | % FPL    | SFY 2002 | SFY 2003 | SFY 2004      | SFY 2005 | SFY 2006 | SFY 2007 | SFY 2008 | SFY 2009 | SFY 2010 |
|--------------------|----------|----------|----------|---------------|----------|----------|----------|----------|----------|----------|
|                    |          | Premiums | Premiums | Premiums      | Premiums | Premiums | Premiums | Premiums | Premiums | Premiums |
| Dr. Dynasaur       | 0-185%   | None     | None     | None          | None     | None     | None     | None     | None     | None     |
| Dr. Dynasaur       | 185-225% | \$10*    | \$20*    | \$25*         | \$25*    | \$30*    | \$30*    | \$15*    | \$15*    | \$30*    |
| Dr. D with ins.    | 225-300% | \$12*    | \$24*    | \$35*         | \$35*    | \$40*    | \$40*    | \$20*    | \$20*    | \$40*    |
| Dr. D without ins. | 225-300% | \$25*    | \$50*    | \$70*         | \$70*    | \$80*    | \$80*    | \$60*    | \$60*    | \$80*    |
|                    |          | 1/1/01   | 6/1/2002 | 7/1/2003      |          | 7/1/2005 |          | 7/1/2007 |          | 7/1/2009 |
| VHAP               | 0-50%    | None     | None     | None          | None     | None     | None     | None     | None     | None     |
| VHAP               | 50-75%   | \$10**   | \$10**   | \$10***       | \$10***  | \$11***  | \$11***  | \$7***   | \$7***   | \$11***  |
| VHAP               | 75-100%  | \$15**   | \$15**   | \$35***       | \$35***  | \$39***  | \$39***  | \$25***  | \$25***  | \$39***  |
| VHAP               | 100-150% | \$20**   | \$40**   | \$45***       | \$45***  | \$50***  | \$50***  | \$33***  | \$33***  | \$50***  |
| VHAP               | 150-185% | \$25**   | \$50**   | \$65***       | \$65***  | \$75***  | \$75***  | \$49***  | \$49***  | \$75***  |
|                    |          | 1/1/01   | 6/1/2002 | 1/1/2004      |          | 7/1/2005 |          | 7/1/2007 |          | 7/1/2009 |
| VHAP Pharmacy      | 0-150%   | N/A      | N/A      | \$13***       | \$13***  | \$13***  | \$15***  | \$15***  | \$17***  | \$17***  |
| VScript            | 150-175% | N/A      | N/A      | \$17***       | \$17***  | \$17***  | \$20***  | \$20***  | \$22***  | \$22***  |
| VScript Expanded   | 175-225% | N/A      | N/A      | \$35***       | \$35***  | \$35***  | \$42***  | \$42***  | \$46***  | \$46***  |
| Effective 1/1/2006 |          |          |          | 1/1/2004 **** |          |          | 7/1/2006 |          |          |          |
| Vpharm 1           | 0-150%   | N/A      | N/A      | N/A           | N/A      | \$13***  | \$15***  | \$15***  | \$17***  | \$17***  |
| Vpharm 2           | 150-175% | N/A      | N/A      | N/A           | N/A      | \$17***  | \$20***  | \$20***  | \$22***  | \$22***  |
| Vpharm 3           | 175-225% | N/A      | N/A      | N/A           | N/A      | \$35***  | \$42***  | \$42***  | \$46***  | \$46***  |

\* Per family per month

\*\* Per individual for 6 months

\*\*\* Per individual per month

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

**Vermont Medicaid Co-Pay History Through SFY 2010**

| Program                                                                                                                  | % FPL    | Cost per Prescription | SFY 2002                                                                     | SFY 2003                                                                                                                       | SFY 2004 | SFY 2005 | SFY 2006 | SFY 2007 | SFY 2008 | SFY 2009 | SFY 2010 |
|--------------------------------------------------------------------------------------------------------------------------|----------|-----------------------|------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|----------|----------|----------|----------|----------|----------|----------|
|                                                                                                                          |          |                       | Co-Pay                                                                       | Co-Pay                                                                                                                         | Co-Pay   | Co-Pay   | Co-Pay   | Co-Pay   | Co-Pay   | Co-Pay   | Co-Pay   |
| Traditional Medicaid<br>(*Does not apply to children <18<br>effective 1/1/2007 <21), pregnant<br>women, or LTC Patients) | 0-185%   | \$29.99 or Less       | \$1.00                                                                       | \$1.00                                                                                                                         | \$1.00   | \$1.00   | \$1.00   | \$1.00   | \$1.00   | \$1.00   | \$1.00   |
|                                                                                                                          |          | \$30.00 - \$49.99     | \$2.00                                                                       | \$2.00                                                                                                                         | \$2.00   | \$2.00   | \$2.00   | \$2.00   | \$2.00   | \$2.00   | \$2.00   |
|                                                                                                                          |          | \$50.00 or more       | \$3.00                                                                       | \$3.00                                                                                                                         | \$3.00   | \$3.00   | \$3.00   | \$3.00   | \$3.00   | \$3.00   | \$3.00   |
| 11/1/01                                                                                                                  |          |                       |                                                                              |                                                                                                                                |          |          |          |          |          |          |          |
| VHAP                                                                                                                     | 0-50%    | \$29.99 or Less       |                                                                              |                                                                                                                                | N/A      | N/A      | N/A      | N/A      | N/A      | N/A      | \$1.00   |
|                                                                                                                          |          | \$30.00 - \$49.99     |                                                                              |                                                                                                                                | N/A      | N/A      | N/A      | N/A      | N/A      | N/A      | \$2.00   |
|                                                                                                                          |          | \$50.00 or more       |                                                                              |                                                                                                                                | N/A      | N/A      | N/A      | N/A      | N/A      | N/A      | \$3.00   |
| VHAP                                                                                                                     | 50-75%   | \$29.99 or Less       |                                                                              |                                                                                                                                | N/A      | N/A      | N/A      | N/A      | N/A      | N/A      | \$3.00   |
|                                                                                                                          |          | \$30.00 - \$49.99     |                                                                              |                                                                                                                                | N/A      | N/A      | N/A      | N/A      | N/A      | N/A      | \$3.00   |
|                                                                                                                          |          | \$50.00 or more       |                                                                              |                                                                                                                                | N/A      | N/A      | N/A      | N/A      | N/A      | N/A      | \$3.00   |
| VHAP                                                                                                                     | 75-100%  | \$29.99 or Less       | 60% Limited/<br>50% Managed Care                                             |                                                                                                                                | N/A      | N/A      | N/A      | N/A      | N/A      | N/A      | \$3.00   |
|                                                                                                                          |          | \$30.00 - \$49.99     | \$750.00 Beneficiary/\$1500.00 Family Out Of<br>Pocket Calendar Year Maximum |                                                                                                                                | N/A      | N/A      | N/A      | N/A      | N/A      | N/A      | \$3.00   |
|                                                                                                                          |          | \$50.00 or more       |                                                                              |                                                                                                                                | N/A      | N/A      | N/A      | N/A      | N/A      | N/A      | \$3.00   |
| VHAP                                                                                                                     | 100-150% | \$29.99 or Less       |                                                                              |                                                                                                                                | N/A      | N/A      | N/A      | N/A      | N/A      | N/A      | \$3.00   |
|                                                                                                                          |          | \$30.00 - \$49.99     |                                                                              |                                                                                                                                | N/A      | N/A      | N/A      | N/A      | N/A      | N/A      | \$3.00   |
|                                                                                                                          |          | \$50.00 or more       |                                                                              |                                                                                                                                | N/A      | N/A      | N/A      | N/A      | N/A      | N/A      | \$3.00   |
| VHAP                                                                                                                     | 150-185% | \$29.99 or Less       |                                                                              |                                                                                                                                | N/A      | N/A      | N/A      | N/A      | N/A      | N/A      | \$3.00   |
|                                                                                                                          |          | \$30.00 - \$49.99     |                                                                              |                                                                                                                                | N/A      | N/A      | N/A      | N/A      | N/A      | N/A      | \$3.00   |
|                                                                                                                          |          | \$50.00 or more       |                                                                              |                                                                                                                                | N/A      | N/A      | N/A      | N/A      | N/A      | N/A      | \$3.00   |
| 11/1/2002                                                                                                                |          |                       |                                                                              |                                                                                                                                |          |          |          |          |          |          |          |
| VHAP Pharmacy                                                                                                            | 0-150%   | \$29.99 or Less       | \$1.00                                                                       | \$3.00 Generic/\$6.00 Brand**<br>\$50.00 per beneficiary per quarter maximum<br>\$1.00 Diabetic Supply                         |          |          |          |          |          |          | \$3.00   |
|                                                                                                                          |          | \$30.00 - \$49.99     | \$2.00                                                                       | \$3.00 Generic/\$6.00 Brand**<br>\$50.00 per beneficiary per quarter maximum<br>\$2.00 Diabetic Supply                         |          |          |          |          |          |          | \$5.00   |
|                                                                                                                          |          | \$50.00 or more       | \$3.00                                                                       | \$3.00 Generic/\$6.00 Brand**<br>\$50.00 per beneficiary per quarter maximum<br>\$3.00 Diabetic Supply                         |          |          |          |          |          |          | \$7.00   |
| VScript                                                                                                                  | 150-175% | \$29.99 or Less       | \$2.00                                                                       |                                                                                                                                |          |          |          |          |          |          | \$3.00   |
|                                                                                                                          |          | \$30.00 - \$49.99     | \$4.00                                                                       |                                                                                                                                |          |          |          |          |          |          | \$5.00   |
|                                                                                                                          |          | \$50.00 or more       |                                                                              |                                                                                                                                |          |          |          |          |          |          | \$7.00   |
| VScript Expanded                                                                                                         | 175-225% | \$29.99 or Less       | 41.25%                                                                       | \$275.00 Deductible per beneficiary per SFY<br>41% coinsurance for maintenance drugs<br>\$2500.00 annual out-of-pocket maximum |          |          |          |          |          |          | \$3.00   |
|                                                                                                                          |          | \$30.00 - \$49.99     |                                                                              |                                                                                                                                |          |          |          |          |          |          | \$5.00   |
|                                                                                                                          |          | \$50.00 or more       |                                                                              |                                                                                                                                |          |          |          |          |          |          | \$7.00   |
| 11/1/2004                                                                                                                |          |                       |                                                                              |                                                                                                                                |          |          |          |          |          |          |          |
| VPharm 1                                                                                                                 | 0-150%   | \$29.99 or Less       | N/A                                                                          | N/A                                                                                                                            | N/A      | N/A      | N/A      | N/A      | N/A      | N/A      | \$3.00   |
|                                                                                                                          |          | \$30.00 - \$49.99     |                                                                              |                                                                                                                                |          |          |          |          |          |          | \$5.00   |
|                                                                                                                          |          | \$50.00 or more       |                                                                              |                                                                                                                                |          |          |          |          |          |          | \$7.00   |
| VPharm 2                                                                                                                 | 150-175% | \$29.99 or Less       | N/A                                                                          | N/A                                                                                                                            | N/A      | N/A      | N/A      | N/A      | N/A      | N/A      | \$3.00   |
|                                                                                                                          |          | \$30.00 - \$49.99     |                                                                              |                                                                                                                                |          |          |          |          |          |          | \$5.00   |
|                                                                                                                          |          | \$50.00 or more       |                                                                              |                                                                                                                                |          |          |          |          |          |          | \$7.00   |
| VPharm 3                                                                                                                 | 175-225% | \$29.99 or Less       | N/A                                                                          | N/A                                                                                                                            | N/A      | N/A      | N/A      | N/A      | N/A      | N/A      | \$3.00   |
|                                                                                                                          |          | \$30.00 - \$49.99     |                                                                              |                                                                                                                                |          |          |          |          |          |          | \$5.00   |
|                                                                                                                          |          | \$50.00 or more       |                                                                              |                                                                                                                                |          |          |          |          |          |          | \$7.00   |
| Effective 1/1/06                                                                                                         |          |                       |                                                                              |                                                                                                                                |          |          |          |          |          |          |          |

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

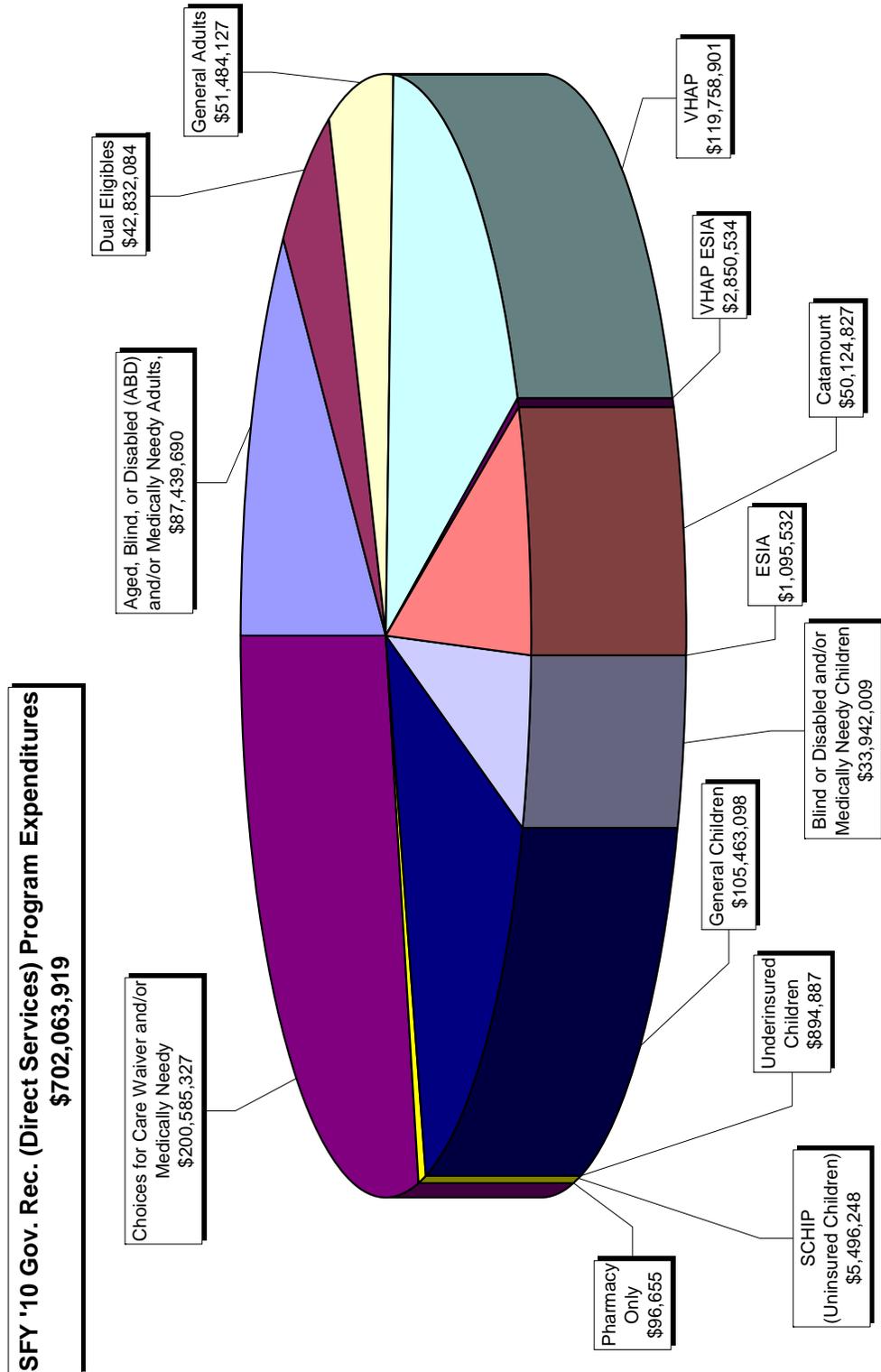
**Additional Hospital Tax Revenue Based on 5.5% Rate**

| <b>Summary of Hospital Medicaid Revenues and Assessments</b>     |                     |                      |                      |                      |                      |                      |                      |                      |
|------------------------------------------------------------------|---------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
|                                                                  | SFY '03 Actual      | SFY '04 Actual       | SFY '05 Actual       | SFY '06 Actual       | SFY '07 Actual       | SFY '08 Actual       | SFY '09 Estimated    | SFY '10 Estimated    |
| <b>Hospital Revenues</b>                                         |                     |                      |                      |                      |                      |                      |                      |                      |
| Total Medicaid Claims Payments*                                  | \$68,548,198        | \$85,124,155         | \$92,046,564         | \$95,785,122         | \$92,275,078         | \$94,545,356         | \$112,419,122        | \$116,197,504        |
| Rate Increases (Decreases)                                       | \$                  | 15,136,450           | \$                   | (11,500,000)         | \$                   | 2,000,000            | \$                   | 14,000,000           |
| Disproportionate Share Hospital (DSH) Revenues                   | \$28,868,690        | \$29,259,141         | \$34,793,164         | \$35,205,323         | \$59,377,729         | \$49,003,898         | \$35,648,781         | \$37,148,781         |
| <b>Total Hospital Medicaid Revenues</b>                          | <b>\$97,416,888</b> | <b>\$114,383,296</b> | <b>\$126,839,728</b> | <b>\$130,990,445</b> | <b>\$151,652,807</b> | <b>\$143,549,254</b> | <b>\$148,067,903</b> | <b>\$153,346,285</b> |
| <b>Provider Assessments</b>                                      |                     |                      |                      |                      |                      |                      |                      |                      |
| Provider Assessment Rate**                                       |                     |                      | 4.54%                | 6.00%                | 6.00%                | 5.75%                | 5.50%                | 5.50%                |
| <b>Total Provider Assessments***</b>                             | <b>\$27,618,690</b> | <b>\$38,781,885</b>  | <b>\$42,004,677</b>  | <b>\$55,512,789</b>  | <b>\$59,381,561</b>  | <b>\$61,686,261</b>  | <b>\$66,413,401</b>  | <b>\$74,273,957</b>  |
| <b>Assessments as a Percentage of Medicaid Hospital Revenues</b> | <b>28.35%</b>       | <b>33.91%</b>        | <b>33.12%</b>        | <b>42.38%</b>        | <b>39.16%</b>        | <b>42.97%</b>        | <b>44.85%</b>        | <b>48.44%</b>        |

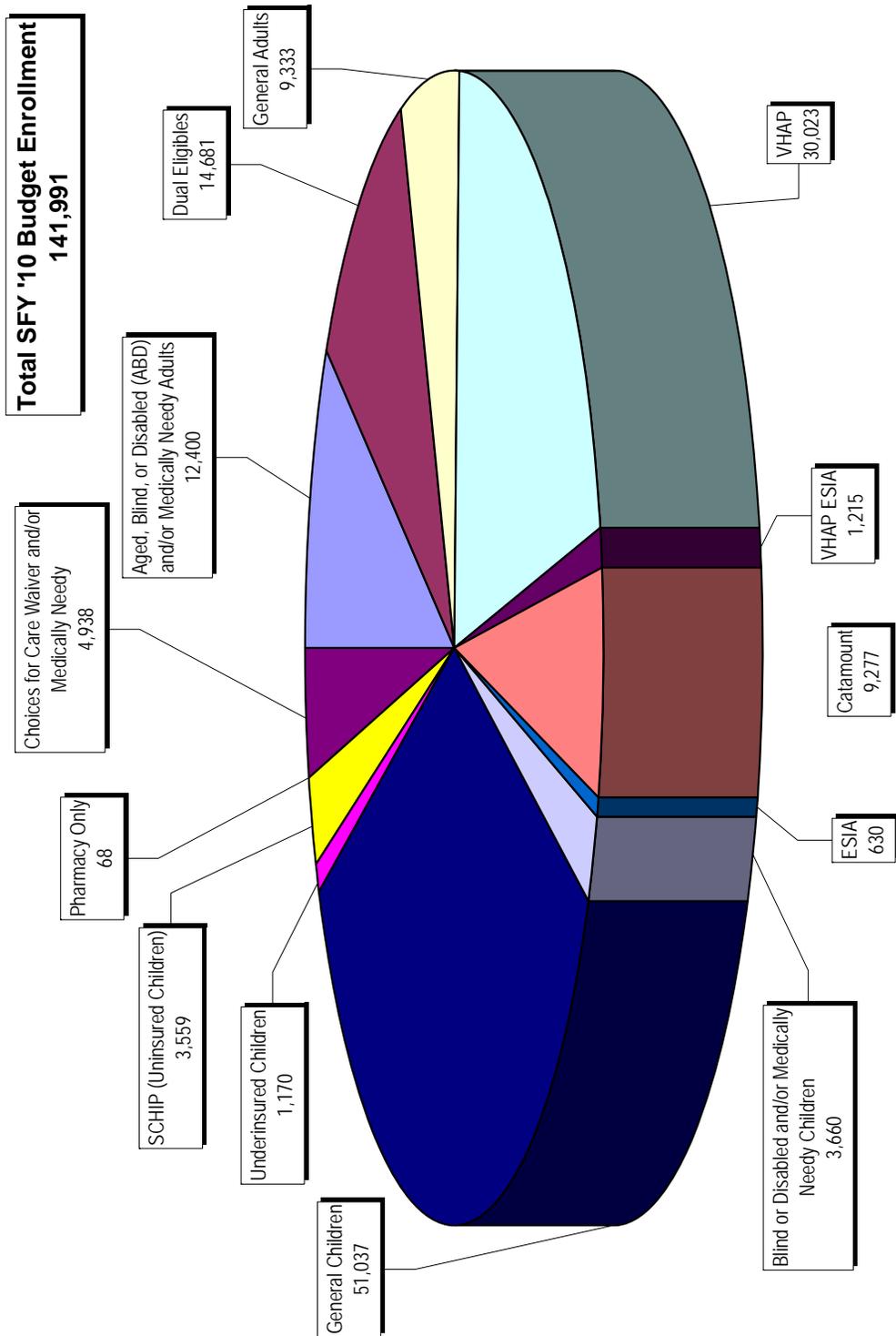
\*Inclusive of all Vermont Hospital Inpatient and Outpatient Hospital Medicaid Claims Payments

\*\*Assessment based on total hospital revenues

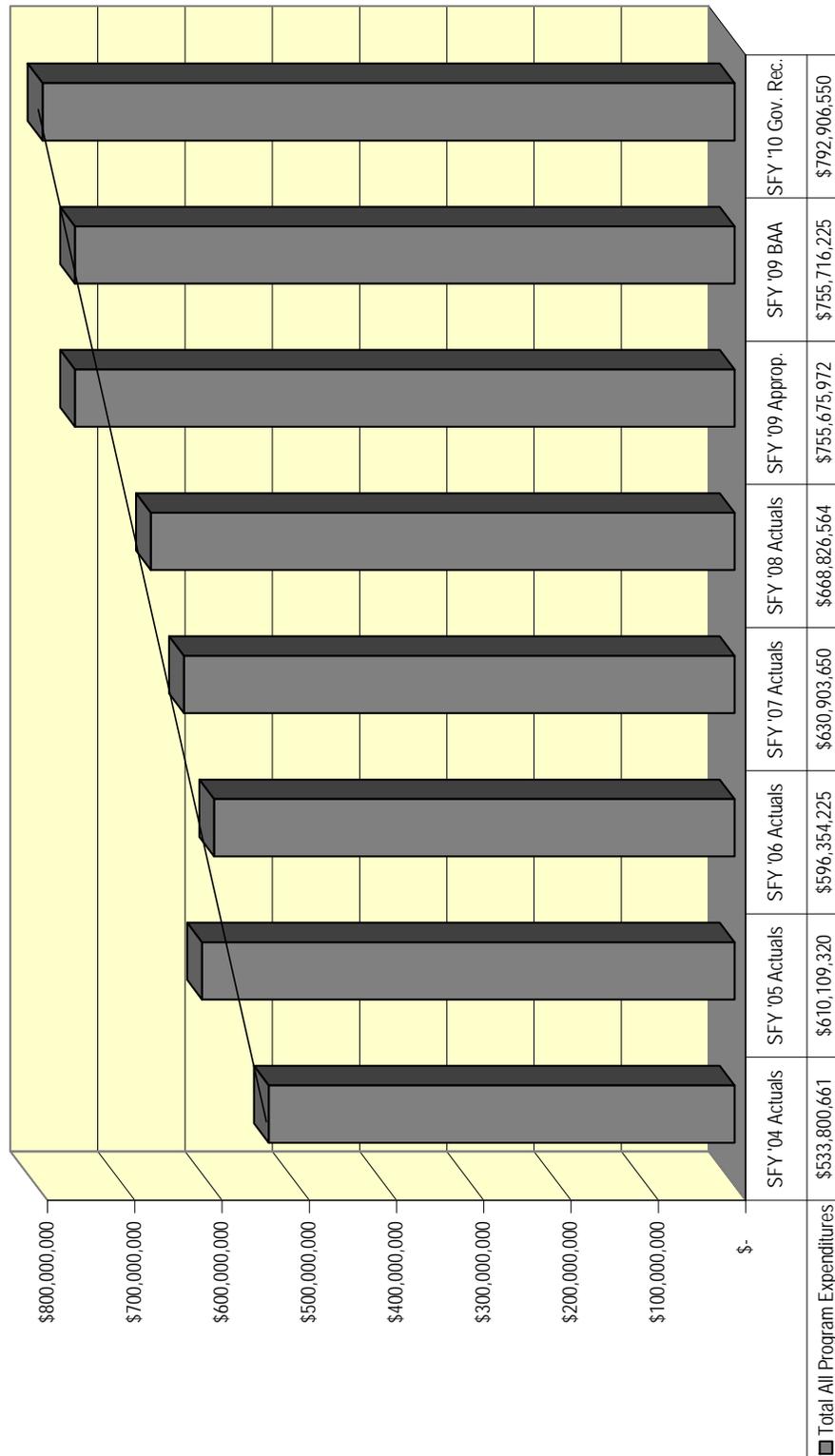
\*\*\*Provider Assessment does not include the State hospital or Brattleboro retreat

