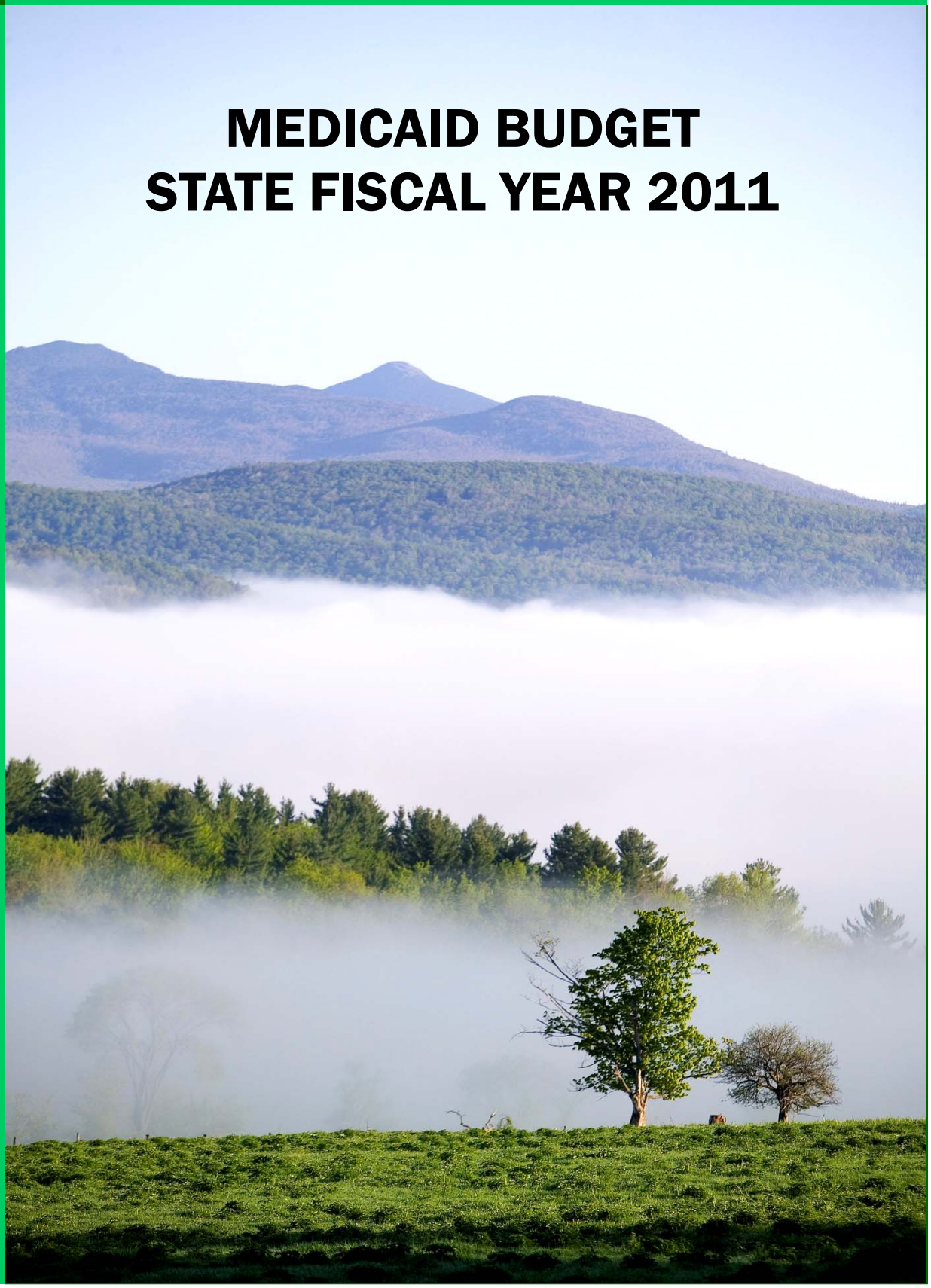
OFFICE of VERMONT HEALTH ACCESS

MEDICAID BUDGET
STATE FISCAL YEAR 2011



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FAST FACTS

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

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

CONTACT INFORMATION

Susan Besio, Director
Email: susan.besio@ahs.state.vt.us

Hunt Blair, Deputy Director, Health Care Reform
Email: hunt.blair@ahs.state.vt.us

Lori Collins, Deputy Director, Policy, Fiscal and Support Services
Email: lori.collins@ahs.state.vt.us

Victoria Loner, Deputy Director, Managed Care Organization
Email: victoria.loner@ahs.state.vt.us

