

*Office of Vermont Health Access*

# **Medicaid Budget State Fiscal Year 2009**



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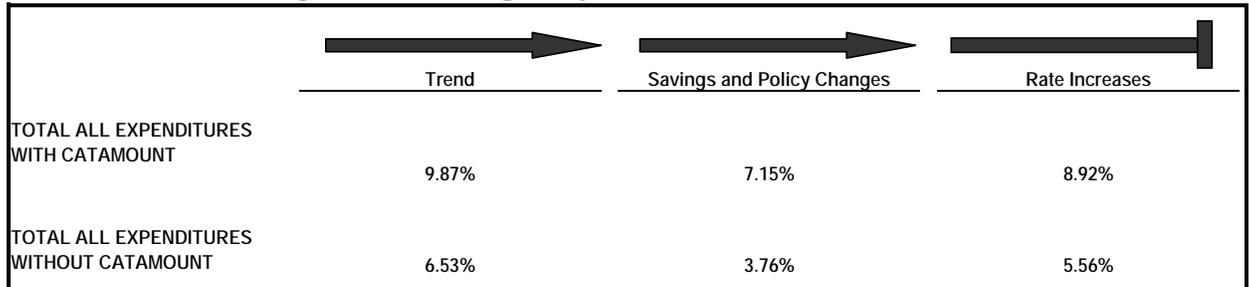
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## Section 2: Fast Facts

1) The Governor's Recommend for SFY '09 is:

- \$789,950,714

**Percent Change - SFY '08 Budget Adjustment to SFY '09 Governor's Recommend**



	Trend	Savings and Policy Changes	Rate Increases
TOTAL ALL EXPENDITURES WITH CATAMOUNT	9.87%	7.15%	8.92%
TOTAL ALL EXPENDITURES WITHOUT CATAMOUNT	6.53%	3.76%	5.56%

The above percent changes demonstrate the impact of trend, savings initiatives, and policy recommendations included in the Governor's recommended budget as well as increases to providers on the final budget figures for SFY '09.

- 148,437 covered lives (excluding Healthy Vermonters) (63,417 children) in Vermont's publicly funded health insurance programs
  - 117 Employees ~ see Appendix 1 for Organizational Chart
- 2) State of Vermont's largest single programmatic expenditure
  - 3) Largest insurer in Vermont
    - 1st ~ Dollars spent
    - 2nd ~ Number of covered lives
  - 4) Pays some or all of the health care costs for 25% of Vermont's population
  - 5) 9,536 enrolled providers
  - 6) 9 million claims processed annually, 84% received electronically
  - 7) 99.4% of all claims are processed within 30 days, with the average time from claim receipt to provider payment of nine days
  - 8) Member services averages close to 26,000 calls a month, about 1,600 a day; all calls are picked up by the automatic attendant within 25 seconds and answered by a live person within 2 minutes 95% of the time
  - 9) In 2009, health care expenditures for Vermont residents is expected to total approximately \$5 billion ~ Vermont Medicaid's share is about 25%.

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### Section 3: Green Mountain Care Program Descriptions



**Green Mountain Care** is a 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 pages 86-87.

#### Catamount Health

Catamount Health is a new health insurance plan that became available for enrollment on October 1, 2007 and is 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. Help is also available in paying premiums, based on income. The intent of this program is to reduce the number of uninsured citizens of Vermont. 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, Medicare or Vermont Health Access Plan (VHAP);
- Have been uninsured for 12 months or more or have recently lost their insurance because of a life change such as a divorce or loss of a job;
- Have income of more than \$1,307 a month or a parent making more than \$1,612 a month;
- 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).

Monthly Individual Income*	Monthly Premium
\$1,307 - \$1,742	\$60
\$1,743 - \$1,960	\$90
\$1,961 - \$2,178	\$110
\$2,179 - \$2,395	\$125
\$2,396 - \$2,613	\$135
More than \$2,613	\$393.11 (subject to change) (no premium assistance)

\*May still qualify with monthly income up to \$200 per month higher and with earned income and/or child care expenses (higher for larger households).

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

<i>Catamount Health</i>		
SFY	Caseload	Expenditures
SFY '08 Appropriated	2,831	\$ 12,281,414
SFY '08 Budget Adjustment	2,798	\$ 13,198,880
SFY '09 Governor's Recommend	7,995	\$ 37,851,229

### 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 \$2,613 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 '09 for Employer-Sponsored Insurance (ESI) Premium Assistance:

<i>Catamount ESI</i>		
SFY	Caseload	Expenditures
SFY '08 Appropriated	142	\$ 186,751
SFY '08 Budget Adjustment	140	\$ 184,424
SFY '09 Governor's Recommend	469	\$ 658,636

<i>VHAP ESI</i>		
SFY	Caseload	Expenditures
SFY '08 Appropriated	389	\$ 558,789
SFY '08 Budget Adjustment	516	\$ 741,385
SFY '09 Governor's Recommend	1,169	\$ 1,794,204

## Dr. Dynasaur

The Dr. Dynasaur program provides low-cost or free health coverage for Vermont children, teenagers under age 18, and pregnant women. Eligibility is based on family income, and income guidelines are based on family size. A family of three can earn up to \$4,413 per month and a family of four can earn up to \$5,313 per month and still be eligible.

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. The following table depicts the caseload and expenditure information by SFY, including the Governor's Recommend for SFY '09 for the State Children's Health Insurance Program (SCHIP):

<i>SCHIP</i>		
SFY	Caseload	Expenditures
SFY '05 Actual	3,147	\$ 4,045,623
SFY '06 Actual	3,092	\$ 4,901,663
SFY '07 Actual	3,013	\$ 4,742,420
SFY '08 Appropriated	4,070	\$ 6,127,843
SFY '08 Budget Adjustment	3,495	\$ 4,980,534
SFY '09 Governor's Recommend	3,646	\$ 5,540,466

## Uninsured Children

The general eligibility requirements for Underinsured Children are: up to age 18 and up to 300% FPL; designed as part of the original 1115 waiver to Title XIX of the

Social Security Act to provide health care coverage for children who would otherwise be underinsured. The following table depicts the caseload and expenditure information by SFY, including the Governor's Recommend for SFY '09 for Uninsured Children:

<i>Underinsured Children</i>		
SFY	Caseload	Expenditures
SFY '05 Actual	1,661	\$ 1,196,600
SFY '06 Actual	1,284	\$ 821,382
SFY '07 Actual	1,214	\$ 794,697
SFY '08 Appropriated	1,520	\$ 1,860,768
SFY '08 Budget Adjustment	1,273	\$ 986,717
SFY '09 Governor's Recommend	1,297	\$ 1,112,606

### **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 have had health insurance in the past 12 months but lost it because of lost job; divorce; no longer have COBRA coverage; became ineligible for Medicaid; had insurance through someone else who died; are no longer a dependent on parent's insurance; graduated, took a leave of absence, or finished college or university and purchased insurance through school.

Adults without children can earn up to \$1,306 per month and parents can make up to \$2,116 per month for a family of two, \$2,721 per month for a family of three, and \$3,276 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 '09 for VHAP:

<i>VHAP</i>		
SFY	Caseload	Expenditures
SFY '05 Actual	24,456	\$ 73,431,832
SFY '06 Actual	22,525	\$ 77,321,380
SFY '07 Actual	22,047	\$ 74,809,390
SFY '08 Appropriated	24,400	\$ 89,397,564
SFY '08 Budget Adjustment	22,589	\$ 86,378,579
SFY '09 Governor's Recommend	23,513	\$ 92,242,692

### **Medicaid**

Medicaid provides low-cost or free coverage for low-income children, young adults under age 21, 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. Children, pregnant women and people in nursing facilities never have to pay co-payments.

### Dual Eligibles

The general eligibility requirements for Dual Eligibles are: eligible for both Medicare and Medicaid, at least 65 years of age, below the protected income level (PIL) and categorized as aged, blind, or disabled; excludes buy-in and clawback.

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

<i>Dual Eligibles</i>		
SFY	Caseload	Expenditures
SFY '05 Actual	8,961	\$ 68,407,653
SFY '06 Actual	8,881	\$ 30,976,189
SFY '07 Actual	8,409	\$ 29,969,846
SFY '08 Appropriated	8,354	\$ 35,914,662
SFY '08 Budget Adjustment	8,446	\$ 32,446,127
SFY '09 Governor's Recommend	8,679	\$ 36,420,756

### 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 '09 for ABD and/or Medically Needy Adults:

<i>Aged, Blind, &amp; Disabled (ABD) and/or Medically Needy Adults</i>		
SFY	Caseload	Expenditures
SFY '05 Actual	14,261	\$ 86,965,332
SFY '06 Actual	15,481	\$ 91,739,541
SFY '07 Actual	15,829	\$ 91,557,999
SFY '08 Appropriated	15,725	\$ 109,719,437
SFY '08 Budget Adjustment	15,897	\$ 99,123,046
SFY '09 Governor's Recommend	16,338	\$ 111,265,555

### 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 '09 for Choices for Care:

<i>Choices for Care Waiver and/or Medically Needy</i>		
SFY	Caseload	Expenditures
SFY '05 Actual	3,429	\$ 140,171,168
SFY '06 Actual	3,698	\$ 154,787,921
SFY '07 Actual	4,723	\$ 172,962,458
SFY '08 Appropriated	4,723	\$ 187,675,107
SFY '08 Budget Adjustment	4,723	\$ 189,793,638
SFY '09 Governor's Recommend	4,841	\$ 195,885,710

### 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 '09 for General Adults:

<i>General Adults</i>		
SFY	Caseload	Expenditures
SFY '05 Actual	7,826	\$ 28,074,607
SFY '06 Actual	7,601	\$ 25,426,874
SFY '07 Actual	7,973	\$ 24,600,814
SFY '08 Appropriated	7,921	\$ 29,480,630
SFY '08 Budget Adjustment	8,008	\$ 26,633,475
SFY '09 Governor's Recommend	8,230	\$ 29,896,059

## 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 '09 for BD and/or Medically Needy Children:

<i>Blind or Disabled and/or Medically Needy Children</i>		
SFY	Caseload	Expenditures
SFY '05 Actual	3,011	\$ 27,666,388
SFY '06 Actual	3,167	\$ 24,434,952
SFY '07 Actual	3,393	\$ 23,641,118
SFY '08 Appropriated	3,371	\$ 28,330,569
SFY '08 Budget Adjustment	3,408	\$ 25,594,483
SFY '09 Governor's Recommend	3,502	\$ 28,729,791

## 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 '09 for General Children:

<i>General Children</i>		
SFY	Caseload	Expenditures
SFY '05 Actual	54,135	\$ 98,393,401
SFY '06 Actual	52,845	\$ 95,671,279
SFY '07 Actual	53,258	\$ 92,563,144
SFY '08 Appropriated	52,910	\$ 110,923,964
SFY '08 Budget Adjustment	53,490	\$ 100,211,244
SFY '09 Governor's Recommend	54,972	\$ 112,487,056

## Prescription Assistance

### Pharmacy Only Programs

Vermont 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.

**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.

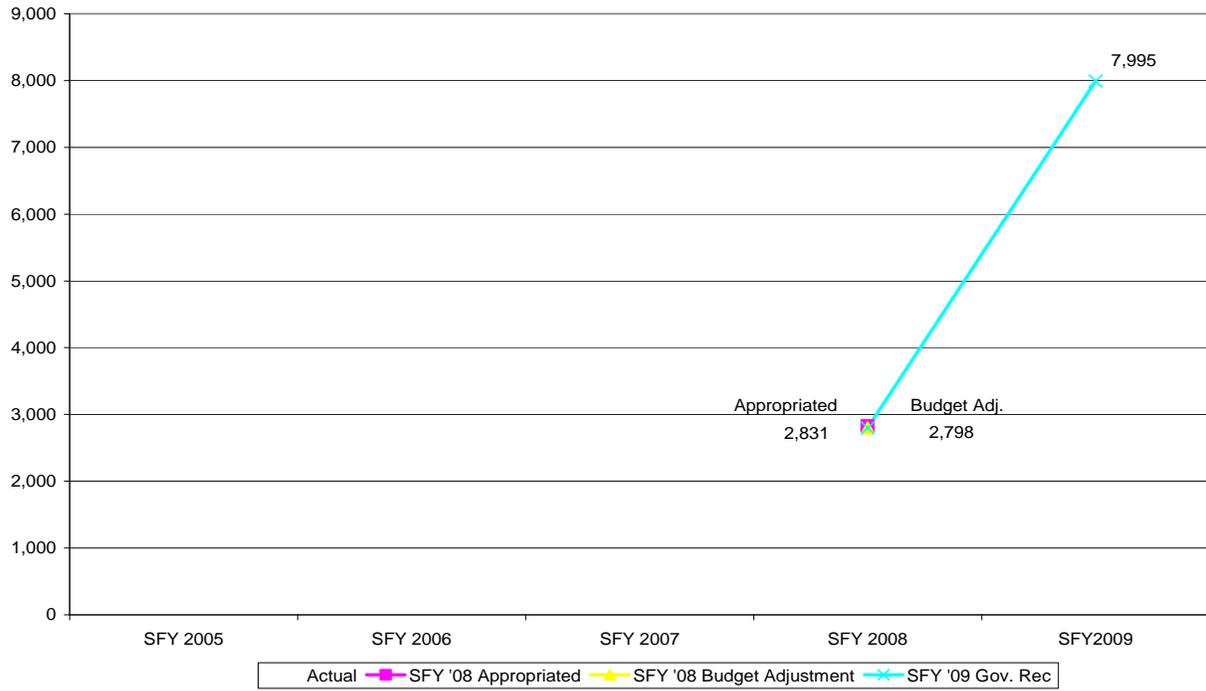
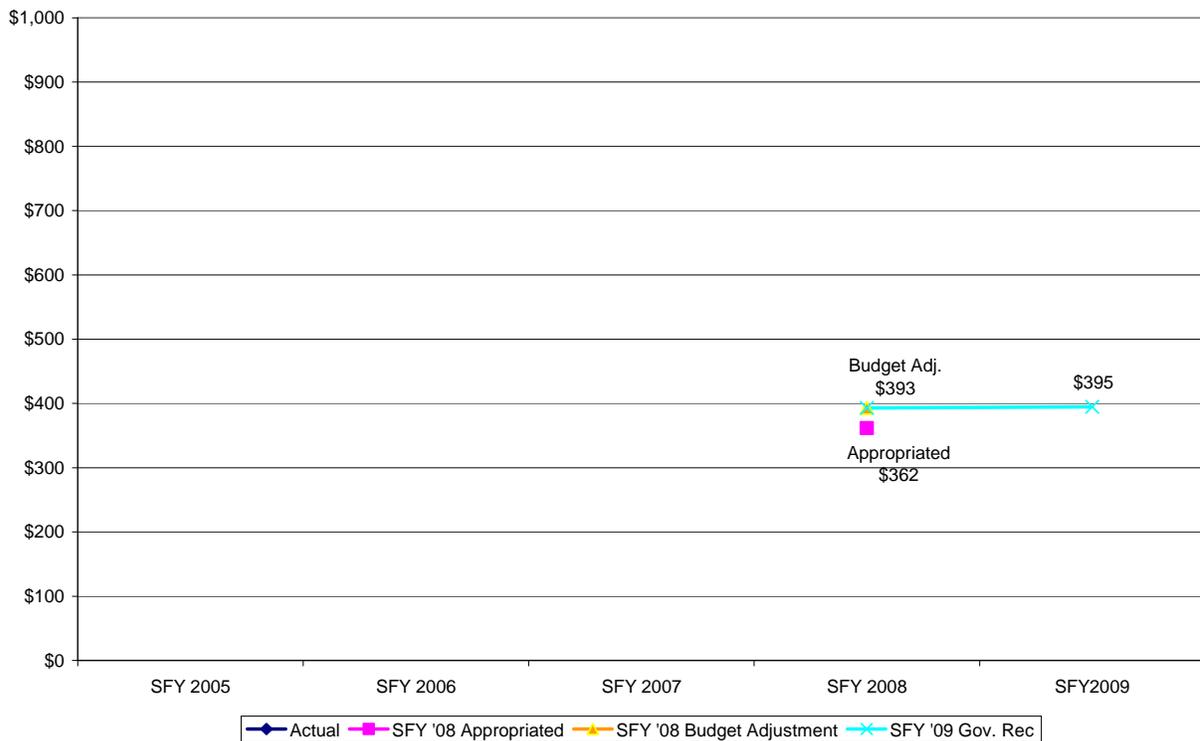
**VScript** helps Vermonters age 65 and older and people of all ages with disabilities who are not enrolled in Medicare pay for prescription medicines for long-term medical problems. There is also an affordable monthly premium based on income.

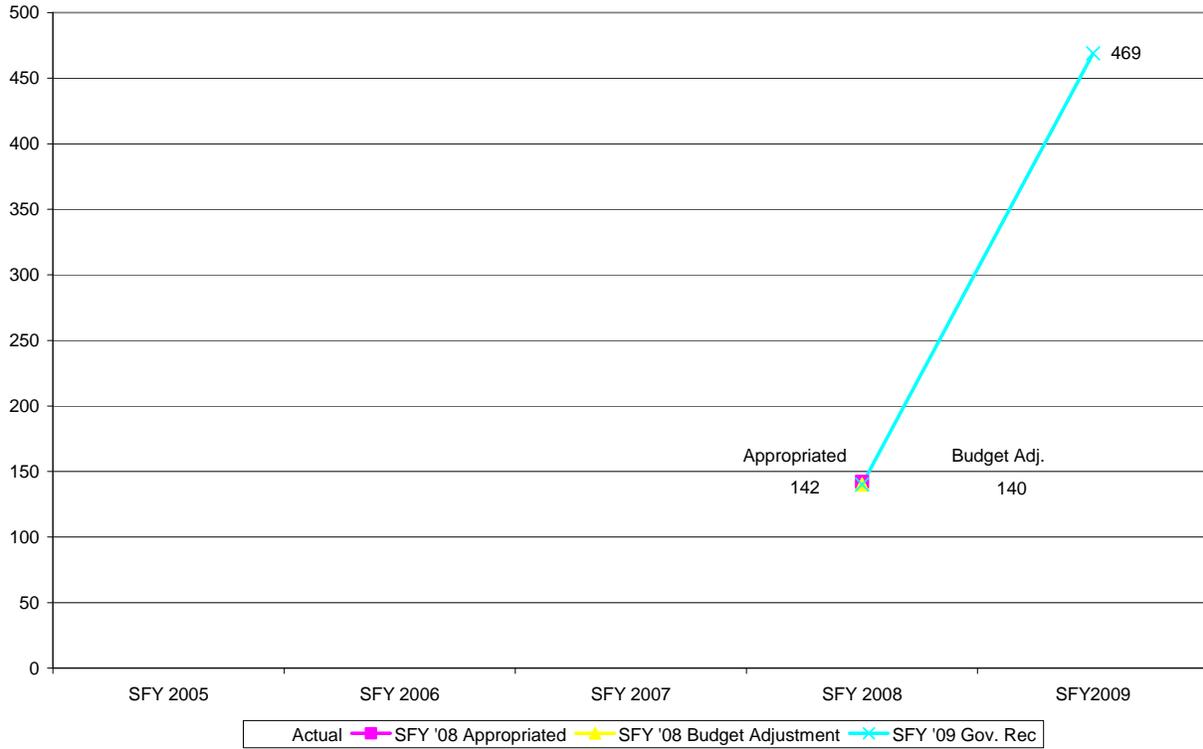
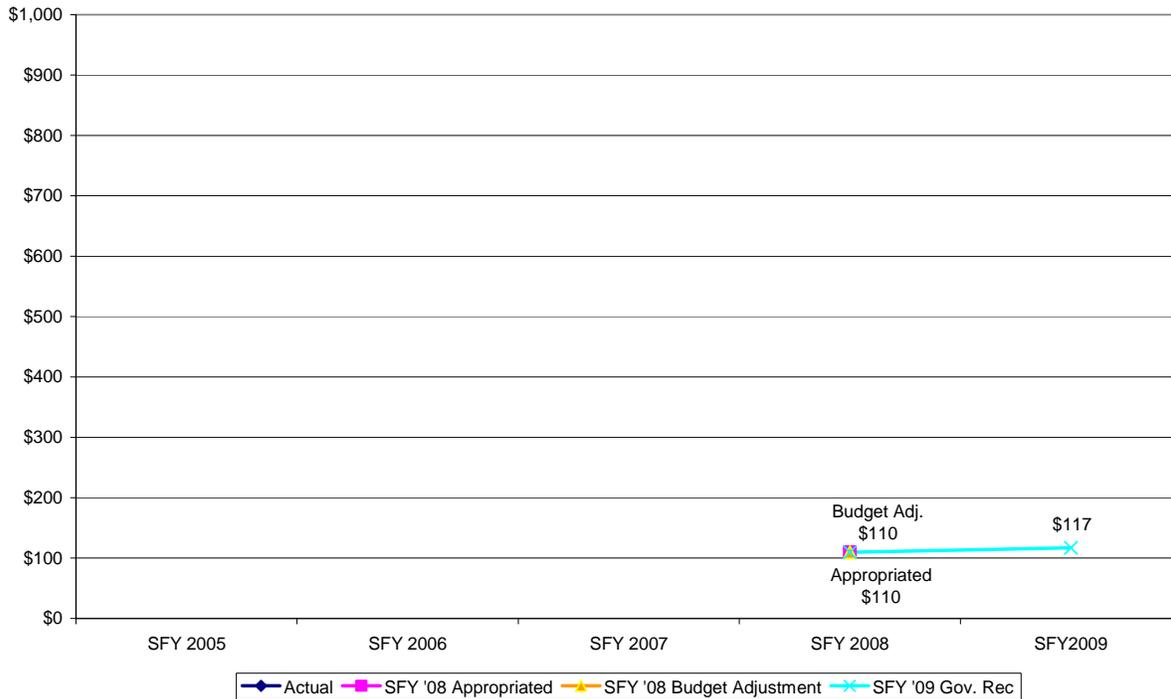
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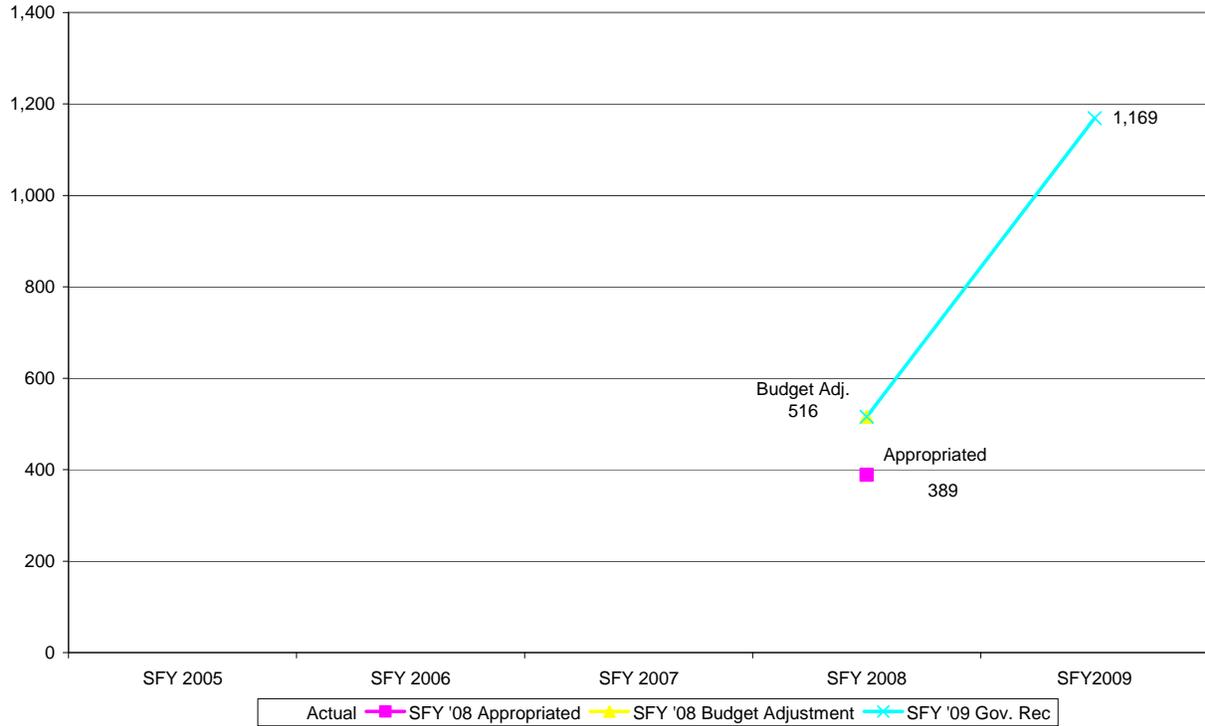
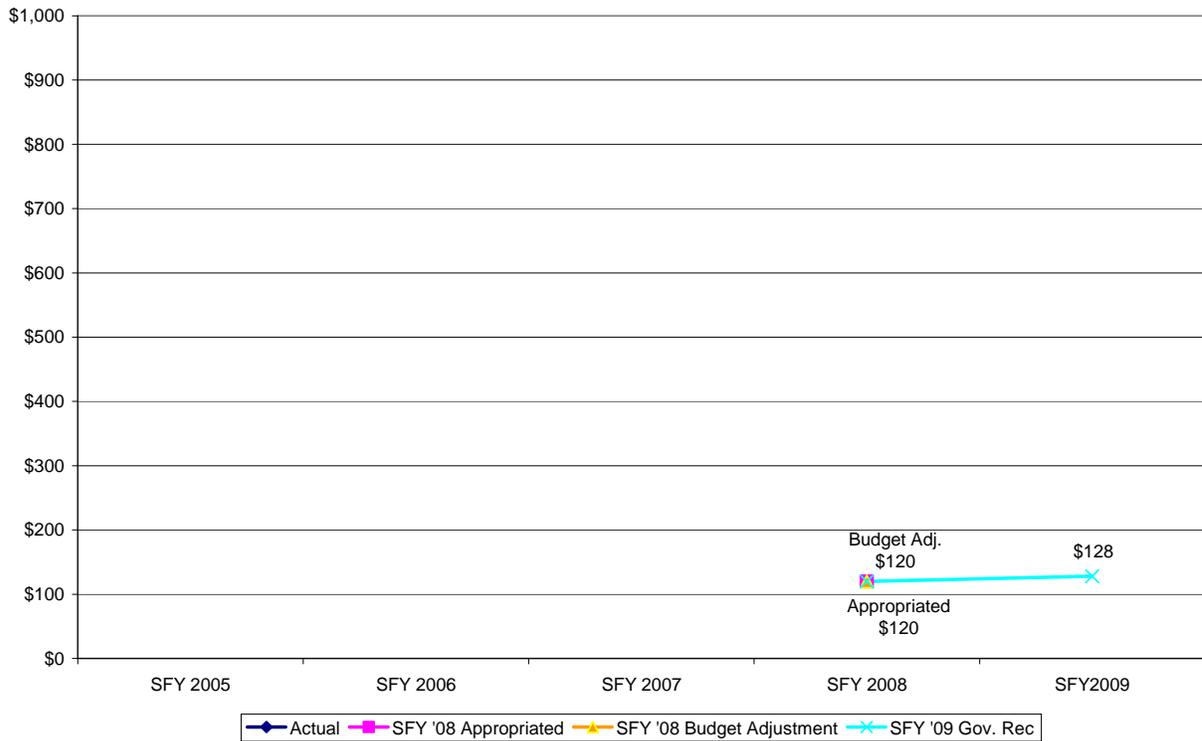
<i>Pharmacy Only Program</i>		
SFY	Caseload	Expenditures
SFY '05 Actual	13,802	\$ 31,336,048
SFY '06 Actual	13,666	\$ 25,668,961
SFY '07 Actual	13,113	\$ 14,094,144
SFY '08 Appropriated	14,998	\$ 9,913,377
SFY '08 Budget Adjustment	13,652	\$ 14,645,763
SFY '09 Governor's Recommend	13,786	\$ 14,860,169

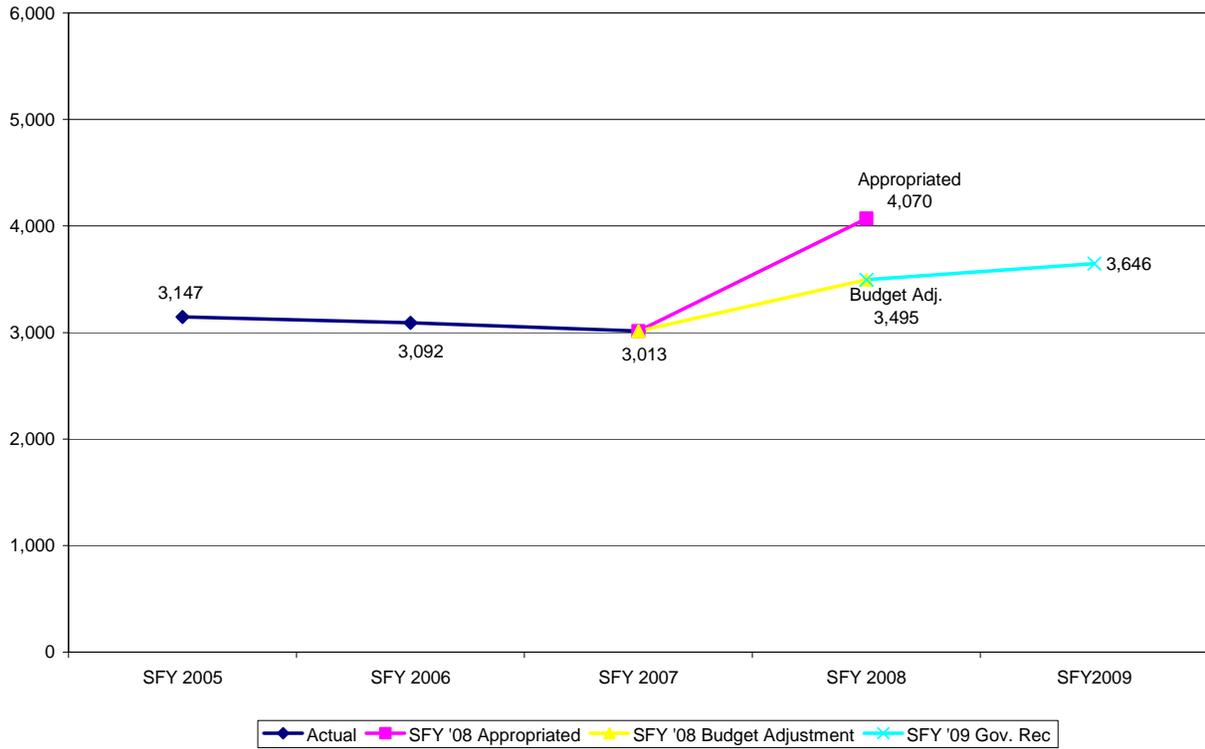
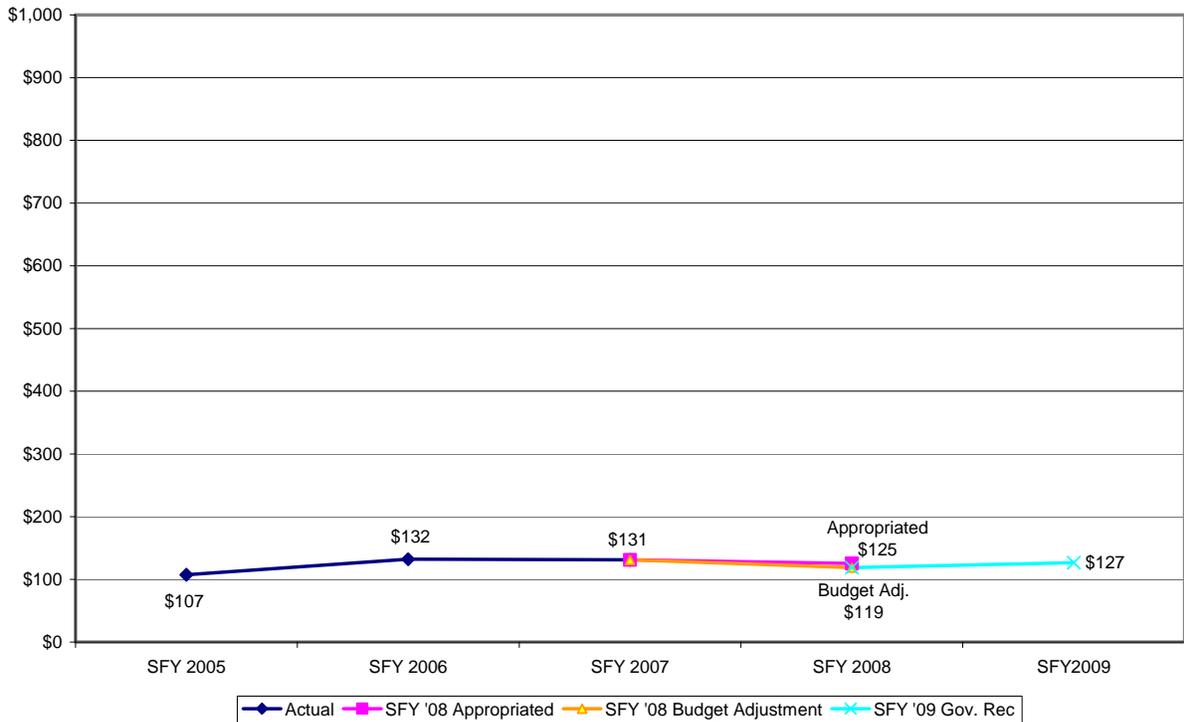
**Healthy Vermonters** provides a discount on short-term and long-term prescription medicines. There are no monthly premiums and eligibility is based on family income. The following table depicts the caseload and expenditure information by SFY, including the Governor's Recommend for SFY '09 for the Healthy Vermonters Program:

<i>Healthy Vermonters</i>		
SFY	Caseload	Expenditures
SFY '05 Actual	13,255	N/A
SFY '06 Actual	13,707	N/A
SFY '07 Actual	9,413	N/A
SFY '08 Appropriated	8,841	N/A
SFY '08 Budget Adjustment	8,199	N/A
SFY '09 Governor's Recommend	9,211	N/A

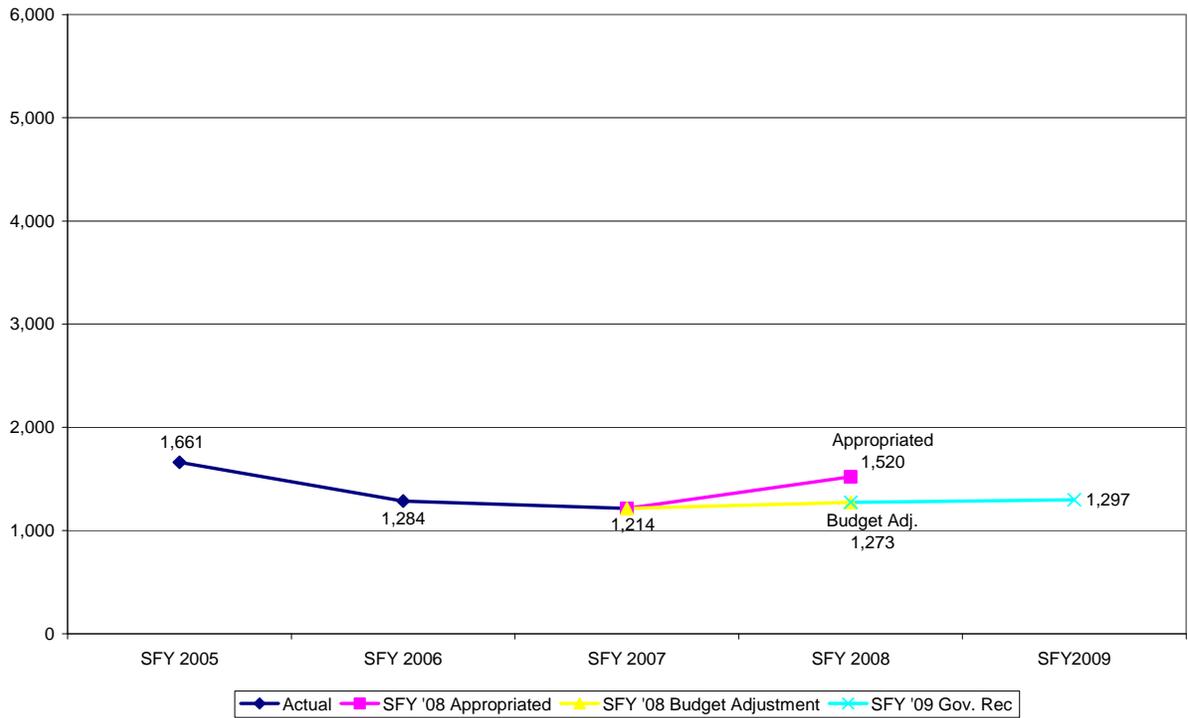
**CATAMOUNT HEALTH ENROLLMENT**

**CATAMOUNT HEALTH PMPM**


**CATAMOUNT ESI ENROLLMENT**

**CATAMOUNT ESI  
PMPM**


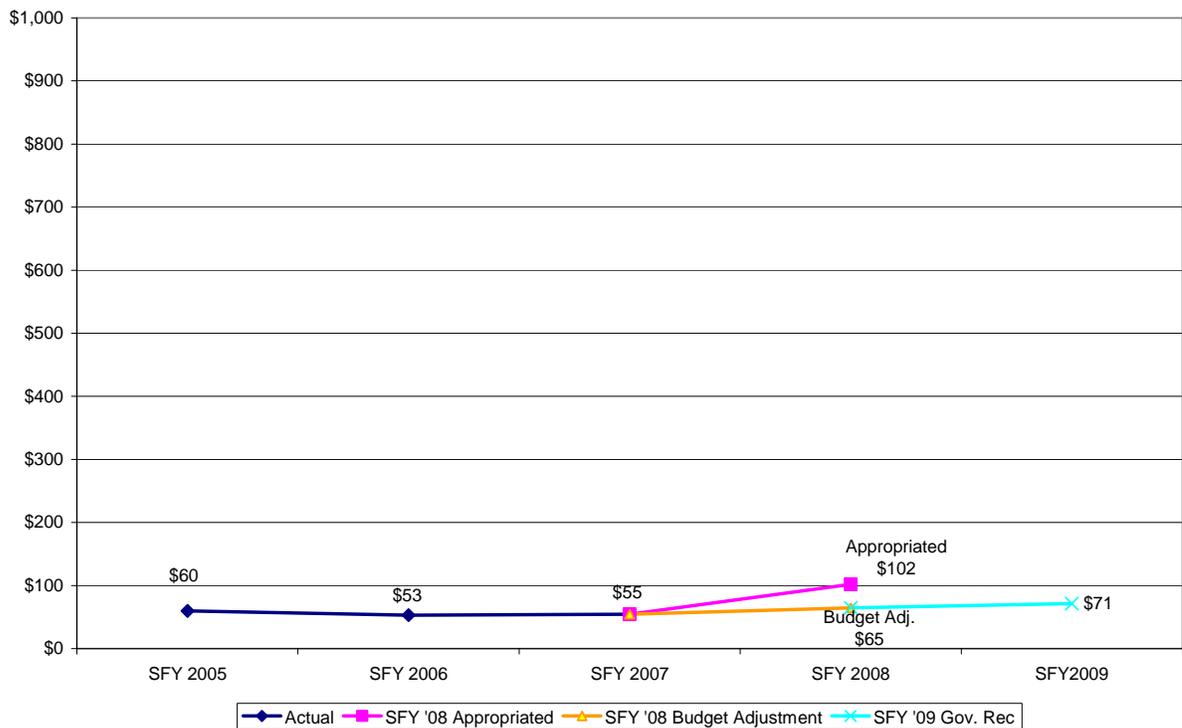
**VHAP ESI ENROLLMENT**

**VHAP ESI PMPM**


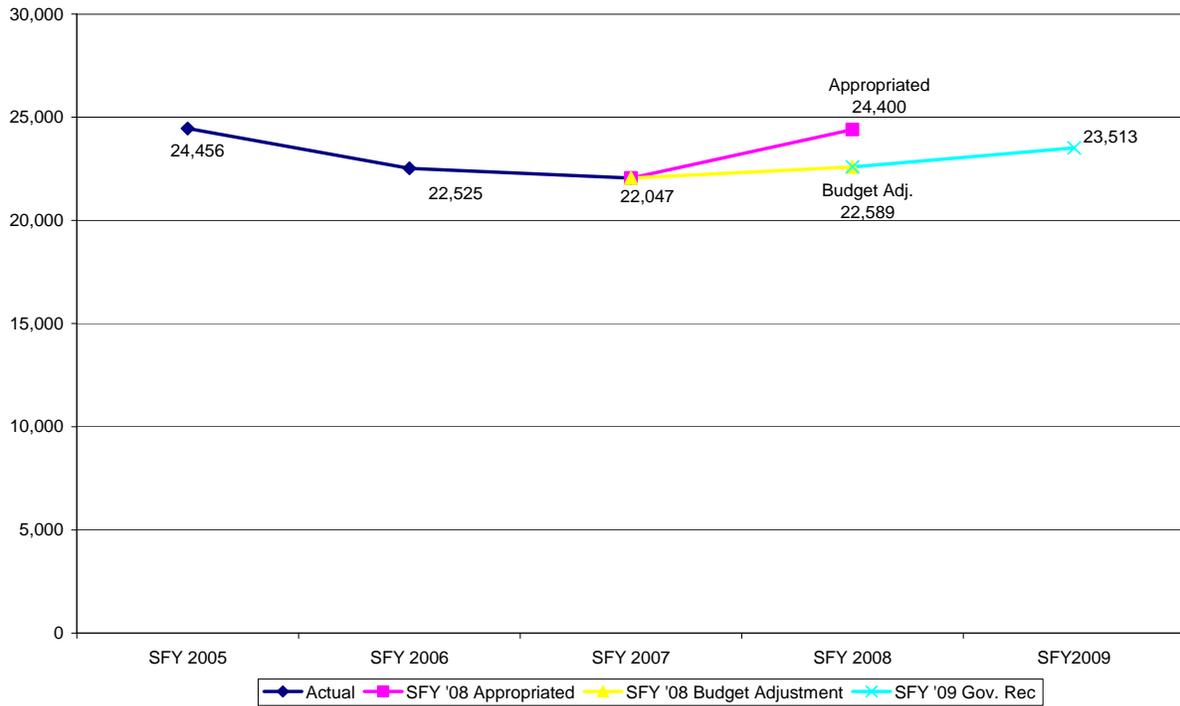
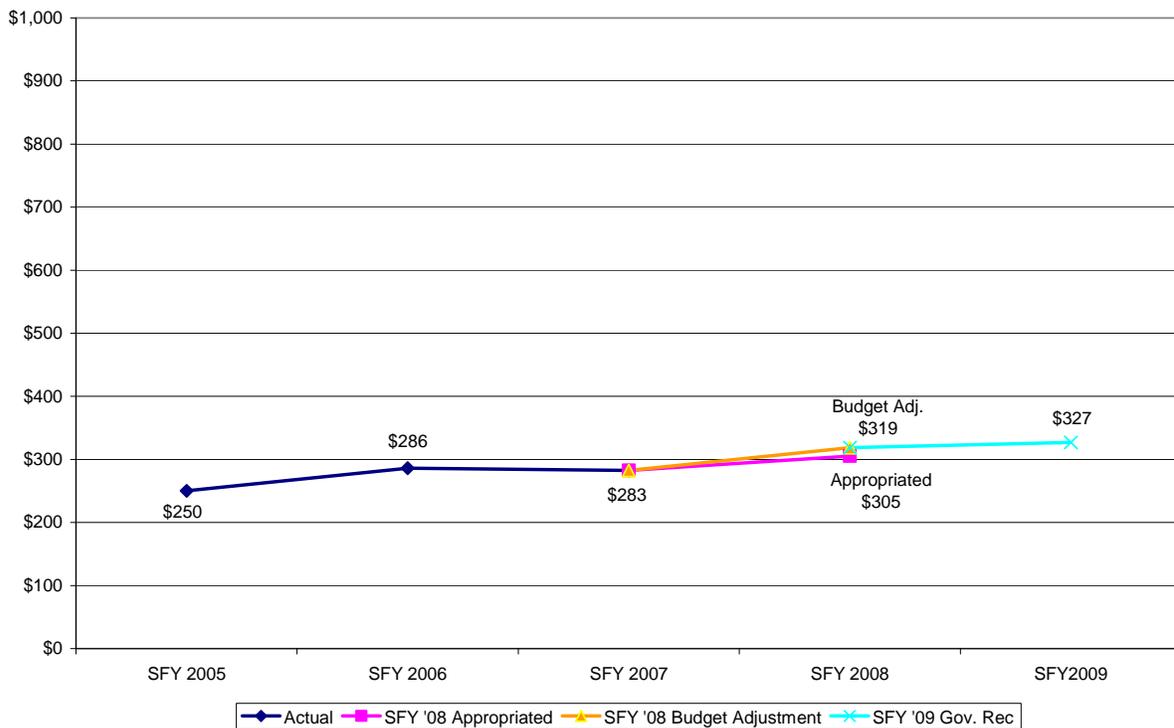
**SCHIP Enrollment**

**SCHIP PMPM**


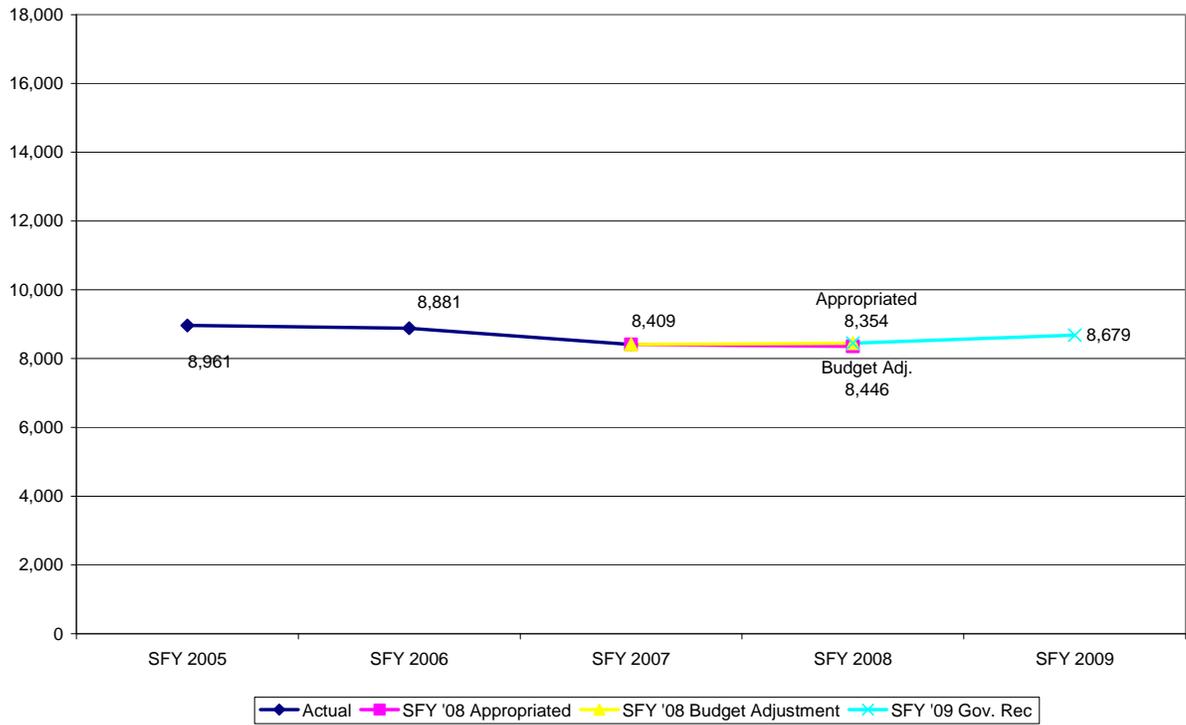
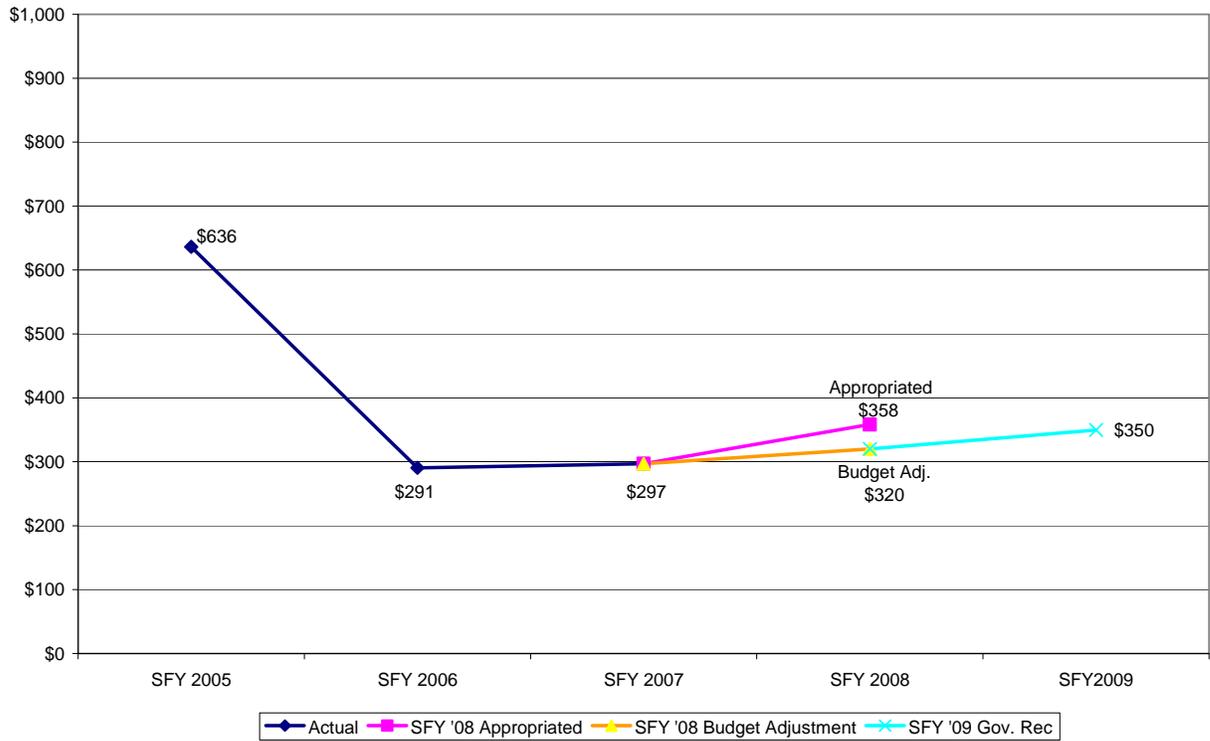
### Underinsured Children Enrollment