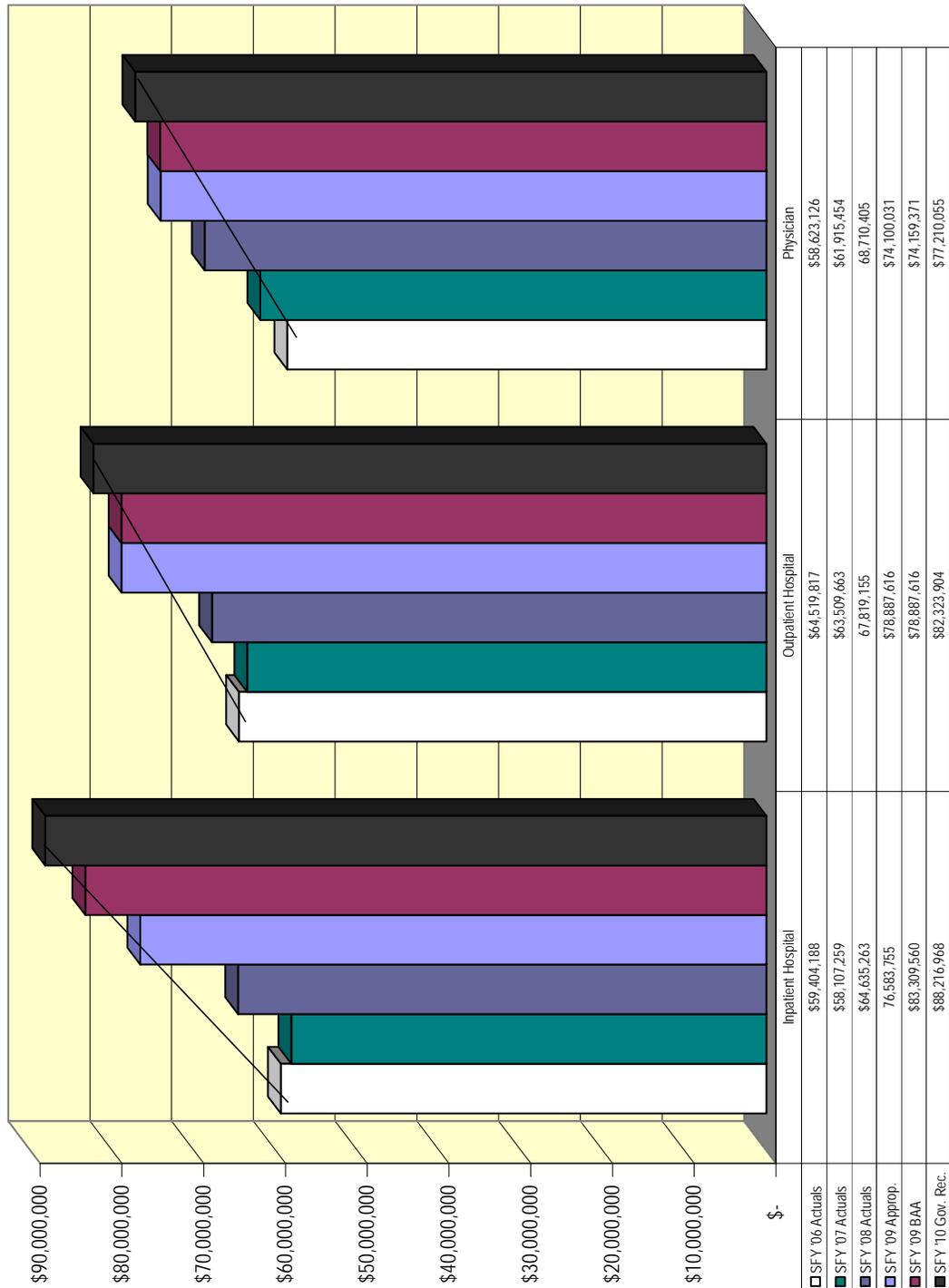
**Table 1: SFY'10 Governor's Recommend: Program Expenditures**


\*Excludes Miscellaneous Programs, see Insert 3

**Table 2: SFY '10 Governor's Recommend: Enrollment**


\*Excludes Miscellaneous Programs, see Insert 3

**Table 3: Total All Program Expenditures**


**Table 4: Inpatient Hospital, Outpatient Hospital & Physician Expenditures**


## Appendix 1: Acronyms

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

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

|             |                                                 |              |                                                                             |
|-------------|-------------------------------------------------|--------------|-----------------------------------------------------------------------------|
| 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                                                    |
| NDO .....   | Newport District Office                         | PRWORA...    | Personal Responsibility & Work Opportunity Reconciliation Act               |
| NEKCA.....  | Northeast Kingdom Community Action              | PSE.....     | Post-Secondary Education                                                    |
| NEMT        | Non-Emergency Medical Transportation            | QC.....      | Quality Control                                                             |
| NGA.....    | National Governors Association                  | QI .....     | Qualified Individual                                                        |
| NPA.....    | Non-Public Assistance                           | QIAC.....    | Quality Improvement Advisory Committee                                      |
| NPF .....   | National Provider File                          | QMB.....     | Qualified Medicare Beneficiary                                              |
| NPI .....   | National Provider Identifier                    |              |                                                                             |
| OADAP.....  | Office of Alcohol & Drug Abuse Programs         |              |                                                                             |

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

## Appendix 2: Federal Poverty Level (FPL) Guidelines January 1, 2009 to December 31, 2009

| 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 |         |

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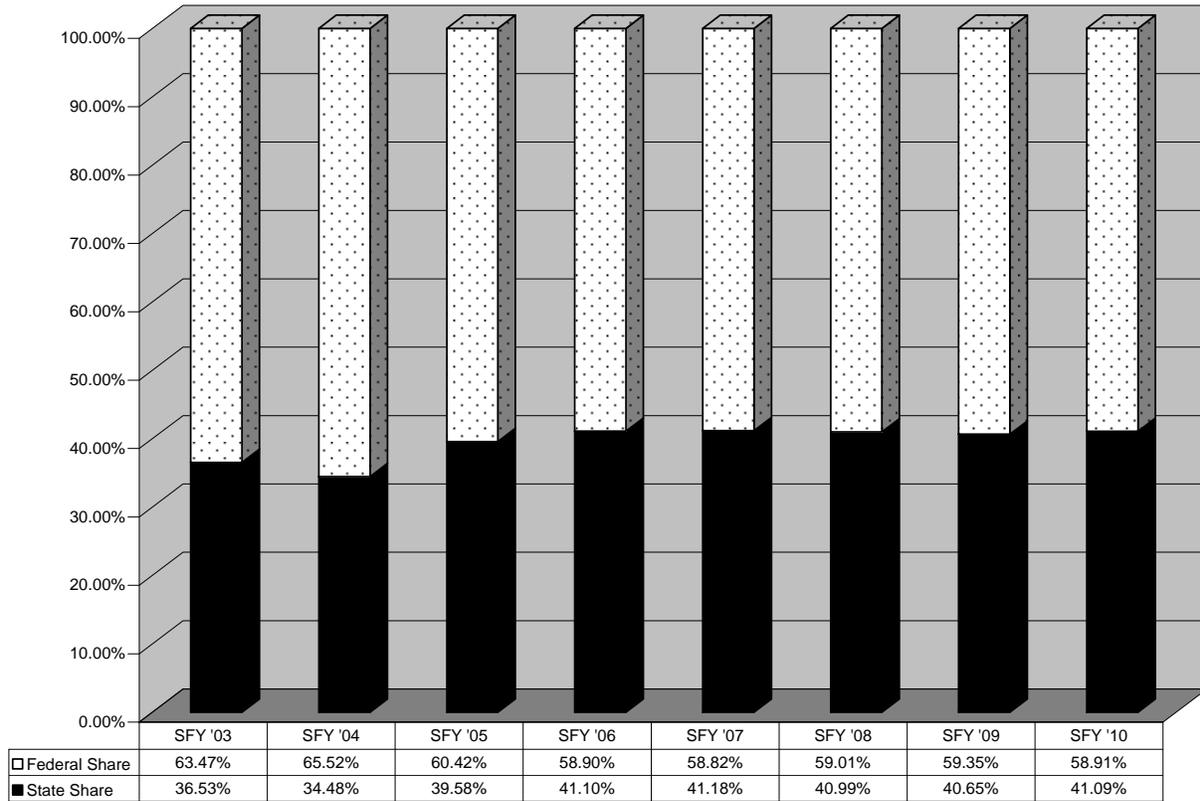
**Appendix 3: Federal Match Rates**
**Title XIX / Medicaid (program) & Title IV-E / Foster Care (program):**

| <u>Federal Fiscal Year</u>                                 |                 |                 |                      |                    | <u>State Fiscal Year</u>            |             |           |                      |                    |        |
|------------------------------------------------------------|-----------------|-----------------|----------------------|--------------------|-------------------------------------|-------------|-----------|----------------------|--------------------|--------|
| <u>FFY</u>                                                 | <u>From</u>     | <u>To</u>       | <u>Federal Share</u> | <u>State Share</u> | <u>SFY</u>                          | <u>From</u> | <u>To</u> | <u>Federal Share</u> | <u>State Share</u> |        |
| 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                                              | <b>04/01/03</b> | <b>09/30/03</b> | <b>66.01%</b>        | <b>33.99%</b>      | 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                                              | <b>10/01/03</b> | <b>06/30/04</b> | <b>65.36%</b>        | <b>34.64%</b>      | 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%               | 39.89%             | 2005                                | 7/1/2004    | 6/30/2005 | 60.42%               | 39.58%             |        |
| 2006                                                       | 10/01/05        | 09/30/06        | 58.49%               | 41.51%             | 2006                                | 7/1/2005    | 6/30/2006 | 58.90%               | 41.10%             |        |
| 2007                                                       | 10/01/06        | 09/30/07        | 58.93%               | 41.07%             | 2007                                | 7/1/2006    | 6/30/2007 | 58.82%               | 41.18%             |        |
| 2008                                                       | 10/01/07        | 09/30/08        | 59.03%               | 40.97%             | 2008                                | 7/1/2007    | 6/30/2008 | 59.01%               | 40.99%             |        |
| 2009                                                       | 10/01/08        | 09/30/09        | 59.45%               | 40.55%             | 2009                                | 7/1/2008    | 6/30/2009 | 59.35%               | 40.65%             |        |
| 2010                                                       | 10/01/09        | 09/30/10        | 58.73%               | 41.27%             | 2010                                | 7/1/2009    | 6/30/2010 | 58.91%               | 41.09%             |        |
| <i>projected FMAP rate</i>                                 |                 |                 |                      |                    | <i>based on projected FMAP rate</i> |             |           |                      |                    |        |

**Title XXI / SCHIP (program & admin):**

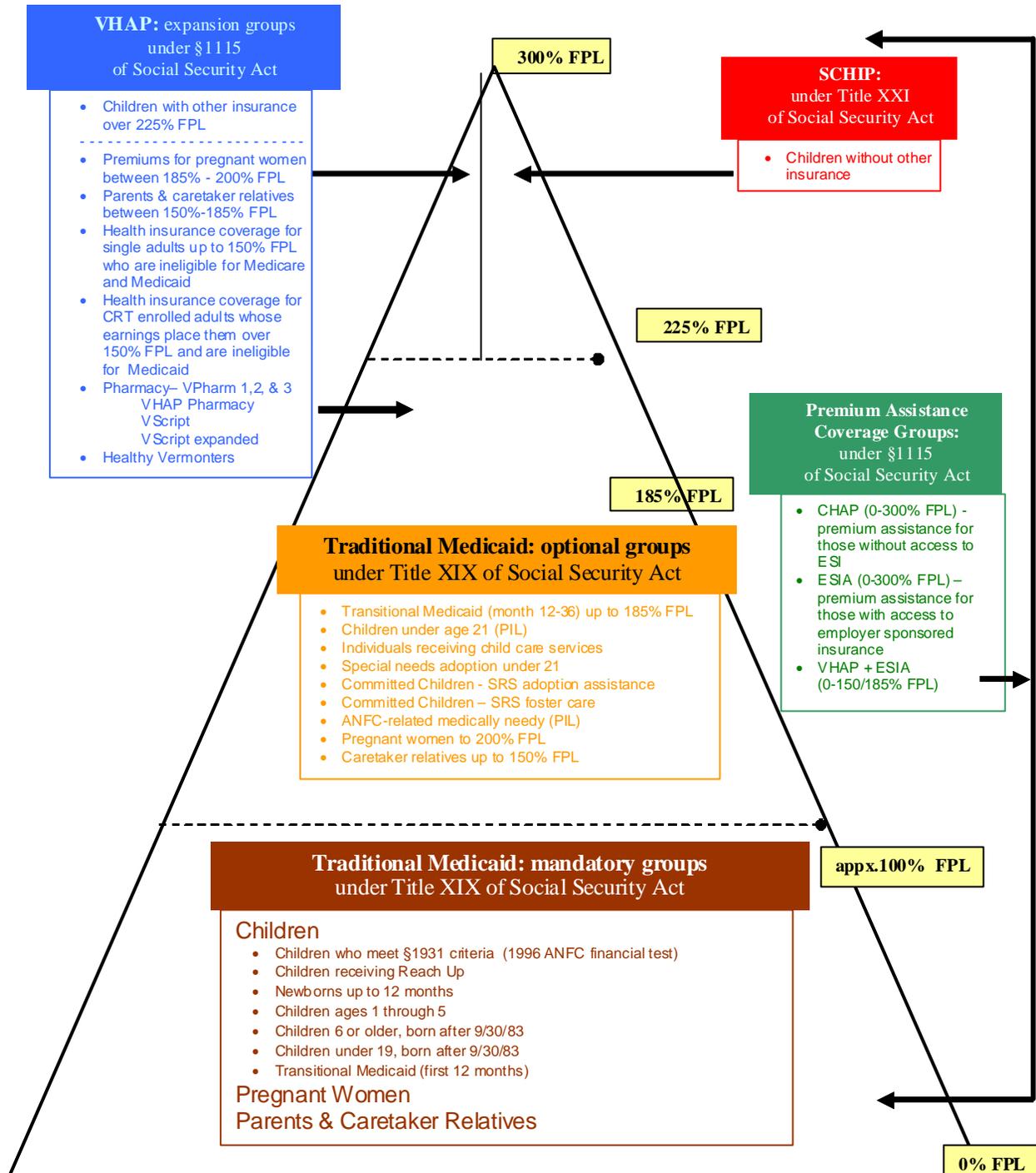
| <u>Federal Fiscal Year</u> |             |           |                      |                    | <u>State Fiscal Year</u>        |             |           |                      |                    |
|----------------------------|-------------|-----------|----------------------|--------------------|---------------------------------|-------------|-----------|----------------------|--------------------|
| <u>FFY</u>                 | <u>From</u> | <u>To</u> | <u>Federal Share</u> | <u>State Share</u> | <u>SFY</u>                      | <u>From</u> | <u>To</u> | <u>Federal Share</u> | <u>State Share</u> |
| 1999                       | 10/01/98    | 09/30/99  | 73.38%               | 26.62%             | 1999                            | 07/01/98    | 06/30/99  | 73.38%               | 26.62%             |
| 2000                       | 10/01/99    | 09/30/00  | 73.57%               | 26.43%             | 2000                            | 07/01/99    | 06/30/00  | 73.52%               | 26.48%             |
| 2001                       | 10/01/00    | 09/30/01  | 73.68%               | 26.32%             | 2001                            | 07/01/00    | 06/30/01  | 73.65%               | 26.35%             |
| 2002                       | 10/01/01    | 09/30/02  | 74.14%               | 25.86%             | 2002                            | 07/01/01    | 06/30/02  | 74.03%               | 25.97%             |
| 2003                       | 10/01/02    | 09/30/03  | 73.69%               | 26.31%             | 2003                            | 07/01/02    | 06/30/03  | 73.80%               | 26.20%             |
| 2004                       | 10/01/03    | 09/30/04  | 72.94%               | 27.06%             | 2004                            | 07/01/03    | 06/30/04  | 73.13%               | 26.87%             |
| 2005                       | 10/01/04    | 09/30/05  | 72.08%               | 27.92%             | 2005                            | 07/01/04    | 06/30/05  | 72.30%               | 27.71%             |
| 2006                       | 10/01/05    | 09/30/06  | 70.94%               | 29.06%             | 2006                            | 07/01/05    | 06/30/06  | 71.23%               | 28.78%             |
| 2007                       | 10/01/06    | 09/30/07  | 71.25%               | 28.75%             | 2007                            | 07/01/06    | 06/30/07  | 71.17%               | 28.83%             |
| 2008                       | 10/01/07    | 09/30/08  | 71.32%               | 28.68%             | 2008                            | 07/01/07    | 06/30/08  | 71.30%               | 28.70%             |
| 2009                       | 10/01/08    | 09/30/09  | 71.62%               | 28.38%             | 2009                            | 07/01/08    | 06/30/09  | 71.55%               | 28.46%             |
| 2010                       | 10/01/09    | 09/30/10  | 71.11%               | 28.89%             | 2010                            | 07/01/09    | 06/30/10  | 71.24%               | 28.76%             |
| <i>Projected EFMAP</i>     |             |           |                      |                    | <i>based on projected EFMAP</i> |             |           |                      |                    |

### Appendix 3: Federal Match Rates – Vermont Specific



## Appendix 4: Medicaid Coverage Groups for Children and Families

### “ANFC-Related” Medicaid: Global Commitment Coverage groups for children and families\*



**“SSI-related” Medicaid: Global Commitment & Choices for Care Coverage Groups for Aged, Blind and Disabled\***
**MEDICAID EXPANSION GROUPS**
**Section 1915(c) Waivers**

- ❖ Traumatic Brain Injury
- ❖ Kids Mental Health
- ❖ Developmentally Disabled

**Section 1115 Waivers**
**Pharmacy**

- ❖ VPharm 1, 2, & 3
- ❖ VHAP Pharmacy
- ❖ VScript
- ❖ VScript expanded

**Choices for Care**

- ❖ Nursing Home
- ❖ Enhanced Residential Care
- ❖ Home-based care

**TRADITIONAL MEDICAID - OPTIONAL GROUPS**

- ❖ 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))

**TRADITIONAL MEDICAID – MANDATORY GROUPS**

- ❖ SSI cash recipients
- ❖ Individuals receiving state supplemental payments (AABD)
- ❖ Disabled children eligible under §4913
- ❖ Disabled adult children
- ❖ Qualified Medicare Beneficiaries (QMB)
- ❖ Specified Low-Income Medicare Beneficiaries (SLMB)
- ❖ Qualified Individuals (QI-1)
- ❖ Qualified Disabled Working Individuals (QDWI)
- ❖ 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

\* This is only a tool for general discussion and not a complete or exhaustive list of coverage groups.  
 Prepared by Marybeth McCaffrey, Esq., Economic Services Division, DCF – January 14, 2009

## MEMORANDUM

**TO:** Senator Kevin Mullin

**CC:** Cynthia D. LaWare, Secretary, Agency of Human Services  
Susan W. Besio, Ph.D., Director of Health Care Reform Implementation  
Joshua Slen, Director, Office of Vermont Health Access

**FROM:** Betsy Forrest, OVHA Health Care Affordability Director

**DATE:** April 16, 2008

**RE:** Premium assistance income computation

Susan Besio asked me to answer a question you raised during Senate Health and Welfare Committee discussion on April 15 concerning the computation of income for young adults who live with their parents and apply for health care assistance.

Young adults under the age of 21 who are living with their parents are included in their parents' household for purposes of determining income eligibility for VHAP and premium assistance. The income of the young adult and his parent(s) are combined and compared against the income limit for a household of that size. Young adults age 21 and older are considered to be a household of one (parents' income is not included).

Periodically legislators and others ask whether household composition rules should be changed to regard young adults (18 to 20 years old) as their own household. The Department for Children and Families considered this issue as recently as last fall and concluded that while it would help young adults with little or no income, it would actually harm some families by rendering the parents or younger siblings ineligible, since removing the young adult would reduce the household size and the maximum income limit.

For example, if a young adult lives with his two parents and younger sibling, they are considered to be a household of four. If their total household income is just under 185% of the federal poverty level, the adults are eligible for VHAP and the younger sibling is eligible for Dr. Dynasaur. If the adult child were removed from the parents' household, the parents and younger sibling would then be a household of three and may exceed the income limit for a household of three, thus causing the parents to lose their VHAP eligibility. Because of the uncertainty around how many people would be helped vs. harmed by a change in the household composition rule, the original rule remains in place.

I understand that one of your constituents believes he or she received incorrect information from our Member Services unit on young adults and household composition. I will speak with the supervisor of the Member Services unit to ensure that any misunderstanding of this policy is corrected.

Please let me know if you have further questions.

**M E M O R A N D U M**

**TO:** Senator Jane Kitchel  
 Representative Martha Heath  
 Representative Steve Maier

**FROM:** Betsy Forrest

**DATE:** May 15, 2008

**RE:** Income disregard for Catamount Health and Employer-Sponsored Insurance premium assistance

Section 5.203.2 of H.891, the SFY 09 budget bill, authorizes the Agency of Human Services to implement, using an expedited rulemaking process, income disregards when determining premium contributions for Catamount Health premium assistance (CHAP) and Employer-Sponsored Insurance premium assistance (ESIA).

Susan Besio and Joshua Slen requested that I brief you on the Agency’s proposed rule to implement a \$400-per-month earned income disregard for certain individuals and families who qualify for premium assistance. The Agency (DCF and OVHA) will be presenting the rule to the Legislative Committee on Administrative Rules sometime in June for a July 1 implementation date. Since some low-income advocates have expressed concern that the application of the income disregard will be limited to earned income, we wanted to present our rationale and request your support for this approach. Joshua Slen and I would be happy to arrange a conference call with you if you have questions or concerns about the proposed approach.

**Proposed implementation of the income disregard**

The Agency is proposing to implement a \$400-per-month earned income disregard when computing premium payments for CHAP and ESIA beneficiaries with income between 200% and 300% of the Federal Poverty Level. The \$400 figure was derived by calculating the payroll deductions for two- and three-person families at 250% FPL, the midpoint of the range. The chart below contains those calculations.

**Income at 250% of FPL**

| <b>Category</b>                 | <b>2-person household<br/>(includes one child)</b> | <b>3-person household<br/>(includes one child)</b> | <b>Average of 2- and<br/>3-person household</b> |
|---------------------------------|----------------------------------------------------|----------------------------------------------------|-------------------------------------------------|
| Income                          | \$34,225                                           | \$42,925                                           |                                                 |
| Federal Tax                     | \$2,474                                            | \$2,654                                            | \$2,564                                         |
| State Tax                       | \$730                                              | \$809                                              | \$770                                           |
| FICA (7.65%)                    | \$2,618                                            | \$3,284                                            | \$2,951                                         |
| <b>Total per month<br/>cost</b> | \$485                                              | \$562                                              | \$524                                           |

The income determination process for health care assistance programs such as VHAP and Dr. Dynasaur, and now premium assistance, already employs a \$90-per-month-per-adult-earner disregard. The \$90 figure has not been updated for many years, and obviously is not adequate to cover actual withholdings for higher-income families. The additional \$400 disregard, in conjunction with the existing \$90, will bring family income closer to actual net income, which is the income families presumably have available to pay health care premiums.

Since both the existing \$90 disregard and the proposed additional \$400 disregard are intended to offset payroll deductions, the Agency is not proposing to apply the disregards to families whose only income is unearned income.

### **How the disregard is applied**

The additional \$400 disregard will be applied to earned income only after the individual or family has been found to qualify for premium assistance based on gross income minus the \$90 disregard (and child care expenses if applicable). The \$400 disregard, therefore, does not affect a family's eligibility for premium assistance; rather, it reduces the premium liability once the family is determined to be eligible.

#### **Example:**

A 2-person family (mother and child) has gross earned income of \$2915 per month. After application of the \$90 disregard, the family's income is \$2825, which is 241% FPL. Since the family is between 200% and 300% FPL, the additional \$400 disregard is applied, which brings income down to \$2425, or 207% FPL. Without the \$400 disregard, this family would have been subject to a CHAP or ESIA premium of \$135 per month. With the disregard, the family pays only \$110 per month.