Michael Farber, Medical Director
Email: michael.farber@ahs.state.vt.us

Lorraine Siciliano, Legislative Liaison
Email: lorraine.siciliano@ahs.state.vt.us

Address

312 Hurricane Lane, Suite 201
Williston, Vermont 05495

Phone

802-879-5900

Fax

802-879-5651

Website
www.ovha.vermont.gov

Additional Resources

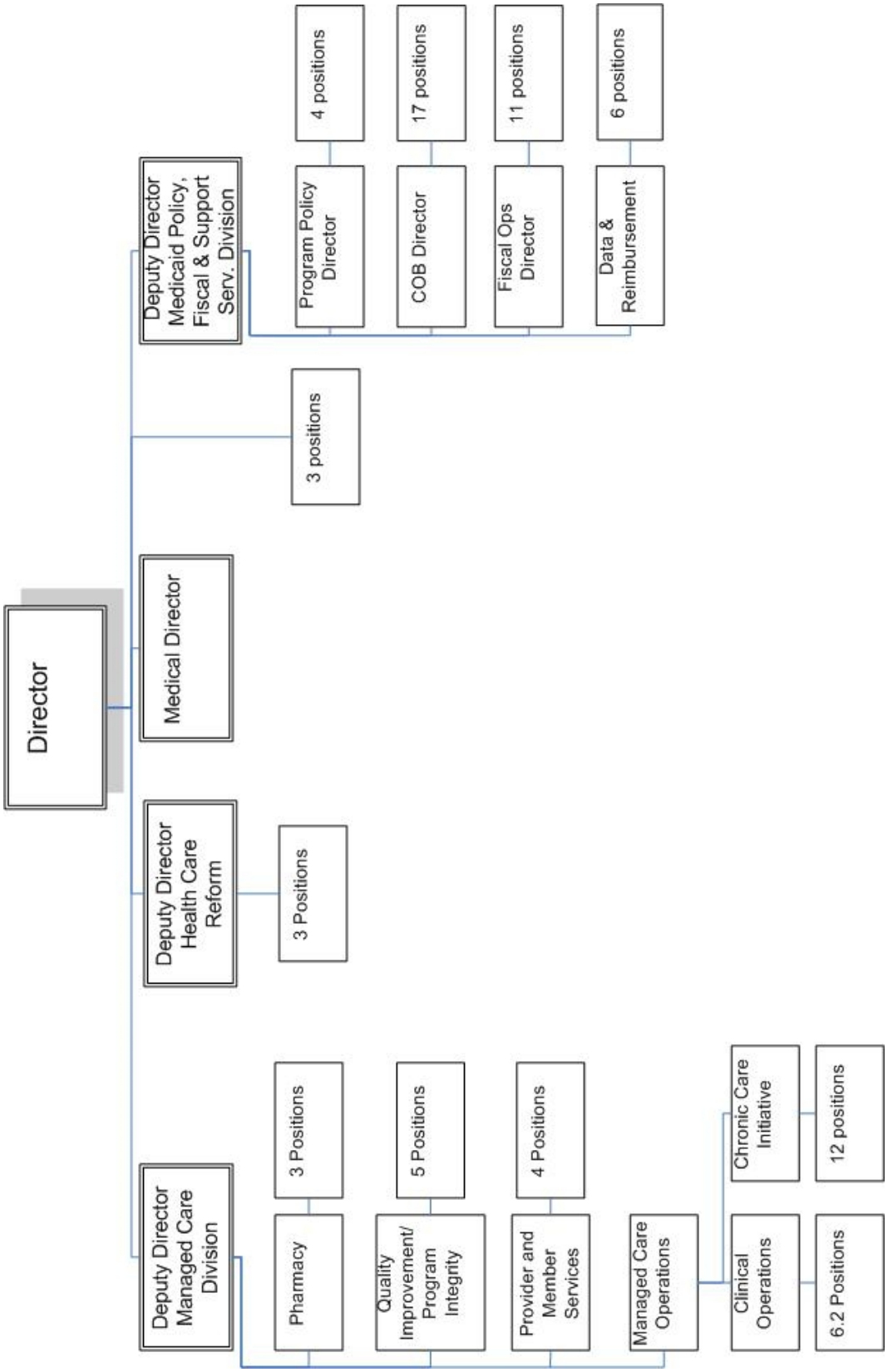
Vermont Health Care Reform
www.hcr.vermont.gov