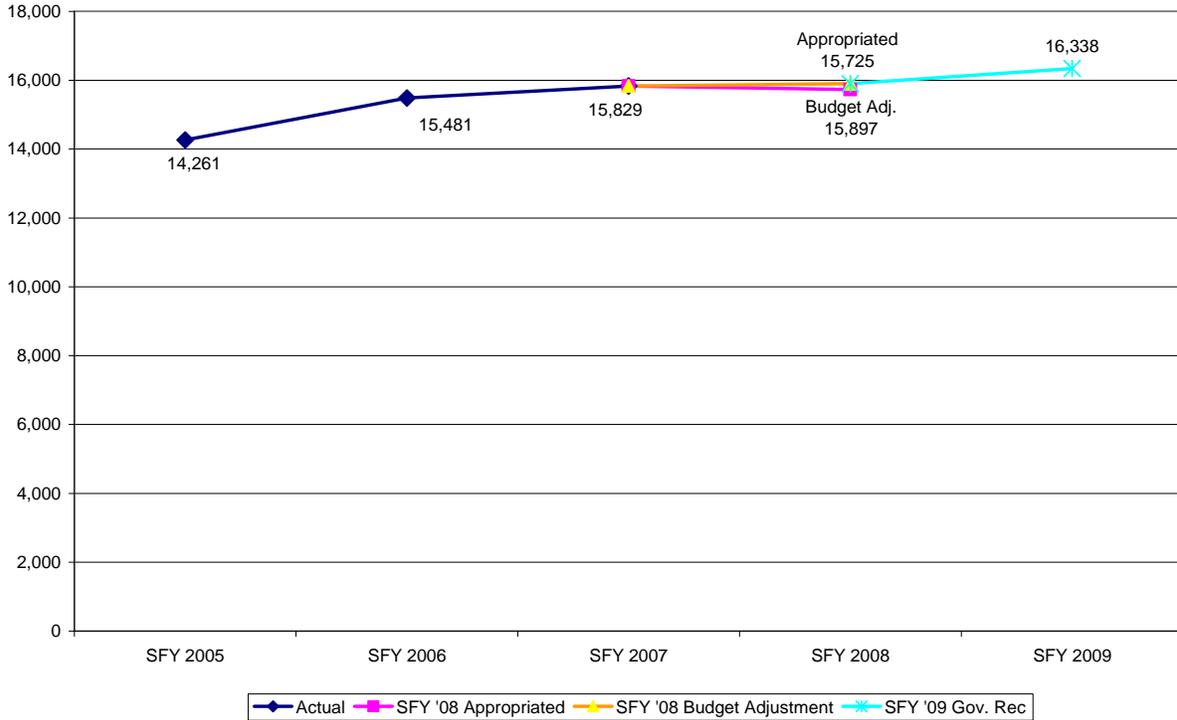
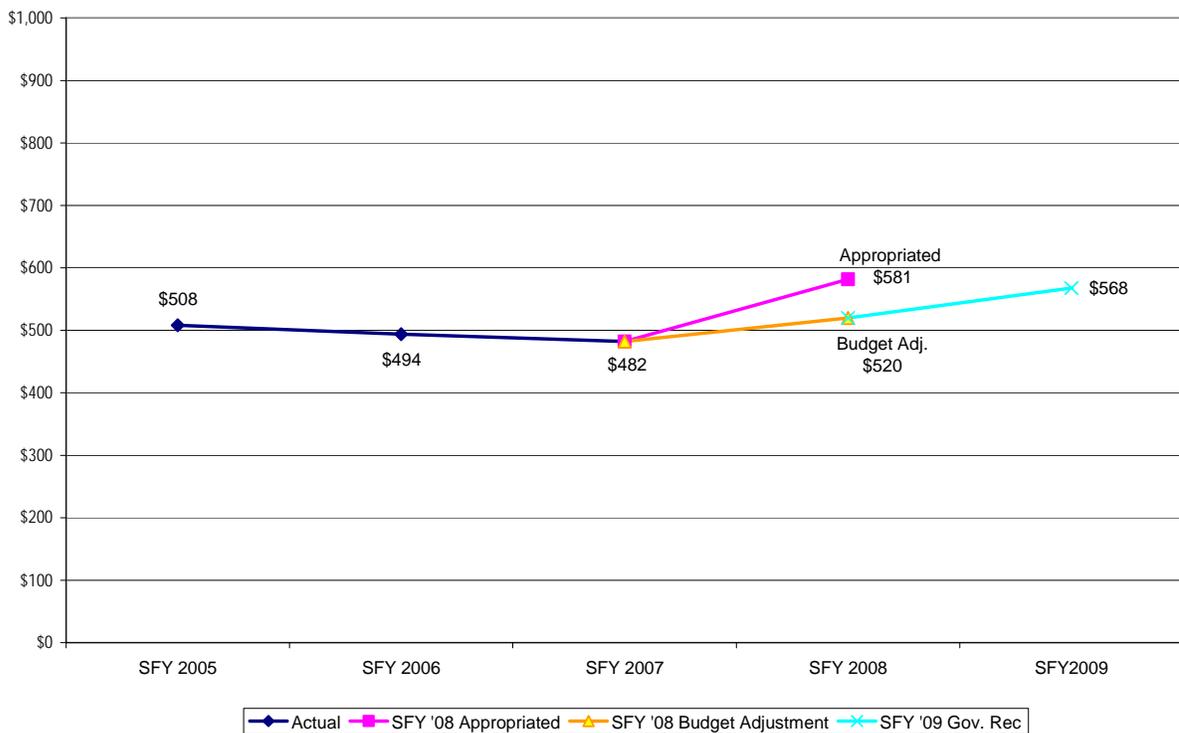


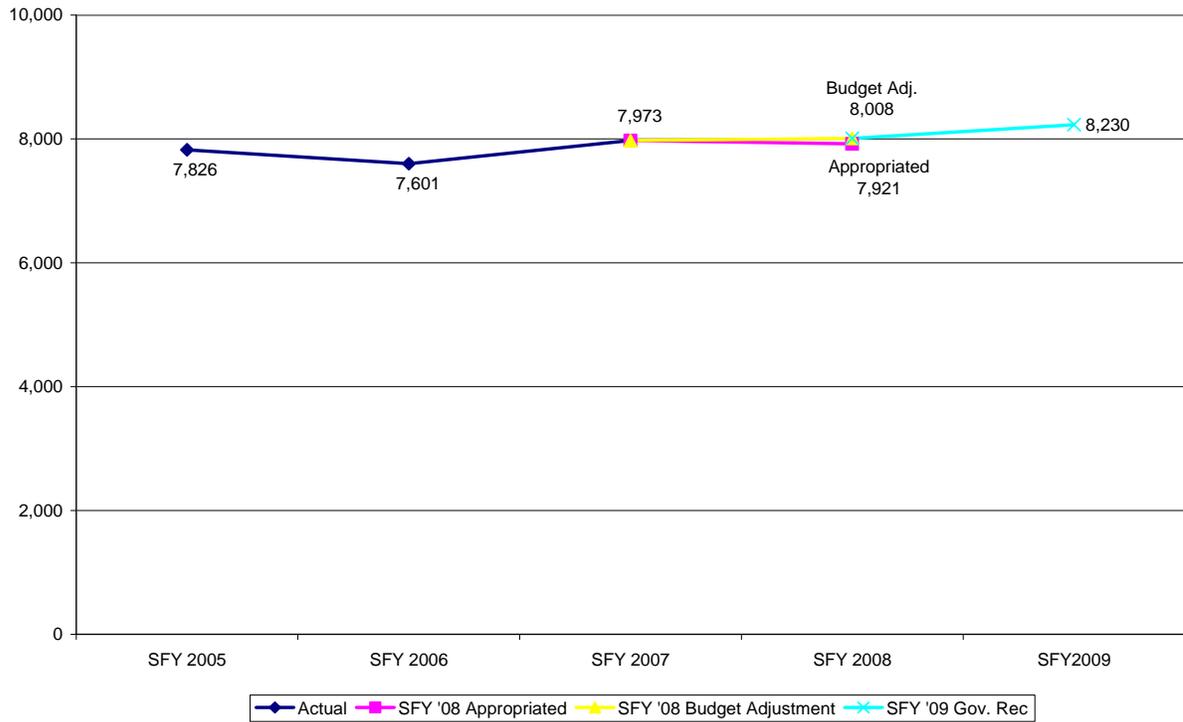
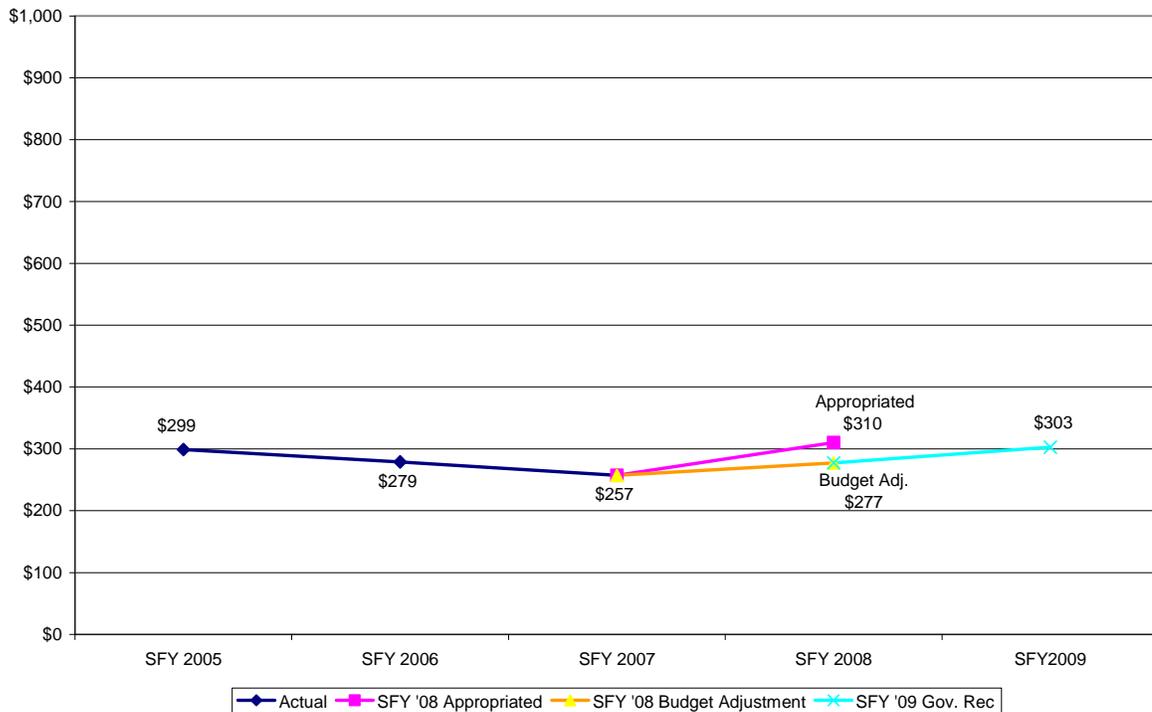
### Underinsured Children PMPM

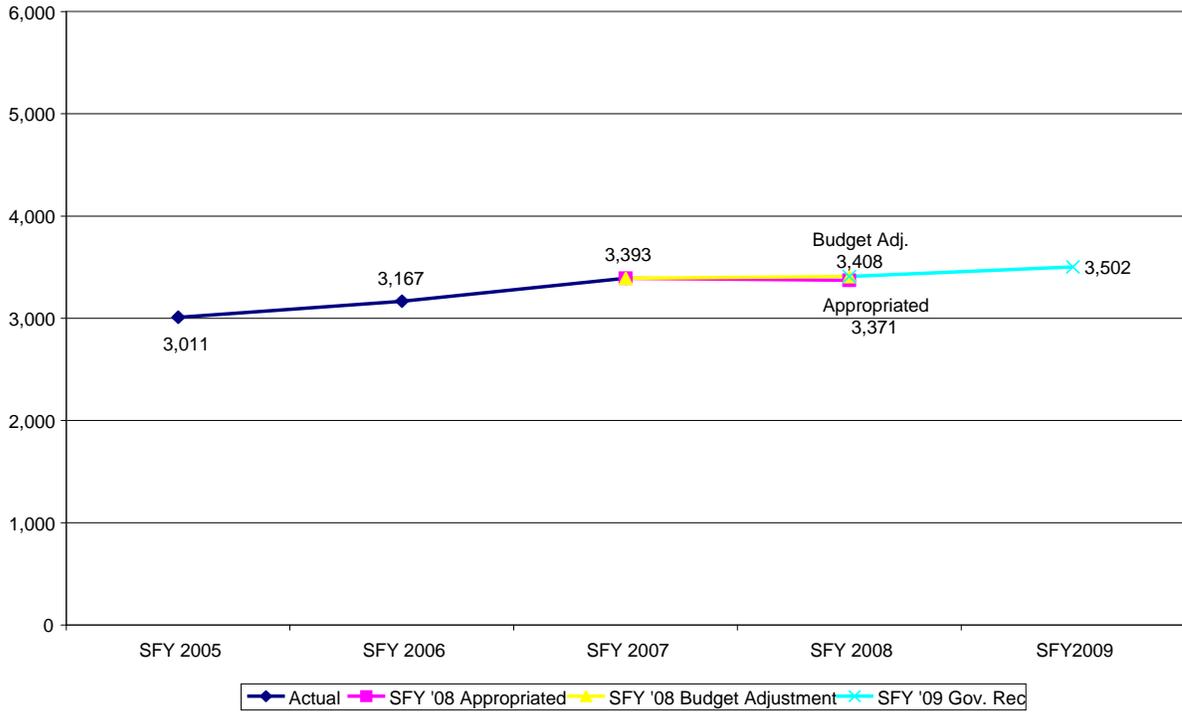
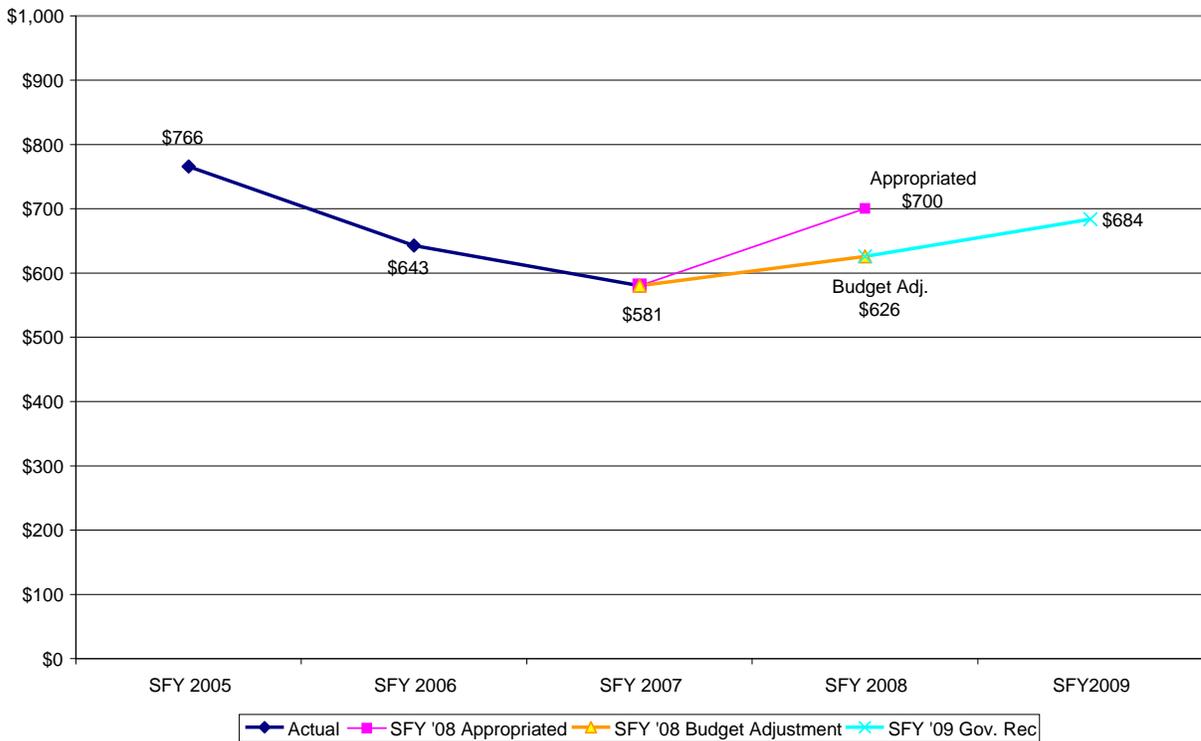


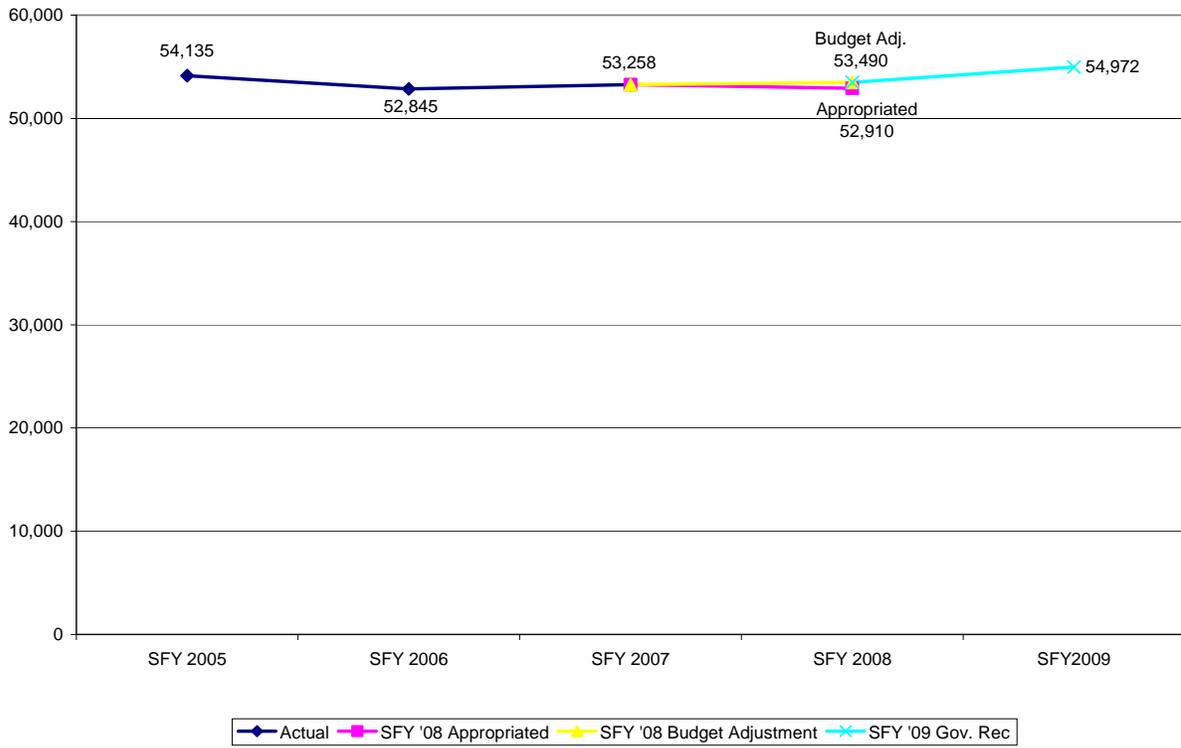
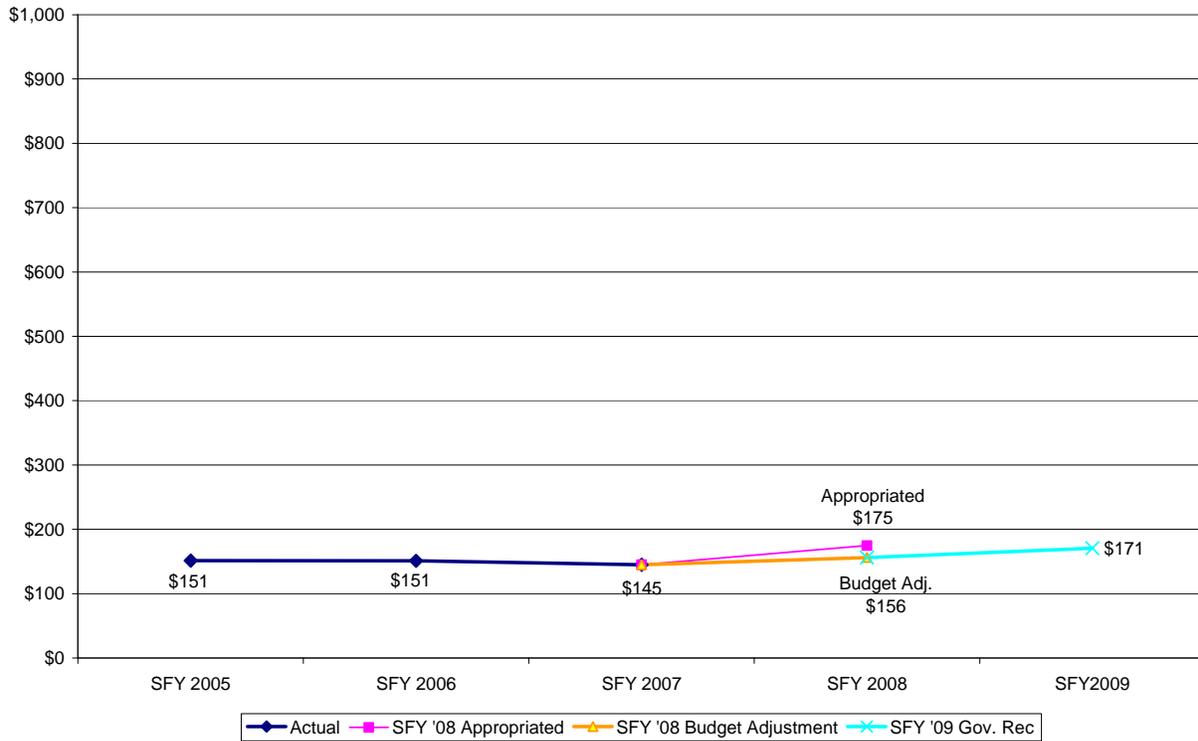
**VHAP Enrollment**

**VHAP PMPM**


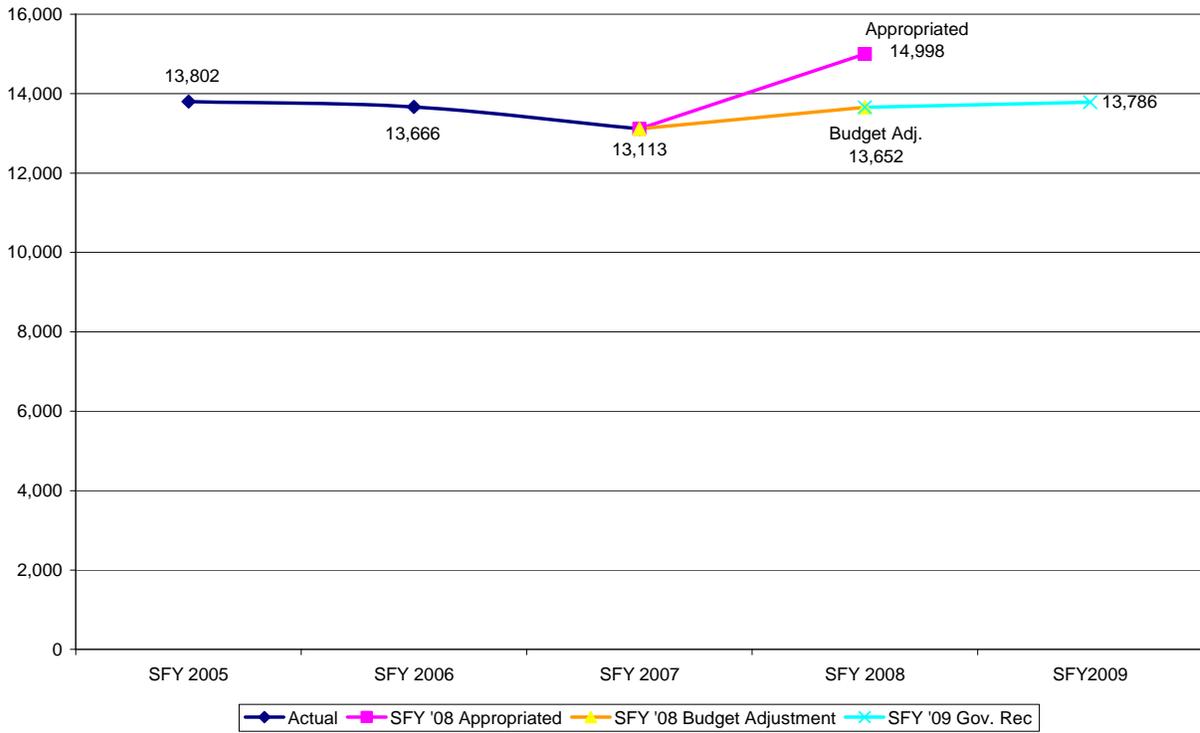
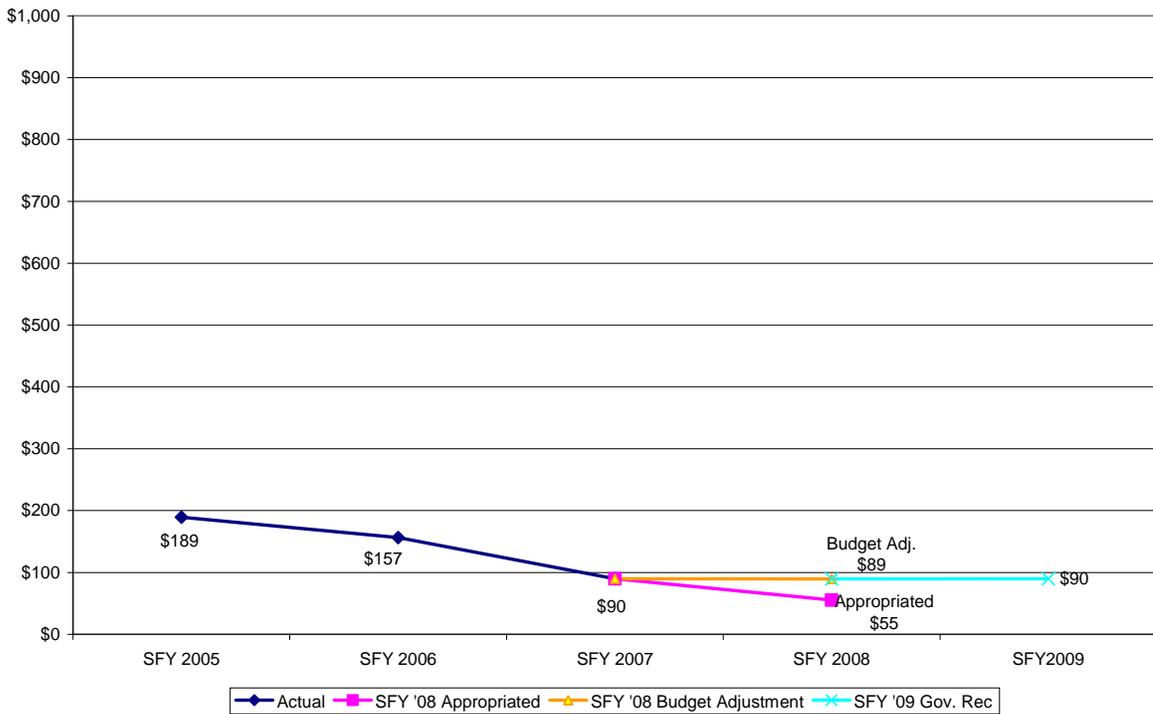
**Dual Eligibles Enrollment**

**Dual Eligibles PMPM**


**Aged, Blind and Disabled (ABD) Adults Enrollment**

**Aged, Blind, and Disabled (ABD) Adults PMPM**


**General Adults Enrollment**

**General Adults PMPM**


**Blind or Disabled (Children) Enrollment**

**Blind or Disabled (Children) PMPM**


**General Children Enrollment**

**General Children PMPM**


**Pharmacy Programs Enrollment**

**Pharmacy PMPM**


## Section 4: Catamount Health & Employer-Sponsored Insurance (ESI) Implementation Update

### Fast Facts:

- Over 65,000 (9.2%) of Vermonters are uninsured.
- Half of those qualify for existing state-sponsored health insurance programs but are not enrolled
- Act 191 goal: Achieve 96% coverage by 2010.
- Catamount Health is offered by BCBS of Vermont and MVP Health Care.
- Premium assistance for qualified individuals to access Catamount Health or employer-sponsored insurance became available October 1, 2007.
- <http://www.GreenMountainCare.org> was launched October 1, 2007.
- Marketing campaign for Green Mountain Care was launched November 1, 2007.
- 1-800-250-8427 is the number for Health Access Member Services for Green Mountain Care.

Act 191 created the new 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 the new 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.

The Office of Vermont Health Access (OVHA) and the Department for Children and Families' Economic Services Division (DCF/ESD) cooperatively began processing premium assistance applications on October 1, 2007.

Because half of the 65,000 Vermonters who do not have health insurance qualify for existing state-sponsored health insurance programs, one overarching brand (i.e., 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 new website, <http://www.GreenMountainCare.org>, was launched on October 1, 2007. The website 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.

The Green Mountain Care marketing campaign was launched on November 1, 2007 with a press conference with Governor James Douglas, TV and print/internet ads designed by the Green Mountain Care marketing contractor, GMMB. The response from the public has been overwhelmingly positive, and as a result, the number of visitors to the website increased from 2,960 in October 2007, to 9,423 in November 2007. The number of Catamount Health calls to the 1-800 number at Health Access Member Services for Green Mountain Care has also increased.

The OVHA coordinates an Outreach and Enrollment Steering Committee comprised of about 30 stakeholders who function as information conduits to their individual constituency. Some members are directly involved in assisting consumers, like the Vermont Association of Hospitals and Health Systems (VAHHS) and Health Care Ombudsman Program, or they represent the community through a business association such as the Vermont State Chamber and Lake Champlain Chamber of Commerce. The Campaign for Health Care Security is also a member and employs outreach workers to provide direct consumer assistance in the application process. Each member, as well as others in the community, is helping to spread the word about Green Mountain Care through emails, newsletters, and events.

## **Enrollment**

Thousands of uninsured Vermonters have responded to the marketing campaign by calling for more information about Green Mountain Care, visiting the new website, and applying for premium assistance. As of the end of December, 3,319 households have been approved for Catamount Health premium assistance, and 907 households have been approved for ESI premium assistance. Many of these households are still in the process of enrolling in their ESI plans or choosing a Catamount Health plan.

Enrollment reports, including information on income range, age, gender, and county of residence for Vermonters enrolled in the various programs will be available on a monthly basis from the OVHA.

## **Application Tracking**

Act 71 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. The OVHA has taken the lead in creating a work group to implement a tracking tool; the work group includes representatives from the OVHA, DCF/ESD, and Bi-State Primary Care Association. The tracking tool, and the links to outreach specialists who can provide assistance to Vermonters applying for health care programs, will be in place in the spring of 2008.

SFY '08 Catamount Health Actual Revenue and Expense Tracking  
Thursday, January 31, 2008

	SFY '08 Revised Appropriated		Consensus Estimates for SFY to Date		Actuals thru 12/31/07		% of SFY to-Date	
	<=200%	>200%	Total	<=200%	>200%	Total		
<b>TOTAL PROGRAM EXPENDITURES</b>								
Catamount Health	6,317,850	6,881,030	13,198,880	377,509	411,552	789,061	566,078	71.74%
Catamount Eligible Employer-Sponsored Insurance	88,278	96,147	184,424	2,116	2,304	4,420	13,762	311.37%
Subtotal New Program Spending	6,406,128	6,977,177	13,383,304	379,625	413,856	793,480	579,840	73.08%
Catamount and ESJ Administrative Costs	1,688,833	1,839,378	3,528,211	422,208	459,844	882,053	882,053	100.00%
TOTAL GROSS PROGRAM SPENDING	8,094,961	8,816,554	16,911,515	801,833	873,700	1,675,533	1,461,893	87.25%
<b>TOTAL STATE PROGRAM SPENDING</b>	<b>3,318,125</b>	<b>8,816,554</b>	<b>12,134,679</b>	<b>328,671</b>	<b>873,700</b>	<b>1,202,372</b>	<b>764,464</b>	<b>87.36%</b>
<b>TOTAL OTHER EXPENDITURES</b>								
Immunizations Program	-	4,000,000	4,000,000	-	2,000,000	2,000,000	2,000,000	100.00%
VT Dept. of Labor Admin Costs Assoc. With Employer Assess.	-	394,072	394,072	-	197,036	197,036	197,036	100.00%
Marketing and Outreach	1,316,167	-	1,316,167	658,084	-	658,084	658,084	100.00%
Blueprint	-	1,846,713	1,846,713	-	923,357	923,357	923,357	100.00%
TOTAL OTHER SPENDING	1,316,167	6,240,785	7,556,952	658,084	3,120,392	3,778,476	3,778,476	100.00%
<b>TOTAL STATE OTHER SPENDING</b>	<b>539,497</b>	<b>6,240,785</b>	<b>6,780,282</b>	<b>269,748</b>	<b>3,120,392</b>	<b>3,900,141</b>	<b>3,900,141</b>	<b>100.00%</b>
<b>TOTAL ALL STATE SPENDING</b>	<b>3,857,621</b>	<b>15,057,339</b>	<b>18,914,960</b>	<b>598,420</b>	<b>3,994,093</b>	<b>4,592,512</b>	<b>4,440,481</b>	<b>96.89%</b>
<b>TOTAL REVENUES</b>								
Catamount Health Premiums	964,287	2,012,969	2,977,257	57,619	120,395	178,014	188,040	105.63%
Catamount Eligible Employer-Sponsored Insurance Premiums	48,371	100,976	149,347	1,159	2,420	3,579	9,720	271.58%
Subtotal Premiums	1,012,659	2,113,945	3,126,604	58,778	122,815	181,593	197,760	108.90%
Federal Share of Premiums	(597,570)	-	(597,570)	(34,685)	-	(34,685)	(39,844)	114.87%
TOTAL STATE PREMIUM SHARE	415,089	2,113,945	2,529,034	24,093	122,815	146,908	157,916	107.49%
Cigarette Tax Increase (\$.60 / \$.80)	-	-	9,052,000	-	-	4,526,000	4,571,997	101.02%
Floor Stock	-	-	-	-	-	-	29,329	0.00%
Employer Assessment	-	7,500,000	7,500,000	-	3,750,000	3,750,000	2,767,791	73.81%
Interest	161,625	-	161,625	80,813	-	80,813	79,995	98.99%
TOTAL OTHER REVENUE	161,625	-	161,625	80,813	-	80,813	79,995	98.99%
<b>TOTAL STATE REVENUE</b>	<b>415,089</b>	<b>2,113,945</b>	<b>19,242,659</b>	<b>24,093</b>	<b>122,815</b>	<b>8,503,720</b>	<b>7,607,029</b>	<b>89.46%</b>
State-Only Balance	-	-	327,699	-	-	3,911,208	3,166,548	80.72%
Carryforward	-	-	4,617,848	-	-	4,617,848	4,617,848	100.00%
(DEFICIT)/SURPLUS	-	-	4,945,547	-	-	8,529,056	7,784,396	91.25%
Reserve Account Funding	-	-	3,500,000	-	-	3,500,000	3,500,000	100.00%
<b>REVISED (DEFICIT)/SURPLUS WITH RESERVE FUNDING</b>	<b>-</b>	<b>-</b>	<b>8,445,547</b>	<b>-</b>	<b>-</b>	<b>12,029,056</b>	<b>11,284,396</b>	<b>93.80%</b>

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

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## Section 5: Clinical Initiatives

### *Buprenorphine Program*

**Mission:**

Increase access to effective treatment for opiate dependency.

**Goal**

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

The OVHA was appropriated \$500,000 in one-time funds by the legislature to implement the Buprenorphine initiative in 2006. The current plan for the use of these funds, established in a collaborative manner between ADAP and OVHA, is a capitated program that increases reimbursement in a step-wise manner depending on the number of patients treated by a physician.

The Capitated Payment Methodology is depicted below:

Level	Complexity Assessment	Rated Capitation Payment				Final Capitated Rate (depends on the number of patients per level, per provider)
III.	Induction	\$348.97	+	<b>BONUS</b>	=	
II.	Stabilization/Transfer	\$236.32				
I.	Maintenance Only	\$101.28				

### Implementation

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.

VDH/ADAP was appropriated \$350,000 by the legislature in 2006 for technical assistance and training of physicians in the use of Buprenorphine. Out of the \$350,000, \$25,000 has been allocated to cover the expense of obtaining a waiver to prescribe Buprenorphine with remaining funds allocated to Howard Mental Health and the Office Based Medication Assisted Therapy, for a program called Coordination of Office Based

Medication Assisted Therapy (COB-MAT) which will be providing case management services.

The implementation of COB-MAT, by VDH/ADAP, commenced in June 2006 when Howard Mental Health was awarded the contract to act on behalf of OVHA and VDH/ADAP at the local level. To date, Howard Mental Health has hired and established the roles and responsibilities of the Care Coordinators, and the Care Coordinators have started working with Buprenorphine providers as of January 2007. The OVHA has also commenced the provider outreach process. Further meetings with other providers across the State have been scheduled. The DOC has agreed to participate with their population, and final procedures and protocols are being vetted within the DOC.

<b>CPTOD 2007 Payment Summary</b>	
May-07	\$ 680.00
Jun-07	\$ 15,595.40
Jul-07	\$ 15,149.40
Aug-07	\$ 20,505.59
Sep-07	\$ 28,315.04
<b>SURVEY</b>	\$ 10,000.00
Oct-07	\$ 27,968.12
Nov-07	\$ 30,492.75
	<b>\$ 148,706.30</b>

As of December 2007, the Capitated Program for the Treatment of Opiate Dependency (CPTOD) as implemented by the OVHA has 30 enrolled providers, 25 of which have active patient rosters and approximately 300 patients undergoing opiate addiction treatment. In the first quarter of SFY '08, the Buprenorphine Program paid \$63,970 in Buprenorphine claims for the 577 patients who received care, and paid a total \$58,507 to 18 enrolled providers. The OVHA will be obtaining rosters for the remaining seven providers and will continue statewide outreach to increase enrollment in the program.

### **SFY '09 New Program & Savings Initiative: Buprenorphine**

The projected savings from Buprenorphine Program for SFY '09 is **\$369,000**; the OVHA's SFY '09 commitment is **\$500,000**.

### **Care Coordination Program**

**Mission:**

- Identify and assist the most complex Medicaid beneficiaries in accessing clinically appropriate health care 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 Care Coordination Program (CCP), in conjunction with the Chronic Care Management Program (CCMP), exemplifies the Chronic Care Model in action. The CCP and CCMP are the vanguard of a system redesign to improve the health outcomes of beneficiaries.

## Goal

The OVHA is committed to partnering with primary care providers, hospitals, community agencies, and other Agency of Human Services (AHS) departments, to address the need for enhanced coordination of services in a climate of increasingly complex health care needs and scarce resources by utilizing the flexibility granted by the Global Commitment to Health Waiver.

The CCP facilitates the beneficiary-provider relationship by offering services that assist providers in tending to the intricate medical and social needs of beneficiaries, without increasing the administrative burden. The CCP supports providers by providing intensive case management to the beneficiary between office visits to enable the plan of care (POC) to be successful. Ultimately, the CCP aims to improve health outcomes, decrease inappropriate utilization of services, and increase appropriate utilization of services.

## Method

Annually, the CCP focuses on approximately 1,500 beneficiaries with chronic conditions. Individuals have at least one chronic condition including, but not limited to: Arthritis, Asthma, Chronic Obstructive Pulmonary Disease (COPD), Chronic Renal Failure, Congestive Heart Failure (CHF), Depression, Diabetes, Hyperlipidemia, Hypertension, Coronary Artery Disease, or Low Back Pain. These conditions and their management are further complicated by the often co-occurring conditions of mental health and substance abuse; as well as challenges including food security, availability of safe and affordable housing and transportation due to financial insecurity. As many as 20 different agencies and service providers have been engaged in care coordination efforts to successfully address the priority health and security needs of beneficiaries.

The CCP is based upon the desire for Vermonters to help other Vermonters. As supported by the Chronic Care Model, the CCP 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 (ER) and inpatient utilization. CCP professionals, working at the local level, facilitate engagement of other community service providers to support the beneficiary to achieve sustainability change required for long term health outcomes.

## Assessment and Intervention

Teams of nurses and social workers assess high risk members to determine needs and develop a customized plan of care, in collaboration with the primary care provider, using a holistic approach.

Assessment domains to help define client specific interventions include:

- Clinical prognosis: Can the chronic conditions be improved with medical treatment?

- Medical home: Is there a primary care provider relationship with appropriate communication and coordination among specialty providers?
- System barriers: Are there gaps and/or barriers to beneficiary receipt of appropriate medical care, including transportation or other support services?
- Housing and food security: Does the beneficiary have a safe home environment and basic food security to facilitate health goals?
- Self-Management: Is the beneficiary able to self-manage with appropriate support to improved disease knowledge, management goals and self-efficacy skills?
- Social Support network: Are there family members, friends, community 'wrap around' and/or other support services in place for sustainable behavioral changes?

Based on a customized tool under development with APS Healthcare to assess the above priorities, CCP teams will initiate interventions which may include any of the following:

- Facilitate access to a medical home, development of a holistic plan of care and coordination among existing medical service providers, including mental health and substance abuse resources as indicated
- Facilitate transportation requirements to medical care provider(s) for proactive, evidence based care delivery
- Coaching, education and/or referral based on disease specific best practice guidelines and health literacy requirements
- Facilitate 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.

### **Coordinated Implementation**

The high risk beneficiaries who will most benefit from the CCP are selected based upon criteria identified through claims data and in collaboration with the primary care provider. Selection of this population as well as monitoring assistance is performed by the Center for Health Policy and Research (CHPR) at the University of Massachusetts Medical School, under contract with OVHA. Our regionally-based Care Coordination teams [one Registered Nurse (RN) and one social worker] work with the identified beneficiary, their provider(s), community based organizations, and State entities to devise a tailored Plan of Care (POC) through assessment of current treatments, services, and resources. Care Coordination teams access resources from many avenues, including the Vermont Blueprint for Health-related activities, to enable the beneficiary to obtain better self-management skills and empower the beneficiary to promote their own health and well-being.

During calendar year 2007, the OVHA hired 12 staff members to support the CCP infrastructure for statewide launch, including a Field Director, two Regional Supervisors, six medical social workers and four nurses. The CCP will soon be fully staffed in

Orange/Washington and Bennington Counties, completing the statewide implementation structure.

As of December 2007, Care Coordination staff have been deployed in Franklin/Grand Isle, Rutland/Addison, Bennington, Windham/Windsor and Lamoille Counties, which supplement our existing presence in Caledonia/Orleans, Washington/Orange and Chittenden Counties. While the Lamoille County location is covered by a single medical social worker due to low beneficiary penetration and utilization data, the social worker has supplemental resources available with three nursing resources in surrounding district service areas, depending on the beneficiary location. This configuration provides the OVHA with statewide coverage.

The Agency of Human Services (AHS) reorganization recognized the need for coordination of services at the community level. As such, Care Coordination teams are located primarily at the local district offices to provide a unique and critical aspect of the AHS support network and to establish relationships with primary care providers that are focused on health outcomes. Care Coordination teams are informed about local and statewide quality improvement initiatives and are able to assist providers to access these initiatives.

Consistent with the AHS four key practices, Care Coordination teams focus on customer service, holistic support, strength based relationships and outcomes. Teams work closely with the AHS district field service directors on common beneficiaries and are instrumental in identification of service gaps and barriers critical to successful and effective resolution. Mature CCP teams also engage with the local interagency teams (LITs) as well as the Regional Partnerships. The result of implementing locally-based Care Coordination teams is the opportunity to collaborate creatively and effectively to address the unique needs of an individual beneficiary. To date, this collaboration has been rewarding for both beneficiaries and the OVHA, and supports the existing local infrastructure for our AHS clients in common.

For instance, a beneficiary with asthma and high emergency room utilization was found by the CCP team to be living in housing with significant mold and other health and safety concerns. The CCP team engaged the Town Health Officer to expedite a Section 8 housing voucher; the Field Service Director identified emergency resources to secure the required deposit on an available apartment. The beneficiary was relocated to a healthier home environment, thus removing the source of respiratory exposure exacerbating her asthma.

The CCP has begun to make significant advancements towards achieving the goals of the Vermont Blueprint for Health by addressing the unique characteristics of the most complex 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. Care Coordination teams provide additional support by facilitating the implementation of the essential components of disease management programs, as identified by Dr. Kenneth Thorpe, such as team-based care, cross-consortium coordination, patient education, outreach and care management.

Because Care Coordination teams are locally-based, they are able to implement these components within the context of the beneficiary's community, taking into account what is available and acceptable to the beneficiary and their primary care provider.

The OVHA also assures alignment with the Blueprint at the state level with staff serving on key Blueprint workgroups and committees. The OVHA Medical Director worked through the Blueprint Provider Practice Workgroup to develop and approve a uniform set of clinical guidelines and supporting outcome metrics for chronic conditions under management, including Asthma, Coronary Artery Disease, Hyperlipidemia and Hypertension in addition to Diabetes. Additional guidelines will be selected and approved in 2008. The OVHA also serves on the Evaluation Committee, a statewide stakeholders group working to assure common guidelines and metrics of success. Additionally, the OVHA participates on the Blueprint's newly formed team engaged with the Institute for Healthcare Improvement (IHI) Triple Aim initiative. The Triple Aim focus is on health outcomes for a defined population, the consumer experience of care and per capita cost of care, which align with both the Blueprint and the OVHA mission. The initial site visit by IHI experts is scheduled for January 2008 with the Blueprint assuming leadership for priorities to be undertaken for this quality improvement initiative.