In the above example, if the family's gross earned income had been \$3800, the family would not have been eligible for CHAP or ESIA, since \$3800 minus \$90 is 317% FPL. The additional \$400 disregard is not applied unless the family's income is below 300% before the \$400 deduction.

The attached draft chart, which Nolan Langweil and I worked on together, shows the potential impact of the \$400 income disregard on premium levels for families of various sizes and income levels.

### **Conclusion**

We believe that the \$400 earned income disregard is defensible based on our analysis of actual payroll deductions for an average family in the 200-300% FPL range. We do not believe we have a defensible basis for extending the disregard to families whose only income is unearned. Furthermore, although we do not have data to support this assumption, we believe the vast majority of families within this income range have earned income, since unearned income alone (e.g., unemployment benefits or Social Security income) would not likely push the family above 200%.

We would appreciate your input and support on our proposed approach to implementing the earned income disregard. Thanks very much.

**Catamount Health and Employer-Sponsored Insurance Premium Assistance:**

Examples of possible income disregard impacts

(NOTE: This chart is not meant to help determine eligibility. Rather it is designed to present possible scenarios).

| Family Size*** | The monthly premium per adult <u>MAY</u> be:* | Examples of gross monthly earned & unearned income |              |              |              |
|----------------|-----------------------------------------------|----------------------------------------------------|--------------|--------------|--------------|
|                |                                               | % of FPL **                                        |              |              |              |
|                |                                               | 201-225%                                           | 226-250%     | 251-275%     | 276-300%     |
|                | <b>Current Premium FY08</b>                   | <b>\$90</b>                                        | <b>\$110</b> | <b>\$125</b> | <b>\$135</b> |
|                | <b>New Premiums FY09</b>                      | <b>\$110</b>                                       | <b>\$135</b> | <b>\$160</b> | <b>\$185</b> |
| <b>1</b>       | Monthly Income                                | \$1,900                                            | \$2,150      | \$2,300      | \$2,600      |
| 1 wage earner  | Without Income Disregards                     | \$110                                              | \$135        | \$160        | \$185        |
|                | <i>With Income Disregards</i>                 | \$60                                               | \$65         | \$110        | \$135        |
| <b>2</b>       | Monthly Income                                | \$2,550                                            | \$2,850      | \$3,150      | \$3,450      |
| 1 wage earner  | Without Income Disregards                     | \$110                                              | \$135        | \$160        | \$185        |
|                | <i>With Income Disregards</i>                 | \$65                                               | \$110        | \$135        | \$160        |
| 2 wage earners | Without Income Disregards                     | \$110                                              | \$135        | \$160        | \$185        |
|                | <i>With Income Disregards</i>                 | \$60                                               | \$65         | \$110        | \$135        |
| <b>3</b>       | Monthly Income                                | \$3,150                                            | \$3,500      | \$3,850      | \$4,250      |
| 1 wage earner  | Without Income Disregards                     | \$110                                              | \$135        | \$160        | \$185        |
|                | <i>With Income Disregards</i>                 | \$65                                               | \$110        | \$135        | \$160        |
| 2 wage earners | Without Income Disregards                     | \$110                                              | \$135        | \$160        | \$185        |
|                | <i>With Income Disregards</i>                 | \$60                                               | \$65         | \$110        | \$135        |
| <b>4</b>       | Monthly Income                                | \$3,650                                            | \$4,200      | \$4,650      | \$5,100      |
| 1 wage earner  | Without Income Disregards                     | \$110                                              | \$135        | \$160        | \$185        |
|                | <i>With Income Disregards</i>                 | \$65                                               | \$110        | \$135        | \$160        |
| 2 wage earners | Without Income Disregards                     | \$110                                              | \$135        | \$160        | \$185        |
|                | <i>With Income Disregards</i>                 | \$60                                               | \$110        | \$135        | \$160        |
| <b>5</b>       | Monthly Income                                | \$4,200                                            | \$4,900      | \$5,400      | \$5,750      |
| 1 wage earner  | Without Income Disregards                     | \$110                                              | \$135        | \$160        | \$185        |
|                | <i>With Income Disregards</i>                 | \$65                                               | \$110        | \$135        | \$160        |
| 2 wage earners | Without Income Disregards                     | \$110                                              | \$135        | \$160        | \$185        |
|                | <i>With Income Disregards</i>                 | \$60                                               | \$110        | \$135        | \$135        |

\* This does not include deductions for child care, which are currently up to \$200 per child under 2 years old and up to \$175 per child age 2 or older.

\*\* Only those between 200-300% FPL will get the \$400 income disregard. However, everyone does get the \$90 income disregard.

\*\*\* One wage earner households = \$400+\$90=\$490. Two wage earner households = \$400+\$90+\$90=\$580. Again, this does not include child care deductions, which could reduce the gross income further.

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## MEMORANDUM

**TO:** Sharon Gutwin, PT

**CC:** Senator White, Chair, Senate Government Operations Committee  
Cynthia D. LaWare, AHS Secretary  
Joshua Slen, OVHA Director  
Tim Tourville, MEd, ATC;  
Michael Landsberg, ATC, CSCS, PES

**FROM:** Lori Collins, Deputy Director

**DATE:** October 29, 2008

**RE:** Medicaid and Act 141, An Act Relating to Health Insurance Plan Coverage for Athletic Trainer Services

The Office of Vermont Health Access (OVHA) has received inquiries from athletic trainers who point to Act 141 (An Act Relating to Health Insurance Plan Coverage for Athletic Trainer Services) as a basis for enrolling athletic trainers as Medicaid providers. However, the definition of insurer in Act 141 references 18 V.S.A. § 9402(8). This statutory definition does not include Medicaid as a “health insurer.” It is well settled in the law that, in the absence of clear and explicit language that requires Medicaid to enroll a particular type of provider, statutes that refer to “health insurer” do not apply to the state Medicaid program.

In a related issue regarding Medicaid enrollment of providers, Naturopaths were the subject of 2007 Act 59 (Health Insurance Plan Reimbursement for Covered Services Provided by Naturopathic Physicians). There, like here, the initial legislation did not specifically refer either to OVHA or its health care programs. Additional legislation was required to include Medicaid in the enrollment of Naturopaths. Act 88 was passed to clarify the legislative intent of including Medicaid in the provision.

Legislative action on the Athletic Trainer bill, which was confined to the Senate Government Operations Committee, did not include a request for testimony from the Office of Vermont Health Access regarding the potential impact to Medicaid services or resources.

If Athletic Trainers were to be enrolled as Medicaid providers, resources would be required to define and accomplish program edits for the definition of allowable codes, and to assure the correct processing of claims in accordance with cost-effectiveness, clinical efficiency and scope-of-practice standards. The budgetary impact of these required resources are yet to be determined.

To summarize, Act 141 does not require the Office of Vermont Health Access to enroll Athletic Trainers as providers. An amendment to the legislative language is needed to specify the intent to include Medicaid in the provision.

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State of Vermont  
Agency of Human Services  
Office of the Secretary  
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Robert D. Hofmann, Secretary

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## MEMORANDUM

**TO:** Senate Appropriations Committee  
House Appropriations Committee

**FROM:** Robert D. Hofmann, AHS Secretary *Robert D. Hofmann*  
Susan Besio, OVHA Director *SB besio*

**DATE:** December 15, 2008

**RE:** Act 192 Sec. 5.203 Health Care Charitable Initiative Partnership

The Vermont Legislature passed the SFY 2009 Budget Act with the following directions to the Agency of Human Services:

Act 192 Sec. 5.203. Health Care Charitable Initiative Partnership

- (a) The agency of human services shall analyze the potential to create a charitable initiative in partnership with hospitals to assist Vermonters who are uninsured and/or underinsured. Elements to include in this analysis are enumerated in subsection (b) below. The agency shall report to the house and senate committees on appropriations on or before December 15, 2008.
- (b) Elements of a health care charitable initiative partnership shall include but are not limited to the following:
  - (1) Hospitals, other institutions, and individuals making voluntary contributions to a state special fund.
  - (2) The monies in the special fund being used to provide grants to support initiatives meeting one of the following criteria provided for in number 57 of the amended Special Terms and Conditions for Global Commitment to Health Section 1115 Medicaid Waiver ("Global Commitment");
    - (A) Reducing the rate of uninsured and/or underinsured in Vermont;
    - (B) Increasing the access of quality health care to uninsured;
    - (C) Providing public health approaches to improve the health outcomes and the quality of life for Medicaid-eligible individuals in Vermont; and
    - (D) Encouraging the formation and maintenance of public-private partnerships in health care.
  - (3) Creating a process to provide grants meeting the criteria in subdivision (2) of this subsection involving contributors to the special fund in the grant process.
  - (4) To the extent allowed under Global Commitment, matching monies in the state special funds with federal funds.

The Agency of Human Services analyzed whether creation of the Health Care Charitable Initiative Partnership (HCCIP) is permissible under federal laws and regulations. The Agency believes that creation of the HCCIP is not permissible under federal laws and regulations that restrict voluntary contributions from health care providers, as described by the following federal restrictions:

## **Federal Restrictions on Provider-Related Donations**

In response to growing concern that states were using provider donations and taxes to increase the federal share that supports Medicaid programs, Congress passed the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234). This legislation essentially banned voluntary contributions as a Medicaid funding source.

Permissible contributions are limited to those classified as “bona fide” donations. A bona fide donation must have no direct or indirect relationship to Medicaid payments made to the health care provider, a related entity or other providers furnishing the same class of services. A direct or indirect relationship exists if:

1. the amount of payment received (other than under Title XIX) is positively correlated to the donation;
2. all or a portion of the Medicaid payment made to the provider or provider class varies based on the amount of donation received; or
3. the unit of government receiving the donation provides for any payment, offset or waiver that guarantees the return of any portion of the donation

Because the amount of contributions paid into the HCCIP special fund would be directly or indirectly related to payments made from the special fund to the provider or provider class, the Agency believes that contributions would not meet the definition of bona fide donations. When the Centers for Medicare and Medicaid Services (CMS) makes a finding that a provider-related donation is not bona fide, CMS reduces the total amount of Medicaid expenditures prior to calculating the Federal Financial Participation amount.<sup>1</sup>

In addition to its review of federal laws and regulations, the Agency contacted CMS to inquire whether donations could be used as state match. The CMS Associate Regional Administrator indicated that use of donations as state match would present a problem. The table on the following page provides the Agency’s findings as it relates to each of the four elements specified in the Act regarding the Health Care Charitable Initiative Partnership (HCCIP).

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<sup>1</sup> The regulations (42 CFR 433.54) provide that CMS will presume a donation to be “bona fide” if the amount of voluntary contribution made by or on behalf of a health care organization does not exceed \$50,000 per year. However, these contributions would not be considered bona fide if there is a direct or indirect relationship between the contribution and payments made to the provider or class of providers.

| <b>Element</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <b>AHS Findings</b>                                                                                                                                                                                                                         |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| (1) Hospitals, other institutions, and individuals making voluntary contributions to a state special fund.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Contributions would be permissible if there is no direct or indirect relationship between the contributions to the special fund and payments made from the fund.                                                                            |
| (2) The monies in the special fund being used to provide grants to support initiatives meeting one of the following criteria provided for in number 57 of the amended Special Terms and Conditions for Global Commitment to Health Section 1115 Medicaid Waiver (“Global Commitment”);<br>(A) Reducing the rate of uninsured and/or underinsured in Vermont;<br>(B) Increasing the access of quality health care to uninsured;<br>(C) Providing public health approaches to improve the health outcomes and the quality of life for Medicaid-eligible individuals in Vermont; and<br>(D) Encouraging the formation and maintenance of public-private partnerships in health care. | Monies in the fund could not be used to make payments to the any contributing providers or the provider class (e.g., any hospital) if the total amount of payments made is dependent on amount of voluntary contributions made to the fund. |
| (3) Creating a process to provide grants meeting the criteria in subdivision (2) of this subsection involving contributors to the special fund in the grant process.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | A process could be established that involves contributors to the fund, provided no payments from the fund are made to a contributing provider or the provider class.                                                                        |
| (4) To the extent allowed under Global Commitment, matching monies in the state special funds with federal funds.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Matching funds only would be available for special fund contributions that meet the definition of bona fide donations.                                                                                                                      |

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Memo to: House Committee on Human Services  
House Committee on Health Care  
Senate Committee on Health and Welfare

From: Susan Besio, Ph. D., Director, Office of Vermont Health Access  
Joan Senecal, Commissioner, Department of Disabilities, Aging and Independent Living

Re: Medicaid MCO Legislative Grievance and Appeal Report: July 1, 2008 – December 31, 2008  
Choices for Care Appeal Report: July 1, 2008 – December 31, 2008

Date: January 30, 2009

The Office of Vermont Health Access became the first state-wide publically run Managed Care Organization (MCO) under the Global Commitment to Health waiver. The Grievance and Appeal process is a federal requirement under MCO regulations [42 C.F.R. 438.408]. In addition, the Choices for Care (CFC) program, operated within DAIL, utilizes the MCO Grievance and Appeals database to track appeals, bringing all public health care programs into alignment with one standard process. Following the direction of Act 65 of the 2007 legislative session, AHS is pleased to present to you our third semi-annual report on the implementation of the Grievance and Appeal process.

Act 65, Sec. 111a. Global Commitment; Grievance And Appeal Rules: Beginning July 1, 2008 and every six months thereafter, the secretary of the agency of human services or designee shall report on the implementation of the grievance and appeal rules for Global Commitment for health and for Choices for Care, including the number and types of grievances, internal appeals, and appeals to the human services board, and the number of internal appeals that were reversed by the independent decision-maker.

The MCO is composed of various administrative areas within the Agency of Human Services (AHS). These include: the Office of Vermont Health Access (OVHA), the Department of Mental Health (DMH), the Department of Disabilities, Aging and Independent Living (DAIL), and the Department of Health (VDH). Also included in the MCO are the Designated Agencies (DA) and Specialized Service Agencies (SSA) that provide service authorizations for DMH and DAIL. Each entity has at least one assigned grievance and appeal coordinator who enters data into the MCO database. This report is based on data compiled from the centralized database as of January 12, 2009.

Grievances: A grievance is an expression of dissatisfaction about any matter that is not an action taken by the MCO. It includes a request for a written response.

During this report period (July 1, 2008 – December 31, 2008), there were 16 grievances filed with the MCO. The grievance and appeal coordinator analyzes the content of each grievance and categorizes each grievance into one or more topic areas. Again, approximately half of these grievances related to quality of service. The breakdown of topic areas is in the attached data summary.

The DAIL Choices for Care program does not have a grievance component.

- Appeals: Medicaid rule M180.1 defines actions that an MCO entity makes that are subject to an internal appeal. These actions are:
1. denial or limitation of authorization of a requested covered service or eligibility for service, including the type, scope or level of service;
  2. reduction, suspension or termination of a previously authorized covered service or a service plan;
  3. denial, in whole or in part, of payment for a covered service;
  4. failure to provide a clinically indicated, covered service, when the MCO provider is a DA/SSA;
  5. failure to act in a timely manner when required by state rule;
  6. denial of a beneficiary's request to obtain covered services outside the network.

During this report period (July 1, 2008 – December 31, 2008), there were 58 appeals filed with the MCO. Twelve of these cases requested an expedited appeal and all of them were denied because they did not meet expedited criteria. They were all processed as regular appeals. Of the 58 appeals, 49 were resolved within this reporting period (84%). In 32 cases (65% of those resolved), the original decision was upheld by the hearing officer. There were eight cases reversed (16%), no cases were modified from the original decision, three were withdrawn (6%), six were approved as a result of the information received prior to or at the appeal meeting (12%), and there were no cases closed because the person filing the appeal was not authorized by the beneficiary. There was an increase in the number of MCO appeals that can be partially attributed to changes in prior authorization requirements for specific prescription medications.

As each appeal was received, the grievance and appeal coordinator assigned it to an action category that related to the content of the appeal. There were 48 appeals for a denial or limitation of authorization of a requested service or eligibility for service (89%), nine were for a reduction/suspension/termination of a previously authorized covered service or service plan (16%), and one case has not had its category entered yet (2%).

At the end of the last report period (January 1, 2008 – June 30, 2008), there were seven appeals pending. Five of them (71%) were resolved in this reporting period. In one case (20%) the original decision was upheld by the hearing officer, one case (20%) was reversed, three (60%) were modified from the original decision, and none were withdrawn.

During this report period (July 1, 2008 – December 31, 2008), there were 25 appeals filed in the Choices for Care program. There were no requests for an expedited appeal. Of those 25 appeals, nine have been resolved within this reporting period. In seven cases (78%), the original decision was upheld by the hearing officer. There were no cases reversed, none were modified from the original decision, and two were withdrawn (22%). The Choices for Care program also assigns one of the MCO action categories to each appeal, bringing all public health care programs into alignment with one standard process. Of the 25 appeals, 13 were for a denial or limitation of authorization of a requested service or eligibility for service (52%), and 12 were for a reduction/suspension/termination of a previously authorized covered service or service plan (48%).

At the end of the last report period (January 1, 2008 – June 31, 2008), there were seven appeals left pending for CFC, and six were resolved within this reporting period. In four cases (66%), the original decision was upheld by the hearing officer. There was one case reversed (17%), none were modified from the original decision, and one was withdrawn (17%).

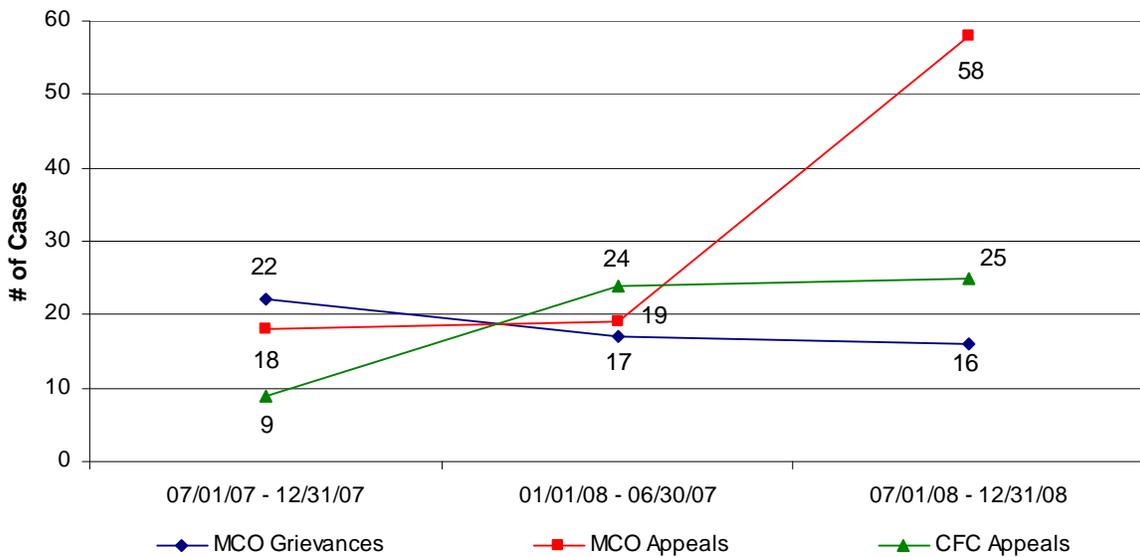
Fair Hearings

Individuals can file an appeal and a fair hearing at the same time, and they can file a fair hearing if their appeal is not decided in their favor.

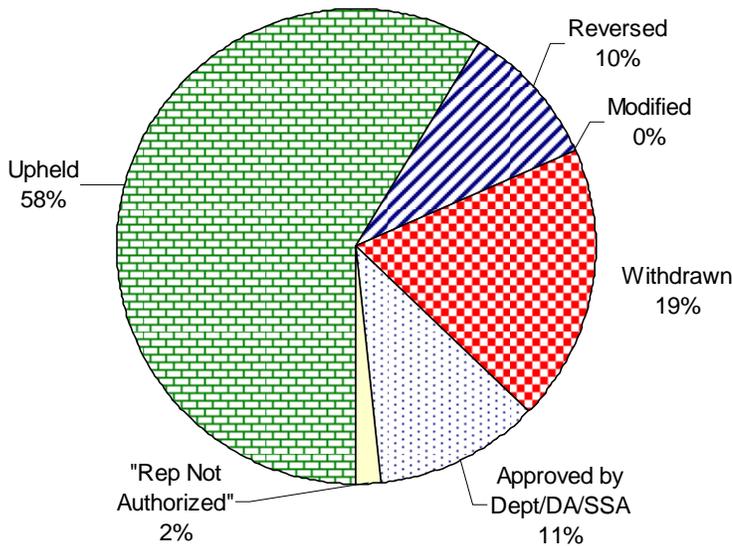
During this report period (July 1, 2008 – December 31, 2008), there were six fair hearings filed for MCO appeal decisions. One of them was withdrawn this period. There were five fair hearings pending from all previous periods and two of them were resolved. One case was upheld, while the other was reversed. There are now eight fair hearings pending at the end of this report period.

During this report period (July 1, 2008 – December 31, 2008), there were eight fair hearings filed for the Choices for Care program. None of them were resolved. There were ten fair hearings pending from all previous periods, and one of them was withdrawn this period. There are now seventeen total fair hearings pending at the end of this report period.

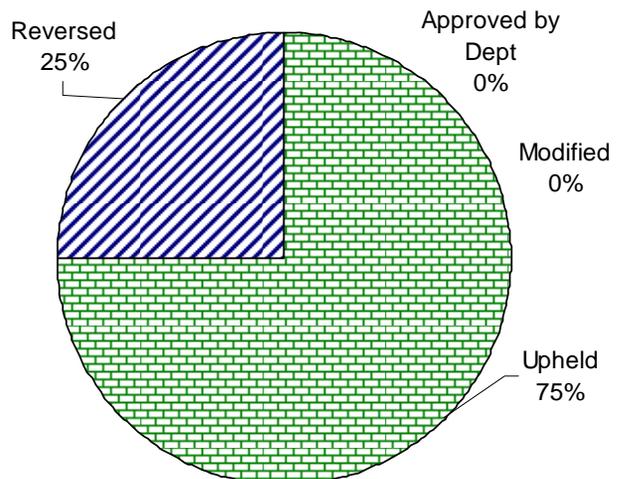
**Grievances and Appeals**



**MCO Appeal Resolutions**



**CFC Appeal Resolutions**



Medicaid MCO Legislative Grievance and Appeal Report  
 Data Summary  
 July 1, 2008 – December 31, 2008

 Number of Grievances filed: 16

## Number by Category:

|                                 |          |
|---------------------------------|----------|
| Staff/Contractor:               | <u>6</u> |
| Program Concern:                | <u>1</u> |
| Management:                     | <u>0</u> |
| Policy or Rule Issue:           | <u>3</u> |
| Quality of Service:             | <u>4</u> |
| Service Accessibility:          | <u>4</u> |
| Timeliness of Service Response: | <u>4</u> |
| Service Not Offered/Available:  | <u>3</u> |
| Other:                          | <u>3</u> |

*Since more than one category can be chosen for each grievance or appeal, total number by category may exceed total number filed.*

*The number of resolved appeals may not add up to the number filed, since an appeal may span two report periods.*

 Number of Appeals Filed: 58

|                                   |           |
|-----------------------------------|-----------|
| Regular Appeals:                  | <u>58</u> |
| Expedited (met criteria) Appeals: | <u>0</u>  |

 From Last Period - Pending: 7

 Number Resolved: 5

|                                 |           |
|---------------------------------|-----------|
| Number Upheld:                  | <u>32</u> |
| Number Reversed:                | <u>8</u>  |
| Number Modified:                | <u>0</u>  |
| Number Withdrawn:               | <u>3</u>  |
| Number Approved by Dept/DA/SSA: | <u>6</u>  |
| "Representative not authorized" | <u>0</u>  |

|                                 |          |
|---------------------------------|----------|
| Number Upheld:                  | <u>1</u> |
| Number Reversed:                | <u>1</u> |
| Number Modified:                | <u>3</u> |
| Number Withdrawn:               | <u>0</u> |
| Number Approved by Dept/DA/SSA: | <u>0</u> |

## Number by "Action" Category:

|                                                                                              |           |
|----------------------------------------------------------------------------------------------|-----------|
| Denial or limitation of authorization of a requested service or eligibility for service:     | <u>48</u> |
| Reduction/suspension/termination of a previously authorized covered service or service plan: | <u>9</u>  |
| Denial, in whole or in part, of payment for a covered service:                               | <u>0</u>  |
| Failure to provide clinically indicated covered service when the MCO provider is a DA/SSA:   | <u>0</u>  |
| Denial of a beneficiary request to obtain covered services outside the network:              | <u>0</u>  |
| Failure to act in a timely manner when required by state rule:                               | <u>0</u>  |
| Did not answer:                                                                              | <u>1</u>  |

 Number of Fair Hearings Filed with an Appeal this period: 6

 Pending from last period: 5

 Number of Resolved Fair Hearings with an Appeal: 1

 Resolved from last period: 2

|                   |          |
|-------------------|----------|
| Number Upheld:    | <u>0</u> |
| Number Reversed:  | <u>0</u> |
| Number Modified:  | <u>0</u> |
| Number Withdrawn: | <u>1</u> |

|                   |          |
|-------------------|----------|
| Number Upheld:    | <u>1</u> |
| Number Reversed:  | <u>1</u> |
| Number Modified:  | <u>0</u> |
| Number Withdrawn: | <u>0</u> |

Total Number of Pending Fair Hearings (all report periods): 8

Choices for Care Legislative Appeal Report  
Data Summary  
July 1, 2008 – December 31, 2008

Number of Appeals Filed: 25

Regular Appeals: 25

Expedited (met criteria) Appeals: 0

From Last Period - Pending: 7

Number Resolved: 6

Number Resolved: 9

Number Upheld: 7

Number Upheld: 4

Number Reversed: 0

Number Reversed: 1

Number Modified: 0

Number Modified: 0

Number Withdrawn: 2

Number Withdrawn: 1

Number Approved by Dept/DA/SSA: 0

Number Approved by Dept/DA/SSA: 0

Number by "Action" Category:

Denial or limitation of authorization of a requested service or eligibility for service: 13

Reduction/suspension/termination of a previously authorized covered service or service plan: 12

Denial, in whole or in part, of payment for a covered service: 0

Failure to provide clinically indicated covered service when the MCO provider is a DA/SSA: 0

Denial of a beneficiary request to obtain covered services outside the network: 0

Failure to act in a timely manner when required by state rule: 0

Number of Fair Hearings Filed with an Appeal this period: 8

Pending from last period: 10

Number of Resolved Fair Hearings with an Appeal: 0

Resolved from last Period: 1

Number Upheld: 0

Number Upheld: 0

Number Reversed: 0

Number Reversed: 0

Number Modified: 0

Number Modified: 0

Number Withdrawn: 0

Number Withdrawn: 1

Total Number of Pending Fair Hearings (all report periods): 17

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**REPORT TO THE GENERAL ASSEMBLY**

**REVIEW OF DEPARTMENT OF  
HEALTH PROGRAMS THAT PROVIDE  
DIRECT HEALTH CARE SERVICES  
TO VERMONTERS**

**Submitted by**

**Susan Besio, Director,  
Office of Vermont Health Access  
and  
Wendy Davis, M.D., Commissioner,  
Department of Health**

**January, 2009**

## **Introduction**

The 2009 legislature requested the Office of Vermont Health Access (OVHA) and the Vermont Department of Health (VDH) to review existing VDH programs to determine if any programs could be eliminated by enrolling participants in Catamount Health.