Vermont Medicaid
www.vtmedicaid.com

Green Mountain Care
www.greenmountaincare.org

Vermont Chronic Care Initiative
www.vtccmp.com

ORGANIZATIONAL CHART



FY11 Department Request - OVHA

	GF	SF	FF	ARRA Fed	Catamnt	Medicaid GCF	Invmnt GCF	Total
OVHA Administration - As Passed FY10	**429,107**	**400,000**	**2,848,458**		**94,739**	**31,887,944**		**35,660,248**
Rescissions:								**0**
Round 3 position reduction						**(705,183)**		**(705,183)**
Early retirement & Round 4	**(9,164)**					**(118,984)**		**(128,148)**
								0
Total Rescissions	**(9,164)**	**0**	**0**	**0**	**0**	**(824,167)**	**0**	**(833,331)**
Total After FY10 Rescission	**419,943**	**400,000**	**2,848,458**	**0**	**94,739**	**31,063,777**	**0**	**34,826,917**
FY10 After Rescission								
Personal Services:								**0**
Annualization of salary						149,570		**149,570**
LTD change						145		**145**
Health insurance change						54,861		**54,861**
Dental change						3,143		**3,143**
Life insurance change						2,875		**2,875**
Retirement change						190,900		**190,900**
FICA change						10,363		**10,363**
EAP change						56		**56**
Cost of retirement benefit	15,000							**15,000**
MMIS procurement	1,115,000		10,035,000					**11,150,000**
Annualization of Catamount in Waiver					(94,739)	94,739		**0**
Movement of HIT Program Management from DII (GC has corresponding down in DII)		2,616,174					339,500	**2,955,674**
Increase Contracts due to the need to feed data to VHCURES						120,000		**120,000**
Staff required to implement program changes:								
1 FTE Need to Expand HIPP Option						60,000		**60,000**
3 FTE addl Program Integrity staff associated with expected program integrity savings						240,000		**240,000**
1 FTE - transportation quality control position						75,000		**75,000**
								0
Operating Expenses:								**0**
Vision charges decrease						(45,834)		**(45,834)**
DII charges decrease						(14,142)		**(14,142)**
Increase in workers' comp and general liability						9,131		**9,131**
								0
Grants:								**0**
								0
FY11 Changes	**1,130,000**	**2,616,174**	**10,035,000**	**0**	**(94,739)**	**950,807**	**339,500**	**14,976,742**
FY11 Gov Recommended	**1,549,943**	**3,016,174**	**12,883,458**	**0**	**0**	**32,014,584**	**339,500**	**49,803,659**
FY11 Subtotal of Legislative Changes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
FY11 As Passed - Dept ID 3410010000	**1,549,943**	**3,016,174**	**12,883,458**	**0**	**0**	**32,014,584**	**339,500**	**49,803,659**