### **Current Participating Providers, Agencies and Stakeholders**

As of December 2007, the CCP has engaged providers, agencies and stakeholders statewide including, but not limited to:

- 1) Area Health Education Centers
- 2) Blueprint for Health
- 3) Department for Children and Families (DCF) - field service districts
- 4) Department of Disabilities, Aging and Independent Living (DAIL)
- 5) Department of Mental Health
- 6) Hospitals and Physician Hospital Organizations (PHO)
- 7) Planned Parenthood of Northern New England
- 8) Provider practice groups, including independent practices, hospital owned practices and Federally Qualified Health Centers (FQHCs)
- 9) Regional Mental Health Service providers
- 10) Substance Abuse treatment providers
- 11) Vermont Association of Hospitals & Health Systems (VAHHS)
- 12) Vermont Department of Health (VDH) and district health offices
- 13) Visiting Nurse's Association (VNA)
- 14) Vocational Rehabilitation Services

### **Integration with the Chronic Care Management Program (CCMP)**

The OVHA's Chronic Care Management Program (CCMP) is designed to address the needs of beneficiaries with more moderate needs on a continuum extending downward from the CCP population, which is the highest risk. Beneficiaries will be transitioned into the CCMP from the CCP when they are no longer in need of intensive case

management, and early goals have been met. A case duration of between 4 - 6 months for most cases is expected, with variation based on individual need and complexity. It is anticipated that there will be fluidity between the CCP and CCMP as beneficiaries move up and down the health needs continuum and transition between the CCP and CCMP. An additional feature of the model is the existence of CCMP Community Health Coaches (Registered Nurses) at the local level, who can help facilitate case transition and management from CCP to CCMP. CCP and CCMP teams work closely, with weekly meetings between clinical leaders, management teams and information and data technology experts to facilitate communication, data tracking, program management and evaluation requirements.

Population selection and monitoring for the CCMP initiative is also a function of CHPR, under contract with OVHA. This facilitates and assures independent evaluation of both programs by an external party.

### **Provider Payments as a Component of CCP**

A segment of the operating costs for the CCP are set aside for reimbursing participating providers. A strategy has been implemented to reimburse providers with an enhanced capitated payment rate of \$15 per month for a CCP participant. To emphasize the importance of developing a POC with the primary care provider, the OVHA will also reimburse the provider \$55 for meeting with Care Coordination teams when one of their patients is enrolled in the CCP. Providers are also reimbursed \$55 for a “discharge” meeting to emphasize the importance of a smooth transition when a participant leaves the CCP.

The combination of incentive payments for meetings and an enhanced case management fee - \$10 more than the PC Plus case management fee - provides primary care providers with an attractive incentive for participation in the CCP.

### **2007 Achievements Highlights**

- 1) Over 750 beneficiaries have received Care Coordination services since inception. With expanded staffing and beneficiaries being actively enrolled statewide, the OVHA anticipates serving up to 1,500 individuals in calendar year 2008.
- 2) Care Coordination teams are receiving education and training on topics to assure skill development including *Medicaid Boot Camp*, *Bridges out of Poverty* and *Motivational Interviewing* and *De-escalation Techniques*.
- 3) The OVHA has trained 20 CCP and other clinical staff to become certified as Chronic Care Professionals (a nationally recognized certification). An estimated 80% are currently certified. The few remaining CCP staff will be trained and certified in the spring of 2008.
- 4) Developed and disseminated a brochure for providers which outlines the OVHA's clinical initiatives including the CCP, CCMP and the Buprenorphine Program.

- 5) Developed a consumer brochure outlining the CCP, which is in final stages of approval.
- 6) Multiple AHS departments and OVHA units have collaborated to ensure the successful implementation of the CCP.
- 7) The more mature OVHA CCP teams have developed partnerships with AHS field service directors, participate on Local Interagency Teams (LITs) and participate in Regional Partnership team meetings.
- 8) Community and local outreach to key stakeholders, including AHS departments, non-profit organizations and the physician community, have been completed in 10 of 13 counties, starting with areas with highest need and interest. Orleans, Addison and Orange County stakeholder meetings will be held in early calendar year 2008.
- 9) Hospital outreach has been successful and well received.
- 10) A reimbursement strategy is being implemented to encourage providers to participate in the CCP.
- 11) A CCP Orientation Manual has been completed and is being used as a staff development tool; various additional operating protocols are also in development.
- 12) The Care Connection® data management and tracking system [a proprietary system of APS - the OVHA vendor for the Chronic Care Management Program (CCMP)] is being used by CCP staff to assure service coordination between CCP and CCMP.
- 13) Baseline data and early metrics for programmatic monitoring and evaluation have been established in partnership with CHPR.
- 14) Meetings with Blueprint staff occur to enhance alignment and consistency. OVHA staff serve on Blueprint committees including the Evaluation Committee to assure coordinated evaluation with common metrics of success.
- 15) The OVHA has taken the lead on development of clinical guidelines for Hypertension, Asthma, Hyperlipidemia and Congestive Heart Failure (CHF), working with the Blueprint Physician and Provider Practice Workgroup.
- 16) The OVHA is a key member of the newly formed Institute for Healthcare Improvement (IHI) 'Triple Aim' team, lead by the Blueprint. IHI is an internationally recognized leader in healthcare quality improvement.

### **SFY '09 Savings Initiative: Care Coordination Program**

The estimated savings from CCP interventions in SFY'09 is **\$2.5 million**. Savings will be achieved by improved health outcomes, decreased inappropriate utilization of services (e.g., avoidable ambulance, ER, and inpatient services), and increased appropriate utilization of services (e.g., primary and specialist outpatient care).

## **Chronic Care Management Program (CCMP)**

### **Mission:**

- Identify and assist 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 appropriately self-manage their chronic conditions.

### **Goal**

The goal of the OVHA's Chronic Care Management Program (CCMP) is to improve health outcomes and reduce costs for beneficiaries with chronic conditions and to collaborate with providers, hospitals and community agencies to support a patient-focused model of care, committed to healthcare systems improvement and enhanced patient self-management skills.

### **Method**

In association with the Blueprint for Health and in partnership with the Care Coordination Program (CCP), which addresses the needs of beneficiaries at the highest risk level, the CCMP addresses the increasing prevalence of chronic illness for the Medicaid population. The CCMP is based on the Chronic Care Model and is designed to take a holistic approach by evaluating physical conditions and socioeconomic issues for Medicaid beneficiaries.

The CCMP focuses on beneficiaries who have been identified as having one of the 11 following chronic illnesses: Arthritis, Asthma, Chronic Obstructive Pulmonary Disease (COPD), Chronic Renal Failure, Congestive Heart Failure (CHF), Depression, Diabetes, Hyperlipidemia (i.e., high cholesterol, high triglycerides), Hypertension, Ischemic Heart Disease (i.e., coronary artery disease) and Low Back Pain. Beneficiaries who are currently enrolled in Medicaid, VHAP, PCPlus and Dr. Dynasaur and who have a chronic illness are eligible for the CCMP. The OVHA estimates that there are approximately 25,000 beneficiaries with at least one of the above-cited diagnoses.

The CCMP is administered by two contracts: 1) the Center for Health Policy and Research (CHPR) at the University of Massachusetts Medical School has provided population selection and program monitoring services since January 24, 2007, and 2) APS Healthcare Services, Inc has provided Health Risk Assessments (HRA) and Intervention Services (IVS) since July 1, 2007.

### **Implementation**

Based upon a predictive modeling system, CHPR provides OVHA with the 25,000 Medicaid beneficiaries selected for CCMP, who are then uploaded into the APS CareConnection® case tracking system. APS CareConnection® is a proprietary system that documents HRAs and interventions, educational tools and self-management strategies to assist practitioners, beneficiaries and APS health care professionals in the

prevention and treatment of chronic conditions. The 25,000 beneficiaries who are selected for CCMP receive a Member Handbook and welcome letter, which includes contact information and an invitation to call APS to complete an HRA. They also receive a quarterly newsletter with general and disease-specific health information.

The next point of contact with the beneficiary is the administration of the HRA, which has been rolled-out in a randomized order across the state. The HRA is a nationally standardized eight-question survey that scores the general state of health of the beneficiary, ranged from 8 to 42. This survey is conducted telephonically, but beneficiaries are also given the option to complete it in paper form to mail in to APS.

The daily results of the HRAs are forwarded to the Disease Management Coordinators (DMC) who then identify beneficiaries who score 30 or higher. Beneficiaries who score 30 or above on the HRA are contacted by the DMC to complete a more detailed health assessment, the Adult General Assessment (AGA). Those who score below 30 on the HRA receive newsletters, disease specific materials, and have continuous access to web-based education and behavior change tools.

The AGA is a 56-question telephonic health assessment that provides baseline data about the beneficiary's current health status, self-care practices and recent health history from their perspective. Upon completion of the AGA, the DMC assigns the case to the appropriate Health Coach to receive additional Intervention Services (IVS). The level of risk and associated intervention services (low, moderate, moderately high or high) are determined by the combination of the health care claims and the outcomes of the HRA and AGA. IVS includes providing informational material on their chronic health care conditions, establishing a Plan Of Care (POC) for one or more health issues, identifying barriers to their health care needs, referrals to a CCMP Social Worker as needed, and following up with the beneficiary either by phone or meeting face-to-face.

### Risk Stratification and Intervention Services

	LOW	MODERATE	MODERATELY HIGH	HIGH
<b>INTERVENTION SERVICES</b>				
HRA administration	X	X	X	X
Initiate IVS after HRA completion	Within 45 days	Within 30 days	Within 15 days	Within 15 days
Welcome letter	X	X	X	X
Quarterly newsletter with disease-specific insert	X	X	X	X
Access to health coach telephonic support	X	X	X	X
Access to RN support	X	X	X	X
List to primary care providers of patients due for disease specific monitoring	Quarterly	Monthly	Monthly	Monthly
List to primary care providers of patients needing drug related interventions	Quarterly	Monthly	Monthly	Monthly
One-time face-to-face outreach visit to primary care provider		X	X	X
Care plan developed in coordination with primary care provider		X	X	X
Outgoing phone contact or correspondence		Quarterly	Monthly	Bi-weekly
Face-to-face contact			One-time	Monthly

## Collaboration with Providers

The CCMP has provided on-going provider outreach, education and support since the commencement of the program. A CCMP introductory letter was sent to all Medicaid providers informing them of the support services for their office and their patients, the case management services in support of the POC, and 24-hour access to patient information via CareConnection® to monitor POC implementation and progress. In addition, the CCMP Outreach Coordinator provides information and training for providers and their office staff on the APS CareConnection® case tracking system.

As of December 31, 2007, CCMP staff have outreached to 16 Vermont hospitals, eight hospital affiliates, 20 Family Practices, 12 Pediatricians, 25 Federally Qualified Health Centers (FQHCs), 18 Regional Health Centers, 14 Vermont health organizations (e.g., Vermont Assembly of Home Health Agencies, Vermont Association of Hospitals and Health Systems), and three Vermont chapters of the American Diabetes Association, the American Heart Association, and the American Lung Association. Outreach efforts to beneficiaries and providers will continue as CCMP expands across the state.

## Data

- Targeted beneficiaries as of July 1, 2007: **22,865**
- HRAs completed for CCMP and CCP as of January 27, 2008: **9,007**
- Intervention Services (IVS) Assessments completed as of January 20, 2008: **1,430**

## Achievements to Date

- 1) January 24, 2007, the OVHA commenced contracting services with the Center for Health Policy and Research (CHPR) at the University of Massachusetts Medical School to perform population selection and program monitoring.
- 2) July 1, 2007, the OVHA commenced contracting services with APS Healthcare, Inc. to provide Health Risk Assessment (HRA) administration and for Intervention Services (IVS).
- 3) APS established a service center in Williston, Vermont, staffed with local Vermonters: 1 Medical Director, 1 Reporting Analyst, 1 Executive Assistant, 1 Outreach Coordinator, 9 HRA Coordinators, 2 Health Services Managers, 5 Community Health Coaches, 1 Social Worker, 2 Disease Management Coordinators, 1 Senior Health Coach and 2 Health Coaches. The Executive Director position remains under recruitment.
- 4) All 5 Community Health Coaches, who are RNs located throughout the state, have been hired to provide IVS and POC coordination, especially to higher risk CCMP beneficiaries, and to assist with provider education.
- 5) July 10, 2007, Welcome Letters mailed to 22,865 beneficiaries; follow-up postcard mailing was sent on October 2, 2007; an additional mailing for HRA completions occurred in December. These outreach efforts resulted in a 10% response rate, which is higher than the national average of a 2% response rate to mailings.

- 6) As of January 27, 2008, 9,007 HRAs have been administered by APS to both CCP and CCMP beneficiaries, ahead of the 8,000 goal. APS will continue HRA administration at a rate of 2,000 per month during calendar year 2008 until the initial 22,865 beneficiaries enrolled in CCMP have been contacted.
- 7) Disease management guidelines have been written and vetted via the Vermont Blueprint for Health for Ischemic Heart Disease (i.e., Coronary Artery Disease), Diabetes, Hypertension, Asthma, and Hyperlipidemia (i.e., high cholesterol, high triglycerides). APS subcontracted with the Morehouse School of Medicine, which provided additional national guidelines for Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF), Morehouse is scheduled to provide guidelines by February 15, 2008, for the remaining conditions of Depression, Arthritis, Low Back Pain, and Chronic Renal Failure.
- 8) CHPR produced a Baseline Monitoring Report, which compares Vermont's CCMP population to measures and benchmarks that will be used for evaluation; both process and outcome measures are used and are derived from a variety of sources, including the Healthcare Effectiveness Data and Information Set (HEDIS), Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators, American Medical Association (AMA), Health Resources and Services Administration (HRSA), and national disease collaboratives, such as the National Asthma Education and Prevention Program and the National Diabetes Quality Improvement Alliance.

### **SFY '09 Savings Initiative: Chronic Care Management Program**

The estimated savings from CCMP interventions in SFY'09 is **\$4.9 million**. These savings will be achieved by providing low cost support to beneficiaries and improving patient self-management skills. The savings will be indirectly achieved by collaborating with providers, hospitals and community agencies to support a patient-focused model of care.

### **Health Risk Assessment**

The SF-8™ Health Survey is a nationally standardized health risk assessment instrument that scores the general state of health of the beneficiary; all beneficiaries enrolled in the CCMP are asked to complete it. Results help Disease Management Coordinators determine which beneficiaries are referred for more detailed health assessments and interventions.

### SF-8™ Health Survey Scoring Demonstration

This survey asks for your views about your health. This information will help you keep track of how you feel and how well you are able to do your usual activities. Thank you for completing this survey!

Answer every question by selecting the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

For each of the following questions, please mark an [x] in the one box that best describes your answer.

1. Overall, how would you rate your health during the **past 4 weeks**?

<b>Excellent</b>	<b>Very good</b>	<b>Good</b>	<b>Fair</b>	<b>Poor</b>	<b>Very poor</b>
<input type="checkbox"/>					

2. During the **past 4 weeks**, how much did physical health problems limit your usual physical activities (such as walking or climbing stairs)?

<b>Not at all</b>	<b>Very little</b>	<b>Somewhat</b>	<b>Quite a lot</b>	<b>Could not do physical activities</b>
<input type="checkbox"/>				

3. During the **past 4 weeks**, how much difficulty did you have doing your daily work, both at home and away from home, because of your physical health?

<b>None at all</b>	<b>A little bit</b>	<b>Some</b>	<b>Quite a lot</b>	<b>Could not do daily work</b>
<input type="checkbox"/>				

4. How much **bodily** pain have you had during the **past 4 weeks**?

<b>None</b>	<b>Very mild</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>	<b>Very Severe</b>
<input type="checkbox"/>					

5. During the **past 4 weeks**, how much energy did you have?

<b>Very much</b>	<b>Quite a lot</b>	<b>Some</b>	<b>A little</b>	<b>None</b>
<input type="checkbox"/>				

6. During the **past 4 weeks**, how much did your physical health or emotional problems limit your usual social activities with family or friends?

<b>Not at all</b>	<b>Very little</b>	<b>Somewhat</b>	<b>Quite a lot</b>	<b>Could not do social activities</b>
<input type="checkbox"/>				

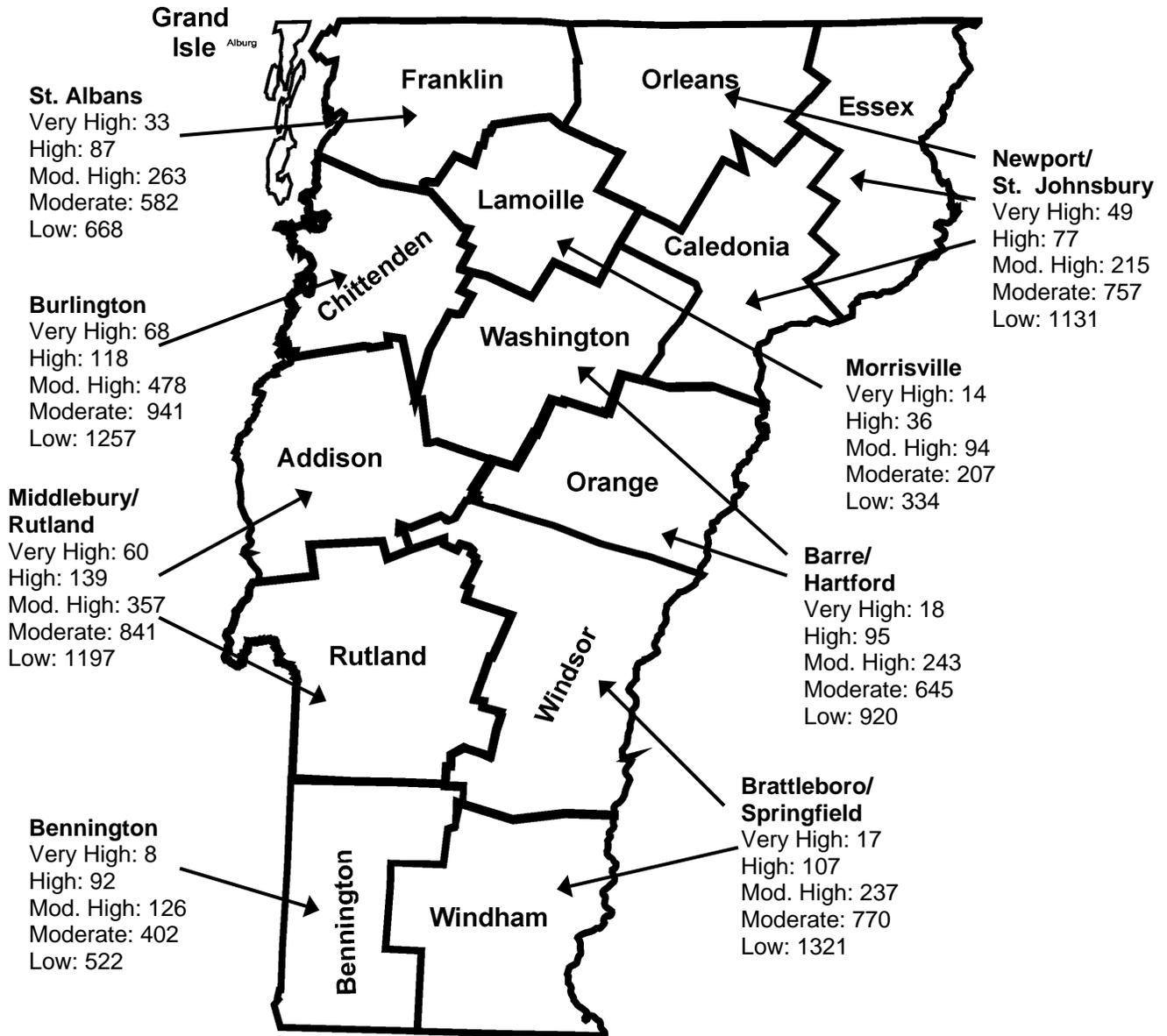
7. During the **past 4 weeks**, how much have you been bothered by **emotional problems** (such as feeling anxious, depressed or irritable)?

<b>Not at all</b>	<b>Slightly</b>	<b>Moderately</b>	<b>Quite a lot</b>	<b>Extremely</b>
<input type="checkbox"/>				

8. During the **past 4 weeks**, how much did personal or emotional problems keep you from doing your usual work, school or other daily activities?

<b>Not at all</b>	<b>Very little</b>	<b>Somewhat</b>	<b>Quite a lot</b>	<b>Could not do daily activities</b>
<input type="checkbox"/>				

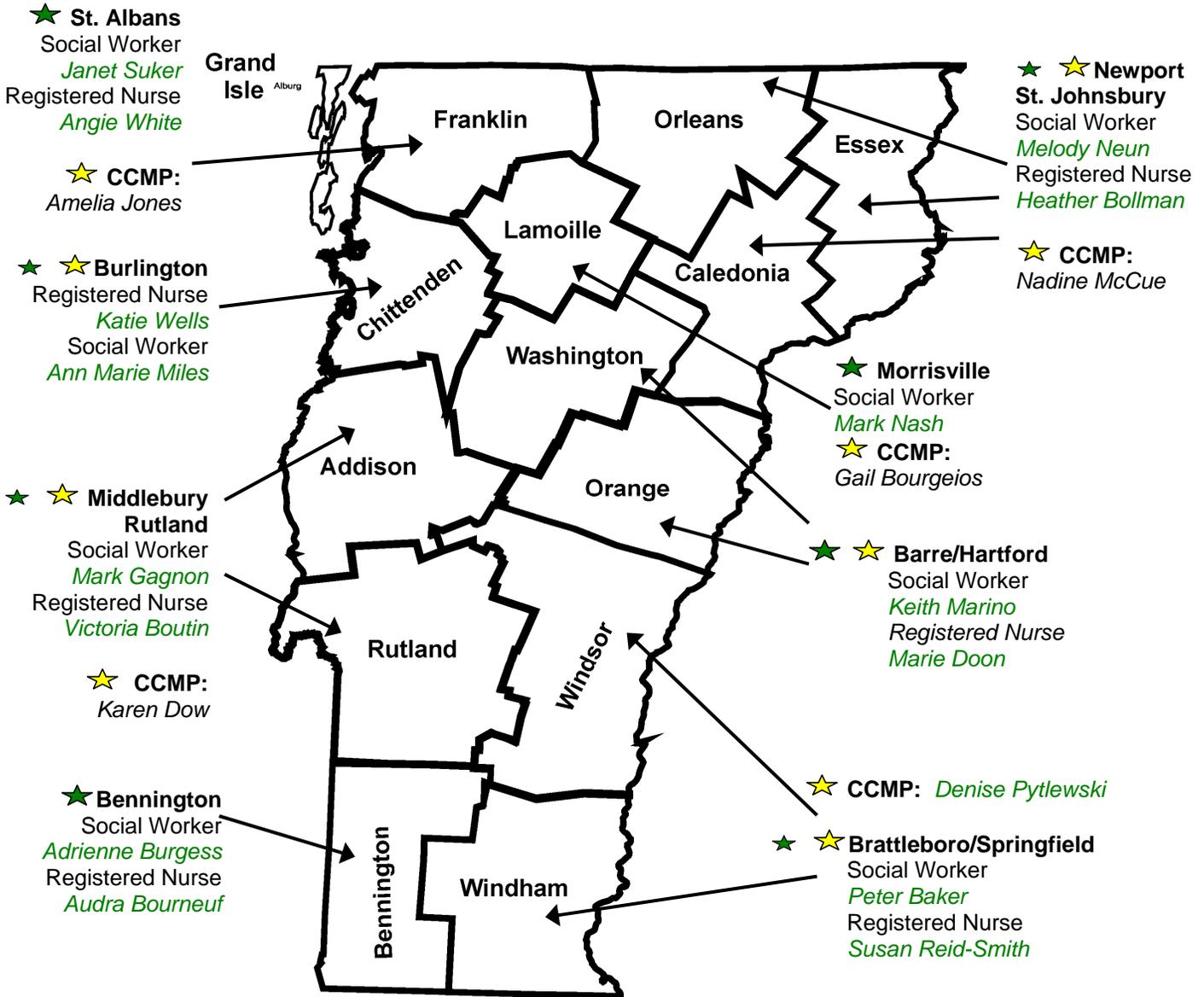
Thank you for completing these questions!

**Chronic Care Management Initiative: Current Enrollment by Risk Levels 1/31/08**


<u>Total</u>	
<b>Care Coordination</b>	Very High: 267
<b>Chronic Care Management</b>	High: 751 Mod. High: 2013 Moderate: 5145 Low: 7350

## Care Coordination Program & Chronic Care Management Program Teams

January 31, 2008



**Northern Regional Supervisor**  
*Georgette Coleman*  
**Southern Regional Supervisor**  
*Janice McCann*  
**CCP Field Director**  
*Eileen Girling*

★ OVHA Care Coordination Team  
 1 Social Worker & 1 Registered Nurse

★ CCMP Community Health Coach  
 1 Registered Nurse

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## **Section 6: Global Commitment/Managed Care Organization (MCO)**

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 the following:

- 1) The applicability and impact of CMS actions (e.g., rules related to targeted case management, rehabilitative services) on the Waiver.
- 2) Enrollment of Catamount-eligible individuals with incomes between 200 and 300 percent of the Federal Poverty Level (FPL) into the Waiver.
- 3) 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.

The request must be accompanied by an interim evaluation report for the Waiver. The AHS submitted a draft evaluation design to CMS that describes how the State will evaluate whether the Waiver met its goals and objectives and achieved specific outcome measures. The AHS and OVHA need to collect and analyze data to support the evaluation report during State Fiscal Year (SFY) 2009.

Federal law provides for a “streamlined” extension process, but this process limits 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. 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.

### **Grievance and Appeal**

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. Some of the key points in the rule include:

- 1) Beneficiaries or their representatives or the provider may ask for a reconsideration of a denial, reduction, or termination of a covered service. This occurred on an informal basis before the rules were enacted. Now the rules inform beneficiaries of this option, especially if there is additional information that might change the decision.
- 2) Beneficiaries or their representatives, or the provider, at the beneficiary's request, may appeal a denial, reduction, or termination of a covered service. An appeal is heard by a qualified person who was not involved in the original decision. The provider may be asked to attend an appeal meeting by phone or in person, or submit additional clinical evidence for review. The MCO will try to decide the appeal in 30 days; however, it can take up to 45 days. An extension of 14 days might occur if it is in the beneficiary's best interests (such as to get more information or to reschedule the meeting). The beneficiary may ask for a **fair hearing** simultaneously with an appeal.

If the provider or beneficiary believes that taking the usual time for an appeal might "seriously jeopardize the beneficiary's life or health or ability to attain, maintain or regain maximum function," either the beneficiary or the provider on the beneficiary's behalf may ask for an **expedited appeal**. If it is determined that the appeal meets the expedited criteria, a decision will be rendered within three working days.

- 3) A beneficiary may file a grievance when a written response from the MCO is requested. The grievance process is intended to address questions about the quality of care, the manner in which the care was provided, and the like. The MCO will try to deal with the complaint informally at first, and offer possible avenues for the complainant to follow, but the MCO will issue a formal, written response.

The first legislative report on this process was due in January 2008 and is included in Appendix 7.

For the complete rules, visit the OVHA website at <http://ovha.vermont.gov/statutes-rules/adopted-rule-changes/2007/bulletin-06-05-global-committment-to-health-grievance-appeal-rules/word-version>

The summary MCO Investment list for State Fiscal Years (SFY) 2007 (Actuals) and SFY 2008 (Budget Adjustment) is on the following page:

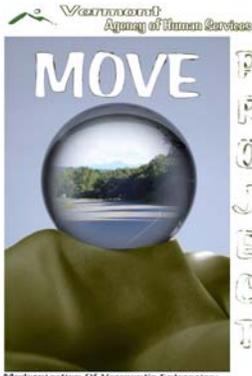
No.	Dept.	Investment Description	SFY07 Actuals	SFY08 Budget Adjustment
1	Department of Education	School Health Services		\$ 8,956,247
2	BISHCA	Health Care Authority	\$ 914,629	\$ 1,404,997
3	VITL	Vermont Information Technology Leaders	\$ 105,000	\$ 105,000
4	VVH	Vermont Veterans Home	\$ 913,047	\$ 881,261
5	Vermont State Colleges	Health Professional Training	\$ 391,698	\$ 405,407
6	University of Vermont Medical School	Vermont Physician Training	\$ 3,870,682	\$ 4,006,156
7	VDH	Emergency Medical Services	\$ 436,642	\$ 142,409
8	VDH	AIDS Services/HIV Case Management	\$ -	\$ -
9	VDH	Medication Assistance for Individuals with HIV/AIDS	\$ -	\$ -
10	VDH	TB Medical Services	\$ 29,129	\$ 36,471
11	VDH	Epidemiology	\$ 427,075	\$ 234,138
12	VDH	Health Research and Statistics	\$ 403,244	\$ 249,402
13	VDH	Health Laboratory	\$ 1,908,982	\$ 1,799,542
14	VDH	Tobacco Cessation	\$ 1,647,129	\$ 1,458,517
15	VDH	Family Planning	\$ 122,961	\$ 140,876
16	VDH	Physician/Dentist Loan Repayment Program	\$ 439,140	\$ 1,400,000
17	VDH	Renal Disease	\$ 7,601	\$ 15,000
18	VDH	Newborn Screening	\$ 166,795	\$ 99,650
19	VDH	WIC Coverage	\$ 1,165,699	\$ 428,032
20	VDH - Alcohol and Drug Abuse	Substance Abuse Treatment	\$ 2,514,963	\$ 2,896,839
21	VDH - Alcohol and Drug Abuse	Recovery Centers	\$ 287,374	\$ 229,704
31	VDH	Vermont Blueprint for Health	\$ 1,975,940	\$ 1,175,706
	VDH	AHEC	\$ 35,000	\$ 450,000
	VDH	Community Clinics	\$ -	\$ 340,000
	VDH	FOHC Lookalike	\$ -	\$ 200,000
	VDH	Adverse Events	\$ -	\$ 76,000
	VDH	CHAMPS	\$ 100,000	\$ 224,200
22	DMH	Transportation - Children in Involuntary Care	\$ 1,075	\$ -
23	DMH	Emergency Mental Health for Children and Adults	\$ 1,988,548	\$ 2,002,639
24	DMH	Respite Services for Youth with SED and their Families	\$ 485,586	\$ 496,147
25	DMH	Special Payments for Medical Services	\$ 131,309	\$ 108,427
26	DMH	MH Outpatient Services for Adults	\$ 1,393,395	\$ 1,631,712
27	DMH	Mental Health Elder Care	\$ 37,682	\$ 38,502
28	DMH	Mental Health Consumer Support Programs	\$ 546,987	\$ 569,881
29	DMH	Mental Health CRT Community Support Services	\$ 602,186	\$ 749,101
30	DMH	Mental Health Children's Community Services	\$ 3,066,774	\$ 3,234,381
	DMH	CRT Staff Secure Transportation	\$ -	\$ 52,152
	DMH	Peer Supports - FUTURES	\$ -	\$ 235,277
	DMH	Recovery Housing	\$ -	\$ 235,277
32	OVHA	Buy-In	\$ 314,376	\$ 474,078
33	OVHA	VSript Expanded	\$ -	\$ -
34	OVHA	HIV Drug Coverage	\$ 42,347	\$ 45,000
35	OVHA	Civil Union	\$ 543,986	\$ 725,000
36	DCF	Family Infant Toddler Program	\$ 199,064	\$ 1,354,600
37	DCF	Medical Services	\$ 91,569	\$ 100,000
38	DCF	Residential Care for Youth/Substitute Care	\$ 10,536,996	\$ 10,199,521
39	DCF	Aid to Aged, Blind and Disabled Administration	\$ -	\$ -
40	DCF	Aid to Aged, Blind and Disabled	\$ -	\$ -
41	DCF	Aid to the Aged, Blind and Disabled CCL Level III	\$ 2,617,350	\$ 2,640,000
42	DCF	Aid to the Aged, Blind and Disabled Res Care Level III	\$ 143,975	\$ 140,000
43	DCF	Aid to the Aged, Blind and Disabled Res Care Level IV	\$ 312,815	\$ 300,000
44	DCF	Essential Person Program	\$ 675,860	\$ 670,000
45	DCF	GA Medical Expenses	\$ 339,928	\$ 410,000
	DCF	CUPS	\$ -	\$ -
	DCF	VCRHYP	\$ -	\$ 1,763,827
	DCF	HBKF	\$ -	\$ -
46	DDAIL	Elder Coping w/MMA	\$ -	\$ -
47	DDAIL	Mobility Training/Other Svcs.-Elderly Visually Impaired	\$ 250,000	\$ 250,000
48	DDAIL	DS Special Payments for Medical Services	\$ 192,111	\$ 435,000
49	DDAIL	Flexible Family/Respite Funding	\$ 1,135,213	\$ 1,570,912
	DDAIL	Quality Review of Home Health Agencies & Nursing Homes	\$ 77,467	\$ 240,000
	DDAIL	Registry	\$ -	\$ 100,000
50*	DOC	Intensive Substance Abuse Program (ISAP)	\$ 299,602	\$ 200,000
51*	DOC	Intensive Sexual Abuse Program	\$ 46,078	\$ 190,000
52	DOC	Intensive Domestic Violence Program	\$ 134,663	\$ 224,000
53	DOC	Women's Health Program (Tapestry)	\$ 487,344	\$ 487,344
54	DOC	Community Rehabilitative Care	\$ 1,982,456	\$ 1,992,800
<b>Total MCO Investments</b>			<b>\$ 46,539,473</b>	<b>\$ 61,221,132</b>

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## Section 7: 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. The OVHA has several initiatives underway or planned.

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



The MOVE Project, the Modernization of Vermont's (Medicaid) Enterprise, is on a fast track to update and upgrade system support for the Medicaid program. Over the next several years Vermont will implement a new health care eligibility determination system and claims processing/payment system (Medicaid Management Information System – MMIS). These 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 Underway and Planned for SFY 2009

The MOVE Project commenced in July 2007 with the creation of a detailed project work plan. Shortly thereafter project governance was established, consisting of an Executive Steering Committee, Project Team, and a Departmental Key Contacts Team. The Executive Steering Committee is chaired by the Agency of Human Services (AHS) Deputy Secretary. Every department in the AHS is participating at both the vision and detail level. Input has also been acquired from the Commissioner of the Department of Information and Innovation (DII), the Director of Health Care Reform Implementation, Vermont Information Technology Leaders (VITL) and other states.

The major work-in-progress (slated for completion by March 2008) is the Medicaid Information Technology Architecture (MITA) State Self Assessment (SSA), which is a process that states must complete to implement the Center for Medicare and Medicaid Services (CMS) MITA initiative. The MITA establishes a vision and framework for future Medicaid Management Information Systems (MMIS) development. Its goal is to change the way states design, build and modify their MMIS and perform Medicaid IT investment planning.

In order to receive federal funding for MMIS procurements states must align their business goals and objectives with MITA goals and objectives and must plan MMIS

procurements and enhancements within the MITA framework. CMS is requiring each state to complete a state self assessment (SSA) for submission with a funding request. The assessment methodology is defined by CMS and entails an extensive evaluation of the current systems and business processes in the “Medicaid enterprise” compared to Vermont’s vision and the MITA framework, goals and objectives. The SSA encompasses all related business processes including eligibility and enrollment, claims processing/payment, and program integrity. The State must develop strategies for meeting its objectives in accordance with the MITA framework because CMS expects improvements in return for federal funding.

Completing the MITA SSA involves four fundamental components:

- 1) As-Is Assessment – documents the current state of the business processes performed within the Vermont Medicaid enterprise and the maturity of those processes as measured against CMS definitions.
- 2) To-Be Assessment - presents the detailed analysis of the envisioned or desired future state of Vermont Medicaid enterprise business processes and capabilities; this analysis identifies how those envisioned business processes and associated technology align with the CMS MITA Framework Version 2.0.
- 3) Gap Analysis - presents a detailed comparison between the As-Is and the To-Be Assessment findings; this comparison identifies the gaps between the current environment and desired environment enabling Vermont to prioritize improvement projects and plan the strategies necessary to realize the desired future state of the Vermont Medicaid enterprise.
- 4) Roadmap - describes the strategy for transitioning people, processes and technology to a MITA aligned plan for the future Vermont Medicaid Enterprise; discusses at a high-level the portfolio of projects that must be completed to successfully enable Vermont to close the gap between the As-Is and To-Be environments and realize the MITA aligned vision for its Medicaid Enterprise.

In addition to the MITA SSA, the OVHA has begun to specifically plan for procurement of the health care eligibility determination system. Demonstrations of existing technologies were held in November 2007. The drafting of general requirements occurred during December 2007, and facilitated sessions to elicit detailed requirements are scheduled for January through March 2008. During the remainder of SFY 2008 and throughout SFY 2009 the OVHA will develop the federally required Advance Planning Document (APD), the Request for Proposal (RFP) and manage the procurement process.

### **Future MOVE Work**

The OVHA anticipates selecting a vendor and finalizing a contract so development and implementation of the new health care eligibility determination system can begin in July

2009. This system will replace those functions which currently exist in the ACCESS system, where coverage under Green Mountain Care is decided and authorized. The ACCESS system has been in operation since 1983. Staff struggle to make system changes in response to the demands and deadlines of the current health care environment. Significant cost is associated with implementation of each program initiative or change. ACCESS constraints hinder Vermont's ability to realize its health care vision through enhanced consumer services, such as web based screening and enrollment.

An anticipated positive outcome of the MOVE Project is more efficient and effective processes – re-thinking/re-engineering the way business is conducted. Employees will be directly impacted, necessitating a major change management initiative prior to system implementation planned for SFY 2011. The OVHA anticipates acquiring external resources to support this initiative within the IV&V for Eligibility Implementation contract referenced below as a required contract.

The OVHA must soon begin a procurement cycle for its claims processing/payment system (MMIS). The contract with the current fiscal agent, Electronic Data Systems (EDS), is set to expire on December 31, 2008, with extensions available through 2011. A contemporary MMIS that leverages the benefits that newer technologies afford, such as greater flexibility and responsiveness, will better serve the needs of Vermont's public health care programs.

The MOVE Project is proceeding under the OVHA's direction but has AHS-wide input and impact. Administration of the Medicaid program involves all AHS departments in some way. For that reason, it is possible that functions from other existing systems will be incorporated into either the new health care eligibility determination system or MMIS, or that the need for additional system procurements will become clear as the MOVE Project progresses.

## Timeline

Task	Anticipated Completion	SFY Budget
1. Required (by CMS) Medicaid Information Technology Architecture State Self Assessment	February 2008	2008
2. Eligibility System Requirements	July 2008	2008 and 2009
3. Federal Funding Request and RFP	December 2008	2009
4. Eligibility System Procurement	June 2009	2009
5. Eligibility System Implementation	December 2010	2010-2011
6. MMIS Requirements	January 2010	2010
7. Federal Funding Request and RFP	June 2010	2010
8. MMIS Procurement	December 2010	2011
9. MMIS Implementation	December 2012	2011-2013

### Required Contracts and Estimated Costs by SFY in millions

Contract Charge	SFY					
	2008	2009	2010	2011	2012	2013
Project Management Support for Eligibility System through Procurement*	\$ .8 F \$ .5 S	\$ .72 F \$ .48 S				
Eligibility System Vendor (Task 5)			\$ 7.5 F \$ 5.0 S	\$ 7.5 F \$ 5.0 S		
IV&V for Eligibility Implementation (Task 5)			\$ .9 F \$ .6 S	\$ .9 F \$ .6 S		
Operations vendor for legacy eligibility system during implementation (Task 5)			\$ .9 F \$ .6 S	\$ .9 F \$ .6 S		
Project Management Support for MMIS through Procurement (Tasks 6-8)				\$ 2.7 F \$ .3 S		
MMIS Vendor (Task 9)				\$ 9.0 F \$ 1.0 S	\$31.5 F \$ 3.5 S	\$31.5 F \$ 3.5 S
IV&V for MMIS Implementation (Task 9)				\$ .9 F \$ .1 S	\$ 1.8 F \$ .2 S	\$ 1.8 F \$ .2 S
Total Federal	\$ .8	\$ .72	\$ 9.3	\$ 21.9	\$ 33.3	\$ 33.3
Total State	\$ .5	\$ .48	\$ 6.2	\$ 7.6	\$ 3.7	\$ 3.7
Grand Total	\$ 1.3	\$ 1.2	\$ 15.5	\$ 29.5	\$ 37.0	\$ 37.0

\*Tasks 1-4: Contract awarded to FourThought Group for period 7/2/2007-6/30/2009

Costs listed other than for the existing contract are gross estimates. A cost benefit analysis and recommendations for the health care eligibility determination system are due to be completed under the FourThought contract by the end of April 2008, at which time more concrete expenditure estimates for SFY 2010 will be available.

### Participation in Vermont Information Technology Leaders (VITL)

The OVHA is actively participating in VITL's initiatives to create and expand utilization of Vermont's health information exchange infrastructure. The OVHA expects these projects, such as the medication history project, to facilitate improvements in the quality of healthcare and to help control healthcare spending by making data available to the right people at the right time.

Currently in process is a project to help a number of small physician practices with the implementation of an electronic health record (EHR) through financial assistance from the Interim Health Information Technology Fund established during the 2007 session of the Vermont General Assembly and technical assistance. The OVHA participated in the screening of certified EHR vendors to select those best suited for the purpose of ensuring that practices and the State receive good value. The Medicaid program and its beneficiaries will derive benefits from being represented as decisions are made and the network is created.

## Section 8: Federal Requirements and Decisions

The federal government continues to impose requirements and issue decisions that impact State of Vermont agencies and departments/offices either fiscally or operationally, with cascading impact on beneficiaries and providers. The following sections describe a number of these requirements/decisions: Targeted Case Management Services, National Drug Code (NDC), National Provider Identifier (NPI), Qualified Individuals (QI1), Rehabilitative Services, State Children’s Health Insurance Program (SCHIP), School Administrative Expenditures and Costs Related to Transportation of Students between Home and School, and Tamper Resistant Drug Pads.

### Targeted Case Management Services

The federal rule includes major changes that impact the ability of states to secure federal Medicaid funding to support case management activities. Because the effective date of the proposed rule is March 3, 2008, changes affecting Vermont programs could include the following:

The top end of the preliminary analysis of potential Loss of Federal Medicaid Revenues (millions) absent congressional action is as follows:

Policy Area	SFY08	SFY09	SFY10
School-Based Health Services	\$1.4	\$6.9	\$6.9
Department for Children and Families	\$1.4	\$4.3	\$4.3
DMH/Designated Agencies	\$0.4	\$1.6	\$1.6
DS Public Guardian		\$0.9	\$0.9
Single Case Manager			\$0.6
<b>Total</b>	<b>\$3.2</b>	<b>\$13.7</b>	<b>\$14.3</b>

Current Status: Congressional discussion regarding the potential for legislation that would delay implementation of this rule has begun.

### National Drug Code (NDC)

The Deficit Reduction Act of 2005 (DRA) included new provisions regarding State collection and submission of data for the purpose of collecting Medicaid drug rebates from manufacturers for physician-administered drugs. The DRA requires States to collect rebates on physician-administered drugs. States were required to meet this mandate by January 2008. The Secretary was given authority to delay applications of the collection and submission requirements to prevent hardship to States.

Current Status: Providers petitioned OVHA to request a waiver to delay implementation for six months and OVHA has requested and received a waiver delaying the implementation.

## **National Provider Identifier (NPI)**

The National Provider Identifier (NPI) is a federally mandated initiative under the Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for applicable health care providers (e.g., physicians, hospitals, dentists, etc). Health care providers, health plans and health care clearinghouses will use NPIs in their administrative and financial transactions (e.g., billing) adopted under HIPAA. The NPI is a 10-digit number. The compliance deadline is May 23, 2008.

Currently, there is a subset of Vermont Medicaid providers who are submitting claims incorrectly in an attempt to comply with NPI requirements, which results in claims being deleted. This means that these providers are either not being paid, resulting in OVHA's budget reserve being artificially inflated, or that they are resubmitting claims in the correct format after multiple attempts. Recent data indicates that only 26% of electronic claims and 66% of paper claims are NPI compliant (appropriately submitting NPI data).

**Current Status:** The deadline for mandated compliance is May 23, 2008. OVHA is collaborating with EDS on an extensive and intensive provider outreach plan to help providers submit their NPI claims accurately. The goal is to reach 100% compliance prior to the May 2008 deadline.

## **Qualified Individuals (QI1s)**

The OVHA implemented a policy change in December 2005 eliminating the asset test for individuals eligible for Medicare Savings Programs (MSP). The Medicare savings programs include three different programs: Qualified Medicare Beneficiaries (QMB), Specified Low Income Medicare Beneficiaries (SLMB) and Qualified Individuals (QI). By eliminating the asset test for these programs the State is able to make all of these individuals eligible for the low income subsidy (LIS). The LIS pays for many costs after Medicare Part D, the prescription drug plan implemented by the Centers for Medicare and Medicaid Services (CMS) on January 1, 2006.

**Current Status:** By Congressional action at the close of CY2007, the QI program funding was extended to June 30, 2008.

## **Rehabilitative Services**

Since 1988, federal law has allowed school districts to bill for special education services provided in accordance with an Individual Education Plan (IEP) for students enrolled in Medicaid. Billable services include: case management, physical therapy, occupational therapy, speech language therapy, personal care, mental health counseling, developmental and assistive therapy, vision services, rehabilitative nursing services and durable medical equipment.

In recent years, federal officials have begun to challenge the “appropriateness” of certain services. They’ve argued that the Medicaid program should be the payer of last resort, and claimed that the program has inappropriately reimbursed for claims under the rehabilitative services option that they assert should have been paid for using funds from other federal or state programs.

Depending on how narrowly one reads the CMS proposal, a majority of the school based billing may be disallowed. In addition, the proposed rule requires a Rehabilitative Treatment Plan, and while the plan tracks closely to an IEP, the progress notes for service and stringent provider qualifications may create a paperwork burden that would not be cost effective for the school districts.

An expansive interpretation of the rule could suggest a potential impact to Vermont school districts of approximately \$22.5 million in federal reimbursement. In addition, estimates from across the AHS range from \$183,000 in DAIL to \$5 million in DCF and DMH.

Current Status: Congressional action prior to the end of 2007 has delayed the effective date of the rule by 6 months.

### **School Administrative Expenditures & Costs Related to Transportation of Students between Home & School**

For more than 15 years, CMS has allowed state agencies to reimburse schools for Medicaid related activities performed by school personnel and certain transportation costs. These activities include outreach and enrollment assistance for Medicaid, assisting families in accessing care from a primary care provider, and helping children, particularly children on Medicaid, access primary care from a dentist.

The proposed rule change would result in up to a \$3 million reduction statewide for schools. Funds are used to hire school nurses, dental hygienists, substance abuse professionals, guidance counselors and others; and fund after school programs, nutrition, and physical activity programs. Additionally, VDH would see a reduction of \$450,000 in non-federal funds or approximately one Public Health Nurse in each district office.

Current Status: Congressional action prior to the end of 2007 has delayed the effective date of the rule by 6 months.

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

The Vermont SCHIP program started in 1998 and covers uninsured children between 225-300% of the Federal Poverty Level (FPL). The program provides health care for 3,100 children at any time, and the premiums are \$40.00 per family a month. In SFY 09 enrollment has been projected to increase from an average monthly enrollment of 3,495 to 3,646 the result of increased outreach and reduced premiums.

There are two significant challenges facing the Vermont SCHIP program in the next year. First, authorization for the Federal SCHIP program ended in September 2007.

Current Status: Congress has not reauthorized the program, but it has extended funding for the program through March 2009 under the Medicare, Medicaid SCHIP Extension Act of 2007. While the extension provides funding for the short term, long term Federal funding for the program remains unclear.

In the long term if SCHIP is not reauthorized, Vermont may be able to move SCHIP children into the Global Commitment to Health (GC) waiver. Vermont could also consider this option if it could not live with the requirements outlined in the August 17, 2007 Centers for Medicare and Medicaid Services (CMS) letter. However, moving SCHIP to the GC Waiver puts pressure on the 5-year \$4.7 billion cap. Moving SCHIP children to the GC Waiver could result in an increase in cumulative expenditures under GC of approximately \$17 million including all department spending. The impact of loss of SCHIP funding is depicted below:

SFY	SFY SCHIP Expenditures			SCHIP Match Rate	Global Commitment (GC)	Federal Loss**		
	Office of Vermont Health Access	All Other Departments	Total SCHIP Program					
2009	\$ 5,540,466	\$ 1,824,500	\$ 7,364,966	71.55%	\$ 5,269,633	59.35%	\$ 4,371,107	\$ 898,526
2010	\$ 5,811,949	\$ 1,913,901	\$ 7,725,850	71.76%	\$ 5,544,070	59.66%	\$ 4,609,242	\$ 934,828
2011	\$ 1,524,184	\$ 501,921	\$ 2,026,104	71.76%	\$ 1,453,932	59.66%	\$ 1,208,774	\$ 245,159
	\$ 12,876,599	\$ 4,240,322	\$ 17,116,920		\$12,267,635		\$10,189,123	\$ 2,078,512
<b>Current GC Cap Impact</b>			<b>\$ 17,116,920</b>					

\*\* Federal Loss = GC Match Rate - SCHIP Match Rate

Second, the Centers for Medicare and Medicaid Services (CMS) issued a State Health Official letter (August 17, 2007) reinterpreting SCHIP regulations as they relate to concerns of children giving up employer sponsored coverage for publicly funded coverage. When SCHIP was first implemented there were concerns that substitution would occur, and states were required to have plans in place to prevent substitution.