Section 5.208.2 of Act 192, Making Appropriations for the Support of Government, contains the following language:

Health - administration and support (Sec. 2.211, #3420010000)

- (a) Program Review and Presentation: The commissioner of health and the director of the office of Vermont health access shall review existing programs that provide health services and coverage to Vermonters and determine if any programs could be eliminated and the Vermonters currently served by these programs could be enrolled in Catamount Health to continue to receive said health services. The commissioner and director shall update the legislature on any recommendations in this regard in the fiscal year 2010 budget presentation process. The commissioner shall also provide in the fiscal year 2010 budget presentation a summary of the public health budget by major programmatic areas.

To comply with this requirement the OVHA and the VDH formed the Program Overlap Work Group, with representation from both organizations. The work group met during the summer and fall of 2008. This report contains their conclusions and recommendations.

## **Summary of Findings**

The Program Overlap Work Group reviewed all VDH programs, with a focus on those programs that provide direct service to individuals. As a result of this review, the work group concluded that no VDH program could be eliminated by enrolling participating individuals in Catamount Health. The primary reasons that programs could not be eliminated are as follows:

- Analysis of several programs revealed that the services provided do not involve a direct connection between the program and the individual recipient of services and so could not be replaced by a private insurance product
- VDH programs offer services not covered by Catamount Health
- Some participants in VDH programs would not be eligible to enroll in Catamount Health.

- Catamount Health does not cover pre-existing conditions for the first twelve months of enrollment

However, in the course of the program review, the work group found potential opportunities to improve program efficiency.

The next section provides a more detailed description of the programs providing direct service to individuals, the reasons why the programs cannot be replaced by Catamount Health, and recommendations for program efficiencies. The spreadsheet at the end of this report contains a description of all of the programs reviewed by the workgroup.

### **Catamount Health**

Catamount Health is a private health insurance plan that is offered through Blue Cross Blue Shield of Vermont and MVP Health Care to Vermonters who have been uninsured for at least 12 months and are not eligible for other public health care programs. Vermonters who become uninsured due certain reasons, including the loss of a job, divorce or death of a spouse or civil union partner, loss of eligibility under a parent's insurance, or loss of eligibility for a college plan, may enroll in Catamount Health without waiting 12 months.

Catamount Health offers the following benefits:

- Primary care, preventive care, acute episodic care, hospital services, chronic care management, and medications
- Low deductibles (in-network: \$250/individual, \$500/family; out-of-network: \$500/individual, \$1,000/family)
- \$10.00 office visit co-payment
- Free preventive care (not subject to deductible, co-insurance, and co-payments)
- Free care for chronic conditions (if enrolled in the carrier's chronic care management program)
- Low prescription drug costs (no deductible; co-payments = \$10 generic drugs, \$30 preferred drugs, \$50 non-preferred drugs)
- Low out-of-pocket maximum: (in-network \$800/individual, \$1,600/family; out-of-network \$1,500/individual, \$3,000/family)

As is true for all insurance products sold through the individual (nongroup) market, Catamount Health excludes pre-existing conditions from coverage for the first 12 months.

## **VDH Programs**

### **Ladies First/Wise Woman**

Ladies First/ Wise Woman screens women for breast and cervical cancer and for risk factors leading to heart disease, and offers a range of services to eligible women. These services include case management services to provide coordination of medical appointments, follow-up communication, transportation, help with interpreting the results of medical tests, and psycho-social support for diagnoses of cancer. Federally funded through a grant to VDH, Ladies First pays for annual mammograms, clinical breast exams, pelvic exams, cervical Pap tests, instruction in breast self-exam, and cardiovascular disease risk factor (cholesterol, high blood pressure, diabetes) screening for women under 250% of the Federal Poverty Level (FPL). Services are usually provided locally by the woman's own physician.

Ladies First also pays for repeat mammograms, ultrasounds, biopsies, and colposcopies. In addition to the income test, Ladies First participants must be uninsured or underinsured (underinsured participants generally have insurance that does not cover diagnostic testing or insurance with high deductibles). Ladies First participants who are diagnosed with breast or cervical cancer become Medicaid eligible for the period of time they are receiving treatment for their condition.

#### *Reasons why Ladies First could not be replaced by Catamount Health:*

- Approximately 30% of Ladies First participants are insured and are therefore not eligible for Catamount Health
- Participants would lose case management services
- The pre-existing condition exclusion under Catamount would preclude coverage of breast or cervical cancer for women who were previously uninsured and have positive test results
- Ladies First provides these services at no cost (no premium is required) to members
- Ladies First offers lifestyle interventions and counseling for woman who receive cardiovascular disease screening.

#### *Opportunities for program improvement:*

Representatives from VDH and OVHA have been meeting for several months to identify areas for improvement in the Ladies First program. The following is a summary of the areas they have discovered:

- Eligibility/Enrollment

There may be ways to integrate and streamline enrollment in health care programs. In April of 2008 representatives from Department for Children and

Families (DCF) and VDH met to explore the integration of Ladies First into the IT system used to determine eligibility for other health care programs, such as Medicaid, Dr. Dynasaur, VHAP, and premium assistance. In the meantime, the DCF/VDH team is exploring what can be done to introduce efficiencies into the Ladies First business processes.

- Provider Agreements

An OVHA/VDH/DCF work group has developed a joint Medicaid/Ladies First enrollment and recertification process for those providers participating in both Medicaid and Ladies First. The combined provider recertification agreement will reduce replication and frustration at the provider level, since providers submit the same set of information to both programs. Additional work with EDS needs to be completed to fully implement the combined provider agreement.

- Billing

EDS, the contractor for Medicaid claims processing, has established a monthly meeting with Ladies First staff to review and prioritize systems improvements, particularly in the areas of provider relations and denied claims. Reducing the number of paper claims and reducing the number of claims containing errors will benefit providers, Ladies First staff, and beneficiaries.

## **Alcohol and Drug Abuse Program (ADAP)**

ADAP uses Substance Abuse and Treatment Block Grant funds provided by the Substance Abuse and Mental Health Services Administration (SAMHSA) to contract with service providers for outpatient and residential treatment for Vermonters who have no insurance, whose treatment needs have exceeded the limits of coverage under their private insurance, or who have Medicare (Medicare does not cover residential treatment for substance abuse or outpatient methadone treatment). ADAP services are funded by a federal block grant and are delivered through the mental health agencies and other approved substance abuse providers. All block grant funds must be expended through non-profit organizations and are used as a last resort; private insurance and Medicaid are billed first.

*Reasons why ADAP could not be replaced by Catamount Health:*

- People eligible for Catamount can already enroll, and Catamount will cover services offered in the benefit plan, with the exception of the pre-existing condition clause
- Under the current Substance Abuse Prevention and Treatment Block Grant agreement, Block Grant funds cannot be used to pay insurance premiums or pay for health care services other than substance abuse prevention and treatment. Exploratory discussions with the Grant Project

Officers suggest that it is unlikely that using funds in this way in future grants would be allowed.

### **HIV Program**

The HIV Program is funded through the federal Ryan White Care Act and consists of two parts, the base award and AIDS Medication Assistance Program (AMAP) earmark. The base award must go to the AIDS Service Organizations (ASOs) and Fletcher Allen Health Care Comprehensive Care Clinic to pay only for case management. The AMAP earmark can be used only for formulary approved medications, access/adherence/monitoring of medications, and/or for insurance premiums and co-pays. Any unspent funds must be expended on Ryan White program activities. Participants in any HIV component must have income below 200% of the Federal Poverty Level and assets of no more than \$10,000.

The Early Intervention Program (EIP) is for uninsured or underinsured individuals who have been newly diagnosed with HIV. EIP pays for the initial (one) visit with a health care provider and for various lab tests. The purpose of this program component is to get newly diagnosed individuals into care and onto some form of insurance coverage.

AMAP pays for medications for participants who have tested positive for HIV. AMAP pays for HIV-related, formulary-approved medications, insurance premiums for state programs, and co-pays and deductibles. AMAP is the payer of last resort; thus, private insurance and Medicaid must be billed first.

The dental component of the program pays for dental services for participants.

The Insurance Continuation Assistance Program (ICAP) pays private insurance premiums for people who can no longer work but who have insurance available through COBRA, or people who are still working but are too ill with an HIV-related illness to continue to work a sufficient number of hours to afford individual or group health insurance. ICAP eligibility requires a doctor's verification that full-time work can no longer be performed. ICAP pays for continuation coverage only if the coverage is less costly to the state than other available options such as Catamount.

#### *Reasons why the HIV Program could not be replaced by Catamount:*

- Even if state dollars could be saved by, for example, by enrolling AMAP participants in Catamount Health the saved dollars must be passed through to the ASOs and so could not be used to fund other programs/services. In addition, forcing high-cost AMAP participants into the Catamount pool could increase Catamount premiums.
- Catamount does not cover dental services and so could not replace the dental component.

- Catamount does not provide case management and social service support provided through the base awards to the ASOs.
- The ICAP component already considers Catamount Health as an option in determining the least costly coverage option.

### **Children with Special Health Needs (CSHN)**

CSHN provides a selection of services to children under 21 who have complex health conditions, and to their families. In addition, patients with Cystic Fibrosis are followed by the CSHN program throughout their lifetime. CSHN clinic services are provided by teams that may include physician specialists, nurses, nurse practitioners, social workers, physical or occupational therapists, nutritionists, orthotists, speech and language specialists, audiologists, dentists and orthodontists. The make-up of a particular clinic team will depend upon the specific needs of the children who are being served and the nature of the conditions that are being followed. Although eligibility is based on diagnosis, not income, higher-income families must meet a deductible before CSHN assistance becomes available to them. CSHN bills private insurance first, then Medicaid, then state funds. CSHN services are funded through a combination of the Maternal and Child Health Block Grant federal funds and state funds.

#### *Reasons why CSHN cannot be replaced by Catamount:*

- CSHN pays only for the gaps caused when needed services are not covered by the patient's insurance. Examples include a policy deductible the family cannot meet, a needed service that is outside the benefit package or which the insurer determines is not medically necessary, or services that exceed the number allowed by a policy. This would include covering these gaps in Catamount coverage.

#### *Opportunities for program improvement:*

Prior to the formation of the Program Overlap work group, another workgroup was evaluating the need to integrate CSHN with other children's programs. CSHN recently reviewed a three-year federal grant to work toward three goals:

- Strengthen medical homes
- Ensure community-based services
- Review the CSHN financial assistance program

The workgroup contains representatives from the Department for Children and Families, OVHA, and Electronic Data Systems (EDS is the contractor for processing Medicaid claims). The work group is planning to begin processing CSHN claims through the EDS system, which would create these positive outcomes:

- Private insurance and Medicaid would more reliably be billed as primary payers
- Providers would be paid more quickly (EDS would pay the claim first and then recoup from third parties, (a process known as “pay and chase”)
- Electronic processing of claims would reduce manual labor
- OVHA’s pharmacy benefit manager could provide formulary management in place of CSHN’s current open formulary
- A more robust database would be created for future analysis.

## **Conclusion**

In addition to the program-specific reasons that Catamount Health cannot replace VDH programs, there would be general disadvantageous effects of pursuing such a course. They are as follows:

- Although state funds might be saved by the elimination of one or more programs, participating individuals could be harmed, and federal funds would be lost.
- Injection of even a small number of individuals with high medical costs to the Catamount Health pool would drive up the cost of the Catamount Health premium; such an increase would run counter to the goal of keeping Catamount affordable and therefore attractive to uninsured Vermonters.

Although the Program Overlap Work Group did not identify any VDH programs that could be eliminated by enrolling participants in Catamount Health, many opportunities for potential program improvement were discovered as a result of the evaluation process. These opportunities will be explored in more detail over the next few months, and changes to the programs will be made if determined to be feasible, cost-effective, and not detrimental to services.



**PHARMACY BEST PRACTICES  
AND  
COST CONTROL REPORT  
2009**

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

### **Report Facts and Figures from State Fiscal Year (SFY) 2008**

- A total of 2,227,758 pharmacy drug claims were paid for all of Vermont's publicly funded pharmacy programs.
- Gross spending was \$112,406,224.
- The rate of generic dispensing; that is, the use of generics as a percentage of all drugs dispensed, was 65.25%.
- The overall generic substitution rate when a generic equivalent was available was 98.00%.
- Federal rebates totaled \$30,496,900.
- Supplemental rebates collections were \$5,318,443.
- Net of rebates, the program spend was .49% less in SFY 2008 than in SFY 2007.

### **Overview**

Pharmacy is the second highest spending item in OVHA's benefit programs. In SFY 2008, the gross spending of \$112,406,224 was second only to nursing home care, which was \$115,642,835.

Vermont's publicly funded health insurance programs covered an average of 142,526 beneficiaries monthly in SFY 2008.

Some of these programs include full health insurance coverage. All of them included a pharmacy benefit in SFY 2008. These programs are:

- Programs for Adults:
  - Traditional Medicaid
  - Vermont Health Access Plan
  - Employer Sponsored Insurance Assistance (ESIA)
- Programs for Children:
  - Traditional Medicaid
  - Dr. Dynasaur
- Pharmacy Only Benefits:
  - Pharmacy Benefit
    - VHAP-Pharmacy
    - VScript
    - VScript Expanded
  - Medicare Part D Wrap Benefit
    - VPharm
  - Discount Benefit
    - Healthy Vermonters

### ***Critical Issues***

The goals of the Vermont Health Access Pharmacy Benefit Management (PBM) Program are:

- To assure the availability of clinically appropriate services and
- To do so at the most reasonable cost possible.

At stake is preserving the benefit that has evolved in Vermont's programs to the greatest extent possible.

### ***Vermont Strategies in Pharmacy Benefits Management***

The Vermont pharmacy best practices and cost control program was authorized in 2000 and established in SFY 2002 by Act 127. This program, as the Vermont Health Access Pharmacy Benefits Management (PBM) Program, is administered by the OVHA. Operational strategies include:

- Partnering with a vendor with skills and expertise in pharmacy benefit administration
- Managing and processing claims
- Managing benefit design
- Monitoring and managing utilization
- Procuring supplemental rebates on drugs used
- Managing reimbursement
- Responding to change

### ***Pharmacy Benefit Administration***

Pharmacy benefit administration (PBA) services support the program in the following areas:

- Claims operations
- Benefit management
- Utilization review and management
- Rebate management
- Analysis and reporting

The OVHA contracts with MedMetrics Health Partners of Worcester, Massachusetts as the Pharmacy Benefits Administrator (PBA) for Vermont's programs. MedMetrics is a non-profit, full-service pharmacy benefit manager, wholly owned by Public Sector Partners (PSP) and affiliated with the University of Massachusetts Medical School and the University of Massachusetts Memorial Medical Center. MedMetrics was selected as OVHA's PBA contractor through a competitive bid process in 2005. The contract was

for three years with an option to extend for two additional years. OVHA chose that option in 2008. Thus, the PBA contract will be rebid in 2010.

### ***Managing and Processing Claims***

Claims processing activities include accepting drug claims according to the rules of coverage under Vermont programs; providing the mechanisms to support the application of the generic and alternative drug requirements authorized by Title 18, Chapter 91 of the Vermont Statutes; transmitting program requirement messages to pharmacies as drugs are dispensed and claims are processed (e.g., eligibility verification, federal/state drug rebate requirements, coverage limitations, prior authorization needs, prospective and retrospective drug utilization review (DUR) issues, etc.); and authorizing payments according to the reimbursement rules. Claims are submitted by pharmacies enrolled to provide benefits in Vermont's programs. As of December 2008, 224 pharmacies were enrolled and processing claims.

The maximum reimbursement is established on a per claim basis at the individual drug level in all cases but VPharm. In SFY 2008 the amount was the lesser of:

- Average wholesale price (AWP) less 11.9% plus a dispensing fee,
- The Centers for Medicaid and Medicare Services established Federal Upper Limit (FUL) plus a dispensing fee,
- The MedMetrics managed Vermont Maximum Allowable Cost (MAC) amount plus a dispensing fee, or
- The pharmacy's usual and customary/submitted fee including a dispensing fee.

The beneficiary pays the rate established with this methodology in the Healthy Vermonters Program. For the programs other than VPharm, Vermont pays the difference between the rate set and any other insurance payment.

VPharm provides a wrap benefit to Medicare Part D coverage for drugs for those beneficiaries who prior to the implementation of Part D received their primary coverage through Medicaid, VHAP-Pharmacy, VScript, and VScript Expanded.

Under VPharm, Medicaid beneficiaries receive Vermont coverage for Medicaid covered drugs in classes excluded from Medicare coverage.

Others beneficiaries are limited to drugs that would be covered under Vermont primary coverage; that is, VPharm1, VPharm2, and VPharm3 beneficiaries receive coverage for the drugs covered in the comparative primary program (VHAP-Pharmacy (VPharm1), VScript (VPharm2), and VScript Expanded (VPharm3)). This coverage is in the form of the Part D Prescription Drug Plan (PDP) cost-sharing including deductibles, coinsurance, copayments, and coverage in the "donut hole", which is the period in a coverage year when there is a lapse in Part D coverage. These VPharm beneficiaries

also are eligible for drugs covered under VHAP-Pharmacy, VScript, and VScript Expanded respectively that are in classes excluded from Medicare coverage. Details are outlined below.

In SFY 2008, a total of 2,227,758 drug claims were paid for all of Vermont's publicly funded pharmacy programs.

## ***Managing Benefit Design***

### *General Design*

Benefit management activities occur in all programs for all beneficiaries. Fundamental to understanding the difference in benefits is identifying the individual drug classes covered in the specific programs:

- Medicaid, Dr. Dynasaur, VHAP (including VHAP-ESIA), and VHAP-Pharmacy: All drugs for which a rebate is paid to the federal Medicaid program. Limitations may apply.
- VScript: All maintenance drugs for which a rebate is paid to the federal Medicaid program. Limitations may apply.
- VScript Expanded: All maintenance drugs for which a rebate is paid to the State of Vermont. Limitations may apply.
- Healthy Vermonters Program: All Medicaid covered drugs.
- VPharm:
  - Coverage for Medicaid drugs in classes excluded from Medicare coverage (Medicaid).
  - Cost sharing to Medicare Part D coverage and coverage for drugs in classes excluded from Medicare coverage; both limited to Medicaid covered drugs (VPharm1).
  - Cost sharing to Medicare Part D coverage and coverage for drugs in classes excluded from Medicare coverage; both limited to VScript maintenance drugs (VPharm2).
  - Cost sharing to Medicare Part D coverage and coverage for drugs in classes excluded from Medicare coverage; both limited to VScript Expanded maintenance drugs for which a rebate is paid to the State of Vermont for VScript Expanded (VPharm3).
- Employer Sponsored Insurance Assistance Chronic Care Wrap Program for beneficiaries not eligible for VHAP: Employer sponsored insurance cost sharing for Medicaid covered drugs used to treat the following chronic health conditions: Arthritis, Asthma, Chronic Obstructive Pulmonary Disease (COPD), Chronic Renal Failure (CRF), Congestive Heart Failure (CHF), Depression, Diabetes, Hyperlipidemia, Hypertension, Ischemic Heart Disease, and Low Back Pain.

### *Preferred Drug List (PDL)*

When limitations apply for Medicaid, Dr. Dynasaur, VHAP (including VHAP-ESIA), and VHAP-Pharmacy and for VScript maintenance coverage, the OVHA PBM Program utilizes a Preferred Drug List (PDL). The PDL is a key feature in the program. The PDL identifies drugs in which specific clinical criteria has to be met in order for them to be covered. It also identifies drugs that are clinically effective, but less costly. If a drug is not listed as "preferred" in a particular category on the PDL, it requires Prior Authorization in order for the drug to be covered.

The PDL has been developed with the help of the Vermont Medicaid Drug Utilization Review (DUR) Board acting as the Program's Pharmacy and Therapeutics (P&T) Committee. In 2008 the Board membership included six Vermont doctors and four pharmacists.

The PDL features clinically appropriate, low-cost options including:

- OTCs as prescribed by physicians
  - For Medicaid, VHAP and VHAP Pharmacy - without restriction and
  - For VScript, VScript Expanded and VHAP Limited - limited to loratadine (generic Claritin<sup>®</sup> and the like); omeprazole (generic Prilosec OTC<sup>®</sup> and the like); non-steroid anti-inflammatory drugs; and cetirizine (generic Zyrtec<sup>®</sup> and the like). VHAP Limited also covers smoking cessation products.
- generics;
- lower-cost brands;
- brands where manufacturers pay a level of federal Medicaid rebates that makes the net cost of the drug comparative to other products in the drug's therapeutic class; and
- brands where manufacturers pay Vermont rebates supplemental to required federal Medicaid rebates to make their products more affordable.

In March 2002, the first iteration of the PDL was completed with PA required for any drug not identified as "Preferred" in designated PDL classes. Throughout 2002, additional classes were systematically implemented. By 2003, the foundation of the PDL was established. Since that time, the PDL has been modified to reflect changes in clinical approaches, prescribing practices, product availability, and supplemental rebate opportunities. Since January 1, 2006, the PDL has been expanded by almost 60%, from 79 drug classes to over 140 drug classes today. Automated step-therapy protocols and over 100 new product-specific dispensing limits have also been instituted. It is estimated that since January 2006 this has resulted in over \$25 million in cost avoidance.

### *Management of Mental Health Drugs*

In 2002, when the Vermont Health Access Pharmacy Benefit Management Program's PDL was implemented, drugs used to treat severe and persistent mental illness (SPMI) were exempt from management. All other major cost categories of drug treatment were subject to management. In SFY '05, 31.7% of the total drug spending was for mental health drugs. In 2005, Act 71 approved the management of mental health drugs subject to the review of the DUR Board.

In the summer of 2005 the DUR Board agreed that mental health drug classes could be managed through the Preferred Drug List (PDL). The proposed PDL changes identified the most cost-effective clinically appropriate drugs in specified classes. These drugs included generic equivalents and alternatives as well as other low-cost alternatives. More expensive alternatives were made available with prior authorization using criteria developed through literature review of acceptable evidence-based standards, including the Texas Implementation of Medication Algorithms (TIMA), the International Psychopharmacology Algorithm Project (IPAP), class reviews from the Oregon Evidence Based Practice Center, the Veterans' Administration, and the Micromedex<sup>®</sup> Health Series.

At the time, the Board recommended that certain beneficiaries' active treatment be "grandfathered" so as not to risk destabilization. For that it was decided that patients of all ages, using antipsychotics, antidepressants, and/or mood stabilizers would continue to use existing drug therapies. For drugs without generic equivalents, lapses in treatment of four months or longer or changes in treatment would result in the application of the PDL and its clinical criteria. For drugs with generic equivalents, grandfathering would continue for four months to allow prescribers to transition patients to the generic option. The PDL and the criteria would apply to all new patients.