OVHA Global Commitment - As Passed FY10						**522,020,786**		**522,020,786**
Rescissions and other changes								**0**
Expand specialty pharmacy initiative in oncology therapies						**(90,000)**		**(90,000)**
Increased pharma rebate collections due to Vpharm in GC						**(3,200,000)**		**(3,200,000)**
possible revision to Vpharm estimate						**591,045**		**591,045**
Mandate providers use VDH for immunization services						**(213,750)**		**(213,750)**
Total Rescissions	**0**	**0**	**0**	**0**	**0**	**(2,912,705)**	**0**	**(2,912,705)**
Total After FY10 Rescission	**0**	**0**	**0**	**0**	**0**	**519,108,081**	**0**	**519,108,081**
FY10 After Rescission								
Grants:								**0**
Caseload - all standard MEGs						58,468,659		**58,468,659**
Utilization - all standard MEGs (including budgeted efficiency actions, incl DRG and ACCESS Fix)						7,462,227		**7,462,227**
								0
Caseload & trend - Catamount & ESI UNDER 200%						13,288,430		**13,288,430**
								0
Other base pressures:								**0**
Lund and other providers not in trend						1,843,256		**1,843,256**
Buy-in rate increase						3,659,063		**3,659,063**
								0
Pressures, caseload and trend at non-ARRA rate:								**0**
Annualization of Vpharm in waiver - at non-enhanced rate						2,415,819		**2,415,819**
Annualization of Catamount in waiver - at non-enhanced rate						3,318,828		**3,318,828**
Catamount Caseload >200% -						1,364,437		**1,364,437**
ESIA Caseload - >200% -						149,673		**149,673**
Vpharm - non-waiver - caseload -						236,148		**236,148**
Catamount Utilization >200% -						(148,764)		**(148,764)**
ESIA Utilization - >200% -						(115,902)		**(115,902)**
Vpharm - non-waiver - utilization -						(821,175)		**(821,175)**
OVHA - Global Commitment - Continued								
AHS net neutral transactions:								**0**
From OVHA to DAIL - funding for Bridges Program - AHS net neutral						(800,000)		**(800,000)**
From OVHA to DAIL - funding for ISPs - AHS net neutral - added after 12/4						(1,200,000)		**(1,200,000)**
CSHN Direct Billing via EDS (AHS Net Neutral) - From VDH to OVHA - AHS net neutral						312,782		**312,782**
Transfer from DCF to OVHA - FITP Direct Billing via EDS (AHS net neutral)						423,226		**423,226**
								0
Reductions:								**0**
Limit PT/OT/ST to 30 Visits per Calendar Year Eff 7/1/10						(135,571)		**(135,571)**
Require Prior Authorization for Selected Radiology Svcs Eff 7/1/10						(2,000,000)		**(2,000,000)**
Reduce Drug Testing Lab Reimbursement Rate						(110,000)		**(110,000)**
Reduce # of Drug Tests Allowed to 8 per Month						(450,000)		**(450,000)**
Trend cost avoidance: approve 6 positions for Eligibility Determination Quality Control - See new staff in DCF-Admin						(2,563,780)		**(2,563,780)**
AWP Adjustment on Drugs Historically Overfunded						(3,389,429)		**(3,389,429)**
Expand HIPP Option - see new staff in OVHA-Admin						(795,000)		**(795,000)**
Limit emergency svcs to 12 (non-admission) visits per yr						(301,530)		**(301,530)**
Program integrity savings - see new staff in OVHA-Admin						(1,170,000)		**(1,170,000)**
Quality control for transportation program - see new staff in OVHA-Admin						(575,000)		**(575,000)**
Tighten eligibility in Children's Personal Care						(1,000,000)		**(1,000,000)**
Reduce FQHC reimbursement rate						(138,526)		**(138,526)**
Limit adult dental to $200 - net of add'l GA emergency costs						(1,476,501)		**(1,476,501)**
Shift to Catamount II						(11,482,134)		**(11,482,134)**
FY11 Changes	**0**	**0**	**0**	**0**	**0**	**64,269,236**	**0**	**64,269,236**
FY11 Gov Recommended	**0**	**0**	**0**	**0**	**0**	**583,377,317**	**0**	**583,377,317**
OVHA Global Commitment - Continued								
FY11 Subtotal of Legislative Changes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
FY11 As Passed - Dept ID 3410015000	**0**	**0**	**0**	**0**	**0**	**583,377,317**	**0**	**583,377,317**

OVHA - Med Prog-non-GC LTC Waiver-As Passed FY10	**61,072,899**		**119,767,105**	**22,465,253**				**203,305,257**
Rescissions:								**0**
Contract & Grant disc reduction Sec. B-1104	**9,738**							**9,738**
Total Rescissions	**9,738**	**0**	**0**	**0**	**0**	**0**	**0**	**9,738**
Total After FY10 Rescission	**61,082,637**	**0**	**119,767,105**	**22,465,253**	**0**	**0**	**0**	**203,314,995**
FY10 After Rescission								
								0
Both Traditional & Acute:								**0**
53rd EDS pmt	2,081,148		3,426,020	327,832				**5,835,000**
								0
Traditional:								**0**
Pressures:								**0**
Traditional LTC share: ARRA e-FMAP reduced 1/2	9,541,907			(9,541,907)				**0**
NH inflation 3% approx	1,008,000		1,644,020	147,980				**2,800,000**
NH - Add 3% est increase on OOS, Crossover, Swing	74,900		123,302	11,799				**210,000**
NH - Case mix creep in post rebase year	641,999		1,056,870	101,131				**1,800,000**
Increases in Consumer Directed Unemployment & WC costs	69,777		114,869	10,992				**195,638**
Nursing Home extraordinary financial relief	535,106		880,901	84,292				**1,500,300**
								0
Reductions:								**0**
Nursing Homes - Cut rate paid for 4 of the lowest case mix scores by 50%	(285,333)		(469,720)	(44,947)				**(800,000)**
HCBS - Modify rules to change reimbursement from 15 minute units to monthly rate of $50.	(108,380)		(178,417)	(17,072)				**(303,869)**
HCBS - Reduce home health agency-directed Personal Care Attendant rate from $26.15/hr to $22/hr	(692,522)		(1,140,041)	(109,089)				**(1,941,652)**
HCBS - Modify rules to change reimbursement from 15 minute units to $110 monthly rate for HB case management services	(151,941)		(250,127)	(23,934)				**(426,002)**
HCBS - Modify rules to tighten personal care variances; maintain variance in service hours for respite and companion services.	(208,217)		(342,771)	(32,799)				**(583,787)**
HCBS - Flexible Choices option, change procedures to reduce authorized budgets and actual expenditures by 10%. Eliminate annual carryover of unspent funds.	(90,316)		(148,680)	(14,227)				**(253,224)**
HCBS - Modify regulations to reduce case management for Enhanced Residential Care participants to 3 hours/year.	(8,806)		(14,497)	(1,387)				**(24,690)**
OVHA - Long Term Care - Continued								
Acute:								**0**
Buy-in rate increase	139,801		230,142	22,022				**391,965**
								0
Acute share: ARRA e-FMAP reduced 1/2	1,690,720			(1,690,720)				**0**
Acute: caseload - assume no increase in home-based caseload	0		0	0				**0**
Acute - utilization	(998,048)	0	(1,627,691)	(155,480)				**(2,781,219)**
								0
FMAP adjustment	197,068		(395,982)	198,914				**0**
								0
FY11 Changes	**13,436,863**	**0**	**2,908,199**	**(10,726,602)**	**0**	**0**	**0**	**5,618,459**
FY11 Gov Recommended	**74,519,500**	**0**	**122,675,304**	**11,738,651**	**0**	**0**	**0**	**208,933,454**
FY11 Legislative Changes								**0**
FY11 Subtotal of Legislative Changes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
FY11 As Passed - Dept ID 3410016000	**74,519,500**	**0**	**122,675,304**	**11,738,651**	**0**	**0**	**0**	**208,933,454**