Current Status: 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 are: 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 not decreased over a period of five years.

A number of states have taken issue with the CMS reinterpretation, and New York and New Jersey each have brought lawsuits to prevent CMS from implementation. If the August letter remains in effect, implementing these strategies would require significant changes in the Vermont SCHIP program.

### **Tamper Resistant Prescription Drug Pads**

The Centers for Medicare and Medicaid Services (CMS) has indicated that as of April 1, 2008, all written prescriptions for outpatient covered drugs must be written on tamper-resistant prescription paper, and that to be considered tamper-resistant as of April 1, 2008, prescription paper must contain one of the following three characteristics:

- 1) One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form;
- 2) One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber; or
- 3) One or more industry-recognized features designed to prevent the use of counterfeit prescription drug forms.

As of October 1, 2008, prescription paper must contain all of the above-cited characteristics to be considered tamper-resistant.

The tamper-resistant prescription pad requirement is applicable: 1) regardless of whether Medicaid is the primary or secondary payer of the prescription being filled, 2) even if the patient is found eligible for Medicaid after the date of service and 3) for covered over-the-counter drugs.

CMS requires that state Medicaid agencies audit to ensure pharmacy compliance with this regulation; federal auditors may audit state audit samples. 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, the OVHA must recover the payment.

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## Section 9: 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. The OVHA's Senior Management Team is responsible for programmatic and operational oversight of the OVHA's units.

The Senior Management Team is responsible for:

- Green Mountain Care Outreach and Education
- Health Care Reform
- Operational Oversight
- Programmatic Oversight
- Provider Assessments
- Reimbursement
- Contract Administration (examples): Electronic Data Systems (EDS), GMMB, MedMetrics Health Partners

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
- Buprenorphine Program
- Care Coordination Program (CCP)
- Chronic Care Management Program (CCMP) (*in conjunction with the Health Integration Programs Unit*)
- Clinical Quality Improvement
- 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*)
- Prior Authorizations (PAs)
- Contract Administration (examples): APS Healthcare

### Communications Unit

The Communications Unit is responsible for:

- Dental Dozen
- Health Insurance Portability and Accountability Act (HIPAA) - Privacy
- Legislative Activities
- Managing the Transportation Benefit
- Medicaid Advisory Board (MAB)

- Media Relations
- Provider Network Adequacy
- Provider Relations
- Website
- Contract Administration (examples): Vermont Public Transportation Association (VPTA), Vermont State Dental Clinic

### Coordination of Benefits (COB) Unit

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

- Catamount Health and Employer Sponsored Insurance Beneficiary Assistance
- Ensure Payer-of-Last-Resort Status via Collections and Coordination of Benefits
- Medicare Part D Casework

### SFY '09 Savings Initiative: Coordination of Benefits Increased Collections

The COB Unit has projected an increase in collections of **\$3.8 million** from increased administrative activities including collections from Prescription Drug Plans (PDPs) that operate under the Medicare Modernization Act.

	SFY '06 Actual	SFY '07 Actual	SFY '08 Approp.	SFY '08 BAA	SFY '09 Gov. Rec.*	'07 Act-'08 BAA % Chg.	08 BAA-'09 Gov. 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							

### Fiscal Operations Unit

The Fiscal Operations Unit is responsible for:

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

### Health Programs Integration Unit (HPIU)

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

- Chronic Care Management Program (CCMP) (*in conjunction with the Clinical Unit*)
- Inter-Governmental Agreements (IGA)
- Long Term Care Projects
- Memorandums of Understanding (MOU)
- Quality Assurance and Performance Improvement Committee
- Quality Council
- State Children's Health Insurance Program (SCHIP) and Youth Health

### **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
- Technical System Security
- Vermont Information Technology Leaders (VITL) Board and Advisory Committee

### **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

### **SFY '09 Savings Initiative: Pharmacy – Specialty Rx**

In 2005 the Legislature added § 1998a to Title 33 to allow the pharmacy best practices and cost control program to require consumers to purchase prescription drugs for selected pharmacy products using mail order options. In the fall of 2007 OVHA sought bids from specialty pharmacies to provide 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 babies and infants). Additional potential conditions identified include hepatitis, cystic fibrosis, cancer, and deep vein thrombosis.

Unlike traditional "mail order" pharmacy services based solely on reducing costs, this initiative is intended to include the better management of disease conditions through

outreach and education to improve patient's understanding of their conditions and adherence to prescribed drug regimens. Applying this approach acts as another tool in chronic care management, serving as a resource in the treatment of complex conditions not requiring the level of support of those addressed in the Chronic Care Management and Care Coordination Programs. It is expected that these new initiatives will yield **\$1.2 million** in savings.

## Policy Unit

The Policy Unit is responsible for:

- Administrative Procedures Act Compliance
- Fair Hearing Process (*in conjunction with the Clinical Unit*)
- Forms Management
- Grievance and Appeals
- Medicaid M108 Exceptions (*in conjunction with the Clinical Unit*)
- Medicaid State Plan (Coverage, Delivery and Reimbursement)
- On-Line Rules Project
- Public Records Requests
- Vermont Health Access Program (VHAP) Rules and Procedures
- Vermont Medicaid Rules and Procedures
- Contract Administration (examples): Maximus, Ombudsman

## Program Integrity (PI) Unit

The Program Integrity (PI) Unit is responsible for:

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

## SFY '09 Savings Initiative: Program Integrity Activity

The OVHA will be collaborating with all applicable AHS departments, the Department of Education (DOE) and the Medicaid Fraud Unit to prevent fraud, waste, and abuse in the Vermont Medicaid program. The OVHA plans to contract with a third party for post-payment review to assist the state in identifying areas for

further review and investigation. The estimate for SFY'09 is that these activities will result in net savings of \$2.5 million.

**SFY '09 Savings Initiative: Public Assistance Reporting Information System (PARIS)**

Number of Hits Requiring Research	Estimated Total Savings	Estimated G.F. Savings
450 Hits	\$350,000	\$142,275
Cost: * 20 minutes x 450 hits = 150 person hours (FTE)		

\*Based on estimation comparison to Connecticut Program

The Public Assistance Reporting Information System (PARIS) is a voluntary federal-state partnership which provides state public assistance agencies information and data to help in maintaining program integrity and detecting and possibly preventing

improper payments. Currently 44 states participate in PARIS. PARIS matching systems include the 1) Interstate Match [same Social Security Number (SSN) in >1 state], 2) Veterans Affairs Match, and 3) Federal Employees & Retirees Match. The estimated Medicaid savings from this program initiative are **\$350,000** in SFY'09.

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## **Section 10: Reimbursement**

### **SFY '09 Provider Rate Increase: Dental Dozen**

The OVHA will partner with the Vermont Department of Health (VDH), Office of Oral Health and the Vermont State Dental Society (VSDS) to determine the methodology for applying the SFY '09 rate increases.

For example, for the SFY '08 rate increases, representatives from the OVHA, VDH and the VSDS met and prioritized all dental treatment code categories; restorative codes received the highest priority and the 50<sup>th</sup> percentile of all fees was determined. If the current fee for Priority 1 (restorative fees) was below the 50<sup>th</sup> percentile, a formula was applied which apportioned the dollars available to the priority codes resulting in the new fee. In a few cases, the formula resulted in an inappropriate fee adjustment. In each of those instances, consensus was reached on the appropriate adjustment.

### **SFY '09 Provider Rate Increase: Annualization of SFY '08 Hospital**

Based on the SFY '08 appropriation, \$2 million was approved for inpatient hospital rate increases starting in January 2008. The first \$1 million was included in the SFY '08 appropriation while the second \$1 million is included in the SFY '09 Governor's Recommend.

### **SFY '09 Provider Rate Increase: Boston Children's Hospital**

Prior to October 1, 2007, Boston Children's Hospital received approximately 17% of their cost for services rendered to Vermont Medicaid beneficiaries. Since then they have been paid equal to Fletcher Allen Health Care per diem rates, which equates to 44% of their cost.

In State Fiscal Year (SFY) '07 services for craniotomy, cardiac/vascular procedures, kidney and one lung transplant were performed by Boston Children's Hospital because the expertise required to perform these services was not available in Vermont hospitals or Dartmouth Hitchcock Medical Center (DHMC).

In SFY '08, as part of the budget adjustment, the OVHA requested \$800,000 to increase Boston Children's Hospital to 70% of their cost. In SFY '09, the OVHA is requesting to annualize this figure and an additional \$1 million is included in the Governor's Recommend for this purpose.

### **SFY '09 Provider Rate Increase: Dartmouth Hospital**

Dartmouth Hitchcock Medical Center (DHMC) paid wages of over \$122 million to Vermont residents in 2006 and 39% of DHMC employees reside in Vermont. Vermont patients make up 41% of inpatient admissions at DHMC with approximately 16% of

those admissions for Medicaid beneficiaries. This makes DHMC comparable to Vermont hospitals.

The OVHA currently pays for inpatient hospitalization using Diagnostic Related Groupings (DRG). DHMC's payments are calculated with a base rate that equals 80% of the rate paid to Vermont hospitals. Vermont hospitals also receive an outlier payment which takes effect when the cost for a case exceeds \$24,000; the outlier payment is for costs exceeding \$24,000 that are paid at 80%. DHMC's outlier currently takes effect at \$50,000 with costs exceeding \$50,000 paid at 50%.

The OVHA is recommending that DHMC be brought to parity with Vermont in-state hospitals effective January 1, 2009 at a cost of \$1.3 million for SFY 2009. This will require an additional \$1.3 million in SFY'10 to annualize the increase.

### SFY '09 Provider Rate Increase: Instate Hospital

The OVHA is requesting an \$8 million inpatient rate increase for Vermont hospitals in SFY '09. The OVHA will request an additional \$8 million in SFY'10.

### SFY '09 Provider Rate Increase: Healthcare Reform Related

The OVHA is requesting approximately \$1.5 million to increase rates for provider types that are furthest from Medicare in their level of reimbursement. Examples of these providers are: ambulances, ophthalmologists/opticians, audiologists, and physical and occupational therapists.

### SFY '09 Policy Change: Pay Medicare Crossover Claims at Medicaid Rates

Medicaid crossover claims are claims for individuals who are covered by both Medicare and Medicaid (i.e., 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

Professional (CPT) Claim Crossover Savings				
CPT Claims Savings	Individuals	Deductible	Deductible Expense	Net Savings
\$ 2,663,323	6,788	\$ 128	\$ 865,470	\$ 1,797,853
Durable Medical Equipment (DME) Claim Crossover Savings				
DME Claims Savings	Individuals	Deductible	Deductible Expense	Net Savings
\$ 1,402,318	7,077	\$ 128	\$ 902,318	\$ 500,000
Total Estimated Savings				
Gross Savings				\$ 2,297,853
G.F. Savings				\$ 934,077

deductible. Once that is met, Medicare will pay 80% up to the allowed amount with a couple of exceptions. This leaves non-covered services, deductible and co-insurance to be considered by Medicaid for payment. Claims covered by Medicare that are

presently submitted to Medicaid for consideration are paid without regard to Medicaid's fee schedule, paying both the deductible and co-insurance left after they are processed

by Medicare. These claims are paid at a rate higher than individuals covered only by Medicaid for services when Medicare's fee schedule is higher than Medicaid. The table with "Professional (CPT) Claim Crossover Savings" and "Durable Medical Equipment (DME) Claim Crossover Savings" depicts the savings associated with paying crossover claims at Medicaid rates.

### **Provider Reimbursement Impact based on Disproportionate Share Hospital (DSH) and Provider Assessment Changes**

Disproportionate Share Hospital (DSH) payments compensate hospitals for the differentials experienced by different hospitals across the state based on the volume of Medicaid patients and uncompensated care provided. These payments are calculated once per year, are administered as lump sums, and are subject to federal limitations. As such, they are not subject to intra-period change based on claims experience. The amount paid for services by Medicaid on a per-claim basis plus the DSH payments equals the total Medicaid reimbursement to hospitals (with one additional component being outpatient cost settlements – cost settlements only through March 31, 2008).

An assessment on hospitals' revenues has historically been utilized as a revenue source for the Medicaid program. From the hospitals' perspective, their reimbursement from Medicaid is the reimbursement indicated above less the assessment paid by them to the State of Vermont. This is a reasonable calculation to arrive at the net paid by the State of Vermont for all hospital services provided to beneficiaries enrolled in public health care programs.

The table "Summary of Hospital Medicaid Revenue and Assessments" depicts the tax paid by hospitals relative to Medicaid revenues received (expressed as a percent) across multiple years. When the percent goes up, hospitals are paid less on a relative basis. The converse is also true.

Vermont is currently maximizing the federal allotment that is paid out in lump-sum DSH payments. Reference "SFY '09 Provider Rate Increase: Instate Hospital" above for supplemental details.

Summary of Hospital Medicaid Revenues and Assessments									
	SFY '03 Actual	SFY '04 Actual	SFY '05 Actual	SFY '06 Actual	SFY '07 Actual	SFY '08 Estimated	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	\$102,395,285	\$119,904,878	\$133,900,122	
Rate Increases (Decreases)	\$ 15,136,450	\$ -	\$ (11,500,000)	\$ (3,000,000)	\$ (3,000,000)	\$ 2,000,000	\$ 8,000,000	\$ 8,000,000	
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>\$151,399,183</b>	<b>\$155,553,659</b>	<b>\$171,048,903</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>\$67,583,004</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>40.74%</b>	<b>42.69%</b>	<b>39.51%</b>	

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

\*\*Assessment based on total hospital revenues

## Section 11: Provider Network and Access

### Mapping and Network Analysis

The Office of Vermont Health Access (OVHA) has initiated systematic analysis and monitoring of the provider network. The first step is geographic mapping of all health care providers to evaluate and monitor access, target licensed but not enrolled providers, and evaluate providers in comparison to beneficiaries to ensure access. Mapping allows for a visual representation of the provider network and helps to identify any access issues. Companion steps to mapping are targeted refinement, evaluation and outreach. The geographic mapping schedule is as follows:

November 2007	Dentists
December 2007	Psychiatric - Psychiatrist, Psychologist and Clinical Social Workers
January 2008	Primary Care - Family Medicine, Pediatrics and Internal Medicine, Nurse Practitioners, Rural Health Centers (RHC) and Federally Qualified Health Centers (FQHC)
February 2008	Surgical - Surgical Specialty, Obstetrician and Gynecology (OBGYN)
March 2008	Nursing - Nursing Homes, Home Health, Pace, Home and Community Based Services (HCBS) Hospice and Other Related Services
April 2008	Pharmacy and Durable Medical Equipment Suppliers
May 2008	Personal Care Services (PCS), Physical Therapists, Occupational Therapists, Speech Therapists (PT, OT, ST)
June 2008	All Others - Chiropractors, Naturopaths, Podiatrists, Opticians, Ophthalmologists

The OVHA testified before the Health Access Oversight Committee (HAOC) on its mapping activities and presented both the Dentists and Psychiatric maps.

The OVHA will begin the sequencing/process again with comparisons from year to year after initially mapping all provider types since the analysis and monitoring is a continuous process.

The maps pertaining to Dentists and Psychiatric providers are available upon request.

**SFY '09 New Program Initiative: Naturopathic Physicians**

The OVHA is supportive of Bill H. 657 as follows:

**AN ACT RELATING TO MEDICAID COVERAGE OF NATUROPATHIC PHYSICIANS**

It is hereby enacted by the General Assembly of the State of Vermont:

Sec. 1. 8 V.S.A. § 4008d(b) is amended to read:

(b) As used in this section, “health insurance plan” means Medicaid, the Vermont health access plan, and any other public health care assistance program, any individual or group health insurance policy, any hospital or medical service corporation or health maintenance organization subscriber contract, or any other health benefit plan offered, issued, or renewed for any person in this state by a health insurer, as defined by 18 V.S.A. § 9402. The term shall not include benefit plans providing coverage for specific disease or other limited benefit coverage.

Sec. 2. EFFECTIVE DATE

This act shall take effect on passage.

**SFY '09 New Program Initiative: Chiropractic Coverage**

Act 65, Sec 111(b) (a) indicates:

Effective on July 1, 2008, the agency of human services is directed to reinstate chiropractic coverage for adults in the Medicaid and VHAP programs consistent with section 4088a of Title 8 and at rates comparable to payments for care or services by other health care providers. The fiscal year 2009 Medicaid expenditure forecast adopted by the emergency board shall include the reinstatement of chiropractic coverage.

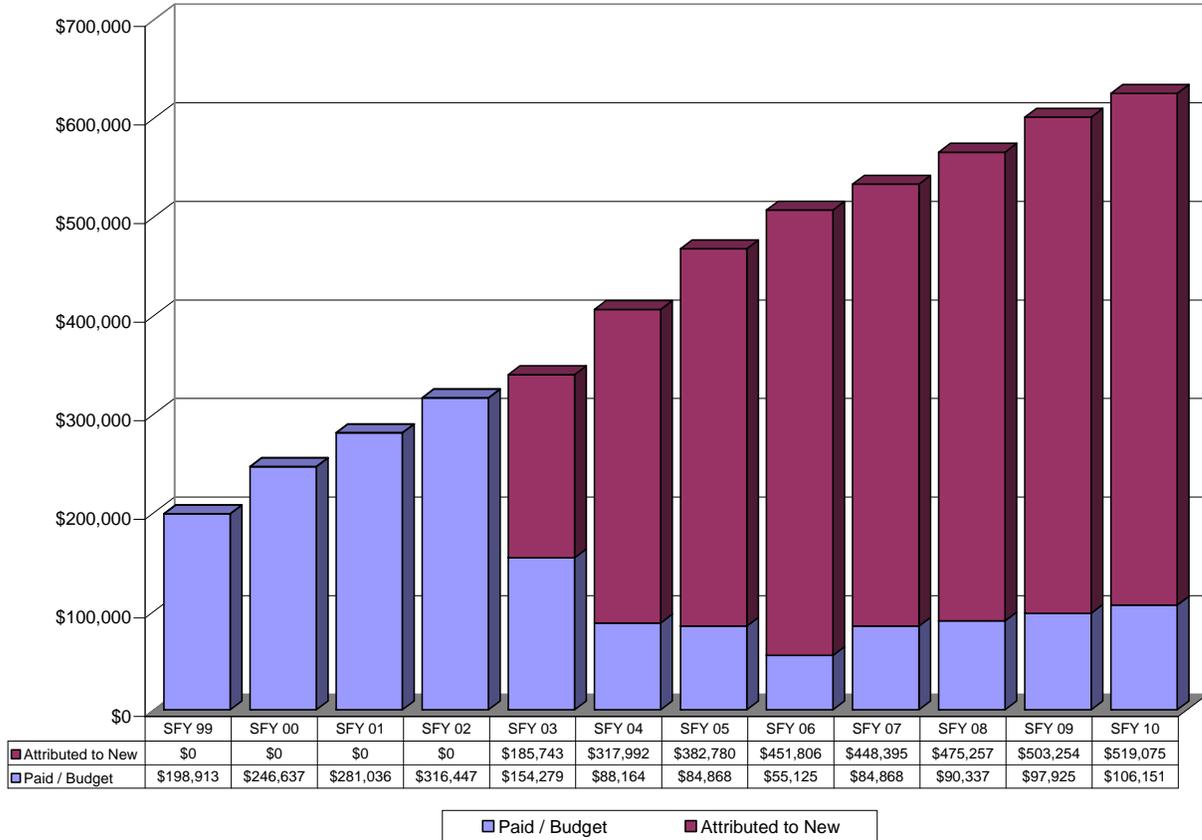
The State cannot afford to reinstate chiropractic coverage at rates comparable to other health care providers in view of the projected Medicaid deficit. The OVHA is supportive of reinstating chiropractic coverage but not “...at rates comparable to payments for care or services by other health care providers.”

In light of this position, the OVHA recommends the following corrective language:

Effective on July 1, 2008, the agency of human services is directed to reinstate chiropractic coverage for adults in the Medicaid and VHAP programs consistent with section 4088a of Title 8 ~~and at rates comparable to payments for care or services by other health care providers~~. The SFY '09 Medicaid expenditure forecast adopted by the Emergency Board includes the reinstatement of chiropractic coverage.

The costs (paid/budget, attributed to new) for SFY '99 – SFY '10 are depicted in the following graph:

**Chiropractic Coverage by State Fiscal Year**



## The Dental Dozen



### Overview

Many Vermonters face challenges in receiving appropriate oral health care due to the limited number of practicing professionals, the affordability of services, and a lack of emphasis on the importance of oral health care. Challenges frequently are more acute for low-income Vermonters, including those Vermonters participating in the State's public health care programs.

As part of the *Office of Vermont Health Access (OVHA) Medicaid Budget Document for State Fiscal Year (SFY) 2008*, the OVHA, in conjunction with the Vermont Department of Health (VDH), introduced *The Dental Dozen*, 12 targeted initiatives to improve oral health for all Vermonters, establish

the framework to remedy existing delivery system issues, promote a cultural transformation by reinforcing the importance of oral health care, and proactively confront future challenges. 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.

As a result of legislative input, the original proposed Dental Dozen were modified resulting in:

- Initiative #1: Ensure Oral Health Exams for School-age Children
- Initiative #2: Increase Dental Reimbursement Rates
- Initiative #3: Reimburse Primary Care Physicians for Oral Health Risk Assessments
- Initiative #4: Place Dental Hygienists in Each of the 12 District Health Offices
- Initiative #5: Selection/Assignment of a Dental Home for Children
- Initiative #6: Enhance Outreach
- Initiative #7: Codes for Missed Appointments/Late Cancellations
- Initiative #8: Automation of the Medicaid Cap Information for Adult Benefits
- Initiative #9: Loan Repayment Program
- Initiative #10: Scholarships
- Initiative #11: Access Grants
- Initiative #12: Supplemental Payment Program

The Dental Dozen are based on the goals and strategies outlined in the *Vermont Oral Health Plan (2005)* and the survey results outlined in the *Vermont Oral Health Initiative Dental Survey Report (December, 2005)*.

Implementation of the Dental Dozen involves a coordinated effort between the OVHA and VDH (specifically the Office of Oral Health), and partnerships with the:

- Vermont State Dental Society (VSDS)
- Vermont Dental Hygienists' Association (VDHA)
- Vermont Chapter of the American Academy of Pediatrics (AAP)
- Department of Education (DOE)
- Maximus
- APS Healthcare

It should be noted that the OVHA is already addressing elements of higher risk, more complex health care populations with its Chronic Care Management Program (CCMP) and Care Coordination Program (CCP). The OVHA has contracted with APS Healthcare for Health Risk Assessment (HRA) and Intervention Services (IVS) administration for its CCMP. As a key component of overall health, oral health will be considered in CCMP and CCP activities, and in the evaluation and health management of beneficiaries who participate in the CCMP.

The Dental Dozen initiatives complement and build on one another to form a comprehensive approach for improving oral health in the State. For example, raising

reimbursement rates, offering loan repayment and providing scholarship opportunities, help attract and retain Medicaid dental providers. Also, Primary Care Physicians (pediatricians and family physicians) will now have the opportunity to incorporate oral health risk assessments as an integrated component of normal well baby visits. The established goals of the Dental Dozen are to:

- Increase the supply of practitioners providing dental care
- Increase supply of providers serving Medicaid beneficiaries
- Increase access to dental care for Medicaid beneficiaries
- Promote preventive oral health care
- Make dental care more affordable
- Reduce missed appointments and late cancellations

The following table depicts the impact of the various initiatives on cited goals:

Impact of Initiatives on Cited Goals						
	Increase Supply of Practitioners Providing Dental Care	Increase Supply of Providers serving Medicaid Beneficiaries	Increase Access to Dental Care for Medicaid beneficiaries	Promote Preventive Oral Health Care	Make Dental Care More Affordable	Reduce Missed Appointments/ Late Cancellations
Ensure Oral Health Exams for School-age Children				✓		
Increase Dental Reimbursement Rates		✓	✓		✓	
Reimburse Primary Care Physicians for Oral Health Risk Assessments			✓	✓		
Place Dental Hygienists in Each of the 12 District Health Offices		✓	✓	✓	✓	
Selection/ Assignment of a Dental Home for Children			✓	✓		
Enhance Outreach	✓	✓	✓	✓		✓
New Codes for Missed Appointments / Late Cancellations		✓	✓			✓
Automate Adult Dental Cap System		✓	✓			
Loan Repayment Program	✓	✓	✓			
Scholarships	✓	✓	✓			
Access Grants		✓	✓		✓	
Supplemental Payment Program		✓	✓			

### SFY '09 New Program Initiative: Dental Dozen

The following *Investment Summary* table lists each initiative with the new investment for SFY '09 and SFY '10.

<b>Investment Summary</b>				
<b>Initiative #</b>	<b>Initiative Description</b>	<b>Start Date</b>	<b>SFY09 Total (New)</b>	<b>SFY10 Total (New)</b>
1	Ensure Oral Health Exams for School-age Children	7/1/2008	\$735,147	\$54,649
2	Increase Dental Reimbursement Rates	1/1/2008	\$1,412,441	\$2,250,851
3	Reimburse Primary Care Physicians for Oral Health Risk Assessments	1/1/2008	\$40,000	\$0
4	Place Dental Hygienists in all 12 District Offices	1/1/2008	\$58,000*	\$0
5	Selection/Assignment of a Dental Home for Children	1/1/2008	\$0	\$0
6	Enhance Outreach	7/1/2007	\$0	\$0
7	Codes for Missed Appointments/Late Cancellations	1/1/2008	\$0	\$0
8	Automation of Medicaid Cap Information for Adult Benefits	1/1/2008	\$0	\$0
9	Loan Repayment Program	7/1/2007	\$0	\$0
10	Scholarships	7/1/2007	\$0	\$0
11	Access Grants	7/1/2007	\$0	\$0
12	Supplemental Payment Program	7/1/2007	\$0	\$0
<b>Total Investment</b>			<b>\$2,187,588</b>	<b>\$2,305,500</b>

*\*This amount is included in the Vermont Department of Health budget; it is not included in the OVHA's SFY '09 total investment.*

## **SFY '09 Savings Initiative: Dental Dozen**

The Dental Dozen will generate savings by increasing the supply of providers with corresponding access so that beneficiaries receive care in a more preventive/proactive manner thus reducing more costly intervention/procedures.

### **Updates**

#### Initiative #1: Ensure Oral Health Exams for School-age Children

The VDH, the OVHA, and the DOE are collaborating to reinforce the importance of oral health exams and encourage appropriate preventive care.

Educational materials will be produced, reviewed and distributed before the start of the 2008 fall school year. The materials will be primarily targeted at second and sixth graders since new adult teeth (i.e., back molars) often come in during these grades and are at risk for tooth decay, and this is the best time for dentists to apply sealants to help prevent future cavities.

#### Initiative #2: Increase Dental Reimbursement Rates

This proposal commits to increase Vermont Medicaid reimbursement rates, over a three-year period, to stabilize the current provider network, encourage new dentists to enroll as Medicaid providers and encourage enrolled dentists to see more Medicaid beneficiaries.

The OVHA collaborated with the Vermont State Dental Society's (VSDS) Government Programs Committee throughout the fall of 2007 to determine application of the January 1, 2008 rate increases. The new Dental Procedure/Fee Schedule was distributed to dentists on December 28, 2007.

### Initiative #3: Reimburse Primary Care Physicians for Oral Health Risk Assessments

Vermont Medicaid will reimburse Primary Care Providers (PCP) for performing Oral Health Risk Assessments (OHRAs) to promote preventive care and increase access for children from 0-3.

A new American Dental Association code, D0145 (Oral Evaluation for a Patient under Three Years of Age and Counseling with Primary Caregiver) was established for dentists on January 1, 2007. Beginning in January, 2008, physicians/pediatricians will be able to bill this code as dentists would, one unit per 180 days, for children under three. The billing code allows for an evaluation and counseling with the primary caregiver.

The VDH has developed an action plan to educate physicians on claiming the D0145 code and has discussed this with the American Academy of Pediatrics (AAP). The VDH has also met with family practice physicians to educate them on claiming this code.

### Initiative #4: Place Dental Hygienists in Each of the 12 District Health Offices

The VDH sees over 16,000 children (ages 0-5) and their parents annually in District Health Office WIC clinics (Women, Infant and Children).

A half-time dental hygienist will be placed in each District Health Office to provide dental health education, early risk assessment, and work to connect children with a "dental home". In addition, the hygienist would be a resource for other human services' programs in connecting children with dental homes. Adding a half-time dental hygienist to the District Health Office staff facilitates integrating oral health into overall health - each District Health Office has nurses, social workers, health outreach specialists and nutritionists.

Dental hygienists will be able to perform their full scope of work at district offices. The Board of Dental Examiners endorsed a Public health rule change allowing dental hygienists to practice all of their skills under the general, indirect supervision of a dentist.

SFY 2008 funding will only cover three dental hygienist positions. The VDH has met with the Directors of the District Offices to help determine where to place the first three dental hygienists. Funding for the expansion of dental hygienist positions and a timeline need to be determined.

#### Initiative #5: Selection/Assignment of a Dental Home for Children

The OVHA would provide for the selection/assignment of a primary dentist to each child and allow for the same continuity of care as assigning a Primary Care Physician (PCP) for health improvement. A Dental Home is a direct way to emphasize the importance of oral health care, and begins an early thought process that oral health and seeing a dentist is just as important as a regular physical and seeing a PCP.

A technical group, led by the OVHA, has evaluated the dental home assignment process at the provider level and has determined the required system changes, and is addressing reporting requirements.

#### Initiative #6: Enhance Outreach

The OVHA and VDH will implement outreach activities that create awareness and understanding of the Dental Dozen, and support implementation and operation of the initiatives. The OVHA and VDH will continue to partner with organizations such as the Vermont State Dental Society and coordinate with programs such as the Care Coordination Program (CCP) to outreach eligible Medicaid beneficiaries and applicable providers.

#### Initiative #7: Codes for Missed Appointments / Late Cancellations

The negative impact of missed appointments and late cancellations is three-fold: 1) the originally scheduled beneficiary does not receive care, 2) that appointment could have gone to another beneficiary, and 3) dental office productivity and income is reduced. Missed appointments and late cancellations directly impact access for both Medicaid beneficiaries and all Vermonters because it impacts the availability of appointments.

The new Dental Procedure/Fee Schedule distributed to dentists on December 28, 2007, includes a code, D0999, which can be used to report missed appointments and late cancellations to the OVHA. This code will be for reporting purposes only; there is NO reimbursement associated with it. The OVHA plans to evaluate this data with the intent of developing processes to reduce missed appointments and late cancellations in the future.

#### Initiative #8: Automation of Medicaid Cap Information for Adult Benefits

The cover memo accompanying the new Dental Procedure/Fee Schedule, distributed to dentists on December 28, 2007, includes information on the system upgrade which allows enrolled dentists to access Medicaid cap information for adult benefits

automatically through the use of Web Eligibility Verification Response System or the Automated Voice Response System. The annual cap for adult benefits is set at \$495.

#### Initiative #9: Loan Repayment Program

The Loan Repayment Program is administered by the VDH in collaboration with the Area Health Education Center (AHEC) at the University of Vermont. The Program will award \$195,000 for FY2008 based on applicants being: 1) a VT resident working as a dentist for at least 20 hours per week in Vermont; 2) in a practice site or region that has a need for dentists, or be in an underserved area, as defined by the Program; 3) able to meet a one-year service commitment; and 4) in agreement to see Medicaid-enrolled beneficiaries—number to be defined in award offer/contract letter.

Applications for the Loan Repayment Program are received in September; a review panel will convene in February, 2008 to determine awards.

#### Initiative #10: Scholarships

This initiative is administered by the VDH, in concert with the VSDS, and then processed through the Vermont Student Assistance Corporation (VSAC). Eligibility hinges on a commitment to work, upon licensure, as a dentist in the State of Vermont for at least one year. Notices for these scholarship opportunities – which also can be used for loan forgiveness – go out each year to dental students who are Vermont residents.

SFY 2008 funding will be combined with SFY 2009 funding since eligible dental students have already had their financial aid packages approved for the 2007/2008 school year. Eligible dental students will be encouraged to apply, through VSAC, for awards for the 2008/09 school year.

#### Initiative #11: Access Grants

Access Grants are administered by the VDH, in concert with the VSDS and the OVHA, and provide a direct incentive for dentists and dental offices to expand access to Medicaid beneficiaries. The VDH collaborates with the VSDS to determine the grant criteria. Notices go out in January and awards are made by the end of March.

#### Initiative #12: Supplemental Payment Program

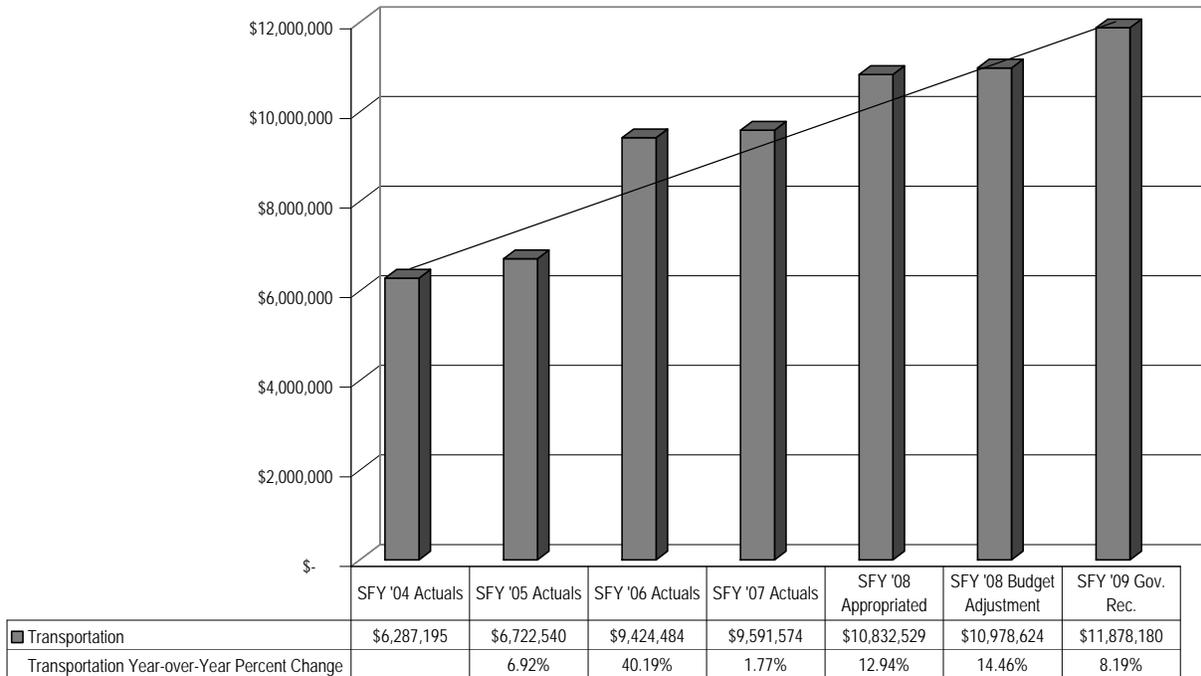
The Vermont Legislature authorized the OVHA to distribute \$292,836 each fiscal year as supplemental payments to recognize and reward dentists serving high volumes of Medicaid beneficiaries. The OVHA and the VSDS agreed that the funds should be distributed biannually. Each dental practice that receives \$50,000 or more biannually in Medicaid reimbursement is eligible for the payment. The amount paid is calculated as a percentage of the Medicaid claims paid.

The first supplemental payments were issued on October 12, 2007 to 30 dental providers who received between \$1,900 and \$12,500. The next supplemental payments will be issued in April, 2008.

Dental practices who receive cost-based reimbursement are ineligible for the program because their overall reimbursement is already greater, based on cost.

## Section 12: Transportation

Transportation continues to be a significant category of service (COS) even with the rate of expenditures leveling off. The expenditures for State Fiscal Year (SFY) 2006 Actuals through SFY 2009 Governor’s Recommend are depicted in the following graph:



During SFY 2007, the OVHA conducted extensive research and analysis into transportation which resulted in the following findings:

- 1) Increases in the mileage rate for volunteer drivers have had a major impact on transportation costs. In SFY 2007, mileage rate increases resulted in about a \$255,000 increase in expenditures. The 3% increase in the volunteer mileage rate expected in calendar year '08 (from \$0.485 to \$0.505) will increase the transportation budget on an annual basis by approximately \$113,053 based on SFY 2007 volunteer miles.
- 2) The utilization of volunteer drivers, taxis, and vans has increased from SFY 2006 levels, while the use of buses and hardship drivers has decreased. Overall, the number of total Medicaid reimbursed trips statewide is:

- 509,366 in SFY 2005

- 591,578 in SFY 2006
  - 579,502 in SFY 2007
- 3) It is estimated that an average of 92 Vermonters are transported on a monthly basis to dialysis services, at an average cost of \$63,661 (per month). This represents a per trip cost of \$691. Total transportation costs to dialysis services are estimated to be \$763,932 annually. Dialysis transportation costs are being reviewed through a Critical Care Transportation Study Group with recommendations expected in early calendar year '08.

Based on the findings, the OVHA has proceeded with some successful changes during SFY 2008:

- 1) **Transportation Provider Manual:** The Transportation Provider Manual has been updated and reissued to all brokers and to the current transportation services vendor, Vermont Public Transportation Agency (VPTA). This is a document essential for proper service/program operation.
- 2) **New Bus Pass Program:** A new bus pass program was implemented in May of '07 in Burlington. The new program ensures that OVHA only gets billed for the medical transport rides that actually occur and that the OVHA has greater control as to who gets a Medicaid bus pass. Chittenden County Transportation Authority (CCTA) buses are all equipped with electronic fare boxes with a swipe system that reads a magnetic card and records the ride. This system is used for the new program and is the basis for billing.

The new program reimburses CCTA at \$1.25 per trip up to the monthly cost of a pass of \$42.00. Thus up to 33 trips per month will be paid based on actual use; 34 and more at the monthly bus pass cost of \$42.

Under the old system, bus passes were paid regardless of use, and there were a significant number of pass holders who used the pass infrequently. As a result of the new bus pass program costs are decreasing.

- 3) **Transportation to Methadone Clinics:** In certain geographic areas, a lack of capacity has kept some costs for transportation to methadone clinics higher than necessary, but overall costs have leveled off now that the majority of beneficiaries are being transported to the nearest available facility. If an eligible beneficiary is in need of methadone treatment and there is not an available slot in the clinic that is closest geographically, transportation is still provided to a clinic where a slot is available. The Office of Drug and Alcohol Prevention (ODAP) and OVHA staff previously analyzed data on the geographic location of clinic users and the actual clinic used to determine if transportation costs could be reduced by increasing clinic capacity in select locations. That analysis resulted in a transfer of funding from OVHA to ODAP during SFY'08 (as part of last year's Budget Bill).

- 4) Request for Proposal (RFP): An RFP to procure a vendor to implement and operate the Medicaid/Reach Up transportation system will be issued.

For SFY 2009, the OVHA plans to:

- 1) Have a contract in place (effective July 1, 2008) for a vendor to implement and operate the Medicaid/Reach Up transportation system.
- 2) Perform a Quality Control (QC) audit based on procedures identified in the Transportation Provider Manual and conduct audits as appropriate. Also, update, amend, and redistribute the Transportation Provider Manual on an as-needed and as-requested basis.
- 3) Investigate, design and consider implementation of alternative reimbursement methodologies for transportation providers.
- 4) Continue to analyze the new bus pass process and the methadone transportation data and operations.

### SFY '09 Savings Initiative: Bus Pass Program

#### Bus Passes:

The new Medicaid Bus Pass program ensures that Medicaid only gets billed for the rides that actually occur and that the Office of Vermont Health Access (OVHA) has greater control as to who gets a Medicaid bus pass. The Chittenden County Transportation Authority (CCTA) buses are all equipped with electronic fare boxes with a swipe system that reads a magnetic card and records the ride. This system will be used for the Medicaid bus pass program and will be the basis for billing.

The new system reimburses CCTA at \$1.25 per trip up to the monthly cost of a pass of \$42.00. Thus up to 33 trips per month will be paid based on actual use, 34 and more at the monthly bus pass cost of \$42.

Under the old system, bus passes were paid regardless of use, and there were a significant number of pass holders who used the pass infrequently.

	Monthly Savings	Annual Savings
Total	\$ 15,000	\$ 180,000
G.F.	\$ 6,098	\$ 73,170

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## Section 13: Premiums and Co-Pays

### Apply Co-Pays (VHAP, VPharm 1, 2, 3)

Currently traditional Medicaid beneficiaries participate in cost sharing (i.e., co-pays) for their pharmaceutical needs. In State Fiscal Year '09, co-pays will be applied to VHAP

Estimated Prescriptions Subject to Co-Pays				
	\$0 - \$29.99	\$30. - \$49.99	\$50. - Over	Total
Medicaid	798,316	85,805	336,237	1,220,358
VHAP < 50% of the Federal Poverty Level (FPL)*	124,356	7,971	116,302	248,629
VHAP > 50% of the Federal Poverty Level (FPL)	150,520	20,861	91,462	262,843
VPharm 1 & VHAP Pharmacy	319,974	6,574	14,660	341,208
VPharm 2 & VScript	90,273	6,544	18,250	115,067
VPharm 3 & VScript Expanded	93,122	9,250	23,603	125,975
<b>Total Number of Scripts Subject to Co-Pays</b>	<b>1,576,561</b>	<b>137,005</b>	<b>600,514</b>	<b>2,314,080</b>

and pharmacy-only beneficiaries. Reference the tables "Estimated Prescriptions Subject to Co-Pays" and "Total Estimated Co-Pays (Beneficiary Impact)"

for a depiction of the detailed analysis. Reference the table "Vermont Medicaid Pharmacy Co-Pay History with SFY '09 Recommendation" for a depiction of the historical pharmacy co-pays and the recommendations for SFY '09.

Total Estimated Co-Pays - Beneficiary Impact							
	\$1.00	\$2.00	\$3.00	\$5.00	\$7.00	Total	G.F.
VHAP < 50% of the Federal Poverty Level (FPL)*	\$ 124,356	\$ 15,942	\$ 348,905		\$ -	\$ 489,203	\$ 198,861
VHAP > 50% of the Federal Poverty Level (FPL)	\$ -	\$ -	\$ 451,560	\$ 104,305	\$ 640,234	\$ 1,196,099	\$ 486,214
VPharm 1 & VHAP Pharmacy	\$ -	\$ -	\$ 959,922	\$ 32,870	\$ 102,620	\$ 1,095,412	\$ 820,722
VPharm 2 & VScript	\$ -	\$ -	\$ 270,819	\$ 32,720	\$ 127,750	\$ 431,289	\$ 320,478
VPharm 3 & VScript Expanded	\$ -	\$ -	\$ 279,366	\$ 46,250	\$ 165,221	\$ 490,837	\$ 490,837
<b>Subtotal Increase in Co-Pay</b>	<b>\$ 124,356</b>	<b>\$ 15,942</b>	<b>\$ 2,310,572</b>	<b>\$ 216,145</b>	<b>\$ 1,035,825</b>	<b>\$ 3,702,840</b>	<b>\$ 2,317,112</b>
Co-Pays Currently Paid by Traditional Medicaid Enrollees	\$ 798,316	\$ 171,610	\$ 1,008,711			\$ 1,978,637	n/a
<b>Total Co-Pays</b>	<b>\$ 922,672</b>	<b>\$ 187,552</b>	<b>\$ 3,319,283</b>	<b>\$ 216,145</b>	<b>\$ 1,035,825</b>	<b>\$ 5,681,477</b>	

\* VHAP < 50% FPL is subject to the \$1.00, \$2.00 and \$3.00 co-pay to coincide with traditional Medicaid

### Return Premiums to SFY'07 Levels (VHAP, Dr. Dynasaur, SCHIP, VPharm 1, 2, 3)

The premium levels do not apply to beneficiaries with very low incomes or traditional eligibility groups (e.g. Aged, Blind, and Disabled). The SFY'09 premium structure simply returns beneficiary financial participation to SFY'07 levels. 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. Reference the table "Vermont Medicaid Premium History with SFY '09 Recommendation" for a depiction of the details. The following table depicts the impact of the premium rate increase on enrollment and PMPM expenditures.

	Prior to Premium Increases		Impact after Premium Increases		Net Change in Enrollment and PMPM	
	Enrollment	PMPM	Enrollment	PMPM	Enrollment	PMPM
SCHIP	3,797	\$ 122.01	3,646	\$ 126.63	(151)	\$ 4.63
Underinsured	1,321	\$ 70.19	1,297	\$ 71.49	(24)	\$ 1.30
VHAP	25,101	\$ 314.94	24,682	\$ 317.49	(419)	\$ 2.55

### Vermont Medicaid Pharmacy Co-Pay History with SFY '09 Recommendation

Program	% FPL	Cost per Prescription	SFY 2002	SFY 2003	SFY 2004	SFY 2005	SFY 2006	SFY 2007	SFY 2008	SFY 2009
			Co-pay	Co-pay	Co-pay	Co-pay	Co-pay	Co-pay	Co-pay	Proposed 2009
Traditional Medicaid <small>* Does not apply to children &lt;18 (effective 1/1/2007 &lt;21), pregnant women, or LTC Patients)</small>	0-185%	\$29.99 or Less	\$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
		\$50.00 or more	\$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	60% Limited/ 50% Managed Care	60% Limited/ 50% Managed Care \$750.00 Beneficiary/\$1500.00 Family Out Of Pocket Calendar Year Maximum	N/A	N/A	N/A	N/A	N/A	\$1.00
		\$30.00 - \$49.99								\$2.00
		\$50.00 or more								\$3.00
VHAP	50-75%	\$29.99 or Less	60% Limited/ 50% Managed Care	60% Limited/ 50% Managed Care \$750.00 Beneficiary/\$1500.00 Family Out Of Pocket Calendar Year Maximum	N/A	N/A	N/A	N/A	N/A	\$3.00
		\$30.00 - \$49.99								\$5.00
		\$50.00 or more								\$7.00
VHAP	75-100%	\$29.99 or Less	60% Limited/ 50% Managed Care	60% Limited/ 50% Managed Care \$750.00 Beneficiary/\$1500.00 Family Out Of Pocket Calendar Year Maximum	N/A	N/A	N/A	N/A	N/A	\$3.00
		\$30.00 - \$49.99								\$5.00
		\$50.00 or more								\$7.00
VHAP	100-150%	\$29.99 or Less	60% Limited/ 50% Managed Care	60% Limited/ 50% Managed Care \$750.00 Beneficiary/\$1500.00 Family Out Of Pocket Calendar Year Maximum	N/A	N/A	N/A	N/A	N/A	\$3.00
		\$30.00 - \$49.99								\$5.00
		\$50.00 or more								\$7.00
VHAP	150-185%	\$29.99 or Less	60% Limited/ 50% Managed Care	60% Limited/ 50% Managed Care \$750.00 Beneficiary/\$1500.00 Family Out Of Pocket Calendar Year Maximum	N/A	N/A	N/A	N/A	N/A	\$3.00
		\$30.00 - \$49.99								\$5.00
		\$50.00 or more								\$7.00
			11/1/2001	11/1/2002	1/1/2004					7/1/2008
VHAP Pharmacy	0-150%	\$29.99 or Less	\$1.00	\$3.00 Generic/\$6.00 Brand - \$50.00 per beneficiary per quarter maximum \$1.00 Diabetic Supply	N/A	N/A	N/A	N/A	N/A	\$3.00
		\$30.00 - \$49.99	\$2.00	\$3.00 Generic/\$6.00 Brand - \$50.00 per beneficiary per quarter maximum \$2.00 Diabetic Supply						\$5.00
		\$50.00 or more	\$3.00	\$3.00 Generic/\$6.00 Brand - \$50.00 per beneficiary per quarter maximum \$3.00 Diabetic Supply						\$7.00
VScript	150-175%	\$29.99 or Less	\$2.00	\$5.00 Generic/\$10.00 Brand \$100.00 per beneficiary per quarter maximum	N/A	N/A	N/A	N/A	N/A	\$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 41% coinsurance for maintenance drugs \$2500.00 annual out-of-pocket maximum	N/A	N/A	N/A	N/A	N/A	\$3.00
		\$30.00 - \$49.99								\$5.00
		\$50.00 or more								\$7.00
			11/1/2001	11/1/2002	1/1/2004					7/1/2008
VPharm 1	0-150%	\$29.99 or Less	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	\$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	\$3.00
		\$30.00 - \$49.99								\$5.00
		\$50.00 or more								\$7.00
										Effective 1/1/06
										7/1/2008

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

### Vermont Medicaid Premium History with SFY '09 Recommendation

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

\* per family per month

\*\* per individual for 6 months

\*\*\* per individual per month

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

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## **Section 14: Other Considerations**

### **Choices for Care Waiver**

The Office of Vermont Health Access (OVHA) works closely with the Department of Disabilities, Aging, & Independent Living (DAIL) to ensure traditional long-term care services receive the appropriate level of funding required to serve clients enrolled in this program. Funding provided to support enhanced residential care, home and community based services, and nursing homes are tracked discreetly. Any dollars not expended in these areas are available for reinvestment in the program to support caseload pressures and the further development of the home and community based system. All other categories of service are trended at the population level and are subject to increases and/or decreases based upon what the trends reflect.