A report on the review and the DUR Board's deliberations was submitted to the Legislature's Health Access Oversight Committee (HAOC) for comment on September 1, 2005. The Committee heard testimony from prescribers and advocates and recommended that Central Nervous System (CNS) Agents used to treat ADHD be included in the "grandfathering" provisions. This recommendation was approved at the DUR Board meeting in September 2005.

A claims processing implementation plan was developed, provided to the DUR Board, and further reviewed with the DUR Board's psychiatrist member and with the Medical Director of the Division of Mental Health at the Department of Health.

Following provider notification, the plan was implemented in January 2006. MedMetrics claims processing system's pharmacy claims history was used wherever possible to determine if the criteria had been met to minimize the impact on prescribers who would otherwise have to request a prior authorization.

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With the implementation of Medicare Part D in January 2006 many beneficiaries transitioned to Part D coverage. With Part D implementation problems, patient care was at risk and provider services were under considerable pressure. As a result, the plan to limit grandfathering on drugs with generic equivalents to four months was not enacted immediately. On August 16, 2006, the OVHA sent a letter to prescribers notifying them that this provision would be effective October 1, 2006.

In 2007 it was reported that the transition to managing the mental health drug classes appeared to cause little disruption to patient care. That situation continued in 2008. Indications are that new patients or patients with a lapse in therapy of four months or more attempt therapy with preferred drugs. Between January 2006 and November 2008, prior authorization requests for non-preferred mental health drugs dropped by 62.45%.

| <b>Mental Health Drug Prior Authorization Requests - January 2006, November 2006, November 2007, and November 2008</b> |                     |                      |                      |                      |
|------------------------------------------------------------------------------------------------------------------------|---------------------|----------------------|----------------------|----------------------|
|                                                                                                                        | <b>January 2006</b> | <b>November 2006</b> | <b>November 2007</b> | <b>November 2008</b> |
| Anti-depressants - Novel                                                                                               | 231                 | 197                  | 164                  | 128                  |
| Anti-depressants - SSRI                                                                                                | 300                 | 236                  | 98                   | 85                   |
| Anti-depressants - Tricyclics                                                                                          | 0                   | 1                    | 0                    | 0                    |
| Anti-psychotics - Atypical & Combinations                                                                              | 159                 | 59                   | 54                   | 69                   |
| Anti-psychotics - Typical                                                                                              | 0                   | 0                    | 0                    | 0                    |
| CNS Stimulants                                                                                                         | 16                  | 34                   | 22                   | 12                   |
| Anti-Hyperkinesis - ADHD, ADD, Narcolepsy                                                                              | 86                  | 101                  | 94                   | 65                   |
| Sedative Hypnotics - Benzodiazepines                                                                                   | 6                   | 0                    | 1                    | 3                    |
| Sedative Hypnotics - Non- Benzodiazepines                                                                              | 212                 | 98                   | 25                   | 18                   |
| Anti-Anxiety - General                                                                                                 | 10                  | 28                   | 12                   | 3                    |
| Totals                                                                                                                 | 1,020               | 754                  | 470                  | 383                  |
| Cumulative percentage reduction since January 2006                                                                     |                     | -26.08%              | -53.92%              | -62.45%              |
| Annual percentage reduction (since previous November)                                                                  |                     |                      | -37.67%              | -18.51%              |

From a funding perspective, it is clear that continued mental health management is necessary. Drug spending for mental illness treatment continues to be a significant. In SFY'05, the top twenty drug classes in terms of spending included seven specific classes identified for the treatment of SPMI. Those seven classes represented 28.1% of the total drug spending in that year. The percentage of total spending by those same classes was 29.3% in SFY '07 and 29.5% in SFY '08.

In 2008 individuals in the community involved with mental health issues expressed their concerns about the use of mental health drugs, particularly with children. The Department of Mental Health has formed a workgroup of stakeholders to determine the

questions the system of care should be asking about usage patterns and potential policy statements on the use of psychotropic medications for Vermont's children and youth with significant mental health concerns. OVHA representatives are and will continue to be members of this workgroup in its deliberations.

### *Specialty Pharmacy Services*

In 2005, the Administration proposed to allow the PBM Program to require the purchase of selected pharmacy products using mail order options. The intention was to assure that when beneficiaries received drug treatments for complex medical conditions that those treatments were obtained in the most economical way possible and that the patients had the opportunity to obtain the best health outcomes through the availability of disease and case management services to assure optimal results from product use. The Legislature approved this requirement with the addition of V.S.A. 33 §1998a. This allowed the use of the mail order services of specialty pharmacies.

In 2007 the OVHA sought bids from specialty pharmacies to provide this additional tool in chronic care management. This serves as a resource in the treatment of complex conditions which do not require the level of support of those addressed in the OVHA Chronic Care Initiative.

Targeted were services for the treatment of such conditions as hemophilia, growth hormone deficiency, multiple sclerosis, and respiratory syncytial virus (RSV) (a condition that is the leading cause of pneumonia and bronchitis in infants). Additional potential conditions identified included hepatitis, cystic fibrosis, cancer, and deep vein thrombosis. It was stated that additional treatments might be identified over time.

In 2008, two specialty pharmacies were selected to serve Medicaid beneficiaries: Wilcox Medical dba Wilcox Home Infusion and ICORE Healthcare, LLC, partnering with our pharmacy benefits administrator, MedMetrics Health Partners. Wilcox Medical is the specialty pharmacy for respiratory syncytial virus (RSV) and ICORE Healthcare/MedMetrics is the specialty pharmacy for all other conditions. Dispensing of identified specialty medications is limited to these pharmacies for Medicaid beneficiaries where Medicaid is the primary insurer.

Both providers were selected based on a combination of the quality and the value of the services they offered and the price of the products involved. Operating in Rutland, Wilcox Medical represents the pharmacy that served the majority of Medicaid RSV patients in the last two RSV seasons. They came with local clinical recommendations including the physician who has been the primary prescriber for most Medicaid RSV patients. In addition, this physician is the Medical Director of the Neonatal Medical Follow-up Clinic at Fletcher Allen Health Care. MedMetrics Health Partners of Worcester, Massachusetts has been OVHA's pharmacy benefit administrator for the last three years. ICORE is their specialty pharmacy partner and is located in Plantation,

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Florida. ICORE is a wholly owned subsidiary of Magellan Health Services, Inc. and provides specialty pharmacy services for 35 managed care contracts covering 60 million subscribers. The partnership of MedMetrics and ICORE assures the coordination of our pharmacy benefit management initiatives with our specialty pharmacy approach.

As of October 1, 2008 Wilcox Medical began providing services for Synagis<sup>®</sup>, the drug used to prevent respiratory syncytial virus (RSV). As of November 3, 2008 ICORE Healthcare, LLC, with MedMetrics Health Partners, began providing services for other select specialty drugs. These include, but are not limited to, hemophilia factors, growth hormones, multiple sclerosis self-injectables, hepatitis C (ribavirin and injectables) treatments, and Elaprase<sup>®</sup> (for Hunter's Syndrome).

The estimated annual gross savings for specialty pharmacy is \$ 328,000 broken down as follows:

- Hemophilia drugs: \$100,000
- Hepatitis drugs: \$110,000
- Multiple sclerosis drugs: \$ 50,000
- Growth Hormones: \$ 35,000
- RSV prevention: \$ 33,000

### *Diabetic Testing Supplies*

Diabetic testing supplies are a specialty need. In 2005, when the Administration proposed managing specialty pharmacy services, they were identified as a target area. However, the use of such supplies generally does not require any specialty disease management services. As a result, the OVHA opted to address this by limiting the product choices available in local pharmacies while seeking rebates from preferred manufacturers, rather than using a specialty pharmacy service.

This initiative began with a partnership between the states of Maine, Utah, North Dakota, and Vermont. Diabetic supply manufacturers were approached in the summer of 2007 and offered preferred status for their products in exchange for rebates against states' utilization in their Medicaid programs.

Abbott and Lifescan were the manufacturer lines chosen by Vermont because all product needs could be met. These products were most commonly used by Vermont program beneficiaries. In addition, there was be no cost to pharmacies, patients, or the Vermont programs for the transition. For patients who had to change to Abbott or Lifescan products, coupons were provided to pay pharmacies for the manufacturer-specific glucometers required in conjunction with the products.

This approach was reviewed and unanimously approved by the DUR Board for an implementation in February 2008.

Rebate amounts received against the first two calendar quarters of 2008 were \$397,669. It is estimated that annualized savings will be greater than \$700,000.

### *Physician-Administered Drugs*

Historically, drugs administered in physician offices have often been billed with other physician services. As such they have not been managed in the same manner as drug dispensed in pharmacies where in the course of claims processing the pharmacy receives messages regarding coverage requirements and conditions. Managing physician-administered drugs promotes consistency in administering the PBM Program's clinical criteria for drug coverage.

In SFY 2007, the OVHA began reviewing physician-administered drugs to identify where and how management techniques should apply. Since then drugs have been identified that are limited to dispensing through pharmacies where prior authorization requirements and utilization review conditions can apply prior to dispensing. Other drugs that must be available in physician offices are subject to prior authorization to assure that established clinical criteria apply. In the process, mechanisms have been established to facilitate the process for the offices. Evaluating physician-administered drugs for clinical management is an ongoing project and will continue in SFY 2009.

### *Compound Drugs*

Compound drugs are produced by a pharmacist combining individual ingredients. Generally insurers cover a compound drug when the prescription is determined to be medically necessary, there is no equivalent manufactured alternative available, and its ingredients meet coverage criteria including program rebate requirements. Prior to 2006, the OVHA's pharmacy claims processing systems were unable to accept the report of individual ingredients. Beginning January 2006 and throughout state fiscal year 2007 the OVHA worked with compounding pharmacists to develop an approach to account and claim reimbursement for compound drugs that assures that they are managed under the PBM Program. The claims processing system now requires that all rebateable ingredients be identified on the claim and only those ingredients that meet coverage criteria are paid. Types of drugs that previously were compounded have since been reviewed by the DUR Board to determine if coverage should require prior authorization. Guidelines for the coverage of compounded products are now described in the Clinical Criteria Manual of the Preferred Drug List.

### *Formulation/Combination Conditions for Non-Managed Products*

Increasingly, products become available as combinations/formulations of products/ingredients that are otherwise readily available in the market. Generally, the resulting item is more costly than its parts and has little, if any, additional value; for

example, the packaging of an ointment or cream with applicators or the combination of ingredients with vitamins. In 2006, the DUR Board approved the establishment of a category in the PDL where products not otherwise in managed classes are identified as requiring prior authorization because the combination/formulation is not the preferred approach, clinically or economically. This category continues to be reviewed routinely.

### *Dose Consolidation Opportunities*

The DUR Board continues to review for opportunities to consolidate dosages to save money when clinically possible. Considerations are the pill burden for patients, the complexity of drug regimens, and the impact on patient adherence to therapy. Reviews occur as classes are reviewed.

### *Educating Health Care Providers*

The Vermont Health Access PBM Program continues to face the challenge of counteracting the influence of manufacturers' national and local marketing and advertising. The Office of the Vermont Attorney General has estimated that \$3.11 million was spent on marketing in Vermont in SFY 2004; another \$2.17 million in SFY 2005; \$2.25 million in SFY 2006; and \$3.13 million in SFY 2007. With a 33% increase in 2007 over 2006, the pressure is clearly significant.

The PBM Program relies on the Drug Utilization Review (DUR) Board for advice on how to best educate providers and address the impact of pharmacy manufacturers advertising, in particular. The DUR Board meets as often as monthly. In calendar year 2008 the Board met eight times. In these meetings counter-detailing opportunities are considered.

In the course of DUR activities, the DUR Board may select certain drugs to target for review in order to ensure that clinical criteria and prescribing patterns are appropriate. Staff makes recommendations for targeted areas and the Board selects those most relevant. When this occurs, OVHA relies on MedMetrics to access clinical researchers from the University of Massachusetts' School of Medicine. Specific providers may be polled regarding the patients affected, and the Board reviews their responses. The Board then determines if follow-up is appropriate either with the identified prescribers or with a clinical advisory to all providers.

In the event a preferred drug is changed to a non-preferred status and specific beneficiaries are affected, prescribers are provided with two tools as recommended by the DUR Board. One is a list of all the patients who were prescribed the specific drug that is being changed. The second is a profile unique to each patient with the drug change listed. This creates a record for use in the patient's file.

To educate providers on general PBM Program coverage activities, various methods are used. Most frequently mailings are prepared around both general and specific changes and they are targeted to prescribers and pharmacies separately. Examples include clinical advisories and alerts. These mailings are also sent electronically to provider affiliates and representatives so that these organizations can use their proprietary methods to distribute the materials. Examples of these organizations include the Vermont Medical Society and the Vermont Pharmacists Association. The OVHA and MedMetrics have also begun to publish a periodic pharmacy bulletin to provide timely updates on claims processing and clinical issues.

Providers may find all general pharmacy benefit management materials posted on the OVHA webpage at [ovha.vermont.gov/](http://ovha.vermont.gov/). These materials include the description of the PBM Program; DUR Board information; the Preferred Drug List and Criteria; prior authorization information and forms; bulletins and mailings; and other information, instructions, and alerts.

### ***Monitoring and Managing Utilization***

#### *Generic Utilization*

Vermont's alternative drug selection law described at 18 V.S.A chapter 91 requires pharmacies to dispense the lowest priced drug which is chemically and therapeutically equivalent, unless the prescriber expressly requires the brand. The Vermont Health Access PBM Program with the support of the DUR Board heavily promotes the use of generics and low cost alternatives in general and directly through identified classes in the PDL.

Generic dispensing rates can be expressed in a variety of ways. The "generic dispensing rate" is a term used to refer to the number of prescriptions dispensed using generic medications as a percentage of all prescriptions dispensed. Not all drugs have generic equivalents available. The "generic substitution rate" is a term used to refer to the number of prescriptions that are dispensed with a generic medication when an equivalent generic version of the drug is available. Generic versions of medications are only available when a brand (that is, innovator) medication has lost patent protection. In general, generic dispensing reflects the extent to which generics are used in a program, while generic substitution represents both the prescribing instructions of the physicians and other prescribers and the dispensing practices of the pharmacies.

The generic dispensing rate for the covered populations in Vermont's programs has increased with the efforts of both Vermont's programs and Medicare Part D Pharmacy Drug Plans to promote generics and the number of generics that have reached the market.

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For the fourth quarter of calendar year 2005, the last quarter prior to Medicare Part D implementation, the generic dispensing rate on all claims was 61.37%. In the first quarter of calendar year 2006, utilization measurement for Part D and non-Part D beneficiaries was difficult with the Part D problems and Vermont temporarily reinstating Vermont program coverage for Part D eligibles. However, for the quarter ending June 30, 2006, with those with Medicare coverage re-transitioned to Part D, the non-Part D rate was 61.47%. In a study of July and August 2006, a point at which Part D transition was effectively complete, the non-Part D rate was 62.4%

In December 2005, the overall generic substitution rate for all generic claims when a generic equivalent was available was 97.7%. That was exactly the rate for non-Part D beneficiaries as of July and August 2006.

For state fiscal years 2007 and 2008, rates were established for both Part D and non-Part D beneficiaries. The following chart identifies the results:

| <b>SFY 2007</b>                                    | <b>Percentage of non-Part D Rx</b> | <b>Percentage of Part D Rx</b> | <b>Percentage of All Rx</b> |
|----------------------------------------------------|------------------------------------|--------------------------------|-----------------------------|
| Generic use as a percentage of all drugs dispensed | 62.54%                             | 65.36%                         | 63.95%                      |
| Generic use when generic equivalent available      | 97.95%                             | 97.18%                         | 97.57%                      |

| <b>SFY 2008</b>                                    | <b>Percentage of non-Part</b> | <b>Percentage of Part D Rx</b> | <b>Percentage of All Rx</b> |
|----------------------------------------------------|-------------------------------|--------------------------------|-----------------------------|
| Generic use as a percentage of all drugs dispensed | 62.99%                        | 69.86%                         | 65.25%                      |
| Generic use when generic equivalent available      | 98.39%                        | 97.30%                         | 98.00%                      |

*Prior Authorization Requirements*

Through prior authorizations prescribers can access any non-preferred drug on the PDL. Under the Vermont Health Access PBM Program, criteria are available for these exceptions. MedMetrics' clinical pharmacists manage the criteria. Criteria have been and continue to be developed as classes are selected for management. They are then reviewed annually. New criteria and proposed changes are reviewed, modified, and approved by the DUR Board acting as the Vermont Health Access PBM Program's Pharmacy and Therapeutics Committee.

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The following chart reports the incidence of prior authorization requests in SFY 2007:

|                             | <b>Number of Prior Authorization Requests</b> | <b>Number of Prior Authorizations Approvals</b> | <b>Number of Prior Authorization Changes</b> | <b>Number of Prior Authorizations Denials</b> |
|-----------------------------|-----------------------------------------------|-------------------------------------------------|----------------------------------------------|-----------------------------------------------|
| July 2006                   | 1,456                                         | 1,128                                           | 122                                          | 206                                           |
| August 2006                 | 1,580                                         | 1,242                                           | 127                                          | 211                                           |
| September 2006              | 1,649                                         | 1,246                                           | 140                                          | 263                                           |
| <b>Q1 Totals</b>            | <b>4,685</b>                                  | <b>3,616</b>                                    | <b>389</b>                                   | <b>680</b>                                    |
| October 2006                | 1,663                                         | 1,244                                           | 128                                          | 291                                           |
| November 2006               | 1,683                                         | 1,294                                           | 91                                           | 298                                           |
| December 2006               | 1,384                                         | 1,100                                           | 99                                           | 185                                           |
| <b>Q2 Totals</b>            | <b>4,730</b>                                  | <b>3,638</b>                                    | <b>318</b>                                   | <b>774</b>                                    |
| January 2007                | 1,635                                         | 1,312                                           | 119                                          | 204                                           |
| February 2007               | 1,318                                         | 1,024                                           | 97                                           | 197                                           |
| March 2007                  | 1,451                                         | 1,093                                           | 112                                          | 246                                           |
| <b>Q3 Total</b>             | <b>4,404</b>                                  | <b>3,429</b>                                    | <b>328</b>                                   | <b>647</b>                                    |
| April 2007                  | 1386                                          | 1066                                            | 85                                           | 235                                           |
| May 2007                    | 1504                                          | 1169                                            | 83                                           | 252                                           |
| June 2007                   | 1411                                          | 1130                                            | 100                                          | 181                                           |
| <b>Q4 Totals</b>            | <b>4301</b>                                   | <b>3365</b>                                     | <b>268</b>                                   | <b>668</b>                                    |
| Totals for <b>SFY '07</b>   | <b>18,120</b>                                 | <b>14,048</b>                                   | <b>1,303</b>                                 | <b>2,769</b>                                  |
| Percent of Totals           | <b>100.00%</b>                                | <b>77.53%</b>                                   | <b>7.19%</b>                                 | <b>15.28%</b>                                 |
| Totals for <b>SFY '06</b>   | <b>26,859</b>                                 | <b>22,486</b>                                   | <b>3,127</b>                                 | <b>1,236</b>                                  |
| Percent of Totals (rounded) | <b>100.00%</b>                                | <b>83.72%</b>                                   | <b>13.91%</b>                                | <b>4.60%</b>                                  |
| <b>Difference</b>           | <b>-32.54%</b>                                | <b>-37.53%</b>                                  | <b>-58.33%</b>                               | <b>124.03%</b>                                |

The decline in prior authorization requests from 2006 to 2007 can be attributed to the following factors:

- When the PDL was implemented, the number of PA requests was significantly higher because of a statutory provision that made it possible for prescribers to override criteria. In 2006, the DUR Board specifically requested a legislative change to require prescribers to provide concrete clinical justification in requesting a criteria override.
- In January 2006, thousands of Medicaid beneficiaries were transitioned to Medicare Part D primary coverage. That meant their drug use no longer subject to the PBM Program's management. Historically beneficiaries who are elderly and disabled were major users of many of the drug classes managed in the Vermont PDL and their use contributed to the volume of prior authorizations.
- In January 2006, the PBA contract with MedMetrics was implemented. Their claims processing system is able to systematically identify areas where certain criteria elements have been met. Examples include age criteria, use of preferred

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drugs, use of preferred drugs for prescribed periods, etc. These step-therapy protocols effectively automate prior approval. This ability has reduced the need for paper/phone requests for authorizations from prescribers.

The following chart reports the incidence of prior authorization requests in SFY 2008:

|                             | Number of Prior Authorization Requests | Number of Prior Authorizations Approvals | Number of Prior Authorization Changes | Number of Prior Authorizations Denials |
|-----------------------------|----------------------------------------|------------------------------------------|---------------------------------------|----------------------------------------|
| July 2007                   | 1,391                                  | 1,134                                    | 73                                    | 184                                    |
| August 2007                 | 1,470                                  | 1,193                                    | 49                                    | 228                                    |
| September 2007              | 1,345                                  | 1,084                                    | 102                                   | 159                                    |
| <b>Q1 Totals</b>            | <b>4,206</b>                           | <b>3,411</b>                             | <b>224</b>                            | <b>571</b>                             |
| October 2007*               | 1,713                                  | 1,354                                    | 142                                   | 217                                    |
| November 2007               | 1,482                                  | 1,193                                    | 111                                   | 178                                    |
| December 2007               | 1,349                                  | 1,102                                    | 105                                   | 142                                    |
| <b>Q2 Totals</b>            | <b>4,544</b>                           | <b>3,649</b>                             | <b>358</b>                            | <b>537</b>                             |
| January 2008                | 1,909                                  | 1,552                                    | 156                                   | 201                                    |
| February 2008               | 1,445                                  | 1,147                                    | 142                                   | 156                                    |
| March 2008                  | 1,647                                  | 1,292                                    | 146                                   | 209                                    |
| <b>Q3 Total</b>             | <b>5,001</b>                           | <b>3,991</b>                             | <b>444</b>                            | <b>566</b>                             |
| April 2008                  | 1495                                   | 1151                                     | 171                                   | 173                                    |
| May 2008                    | 1566                                   | 1242                                     | 155                                   | 169                                    |
| June 2008                   | 1519                                   | 1166                                     | 151                                   | 202                                    |
| <b>Q4 Totals</b>            | <b>4580</b>                            | <b>3559</b>                              | <b>477</b>                            | <b>544</b>                             |
| Totals for SFY '08          | 18,331                                 | 14,610                                   | 1,503                                 | 2,218                                  |
| Percent of Totals           | 100.00%                                | 80%                                      | 8.20%                                 | 12.10%                                 |
| Totals for SFY '07          | 18,120                                 | 14,048                                   | 1,303                                 | 2,769                                  |
| Percent of Totals (rounded) | 100.00%                                | 77.53%                                   | 7.19%                                 | 15.28%                                 |
| <b>Difference</b>           | <b>1.16%</b>                           | <b>4.00%</b>                             | <b>15.35%</b>                         | <b>-19.90%</b>                         |

By appearance, there would seem to be an increase in prior authorization requests from 2007 to 2008. However, in October 2007 (Q2 SFY 2008) quantity limit prior authorization requests became included in total prior authorization requests. Managing quantities to appropriate clinical guidelines assures appropriate, cost-effective use.

Removing quantity limit PA requests from the above analysis to provide a comparative picture of 2008 to 2007, other prior authorizations have decreased:

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|                                | Number of Prior Authorization Requests | Number of Prior Authorizations Approvals | Number of Prior Authorization Changes | Number of Prior Authorizations Denials |
|--------------------------------|----------------------------------------|------------------------------------------|---------------------------------------|----------------------------------------|
| Totals for SFY '08             | 18,331                                 | 14,610                                   | 1,503                                 | 2,218                                  |
| Less Quantity Limit PA's       | -1,158                                 | -939                                     | -123                                  | -96                                    |
| Total Less Quantity Limit PA's | 17,173                                 | 13,671                                   | 1,380                                 | 2,122                                  |
| Percent of Totals              | 100.00%                                | 80%                                      | 8.20%                                 | 12.10%                                 |
| Totals for SFY '07             | 18,120                                 | 14,048                                   | 1,303                                 | 2,769                                  |
| Percent of Totals (rounded)    | 100.00%                                | 77.53%                                   | 7.19%                                 | 15.28%                                 |
| <b>Difference</b>              | <b>-5.23%</b>                          | <b>-2.68%</b>                            | <b>5.91%</b>                          | <b>-23.37%</b>                         |

*Utilization Review Events*

Pharmacies use computer systems to transmit claims “real time”; that is, as they prepare drugs for dispensing. A claim identifies information about the beneficiary, the prescriber, and the drug. With the ability to electronically submit a claim there is the ability to message the pharmacist on that individual claim. Messaging occurs on specific utilization issues as claims are processed. The issues include drug-drug interactions, early refills, therapeutic duplication, ingredient duplications, drug-disease interactions, drug-age precautions, and others. The drug-drug interactions, early refills, and therapeutic duplication edits require the pharmacist to override or otherwise resolve the potential problem before a prescription may be filled. The other messages alert the pharmacist to potential problems, but do not require intervention to fill the prescription.