OVHA - Medicaid Program - State Only - As Passed FY10	**28,195,859**				**3,318,828**		**1,510,264**	**33,024,951**
Rescissions:								**0**
Use FY09 GF carryforward	**(1,196,067)**							**(1,196,067)**
CMS approval for Vpharm in GC waiver	**(2,666,906)**							**(2,666,906)**
								0
Total Rescissions	**(3,862,973)**	**0**	**0**	**0**	**0**	**0**	**0**	**(3,862,973)**
Total After FY10 Rescission	**24,332,886**	**0**	**0**	**0**	**3,318,828**	**0**	**1,510,264**	**29,161,978**
FY10 After Rescission								
Grants:								**0**
One-time carry-forward funds rescinded as on going	1,196,067							**1,196,067**
Clawback Increase	1,301,613							**1,301,613**
Annualization of Vpharm in waiver	(2,415,819)							**(2,415,819)**
Annualization of Catamount in waiver					(3,318,828)			**(3,318,828)**
Civil Union & HIV Caseload							256,639	**256,639**
Civil Union & HIV Utilization							(132,954)	**(132,954)**
Buy-in rate increase							75,560	**75,560**
								0
FY11 Changes	**81,861**	**0**	**0**	**0**	**(3,318,828)**	**0**	**199,245**	**(3,037,722)**
FY11 Gov Recommended	**24,414,747**	**0**	**0**	**0**	**0**	**0**	**1,709,509**	**26,124,256**
FY11 Subtotal of Legislative Changes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
FY11 As Passed - Dept ID 3410017000	**24,414,747**	**0**	**0**	**0**	**0**	**0**	**1,709,509**	**26,124,256**

OVHA - Medicaid Matched NON Waiver Expenses - As Passed FY10	**16,976,310**		**28,515,058**	**1,060,380**				**46,551,748**
FY10 After Rescission								
Grants:								**0**
Correct DSH appropriation related to ARRA funding			1,060,380	(1,060,380)				**0**
CHIP Caseload	189,657		469,790					**659,447**
CHIP Utilization	68,656		170,064					**238,720**
Refugee Caseload & Utilization			195,473					**195,473**
Buy-in rate increases			512,441					**512,441**
								0
FMAP Changes - multiple - DSH and CHIP	34,246		(34,246)					**0**
								0
FY11 Changes	**292,559**	**0**	**2,373,902**	**(1,060,380)**	**0**	**0**	**0**	**1,606,081**
FY11 Gov Recommended	**17,268,869**	**0**	**30,888,960**	**0**	**0**	**0**	**0**	**48,157,829**
FY11 Subtotal of Legislative Changes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
FY11 As Passed - Dept ID 3410018000	**17,268,869**	**0**	**30,888,960**	**0**	**0**	**0**	**0**	**48,157,829**