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**Section 15: SFY '09 Budget Detail Summary**

<b>Section Reference</b>	<b>Provider Rate Increases</b>	
	<b>Revenue Impact</b>	<b>Expenditure Impact</b>
<b>10</b>	Dental Dozen Rate Increases	\$ 1,412,441
<b>10</b>	Annualization of SFY '08 Hospital Increase	\$ 1,000,000
<b>10</b>	Boston Children's Hospital Rate Increase	\$ 1,000,000
<b>10</b>	Dartmouth Hospital Rate Increase	\$ 1,300,000
<b>10</b>	Instate Hospital Rate Increase	\$ 8,000,000
<b>10</b>	Healthcare reform related rate increases	\$ 1,486,559
<b>Total Provider Rate Increases</b>		<b>\$ - \$ 14,199,000</b>

<b>Section Reference</b>	<b>Savings Initiatives</b>	
<b>11</b>	Dental Dozen Savings	\$ (1,167,667)
<b>9</b>	Program Integrity Activity	\$ (2,460,025)
<b>9</b>	Coordination of Benefits Increased Collections	\$ (3,805,043)
<b>9</b>	Pharmacy ~ Specialty Rx	\$ (1,230,012)
<b>5</b>	Chronic Care Management Program	\$ (4,920,049)
<b>5</b>	Care Coordination Program	\$ (2,460,025)
<b>12, 9, 5</b>	Miscellaneous savings initiatives (Bus Pass, PARIS, Buprenorphine)	\$ (899,004)
<b>Total Savings Initiatives</b>		<b>\$ - \$ (16,941,825)</b>

<b>Section Reference</b>	<b>Policy Changes</b>	
<b>10</b>	Pay Medicare Crossover claims @ Medicaid Rates	\$ (2,297,852)
<b>13</b>	Premium Increases (VHAP, Dr. Dynasaur, SCHIP, VPharm 1, 2, 3)*	\$ (4,687,624) \$ -
<b>13</b>	Apply Co-Pays - (VHAP, VPharm 1, 2, 3)	\$ (3,702,840)
<b>Total Policy Changes</b>		<b>\$ (4,687,624) \$ (6,000,692)</b>

<b>Section Reference</b>	<b>New Program Initiatives</b>	
<b>11</b>	Dental Dozen Initiative Costs	\$ 775,147
<b>11</b>	Reinstate Chiropractic Coverage	\$ 503,254
<b>11</b>	Add Naturopathic Physicians	\$ 25,000
<b>5</b>	Buprenorphine Program	\$ 500,000
<b>Total New Program Initiatives</b>		<b>\$ - \$ 1,803,401</b>

\*Note: This is a revenue adjustment. Does not impact affect bottom line expenditures.

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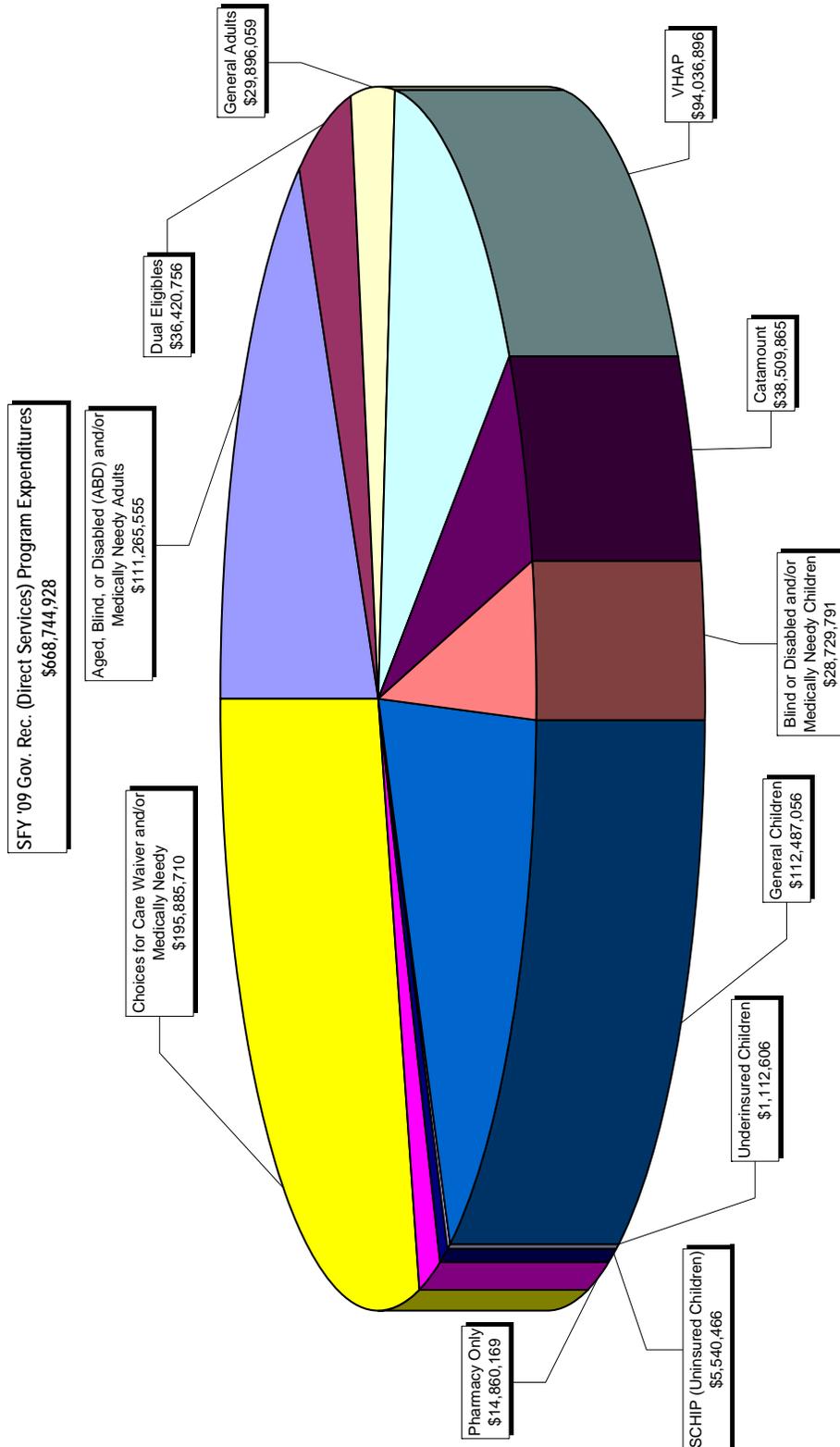


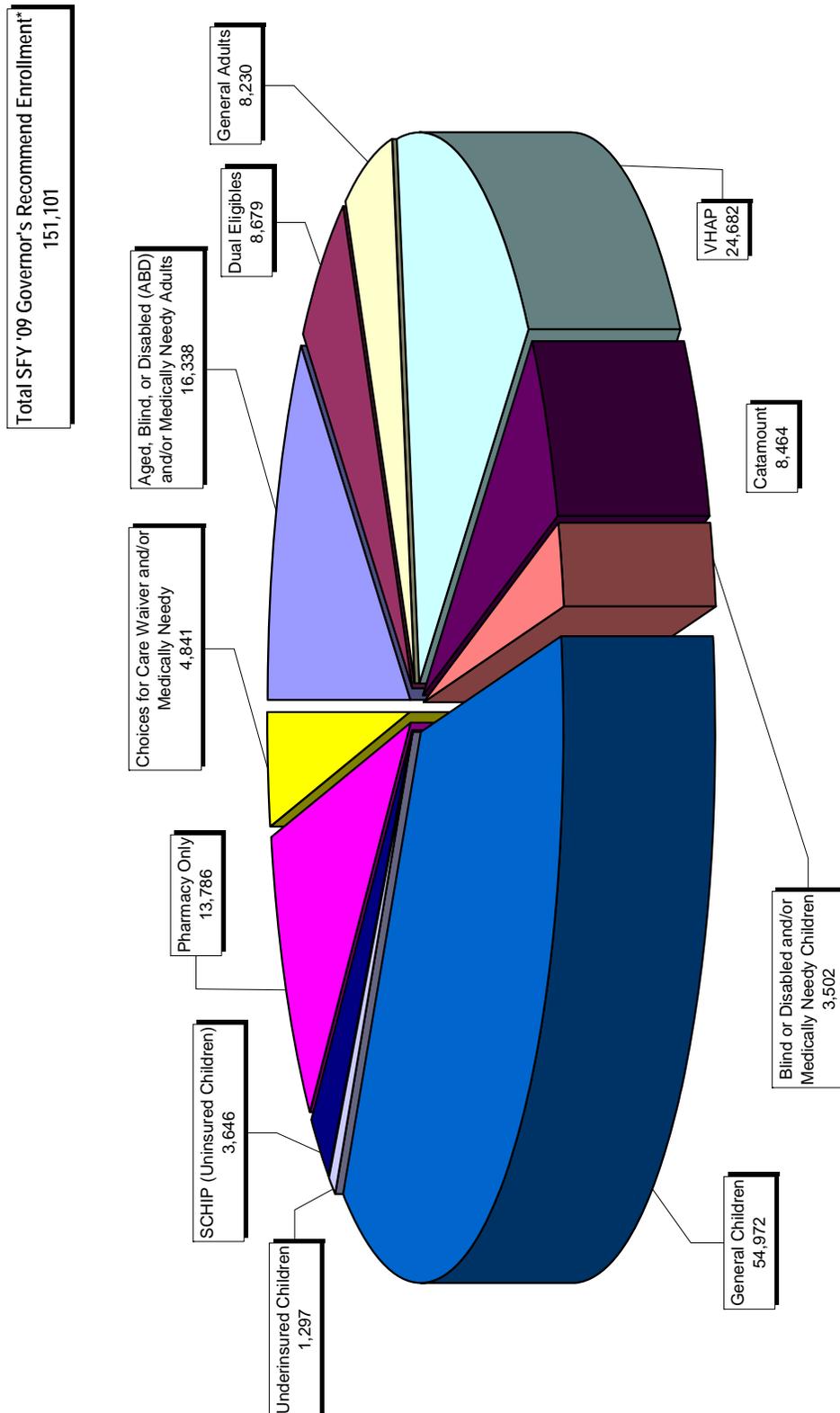
Table 2: Cost Comparison SFY '07 through SFY '09 Governor's Recommend

	PROGRAM EXPENDITURES				PROGRAM EXPENDITURES				PROGRAM EXPENDITURES				
	SFY '07 Actuals	SFY '08 Appropriated	SFY '08 Budget Adjustment	SFY '09 Requested Gov. Rec.	Enrollment	Expenses	PMPM	Enrollment	Expenses	PMPM	Enrollment	Expenses	PMPM
<b>Adults</b>													
Aged, Blind, or Disabled (ABD)/Medically Needy	15,929	\$ 91,557,999	\$ 482	\$ 109,719,437	\$ 581	\$ 15,725	\$ 109,719,437	\$ 581	\$ 15,887	\$ 99,123,046	\$ 520	\$ 16,338	\$ 111,265,555
Dual Eligibles	8,409	\$ 29,969,846	\$ 297	\$ 35,914,662	\$ 358	\$ 8,446	\$ 32,446,127	\$ 320	\$ 8,446	\$ 32,446,127	\$ 320	\$ 8,679	\$ 36,420,756
General	7,973	\$ 24,600,814	\$ 257	\$ 29,480,630	\$ 310	\$ 8,008	\$ 26,633,473	\$ 277	\$ 8,008	\$ 26,633,473	\$ 277	\$ 8,230	\$ 29,996,059
VHAP*	22,047	\$ 74,809,390	\$ 283	\$ 89,966,353	\$ 302	\$ 23,105	\$ 87,119,964	\$ 314	\$ 23,105	\$ 87,119,964	\$ 314	\$ 24,682	\$ 94,036,896
Catamount**	-	-	-	\$ 12,468,165	\$ 349	\$ 2,973	\$ 13,363,304	\$ 380	\$ 2,938	\$ 13,363,304	\$ 380	\$ 6,464	\$ 38,509,865
<b>Subtotal Adults</b>	<b>54,258</b>	<b>\$ 220,938,049</b>	<b>\$ 339</b>	<b>\$ 277,539,248</b>	<b>\$ 387</b>	<b>\$ 59,762</b>	<b>\$ 277,539,248</b>	<b>\$ 387</b>	<b>\$ 59,394</b>	<b>\$ 258,705,917</b>	<b>\$ 369</b>	<b>\$ 66,393</b>	<b>\$ 310,129,131</b>
<b>Children</b>													
Blind or Disabled (BD)/Medically Needy	3,393	\$ 23,641,118	\$ 581	\$ 28,330,569	\$ 700	\$ 3,408	\$ 25,534,483	\$ 626	\$ 3,408	\$ 25,534,483	\$ 626	\$ 3,502	\$ 28,729,791
General	53,258	\$ 92,563,144	\$ 145	\$ 110,923,964	\$ 175	\$ 53,490	\$ 100,211,244	\$ 156	\$ 53,490	\$ 100,211,244	\$ 156	\$ 54,972	\$ 112,487,056
Underinsured	1,214	\$ 794,697	\$ 55	\$ 1,860,768	\$ 102	\$ 1,273	\$ 986,717	\$ 65	\$ 1,273	\$ 986,717	\$ 65	\$ 1,287	\$ 1,112,806
SCHIP (Uninsured)	3,013	\$ 4,742,420	\$ 131	\$ 4,070	\$ 125	\$ 4,070	\$ 4,980,534	\$ 119	\$ 3,495	\$ 4,980,534	\$ 119	\$ 3,646	\$ 5,540,468
<b>Subtotal Children</b>	<b>60,878</b>	<b>\$ 121,741,378</b>	<b>\$ 167</b>	<b>\$ 147,243,144</b>	<b>\$ 198</b>	<b>\$ 61,871</b>	<b>\$ 147,243,144</b>	<b>\$ 198</b>	<b>\$ 61,666</b>	<b>\$ 131,772,978</b>	<b>\$ 178</b>	<b>\$ 63,417</b>	<b>\$ 147,889,918</b>
<b>Pharmacy Only Programs</b>	<b>13,113</b>	<b>\$ 14,094,144</b>	<b>\$ 90</b>	<b>\$ 14,998</b>	<b>\$ 55</b>	<b>\$ 14,998</b>	<b>\$ 9,913,377</b>	<b>\$ 89</b>	<b>\$ 13,652</b>	<b>\$ 14,645,763</b>	<b>\$ 89</b>	<b>\$ 13,786</b>	<b>\$ 14,860,169</b>
<b>Choices for Care</b>													
Nursing Home, Home & Community Based, ERC	4,723	\$ 148,402,416	\$ 2,618	\$ 163,321,831	\$ 2,882	\$ 4,723	\$ 163,921,442	\$ 2,892	\$ 4,723	\$ 163,921,442	\$ 2,892	\$ 4,841	\$ 168,381,716
Acute-Care Services - OVHA	-	\$ 19,562,703	\$ 345	\$ 21,128,918	\$ 373	\$ -	\$ -	\$ -	\$ -	\$ 20,403,891	\$ 360	\$ -	\$ 21,865,525
Acute-Care Services - Other Depts.	-	\$ 2,798,861	\$ 49	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 3,145,618	\$ 56	\$ -	\$ 3,145,618
Buy-In	-	\$ 2,198,479	\$ -	\$ 3,224,358	\$ -	\$ -	\$ 2,322,686	\$ -	\$ -	\$ 2,492,851	\$ -	\$ -	\$ 2,492,851
<b>Subtotal Choices for Care</b>	<b>4,723</b>	<b>\$ 172,962,458</b>	<b>\$ 3,052</b>	<b>\$ 187,675,107</b>	<b>\$ 3,311</b>	<b>\$ 4,723</b>	<b>\$ 189,793,638</b>	<b>\$ 3,349</b>	<b>\$ 4,723</b>	<b>\$ 189,793,638</b>	<b>\$ 3,349</b>	<b>\$ 4,841</b>	<b>\$ 195,885,710</b>
<b>Miscellaneous Program</b>	<b>132,972</b>	<b>\$ 529,736,030</b>	<b>\$ 332</b>	<b>\$ 622,370,876</b>	<b>\$ 367</b>	<b>\$ 141,355</b>	<b>\$ 594,918,296</b>	<b>\$ 358</b>	<b>\$ 138,435</b>	<b>\$ 594,918,296</b>	<b>\$ 358</b>	<b>\$ 148,437</b>	<b>\$ 668,744,928</b>
GC to CFC Funding Reallocation	-	\$ (2,798,861)	\$ -	\$ -	\$ -	\$ -	\$ (3,145,618)	\$ -	\$ -	\$ (3,145,618)	\$ -	\$ -	\$ (3,145,618)
DSH	-	\$ 59,377,729	\$ -	\$ 49,003,898	\$ -	\$ -	\$ 49,003,898	\$ -	\$ -	\$ 49,003,898	\$ -	\$ -	\$ 35,648,781
Clawback	-	\$ 19,142,149	\$ -	\$ 19,630,187	\$ -	\$ -	\$ 19,630,187	\$ -	\$ -	\$ 19,630,187	\$ -	\$ -	\$ 20,841,112
Buy-in (excluding Choices for Care participants)	-	\$ 22,112,036	\$ -	\$ 24,272,681	\$ -	\$ -	\$ 25,174,353	\$ -	\$ -	\$ 25,174,353	\$ -	\$ -	\$ 27,018,677
Legal Aid	-	\$ 506,152	\$ -	\$ 506,142	\$ -	\$ -	\$ 506,142	\$ -	\$ -	\$ 506,142	\$ -	\$ -	\$ 506,142
Rate Setting	-	\$ 778,190	\$ -	\$ 683,085	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
HIV	-	\$ 42,668	\$ -	\$ 40,836	\$ -	\$ -	\$ 42,821	\$ -	\$ -	\$ 42,821	\$ -	\$ -	\$ 44,495
Civil Union	-	\$ 636,322	\$ -	\$ 708,594	\$ -	\$ -	\$ 869,119	\$ -	\$ -	\$ 869,119	\$ -	\$ -	\$ 955,564
Misc. Pymts.	-	\$ 1,371,235	\$ -	\$ -	\$ -	\$ -	\$ 977,165	\$ -	\$ -	\$ 977,165	\$ -	\$ -	\$ 3,679,557
Healthy Vermonters Program	9,413	\$ -	\$ n/a	\$ -	\$ n/a	\$ -	\$ -	\$ -	\$ -	\$ -	\$ n/a	\$ -	\$ -
<b>Subtotal Miscellaneous Program</b>	<b>9,413</b>	<b>\$ 101,167,621</b>	<b>\$ n/a</b>	<b>\$ 94,845,514</b>	<b>\$ 8,841</b>	<b>\$ 8,841</b>	<b>\$ 93,058,068</b>	<b>\$ n/a</b>	<b>\$ 8,199</b>	<b>\$ 93,058,068</b>	<b>\$ n/a</b>	<b>\$ 9,211</b>	<b>\$ 85,551,711</b>
<b>TOTAL PROGRAM EXPENDITURES</b>	<b>132,972</b>	<b>\$ 630,903,651</b>	<b>\$ 141,355</b>	<b>\$ 717,216,390</b>	<b>\$ 141,355</b>	<b>\$ 138,435</b>	<b>\$ 687,976,364</b>	<b>\$ 138,435</b>	<b>\$ 138,435</b>	<b>\$ 687,976,364</b>	<b>\$ 148,437</b>	<b>\$ 754,296,639</b>	
<b>ADMINISTRATIVE EXPENDITURES</b>													
<b>Contract</b>													
Claims Processing	-	\$ 9,928,717	\$ -	\$ 9,133,903	\$ -	\$ -	\$ 9,432,334	\$ -	\$ -	\$ 9,432,334	\$ -	\$ -	\$ 9,432,334
Member Services	-	\$ 2,808,807	\$ -	\$ 3,198,772	\$ -	\$ -	\$ 3,198,772	\$ -	\$ -	\$ 3,198,772	\$ -	\$ -	\$ 3,198,772
Pharmacy Benefits Manager	-	\$ 2,365,316	\$ -	\$ 1,947,259	\$ -	\$ -	\$ 2,964,993	\$ -	\$ -	\$ 2,964,993	\$ -	\$ -	\$ 2,964,993
Care Coordination & Chronic Care Mgmt.	-	\$ 1,257,191	\$ -	\$ 2,092,510	\$ -	\$ -	\$ 5,325,116	\$ -	\$ -	\$ 5,325,116	\$ -	\$ -	\$ 5,325,116
Catamount Outreach	-	\$ 684,427	\$ -	\$ 1,316,167	\$ -	\$ -	\$ 3,686,073	\$ -	\$ -	\$ 3,686,073	\$ -	\$ -	\$ 500,000
Miscellaneous	-	\$ 7,724,262	\$ -	\$ 6,702,423	\$ -	\$ -	\$ 6,990,416	\$ -	\$ -	\$ 6,990,416	\$ -	\$ -	\$ 5,553,729
<b>Operating/Personnel Services</b>	<b>5,509,561</b>	<b>\$ 5,509,561</b>	<b>\$ 7,002,872</b>	<b>\$ 6,990,416</b>	<b>\$ 6,990,416</b>	<b>\$ 6,990,416</b>	<b>\$ 6,990,416</b>	<b>\$ 6,990,416</b>	<b>\$ 6,990,416</b>	<b>\$ 6,990,416</b>	<b>\$ 6,990,416</b>	<b>\$ 6,990,416</b>	<b>\$ 6,990,416</b>
<b>Total Administrative Expenses</b>	<b>5,509,561</b>	<b>\$ 25,258,280</b>	<b>\$ 31,393,906</b>	<b>\$ 31,393,906</b>	<b>\$ 31,393,906</b>	<b>\$ 31,393,906</b>	<b>\$ 31,393,906</b>	<b>\$ 31,393,906</b>	<b>\$ 31,393,906</b>	<b>\$ 31,393,906</b>	<b>\$ 31,393,906</b>	<b>\$ 31,393,906</b>	<b>\$ 31,393,906</b>
<b>TOTAL ALL EXPENDITURES</b>	<b>132,972</b>	<b>\$ 656,161,931</b>	<b>\$ 141,355</b>	<b>\$ 748,610,296</b>	<b>\$ 141,355</b>	<b>\$ 138,435</b>	<b>\$ 725,277,986</b>	<b>\$ 138,435</b>	<b>\$ 138,435</b>	<b>\$ 725,277,986</b>	<b>\$ 148,437</b>	<b>\$ 789,950,714</b>	

\* VHAP is inclusive of Traditional VHAP and VHAP Employed Sponsored Insurance (ESI)

\*\* Catamount is inclusive of the new Catamount Health Assistance Program and Catamount Employer Sponsored Insurance (ESI)

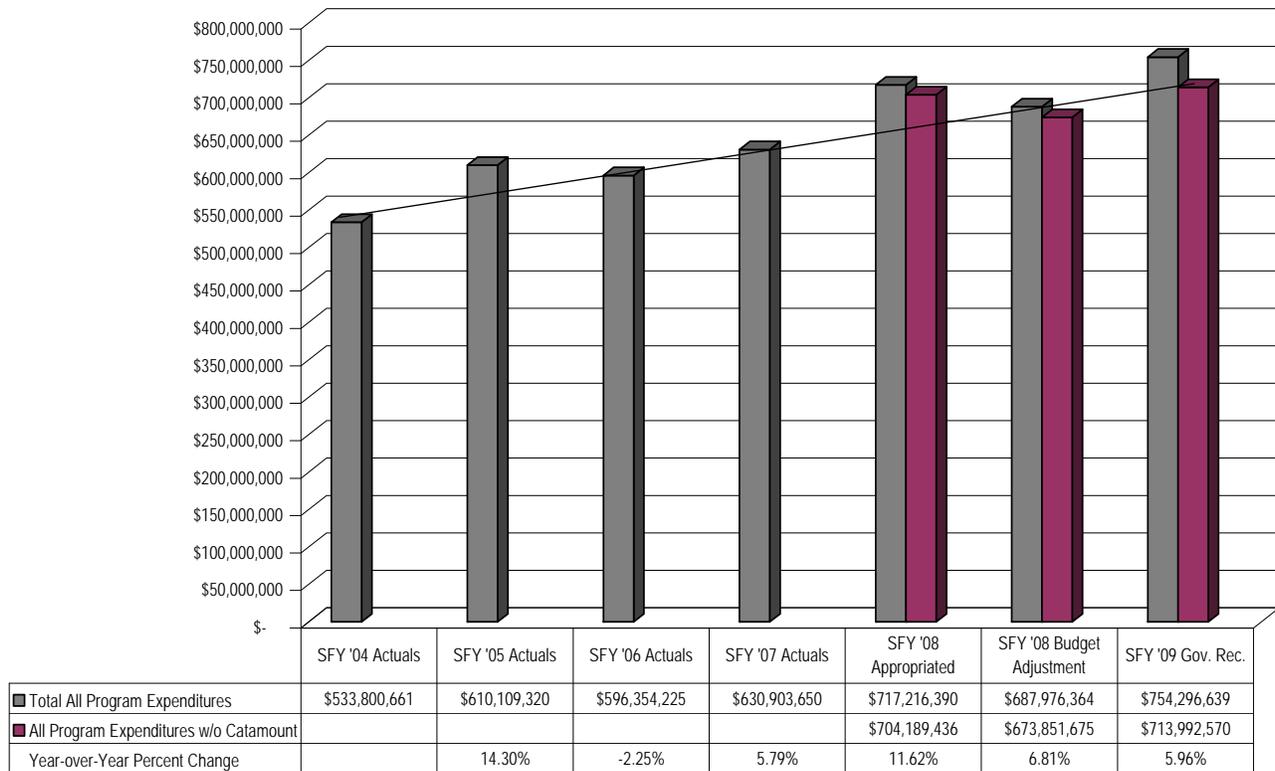
**Table 3: SFY'09 Governor's Recommend: Program Expenditures**


**Table 4: SFY'09 Governor's Recommend: Enrollment**


\*Total SFY '09 Governor's Recommend Enrollment does not include Healthy Vermonters

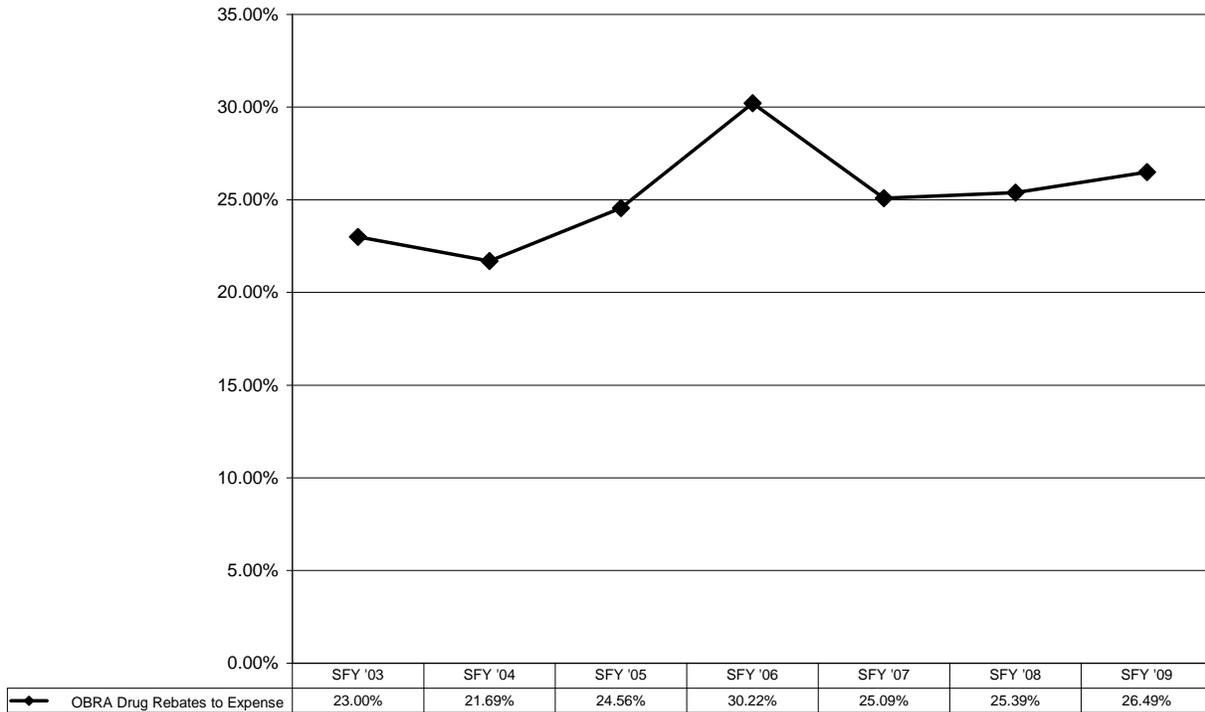
**Table 5: Enrollment History & Detail**

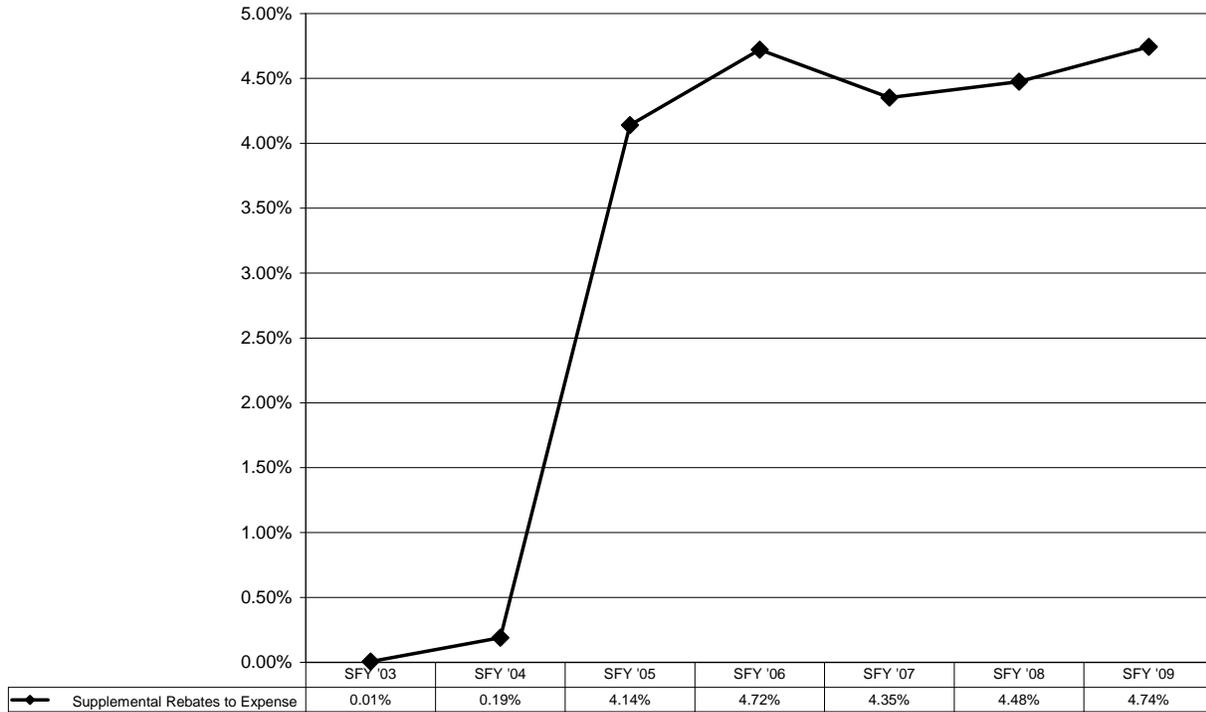
Eligibility Category	SFY '07 Actual	SFY '08 Approp	SFY '08 E-Board	SFY '08 Bud. Adj.	SFY '09 E-Board	SFY '09 Gov. Rec.
ABD ~ Adults	15,829	15,725	15,725	15,897	16,089	16,338
ABD ~ Dual	8,409	8,354	8,354	8,446	8,412	8,679
ABD ~ Children	3,393	3,371	3,371	3,408	3,422	3,502
ANFC ~ Adults	7,973	7,921	7,921	8,008	8,000	8,230
ANFC ~ Children	53,258	52,910	52,910	53,490	53,439	54,972
VHAP (Global Expenditures)	22,047	24,400	24,400	22,589	23,359	23,513
VHAP ESI	0	389	389	516	1,157	1,169
SCHIP	3,013	4,070	3,171	3,495	3,282	3,646
Underinsured Children (Optional Expend)	1,214	1,520	1,220	1,273	1,262	1,297
Catamount	0	2,831	2,798	2,798	7,994	7,994
Catamount ESI	0	142	140	140	469	469
VPharm1 & VHAP Pharmacy	7,592	8,771	8,771	7,697	8,771	7,986
VPharm2 & VScript	2,731	2,969	2,969	3,129	2,969	2,874
VPharm3 & VScript Expanded	2,790	3,258	3,258	2,826	3,258	2,926
LTC - Choices for Care Waiver	4,723	4,723	4,723	4,723	4,923	4,841
<b>TOTAL</b>	<b>132,972</b>	<b>141,354</b>	<b>140,120</b>	<b>138,435</b>	<b>146,807</b>	<b>148,437</b>
Healthy Vermonters	9,413	8,841	8,841	8,199	9,211	9,211

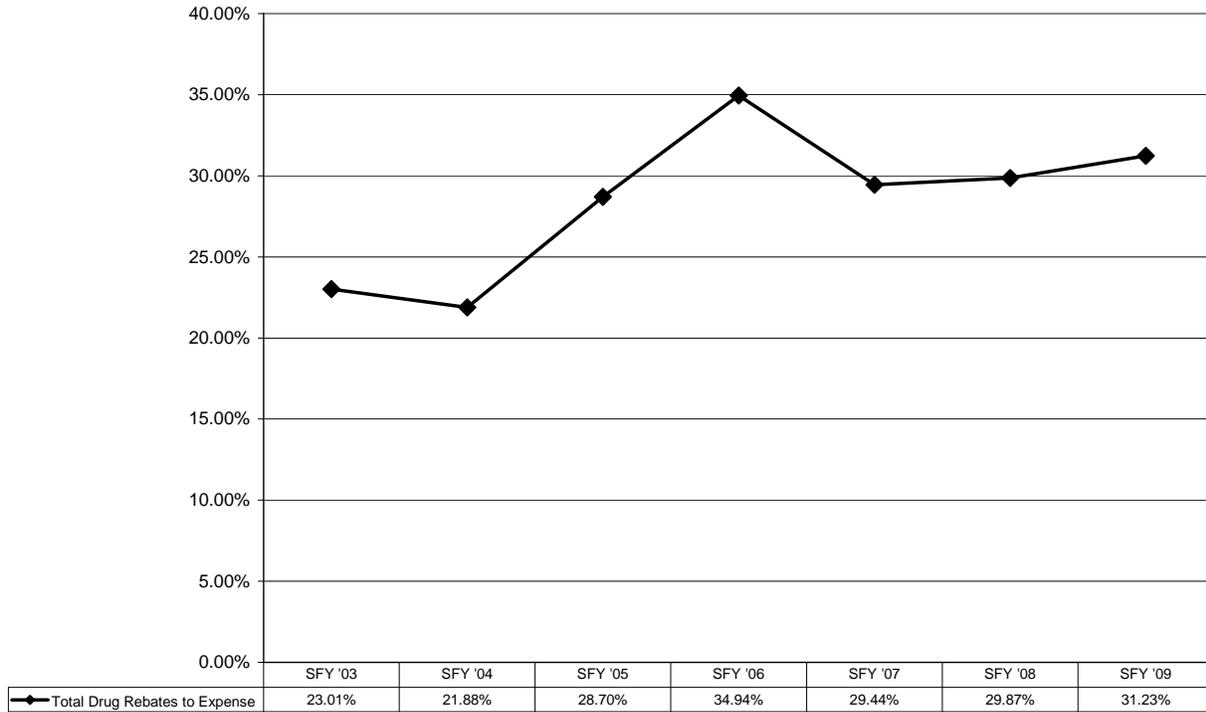
**Table 6: Total All Program Expenditures**


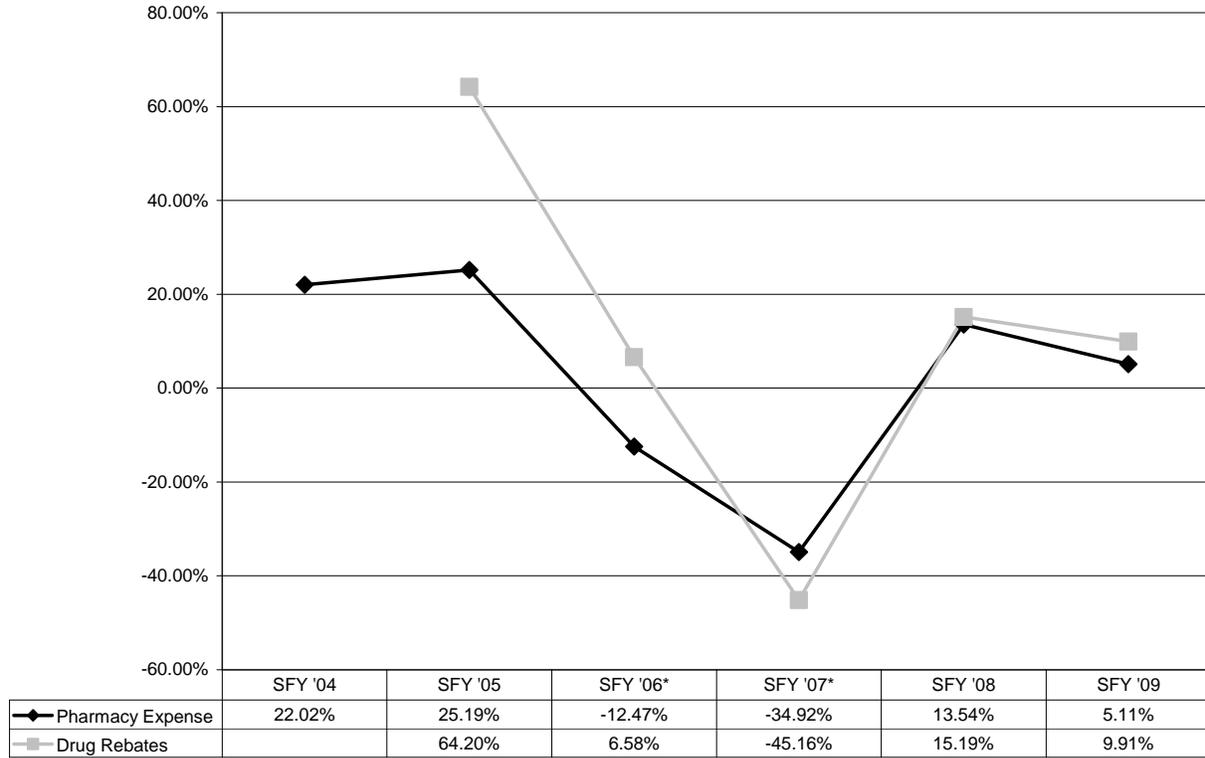
**Table 7: Trend Summary: SFY'07 - SFY'09**

Description of Service	SFY '07	SFY '08 Approp	SFY '08 BAA	SFY '09 Gov. Rec.	% trend from
					BAA
Pharmacy	\$ 109,037,904	\$ 123,798,464	\$ 123,923,464	\$ 130,129,375	11.61%
Outpatient	\$ 63,509,663	\$ 69,534,918	\$ 70,267,995	\$ 78,676,012	14.15%
Inpatient	\$ 58,107,259	\$ 60,781,526	\$ 62,097,536	\$ 78,787,330	10.86%
Physician	\$ 61,915,454	\$ 74,807,063	\$ 67,592,720	\$ 72,988,079	9.41%
Personal Care Services	\$ 16,924,620	\$ 24,711,626	\$ 20,386,388	\$ 24,635,884	23.03%
H&CB Services	\$ 35,946,219	\$ 46,213,025	\$ 46,812,638	\$ 50,437,266	7.74%
Dental	\$ 15,394,658	\$ 17,935,556	\$ 17,935,556	\$ 20,376,083	8.14%
RHC & FQHC	\$ 12,235,391	\$ 11,791,513	\$ 13,044,779	\$ 14,166,105	10.39%
Dept. of Health - Healthy Babies, Kids & Families	\$ 4,722,970	\$ 4,212,237	\$ 6,132,825	\$ 7,349,372	19.84%
Psychologist	\$ 12,791,648	\$ 13,294,718	\$ 13,294,718	\$ 14,370,238	8.22%
Transportation	\$ 9,591,574	\$ 10,832,529	\$ 10,978,624	\$ 11,878,180	9.83%
All Other Services	\$ 211,020,215	\$ 234,207,238	\$ 221,211,183	\$ 230,955,203	3.29%
Subtotal Trend	\$ 611,197,575	\$ 692,120,413	\$ 673,678,426	\$ 734,749,126	8.79%
Catamount Health & ESI	\$ -	\$ 13,026,954	\$ 14,124,689	\$ 40,304,069	185.34%
Disproportionate Share (DSH)	\$ 59,377,729	\$ 49,003,898	\$ 49,003,898	\$ 35,648,781	-27.25%
Additional Revenue Offset Projections	\$ (39,671,654)	\$ (36,934,875)	\$ (48,830,649)	\$ (56,405,336)	15.51%
<b>Total Trend</b>	<b>\$ 630,903,650</b>	<b>\$ 717,216,390</b>	<b>\$ 687,976,364</b>	<b>\$ 754,296,639</b>	<b>10.34%</b>

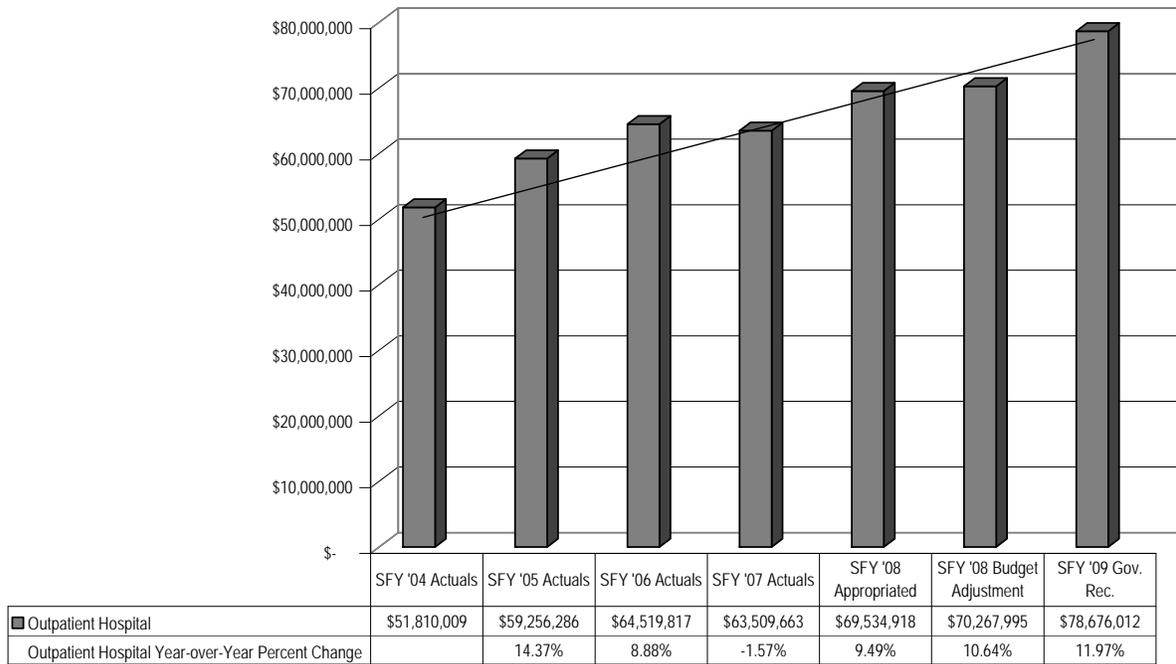
**Table 8: Pharmacy: OBRA Drug Rebates to Expense**


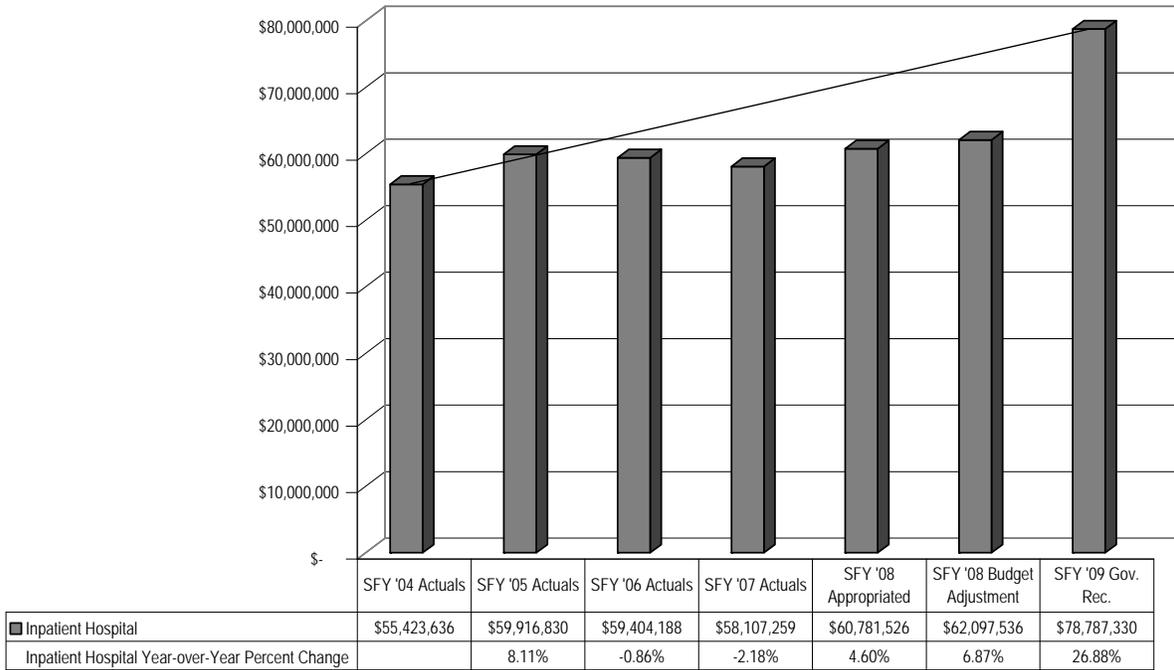
**Table 9: Pharmacy: Supplemental Rebates to Expense**