The following chart reports the incidence of messages in SFY 2007:

|                              | Q1 SFY '07     | Q2 SFY '07     | Q3 SFY '07     | Q4 SFY '07     | Totals           | Percent     |
|------------------------------|----------------|----------------|----------------|----------------|------------------|-------------|
| Drug-Drug Interaction(DD)    | 79,808         | 75,739         | 68,460         | 66,521         | 290,528          | 29%         |
| Early Refill (ER)            | 10,782         | 10,216         | 10,022         | 10,703         | 41,723           | 4%          |
| Drug-Disease (MC)            | 9,959          | 9,754          | 10,337         | 10,048         | 40,098           | 4%          |
| Ingredient Duplication (ID)  | 20,327         | 20,473         | 20,054         | 20,970         | 81,824           | 8%          |
| Drug-Age Precaution (DA)     | 37             | 64             | 65             | 52             | 218              | 0%          |
| Therapeutic Duplication (TD) | 121,859        | 128,665        | 154,480        | 153,582        | 558,586          | 55%         |
| <b>Totals</b>                | <b>242,772</b> | <b>244,911</b> | <b>263,418</b> | <b>261,876</b> | <b>1,012,977</b> | <b>100%</b> |

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The following chart reports the incidence of messages in SFY 2008:

|                              | Q1 SFY '08 | Q2 SFY '08 | Q3 SFY '08 | Q4 SFY '08 | Totals    | Percent |
|------------------------------|------------|------------|------------|------------|-----------|---------|
| Drug-Drug Interaction(DD)    | 68,870     | 73,532     | 76,090     | 65,666     | 286,158   | 25%     |
| Early Refill (ER)            | 10,806     | 11,441     | 12,271     | 11,233     | 45,751    | 4%      |
| Drug-Disease (MC)            | 10,197     | 10,765     | 9,420      | 9,209      | 39,591    | 4%      |
| Ingredient Duplication (ID)  | 21,159     | 25,271     | 25,920     | 25,029     | 97,379    | 9%      |
| Drug-Age Precaution (DA)     | 21         | 50         | 80         | 87         | 238       | 0%      |
| Therapeutic Duplication (TD) | 151,554    | 164,449    | 175,306    | 169,406    | 660,715   | 58%     |
| <b>Totals</b>                | 262,607    | 285,508    | 299,087    | 280,630    | 1,129,832 | 100%    |

***Difference SFY '07 to SFY '08:***

**8%                      17%                      14%                      7%                      12%**

In SFY 2006, 2,783,171 messages were returned to pharmacy providers. With the implementation of MedMetrics' claims processing system in 2006, steps were taken to minimize the processing burden on pharmacists by limiting messages to interactions categorized in pharmacy claims processing standards as "major" as opposed to "moderate" or "minor" in terms of severity or "absolute" as opposed to "potential" or "precaution". For example, a drug-drug interaction or therapeutic duplication edit applies when it is categorized as major in severity and a drug-age precaution edit applies when it is absolute. From 2007 to 2008, there was a 12% increase in utilization review events. The majority of the increases are ingredient duplications, therapeutic duplications, and early refills. These are critical pharmacy benefit management areas where the issues can be related to both health and safety and appropriate, cost-effective use.

*Drug Utilization Review (DUR) Board Activities*

A charge of the DUR Board is to select certain drugs and/or prescribing practices to target for review of actual use and/or application. Staff makes recommendations for targeted areas and the Board selects those most relevant.

Examples of the DUR Board's activities in the last year to target certain drugs and prescribing practices included reviews of the following:

- Health and safety:
  - Topical immunomodulators used to treat skin conditions but potentially dangerous in treating young children

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- Acetaminophen used as an analgesic but dangerous in quantities over 4 grams a day
- Botox<sup>®</sup> /Myobloc<sup>®</sup> while not covered by Vermont Medicaid for cosmetic purposes used for limited clinical reasons
  
- Health and safety/concern for diversion:
  - Carisoprodol used as a skeletal muscle relaxant but abused as a sedative intoxicant
  - Marinol<sup>®</sup> used to treat pain as medical marijuana but abused as a recreational drug
  
- Treatment management:
  - Asthma Medication Therapy – Pre- and Post-Emergency Room or Inpatient Hospital Admission: Assessment of adherence to maintenance medication therapy
  
- Cost containment:
  - Quantity limits and dose consolidation:
    - Select mental health medications
  - Step therapy requirements limiting access to certain drugs before the trial of less expensive therapies
    - Advair<sup>®</sup> used to treat asthma and chronic obstructive pulmonary disease
    - Lidoderm<sup>®</sup> used to treat neuropathic pain
    - Angiotensin receptor block therapy used for controlling high blood pressure, treating heart failure, and preventing kidney failure in people with diabetes or high blood pressure
  - Branded drugs more expensive than generic alternatives:
    - Cough and cold medications
    - Skeletal relaxants; promoting generics
    - Acne products

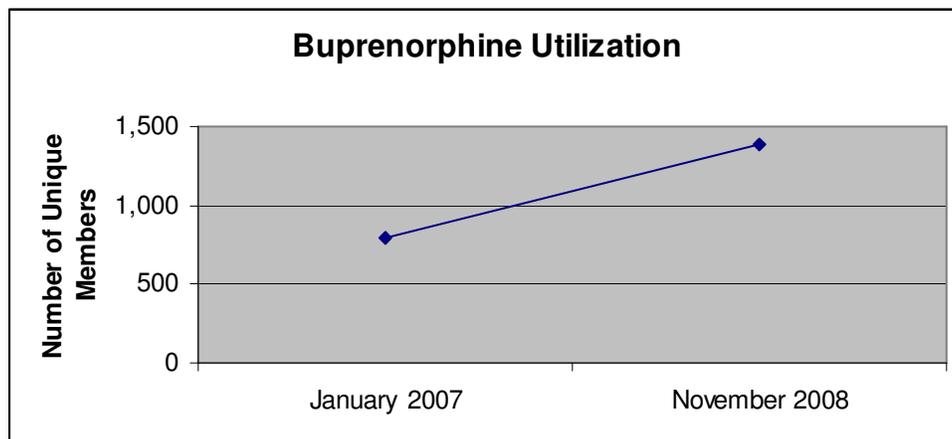
One activity of particular note in 2008 was the DUR Board review of utilization and cost patterns for the buprenorphine products Suboxone<sup>®</sup> and Subutex<sup>®</sup>, FDA approved for use in patients with a diagnosis of opiate dependence. Subutex<sup>®</sup> is more costly than Suboxone<sup>®</sup>, but more importantly, is more easily diverted and abused by injection or intranasal use as it does not contain the added ingredient naloxone.

In December 2007, management of this drug class began and prior authorization was implemented for all new patients being prescribed either Subutex<sup>®</sup> or Suboxone<sup>®</sup>. Under management coverage was limited to those with a diagnosis of opiate dependency. Requests were to be denied for use for pain control. Prescribers were required to have a DATA 2000 waiver ID number. Additionally, a request for Subutex<sup>®</sup> required the

patient to either be pregnant or have a documented allergy to naloxone which would preclude Suboxone<sup>®</sup> use.

At the time of implementation, all current users of either Subutex<sup>®</sup> or Suboxone<sup>®</sup> were “grandfathered”; that is, they were allowed to continue use of the products without having to demonstrate they met the criteria for coverage. In August 2008 the DUR Board decided to end the grandfathering of Subutex<sup>®</sup> users to ensure the use of that specific preparation only when medically necessary.

While the number of total unique members receiving Subutex<sup>®</sup> or Suboxone<sup>®</sup> on a monthly basis has increased 76% during the time period January 2007 through November 2008 (from 788 to 1387) and monthly expenditures have increased 74% (from \$263,000 to \$458,000), the percentage of members on buprenorphine who are using the Subutex<sup>®</sup> preparation has decreased from 10% in January 2007 to 9% in November 2008 after reaching a high of 15.1% in November 2007.



### **Supplemental Rebates**

Federal law requires that manufacturers pay rebates for drugs to be covered by the Medicaid Program. It also allows states to separately negotiate with manufacturers to secure rebates subject to the approval of the Centers for Medicare and Medicaid Services.

When states develop a preferred drug list they “prefer” clinically appropriate products because they are singularly clinically appropriate. When multiple products are clinically appropriate, products may be preferred because they are inherently cost effective or because the manufacturer has offered to make them cost effective.

Beginning in October 2002 Vermont started securing Vermont-only supplemental rebate agreements. From April 2003 until December 2005, Vermont was a member of the

National Medicaid Pooling Initiative (NMPI) with eight other states under the management of the PBA vendor for all of the states, First Health Services Corporation.

In the fall 2005, Vermont committed to the Sovereign States Drug Consortium (SSDC), the first in the nation state-administered Medicaid pooling initiative for supplemental rebates. Member states were Iowa, Maine, and Vermont. Since membership has grown with Utah in 2007, Wyoming in 2008, and West Virginia as of January 1, 2009. A number of other states are considering the Consortium.

As SSDC members, states pool their collective lives, state staff and pharmacy benefit management contractor resources to negotiate supplemental rebate agreements with drug manufacturers. This approach provides significant administrative efficiency. In addition it provides a greater opportunity for state involvement; state-specific drug coverage customization; multi-state collaboration in publicly funded programs; and creates a pool not dependent upon a single contract vendor or a state's affiliation with a PBM vendor.

In the spring of 2007 on behalf of the SSDC, the OVHA released a Request for Proposal for a vendor to act as the rebate procurement agent to negotiate with drug manufacturers for Medicaid supplemental rebates for the SSDC. A contract was awarded to GHS Data Management of Augusta, Maine for two years with an optional contraction extension of up to two additional years. This contract began in September 2007 and is managed by the OVHA for the SSDC.

Supplemental rebates continue to be a valuable resource in the Vermont Health Access PBM Program. SFY 2006 collections on calendar year 2005 utilization were \$10.4 million. With the transition of 30,000 beneficiaries and their utilization to Medicare Part D in calendar year 2006, the rebate collections for SFY 2007 were anticipated to be \$3.9 million. Actual collections for SFY 2007 against calendar year 2006 utilization were greater than projected at \$4.7 million. SFY 2008 collections against calendar year 2007 utilization were \$5.3 million.

### ***Managing Reimbursement***

Nationally, Medicaid programs reimburse individual claims based on the lower of a pharmacy's usual and customary/submitted fee including a dispensing fee, a measure of ingredient costs plus a dispensing fee, the Centers for Medicaid and Medicare Services established Federal Upper Limit (FUL) plus a dispensing fee, or a Maximum Allowable Cost (MAC) amount plus a dispensing fee if the State opts for a MAC list.

As a matter of routine the OVHA monitors reimbursement to pharmacies serving Vermont's programs. The following chart compares Vermont's reimbursement to that of other states in the northeast for the calendar quarter ending December 2008. A note of comparison: AWP minus 11.9% is approximately WAC plus 8.1%.

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| State                                                                                                         | Ingredient Cost                                                                                                  | Dispensing Fee                                                                                            | State MAC List for Multi-source Drugs |
|---------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|---------------------------------------|
| Connecticut                                                                                                   | Ingredient cost is AWP minus 40% for selected multi-source brands and generics; AWP minus 14 (other brands)      | Dispensing fee is \$3.15                                                                                  | Y                                     |
| Maine                                                                                                         | Ingredient cost is AWP minus 15%; AWP minus 17% (on direct supply); AWP minus 20% (mail order)                   | Dispensing fee is \$3.35; \$1.00 (mail order); \$4.35 and \$5.35 (compounding); \$12.50 (insulin syringe) | Y                                     |
| Massachusetts                                                                                                 | Ingredient cost is WAC plus 5% (all drugs except 340B billed drugs); actual acquisition cost (340B billed drugs) | Dispensing fee is \$3.00 (all drugs except 340B billed drugs) \$10 (340B billed drugs)                    | Y                                     |
| New Hampshire                                                                                                 | Ingredient cost is AWP minus 16%                                                                                 | Dispensing fee is \$1.75                                                                                  | Y                                     |
| New York                                                                                                      | Ingredient cost is AWP minus 14% (brand); AWP minus 25% (generic); AWP minus 12% (specialized HIV pharmacies)    | Dispensing fee is \$3.50 (brand); \$4.50 (generic)                                                        | Y                                     |
| Rhode Island                                                                                                  | Ingredient cost is WAC                                                                                           | Dispensing fee is \$3.40 (outpatient), \$2.85 (long-term care)                                            | N                                     |
| Vermont                                                                                                       | Ingredient cost is AWP-11.9%                                                                                     | \$4.75 (in-state); \$3.65 (out-of-state); plus \$15 - compounding                                         | Y                                     |
| (AWP=average wholesale price, WAC=wholesaler acquisition cost, FUL=federal limit, MAC=maximum allowable cost) |                                                                                                                  |                                                                                                           |                                       |
| SOURCE: Centers for Medicaid and Medicare Services Approved State Plans                                       |                                                                                                                  |                                                                                                           |                                       |

Vermont's reimbursement for brand drugs is the highest in the northeast. Vermont pays for many generic drugs based on a competitive MAC price; as a result, Vermont's generic reimbursement is believed to be less than in the other New England states as well as the state of New York. Vermont's dispensing fee for in-state pharmacies is the highest in the region.

Section 107a of Act 215 of the Vermont General Assembly of the 2005-2006 Legislative Session (H.881) authorized a Medicaid generic reimbursement reduction and dispensing fee study. Proposed changes to Medicaid reimbursement on generics effective for calendar year 2007 as contained in the Federal Deficit Reduction Act (DRA)

of 2005 was a driving force for this authorization. The expressed issue was the impact of changes on overall reimbursement.

The federal Deficit Reduction Act of 2005 proposed that, for purposes of Medicaid reimbursement for drugs available from multiple manufacturers, an established pricing standard, the Federal Upper Limit (FUL), be based on Average Manufacturer Price (AMP). Until that time manufacturers' published wholesale prices had been used to establish a ceiling or upper limit for cost reimbursement for multi-source drugs in federal programs when three or more multi-source equivalents were available. The DRA methodology proposed to use AMP to establish the FUL for multi-source drugs when two or more equivalents are available.

To assure a thorough analysis in the study, the OVHA opted to include all possible aspects of drug reimbursement in programs. The study was completed and distributed to the Legislative Health Access Oversight Committee and the Legislative Joint Fiscal Committee in January 2007 and is available on the OVHA's website at <http://ovha.vermont.gov/>.

The findings of that study were:

- The average reported cost of dispensing individual prescriptions in pharmacies serving Vermont Medicaid was \$10.55.
- The full potential impact of the DRA could not be determined as the federal rules proposed in December 2006 were not expected to be finalized until later in 2007.

Section 110g of Act 65 of the Vermont General Assembly of the 2007-2008 Legislative Session (H.537) stated that the OVHA would analyze the impact of the Centers for Medicare and Medicaid Services (CMS) implementation of the final rule revising the federal upper limits (FULs) for prescription drug reimbursement.

Before that analysis was completed, the National Association of Chain Drug Stores (NACDS) and the National Association of Community Pharmacists (NCPA) filed a related lawsuit against CMS and the U.S. Department of Health and Human Services. On November 15, 2007 the NACDS and the NCPA filed a preliminary injunction motion with the United States District Court for the District of Columbia to block its implementation.

On December 14, 2007 a hearing was held and the court issued a preliminary injunction blocking making data on the AMPs available and the implementation of any reimbursement cuts. On December 19, 2007, the order was issued. On December 21, 2007 CMS notified states that the AMPs would not be provided to Medicaid State Agencies and that they would not be used in the calculation of the FUL until further notice.

On July 15, 2008, the Medicare Improvements for Patients and Providers Act of 2008 was enacted. As a result of this legislation, CMS was prohibited from taking any action prior to October 1, 2009, to impose FULs for multiple source drugs.

As a result of these actions, the analysis proposed in response to Act 65 Section 110g cannot be completed until the necessary information can be made available.

### ***Responding to Change***

#### *Medicare Part D*

2008 was the third year where Vermont's publicly funded pharmacy benefit programs were the secondary payer for pharmacy benefits after Medicare Part D.

#### Vermont Coverage for Medicare Eligibles

##### Traditional Medicaid (Primarily below 100% of the FPL)

- The State's coverage is limited to excluded drug classes (benzodiazepines; barbiturates; over-the counter prescriptions; vitamins or minerals; cough and cold preparations; drugs when used for anorexia, weight loss, or weight gain) for those who are enrolled in a Part D plan (or Part C with a drug component) or have creditable coverage.
- No State premium is charged.
- The beneficiary pays the Part D co-pays (from \$1.10 to \$6.00) with the exception that pregnant women and children's co-pays are paid by the State.
- All other cost-sharing is covered by a federal benefit referred to as the low-income subsidy (LIS).
- Drugs that are not on the plan's formulary or are denied by the plan as not medically necessary are not covered without specific approval from the OVHA.
- When a Part C or D plan denies a non-formulary drug or a drug the plan indicates is not medically necessary, beneficiaries may apply to the OVHA for coverage of the drug after the plan's appeal process is exhausted (through the Independent Review Entity level) and the denial remains upheld.
- The plans are required to cover all or substantially all of the drugs in the following categories: antidepressant, anticonvulsive, antipsychotic, anticancer, immunosuppressant, and HIV/AIDS.

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

During 2008, Vermont provided a State wraparound program named VPharm. This program supplemented Medicare coverage to a level that was comparable to state coverage provided prior to the implementation of Part D.

Throughout 2008, beneficiaries eligible for Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualified Individual (QI) programs benefited from a resource test elimination. By virtue of eligibility for these programs, they became eligible for the full federal LIS. Based on historical expenditures the analysis indicated that this change would be (at worst) cost-neutral for the State.

VPharm coverage highlights:

- Beneficiaries must be eligible for Part A or enrolled in Part B.
- Beneficiaries must be enrolled in a Part D plan (or a Part C plan with a drug component, or a Part C plan without a drug component and separately enroll in a Part D plan) and secure the LIS if it appears they might be eligible.
- Beneficiaries pay premiums to the State of \$17, \$23 or \$50.
- The coverage is:
  - Payment of cost-sharing that is not covered by the LIS, including premiums, deductibles, co-payments, coinsurance and the coverage gap (for beneficiaries at the VScript or VScript Expanded coverage level of 150% to 225% FPL, only maintenance drugs are eligible for the cost-sharing coverage); and
  - Coverage of drug classes that are excluded from Part D (benzodiazepines; barbiturates; over-the counter prescriptions; vitamins or minerals; cough and cold preparations; drugs when used for anorexia, weight loss, or weight gain). Some of these may have requirements or limits attached. For beneficiaries at the VScript or VScript Expanded coverage level (150% to 225% FPL), only maintenance drugs in these classes are included in the benefit.
- Drugs that are not on the plan's formulary or are denied by the plan as not medically necessary are not covered without specific approval from the OVHA.
- When a Part C or D plan denies a non-formulary drug or a drug the plan indicates is not medically necessary, beneficiaries may apply to the OVHA for coverage of the drug after the plan's appeal process is exhausted (through the Independent Review Entity level) and the denial remains upheld.
- The plans are required to cover all or substantially all of the drugs in the following categories: antidepressant, anticonvulsive, antipsychotic, anticancer, immunosuppressant, and HIV/AIDS.

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Healthy Vermonters Program  
(Primarily greater than 225% and up to 400% of the FPL)

Healthy Vermonters Program beneficiaries who have Medicare may obtain drugs in the Part D excluded classes (benzodiazepines; barbiturates; over-the counter prescriptions; vitamins or minerals; cough and cold preparations; drugs when used for anorexia, weight loss, or weight gain) at the Medicaid cost.

Phased-Down Contribution

The pharmacy benefit under Medicare is conceptually a federal benefit. However, in the case of full benefit dual eligibles (those Medicare beneficiaries who are also eligible for the health insurance benefit of Medicaid), it is funded in the same way as it is funded under Medicaid, with federal and state funding. What in Medicaid is referred to as the state share is called the phased-down state contribution for Medicare. The Part D design requires that states annually pay a portion of what they would have paid in Medicaid state share in that year for the support of drug coverage of Medicare beneficiaries who are also eligible for Medicaid drug coverage. This is the concept sometimes referred to as “clawback”. Key concepts of the phased-down contribution:

- Based on Medicaid full benefit eligible state expenditures in calendar year (CY) 2003 adjusted for inflation (excluding VHAP-Pharmacy, VScript, and VScript expanded in Vermont since no portion of those expenditures were for Medicaid full benefits eligibles).
- Calculated on expenditures net of drug rebate.
- Premised on states retaining a specified portion in support of providing other coverage to their dual eligibles.

Based on these concepts, for calendar year (CY) 2008, Vermont was expected to pay the phased-down state contribution of 86.67 % of the estimated CY state share of Medicaid/Medicare pharmacy expenditures net of rebate. The contribution in future years will be progressively less:

|                        |        |
|------------------------|--------|
| CY 2009                | 85.00% |
| CY 2010                | 83.33% |
| CY 2011                | 81.67% |
| CY 2012                | 80.00% |
| CY 2013                | 78.33% |
| CY 2014                | 76.67% |
| CY 2015 and thereafter | 75.00% |

For state fiscal year 2008, the Vermont phased-down contribution \$20,339,254.

### PDP Selection

A Medicare-contracted Prescription Drug Plan (PDP) provides the primary pharmacy benefit to Medicare eligibles. Every beneficiary has a choice of at least two PDPs. Beneficiaries choose their plans annually during their annual enrollment period (AEP) which is November 15 through December 31. Dual eligibles may change plans any month in the course of the year. Some beneficiaries have special enrollment periods (SEP) which are the only times they can choose or change plans. As Vermont's State pharmacy program that wraps the Part D benefit, VPharm is designated as a state pharmacy assistance program (SPAP) by the federal government. CMS permits individuals eligible for a SPAP one SEP in addition to their AEP and one SEP in addition if they lose their SPAP eligibility.

### PDP Drug Coverage

Each Medicare PDP sets its coverage plan (formulary) according to Medicare guidelines:

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

### OVHA PDP Administration

The OVHA remains involved in the administration of wrap coverage. These include providing enrollment and eligibility functionality and data transfers to Medicare; managing the medical coverage for traditional Medicaid eligibles; coordinating any State pharmacy benefits with Medicare pharmacy coverage; and educating/supporting beneficiaries/providers.

### OVHA Continuing Support for Beneficiaries

The OVHA continues to take steps to ensure that Vermonters who are having trouble accessing the federal prescription drug benefit have assistance in resolving issues. Since 2006, the OVHA has had a team of employees that acts as a liaison between the beneficiary and the federal prescription program.

### Coordination of Benefits with Medicare Part D

On January 1, 2006, when Medicare drug coverage authorized under the Medicare Modernization Act (MMA) of 2003 was implemented. 30,000 Medicaid, VHAP Pharmacy, VScript, and VScript Expanded beneficiaries were transitioned to primary drug coverage under Part D. Almost instantly it was apparent that there were problems and they were not immediately solved.

With the difficulties, the Legislature appropriated state funds to support the reinstatement of Vermont program provisions as they existed on December 31, 2005. The Governor approved and ordered this on January 5, 2006 and the changes were implemented on January 6, 2006. This provided an answer for assuring both beneficiary access and pharmacy reimbursement while Medicare Part D system issues were being resolved.

In March 2006, the OVHA determined that the Medicare Part D Prescription Drug Plans (PDPs) had demonstrated their ability to handle the coverage of their beneficiaries. At that time the OVHA began transitioning people back to Part D coverage. This was completed by July 2006.

Between January and July 2006, Vermont spent an estimated \$11.7 million on drugs as part of Medicare Part D bailout coverage. Vermont participated in the Centers for Medicare and Medicaid Services (CMS) Medicare Section 402 Demonstration Project to receive reimbursement for administrative expenses and claims on select eligibles. Claims ineligible for or denied under the 402 Demonstration Project must be billed to the Medicare Prescription Drug Plans (PDPs). The OVHA's Pharmacy and Coordination of Benefits (COB) Units developed a process to submit the claim billings and its Administrative Services Unit managed the collection of administrative expenses.

#### *Vermont State Auditor of Accounts Report on \$2.2 Million in Questioned Pharmacy Claims*

In December 2006 the Office of the Vermont State Auditor released a report that identified a possible \$2.2 million in improper payments associated with pharmacy claims processing by First Health for the period January 1, 2004 through December 31, 2005.

Over \$569 thousand has been recovered thus far. In conjunction with our PBM partner, MedMetrics, claims processing changes have been implemented which will minimize the likelihood of future claims errors associated with quantities and/or dosage forms.

To assure a complete review of all First Health claims identified by the state auditor, the OVHA has amended its contract with MedMetrics to include performing provider recovery services against those claims. This process is well underway. In addition, the OVHA's Program Integrity Unit has contracted with Ingenix to perform a variety of claims audits on an ongoing basis.

*Act 80 of the Vermont General Assembly of the 2007-2008 Legislative Session (S.115)*

In the spring of 2007 the Legislature enacted Act 80, *An Act Relating to Increasing Transparency of Prescription Drug Pricing and Information*. This Act:

- Implemented a joint pharmaceuticals purchasing consortium.
- Increased transparency of drug pricing information.
- Increased the federal poverty level for eligibility for the Healthy Vermonters program from 300% to 350% for those who are less than age 65 or not eligible for Medicare or Social Security disability benefits.
- Required increased oversight of pharmacy benefit managers (PBMs) and their practices.
- Established an evidence-based education program.
- Established a generic drug voucher pilot project.
- Protected the confidentiality of prescription information.
- Established a fee for drug manufacturers to fund the education program including the voucher pilot project.
- Enhanced consumer protections.