TOTAL FY10 OVHA Big Bill As Passed	**106,674,175**	**400,000**	**151,130,621**	**23,525,633**	**3,413,567**	**553,908,730**	**1,510,264**	**840,562,990**
TOTAL FY10 OVHA Reductions/Rescissions	**(3,862,399)**	**0**	**0**	**0**	**0**	**(3,736,872)**	**0**	**(7,599,271)**
TOTAL FY11 OVHA Starting Point	**102,811,776**	**400,000**	**151,130,621**	**23,525,633**	**3,413,567**	**550,171,858**	**1,510,264**	**832,963,719**
TOTAL FY11 OVHA ups & downs	**14,941,283**	**2,616,174**	**15,317,101**	**(11,786,982)**	**(3,413,567)**	**65,220,043**	**538,745**	**83,432,797**
TOTAL FY11 OVHA Gov Recommended	**117,753,059**	**3,016,174**	**166,447,722**	**11,738,651**	**0**	**615,391,901**	**2,049,009**	**916,396,516**
TOTAL FY11 OVHA Legislative Changes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL FY11 OVHA As Passed	**117,753,059**	**3,016,174**	**166,447,722**	**11,738,651**	**0**	**615,391,901**	**2,049,009**	**916,396,516**

Budget Considerations SFY 2011

January 20, 2010

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

ADMINISTRATION . . . . . $14,976,742 (gross)

PERSONAL SERVICES. $801,913

Payact and Related Fringe $426,913

New Positions to Implement Savings Initiatives $375,000
Several policy savings initiatives (described in detail on the following pages) require additional staff in order to achieve the estimated reduction in expenditures. The additional full-time-equivalents (FTEs) that will be obtained from the Human Resources position pool are as follows:

HIPP Expansion (1 FTE) . . . . . $ 60,000
Program Integrity Expansion (3 FTEs) $240,000
Transportation Quality Control (1 FTE) . . . . . $ 75,000

OPERATING . . . . . .($50,845)
The OVHA receives allocations from BGS to cover our share of the Vision system and DII costs. BGS notifies each department every year of increases or decreases in their relative share in order to incorporate these changes into budget requests. For SFY ’11 it is anticipated that for the OVHA, Vision costs will decrease by $45,834 and DII costs will decrease by $14,142. Additionally, it is projected that OVHA will have a $9,131 increase in workers’ compensation expenditures.

GRANTS AND CONTRACTS $14,225,674

The MOVE Initiative (one-time) $11,150,000
The Modernization of Vermont's Enterprise, also known as MOVE, is a project to replace key Agency of Human Services (AHS) information systems related to eligibility (current ACCESS) and claims processing (current MMIS system).

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

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

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

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

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

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

- The technical assistance (TA) contractor is responsible for providing consultative services to the State and assist with planning and development of CMS documents (such as funding requests) and Request for Proposal (RFP) efforts (such as producing the RFP and evaluating the proposals). The State is in final contract negotiations with the TA vendor.

- The Design, Develop and Implementation (DDI) contractor is responsible for developing and/or configuring the desired system as it was specified in the requirements which the TA contractor produced. This RFP is expected to be released in June, 2010.

- The Independent Verification and Validation (IV&V) contractor acts as an independent 3rd party assessor providing quality assurance and validates that the work provided by the DDI contractor is in sync with State and CMS expectations as defined in the RFP and the approved contract. This RFP is expected to be released in June, 2010.

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

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

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

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

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

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

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

VHCURES Data Feed . . . . . $ 120,000

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

PROGRAM . . . . . $68,456,055 (gross)

UPDATED TREND CHANGES $98,376,751

Caseload and Utilization Impact $86,669,035

Caseload $75,951,892

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

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

Utilization $10,717,143

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

Green Mountain Care

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

Medicaid for Adults

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

Medicaid covers most health care services such as doctor visits, hospital care, prescription medicines, vision and dental care, long-term care, physical therapy and more. Medicaid is a low-cost program, and costs may include co-payments of $3 for outpatient visits and dentist visits; co-payments of $1-$3 for prescription medicines; and $75 for an inpatient admission.

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

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

The following table depicts the caseload and expenditure information by SFY, including the Governor's Recommend for SFY '11 for ABD and/or Medically Needy Adults:

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

Dual Eligibles

Dual Eligibles are eligible for both Medicare and Medicaid. Medicare eligibility is either due to being at least 65 years of age, or categorized as blind, or disabled; expenditures exclude buy-in and clawback.

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

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

General Adults

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

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

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

Vermont Health Access Plan (VHAP)

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

VHAP covers a wide range of services including hospital care, prescription medicines, mental health and doctor visits.