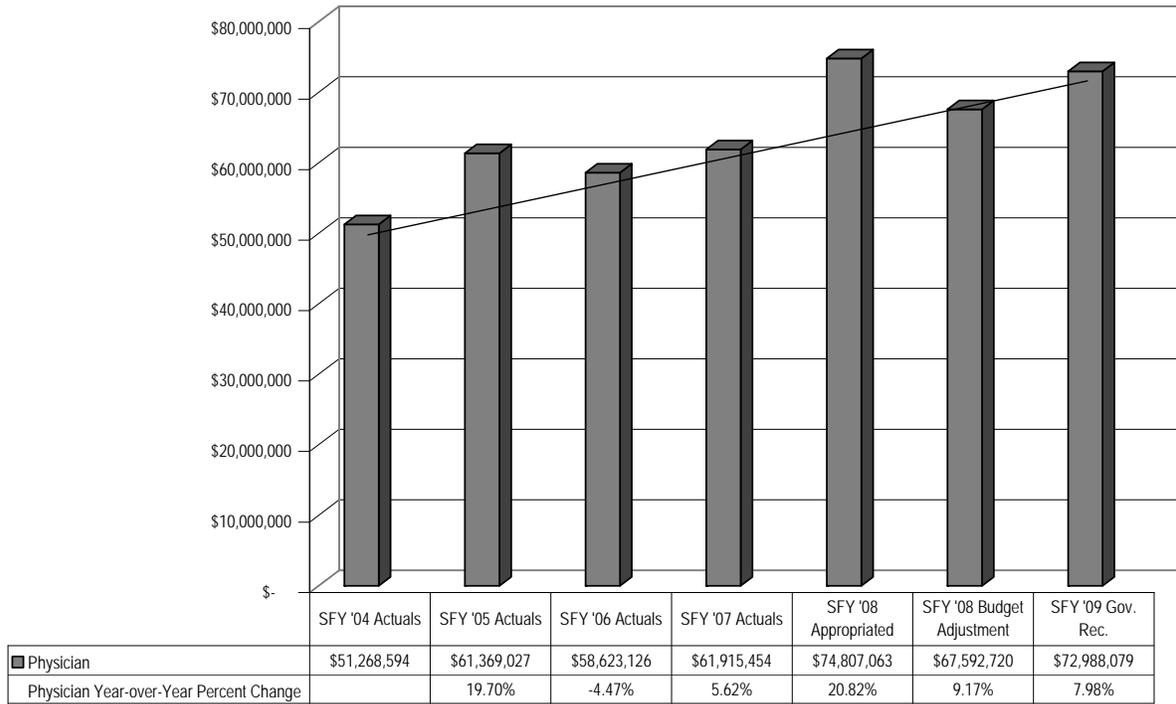
**Table 10: Pharmacy: Total Drug Rebates to Expense**


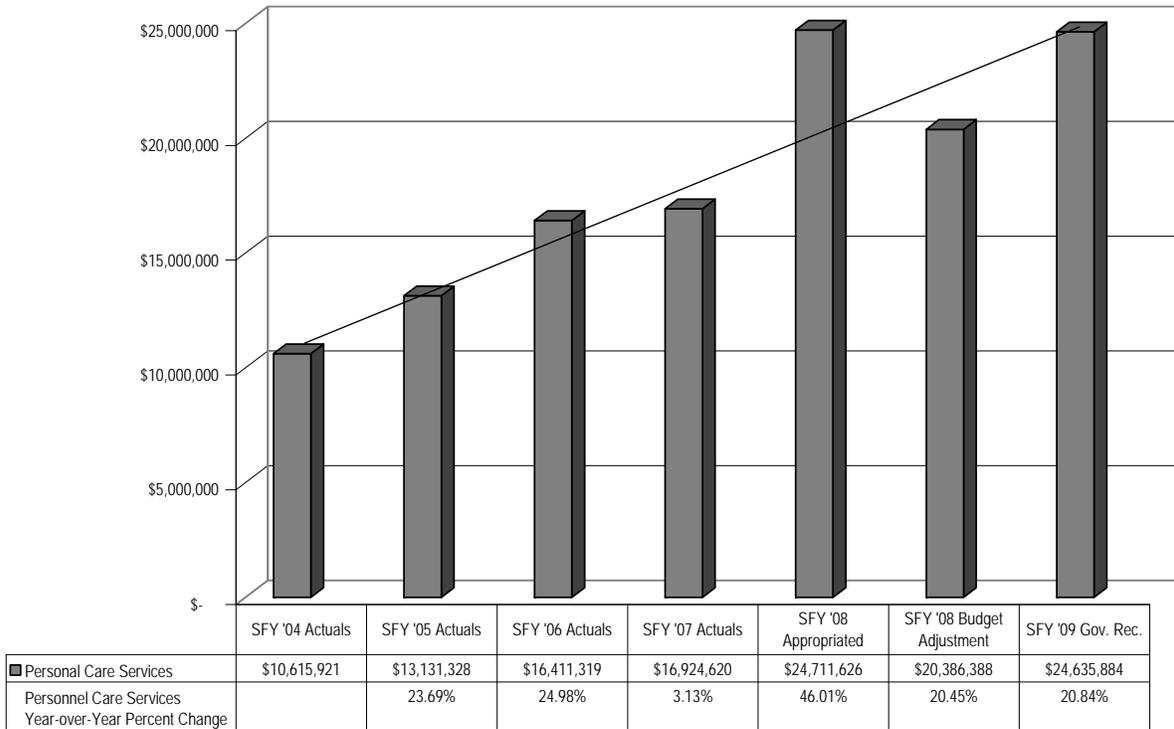
**Table 11: Pharmacy: Trend Change**


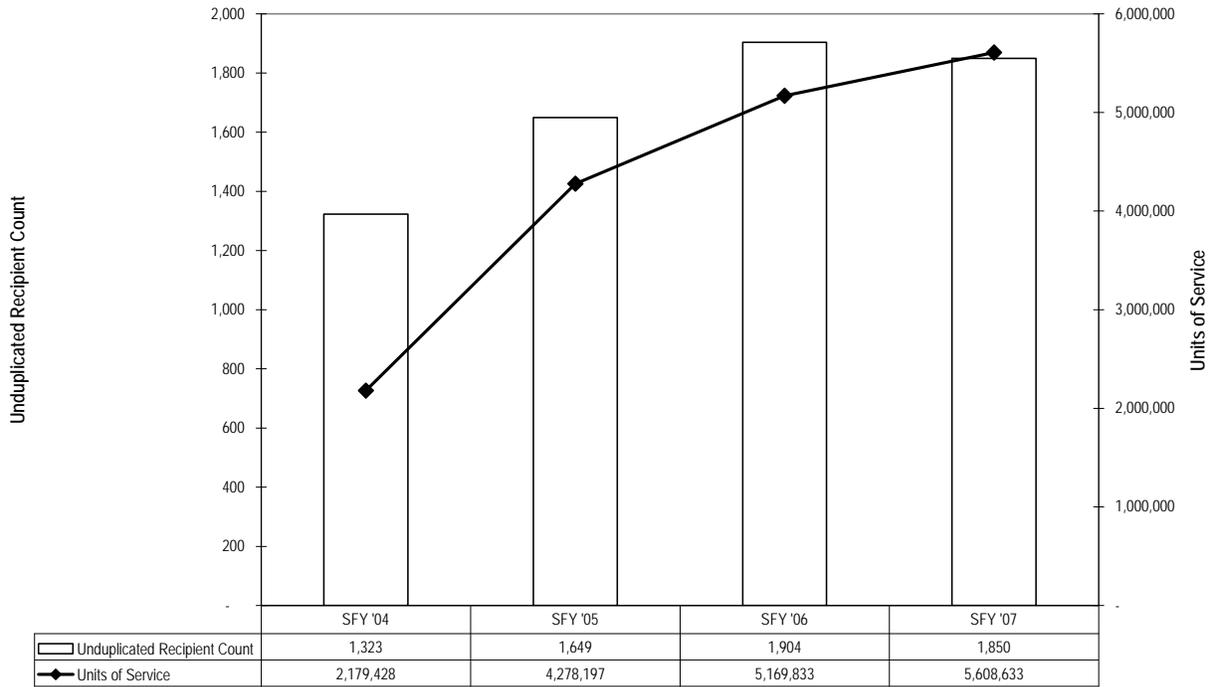
\* Medicare Modernization Impact

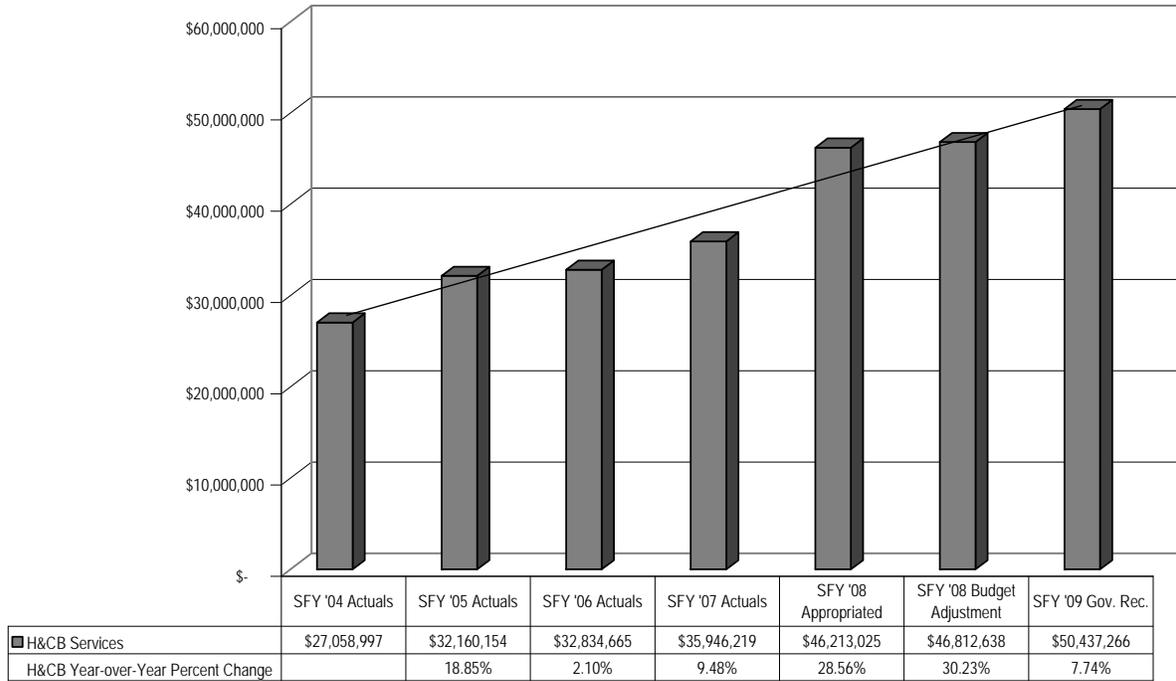
**Table 12: Outpatient Hospital Expenditures**


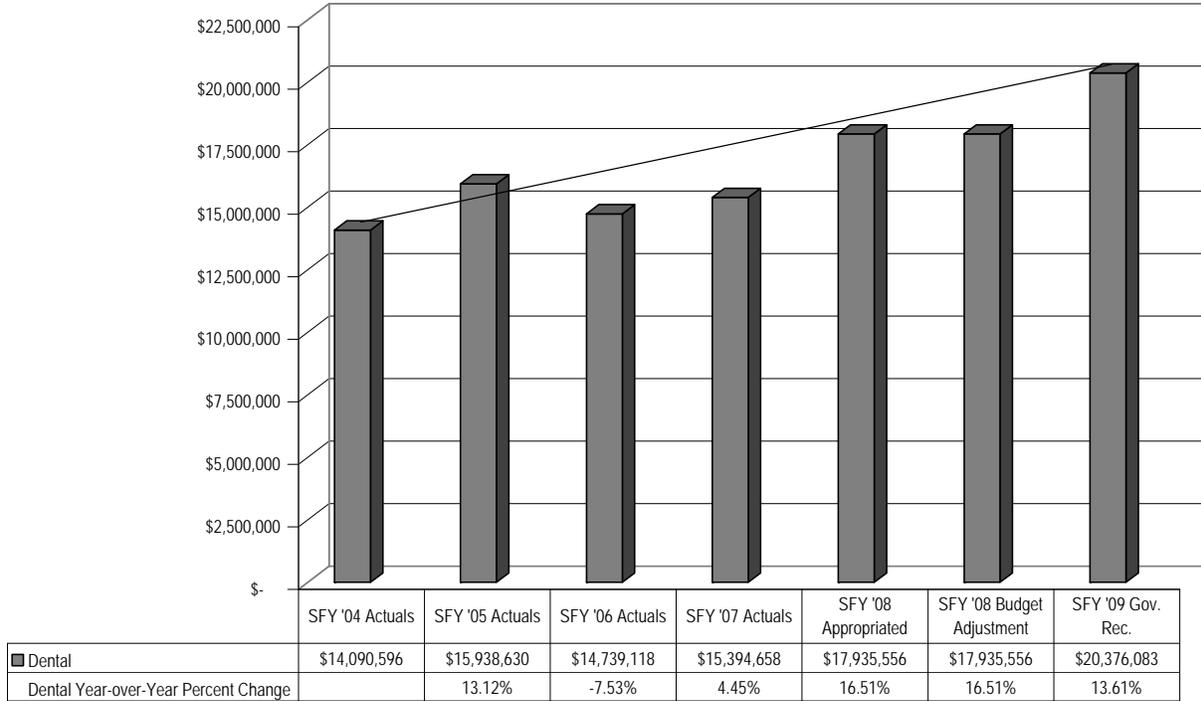
**Table 13: Inpatient Hospital Expenditures**


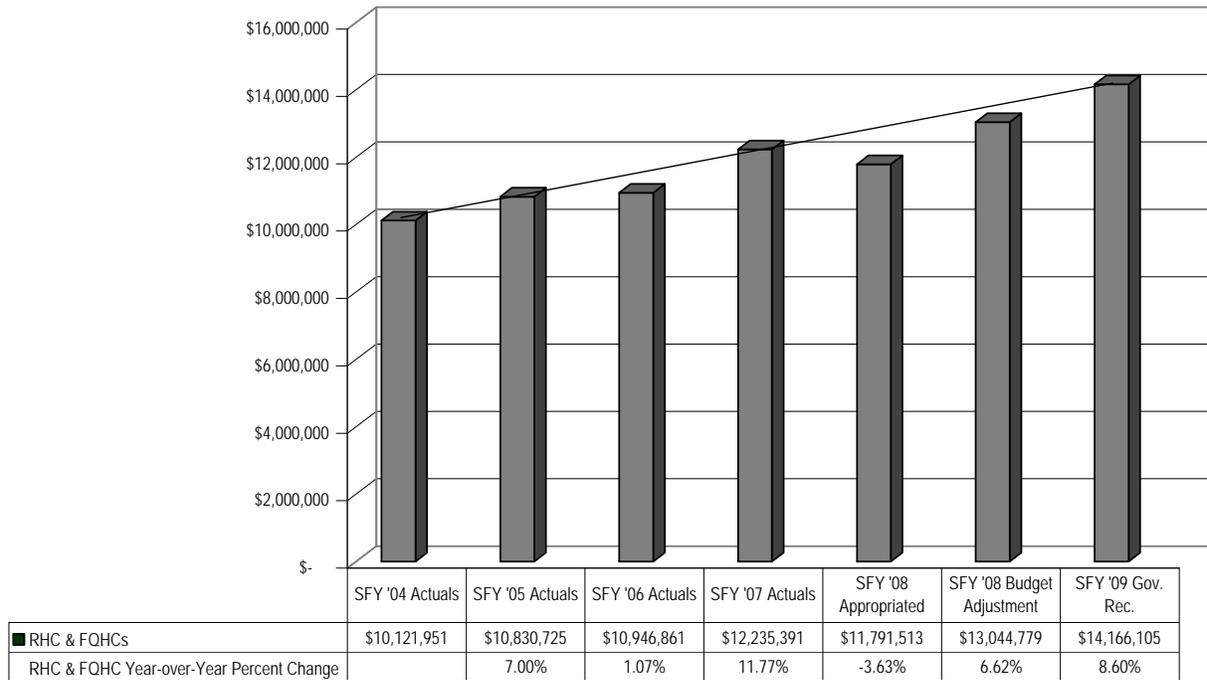
**Table 14: Physician Expenditures**


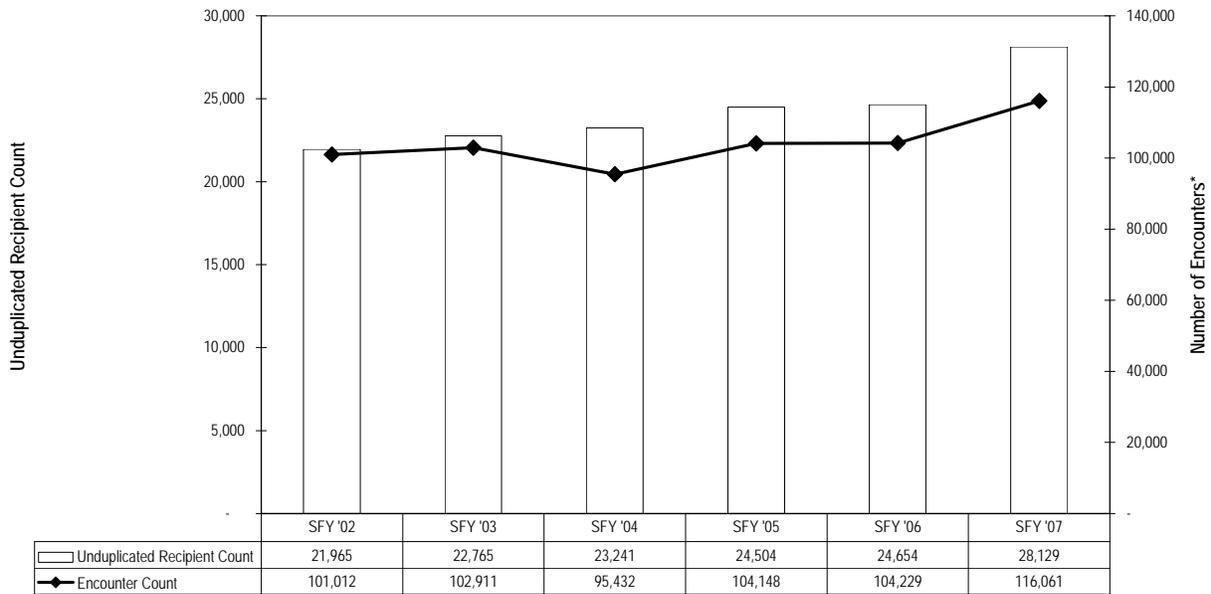
**Table 15: Personal Care Services Expenditures**


**Table 16: Personal Care Services: Unduplicated Recipient Count to Units of Service**


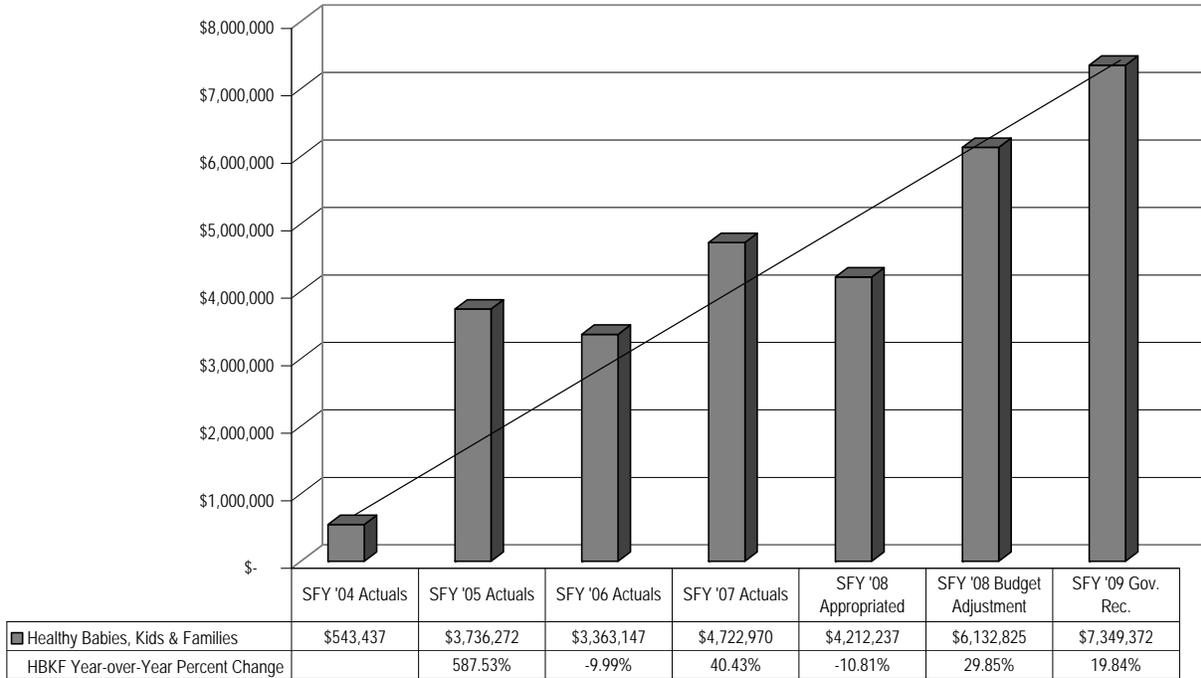
**Table 17: Home & Community Based Services**


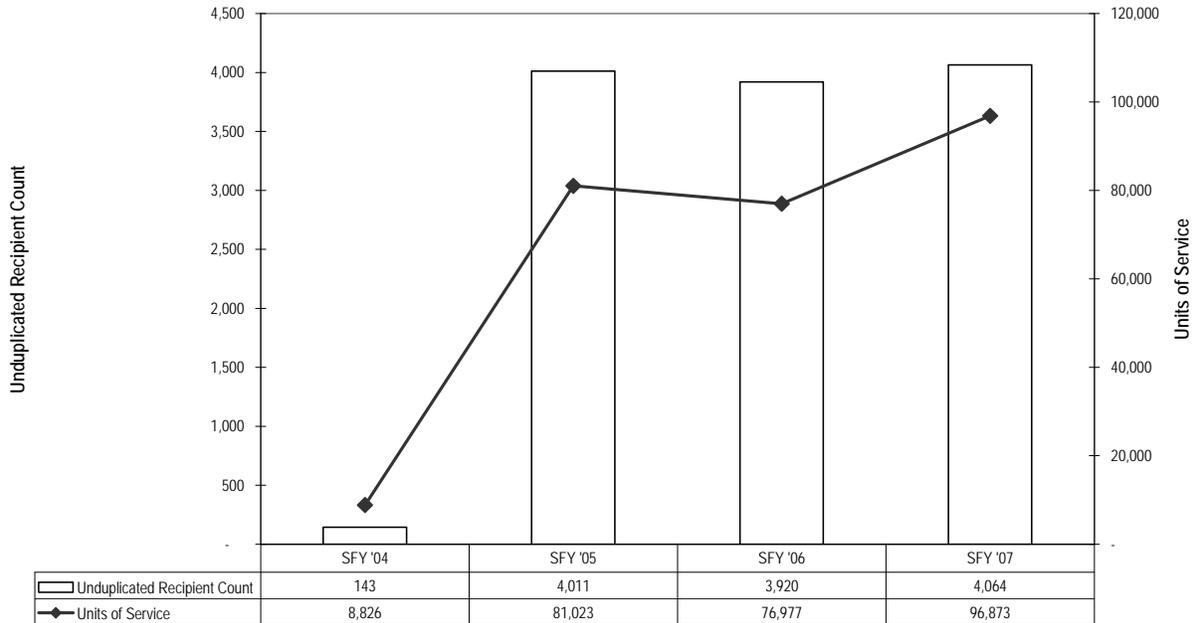
**Table 18: Dental Expenditures**


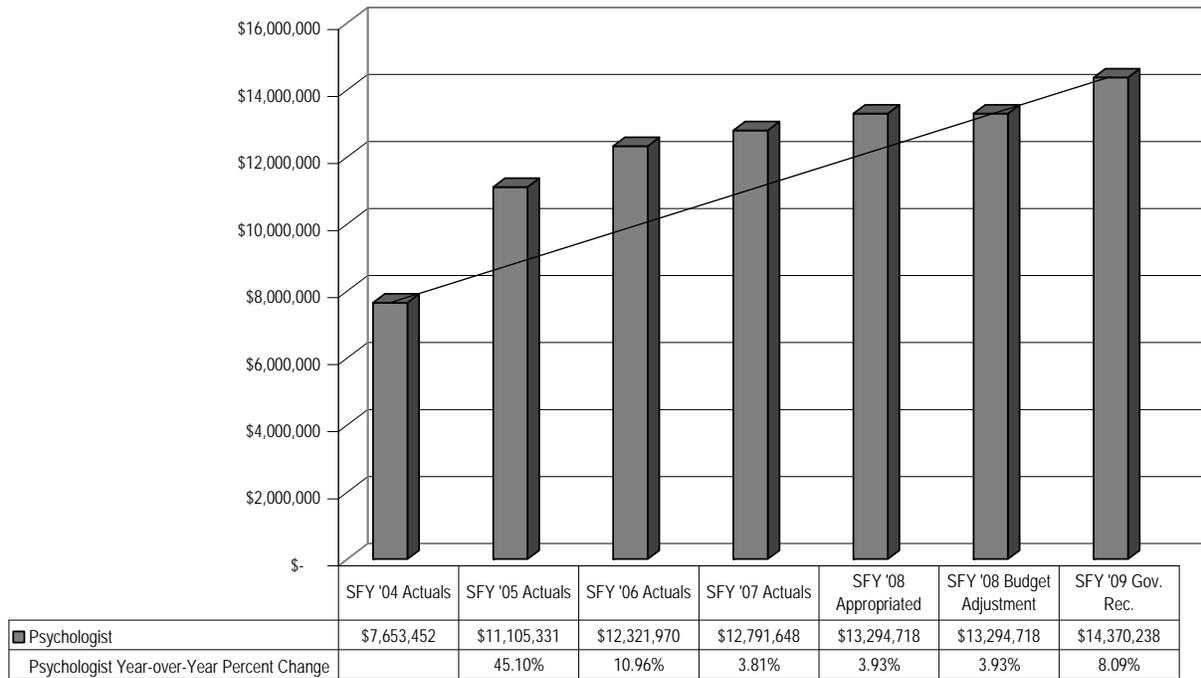
**Table 19: RHCs & FQHCs Expenditures**


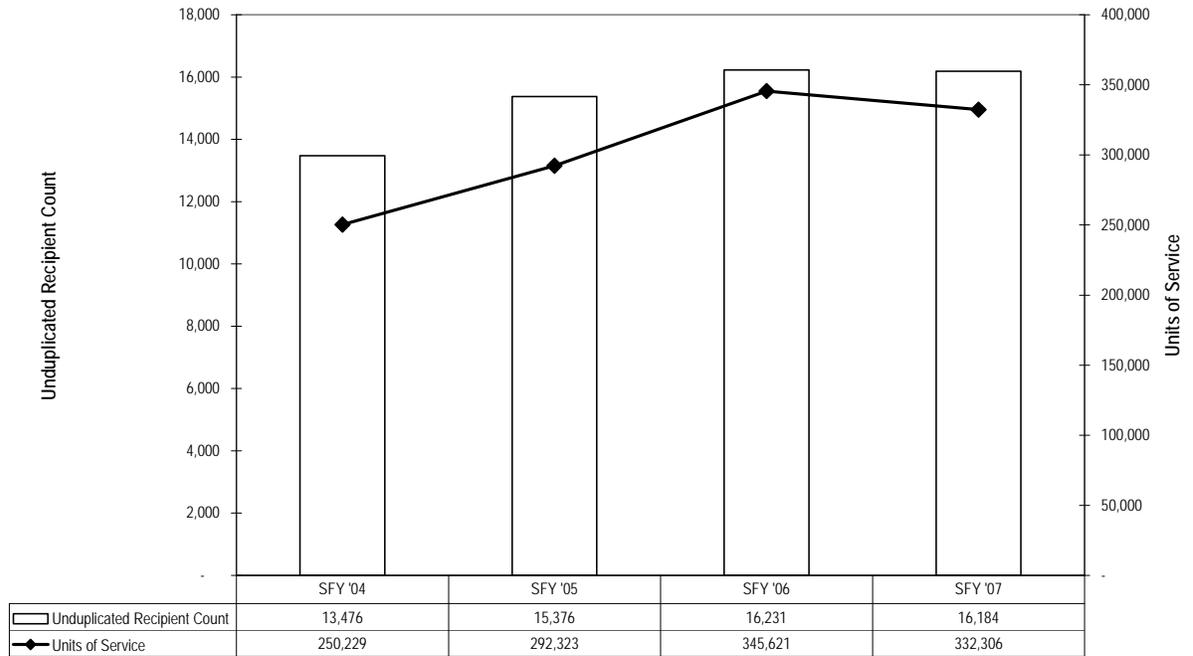
**Table 20: RHCs & FQHCs: Unduplicated Recipient Count to Numbers of Encounters**


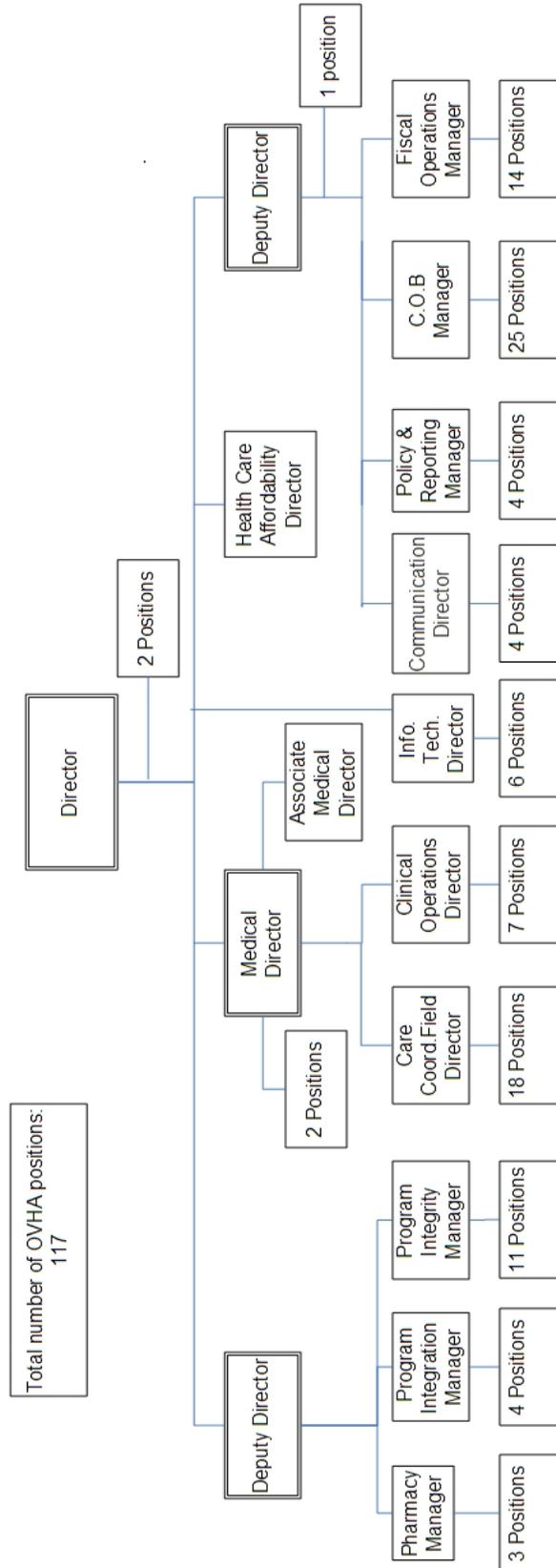
\* Number of Encounters are based on the number of times the encounter rate code is billed

**Table 21: Healthy Babies, Kids & Families Expenditures**


**Table 22: Healthy Babies, Kids & Families: Unduplicated Recipient Count to Units of Services**


**Table 23: Psychologist Expenditures**


**Table 24: Psychologist: Unduplicated Recipient Count to Units of Services**


**Appendix 1: Organization Chart**


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## Appendix 2: 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	OCS .....	Office of Child Support
LAMP .....	Legal Aid Medicaid Project	ODAP .....	Office of Drug & Alcohol Prevention
LAN .....	Local Area Network	OEO .....	Office of Economic Opportunity
LC .....	Legislative Council	OHRA .....	Oral Health Risk Assessment
LDO .....	Brattleboro District Office	OPS .....	Operations
LECC .....	Legally Exempt Child Care	OPPS .....	Outpatient Prospective Payment System
LIHEAP .....	Low-Income Home Energy Assistance Program	OTC .....	Over the Counter
LIS .....	Low-Income Subsidy	OVHA .....	Office of Vermont Health Access
LIT .....	Local Interagency Team	PA .....	Prior Authorization or Public Assistance
LTC .....	Long-Term Care	PACE .....	Program for All-Inclusive Care for the Elderly
LUPA .....	Low Utilization Payment Adjustment	PARIS .....	Public Assistance Reporting Information System
MA .....	Medicare Advantage – Medicare Part C in VT	PATH .....	Department of Prevention, Assistance, Transition, & Health Access (now DCF)
MAB .....	Medicaid Advisory Board	PBA/PBM .....	Pharmacy Benefits Administrator/Pharmacy Benefits Manager
MAC .....	Maximum Acquisition Cost	PC Plus .....	VT Primary Care Plus
MAC .....	Maximum Allowable Cost (refers to drug pricing)	PC .....	Personal Computer
MARS .....	Management & Administrative Reporting	PCCM .....	Primary Care Case Management
MAT .....	Medication Assisted Therapy	PCP .....	Primary Care Provider
MCO .....	Managed Care Organization	PDF .....	Portable Document File
MCP .....	Managed Care Plan	PDL .....	Preferred Drug List
MDB .....	Medicare Database	PDP .....	Pharmacy Drug Plan
MDO .....	Barre District Office	PDSA .....	Plan Do Study Act
MEQC .....	Medicaid Eligibility Quality Control	PEP .....	Proposal Evaluation Plan or Principal Earner Parent
MFRAU .....	Medicaid Fraud & Residential Abuse Unit	PERM .....	Payment Error Rate Measurement
MID .....	Beneficiary Medicaid Identification Number	PES .....	Provider Electronic Solutions
MIS .....	Management Information System	PHO .....	Physician Hospital Organization
MITA .....	Medicaid Information Technology Architecture	PI .....	Program Integrity
MMA .....	Medicare Modernization Act	PIL .....	Protected Income Level
MMIS .....	Medicaid Management Information System	PIRL .....	Plan Information Request Letter
MNF .....	Medical Necessary Form	PMPM .....	Per Member Per Month
MOE .....	Maintenance of Effort	PNMI .....	Private Non-Medical Institution
MOVE .....	Modernization of Vermont's Enterprise	POC .....	Plan of Care
MSIS .....	Medicaid Statistical Information	POS .....	Point of Sale or Point of Service
MSP .....	Medicare Savings Programs	PP&D .....	Policy, Procedures and Development (Interpretive Rule Memo)
MVP .....	Mohawk Valley Physicians	PPR .....	Planning, Policy and Regulation
NCBD .....	National CAHPS Benchmarking Database	PRO .....	Peer Review Organization
NDC .....	National Drug Code	PRWORA .....	Personal Responsibility & Work Opportunity Reconciliation Act
NDO .....	Newport District Office	PSE .....	Post-Secondary Education
NEKCA .....	Northeast Kingdom Community Action	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	QWDI .....	Qualified Working Disabled Individual
OADAP .....	Office of Alcohol & Drug Abuse Programs	RA .....	Remittance Advice
OASDI .....	Old Age, Survivors, Disability Insurance		

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 Agencies
RFP.....Requests for Proposals	VAHHS.....VT Association of Hospital & Health 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 Program
SAMHSA... Substance Abuse and Mental Health Services Administration	VHAT.....VT Health Access Team
SAS.....Statement on Auditing Standards	VIP.....VT Independence Project
SCHIP.....State Children's Health Insurance Program	VISION.....VT's Integrated Solution for Information and Organizational Needs (the statewide accounting system)
SDO.....Springfield District Office	VIT.....VT Interactive Television
SDX.....State Data Exchange System	VITL.....VT Information Technology Leaders
SE.....Systems Engineer	VLA.....VT Legal Aid
SEP.....Special Enrollment Periods	VMS.....VT Medical Society
SF.....Supplemental Fuel	VNA.....Visiting Nurses Association
SFY.....State Fiscal Year	VPHARM...VT Pharmacy Program
SLMB.....Specified Low-Income Medicare Beneficiary	VPQHC.....VT Program for Quality in Health Care
SMM.....State Medicaid Manual	VPTA.....Vermont Public Transportation Agency
SNF.....Skilled Nursing Facility	VR.....Vocational Rehabilitation
SPA.....State Plan Amendment	VRS.....Voice Response System
SPAP.....State Pharmacy Assistance Program	VSA.....VT Statutes Annotated
SRS.....Social & Rehabilitative Services (Department of)	VSAC.....VT Student Assistance Corporation
SSA.....Social Security Administration or State Self Assessment	VScript.....VT Pharmacy Assistance Program
SSI.....Supplemental Security Income	VSDS.....VT State Dental Society
SSN.....Social Security Number	VSEA.....VT State Employees Association
SUR.....Surveillance & Utilization Review	VSECU.....VT State Employees Credit Union
TAD.....Turnaround Documents	VSH.....VT State Hospital
TANF.....Temporary Assistance for Needy Families (Reach Up in VT)	VSHA.....VT State Housing Authority
TBI.....Traumatic Brain Injury	VT.....State of Vermont
TDO.....Bennington District Office	VTD.....VT Part D as Primary
TM.....Transitional Medicaid	VTM.....VT Medicaid as Primary
TPA.....Third Party Administrator	VUL.....VT Upper Limit
TPL.....Third Party Liability	WAM.....Welfare Assistance Manual
UC.....Unemployment Compensation	WIC.....Women, Infants & Children
UCR.....Usual & Customary Rate	WTW.....Welfare to Work
UI.....Unemployment Insurance	YDO.....Middlebury District Office
UIB.....Unemployment Insurance Benefits	ZDO.....State Office/Central Office (Waterbury)
UM.....Utilization Management	

### Appendix 3: Federal Poverty Level (FPL) Guidelines January 1, 2008 to December 31, 2008

#### Monthly

		Household Size							
		1	2	3	4	5	6	7	8
Percent of FPL	<b>50%</b>	436	586	736	886	1,036	1,186	1,336	1,486
	<b>75%</b>	654	879	1,104	1,329	1,554	1,779	2,004	2,229
	<b>100%</b>	871	1,171	1,471	1,771	2,071	2,371	2,671	2,971
	<b>120%</b>	1,045	1,405	1,765	2,125	2,485	2,845	3,205	3,565
	<b>125%</b>	1,089	1,464	1,839	2,214	2,589	2,964	3,339	3,714
	<b>133%</b>	1,159	1,558	1,957	2,356	2,755	3,154	3,553	3,952
	<b>135%</b>	1,176	1,581	1,986	2,391	2,796	3,201	3,606	4,011
	<b>150%</b>	1,307	1,757	2,207	2,657	3,107	3,557	4,007	4,457
	<b>175%</b>	1,524	2,049	2,574	3,099	3,624	4,149	4,674	5,199
	<b>185%</b>	1,612	2,167	2,722	3,277	3,832	4,387	4,942	5,497
	<b>200%</b>	1,742	2,342	2,942	3,542	4,142	4,742	5,342	5,942
	<b>225%</b>	1,960	2,635	3,310	3,985	4,660	5,335	6,010	6,685
	<b>250%</b>	2,178	2,928	3,678	4,428	5,178	5,928	6,678	7,428
	<b>275%</b>	2,395	3,220	4,045	4,870	5,695	6,520	7,345	8,170
	<b>300%</b>	2,613	3,513	4,413	5,313	6,213	7,113	8,013	8,913
<b>350%</b>	3,048	4,098	5,148	6,198	7,248	8,298	9,348	10,398	
<b>400%</b>	3,484	4,684	5,884	7,084	8,284	9,484	10,684	11,884	

#### Annually

		Household Size							
		1	2	3	4	5	6	7	8
Percent of FPL	<b>50%</b>	5,225	7,025	8,825	10,625	12,425	14,225	16,025	17,825
	<b>75%</b>	7,838	10,538	13,238	15,938	18,638	21,338	24,038	26,738
	<b>100%</b>	10,450	14,050	17,650	21,250	24,850	28,450	32,050	35,650
	<b>120%</b>	12,540	16,860	21,180	25,500	29,820	34,140	38,460	42,780
	<b>125%</b>	13,063	17,563	22,063	26,563	31,063	35,563	40,063	44,563
	<b>133%</b>	13,899	18,687	23,475	28,263	33,051	37,839	42,627	47,415
	<b>135%</b>	14,108	18,968	23,828	28,688	33,548	38,408	43,268	48,128
	<b>150%</b>	15,675	21,075	26,475	31,875	37,275	42,675	48,075	53,475
	<b>175%</b>	18,288	24,588	30,888	37,188	43,488	49,788	56,088	62,388
	<b>185%</b>	19,333	25,993	32,653	39,313	45,973	52,633	59,293	65,953
	<b>200%</b>	20,900	28,100	35,300	42,500	49,700	56,900	64,100	71,300
	<b>225%</b>	23,513	31,613	39,713	47,813	55,913	64,013	72,113	80,213
	<b>250%</b>	26,125	35,125	44,125	53,125	62,125	71,125	80,125	89,125
	<b>275%</b>	28,738	38,638	48,538	58,438	68,338	78,238	88,138	98,038
	<b>300%</b>	31,350	42,150	52,950	63,750	74,550	85,350	96,150	106,950
<b>350%</b>	36,575	49,175	61,775	74,375	86,975	99,575	112,175	124,775	
<b>400%</b>	41,800	56,200	70,600	85,000	99,400	113,800	128,200	142,600	

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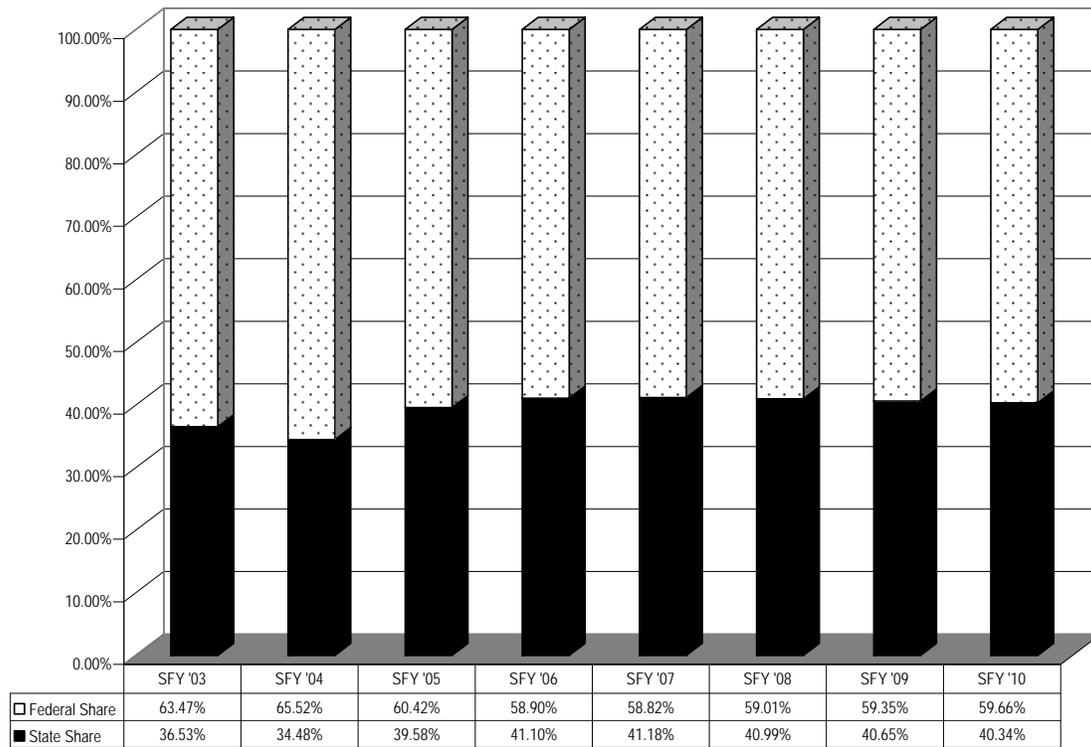
**Appendix 4: Federal Match Rates**

<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	59.73%	40.27%	2010	7/1/2009	6/30/2010	59.66%	40.34%
<i>projected FMAP rate</i>					<i>based on projected FMAP rate</i>				

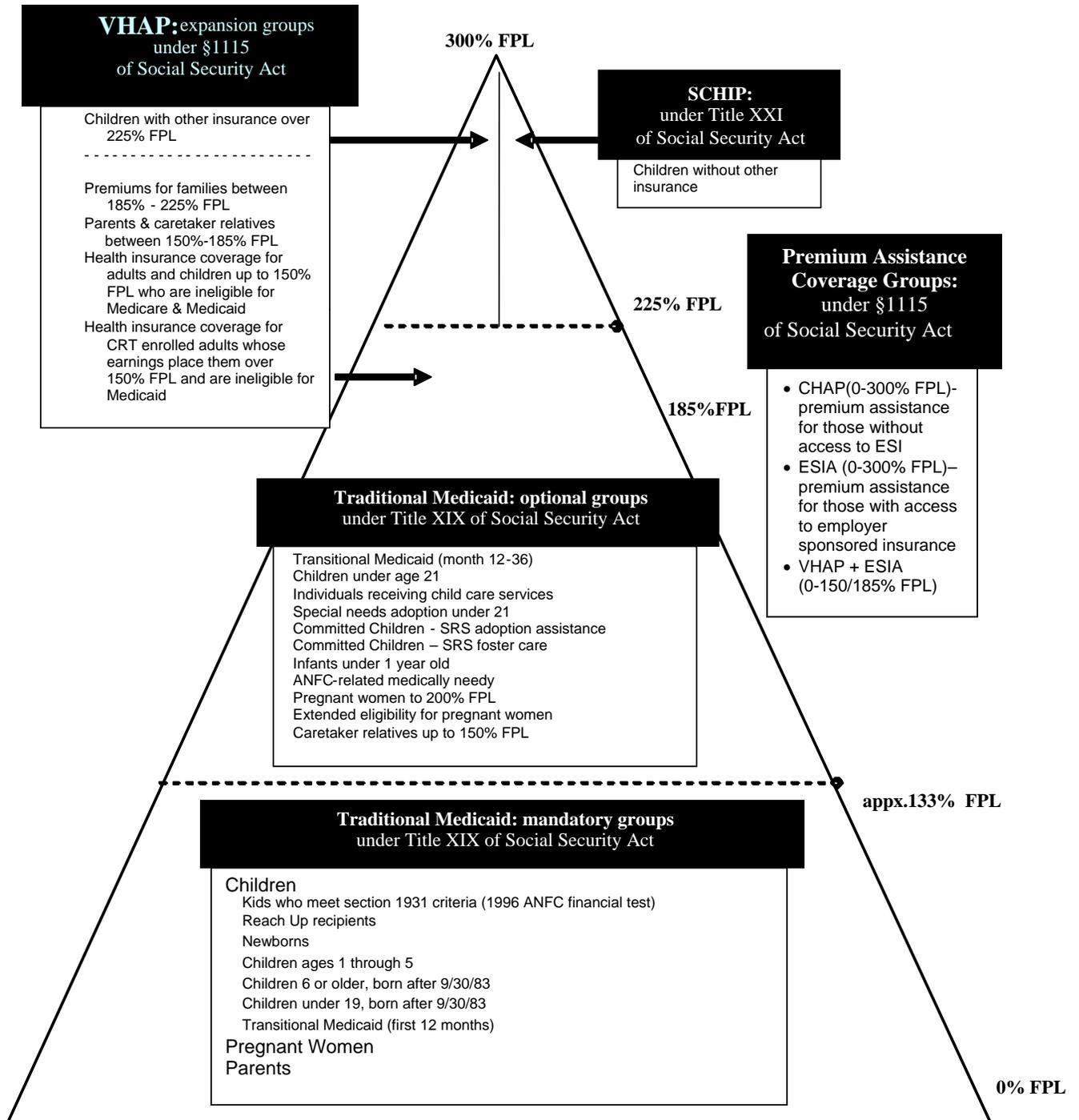
**Title XXI / SCHIP (program & admin):**

<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	71.81%	28.19%	2010	07/01/09	06/30/10	71.76%	28.24%
<i>Projected EFMAP</i>					<i>based on projected EFMAP</i>				

### Appendix 4: Federal Match Rates - Vermont Specific



## Appendix 5: Medicaid Coverage Groups for Children and Families



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To: Rep. Ann Pugh, Co-Chair, Health Access Oversight Committee (HAOC)  
Sen. Jeannette White, Co-Chair, Health Access Oversight Committee (HAOC)  
From: Joshua Slen, Director  
Date: September 25, 2007  
Subject: Act 65 Section 110g  
Deficit Reduction Act of 2005: Federal Upper Limit Impact on Vermont Medicaid  
Pharmacy Reimbursement  
cc: Maria Royle  
Don Dickey  
Jen Carbee  
Lynn Hegamy  
Heidi Tringe  
Ann Rugg

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Act 65 Section 110g states:

#### MEDICAID PHARMACY REIMBURSEMENT

(a) The office of Vermont health access shall conduct an analysis of the impact of the federal final rule revising the federal upper limits for prescription drug reimbursement under the Medicaid program after it is implemented by the Centers on Medicare and Medicaid Services. The analysis shall include recommended reimbursement levels and dispensing fees, any appropriation amount necessary to increase or maintain the reimbursements and fees to the recommended levels, the revenue impact on the office, and specific information on the impact on pharmacies. The office shall request pharmacies in Vermont to provide actual acquisition cost data in the form and format necessary to conduct the analysis. A pharmacy that does not provide the requested information for the analysis may be excluded from receiving any recommended increase in reimbursement or dispensing fees.