The following outlines the status of each of these items:

- Joint pharmaceuticals purchasing consortium (JPPC): The JPPC provides a vehicle to negotiate rebates on behalf of non-Medicaid programs. Preliminary design discussions have occurred exploring options to pool covered lives with other states to maximize opportunities. Implementation of this will require the authorization and funding of OVHA staff.
- Drug pricing information: This component requires drug manufacturers to report to the OVHA the same pricing information reported to the Centers for Medicare and Medicaid (CMS) for Medicaid drug rebate purposes. A quarter of information was collected in 2008 but the effort proved to be very labor intensive. Full implementation of this will require the authorization and funding of OVHA staff.
- Healthy Vermonters' Program: The Act increased the eligibility income test level from 300% to 350% of the Federal Poverty Level for those who are less than age 65 or not eligible for Medicare or Social Security disability benefits. This change was implemented on July 1, 2007. The Act also proposed securing rebates from manufacturers for this program with the approval of CMS. This latter provision will require the authorization and funding of OVHA staff to implement.
- Pharmacy benefit management regulations, registration, audit and oversight of practices: These aspects are related to regulatory oversight taken on by the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA).
- Establishment an evidence-based education program: This program charges the Vermont Department of Health in collaboration with the Office of the Attorney

General (AG), the University of Vermont Area Health Education Centers (AHEC), and the OVHA with the establishment of an evidence-based prescription drug education program for health care professionals designed to provide information and education on the therapeutic and cost-effective utilization of prescription drugs. Litigation has been filed impacting the funding of these activities. The OVHA's participation in the education program is dependent on the authorization and funding of staff. The AHEC Program's participation is dependent on funding.

- Establishment of a generic drug voucher pilot project: This project is a part of the evidence-based education program. Design meetings have been held. Drug selection and plans for determining where and how the pilot might be implemented are outstanding issues. Claims processing specifications have been developed. Litigation has been filed impacting the funding of this component of the evidence-based education program. Implementation of the project will require funding for the benefit, the authorization and funding of OVHA staff to administer the benefit, and funding for claims processing requirements.
- Prescription information confidentiality: This piece of the Act is subject to litigation.
- Consumer protection enhancements: These entail consumer protections in terms of advertising and insurance marketing. These are provisions that provide improved controls for the AG's office and for BISHCA in their respective roles.
- Establishment of a fee for drug manufacturers: This fee is intended to fund collection and analysis of information on pharmaceutical marketing activities, analysis of prescription drug data needed by the AG's office for enforcement activities, and the education-based drug education program's activities including the drug voucher pilot program and the work of the AHEC Program. On August 13, 2008, the Legislative Committee on Administrative Rules approved OVHA's Bulletin 08-03, Pharmaceutical Manufacturer Fee. This authorizes the fee at 0.5% of the previous calendar year's prescription drug spending by OVHA assessed based on labeler codes in the rebate program. This bases the fee on spending in Vermont's publicly funded pharmacy benefit programs. With these programs covering nearly 25% of the total population, this method is a proxy for manufacturer market share in Vermont and applies a greater portion of the fee to those manufacturers with the greater market share.

### *Tamper-Resistant Prescription Drug Pads*

Section 7002(b) of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery and Iraq Accountability Appropriations Act of 2007 set requirements regarding the use of tamper-resistant prescription drug pads in Medicaid. This was signed into law on May 25, 2007. Initially the Centers for Medicare and Medicaid Services (CMS) intended to impose this requirement as of October 1, 2007. However with many concerns raised, President Bush signed legislation into law on September 29, 2007 delaying implementation until April 1, 2008.

The following were the conditions for Medicaid program reimbursement as of April 1, 2008:

- All written prescriptions for outpatient covered drugs must be written on tamper-resistant prescription paper.
- To be considered tamper-resistant, prescription paper must contain one of the following three characteristics:
  - one or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form;
  - one or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber; or
  - one or more industry-recognized features designed to prevent the use of counterfeit prescription drug forms.

As of October 1, 2008, all of the above-referenced characteristics were required for the prescription paper to be considered tamper-resistant.

With implementation, CMS will be requiring that state Medicaid programs audit pharmacies to assure compliance. Pharmacy documentation will be necessary. If it is determined that a payment was made on a claim for a prescription that was not in compliance with the Medicaid tamper-resistant prescription requirements, payments must be recovered. Provisions allow for federal auditors to audit state audit samples to assure that audits occur.

#### *VITL's Electronic Medication History Service*

Late in 2006, Vermont Information Technology Leaders, Inc. (VITL) initiated planning on a pilot project for a service designed to support the Blueprint for Health's Chronic Care Information System.

The service makes insurers' medication history data available electronically to hospital emergency departments. A patient can allow emergency room personnel to quickly review his or her drug utilization using an electronic query transmitted to the claims history databases of participating insurers. Access to this information can lead to faster diagnosis and improved medical treatment for individuals who may not be able to provide a complete medication history, often due to the acute nature of their illness or injury.

The pilot began in the spring of 2007 with two hospitals: Rutland Regional Medical Center in Rutland, Vermont, and Northeastern Regional Vermont Hospital in St. Johnsbury, Vermont. The service utilizes software provided by G.E. Health Care in South Burlington, Vermont.

*Pharmacy Best Practices and Cost Control Report 2009*

Drug history claims data is available from several health insurance claims payers, the largest being the OVHA through its PBA, MedMetrics. Other payers include Blue Cross and Blue Shield of Vermont, MVP Health Care, CIGNA Health Care and some Part D Plans.

The service has now completed its pilot phase and is being offered to additional hospitals in Vermont. Both hospitals involved in the pilot are still participating as is Brattleboro Memorial Hospital in Brattleboro which began using the service at the end of 2008.

*Assessment of SFY 2008*

In the early years of the Vermont Health Access Pharmacy Benefit Management Program, the major drug classes with regard to expenses were gastric acid reducers, anti-inflammatory drugs, and analgesic pain relievers. It was easy to focus on such classes where utilization was high. Success was measured in terms of millions of dollars in reduced spending as beneficiaries were moved to the least expensive alternatives.

With the maturing of the Program, success in drug class management is not as easily accomplished. The promotion of generics, the management of select utilization, and the acquisition of supplemental state rebates on drugs used in Vermont's programs have contributed the most to expense avoidance.

As indicated before, Vermont programs' generic usage is as follows:

| <b>SFY 2007</b>                                    | <b>Percentage of non-Part D Rx</b> | <b>Percentage of Part D Rx</b> | <b>Percentage of All Rx</b> |
|----------------------------------------------------|------------------------------------|--------------------------------|-----------------------------|
| Generic use as a percentage of all drugs dispensed | 62.54%                             | 65.36%                         | 63.95%                      |
| Generic use when generic equivalent available      | 97.95%                             | 97.18%                         | 97.57%                      |

| <b>SFY 2008</b>                                    | <b>Percentage of non-Part</b> | <b>Percentage of Part D Rx</b> | <b>Percentage of All Rx</b> |
|----------------------------------------------------|-------------------------------|--------------------------------|-----------------------------|
| Generic use as a percentage of all drugs dispensed | 62.99%                        | 69.86%                         | 65.25%                      |
| Generic use when generic equivalent available      | 98.39%                        | 97.30%                         | 98.00%                      |

The University of Connecticut, School of Pharmacy assisted the OVHA in the production of the Generic Reimbursement Reductions and Dispensing Fee Study in 2006. They procured an independent vendor, Advance Pharmacy Concepts (APC), knowledgeable in pharmacy operations to assist in data analysis. APC reports that the use of generic products has been seen to be the single most valuable cost-saving initiative that can be

*Pharmacy Best Practices and Cost Control Report 2009*

implemented by any insurer. APC indicated that the generic use performance in Vermont programs is excellent compared to commercially administered drug benefits.

Examples of generic savings as a result of drug specific targeting in 2008 include:

|                            | Estimated annual gross savings |
|----------------------------|--------------------------------|
| Cough and cold medications | \$ 77,256                      |
| Skeletal relaxants         | \$ 155,654                     |
| Acne products              | \$ 311,308                     |

Examples of PBM Program utilization management activities that produced program savings include:

|                                       | Estimated annual gross savings |
|---------------------------------------|--------------------------------|
| Carisoprodol                          | \$ 13,863                      |
| ARB step therapy                      | \$ 54,766                      |
| Topical immunomodulators              | \$ 62,684                      |
| Lidoderm <sup>®</sup>                 | \$ 235,083                     |
| Mental health drug dose consolidation | \$ 621,359                     |

As previously described, supplemental rebates continue to be another valuable tool in Vermont. Even with the transition of 30,000 beneficiaries and their utilization to Medicare Part D, collections for SFY 2007 against calendar year 2006 utilization were \$4,746,226; SFY 2008 collections against calendar year 2007 utilization were \$5,318,443.

At this stage the charges of the PBM Program are to maintain the level of success achieved to date and to monitor the benefits vigilantly to identify areas where additional returns may be found.

With the implementation of Medicare Part D and the transition of 30,000 beneficiaries to primary coverage under Part D, it is estimated that 95.9% of elderly beneficiaries and 46.8% of disabled beneficiaries became Part D covered. Historically beneficiaries who are elderly and disabled are major users of Vermont drug programs' coverage, particularly in many of the drug classes managed in the Vermont PDL. Prior to Part D, much of the PBM Program's focus was directed to Medicare eligibles.

The following chart illustrates the impact of the Part D change with paid claims volume attributed by age. The 2005 figures show program activity with all Vermont programs including coverage for those who would become eligible for Part D in 2006. The 2008 figures show beneficiary activity in Vermont programs fully managed by the PBM

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Program; that is, those without Part D coverage. This illustrates that for those ages 65 and older the vast majority of primary claims have now transitioned to Part D coverage. In addition, with those ages 21 to 64, a number of primary claims can also now be attributed to Part D:

| Primary Vermont Program Paid Pharmacy Claims |              |       |              |       |
|----------------------------------------------|--------------|-------|--------------|-------|
| Ages                                         | Jul-Dec 2005 |       | Jul-Dec 2008 |       |
| 0-12                                         | 102,687      | 6.3%  | 100,326      | 13.7% |
| 13-20                                        | 85,055       | 5.2%  | 85,476       | 11.7% |
| 21-40                                        | 265,438      | 16.3% | 226,655      | 30.9% |
| 41-50                                        | 240,446      | 14.7% | 149,627      | 20.4% |
| 51-64                                        | 206,637      | 12.7% | 166,562      | 22.7% |
| 65 and older                                 | 731,558      | 44.8% | 4,413        | 0.6%  |
| Totals                                       | 1,631,821    |       | 733,059      |       |

As a result, at this point the age focus is first on adults and then on children.

In SFY 2005, prior to the transition of many beneficiaries and their expenditures to Medicare Part D, the top five drug classes with regard to expenditures were:

1. Antipsychotics, atypical, dopamine, & serotonin antagonists
2. Anticonvulsants
3. Lipotropics
4. Gastric acid reducers
5. Selective serotonin reuptake inhibitors (SSRIs)

For the non-Part D beneficiaries, management of antipsychotics, atypical, dopamine, & serotonin antagonists; anticonvulsants; and selective serotonin reuptake inhibitors (SSRIs) began in SFY 2006. In addition, lipotropics and gastric acid reducers were on the PDL and managed to the extent possible to meet clinical needs.

In SFY 2008, the top five drug classes for all beneficiaries with regard to expenditures were:

1. Antipsychotics, atypical, dopamine, & serotonin antagonists
2. Anticonvulsants
3. Analgesic narcotics
4. Gastric acid reducers
5. Drugs for attention deficit – hyperactivity (ADHD)/narcolepsy

Clearly, some areas requiring attention remain the same. Drugs used to treat attention deficit, hyperactivity, and narcolepsy reflects the impact of the change in populations served. Drugs taken by largely an older population (such as lipotropics) have moved from being paid primarily by Medicaid to being paid primarily by Medicare Part D.

*Pharmacy Best Practices and Cost Control Report 2009*

Looking at overall utilization and claims specific spending during each of SFY 2006, SFY 2007, and SFY 2008, with all eligibles including Part D eligibles, the following occurred:

| All Paid Pharmacy Claims for All Beneficiaries |               |               |               |
|------------------------------------------------|---------------|---------------|---------------|
|                                                | SFY 2006      | SFY 2007      | SFY 2008      |
| Claims                                         | 2,832,959     | 2,270,948     | 2,188,538     |
| Days Supply                                    | 73,625,601    | 58,626,935    | 57,065,126    |
| Claims Payments                                | \$167,532,603 | \$109,319,875 | \$112,298,713 |
| Average Monthly Eligibles                      | 132,240       | 132,554       | 135,509       |
| Claims per Eligible per Month                  | 1.8           | 1.4           | 1.3           |
| Days Supply per Eligible per Month             | 46.4          | 36.9          | 35.1          |
| Paid per Eligible per Month                    | \$105.57      | \$68.73       | \$69.06       |

From 2006 to 2007 the reduction in paid per eligible per month can be attributed to eligibles moving to Part D coverage and out of primary coverage in Vermont programs.

From 2007 to 2008 there is only a 1.51% increase in the amount paid per eligible per month. This is a credit to all of the 2008 activities of the PBM Program including the commitment of both prescribers and pharmacies that resulted in 3.06% increase in pharmacy spending before rebates and .49% **decrease** in spending after rebates from SFY 2007 to SFY 2008.

Note, though, that eligibles have increased. This is a likely result of the downturn in the economy. Removing Medicare eligibles and looking at only the last six months of each of the last three years produces the following:

| All Paid Pharmacy Claims for Beneficiaries Without Medicare Coverage |                |                |                |
|----------------------------------------------------------------------|----------------|----------------|----------------|
|                                                                      | Jul - Dec 2006 | Jul - Dec 2007 | Jul - Dec 2008 |
| Claims                                                               | 693,553        | 689,861        | 733,400        |
| Days Supply                                                          | 16,488,946     | 16,664,689     | 17,866,703     |
| Claims Payments                                                      | \$45,784,079   | \$47,159,832   | \$52,833,594   |
| Average Monthly Eligibles                                            | 104,363        | 102,486        | 116,536        |
| Claims per Eligible per Month                                        | 0.6            | 0.6            | 0.5            |
| Days Supply per Eligible per Month                                   | 13.2           | 13.6           | 12.8           |
| Paid per Eligible per Month                                          | \$36.56        | \$38.35        | \$37.78        |
| Percentage Increase Over Previous Year                               | 2.19%          | 4.89%          | -1.48%         |

While the paid per eligible is less in 2008 than in 2007 the average number of eligibles has increased by 13.7% and the resulting total spending has increased by 12%. Containing costs becomes all the more critical to maintaining pharmacy benefit coverage.

*Planned for SFY 2009*

Activities planned in the coming year include:

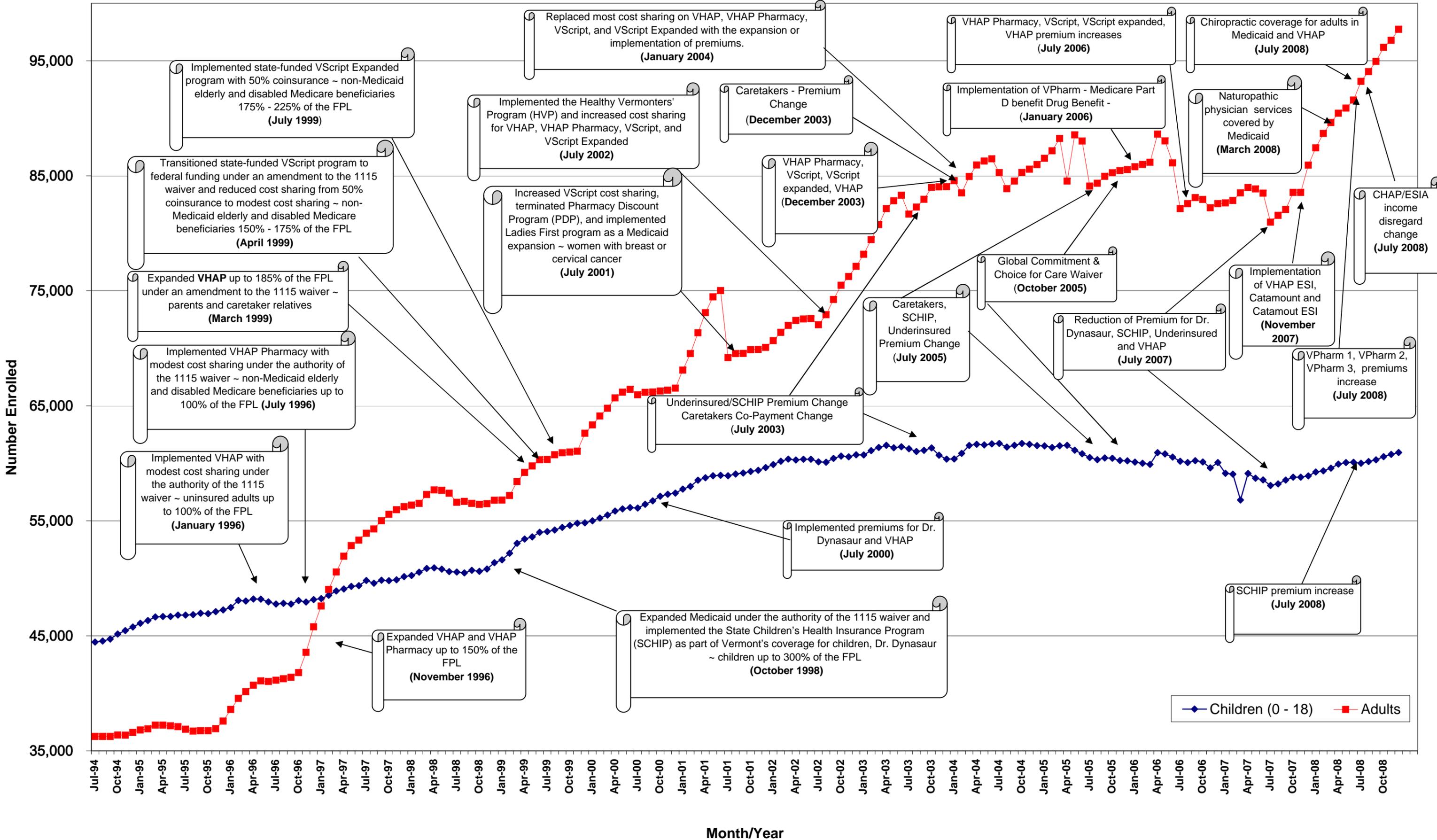
- Addressing changes in pharmacy benefits coverage in Vermont's publicly funded programs in light of dwindling cash resources to support them;
- Reviewing and updating the PDL as needed;
- Managing the cost and utilization in specific therapeutic categories where appropriate;
- Promoting over-the-counter medications when they are less expensive alternatives to prescription medications;
- Continuing to review the dispensing of drugs under medical procedure codes;
- Continuing to establish criteria for appropriate dose consolidation and optimization;
- Continuing to implement the Specialty Pharmacy Initiative to support beneficiaries in managing complex health conditions;
- Coordinating activities with the OVHA's Chronic Care Initiative;
- Coordinating activities with the Office of Alcohol and Drug Abuse Programs on treatment approaches for opiate dependence;
- Coordinating activities with the Department of Health on treatment options for smoking cessation;
- Coordinating activities with the Department of Health in addressing needed vaccines;
- Coordinating activities with the Department of Mental Health on treatment options for mental illness;
- Partnering with the OVHA Program Integrity Unit and other state and law-enforcement agencies to identify areas where program oversight can be improved;
- Working to promote new state membership in the SSDC to expand the Medicaid supplemental rebate pool;
- Working with the University of Vermont Area Health Education Centers (AHEC) on the creation of an evidence-based prescription drug education program to promote the most appropriate therapeutic and cost-effective utilization of prescription drugs; and
- Supporting the expansion of VITL's Electronic Medication History Service to hospitals in Vermont

### Insert 1: Category of Service (COS)

State of Vermont  
Agency of Human Services  
Office of Vermont Health Access  
Medicaid Budget SFY 2010