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

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

VHAP Employer-Sponsored Insurance Premium Assistance

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

- The employee meets the eligibility criteria to enroll in the Vermont Health Access Plan (VHAP);
- The employee's household income is under 300%FPL for one person;

- The employer's plan has comprehensive benefits; and
- The cost of providing premium assistance to enroll in an employer's plan is less than the cost of providing premium assistance to enroll in Catamount Health or the VHAP.

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

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

Catamount Health and Premium Assistance

Catamount Health is a health insurance plan offered in cooperation with Blue Cross Blue Shield of Vermont and MVP Health Care. It provides comprehensive, quality health coverage at a reasonable cost no matter how much an individual earns. The intent of this program is to reduce the number of uninsured citizens of Vermont. Help is also available in paying premiums, based on income. Premium subsidies are available to those who fall at or below 300% of the federal poverty level (FPL).

Catamount Health is designed for Vermont residents who meet the following qualifications:

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

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

- Access is not available to comprehensive health insurance through their employer as determined by the state; or
- Employer's plan offers comprehensive benefits, but it is more cost-effective for the state to provide premium assistance to enroll in Catamount Health or VHAP than to provide premium assistance to enroll in employer's plan; or
- Waiting for the open enrollment period to enroll in employer's plan.

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

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

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

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

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

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

Dr. Dynasaur

Dr. Dynasaur is the umbrella name that encompasses all of the health care coverage programs available for children up to age 18 (SCHIP, Underinsured Children) or up to age 21 (Blind or Disabled (BD) and/or Medically Needy Children and General Medicaid).

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

Blind or Disabled (BD) and/or Medically Needy Children
The general eligibility requirements for BD and/or Medically Needy Children are:

under age 21, categorized as blind or disabled, generally includes Supplemental Security Income (SSI) cash assistance recipients, hospice patients, eligible under "Katie Beckett" rules, and medically needy Vermonters [i.e., eligible because their income is greater than the cash assistance level but less than the Medicaid protected income level (PIL)]. Medically needy children may or may not be blind or disabled.

The following table depicts the caseload and expenditure information by SFY, including the Governor's Recommend for SFY '11 for BD and/or Medically Needy Children:

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

General Children

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

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

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

Underinsured Children

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

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

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

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

The following table depicts the caseload and expenditure information by SFY, including the Governor's Recommend for SFY '11 for the State Children's Health Insurance Program (SCHIP):

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

Prescription Assistance Pharmacy Only Programs

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

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

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

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

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

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

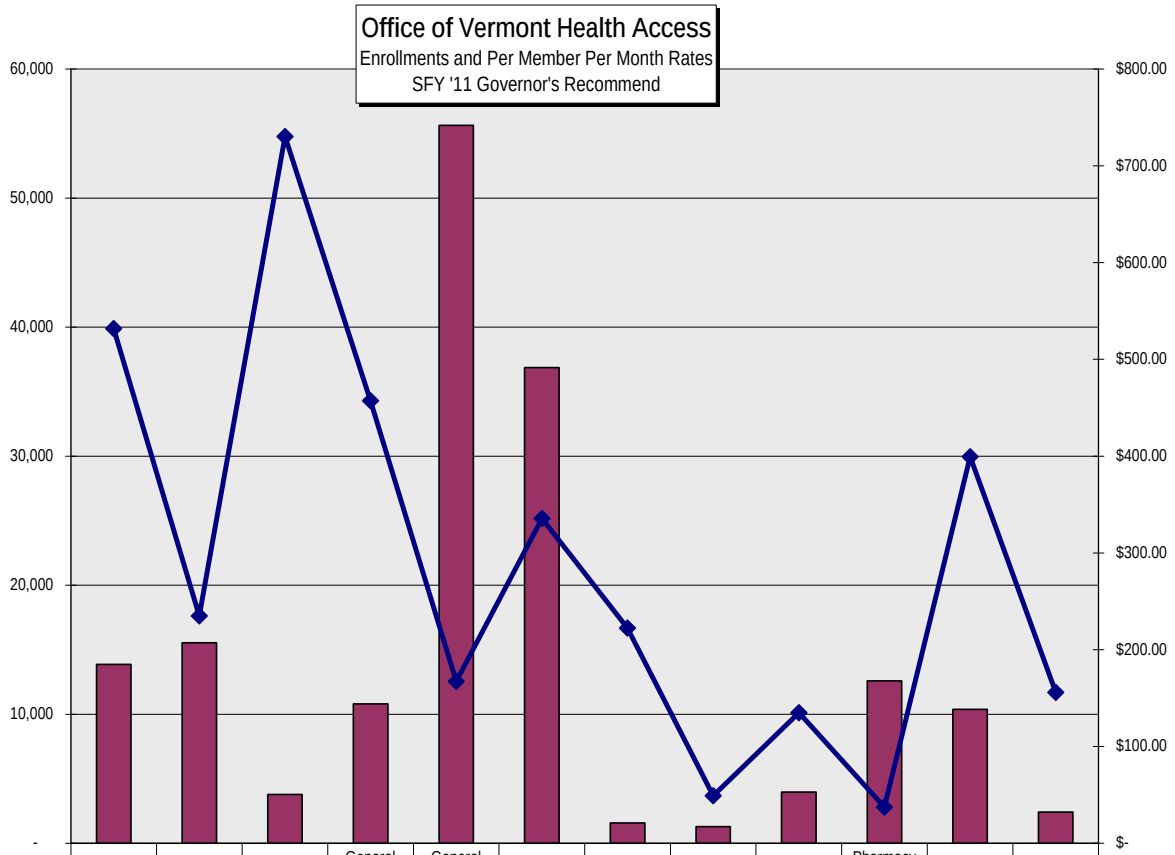
Pharmacy Only Programs			
SFY	Caseload	Expenditures	P.M.P.M.
SFY '08 Actual	12,737	$ 8,052,596	$ 52.69
SFY '09 Actual	12,456	$ 7,535,743	$ 50.42
SFY '10 Appropriated	12,498	$ 6,513,896	$ 43.43
SFY '10 Budget Adjustment	12,659	$ 1,399,166	$ 9.21
SFY '11 Governor's Recommend	12,580	$ 5,637,397	$ 37.34