(b) The office shall provide an interim report on its analysis and recommendations to the health access oversight committee at its September 2007 meeting and a final report no later than November 15, 2007.

(c) As part of its annual report, the health access oversight committee shall provide a recommendation on the issues relating to the changes to reimbursement contained in the deficit reduction act to the house and senate committees on appropriations for inclusion in the budget adjustment bill and include a recommendation that any suggested changes be retroactive to the beginning of the fiscal year.

Vermont pharmacy programs reimburse for drugs using the lesser of:

- Average Wholesale Price (AWP) minus 11.9% plus the dispensing fee;
- the Federal Upper Limit (FUL) plus the dispensing fee;

- the OVHA Maximum Allowable Cost (MAC) plus the dispensing fee; or
- the usual and customary charge (U&C) including a dispensing fee.

The Deficit Reduction Act (DRA) of 2005 proposes that the Federal Upper Limit be based on Average Manufacturer Price (AMP) which has not been previously used for Medicaid reimbursement. To date manufacturers' published wholesale prices have been used to establish a ceiling or Federal Upper Limit (FUL) for cost reimbursement for generic drugs in federal programs when three or more generic equivalents are available. The DRA methodology will use AMP to establish the FUL for generic (also known as multi-source) drugs when two or more equivalents are available.

The impact of this change has been a question since the DRA was passed. With the University of Connecticut School of Pharmacy, the Office of Vermont Health Access prepared the Medicaid Generic Reimbursement Reductions and Dispensing Fee Study. This study was provided to the Legislature in January of this year. At that time it was acknowledged that with the use of generics in Vermont programs there could be a change in reimbursement to pharmacies. However, it was concluded that the full potential impact of the DRA could not be determined until federal rules proposed in December 2006 were finalized during 2007.

Since this spring OVHA has reviewed the AMP CMS has made available to states since last summer to assess if there is any correlation with the FULs currently available. To date there has been none.

On July 6, 2007, CMS released the final rules for the adoption of average manufacturer price as the basis for Medicaid reimbursement of generic drugs. These rules go into effect on October 1, 2007. The following outlines the highlights of these rules and the key dates the Centers for Medicare and Medicaid Services (CMS) have set:

1. The Federal Upper Limits (FULs) for multi-source generic drugs will be calculated based on Average Manufacturer Price (AMP). The calculation methodology will change from 150% of the lowest average wholesale price (AWP) within a group of equivalents to 250% of the lowest average manufacturer price (AMP) within a group of equivalents.

October 1 through October 31, 2007 is the first reporting period for manufacturers to report AMP to be used under the regulation.

2. In addition to the change in the FUL calculation's source data, the number of generics that are subject to FUL reimbursement will increase. Currently, the definition of multi-source drug includes drugs that have at least three therapeutically equivalent versions sold by at least three suppliers. Effective October 1, 2007, the definition will change to include drugs where there is at least one other drug sold and marketed as a therapeutic equivalent by another supplier. The definition of therapeutic equivalent includes brands, authorized generics and true generics. The expectation is that with this change more drugs will be subject to the FUL calculation.
3. CMS will use the reported AMP to calculate the new FUL for multi-source drugs as defined under the regulation.

4. The first newly calculated FUL based on the October 2007 AMPs will be made available to states by December 30, 2007 and the effective date will be January 30, 2008. This will be the earliest date that pharmacies will see any FUL changes.

The process and time frames set by CMS ultimately mean that Vermont will not be able to estimate the impact of this change until the October AMPs are available. As a result, OVHA will not be able to make recommendations for any changes before November 2007.

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## MEMORANDUM

**TO:** Sen. Susan Bartlett, Chair, Senate Appropriations Committee  
Rep. Martha Heath, Chair, House Appropriations Committee

**CC:** Rep. Ann Pugh, Chair, Health Access Oversight Committee  
Cindy LaWare, Secretary, Agency of Human Services

**FROM:** Joshua Slen, Director

**DATE:** November 14, 2007

**RE:** Act 65 Section 110g: Deficit Reduction Act of 2005: Federal Upper Limit Impact on Vermont Medicaid FUL/AMP Report

The Office of Vermont Health Access (OVHA) respectfully requests the Joint Fiscal Committee approve the delayed filing of the report required by Act 65, Section 110g.

The federal Deficit Reduction Act (DRA) of 2005 proposes that for purposes of Medicaid reimbursement for drugs available from multiple manufacturers that an established pricing standard, the Federal Upper Limit (FUL), be based on Average Manufacturer Price (AMP). To date manufacturers' published wholesale prices have 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 are available. The DRA methodology will use AMP to establish the FUL for multi-source drugs when two or more equivalents are available.

Vermont's Act 65 Section 110g states that the OVHA will 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. This analysis is to include:

- recommended reimbursement levels and dispensing fees,
- any appropriation amount necessary regarding the recommended levels and fees,
- the revenue impact on OVHA, and
- information on the impact on pharmacies.

The final analysis was to be presented to the Health Access Oversight Committee no later than November 15, 2007. (c) so that as part of its annual report, a recommendation could be provided to the house and senate committees on appropriations on the issues relating to the changes to reimbursement that might impact on the budget adjustment bill.

At the Health Access Oversight Committee meeting on November 13, 2007, OVHA indicated that this analysis cannot be completed by the required date because the information supporting the analysis is

dependent on CMS establishing the FULs according to the requirements of the final rule. Those FULs will not be available until December 31, 2007.

To date all states believed that they would be able to obtain the components of the calculation in sufficient detail to make it possible to determine what the FUL would be on each affected drug. However, one critical piece in the calculation is not available and that is identifying what drugs are in each designated “FUL group” to which the calculation applies. CMS has not provided drug listings by group. In a conference call on October 25<sup>th</sup> CMS indicated that the groups were not yet finalized and, thus, could not be made available. They further indicated that it appeared unlikely that they will be finalized until the first set of new FULs is completed. The result is that states cannot establish the impact of the change between now and then.

At the Health Access Oversight Committee meeting on November 13<sup>th</sup>, OVHA committed to preparing the required analysis and recommendations and providing the report on January 15<sup>th</sup>, 2008. Even though meeting this deadline hinges on information not available until December 31<sup>st</sup>, OVHA has built an analysis model that can determine the impact of this change in this timeframe. The model identifies all drugs by individual NDCs (National Drug Codes). The model can determine what products the new FUL will apply to and compare the new pricing to current pricing. The model will then apply the resulting change to actual utilization to establish the impact.

OVHA has agreed to provide the Health Access Oversight Committee with more details on its analysis model including what data will be used and the steps that will occur to develop the analysis at their December 11, 2007 meeting. At that time, OVHA also plans to provide the Committee with a template of the report that will be made available from the analysis.

**TO:** The Health Access Oversight Committee

**FROM:** Joshua Slensky, Director

**CC:** Cynthia D. LaWare, Secretary, Agency of Human Services

**DATE:** December 11, 2007

**RE:** Analytical Framework: Federal Deficit Reduction Act of 2005: Federal Upper Limit Impact on Vermont Medicaid Pharmacy Reimbursement

The federal Deficit Reduction Act (DRA) of 2005 proposes that for purposes of Medicaid reimbursement for drugs available from multiple manufacturers that an established pricing standard, the Federal Upper Limit (FUL), be based on Average Manufacturer Price (AMP). AMP is defined as the average unit price paid to the manufacturer for the drug in the United States by wholesalers for drugs distributed to “the retail pharmacy class of trade” including cash discounts and all other price reductions unless otherwise excluded by law or regulations.

To date manufacturers’ published wholesale prices have 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 are available. The DRA methodology will use AMP to establish the FUL for multi-source drugs when two or more equivalents are available.

Vermont’s Act 65 Section 110g states that the Office of Vermont Health Access (OVHA) will 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. This analysis is to include:

- recommended reimbursement levels and dispensing fees,
- any appropriation amount necessary regarding the recommended levels and fees,
- the revenue impact on OVHA, and
- information on the impact on pharmacies.

The final analysis was to be presented to the Health Access Oversight Committee no later than November 15, 2007. At the Health Access Oversight Committee meeting on November 13, 2007, OVHA indicated that this analysis could not be completed by the required date because the information supporting the complete and accurate analysis is dependent on CMS establishing the FULs according to the requirements of the final rule including all the exceptions and conditions. Those FULs will not be available until December 31, 2007.

While the components of the process that CMS will utilize in establishing the new pricing are known and are listed below, it is not possible, prior the final release of information by CMS, to accomplish an accurate estimate of the impact on Vermont.

1. Identify affected drugs using the FDA Orange Book where
  - a. There are at least two (2) equivalent multiple source drugs ("A" rated drugs; that is, considered bioequivalent to the original brand-name drug) and
  - b. The drugs have at least two (2) market suppliers.
2. Apply methodology
  - a. Establish at 250% of lowest AMP in the FUL "group" (the 250% adjustment is intended to reflect the costs and revenue expectations of wholesalers in providing the drugs to pharmacies and pharmacies in dispensing them to the public).
  - b. Exclude
    - i. Terminated drugs (no longer available in the market),
    - ii. Outlier AMPs (where AMP is less than 40% of the next lowest AMP in the FUL "group"), and
    - iii. "B" rated drugs ("B" rated; that is, have not been demonstrated to be bioequivalent by *in vivo* test).

To illustrate the application, the following might represent the establishment in a FUL "group" with three drugs:

- AMP #1       \$ 3.90
- AMP #2       \$10.00
- AMP #3       \$15.00

The FUL for each drug in the group would be set based on drug #2 because the lowest drug in the group (drug #1) is an outlier at less than 40% of drug #2. The FUL for the whole group would be 250% of drug #2 or \$25.

The critical piece in the application of the process that has not been available is identifying what drugs are in each designated FUL "group" to which the methodological process applies. At last report in November, OVHA indicated that in a conference call on October 25<sup>th</sup> CMS indicated that the groups were not yet finalized and, thus, could not be made available. They further indicated that it appeared unlikely that the groups would be fully finalized until the first set of new FULs was completed. The final list of FULs will become available on December 31, 2007.

OVHA is committed to preparing the required analysis and recommendations and providing the report on January 15th, 2008, even though meeting this deadline hinges on information not available until December 31<sup>st</sup>.

The Analytic Framework to be Utilized by OVHA:

The OVHA model for estimating the impact will organize drugs by the FUL groups.

Within the groups all affected multi-source drugs will be identified by individual NDCs (National Drug Codes) with actual data on drug claims paid by Vermont's programs on those NDCs in the fourth quarter of calendar year 2007. Details captured or calculated on all NDCs will include:

- NDC
- Product name
- Group number
- Rx's (number of scripts)
- Total quantity (units)
- Total ingredient cost paid
- Average ingredient cost per quantity
- New FUL (as newly established by CMS)
- Lower price per quantity (identified as pricing methodology)

The average ingredient price will be reported based on how it was priced at the time the claim was priced using the pricing methodology used by Vermont programs to pay for drug ingredients. This is the lesser of:

- Average Wholesale Price (AWP) minus 11.9%
- FUL
- Maximum Allowable Cost (MAC) where established on multi-source drugs
- The pharmacy's billed usual and customary (U&C) charge for ingredients (the U&C adjusted to account for a dispensing fee reflected in the U&C)

The model will then apply on an NDC level for those NDCs impacted the new FUL price per unit to the total quantity in the analysis period. Comparing the result to what was paid under the old pricing results in the difference between the old and the new.

Reported will be the same information as above adding:

- Calculated new FUL ingredient cost for quantities dispensed
- Difference in ingredient cost as priced when processed and when priced with new FUL

The model will then summarize the details of the analysis reporting:

- NDCs and claims
- NDCs and claims where current pricing is less than the new FUL and the percentage of totals

- NDCs and claims where current pricing is more than the new FUL and the percentage of totals
- NDCs and claims where current pricing is less than the new FUL and the percentage of totals and the breakdown of those by pricing methodology
- Summary estimated financial impact

To illustrate, attached is a template of the planned report that will be made available from this analysis.

While this will serve as the first report of impact on pharmacies, in time, the real impact will change. CMS has indicated that the purpose of this rule is to allow Medicaid to pay more appropriately for prescription drugs and to bring transparency to drug prices. In the process CMS expects the FULs to be more meaningful in reflecting reasonable pricing. It has been reported that initially the affect might seem dramatic because pharmacies may be stocking products where costs are at the high end of the FUL group. However, it is believed by CMS that in a short time pharmacies will opt to choose products available from wholesalers/suppliers at or below the FUL price for the group.

National federal Medicaid savings estimates as a result of FUL are \$8 billion nationally over five years. With an expected shift to lowest cost products within therapeutic groups CMS anticipates that while this will be a 5.6% reduction in Medicaid drug spending, this will only result in a 1% reduction in drug revenue to retail pharmacies. Thus, CMS is cautioning states in two areas, adjusting reimbursement to accommodate individual drug prices and immediately changing dispensing fees to make up for identified losses in ingredient reimbursement.

The regulations expressly indicate that FUL pricing applies in the aggregate to all FUL drug expenditures. This means that the payment for individual drugs may be reimbursed at a level different from the limits established but the payment of all affected multi-source drugs cannot vary from the required FUL calculation in the aggregate.

CMS has indicated to states that Medicaid State Plan Amendments will need to be submitted and approved on dispensing fee changes and CMS has indicated that such proposals must be justified for reasons other than changes in pharmacy revenues.



**Office of Vermont Health Access  
 AMP Analysis**



Q4 2007 Data	
Total NDCs with Utilization -- Multi-source Only	#
# of NDCs where MHP Utilization Pricing was less than New FUL	# %
# of NDCs where New FUL was less than MHP Utilization Pricing	# %
Total # of Claims -- Multi-source Only	#
# of Claims where MHP Utilization Pricing was less than New FUL	# %
# of Claims where New FUL was less than MHP Utilization Pricing	# %

Q4 2007 Data Where New FUL is less than MHP Utilization Pricing -- Multi-source Only			
	Total	% to Total	
NDCs	#		%
Rx's	#		%
Price Type Breakout	Rx's	% of Rx's	
AWP	#		%
FUL	#		%
MAC	#		%
U&C	#		%
Totals	0		%

MHP = MedMetrics Health Partners  
 New FUL = FUL group price calculated at 250% of the AMP of the NDC that has the lowest AMP in the FUL group

Estimated Financial Impact				
Rx's	Rx's	MHP Utilization Pricing	FUL Pricing	Difference in Ingred Cost
	#	\$	\$	\$
	0	\$0.00	\$0.00	\$0.00

Report Fields:

**NDCs Impacted by New FUL change**

NDC	Product Name	Group Number	Rx's	Total Qty	Total Ingred Cost Paid	Avg Ingred Cost per Qty	New FUL	Lower Price per Qty	New FUL Ingred Cost	Difference in Ingred Cost
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**All NDCs**

NDC	Product Name	Group Number	Rx's	Total Qty	Total Ingred Cost Paid	Avg Ingred Cost per Qty	New FUL	Lower Price per Qty
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**TO:** Sen. Susan Bartlett, Chair, Senate Appropriations Committee  
Rep. Martha Heath, Chair, House Appropriations Committee

**CC:** Rep. Ann Pugh, Chair, Health Access Oversight Committee  
Cynthia D. LaWare, Secretary, Agency of Human Services

**FROM:** Joshua Slen, Director

**DATE:** January 15, 2008

**RE:** Act 65 Section 110g Analysis: Federal Deficit Reduction Act of 2005: Federal Upper Limit Impact on Vermont Medicaid Pharmacy Reimbursement

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The federal Deficit Reduction Act (DRA) of 2005 proposes 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).

Vermont's Act 65 Section 110g states that the Office of Vermont Health Access (OVHA) will 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. This analysis is dependent on CMS establishing the FULs according to the requirements of the final rule. Those FULs were scheduled to be available on December 31, 2007.

On November 7, 2007, the National Association of Chain Drug Stores (NACDS) and the National Association of Community Pharmacists (NCPA) filed a lawsuit against CMS and the U.S. Department of Health and Human Services regarding this change. 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 that forbids the disclosure of data on the AMPs and also forbids the implementation of any reimbursement cuts. This order was issued on December 19, 2007. On December 21, 2007, CMS notified states that the AMPs would not be provided to Medicaid State Agencies and that AMPs would not be used in the calculation of the FUL until further notice. Copies of the order and the CMS letter are attached here for reference.

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.

Attachments: AMP Federal Court Order 12/19/2007  
CMS Response to Federal Court Order 12/21/07

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3. The harm that will result to Plaintiffs' member pharmacies as a result of Defendants' actions outweighs any harm that may result to Defendants as a result of preliminary injunction; and

4. Issuance of a preliminary injunction will serve the public interest as it is in the public interest for federal departments and agencies to operate in compliance with the law and Medicaid beneficiaries may find access to their retail community pharmacies reduced or eliminated should the injunction not be issued.

Therefore, it is hereby

ORDERED that Plaintiffs' Motion is GRANTED for the reasons stated above and on the record in open court at the conclusion of the hearing on December 14, 2007; and it is further

ORDERED that Defendants United States Department of Health and Human Services ("HHS"), HHS Secretary Leavitt, Centers for Medicare and Medicaid Services ("CMS"), and CMS Acting Administrator Weems, as well as HHS and CMS officers, agents, servants, employees, and attorneys be and hereby are enjoined, until further order of this Court, from:

a. Undertaking any and all action to implement the AMP Rule to the extent such action affects Medicaid reimbursement rates for retail pharmacies under the Medicaid program. Defendants may, however, continue to require drug manufacturers to make AMP calculations and best price calculations under the AMP Rule for purposes of calculating rebates paid to States in the Medicaid program; and

b. Posting any AMP data on a public website or otherwise disclosing any AMP data to any individuals or entities, including but not limited to States and their representatives or agencies, except that Defendants may disclose AMP data within the U.S. Department of Health and Human Services or to the U.S. Department of Justice for their internal use or enforcement activities only.

SO ORDERED.

Signed by Royce C. Lamberth, United States District Judge, on December 19, 2007.

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DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S2-14-26  
Baltimore, Maryland 21244-1850



Center for Medicaid and State Operations  
Disabled and Elderly Health Programs Group (DEHPG)

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December 21, 2007

Dear State Medicaid Directors,

The United States District Court for the District of Columbia has issued a preliminary injunction that enjoins CMS from implementing the final rule with comment concerning Average Manufacturer Prices (AMPs) to the extent that it affects Medicaid reimbursement rates for retail pharmacies under the Medicaid program. The order also enjoins CMS from disclosing AMP data to certain individuals or entities, including States or their representatives. A copy of the Order is attached to this letter.

As a result of this preliminary injunction, CMS will not be posting AMPs or Federal Upper Limits (FULs) on our website in late December 2007 despite the schedule we provided for such postings when the final rule with comment was published on July 17, 2007. Consequently, the schedule for States to implement the new FULs will be delayed until further notice. In addition, CMS is suspending the sending of monthly files of AMPs to States.

The preliminary injunction does not affect the use of AMP as defined in the July 17, 2007 final rule with comment for purposes of the Medicaid drug rebate program. Therefore, drug manufacturers will continue to report AMPs in accordance with the provisions of the July 17, 2007 rule and CMS will continue to issue unit rebate amounts (URAs) to the States based on the quarterly manufacturer submissions.

Sincerely,

A handwritten signature in black ink that reads "Gale P. Arden". The signature is written in a cursive style.

Gale P. Arden  
Director

Attachment

cc:

CMS Regional Administrators

CMS Associate Regional Administrators  
for Medicaid and State Operations

Martha Roherty  
Director, Health Policy Unit  
American Public Human Services Association

Dennis Smith  
Director  
Center for Medicaid & State Operations

Bill Lasowski  
Center for Medicaid & State Operations

David Hoskins  
Office of General Council

Winnie Pizzano  
Office of External Affairs

Susan McNally  
Office of Legislation

Laura Caliguiri  
Office of the Secretary

Deirdre Duzor  
Director, Division of Pharmacy  
Disabled & Elderly Health Programs Group

Larry Reed  
Technical Director, Division of Pharmacy  
Disabled & Elderly Health Programs Group

To: Rep. Ann Pugh, Co-Chair, Health Access Oversight Committee (HAOC)  
Sen. Jeannette White, Co-Chair, Health Access Oversight Committee (HAOC)

From: Joshua Slen, Director

Date: July 24, 2007

Subject: Grievance & Appeal Database Fields & Reporting

cc: Maria Royle  
Don Dickey  
Lynn Hegamy  
Esther Perelman

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At the Health Access Oversight Committee (HAOC) meeting on July 10, 2007, the HAOC asked about the type of data being tracked in the Grievance and Appeal Database and the reporting that will be generated based on that data.

First, the attached document "Grievance & Appeal Database Fields" lists the fields that comprise the Grievance and Appeal Database. To the extent possible, the State will compile the relevant data to complete the database fields and thus retain a comprehensive record.

Second, reports can be generated based on most of the database fields. For internal purposes, reports will indicate all of the necessary information to reach an informed decision. However, because of the sensitivity and confidentiality of much of the data in the database, reporting to the Legislature will be done in the aggregate and will exclude fields where an individual or group of individuals can be identified.

A report to the Legislature may contain such reporting elements as: number of grievances, appeals, and fair hearings; types of issues; and resolutions. Report formats are currently being developed. Reports will be issued to the Legislature every six months (per Act 65) with the first report due to the Legislature in January 2008 for the period July 1, 2007 – December 31, 2007.

Enc. Grievance & Appeal Database Fields

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All grievances and appeals will be recorded in the grievance and appeal database. The grievance and appeal database includes the following information:

**All Cases Data Fields:**

- Beneficiary Information (last name, first name, SSN, DOB, Gender, Phone #, extension, Alternate phone #, Alt. extension, address, city, state, zip)
- If needed, based on who filed:
  - Representative Information (last name, first name, Phone #, extension, Alternate phone #, Alt. extension, address, city, state, zip)
  - Provider Information (last name, first name, Phone #, extension, Alternate phone #, Alt. extension, address, city, state, zip)
- Source (Beneficiary, Beneficiary Rep or Provider {appeals only})
- AHS Office Responsible (DAIL, DCF, OVHA, VDH)
- AHS Office Division (i.e. VDH: SCHN, ADAP, Mental Health)
- Specific Entity (DA/SSA)
- Medicaid Program (i.e. Dr. Dynasaur, VHAP, VPharm)
- Specific Program (i.e. Adult Mental Health, Emergency Services, TBI, Choices for Care)
- AHS District Office (Barre, Bennington, Brattleboro, Burlington, etc.)
- Service Category (i.e. Supplies, Physical Therapy, Dental)
- Case Assigned to (dropdown list of authorized users – G&A Coordinators)
- Copy to (dropdown list of authorized users – G&A Coordinators)
- Case Originator (person entering data)
- Person Deciding Appeal/Addressing Grievance
- Date Filed
- Due Date [automatically calculated]
- Date Information Input [automatically calculated]
- Date of Notice of Action (appeal) or Pertinent Issue (grievance)
- Action Appealed/Pertinent Issue
- Date Written Acknowledgment Letter Due [automatically calculated]
- Date Written acknowledgement Letter Done
- Document and Letter “Storage” able to upload copies of letters.
- Notes field
- Case Reassignment & Reassignment History
- If case is withdrawn:
  - Date Withdrawn
  - Is it Orally Withdrawn or In Writing?
  - If Orally, Date Letter Due [automatically calculated]
  - If Orally, Date Letter Done
- If a Fair Hearing is filed:
  - Date Filed
  - Outcome/Decision (Upheld, Reversed, Withdrawn, Modified)
  - Decision Date

**For Grievances:**

- Date Addressed
- Date Letter Sent
- If a Grievance Review is Requested:
  - Date Review Requested
  - Date Review Acknowledged
  - Person Addressing Grievance Review
  - Date Grievance Review Findings Letter Done

**For Appeals:**

- Meeting Date
- Type of action appealed [based on rule language]
- Did the beneficiary request that their services be continued? Yes/No
- If so, did the request meet criteria? Yes/No/NA
- Expedited: Did it meet criteria or not?
- If it did not meet expedited criteria:
  - Oral Notification Date Due
  - Oral Notification Date Done
  - Written Notification Letter Date Due
  - Written Notification Letter Date Done
- Extended requested by (Beneficiary or MCO)
- If extended by MCO, date written letter done
- [New appeal due date automatically calculated]
- Resolution/Decision Date
- Resolution (Upheld, Reversed, Modified)
- Resolution/Decision Letter Date

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

**From:** Joshua Slen, 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, 2007 – December 31, 2007  
Choices For Care Grievance and Appeal Report: July 1, 2007 – December 31, 2007

**Date:** January 15, 2008

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 grievances and 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 first semi-annual report on the implementation of the Grievance and Appeal process.

Act 65, Sec. 111a. Global Commitment; Grievance And Appeal Rules: Beginning January 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.

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 the first report period (July 1, 2007 – December 31, 2007), there were 22 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. Approximately half of these grievances related to quality of service. The breakdown of topic areas is in the attached data summary.

During the first report period (July 1, 2007 – December 31, 2007), there were no grievances filed for the DAIL Choices for Care program.

- 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 the first report period (July 1, 2007 – December 31, 2007), there were 17 appeals filed with the MCO. Of the 17 appeals, 12 were resolved within the first reporting period (71%). In nine cases (75% of those resolved), the original decision was upheld by the hearing officer. There were no cases reversed or modified from the original decision, two were withdrawn (17%) and one was approved as a result of the information received at the appeal meeting (8%).

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 13 appeals for a denial or limitation of authorization of a requested service or eligibility for service (76%), one was for a reduction/suspension/termination of a previously authorized covered service or service plan (6%), two were for a denial, in whole or in part, of payment for a covered service (12%), and one case has not had its category entered yet (6%).

During the first report period (July 1, 2007 – December 31, 2007), there were seven appeals filed in the Choices for Care program. There were no requests for an expedited appeal. Of those seven appeals, none have been resolved within this first reporting period. 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 seven appeals, five were for a denial or limitation of authorization of a requested service or eligibility for service (71%), and two were for a reduction/suspension/termination of a previously authorized covered service or service plan (29%).

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. Although there have been nine appeals that have not been decided in the individual's favor for the MCO, none of these have gone to a fair hearing yet. Of the two cases that have gone to fair hearing, one was filed simultaneously with the appeal and the other was filed after the appeal was withdrawn. For the Choices for Care program, during this period there were no fair hearings filed with the appeals.

Medicaid MCO Legislative Grievance and Appeal Report  
 Data Summary  
 July 1, 2007 – December 31, 2007

 Number of Grievances filed: 22

## Number by Category:

Staff/Contractor:	<u>7</u>
Program Concern:	<u>3</u>
Management:	<u>1</u>
Policy or Rule Issue:	<u>2</u>
Quality of Service:	<u>11</u>
Service Accessibility:	<u>6</u>
Timeliness of Service Response:	<u>6</u>
Service Not Offered/Available:	<u>4</u>
Other:	<u>4</u>

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

 Number of Appeals Filed: 17

Regular Appeals:	<u>17</u>
Expedited (met criteria) Appeals:	<u>0</u>

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

 Number Resolved: 12

Number Upheld:	<u>9</u>
Number Reversed:	<u>0</u>
Number Modified:	<u>0</u>
Number Withdrawn:	<u>2</u>
Number Approved by Dept/DA/SSA:	<u>1</u>

*"Approved by Dept/DA/SSA" is when additional information received allowed the department/DA/SSA that made the original decision to reverse itself without a decision from the person hearing the internal appeal.*

## Number by "Action" Category:

Denial or limitation of authorization of a requested service or eligibility for service:	<u>13</u>
Reduction/suspension/termination of a previously authorized covered service or service plan:	<u>1</u>
Denial, in whole or in part, of payment for a covered service:	<u>2</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>

 Number of Fair Hearings Filed with an Appeal: 2

(these are fair hearings filed during this reporting period that have also had an appeal filed for the same action)

 Number of Pending Fair Hearings with an Appeal: 2

*The number of pending and resolved fair hearings may not add up to the number filed, since a fair hearing may span two report periods.*

 Number of Resolved Fair Hearings with an Appeal: 0

Number Upheld:	<u>0</u>
Number Reversed:	<u>0</u>
Number Modified:	<u>0</u>
Number Withdrawn:	<u>0</u>

Choices for Care Legislative Grievance and Appeal Report  
 Data Summary  
 July 1, 2007 – December 31, 2007

 Number of Grievances filed:   0  

## Number by Category:

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

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

 Number of Appeals Filed:   7  

Regular Appeals:	<u>  7  </u>
Expedited (met criteria) Appeals:	<u>  0  </u>

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

 Number Resolved:   0  

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

*"Approved by Dept/DA/SSA" is when additional information received allowed the department/DA/SSA that made the original decision to reverse itself without a decision from the person hearing the internal appeal.*

## Number by "Action" Category:

Denial or limitation of authorization of a requested service or eligibility for service:	<u>  5  </u>
Reduction/suspension/termination of a previously authorized covered service or service plan:	<u>  2  </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>

 Number of Fair Hearings Filed with an Appeal:   0  

(these are fair hearings filed during this reporting period that have also had an appeal filed for the same action)

 Number of Pending Fair Hearings with an Appeal:   0  

*The number of pending and resolved fair hearings may not add up to the number filed, since a fair hearing may span two report periods.*

 Number of Resolved Fair Hearings with an Appeal:   0  

Number Upheld:	<u>  0  </u>
Number Reversed:	<u>  0  </u>
Number Modified:	<u>  0  </u>
Number Withdrawn:	<u>  0  </u>

## MEMORANDUM

TO: Health Access Oversight Committee

CC: Cindy LaWare, AHS Secretary

FROM: Joshua Slen, Director

DATE: November 13, 2007

RE: Act 80 Implementation update

The major obstacle to implementation of this legislation is the funding. There are major new programs that require permanent new staff. There are also ongoing systems, monitoring and auditing costs. The funding source is the manufacturers' fee and that fee will not be collected this fiscal year. Below are the items that require action on the part of OVHA.

1. Establish a Joint Pharmaceutical Purchasing Consortium;
2. Collect drug pricing information from manufacturers;
3. Negotiate rebates for the Healthy Vermonters Program;
4. Notify beneficiaries of changes to the Preferred Drug List;
5. Establish an evidence-based prescription drug education program;
6. Establish a generic drug voucher pilot program;
7. Collect a fee from pharmaceutical manufacturers;
8. Produce a report on the drug voucher pilot program;
9. Promulgate rules regarding manufacturers' responsibilities in providing marketing information to prescribers.

Implementation of this legislation poses the following challenges:

1. **Establish a Joint Pharmaceutical Purchasing Consortium.**  
The Joint Pharmaceutical Purchasing Consortium represents a substantial increase in workload and requires new permanent staffing. The staffing associated with this section of the legislation has no current year funding.
2. **Collect drug pricing information from manufacturers.**  
This is an area where OVHA will be promulgating rules to support the collection of drug pricing information from manufacturers and collecting, maintaining and reporting on the pricing information. The rule promulgation is moving forward. However, the ongoing collection, maintenance and reporting will require permanent new staffing. The staffing associated with this section of the legislation has no current year funding.
3. **Negotiate rebates for the Healthy Vermonters Program.**  
The federal waiver request required in order to implement the rebates for the Healthy Vermonters Program has been submitted. The timing of a response from our federal partner is uncertain at this time.

4. **Notify beneficiaries of changes to the Preferred Drug List.**  
This has been completed for this year by OVHA, and will be done annually.
5. **Establish an evidence-based prescription drug education program.**  
This is a Vermont Department of Health lead, however with substantial collaboration from OVHA requiring permanent staff support in order to develop guidelines, build work plans, monitor ongoing program operations and to report on outcomes. The staffing associated with this section of the legislation has no current year funding.
6. **Establish a generic drug voucher pilot program.**  
This is a Vermont Department of Health lead. However, it requires substantial OVHA support in order to operationalize the pilot voucher program. This will include program design as well as ongoing permanent duties associated with payment, tracking, program integrity and reporting. The staffing associated with this section of the legislation has no current year funding. This activity will also require claims processing support through MedMetrics.
7. **Collect a fee from pharmaceutical manufacturers.**  
The collection of the manufacturers' fees requires permanent staff support to collect and process the fees. The staffing associated with this section of the legislation has no current year funding. New tracking and record retention as well as reporting will require permanent system support.
8. **Produce a report on the drug voucher pilot program.**  
The production of the pilot voucher report would be completed by the same staff providing support for the evidence based education program, the voucher pilot program and the manufacturers' fee collection program
9. **Promulgate rules regarding manufacturers' responsibilities in providing marketing information to prescribers.**  
The OVHA is required to promulgate rules in support of this section of the legislation. No action to date. The OVHA is working with the Office of Attorney General on the appropriate next steps.

In summary, the challenges of implementing all of the provisions of the Act 80 legislation come down to one issue. The collection of the manufacturers fee supports all of the legislation's mandates. This fee will not be collected prior to October 2008, as the legal action surrounding it will not be resolved prior to that time. Due to this lack of funding, no staff or contractual resources are available to perform the majority of the activities required by the legislation.

The OVHA is moving forward on the pieces of the legislation that place us in the position to rapidly implement different sections, once decisions regarding funding and staffing are made. However, most of the legislation's provisions will not be implemented this fiscal year as a result of the funding delays.

**MEMORANDUM**

**TO:** The Health Access Oversight Committee

**CC:** Cynthia D. LaWare, AHS Secretary

**FROM:** Joshua Slen, Director

**DATE:** December 11, 2007

**RE:** Act 80 Rule Drafting for Sec. 20

Act 80, an Act relating to increasing transparency of prescription drug pricing and information, established a manufacturer fee under 33 V.S.A. § 2004, in the 2007 legislative session. The statute directs the Secretary of the Agency of Human Services or a designee to make rules for the implementation of the portion of the statute dealing with the manufacturer fee.

This statute establishes a fee on pharmaceutical manufacturers and labelers of prescription drugs that are paid for by the Office of Vermont Health Access in order to fund the collection and analysis of information on pharmaceutical marketing activities under sections 4632 and 4633 of Title 18, analysis of prescription drug data needed in enforcement activities by the attorney general's office, and the evidence-based education program established in subchapter 2 of Title 18. The fees will be deposited in the evidence-based education and advertising fund.

The effective date for this rule was originally May 1, 2007. The final draft was sent to the Medicaid Advisory Board on Monday, October 8, 2007 and returned, without comment, on Monday, October 15, 2007. The rule was sent for signature to the Secretary of the Agency of Human Services on Friday, October 19, 2007. The rule was returned unsigned. The effective date of the rule was postponed in light of lawsuits filed against the State to enjoin the operation of Act 80 generally. It is expected that the court assigned to these cases will decide the claims pertaining to the manufacturer fee by October, 2008.

After consultation with the AGO litigation team and, as a result of the conversation, OVHA has postponed the filing of its rule. Therefore, the effective date for implementation was moved ahead, by six months, from May 1, 2008 to October 1, 2008. Because of the change in implementation, the pre-filing of the rule with the Interagency Committee on Administrative Rules (ICAR) will occur in March or April of 2008. There will be no substantive changes made to the draft rule, except for the date of implementation. The cover page will include clarification of the collection period.

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To: Senate Committee on Health and Welfare  
House Committee on Health Care  
House Committee on Human Services  
Health Access Oversight Committee  
Health Care Reform Commission  
Senator Hinda Miller

From: Joshua Slen, Director

Date: October 3, 2007

Subject: Act 59: Naturopathic Physicians & Chiropractic Coverage

cc: Bill Russell  
Maria Royle  
Don Dickey  
Jen Carbee  
Lynn Hegamyer  
Heidi Tringe  
Ann Rugg

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The following is an update from the OVHA on both Act 59 and Chiropractic Coverage.

### Act 59 – Naturopathic Physicians

As follow-up to Chief Legislative Counsel Bill Russell’s memo, dated August 31, 2007, regarding “S.39, Naturopathic Physicians and Medicaid”, **the Administration, including the Agency of Human Services and the Office of Vermont Health Access, is prepared to support new legislation which changes the definition of “health insurer” used in Act 59 so that it includes Medicaid and the Vermont Health Access Plan (VHAP).**

During the last couple of months, while the debate has ensued regarding the applicability of Act 59 to the OVHA, it has never been the OVHA’s intention to evade responsibility. Instead, the OVHA has relied upon Green Book law and Supreme Court decisions in adhering to its position in regard to the definition of health insurer. The larger context is the accurate interpretation of state statute across many different areas of coverage. Bill Russell’s memo outlined the issues and ultimately concurred with the OVHA’s position.

However, the OVHA is supportive of its inclusion in Act 59 and will recommend the following corrective language (underlined) as part of its proposals for the upcoming legislative session:

8 V.S.A. § 4008d (b) is amended to read:

(b) As used in this section, “health insurance plan” means Medicaid, Vermont health access plan, and any other public health care assistance program, any individual or group health insurance policy, any hospital or medical service corporation or health maintenance organization subscriber contract, or any other health benefit plan offered, issued, or renewed for any person in this state by a health insurer, as defined by 18 V.S.A. § 9402. The term shall not include benefit plans providing coverage for specific disease or other limited benefit coverage.

### **Chiropractic Coverage**

Act 65, Sec 111(b) (a) indicates:

Effective on July 1, 2008, the agency of human services is directed to reinstate chiropractic coverage for adults in the Medicaid and VHAP programs consistent with section 4088a of Title 8 and at rates comparable to payments for care or services by other health care providers. The fiscal year 2009 Medicaid expenditure forecast adopted by the emergency board shall include the reinstatement of chiropractic coverage.

The State cannot afford to reinstate chiropractic coverage at rates comparable to other health care providers in view of the projected Medicaid deficit. The OVHA is supportive of reinstating chiropractic coverage but not “...at rates comparable to payments for care or services by other health care providers.”

In light of this position, the OVHA will recommend the following corrective language (strikethrough) as part of its proposals for the upcoming legislative session:

Effective on July 1, 2008, the agency of human services is directed to reinstate chiropractic coverage for adults in the Medicaid and VHAP programs consistent with section 4088a of Title 8 ~~and at rates comparable to payments for care or services by other health care providers~~. The fiscal year 2009 Medicaid expenditure forecast adopted by the emergency board shall include the reinstatement of chiropractic coverage.



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**Agency of Human Services**

Office of the Secretary

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*Cynthia D. LaWare, Secretary*

**TO:** Gloria Nagle, Centers for Medicare and Medicaid Services  
Chong Tieng, Centers for Medicare and Medicaid Services

**FROM:** Suzanne Santarcangelo, Director, AHS Health Care Operations, Compliance and Improvement  
Joshua Slen, Director, Office of Vermont Health Access

**DATE:** January 22, 2008

**SUBJ: Discussion of Interim Final Rule for Medicaid Case Management and the Vermont Global Commitment to Health Demonstration December 20, 2007**

CMS has recently taken a number of regulatory actions to clarify and refine Medicaid coverage policies including publishing the interim final rule for case management services. The overall objectives for clarifying coverage policies include cost containment and improved health care outcomes.

Vermont respects and concurs with these overall objectives for our health care system and its beneficiaries. We, however, respectfully request clarification regarding the applicability of these policies to the unique Vermont 1115 Demonstration program. Outlined below is an overview of Vermont's issues, discussion questions and position.

### Overview

The Centers for Medicare and Medicaid Services and the State of Vermont have partnered to develop a truly innovative 1115 Demonstration, the Global Commitment to Health. This Demonstration provides greater flexibility with regard to the financing and delivery of health care while limiting financial exposure for our federal partners. As a result of the Global Commitment Demonstration and in conjunction with the Choices for Care Long-Term Care Demonstration, nearly all Medicaid expenditures in Vermont are subject to a controlled growth rate and aggregate expenditure limits.

The Global Commitment Demonstration has provided Vermont with the opportunity to undertake true reform. However, Vermont will face serious challenges in undertaking systemic reform if it also is compelled to abide by traditional program rules.

## Discussion Issues

***The Global Commitment Demonstration provides Vermont with additional program flexibility in exchange for controlled growth in federal resources. Is the application of individual policy initiatives, such as the interim final rule for case management services, consistent with the broad policy goals underpinning the Global Commitment agreement?***

Vermont recognizes the difficult challenges CMS faces in meeting the health care needs of our low-income citizens while preserving the integrity of the Medicaid program. We therefore understand CMS's intent in clarifying and refining federal policies related to case management. However, we believe that the Global Demonstration agreement has already achieved the objectives sought by CMS: overall program costs have been contained and Vermont is developing a person-centered, clinically-effective delivery system.

Vermont has taken several steps in recognition of the fact that the federal funding is limited under the Global Commitment Demonstration. As an example, Vermont administers a school health program that relies on local funds as match for Medicaid-covered mental health services. Prior to implementation of the Demonstration, this program was growing at a rate of eighteen percent per year. As a direct result of the fiscal restraints imposed under Global Commitment, growth in this program has been contained to a rate of seven percent per year.

***How does the application of the rule impact Vermont's ability to undertake program reform?***

In the two years Vermont has operated its Medicaid program under the terms of the Global Commitment to Health Demonstration, it has undertaken a number of program initiatives designed to improve the efficiency and effectiveness of its health care system. Examples include the following:

- Vermont is in the process of implementing a number of performance-based contracting initiatives. The goal of these initiatives is to reform the way health care is financed. In exchange for greater flexibility at the service delivery level, the state is establishing outcomes-based performance measures. We believe that performance-based payment approaches will improve efficiency and economy by shifting the focus of providers from the volume of services delivered to the effectiveness of service delivery. However, relative to the Targeted Case Management rule, we understand that CMS has suggested that "bundled" or "case" rates are not consistent with efficiency and economy and case management services therefore should be billed in 15-minute increments, effectively nullifying any benefit derived from a performance based model.
- Vermont is working with community providers to examine methods to improve the delivery of mental health services for children and control program costs. The workgroup is developing the infrastructure and program policies to enhance the availability of cost-effective, community-based care in lieu of residential placement. One of the findings of the workgroup is that discharge planning should begin at the time of admission and community-based treatment options must be explored throughout the course of residential treatment. We understand that the interim rule will limit case management functions to the final days of a residential stay. We believe that the lack of aggressive, continuous discharge planning activities will increase lengths of stay and increase costs under the Demonstration.

***How does the interim rule apply in a capitated environment?***

The interim rule includes the following language regarding case management services under managed care:

*Individuals participating in a managed care plan receive case management services as an integral part of the managed care services. This case management is for the purpose of managing the medical services provided by or through the plan and does not extend to helping an individual gain access to social, educational, and other services the individual may need. Thus, an individual receiving services through a managed care plan may also receive case management or targeted case management services when the individual is eligible for those services.*

The Vermont Agency of Human Services, as the Single State Agency, makes capitation payments to Vermont's public Managed Care Organization (MCO), the Office of Vermont Health Access. Federal financial participation (FFP) is based on the actuarially-certified capitation payments to the MCO. Therefore, Vermont no longer makes claims for FFP based on discreet Medicaid services (except for services provided under the Choices for Care and SCHIP initiatives). Also, OVHA operates within the framework of federal managed care rules. In effect, Vermont no longer operates a fee-for-service Medicaid program.

Vermont's position is that given our current demonstration project's MCO model, capitated rate methodology, controlled growth rate and aggregate expenditure limits, we should not be subject to the regulatory framework of the Medicaid fee for service program.

We appreciate the opportunity to discuss with CMS the challenges in operating a managed care program within the constraints of federal policies that are geared toward traditional, fee-for-service programs.

Cc: Cynthia D. LaWare  
Jim Giffin  
Nancy Clermont  
Susan Besio  
Richard McGreal

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**PHARMACY BEST PRACTICES  
AND  
COST CONTROL REPORT  
2008**

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

### **Report Facts and Figures from State Fiscal Year (SFY) 2007**

- A total of 2.3 million pharmacy drug claims were paid for all of Vermont's publicly funded pharmacy programs.
- Gross spending was \$109,037,904.
- The rate of generic dispensing; that is, the use of generics as a percentage of all drugs dispensed, was 63.95%.
- The overall generic substitution rate when a generic equivalent was available was 97.57%.
- Federal rebates totaled \$27,355,487.
- Supplemental rebates collections were \$4,746,226.

### **Overview**

Pharmacy is the second highest spending item in Vermont's programs. In SFY 2007, the gross spending of \$109,037,904 was second only to nursing home care by \$77,065.

Vermont's publicly funded health insurance programs covered 141,958 beneficiaries monthly in SFY 2007.

Some of these programs include full health insurance coverage. All of them include a pharmacy benefit. 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

In October 2007 a chronic care wrap program was added with the implementation of Employer Sponsored Insurance Assistance (ESIA) for Vermonters not eligible for VHAP. This program provides for coverage of the other insurance's cost sharing on

drugs used to treat the chronic conditions managed under the Chronic Care Management Program of the Office of Vermont Health Access (OVHA). For ESIA beneficiaries who meet VHAP eligibility requirements, coverage of cost sharing applies to all VHAP covered drugs. Coverage is not limited to drugs used to treat the chronic conditions referenced above.

### ***Critical Issues***

At all times, the goals of the Vermont Health Access Pharmacy Benefit Management (PBM) Program are:

- To assure the availability of clinically appropriate services as they are available and as they are developed 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. The program was 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
- Claims management and processing
- Managing the 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

When the Vermont Health Access PBM program was implemented, Vermont contracted with First Health Services Corporation of Glen Allen, Virginia. In March 2005 the OVHA issued a Request for Proposal to provide pharmacy benefits management (PBM) services for Vermont's publicly funded programs. The existing contract was due for renewal. It was felt that with the number of needed pharmacy initiatives that were critical to immediate needs; the advantages and potential opportunities in care management in existing operations and those under the Global Commitment; and the planned implementation of the Medicare Part D benefit, that it would be wise to explore a new contract. The intention was to assure that the OVHA had the appropriate resources to adequately respond to the rapidly developing environment.

In September 2005, the OVHA selected a new Pharmacy Benefits Administrator (PBA), MedMetrics Health Partners of Worcester, Massachusetts. It is estimated that in the first three years in administrative expenditures this contract will save Vermont \$1.1 million over the prior contractual arrangement.

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 provides Drug Utilization Review services for the Commonwealth of Massachusetts and pharmacy benefit management services for the Massachusetts Medicaid program through a designated managed care organization, Neighborhood Health Plan. Additionally, MedMetrics provides program management and benefit coordination services for Massachusetts' State Pharmacy Assistance Program. As such they are a regional presence with clinical, pharmacy, and Medicaid experience.

### ***Claims Management and Processing***

Claims processing activities include accepting drug claims according to the rules set for coverage under Vermont programs; providing the mechanisms to support the application of the generic drug requirements authorized by Title 19, Chapter 91 of the Vermont Statutes; messaging at the pharmacy point of sale during drug claims processing about program requirements (e.g., eligibility, federal/state drug rebate requirements, coverage limitations, etc.), prior authorization needs, and prospective and retrospective drug utilization review (DUR) issues; and authorizing payments according to the reimbursement rules. Claims are submitted by pharmacies enrolled to provide benefits in Vermont's programs. As of December 2007, 246 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. The amount is the lesser of:

- Average wholesale price (AWP) less 11.9% plus a dispensing fee,

*Pharmacy Best Practices and Cost Control Report 2008*

- 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 is the payer of last resort paying 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, in the absence of Part D, would receive their primary coverage through Medicaid, VHAP-Pharmacy, VScript, and VScript Expanded. Medicaid beneficiaries receive Vermont coverage for Medicaid covered drugs in classes excluded from Medicare coverage. VPharm coverage is limited to drugs that would be covered if they were receiving Vermont primary coverage; that is, VPharm1, VPharm2, and VPharm3 beneficiaries receive coverage for the drugs covered in the comparative 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. 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 2007, a total of 2.3 million claims for drugs 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 is identifying the individual drugs 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:

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- 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 where clinical limitations apply. The PDL 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. The Board consists of Vermont doctors and pharmacists.