| COS   | Description of Service             | Actual SFY '02 | 2001-2002 % Change | 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 | Appropriated SFY '09 | 2008 Act-2009 Est. % Change | BAA SFY '09 | 2008 Act-2009 Req. % Change | Gov. Rec. SFY '10 | 2009 Est.-2010 SS. % Change |
|-------|------------------------------------|----------------|--------------------|----------------|--------------------|----------------|--------------------|----------------|--------------------|----------------|--------------------|----------------|--------------------|----------------|--------------------|----------------------|-----------------------------|-------------|-----------------------------|-------------------|-----------------------------|
| 01-00 | Inpatient                          | 38,309,697     | 8.4%               | 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%              | 76,583,755           | 18.5%                       | 83,309,560  | 28.9%                       | 88,216,968        | 5.9%                        |
| 02-00 | Outpatient                         | 40,672,924     | 10.7%              | 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%               | 78,887,616           | 16.3%                       | 78,887,616  | 16.3%                       | 82,323,904        | 4.4%                        |
| 03-00 | Physician                          | 44,330,306     | 8.8%               | 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%              | 74,100,031           | 7.8%                        | 74,159,371  | 7.9%                        | 77,210,055        | 4.1%                        |
| 04-00 | Pharmacy                           | 115,827,466    | 13.0%              | 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%               | 134,194,983          | 19.4%                       | 118,998,466 | 5.9%                        | 114,638,236       | -3.7%                       |
| 05-00 | Nursing Home                       | 94,436,397     | 6.9%               | 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%               | 112,828,461          | -2.4%                       | 120,859,380 | 4.5%                        | 118,396,671       | -2.0%                       |
| 07-00 | Mental Health Facility             | 266,575        | -69.2%             | 88,376         | -66.8%             | 346,914        | 292.5%             | (216,883)      | -162.5%            | 66,065         | -130.5%            | 200,938        | 204.2%             | 242,458        | 20.7%              | 255,249              | 5.3%                        | 244,474     | 0.8%                        | 243,373           | -0.5%                       |
| 08-00 | Dental                             | 14,786,888     | 11.5%              | 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%               | 20,376,083           | 27.5%                       | 19,726,602  | 23.4%                       | 20,755,700        | 5.2%                        |
| 09-01 | MH Clinic                          | (39,297)       | -316.9%            | 47,771         | -221.6%            | 18,420         | -61.4%             | 37,525         | 103.7%             | 44,333         | 18.1%              | 133,264        | 200.6%             | 55,163         | -58.6%             | 181,155              | 228.4%                      | 54,373      | -1.4%                       | 50,236            | -7.6%                       |
| 10-00 | Independent Laboratory             | 1,731,442      | 93.5%              | 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%              | 3,597,829            | 3.8%                        | 4,144,701   | 19.5%                       | 4,764,703         | 15.0%                       |
| 11-00 | Home Health                        | 7,771,719      | 12.9%              | 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%              | 7,666,658            | 21.4%                       | 7,620,953   | 20.7%                       | 7,798,828         | 2.3%                        |
| 12-00 | RHC & FQHC                         | 7,691,251      | 28.7%              | 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%              | 14,399,851           | -0.2%                       | 17,319,392  | 20.0%                       | 20,627,472        | 19.1%                       |
| 13-00 | Hospice                            | 372,814        | 60.1%              | 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%              | 1,184,633            | -10.4%                      | 1,593,100   | 20.5%                       | 1,719,329         | 7.9%                        |
| 15-00 | Chiropractor                       | 316,447        | 4.4%               | 154,279        | -51.2%             | 88,164         | -42.9%             | 84,868         | -3.7%              | 55,125         | -35.0%             | 48,784         | -11.5%             | 50,357         | 3.2%               | 552,603              | 997.4%                      | 939,870     | 1766.4%                     | -                 | -100.0%                     |
| 16-00 | Nurse Practitioners                | 395,273        | 18.3%              | 364,337        | -7.8%              | 598,020        | 64.1%              | 617,187        | 3.2%               | 541,354        | -12.3%             | 566,198        | 4.6%               | 507,683        | -10.3%             | 708,488              | 39.6%                       | 544,336     | 7.2%                        | 561,077           | 3.1%                        |
| 17-00 | Skilled Nursing                    | 4,360,886      | 10.3%              | 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%             | 4,281,143            | 47.4%                       | 3,123,453   | 7.6%                        | 3,146,076         | 0.7%                        |
| 18-00 | Podiatrist                         | 119,505        | -4.4%              | 132,681        | 11.0%              | 161,904        | 22.0%              | 211,724        | 30.8%              | 211,990        | 0.1%               | 218,769        | 3.2%               | 238,065        | 8.8%               | 261,543              | 9.9%                        | 268,054     | 12.6%                       | 275,478           | 2.8%                        |
| 19-00 | Psychologist                       | 5,272,285      | 91.7%              | 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%               | 14,607,352           | 7.0%                        | 14,516,549  | 6.3%                        | 14,986,720        | 3.2%                        |
| 20-00 | Optometrist                        | 925,973        | 50.1%              | 669,818        | -27.7%             | 706,214        | 5.4%               | 821,836        | 16.4%              | 786,030        | -4.4%              | 814,027        | 3.6%               | 873,743        | 7.3%               | 941,640              | 7.8%                        | 924,846     | 5.8%                        | 925,423           | 0.1%                        |
| 21-00 | Optician                           | 467,733        | 10.7%              | 244,641        | -47.7%             | 151,077        | -38.2%             | 187,424        | 24.1%              | 202,259        | 7.9%               | 225,809        | 11.6%              | 237,305        | 5.1%               | 274,926              | 15.9%                       | 255,331     | 7.6%                        | 264,045           | 3.4%                        |
| 22-00 | Transportation                     | 4,568,771      | 6.0%               | 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%               | 11,878,180           | 11.4%                       | 11,592,907  | 8.7%                        | 11,933,595        | 2.9%                        |
| 23-00 | Therapy Services                   | 425,860        | 150.4%             | 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%               | 1,625,102            | -0.3%                       | 2,038,371   | 25.0%                       | 2,134,443         | 4.7%                        |
| 24-00 | Prosthetic/Ortho                   | 1,317,025      | 9.4%               | 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%              | 1,579,293            | -11.5%                      | 2,058,248   | 15.4%                       | 2,300,342         | 11.8%                       |
| 25-00 | Medical Supplies & DME (26-00)     | 3,881,390      | -5.7%              | 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%               | 8,240,974            | 20.7%                       | 7,277,252   | 6.6%                        | 7,111,239         | -2.3%                       |
| 27-00 | H&CB Services                      | 19,273,037     | 43.2%              | 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%              | 50,437,266           | 12.8%                       | 47,496,197  | 6.2%                        | 48,709,573        | 2.6%                        |
| 27-02 | H&CB Mental Health Services        | 181,551        | 30619.4%           | 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%              | 317,594              | -46.6%                      | 635,010     | 6.8%                        | 654,169           | 3.0%                        |
| 27-03 | H&CB Mental Retardation            | 19,295         | -11.1%             | 15,389         | -20.2%             | 24,184         | 57.2%              | -              | -100.0%            | 16,486         | 0.0%               | 34,556         | 109.6%             | 20,846         | -39.7%             | 35,466               | 70.1%                       | 47,541      | 128.1%                      | 50,256            | 5.7%                        |
| 27-13 | TBI Services                       | 2,067,138      | -3.1%              | (14,251)       | -100.7%            | (60)           | -99.6%             | -              | -100.0%            | -              | 0.0%               | -              | 0.0%               | -              | 0.0%               | -                    | 0.0%                        | -           | 0.0%                        | -                 | 0.0%                        |
| 27-17 | Enhanced Resident Care             | 1,770,393      | 45.1%              | 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%              | 5,534,172            | -19.8%                      | 7,245,912   | 5.1%                        | 7,647,435         | 5.5%                        |
| 29-00 | Personal Care Services             | 5,715,027      | 34.9%              | 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%               | 24,635,884           | 46.3%                       | 18,860,573  | 12.0%                       | 20,476,895        | 8.6%                        |
| 30-00 | Target Case Management             | 8,182          | 131.8%             | (6)            | -100.1%            | 1,658          | -27411.2%          | 8,196          | 394.4%             | 2,768          | -66.2%             | 2,770          | 0.1%               | 1,914          | -30.9%             | 290,550              | 15079.0%                    | 2,198       | 14.8%                       | 2,440             | 11.0%                       |
| 33-04 | Assistive Community Care Services  | 4,455,949      | 60.7%              | 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%              | 11,349,017           | 2.7%                        | 12,618,357  | 14.2%                       | 13,401,772        | 6.2%                        |
| 34-01 | Day Treatment (MHS)                | 53,373         | 237.5%             | 39,432         | -26.1%             | 80,050         | 103.0%             | 56,415         | -29.5%             | 65,710         | 16.5%              | 75,895         | 15.5%              | 58,122         | -23.4%             | 78,580               | 35.2%                       | 64,492      | 11.0%                       | 67,887            | 5.3%                        |
| 35-07 | ADAP Families in Recovery          | -              | 0.0%               | 53,936         | 146.9%             | 122,782        | 127.6%             | 303,097        | 146.9%             | 12,290         | -95.9%             | 33,820         | 175.2%             | 135,874        | 135.8%             | 130,570              | 63.7%                       | 83,744      | 5.0%                        | 85,249            | 1.8%                        |
| 37-01 | Rehabilitation/D&P Dept. of Health | 81,276         | -37.0%             | 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%             | 7,349,372            | 97.9%                       | 4,306,083   | 15.9%                       | 4,810,081         | 11.7%                       |
| 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              | (545,908)      | -183.0%            | -              | -100.0%            | -              | 0.0%               | -              | 0.0%               | -              | 0.0%               | -              | 0.0%               | -              | 0.0%               | -                    | 0.0%                        | -           | 0.0%                        | -                 | 0.0%                        |
| 38-03 | PC+ Case Management Fees           | 4,755,390      | 22.4%              | 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%              | 5,166,265            | 1.6%                        | 5,283,845   | 3.9%                        | 2,762,947         | -47.7%                      |
| 40-00 | Ambulance                          | 1,412,075      | 13.2%              | 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%               | 2,937,825            | 16.8%                       | 3,784,736   | 50.5%                       | 4,214,666         | 11.4%                       |
| 41-00 | Dialysis                           | 98,166         | 5.8%               | 206,113        | 110.0%             | 294,592        | 42.9%              | 391,569        | 32.9%              | 505,642        | 29.1%              | 692,408        | 36.9%              | 569,685        | -17.7%             | 928,763              | 63.0%                       | 722,552     | 26.8%                       | 897,245           | 24.2%                       |
| 42-00 | ASC                                | 22,941         | -75.3%             | 46,492         | 102.7%             | 9,899          | -78.7%             | 6,277          | -36.6%             | 5,084          | -19.0%             | 3,530          | -30.6%             | 6,097          | 72.7%              | 37,364               | 512.9%                      | 6,537       | 7.2%                        | 6,730             | 2.9%                        |
| 43-00 | Outpatient Rehab                   | 175,503        | -29.8%             | 183,367        | 4.5%               | 240,341        | 31.1%              | 298,602        | 24.2%              | 290,361        | -2.8%              | 203,595        | -29.9%             | 158,647        | -22.1%             | 299,405              | 88.7%                       | 166,861     | 5.2%                        | 170,725           | 2.3%                        |
| 39-06 | PDP Premium Payments               | -              | 0.0%               | -              | 0.0%               | -              | 0.0%               | -              | 0.0%               | 2,287,779      | 0.0%               | 2,421,626      | 5.9%               | 1,888,168      | -22.0%             | 2,499,410            | 32.4%                       | 1,106,561   | -41.4%                      | -                 | -100.0%                     |
| 39-10 | New Premium Payments               | -              | 0.0%               | -              | 0.0%               | -              | 0.0%               | -              | 0.0%               | -              | 0.0%               | -              | 0.0%               | 8,593,929      | 0.0%               | 38,554,069           | 348.6%                      | 32,217,870  | 274.9%                      | 53,969,635        | 63.8%                       |
| 45-00 | Miscellaneous                      | (83,500)       | 54.2%              | 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%             | 2,296,530            | 678.6%                      | 210,767     | -28.5%                      | 161,795           | -23.2%                      |
|       | Total                              | 427,669,219    | 12.4%              | 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%               | 722,085,652          | 17.7%                       | 705,317,039 | 15.0%                       | 738,473,413       | 4.7%                        |
|       | Total w/o Catamount                | -              | 0.0%               | -              | 0.0%               | -              | 0.0%               | -              | 0.0%               | -              | 0.0%               | 559,005,383    | 0.0%               | 604,890,785    | 0.0%               | 683,531,583          | 0.0%                        | 673,099,169 | 0.0%                        | 684,503,778       | 1.7%                        |
|       | Other Expenditures                 | -              | 0.0%               | -              | 0.0%               | -              | 0.0%               | -              | 0.0%               | -              | 0.0%               | -              | 0.0%               | -              | 0.0%               | -                    | 0.0%                        | -           | 0.0%                        | -                 | 0.0%                        |
|       | DSH                                | 26,500,000     | 8.2%               | 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%                      | 35,648,781  | -27.3%                      | 35,648,781        | 0.0%                        |
|       | Clawback                           | -              | 0.0%               | -              | 0.0%               | -              | 0.0%               | -              | 0.0%               | 6,888,177      | 0.0%               | 19,142,150     | 177.9%             | 20,339,254     | 6.3%               | 20,841,112           | 2.5%                        | 21,334,749  | 4.9%                        | 23,113,134        | 8.3%                        |
|       | Insurance Premium Payouts          | 179,675        | -38.4%             | 168,124        | -6.4%              | 237,224        | 41.1%              | 283,304        | 19.4%              | 233,567        | -17.6%             | 66,307         | -71.6%             | (31,616)       | -147.7%            | -                    | -100.0%                     | -           | -100.0%                     | -                 | 0.0%                        |
|       | HIV Insurance Fund F               | 39,181         | 2.0%               | 55,638         | 42.0%              | 46,108         | -17.1%             | 46,738         | 1.4%               | 40,936         | -12.4%             | 49,468         | 20.8%              | 43,914         | -11.2%             | 44,495               | 1.3%                        | 44,495      | 1.3%                        | 44,495            | 0.0%                        |
|       | Lund Home Family Ctr Retro PNMI    | 671,590        | 0.                 |                |                    |                |                    |                |                    |                |                    |                |                    |                |                    |                      |                             |             |                             |                   |                             |

## Insert 2: Enrollment Growth Trend July 1994 – December 2008



**Insert 3: Cost Comparison SFY 2008 through SFY 2010 Governor's Recommend**

State of Vermont  
Agency of Human Services  
Office of Vermont Health Access  
Medicaid Budget SFY 2010

| PROGRAM EXPENDITURES                           |                 |                       |                    |                 |                       |                    |                      |                       |                    |                |                       |                    |                   |                       |                    |
|------------------------------------------------|-----------------|-----------------------|--------------------|-----------------|-----------------------|--------------------|----------------------|-----------------------|--------------------|----------------|-----------------------|--------------------|-------------------|-----------------------|--------------------|
| Adults                                         | SFY '07 Actuals |                       |                    | SFY '08 Actuals |                       |                    | SFY '09 Appropriated |                       |                    | SFY '09 BAA    |                       |                    | SFY '10 Gov. Rec. |                       |                    |
|                                                | 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          | 16,338               | \$ 85,504,244         | \$ 436.12          | 12,037         | \$ 83,212,076         | \$ 576.07          | 12,400            | \$ 87,439,690         | \$ 587.64          |
| Dual Eligibles                                 | 14,073          | \$ 37,371,558         | \$ 221.30          | 14,185          | \$ 35,614,807         | \$ 209.23          | 8,679                | \$ 41,994,267         | \$ 403.22          | 14,453         | \$ 42,007,214         | \$ 242.21          | 14,681            | \$ 42,832,084         | \$ 243.13          |
| General                                        | 9,327           | \$ 41,239,463         | \$ 368.44          | 9,255           | \$ 43,797,118         | \$ 394.36          | 8,230                | \$ 51,642,224         | \$ 522.91          | 9,291          | \$ 50,335,298         | \$ 451.49          | 9,333             | \$ 51,484,127         | \$ 459.70          |
| VHAP                                           | 22,404          | \$ 79,795,246         | \$ 296.80          | 24,771          | \$ 89,891,925         | \$ 302.40          | 23,513               | \$ 94,969,359         | \$ 336.58          | 27,592         | \$ 110,833,046        | \$ 334.74          | 30,023            | \$ 119,758,901        | \$ 332.41          |
| VHAP ESI                                       | -               | \$ -                  | \$ -               | 276             | \$ 571,218            | \$ 172.63          | 1,169                | \$ 1,794,204          | \$ 127.95          | 956            | \$ 1,982,422          | \$ 172.90          | 1,215             | \$ 2,850,534          | \$ 195.54          |
| Catamount                                      | -               | \$ (101)              | \$ -               | 1,730           | \$ 7,995,183          | \$ 385.12          | 7,994                | \$ 36,101,229         | \$ 376.31          | 6,302          | \$ 29,594,265         | \$ 391.33          | 9,277             | \$ 50,124,827         | \$ 450.27          |
| ESIA                                           | -               | \$ -                  | \$ -               | 132             | \$ 168,977            | \$ 106.81          | 469                  | \$ 658,636            | \$ 116.96          | 493            | \$ 748,952            | \$ 126.55          | 630               | \$ 1,095,532          | \$ 144.99          |
| <b>Subtotal Adults</b>                         | <b>57,134</b>   | <b>\$ 226,992,627</b> | <b>\$ 331.08</b>   | <b>62,146</b>   | <b>\$ 250,554,294</b> | <b>\$ 335.98</b>   | <b>66,393</b>        | <b>\$ 312,664,163</b> | <b>\$ 392.44</b>   | <b>71,124</b>  | <b>\$ 318,713,273</b> | <b>\$ 373.43</b>   | <b>77,558</b>     | <b>\$ 355,585,696</b> | <b>\$ 382.06</b>   |
| <b>Children</b>                                |                 |                       |                    |                 |                       |                    |                      |                       |                    |                |                       |                    |                   |                       |                    |
| Blind or Disabled (BD)/Medically Needy         | 3,398           | \$ 28,299,312         | \$ 693.95          | 3,487           | \$ 27,775,036         | \$ 663.78          | 3,502                | \$ 32,750,206         | \$ 779.32          | 3,570          | \$ 32,042,833         | \$ 748.05          | 3,660             | \$ 33,942,009         | \$ 772.74          |
| General                                        | 51,187          | \$ 85,115,012         | \$ 138.57          | 50,664          | \$ 90,807,988         | \$ 149.36          | 54,972               | \$ 107,073,860        | \$ 162.32          | 51,071         | \$ 104,257,972        | \$ 170.12          | 51,037            | \$ 105,463,098        | \$ 172.20          |
| Underinsured                                   | 1,186           | \$ 846,736            | \$ 59.51           | 1,138           | \$ 742,529            | \$ 54.39           | 1,297                | \$ 1,116,433          | \$ 71.73           | 1,156          | \$ 842,837            | \$ 60.77           | 1,170             | \$ 894,887            | \$ 63.74           |
| SCHIP (Uninsured)                              | 3,070           | \$ 4,189,850          | \$ 113.73          | 3,278           | \$ 4,462,004          | \$ 113.42          | 3,646                | \$ 5,540,466          | \$ 126.63          | 3,398          | \$ 5,164,572          | \$ 126.65          | 3,559             | \$ 5,496,248          | \$ 128.70          |
| <b>Subtotal Children</b>                       | <b>58,841</b>   | <b>\$ 118,450,910</b> | <b>\$ 167.76</b>   | <b>58,567</b>   | <b>\$ 123,787,557</b> | <b>\$ 176.13</b>   | <b>63,417</b>        | <b>\$ 146,480,964</b> | <b>\$ 192.48</b>   | <b>59,194</b>  | <b>\$ 142,308,215</b> | <b>\$ 200.34</b>   | <b>59,426</b>     | <b>\$ 145,796,241</b> | <b>\$ 204.45</b>   |
| <b>Pharmacy Only Programs</b>                  | <b>12,952</b>   | <b>\$ 8,585,791</b>   | <b>\$ 55.24</b>    | <b>12,737</b>   | <b>\$ 7,318,162</b>   | <b>\$ 47.88</b>    | <b>13,786</b>        | <b>\$ 16,223,405</b>  | <b>\$ 98.07</b>    | <b>9,488</b>   | <b>\$ 5,905,437</b>   | <b>\$ 51.87</b>    | <b>68</b>         | <b>\$ 96,655</b>      | <b>\$ 118.45</b>   |
| <b>Choices for Care</b>                        |                 |                       |                    |                 |                       |                    |                      |                       |                    |                |                       |                    |                   |                       |                    |
| Nursing Home, Home & Community Based, ERC      | 3,545           | \$ 148,714,078        | \$ 3,496.19        | 3,973           | \$ 166,375,075        | \$ 3,489.85        | 4,841                | \$ 167,251,735        | \$ 2,879.04        | 4,841          | \$ 173,639,852        | \$ 2,989.00        | 4,938             | \$ 172,469,249        | \$ 2,910.64        |
| Acute-Care Services - OVHA                     | 3,545           | \$ 18,015,671         | \$ 423.54          | 3,973           | \$ 20,041,562         | \$ 420.39          | 4,841                | \$ 21,865,524         | \$ 376.39          | 4,841          | \$ 24,403,750         | \$ 420.08          | 4,938             | \$ 24,167,631         | \$ 407.86          |
| Acute-Care Services - Other Depts.             | 3,545           | \$ 627,528            | \$ 14.75           | 3,973           | \$ 1,097,788          | \$ 23.03           | 4,841                | \$ 3,145,618          | \$ 54.15           | 4,841          | \$ 1,180,122          | \$ 20.31           | 4,938             | \$ 1,268,632          | \$ 21.41           |
| Buy-In                                         |                 | \$ 2,198,479          |                    |                 | \$ 2,228,171          |                    |                      | \$ 2,492,851          |                    |                | \$ 2,492,851          |                    |                   | \$ 2,679,815          |                    |
| <b>Subtotal Choices for Care*</b>              | <b>3,545</b>    | <b>\$ 169,555,756</b> | <b>\$ 3,986.17</b> | <b>3,973</b>    | <b>\$ 189,742,595</b> | <b>\$ 3,980.00</b> | <b>4,841</b>         | <b>\$ 194,755,728</b> | <b>\$ 3,352.49</b> | <b>4,841</b>   | <b>\$ 201,716,575</b> | <b>\$ 3,472.31</b> | <b>4,938</b>      | <b>\$ 200,585,327</b> | <b>\$ 3,385.13</b> |
| <b>Subtotal Direct Services</b>                | <b>132,472</b>  | <b>\$ 523,585,084</b> | <b>\$ 329.37</b>   | <b>137,422</b>  | <b>\$ 571,402,607</b> | <b>\$ 346.50</b>   | <b>148,437</b>       | <b>\$ 670,124,261</b> | <b>\$ 376.21</b>   | <b>144,646</b> | <b>\$ 668,643,500</b> | <b>\$ 385.22</b>   | <b>141,990</b>    | <b>\$ 702,063,919</b> | <b>\$ 412.04</b>   |
| <b>Miscellaneous Program</b>                   |                 |                       |                    |                 |                       |                    |                      |                       |                    |                |                       |                    |                   |                       |                    |
| GC to CFC Funding Reallocation                 |                 | \$ (627,528)          |                    |                 | \$ (1,097,788)        |                    |                      | \$ (3,145,618)        |                    |                | \$ (1,180,122)        |                    |                   | \$ (1,268,632)        |                    |
| Refugee                                        | 147             | \$ 93,315             |                    | 183             | \$ 68,304             |                    |                      | \$ -                  |                    | 154            | \$ 68,633             |                    | 162               | \$ 75,939             |                    |
| HIV and Civil Unions                           | 220             | \$ 1,053,512          |                    | 271             | \$ 1,050,133          |                    |                      | \$ 1,003,059          |                    | 285            | \$ 932,267            |                    | 299               | \$ 986,995            |                    |
| DSH                                            |                 | \$ 59,377,729         |                    |                 | \$ 49,003,898         |                    |                      | \$ 35,648,781         |                    |                | \$ 35,648,781         |                    |                   | \$ 35,648,781         |                    |
| Clawback                                       |                 | \$ 19,142,150         |                    |                 | \$ 20,339,254         |                    |                      | \$ 20,841,112         |                    |                | \$ 21,334,749         |                    |                   | \$ 23,113,134         |                    |
| Buy-In - GC                                    |                 | \$ 21,744,731         |                    |                 | \$ 21,063,422         |                    |                      | \$ 23,378,952         |                    |                | \$ 23,378,952         |                    |                   | \$ 25,016,468         |                    |
| Buy-In - State Only (MCO Invest.)              |                 | \$ 314,376            |                    |                 | \$ 419,951            |                    |                      | \$ 380,655            |                    |                | \$ 380,655            |                    |                   | \$ 516,704            |                    |
| Buy-In - Federal Only                          |                 | \$ 2,489,407          |                    |                 | \$ 3,123,135          |                    |                      | \$ 3,259,070          |                    |                | \$ 3,259,070          |                    |                   | \$ 3,503,500          |                    |
| Legal Aid                                      |                 | \$ 564,937            |                    |                 | \$ 476,832            |                    |                      | \$ 506,142            |                    |                | \$ 506,142            |                    |                   | \$ 506,142            |                    |
| Misc. Pymts.                                   |                 | \$ 3,172,979          |                    |                 | \$ 2,976,814          |                    |                      | \$ 3,679,557          |                    |                | \$ 2,743,598          |                    |                   | \$ 2,743,598          |                    |
| Healthy Vermonters Program                     | 9,413           | \$ -                  | n/a                | 8,841           | \$ -                  | n/a                | 9,211                | \$ -                  | n/a                | 9,211          | \$ -                  | n/a                | 9,211             | \$ -                  | n/a                |
| <b>Subtotal Miscellaneous Program</b>          | <b>9,780</b>    | <b>\$ 107,325,609</b> |                    | <b>9,295</b>    | <b>\$ 97,423,956</b>  |                    | <b>9,211</b>         | <b>\$ 85,551,711</b>  |                    | <b>9,650</b>   | <b>\$ 87,072,725</b>  |                    | <b>9,672</b>      | <b>\$ 90,842,631</b>  |                    |
| <b>TOTAL PROGRAM EXPENDITURES</b>              | <b>142,252</b>  | <b>\$ 630,910,693</b> |                    | <b>146,717</b>  | <b>\$ 668,826,564</b> |                    | <b>157,648</b>       | <b>\$ 755,675,972</b> |                    | <b>154,296</b> | <b>\$ 755,716,225</b> |                    | <b>151,662</b>    | <b>\$ 792,906,550</b> |                    |
| ADMINISTRATIVE EXPENDITURES                    |                 |                       |                    |                 |                       |                    |                      |                       |                    |                |                       |                    |                   |                       |                    |
| Contract                                       | SFY '07 Actuals |                       |                    | SFY '08 Actuals |                       |                    | SFY '09 Gov. Rec.    |                       |                    | SFY '09 BAA    |                       |                    | SFY '10 Gov. Rec. |                       |                    |
|                                                | Expenses        |                       |                    | Expenses        |                       |                    | Expenses             |                       |                    | Expenses       |                       |                    | Expenses          |                       |                    |
| Claims Processing                              | \$              | 9,928,717             |                    | \$              | 9,938,968             |                    | \$                   | 9,432,334             |                    | \$             | 10,981,360            |                    | \$                | 9,535,000             |                    |
| Member Services                                | \$              | 2,808,807             |                    | \$              | 2,913,852             |                    | \$                   | 2,913,852             |                    | \$             | 3,200,892             |                    | \$                | 2,913,852             |                    |
| Pharmacy Benefits Manager                      | \$              | 2,112,158             |                    | \$              | 2,704,233             |                    | \$                   | 2,964,993             |                    | \$             | 3,034,358             |                    | \$                | 2,964,993             |                    |
| Care Coordination & Chronic Care Management    | \$              | 1,257,191             |                    | \$              | 3,562,406             |                    | \$                   | 5,325,116             |                    | \$             | 5,159,450             |                    | \$                | 5,035,184             |                    |
| Catamount Outreach                             | \$              | 664,427               |                    | \$              | 1,697,182             |                    | \$                   | 500,000               |                    | \$             | 549,092               |                    | \$                | 500,000               |                    |
| Miscellaneous                                  | \$              | 2,970,378             |                    | \$              | 1,892,349             |                    | \$                   | 6,138,649             |                    | \$             | 3,948,670             |                    | \$                | 4,324,851             |                    |
| MITA/MOVE                                      | \$              | -                     |                    | \$              | 1,184,745             |                    | \$                   | -                     |                    | \$             | 1,400,000             |                    | \$                | 1,950,000             |                    |
| <b>Operating/Personnel Services</b>            | \$              | 5,509,561             |                    | \$              | 7,152,358             |                    | \$                   | 8,679,131             |                    | \$             | 8,156,181             |                    | \$                | 8,036,369             |                    |
| <b>Total Administrative Expenses</b>           | \$              | 25,251,238            |                    | \$              | 31,046,091            |                    | \$                   | 35,954,075            |                    | \$             | 36,430,003            |                    | \$                | 35,260,249            |                    |
| <b>TOTAL ALL EXPENDITURES</b>                  | <b>142,252</b>  | <b>\$ 656,161,931</b> |                    | <b>146,717</b>  | <b>\$ 699,872,655</b> |                    | <b>157,648</b>       | <b>\$ 791,630,047</b> |                    | <b>\$</b>      | <b>792,146,228</b>    |                    | <b>\$</b>         | <b>828,166,798</b>    |                    |

\*Note: This includes total population served under the Choices for Care Waiver and includes a duplication of 809 individuals who participate in both Choices for Care and the Global Commitment to Health waivers.