

SECTION 1: CONTACT INFORMATION

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SECTION 2: BUDGET CONSIDERATIONS

REVISION - April 3, 2009 (pages numbered 4 to 13)

The Office of Vermont Health Access (OVHA) budget request includes an increase in program of ~~\$26,870,669~~ \$28,072,366 and an increase in Administration of \$3,125,428. Please see pages 14-15 for budget reconciliation.

PROGRAM	\$26,870,669	\$28,072,366 (gross)
~ State fund need before enhanced funding	\$ 3,021,653	\$ 3,515,430

UPDATED TREND CHANGES	\$63,474,729 (gross)
~ State fund need before stimulus package enhanced funding	\$22,458,552

Caseload and Trend Impact	\$.46,742,212 (gross)
~ 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
TOTAL	10,835,000

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 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)~~

**GOVERNOR'S RECOMMENDED POLICY INITIATIVES . . . . . (\$34,330,421) (gross)**  
~ State fund need before enhanced funding (\$18,502,662)

**Eliminate VPharm 1, 2, & 3 Programs ... (~~\$ 8,664,421~~) (\$7,462,724) (gross)**  
~ State fund need before enhanced funding (~~\$7,956,504~~) (\$7,462,724)

This option would eliminate Vermont funded coverage under VPharm 1, 2, and 3 (**section 1 below only**) 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                   | \$ 8 per person |
| VPharm2 | 2,547                              | > 150% and <= 175% FPL | \$23                   | \$11 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 13 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 decrease 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 \$5,271,581 (gross)**  
 ~ State fund need before enhanced funding \$6,212,032 \$4,853,634

~~**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) (\$2,588,976) (gross)**~~
~~~ State fund need before enhanced funding (\$3,447,273) (\$3,006,923)~~

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 positions 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.

**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.

**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 is 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.

**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         |