When the PDL features clinically appropriate, low-cost options they include:

- 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 as of January 2008 cetirizine (generic Zyrtec<sup>®</sup> and the like). VHAP Limited also covers smoking cessation products.
- generics;
- lower-cost brands;

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- 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 rolled out. By 2003, the foundation of the PDL was set.

Since that time, the PDL has been modified to reflect changes in clinical approaches, prescribing practices, product availability, and supplemental rebate opportunities.

### *Management of Mental Health Drugs*

At the time of the implementation of Vermont Health Access Pharmacy Benefit Management Program in 2002, 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 could be available with prior authorization using criteria developed through literature review of acceptable evidence-based standards, particularly the Texas Algorithm (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 should be "grandfathered" so as not to risk destabilization. It was decided that patients of all ages currently 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 comments or

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recommendations on September 1, 2005. The Committee heard testimony from prescribers and advocates. As a result, they 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 in December 2005, 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 an authorization.

With the implementation of Medicare Part D in January 2006 many beneficiaries transitioned to Part D coverage. With the 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 continues. Indications are that new patients or patients with a lapse in therapy of four months or more attempt therapy with preferred drugs. Between January and November 2006, prior authorization requests for non-preferred mental health drugs dropped by 26%. Between November 2006 and November 2007 the number of requests dropped 37.7% with the total decrease from January 2006 being 53.9%.

<b>Mental Health Drug Prior Authorization Requests - January 2006, November 2006, and November 2007</b>			
	<b>Jan-06</b>	<b>Nov-06</b>	<b>Nov-07</b>
Anti-depressants - Novel	231	197	164
Anti-depressants - SSRI	300	236	98
Anti-depressants - Tricyclics	0	1	0
Anti-psychotics - Atypical & Combinations	159	59	54
Anti-psychotics - Typical	0	0	0
CNS Stimulants	16	34	22
Anti-Hyperkinesis - ADHD, ADD, Narcolepsy	86	101	94
Sedative Hypnotics - Benzodiazepines	6	0	1
Sedative Hypnotics - Non- Benzodiazepines	212	98	25
Anti-Anxiety - General	10	28	12
<b>Totals</b>	<b>1,020</b>	<b>754</b>	<b>470</b>
Percentage reduction since January 2006		26.1%	53.9%
Percentage reduction since November 2006			37.7%

However, it is clear that continued management is necessary. Drug spending for SPMI 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 classes represented 28.1% of the total drug spending in that year. In SFY'07 those same classes represent 29.3% of the total.

### *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.

In the fall of 2007 the OVHA sought bids from specialty pharmacies to provide 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.

The review of proposals is complete. It is clear that under this arrangement product costs can be reduced. At the same time, better management of disease conditions can be achieved. This can be accomplished through outreach and education to improve the patients' understanding of their conditions and adherence to prescribed drug regimens. Applying this approach acts as another tool in chronic care management, serving as a resource in the treatment of complex conditions not requiring the level of support of those addressed in the Chronic Care Management and Care Coordination Programs.

### *Diabetic Testing Supplies*

Diabetic testing supplies are a specialty need. At the time that the Administration proposed managing specialty pharmacy services in 2005 they were identified as a target area. However, most commonly such supplies do not require any specialty disease management services in their use. As a result, the OVHA opted to address this area not by utilizing a specialty pharmacy service but by limiting the product choices available in local pharmacies while seeking rebates from preferred manufacturers.

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.

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

This approach and the outcome was reviewed and unanimously approved by the DUR Board. Implementation will be in February 2008.

*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. Drugs are being identified that will be limited to dispensing through pharmacies where prior authorization requirements and utilization review conditions can apply prior to drug dispensing. Other drugs that must be available in physician offices will be subject to prior authorization to assure that clinical criteria established apply. In the process, mechanisms will be established to facilitate the process for the offices. Evaluating physician-administered drugs for clinical management is an ongoing project and continues in SFY 2008.

*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 any program rebate requirements. Prior to 2006, the OVHA's pharmacy claims processing systems were unable to accept the report of individual ingredients. Beginning in January 2006 and throughout state fiscal year 2007 the OVHA worked with compounding pharmacists to develop an approach to account for and to 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.

### *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, a resulting item is more costly than the combination of its parts and has little, if any, value over the parts; for example, the packaging of an ointment or cream with applicators or the combination of ingredients with vitamins. This year, the DUR Board approved the establishment of a category in the PDL where products not otherwise in managed classes are identified as requiring authorization because of the combination/formulation is not the preferred approach, clinically or economically.

### *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 impact of manufacturers who advertise nationally and locally. The Office of the Vermont Attorney General has estimated that \$3.11 million was spent in marketing in Vermont alone in SFY 2004; another \$2.17 million in SFY 2005; and \$2.25 million in SFY 2006. This advertising creates a situation where it is necessary to distinguish between what may be wanted and what is needed.

The Program relies on the Drug Utilization Review (DUR) Board for advice on how to best educate providers, in general, and ameliorate the impact of pharmacy manufacturers advertising, in particular. The DUR Board meets as often as monthly. In calendar year 2007 the Board met nine times. In these meetings counter detailing opportunities are considered.

In the course of DUR activities, the DUR Board may 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. When this occurs, specific providers are polled regarding the patients affected and the Board reviews their responses to determine if any 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 patient profile specific 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 changes to the PDL and the criteria for the authorization of non-preferred drugs, and 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 Associations. The OVHA and MedMetrics have also begun to publish a periodic pharmacy bulletin to provide timely updates on claims processing and clinical issues. The bulletin is designed to be a regular communication vehicle, and each volume focuses on either clinical or claims processing updates.

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 generic drug law described at 18 V.S.A chapter 91 requires pharmacies to dispense generics 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 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.

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 year 2007, 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%

*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.

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

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	<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>

Overall changes in prior authorization activity can be attributed to two factors:

1. The transition of beneficiaries to Medicare Part D primary coverage whose drug use is no longer subject to the PBM Program's management. 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.
2. The use of MedMetrics' claims processing. MedMetrics has systematically identified areas where assessments could be applied in claims processing to determine if certain criteria elements had been met without requiring paper/phone requests for authorizations from prescribers. Where possible, these "step-therapy protocols" effectively automate prior approval. Examples include age criteria, use of preferred drugs, use of preferred drugs for prescribed periods, etc.

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Part D had a major impact on the decrease in prior authorizations requests. Step-therapy protocols have an impact on requests, approvals, and changes in that the process of authorization is fully or partially automated in many classes.

A portion of the decrease in approvals and changes and much of the concurrent increase in denials are a result of the application of a 2006 DUR Board requested legislative change that no longer allows prescribers to override approved criteria without concrete clinical justification.

*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 is the ability to respond to the pharmacist or “message” him/her on a claim level. Messaging occurs as claims are processed on specific utilization issues. 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 in order to fill the prescription. 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	<b>Totals</b>	<b>Percent</b>
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>
<b>*Percentages rounded</b>						

This represents a considerable drop from SFY 2006 when messages returned to pharmacy providers were 2,783,171. This is a result of a full state fiscal year with MedMetrics' claims processing. This system minimizes 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.

### *Drug Utilization Review (DUR) Board Activities*

In the course of activities, the DUR Board may 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. When this occurs, specific providers are polled regarding the patients affected and the Board reviews their responses to determine if any follow-up is appropriate either with the identified prescribers or with a clinical advisory to all providers.

For example, in 2007 the DUR Board reviewed the use of short- and long-acting beta agonists with no concomitant controller medication. Evidence-based research indicates that without a controller medication, asthma attacks may be more frequent and severe, resulting in increased hospitalizations. At the advice of the Board, letters were sent to both the pharmacists and prescribers of those beneficiaries whose claims history indicated that they were receiving short-acting or long-acting beta-agonists (inhalers) without a concomitant controller medication.

Other examples of the DUR Board’s activities in the last year to target certain drugs / prescribing practices included reviews of the following:

- The use of combination atypical antipsychotic therapy for greater than a 60-day-period.
- The use of two or more prescriptions for long-acting narcotics and/or buprenorphine.
- The use of dangerously high dosing of acetaminophen.

### ***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 began 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 are Iowa, Maine, Vermont, and beginning in 2007, Utah. A number of other states are considering the Consortium. It is believed that two other states will become members in 2008.

In the SSDC member states are able to pool collective lives as well as state staff and pharmacy benefit management contractor resources to negotiate supplemental rebate agreements with drug manufacturers. This approach provides much administrative efficiency. It also results in greater state involvement with the actual agreements in assuring unique drug coverage customization for each state. This provides greater opportunities for multi-state collaborations in publicly funded health insurance arenas. This also creates a pool that is not dependent on a single contracted vendor and is portable for the future regardless of a state's affiliation with a PBA vendor.

The fall of 2005 marked the first SSDC engagement to secure rebates. As of January 2006, 48 contracts were in place pending federal approval. On July 20, 2006 federal approval was received. While finalizing the 2006 contracts with the federal conditions, the SSDC began the procurement process for 2007. As of January 2007, 50 contracts had been secured.

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 option for up to two additional years. This contract began in September 2007 and will be managed by the OVHA through its term.

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, representing a reduction of 62.6%. This degree of loss did not occur. Actual collections for SFY 2007 against calendar year 2006 utilization were \$4,746,226. SFY 2008 collections are projected to be \$5.5 million.

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**Managing Reimbursement**

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 September 2007:

State	Ingredient Cost	Dispensing Fee	State MAC List for Multi-source Drugs
Connecticut	AWP-14% (brand); AWP-40% (generic)	\$3.60	Y
Maine	AWP-15%; direct supply drug list-usual & customary charge or AWP-17% plus \$3.35 professional fee or FUL or MAC plus \$3.35 professional fee (Mail order lowest of usual & customary charge, AWP-20% plus \$1.00 professional fee-with exceptions per State plan, FUL or MAC plus \$1.00 professional fee)	\$3.35; \$4.35 & \$5.35 (compounding); \$12.50 (insulin syringe)	Y
Massachusetts	WAC+5%	\$3.50 (brand); \$4.50 (generic)	Y
New Hampshire	AWP-16%	\$1.75	Y
New York	AWP-13.25% (brand); AWP-20% (generic) or the State MAC if lower; AWP-12% (specialized HIV pharmacies)	\$3.50 (brand); \$4.50 (generic)	N
Rhode Island	WAC	\$3.40 (outpatient), \$2.85 (long term care)	N
Vermont	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			

AWP minus 11.9% is approximately WAC plus 8.1%. With that Vermont's reimbursement for brand drugs is the highest in the northeast. With Vermont paying for many generic drugs based on a MAC price the reimbursement varies on individual products. However, as a whole it is believed that Vermont's generic reimbursement is less than in the other New England states and in the state of New York.

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. A major factor in this authorization was the federal Deficit

Reduction Act (DRA) of 2005 changes to Medicaid reimbursement on generics in calendar year 2007 and the impact of that on overall reimbursement.

The federal Deficit Reduction Act of 2005 proposes that for purposes of Medicaid reimbursement for drugs available from multiple manufacturers that an established pricing standard, the Federal Upper Limit (FUL), be based on Average Manufacturer Price (AMP). To date manufacturers' published wholesale prices have 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 are available. The DRA methodology proposes to use AMP to establish the FUL for multi-source drugs when two or more equivalents are available.

In order 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 that:

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

Section 110g of Act 65 of the Vermont General Assembly of the 2007-2008 Legislative Session (H.537) states that the OVHA will 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. This analysis is to include:

- recommended reimbursement levels and dispensing fees,
- any appropriation amount necessary regarding the recommended levels and fees,
- the revenue impact on the OVHA, and
- information on the impact on pharmacies.

The final analysis was to be presented to the Health Access Oversight Committee no later than November 15, 2007. At the Health Access Oversight Committee meeting on November 13, 2007, the OVHA indicated that this analysis could not be completed by the required date because the information supporting the analysis was dependent on CMS establishing the FULs according to the requirements of the final rule.

Up until October states believed that they would be able to obtain the components of the calculation in sufficient detail to make it possible to determine what the FUL would be on each affected drug. However, one critical piece in the calculation was not available and that was identifying what drugs would be in each designated “FUL group” to which the calculation applied. CMS had not provided drug listings by group. In a conference call on October 25<sup>th</sup> CMS indicated that the groups were not yet finalized and, thus, could not be made available. They further indicated that it appeared unlikely that they will be finalized until the first set of new FULs was completed and available on December 31, 2007. The result was that states could not predict the impact of the change.

In anticipation of receiving the FUL information on December 31<sup>st</sup>, the OVHA built an analysis model that could determine the impact of this change in a short timeframe. The model was reviewed with the Health Access Oversight Committee on December 11, 2007.

While the OVHA and the Health Access Oversight Committee were considering the analysis of the impact of this federal reimbursement change, the National Association of Chain Drug Stores (NACDS) and the National Association of Community Pharmacists (NCPA) filed a lawsuit regarding it against CMS and the U.S. Department of Health and Human Services on November 7, 2007. 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.

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*

Vermont Medicaid is entering its third year as a secondary payer for pharmacy benefits after Medicare Part D. The pharmacy benefit for individuals covered by Medicare and Medicaid continues in 2008 much as it was in 2007.

## Vermont Coverage for Medicare Eligibles

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

- 1) 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.
- 2) No State premium is charged.
- 3) The beneficiary pays the Part D co-pays (from \$1.05 to \$5.60) with the exception that pregnant women and children whose co-pays are paid by the State.
- 4) All other cost-sharing is covered by a benefit referred to as the federal low-income subsidy (LIS).
- 5) 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.
- 6) 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).
- 7) 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*)

Vermont continues to provide a State wraparound program, VPharm, where Medicare supplemental coverage is comparable to previous coverage from the State in 2005 (prior to the beginning of Part D).

Throughout 2007, 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:

- 1) Beneficiaries must be eligible for Part A or enrolled in Part B.
- 2) 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.
- 3) Beneficiaries pay premiums to the State of \$15, \$20 or \$42.
- 4) The coverage is:

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- a) 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
  - b) 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.
- 5) 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.
  - 6) 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).
  - 7) 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.

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 but in the case of dual eligibles (those Medicare beneficiaries who are also eligible for 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:

- 1) Based on Medicaid state expenditures (excluding VHAP-Pharmacy, VScript, and VScript expanded) in calendar year (CY) 2003 adjusted for inflation.
- 2) Calculated on expenditures net of drug rebate.

- 3) States retain a specified portion in support of providing other coverage to their dual eligibles.

Beginning January 1, 2008, states are 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%

### 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. Dual eligibles may change plans any month. Some beneficiaries have special enrollment periods (SEP) which are the only times they can choose or change plans. VPharm, the State pharmacy program that wraps the Part D benefit, is a state pharmacy assistance program (SPAP) by the federal government. In the summer of 2006, CMS determined that individuals eligible for a SPAP are allowed one SEP in addition to their annual enrollment period (AEP) which is November 15 through December 31.

### PDP Drug Coverage

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

- 1) 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).
- 2) 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.
- 3) 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 January 1, 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 have developed a process to submit these billings.

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Through the federal fiscal year ending September 30, 2007, the OVHA collected a total of \$8,893,740 in claims and administrative expenses. The following chart outlines the collections:

	Due from CMS ~ Program ( <b>402 Specific</b> )	Due from PDPs ~ Program ( <b>Start-Up Related</b> )	Subtotal Program	Due from CMS ~ Admin	Total
<b>Estimated Costs for Reimbursement</b>	<b>8,693,136</b>	<b>3,027,383</b>	<b>11,720,519</b>	<b>974,298</b>	<b>12,694,817</b>
Total Paid Through 11/30/2006	(5,003,394)	-	(5,003,394)	(923,255)	(5,926,649)
Total Paid Through 4/30/2007	(2,110,382)	(488)	(2,110,870)	-	(2,110,870)
Total Paid Through 5/31/2007	-	(27)	(27)	-	(27)
Total Paid Through 6/30/2007	(437,350)	(848)	(438,197)	(51,043)	(489,240)
Subtotal Paid	(7,551,126)	(1,362)	(7,552,488)	(974,298)	(8,526,786)
<b>Balance Owed as of 6/30/07</b>	<b>1,142,010</b>	<b>3,026,021</b>	<b>4,168,031</b>	<b>-</b>	<b>4,168,031</b>
Total Paid Through 7/31/2007	-	(250,949)	(250,949)	-	(250,949)
Total Paid Through 8/31/2007	-	(116,005)	(116,005)	-	(116,005)
Subtotal Paid	-	(366,954)	(366,954)	-	(366,954)
<b>Balance Owed as of 9/30/07</b>	<b>1,142,010</b>	<b>2,659,067</b>	<b>3,801,077</b>	<b>-</b>	<b>3,801,077</b>
<b>Amount Borrowed From Caseload Reserve</b>					<b>8,788,671</b>
<b>Estimated Balance Owed to Reserve Fund</b>					<b>-</b>

*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 in pharmacy claims processing for the period January 1, 2004 through December 31, 2005.

As a result of this finding the OVHA and MedMetrics staff formed an audit and recovery team to review pharmacy claims. Over \$569 thousand has been recovered thus far.

In the process MedMetrics has implemented claims processing changes that minimize the likelihood of claims errors because of quantities and/or dosage forms.

To assure a total review of all claims identified by the State Auditor, the OVHA is developing specifications for a complete review with the help of MedMetrics. At the same time the OVHA's Program Integrity Unit has released a Request for Proposal to secure a vendor dedicated to claims audits for all claim types. The vendor selection process should be completed in the first quarter of calendar year 2008.

*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:

- Implements a joint pharmaceuticals purchasing consortium.
- Increases transparency of drug pricing information.
- Increases 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.
- Requires increased oversight of pharmacy benefit managers (PBMs) and their practices.
- Establishes an evidence-based education program.
- Establishes a generic drug voucher pilot project.
- Protects the confidentiality of prescription information.
- Establishes a fee for drug manufacturers to fund the education program including the voucher pilot project.
- Enhances 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 are underway including 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. Preliminary process discussions have occurred pending resolution of the differences with drug manufacturers regarding provisions of this Act. Implementation of this will require the authorization and funding of OVHA staff. Logistically, the changes in

reporting to CMS as a result of provision of the Deficit Reduction Act of 2005 will have an impact on what is reported to Vermont.

- **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) Program, 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 challenging 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 is under consideration as are plans for determining where and how the pilot might be implemented. Claims processing specifications have been developed. Litigation has been filed challenging 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.
- **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. The calculation of the fee is based 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. This piece of the Act has been challenged in litigation. Presently, collection is scheduled in or around October 2008. Implementation of the fee will

require the authorization and funding of OVHA staff to manage billing and collections.

- 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.

### *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 sets 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 are the conditions for Medicaid program reimbursement as of April 1:

- 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:
  1. one or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form;
  2. one or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber; or
  3. one or more industry-recognized features designed to prevent the use of counterfeit prescription drug forms.

As of October 1, 2008, prescription paper must contain all of the above-referenced characteristics 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 providers in 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 and Northeastern Regional Vermont Hospital in St. Johnsbury. The service utilizes software provided by G.E. Health Care in South Burlington, Vermont.

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.

### ***Assessment of SFY 2007***

In the early years of the Vermont Health Access Pharmacy Benefit Management Program, the major drug classes in terms of 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, largely generics.

The program has saved money in these and other major categories as still more generics have become readily available. A recent example is simvastatin, the generic alternative to the high cholesterol drug, Zocor<sup>®</sup>. And increasingly one-time blockbuster products are becoming available over the counter. Examples of such products include Prilosec OTC<sup>®</sup> for the treatment of gastric acid and Claritin<sup>®</sup> and Zyrtec<sup>®</sup> for allergy relief.

Another major development was the loss of confidence in drug products. A notable example would be the anti-inflammatory drug, Vioxx<sup>®</sup>, which was withdrawn from the

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market for clinical reasons. As a result many prescribers began opting for older, proven, and less expensive alternatives. This may occur as the public reacts to the press questioning the effectiveness of the high cholesterol drugs, Zetia<sup>®</sup> and Vytorin<sup>®</sup>.

Now, with the maturing of the Program, success in drug class management has not been readily measured in terms of money saved but in terms of expenses avoided. This is where generic use and supplemental rebates come into play as the greatest savings have resulted from the promotion of generics and the acquisition of supplemental rebates on drugs utilized in Vermont's programs.

As indicated before, Vermont programs' generic usage is:

<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%

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

As previously described, supplemental rebates continue to be a 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 are projected to be \$5.5 million.

This does not mean that managing the benefit no longer needs to occur. If anything it must be managed more vigilantly to achieve returns.

With the implementation of Medicare Part D and the transition of 30,000 beneficiaries to primary coverage under Medicare 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.

The following chart illustrates the impact of this change with paid claims volume attributed by age. The 2005 figures show program activity with all Vermont programs primary. The 2006 figures show activity with Vermont programs primary for those not

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Part D eligible. On those ages 65 and older the vast majority of primary claims have now transitioned to Part D coverage. With those ages 21 to 64, a number of primary claims can now be attributed to Part D:

Primary Vermont Program Paid Pharmacy Claims				
Ages	Jul-Dec 2005		Jul-Dec 2007	
0-12	102,687	6.30%	95,947	13.91%
13-20	85,055	5.20%	83,152	12.05%
21-40	265,438	16.30%	208,818	30.27%
41-50	240,446	14.70%	140,126	20.31%
50-64	206,637	12.70%	157,793	22.87%
65 and older	731,558	44.80%	4,025	0.58%
Totals	1,631,821		689,861	

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

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

Antipsychotics, atypical, dopamine, & serotonin antagonists; anticonvulsants; and selective serotonin reuptake inhibitors (SSRIs) began experiencing some management in SFY 2006 as a result of the management of mental health drugs. Lipotropics and gastric acid reducers have long been on the PDL and managed to the extent possible to meet clinical needs.

In SFY 2007, the top five drug classes for all beneficiaries in terms of expenditures were:

1. Antipsychotics, atypical, dopamine, & serotonin antagonists
2. Anticonvulsants
3. Gastric acid reducers
4. Analgesic narcotics
5. Lipotropics

Classes for non-Medicare eligibles only were:

1. Antipsychotics, atypical, dopamine, & serotonin antagonists
2. Anticonvulsants
3. Analgesic narcotics

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- 4. Gastric acid reducers
- 5. Drugs for attention deficit – hyperactivity (ADHD)/narcolepsy

Clearly, some areas requiring attention remain the same while #5 reflects the impact of the change in populations served.

Looking at overall utilization in the whole of SFY 2006 and SFY 2007, with all eligibles including Part D eligibles, the following occurred:

All Paid Pharmacy Claims for All Beneficiaries		
	SFY 2006	SFY 2007
Claims	2,832,959	2,270,948
Days Supply	73,625,601	58,626,935
Claims Payments	\$167,532,603	\$109,319,875
Average Monthly Eligibles	132,240	132,554
Claims per Eligible per Month	1.8	1.4
Days Supply per Eligible per Month	46.4	36.9
Paid per Eligible per Month	\$105.57	\$68.73

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’s programs. Removing Medicare eligibles from the picture produces the following:

All Paid Pharmacy Claims for Beneficiaries Without Medicare Coverage		
	Jul - Dec 2006	Jul - Dec 2007
Claims	693,553	689,861
Days Supply	16,488,946	16,664,689
Days Supply	\$45,784,079	\$47,159,832.00
Average Monthly Eligibles	104,363	102,486
Claims per Eligible per Month	0.6	0.6
Days Supply per Eligible per Month	13.2	13.6
Paid per Eligible per Month	\$36.56	\$38.35
Percentage Increase Over Previous Year	2.19%	4.89%

This reflects that the greatest change is in price. Some of the increase is a result of the increase in the cost of pharmaceuticals. According to the *AARP Rx Watchdog* in March 2007, in a study of a sample of 193 branded drugs in 2006, the price increased 6.2% while inflation increased 3.2%. Using a sample of 75 generic drugs, the price decreased on average 2%.

***Planned for SFY 2008***

Activities not previously mentioned but planned in the coming year include:

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- Reviewing and updating the PDL as needed;
- Managing generic utilization, in general:
- Promoting generic alternatives as they become available, for example, the generic for Risperdal<sup>®</sup> expected to be available in June 2008;
- Continuing to promote over-the-counter options as they become available; for example, cetirizine (generic Zyrtec<sup>®</sup>);
- Coordinating activities with the OVHA's Chronic Care Management and Care Coordination (CC/CCM) Programs;
- Implementing the Specialty Pharmacy Initiative to manage drug use for complex health conditions other than those managed in the CC/CCM Programs;
- Implementing the Diabetic Supply Initiative to promote preferred product lines;
- Partnering with the OVHA Program Integrity Unit to identify areas where program oversight can be improved and developing strategies to make that happen;
- Working to promote new state membership in the SSDC to expand the Medicaid supplemental rebate pool;
- Reviewing the dispensing of drugs under medical procedure codes (A, C, J, P, Q, and 99 codes) to assure availability in medical setting while containing costs and adhering to the related requirements of the Deficit Reduction Act of 2005;
- Continuing to educate on appropriate dosage and days supply dispensing;
- Assuring that products are obtained from pharmacies at the most reasonable cost possible;
- Supporting the expansion of VITL's Electronic Medication History Service to hospitals in Vermont; and
- Exploring the development of a web-based tool to provide drug use histories/profiles of Medicaid patients to prescribers and pharmacies.

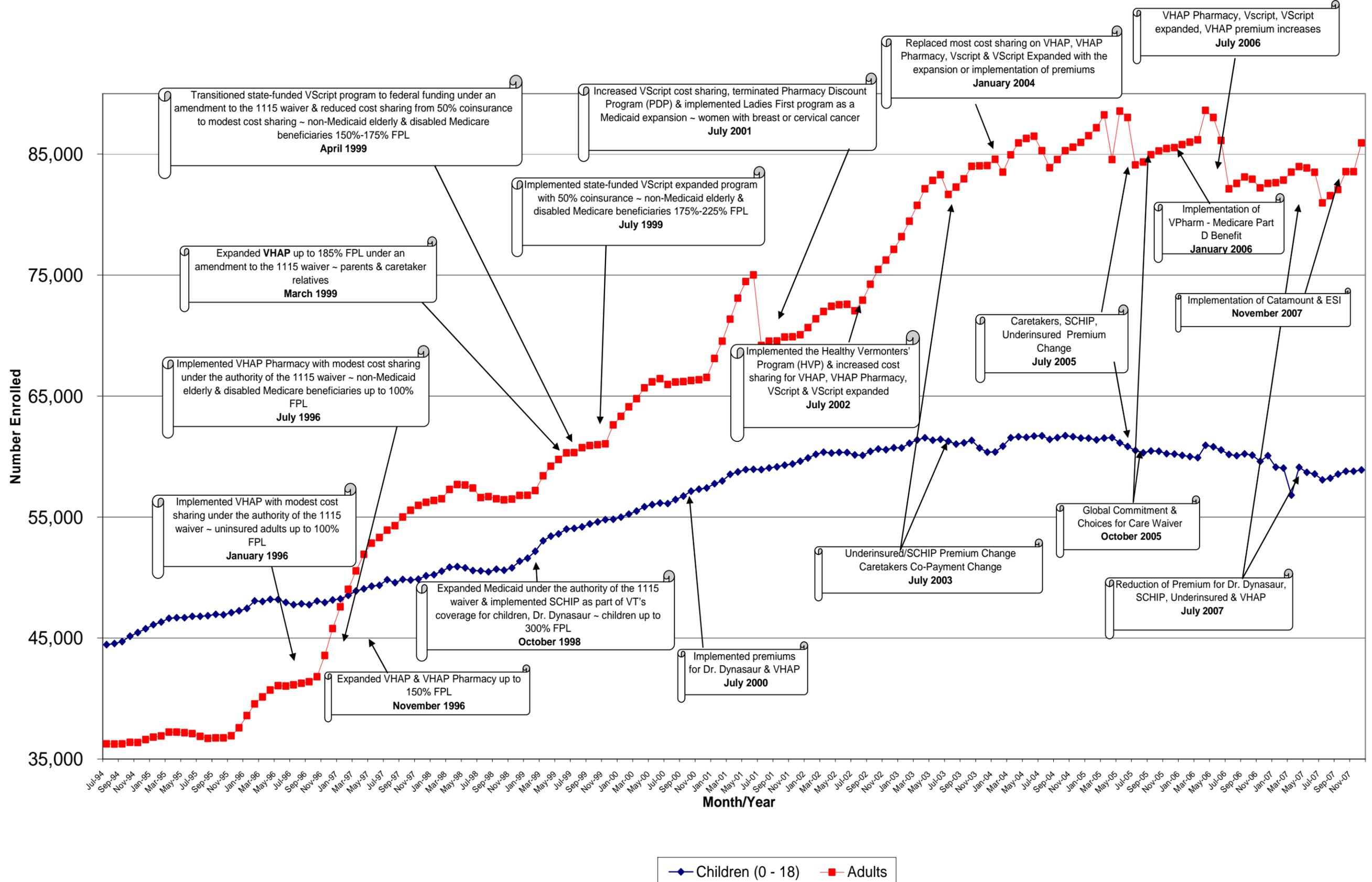
Insert 1: Pharmacy Detail

**PHARMACY**

	SFY '05 Actuals			SFY '06 Actuals			SFY '07 Actuals			SFY '08 Gov. Rec.			SFY '08 Budget Adjustment			SFY '09 Governor's Recommended		
	Enrollment	Costs	PMPM	Enrollment	Costs	PMPM	Enrollment	Costs	PMPM	Enrollment	Costs	PMPM	Enrollment	Costs	PMPM	Enrollment	Costs	PMPM
ABD (Adults, Duals, CFC, & Children)	29,662	\$ 95,796,688	\$ 269	31,227	\$ 72,663,061	\$ 194	32,354	\$ 35,372,574	\$ 118	32,173	\$ 48,103,774	\$ 125	32,474	\$ 39,886,519	\$ 102	33,360	\$ 43,252,002	\$ 108
General (Adults & Children)	61,961	\$ 26,152,702	\$ 35	60,446	\$ 29,862,850	\$ 41	61,231	\$ 31,674,280	\$ 40	60,831	\$ 31,673,452	\$ 43	61,498	\$ 34,630,396	\$ 47	63,202	\$ 37,552,386	\$ 50
VHAP (Adults)	24,456	\$ 25,370,616	\$ 86	22,525	\$ 28,513,911	\$ 105	22,047	\$ 29,123,046	\$ 100	24,789	\$ 29,603,848	\$ 100	23,105	\$ 35,397,724	\$ 128	23,525	\$ 35,145,580	\$ 124
Underinsured Children	1,661	\$ 396,106	\$ 20	1,284	\$ 367,733	\$ 24	1,214	\$ 359,774	\$ 34	1,520	\$ 654,902	\$ 36	1,273	\$ 280,799	\$ 18	1,297	\$ 304,492	\$ 20
SCHIP (Uninsured Children)	3,147	\$ 988,023	\$ 26	3,092	\$ 898,891	\$ 24	3,013	\$ 1,091,105	\$ 33	4,070	\$ 1,576,853	\$ 32	3,495	\$ 1,172,109	\$ 28	3,646	\$ 1,271,007	\$ 29
<b>Subtotal Pharmacy in Direct Program</b>	<b>120,888</b>	<b>\$ 148,704,136</b>	<b>\$ 103</b>	<b>118,574</b>	<b>\$ 132,306,446</b>	<b>\$ 93</b>	<b>119,859</b>	<b>\$ 97,620,779</b>	<b>\$ 72</b>	<b>123,383</b>	<b>\$ 111,612,829</b>	<b>\$ 75</b>	<b>121,845</b>	<b>\$ 111,367,547</b>	<b>\$ 76</b>	<b>125,030</b>	<b>\$ 117,525,467</b>	<b>\$ 78</b>
<b>Global Pharmacy</b>																		
Non Medicare				93	incl. in ttls. below	\$ -	42	\$ 174,866	\$ 300	48	\$ 178,426	\$ 310	49	\$ 186,537	\$ 317	49	\$ 202,277	\$ 344
VHAP Pharmacy prior to 1/1/06	11,187	\$ 34,793,995	\$ 259.18	8,040	\$ 13,402,363	\$ 278												
VPharm1				8,176	\$ 882,052	\$ 18	7,550	\$ 191,826	\$ 4	8,764	\$ 435,168	\$ 4	7,688	\$ 204,629	\$ 2	7,977	\$ 221,895	\$ 2
Vscript prior to 1/1/06				2,684	\$ 4,685,443	\$ 291												
VPharm2				2,608	\$ 409,723	\$ 26	2,731	\$ 106,052	\$ 33	2,928	\$ 1,192,385	\$ 34	3,089	\$ 113,130	\$ 3	2,834	\$ 122,675	\$ 4
<b>Subtotal Global Pharmacy</b>	<b>11,187</b>	<b>\$ 34,793,995</b>	<b>\$ 259.18</b>	<b>10,847</b>	<b>\$ 19,379,581</b>	<b>\$ 149</b>	<b>10,323</b>	<b>\$ 472,744</b>	<b>\$ 12</b>	<b>11,396</b>	<b>\$ 1,805,979</b>	<b>\$ 13</b>	<b>10,826</b>	<b>\$ 504,296</b>	<b>\$ 4</b>	<b>10,860</b>	<b>\$ 546,847</b>	<b>\$ 4</b>
<b>State-Only Pharmacy</b>																		
Non Medicare				70		\$ -	38	\$ 157,967	\$ 295	44	\$ 160,637	\$ 304	49	\$ 173,948	\$ 296	49	\$ 174,027	\$ 296
VPharm1				8,176	incl. in ttls below	\$ -	7,554	\$ 4,330,659	\$ 46	8,764	\$ 4,981,770	\$ 47	7,688	\$ 4,768,790	\$ 52	7,977	\$ 4,770,943	\$ 50
VPharm2				2,684		\$ -	2,731	\$ 2,817,429	\$ 105	2,928	\$ 3,799,634	\$ 108	3,089	\$ 3,102,468	\$ 84	2,834	\$ 3,103,868	\$ 91
VScript Expanded prior to 1/1/06	2,615	\$ 7,899,867	\$ 251.79	2,719	\$ 4,720,556	\$ 289												
VPharm3				2,582	\$ 11,126,020	\$ 718	2,790	\$ 3,638,326	\$ 36	3,214	\$ 1,437,615	\$ 37	2,777	\$ 4,006,415	\$ 120	2,877	\$ 4,008,223	\$ 116
<b>Subtotal State-Only Pharmacy</b>	<b>2,615</b>	<b>\$ 7,899,867</b>	<b>\$ 251.79</b>	<b>13,649</b>	<b>\$ 15,846,576</b>	<b>\$ 97</b>	<b>13,113</b>	<b>\$ 10,944,381</b>	<b>\$ 56</b>	<b>14,950</b>	<b>\$ 10,379,656</b>	<b>\$ 58</b>	<b>13,603</b>	<b>\$ 12,051,620</b>	<b>\$ 74</b>	<b>13,737</b>	<b>\$ 12,057,061</b>	<b>\$ 73</b>
<b>PHARMACY BY CATEGORY OF SERVICE</b>	<b>123,503</b>	<b>\$ 191,397,998</b>	<b>\$ 129</b>	<b>132,033</b>	<b>\$ 167,532,603</b>	<b>\$ 106</b>	<b>132,972</b>	<b>\$ 109,037,904</b>	<b>\$ 68</b>	<b>137,993</b>	<b>\$ 123,798,464</b>	<b>\$ 75</b>	<b>135,497</b>	<b>\$ 123,923,464</b>	<b>\$ 76</b>	<b>138,816</b>	<b>\$ 130,129,375</b>	<b>\$ 78</b>
Clawback				n/a	\$ 6,888,177	n/a	n/a	\$ 19,142,150	n/a	n/a	\$ 19,630,187	n/a	n/a	\$ 19,630,187	n/a	n/a	\$ 20,841,112	n/a
PDP Premium Payments				n/a	\$ 2,287,779	n/a	n/a	\$ 3,480,094	n/a	n/a	\$ 2,233,331	n/a	n/a	\$ 2,186,093	n/a	n/a	\$ 2,263,451	n/a
Drug Rebates	n/a	\$ (52,422,899)	n/a	n/a	\$ (61,035,134)	n/a	n/a	\$ (32,101,713)	n/a	n/a	\$ (25,109,854)	n/a	n/a	\$ (36,977,431)	n/a	n/a	\$ (40,643,414)	n/a
<b>PHARMACY EXPENDITURES</b>	<b>134,690</b>	<b>\$ 138,975,099</b>	<b>\$ 86</b>	<b>132,033</b>	<b>\$ 115,673,425</b>	<b>\$ 73</b>	<b>132,651</b>	<b>\$ 99,558,435</b>	<b>\$ 63</b>	<b>138,381</b>	<b>\$ 120,552,128</b>	<b>\$ 73</b>	<b>135,497</b>	<b>\$ 108,762,312</b>	<b>\$ 67</b>	<b>138,816</b>	<b>\$ 112,590,524</b>	<b>\$ 68</b>

	SFY '05 Actuals			SFY '06 Actuals			SFY '07 Actuals			SFY '08 Gov. Rec.			SFY '08 Budget Adjustment			SFY '09 Governor's Recommended		
Federal Receipts	134,690	\$ 79,195,655	\$ 49	132,033	\$ 54,740,878	\$ 35	132,972	\$ 42,700,007	\$ 27	137,993	\$ 54,649,319	\$ 33	135,497	\$ 47,570,464	\$ 29	138,816	\$ 49,494,197	\$ 30
State Funds	134,690	\$ 59,779,444	\$ 37	132,033	\$ 60,932,548	\$ 38	132,972	\$ 56,858,428	\$ 36	137,993	\$ 65,902,808	\$ 40	135,497	\$ 61,191,848	\$ 38	138,816	\$ 63,096,327	\$ 38
<b>PHARMACY REVENUES</b>	<b>134,690</b>	<b>\$ 138,975,099</b>	<b>\$ 86</b>	<b>132,033</b>	<b>\$ 115,673,425</b>	<b>\$ 73</b>	<b>132,972</b>	<b>\$ 99,558,435</b>	<b>\$ 62</b>	<b>137,993</b>	<b>\$ 120,552,128</b>	<b>\$ 73</b>	<b>135,497</b>	<b>\$ 108,762,312</b>	<b>\$ 67</b>	<b>138,816</b>	<b>\$ 112,590,524</b>	<b>\$ 68</b>

**Insert 2: Enrollment Growth Trend  
July 1994 – December 2007**



Insert 3: Category of Service (COS)

COS	Description of Service	Actual SFY '99	Actual SFY '00	1999-2000 % Change	Actual SFY '01	2000-2001 % Change	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	Approp. SFY '08	2007 Act.-2008 Approp % Change	Budget Adj. SFY '08	2007 Act.-2008 Est. % Change	Gov. Rec. SFY '09	2008 Est.-2009 Req. % Change
01-00	Inpatient	16,156,912	22,829,188	41.3%	35,343,072	54.8%	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%	58,107,259	-2.2%	60,781,526	4.6%	62,097,536	6.9%	78,787,330	26.9%
02-00	Outpatient	10,725,424	19,106,954	78.1%	36,725,550	92.2%	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%	63,509,663	-1.6%	69,534,918	9.5%	70,267,995	10.6%	78,676,012	12.0%
03-00	Physician	10,518,016	19,237,453	82.9%	40,746,638	111.8%	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%	61,915,454	5.6%	74,807,063	20.8%	67,592,720	9.2%	72,988,079	8.0%
04-00	Pharmacy	60,223,045	89,450,114	48.5%	102,536,229	14.6%	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%	109,037,904	-34.9%	123,923,464	13.5%	123,923,464	13.7%	130,129,375	5.0%
05-00	Nursing Home	76,204,422	81,395,841	6.8%	88,371,251	8.6%	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%	109,114,969	4.4%	113,126,970	3.7%	113,126,970	3.7%	113,958,442	0.7%
07-00	Mental Health Facility	-	9,067	0.0%	866,712	9459.0%	266,575	-69.2%	88,376	-66.8%	346,914	292.5%	(216,883)	-162.5%	66,065	-130.5%	51,342	-22.3%	457,996	792.1%	241,077	369.6%	255,249	5.9%
08-00	Dental	9,893,222	13,246,527	33.9%	13,260,843	0.1%	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%	15,394,658	4.4%	17,935,556	16.5%	17,935,556	16.5%	20,376,083	13.6%
09-01	MH Clinic	708	117,867	16544.4%	18,115	-84.6%	(39,297)	-316.9%	47,771	-221.6%	18,420	-61.4%	37,525	103.7%	44,333	18.1%	133,110	200.3%	219,829	65.1%	146,067	9.7%	181,155	24.0%
10-00	Independent Laboratory	98,395	214,552	118.1%	894,953	317.1%	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%	2,934,437	29.7%	3,725,014	26.9%	3,414,548	16.4%	3,539,427	3.7%
11-00	Home Health	4,038,782	5,426,458	34.4%	6,881,155	26.8%	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%	6,598,664	-15.4%	10,445,806	58.3%	7,432,319	12.6%	7,666,658	3.2%
12-00	RHC & FOHC	2,711,241	4,159,143	53.4%	5,978,347	43.7%	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%	12,235,391	11.8%	12,235,391	-3.6%	13,044,779	6.6%	14,166,105	8.2%
13-00	Hospice	158,778	139,689	-12.0%	232,830	66.7%	372,814	60.1%	353,237	-5.3%	524,835	48.6%	576,137	9.8%	550,093	-4.5%	943,707	71.6%	1,057,330	12.0%	1,057,330	12.0%	1,184,633	12.0%
15-00	Chiropractor	229,648	287,509	25.2%	303,149	5.4%	316,447	4.4%	154,279	-51.2%	88,164	-42.9%	84,868	-3.7%	55,125	-35.0%	49,349	-10.5%	90,484	83.4%	49,349	0.0%	543,633	1001.6%
16-00	Nurse Practitioners	73,066	131,216	79.6%	334,056	154.6%	395,273	18.3%	364,337	-7.8%	598,020	64.1%	617,187	3.2%	541,354	-12.3%	642,493	18.7%	653,828	1.8%	663,055	3.2%	696,988	5.1%
17-00	Skilled Nursing	3,566,756	4,206,527	17.9%	3,952,454	-6.0%	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%	4,120,057	-11.0%	6,007,404	45.8%	4,134,827	0.4%	4,281,143	3.5%
18-00	Podiatrist	65,109	95,802	47.1%	125,035	30.5%	119,505	-4.4%	132,681	11.0%	161,904	22.0%	211,724	30.8%	211,990	0.1%	219,265	3.4%	259,800	18.5%	254,305	16.0%	257,297	1.2%
19-00	Psychologist	386,771	703,573	81.9%	2,750,725	291.0%	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%	12,791,648	3.8%	13,294,718	3.9%	13,294,718	3.9%	14,370,238	8.1%
20-00	Optometrist	372,441	474,561	27.4%	616,779	30.0%	925,973	50.1%	669,818	-27.7%	706,214	5.4%	821,836	16.4%	786,030	-4.4%	816,538	3.9%	874,549	9.4%	874,549	7.1%	926,355	5.9%
21-00	Optician	329,706	497,034	50.8%	422,555	-15.0%	467,733	10.7%	244,641	-47.7%	151,077	-38.2%	187,424	24.1%	202,259	7.9%	225,894	11.7%	242,885	7.5%	237,748	5.2%	270,465	13.8%
22-00	Transportation	3,380,465	3,993,157	18.1%	4,310,859	8.0%	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%	9,591,574	1.8%	10,832,529	12.9%	10,978,624	14.5%	11,878,180	8.2%
23-00	Therapy Services	8,439	64,771	667.5%	170,071	162.6%	425,860	150.4%	600,657	41.0%	939,926	56.5%	1,481,146	57.6%	1,469,402	-0.8%	1,543,450	5.0%	1,577,888	2.2%	1,544,514	0.1%	1,625,102	5.2%
24-00	Prosthetic/Ortho	634,853	800,805	26.1%	1,204,058	50.4%	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%	1,528,914	-7.0%	1,947,933	27.4%	1,640,540	7.3%	1,579,293	-3.7%
25-00	Medical Supplies & DME (26-00)	2,796,427	3,304,128	18.2%	4,117,853	24.6%	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%	6,913,662	-1.5%	9,595,131	38.8%	7,491,291	8.4%	7,740,974	3.3%
27-00	H&CB Services	8,232,353	11,821,025	43.6%	13,462,799	13.9%	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%	35,946,219	9.5%	46,213,025	28.6%	46,812,638	30.2%	50,437,266	7.7%
27-02	H&CB Mental Health Services	5,102	1,575	-69.1%	591	-62.5%	181,551	30619.4%	951,432	424.1%	1,138,960	19.7%	1,157,853	1.7%	810,643	-30.0%	660,124	-18.6%	1,106,588	67.6%	495,966	-24.9%	317,594	-36.0%
27-03	H&CB Mental Retardation	-	-	0.0%	21,709	0.0%	19,295	-11.1%	15,389	-20.2%	24,184	57.2%	-	-100.0%	16,486	0.0%	34,556	109.6%	53,768	55.6%	30,706	-11.1%	35,466	15.5%
27-13	TBI Services	1,467,867	1,801,357	22.7%	2,132,467	18.4%	2,067,138	-3.1%	(14,251)	-100.7%	(60)	-99.6%	-	-100.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
27-17	Enhanced Resident Care	771,738	1,024,666	32.8%	1,220,331	19.1%	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%	4,778,937	42.0%	5,534,172	15.8%	5,534,172	15.8%	5,534,172	0.0%
29-00	Personal Care Services	2,159,543	3,635,964	68.4%	4,236,044	16.5%	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%	16,924,620	3.1%	24,711,626	46.0%	20,386,388	20.5%	24,635,884	20.8%
30-00	Target Case Management	6,237	1,669	-73.2%	3,530	111.5%	8,182	131.8%	(6)	-100.1%	1,658	-27411.2%	8,196	394.4%	2,768	-66.2%	50,788	1734.6%	1,670	-96.7%	373,050	634.5%	290,550	-22.1%
33-04	Assistive Community Care Services	-	1,855,464	0.0%	2,772,394	49.4%	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%	9,781,892	18.5%	12,804,642	30.9%	10,520,396	7.5%	11,349,017	7.9%
34-01	Day Treatment (MHS)	26,309	22,773	-13.4%	15,814	-30.6%	53,373	237.5%	39,432	-26.1%	80,050	103.0%	56,415	-29.5%	65,710	16.5%	75,895	15.5%	145,464	91.7%	75,895	0.0%	78,580	3.5%
35-07	ADAP Families in Recovery	-	-	0.0%	-	0.0%	-	0.0%	53,936	0.0%	122,782	127.6%	303,097	146.9%	12,290	-95.9%	165,521	1246.8%	128,832	-22.2%	126,107	-23.8%	130,570	3.5%
37-01	Healthy Babies, Kids & Families	239,052	253,010	5.8%	129,046	-49.0%	81,276	-37.0%	30,022	-63.1%	543,437	1710.2%	3,736,272	587.5%	3,363,147	-10.0%	4,722,970	40.4%	4,212,237	-10.8%	6,132,825	29.9%	7,349,372	19.8%
38-01	Capitation Fee Health Plans	73,003,994	47,729,244	-34.6%	-	-100.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
38-01	Health Care Risk Pool	750,000	-	-100.0%	657,355	0.0%	(545,908)	-183.0%	-	-100.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
38-03	PC+ Case Management Fees	-	1,356,995	0.0%	3,883,670	186.2%	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%	4,971,875	-9.9%	5,381,342	8.2%	4,989,698	0.4%	5,166,265	3.5%
40-00	Ambulance	591,891	814,585	37.6%	1,246,978	53.1%	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%	2,338,473	-6.8%	3,022,093	29.2%	2,575,963	10.2%	2,575,963	14.0%
41-00	Dialysis	-	-	0.0%	92,802	0.0%	98,166	5.8%	206,113	110.0%	294,592	42.9%	391,569	32.9%	505,642	29.1%	692,468	36.9%	1,236,653	78.6%	797,993	15.2%	928,763	16.4%
42-00	ASC	47,549	134,147	182.1%	92,971	-30.7%	22,941	-75.3%	46,492	102.7%	9,899	-78.7%	6,277	-36.6%	5,084	-19.0%	3,530	-30.6%	36,867	944.				