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

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

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

Enrollments and Per Member Per Month Rates SFY 2011



	ABD Adult	ABD Dual	BD Child	General Adult	General Child	VHAP	VHAP ESI	Optional	SCHIP	Pharmacy Only	Catamount	ESIA
SFY '11 Gov. Rec.	13,866	15,536	3,771	10,786	55,631	36,862	1,564	1,282	3,966	12,580	10,379	2,413
SFY '11 P.M.P.M.	$531.93	$234.88	$730.34	$457.17	$167.25	$335.62	$222.30	$49.12	$134.93	$37.34	$399.57	$155.82

Increase in Clawback Rates $1,301,613

The Medicare Modernization Act (MMA) was signed into law on December 8, 2003. On January 1, 2006, after many months of preparation, the Medicare Part D benefit became available. Currently, all beneficiaries of Vermont's publicly funded pharmacy programs who are also covered by Medicare should receive their primary pharmacy benefit from Medicare. Medicare Part D design calls for states to annually pay a portion of what they would have paid in Medicaid "state share" in that year for the support of drug coverage of the Medicare beneficiaries who are or would be eligible for Medicaid drug coverage. This is referred to as "Clawback" or "state phase down." While the design of this contribution included "phased down" sharing, the rate of inflation exceeds that of the federal phase down percentage resulting in a net increase in the Clawback rate.

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

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

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

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

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

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

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

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

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

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

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

GOVERNOR'S RECOMMENDED POLICY INITIATIVES . . . . . ($29,920,696)

Limit PT/OT/ST Visits to 30 per Year . . . . . ($135,572)

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

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

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

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

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

The following will NOT be subject to prior authorization:

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

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

Reduce Drug Testing Lab Reimbursement Rates . . . . . ($110,000)
In SFY '09, approximately 7,991 beneficiaries received urine drug testing to test for the presence of illegal drugs, for a total Medicaid expenditure of $6,253,667. The estimated cost of this urine test is $1.03 per unit. Vermont's current rates of Medicaid reimbursement are $17.49 to independent laboratories, $10.84 for outpatient laboratories, and $10.49 for inpatient laboratories. New York Medicaid pays $1.25, Massachusetts $13.81, and New Hampshire $15.22. All of these states have only one rate of reimbursement. This proposal would set on standard rate of reimbursement for Vermont at $10.49.

Reduce # of Urine Drug Tests Allowed to 8/Month . . . . . ($450,000)
Currently there are no limitations in place on how many urine drug tests can be performed for a beneficiary in any given time period. For example, some Vermonters have these checks done daily. However, according to SAMSHA (Substance Abuse and Mental Health Services Administration) guidelines "...each new patient is asked to provide one random urine sample per week for the first six months and samples less frequently thereafter, based on treatment progress." In addition, SAMSHA's guideline for Opioid Treatment Programs (OTP) references the following regulation:

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

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

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

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

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

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

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

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

to add 6 FTEs from the Human Resources position pool to the DCF QC/Fraud Unit, with an estimated savings for SFY '11 of $2,563,780**.** As we embark on expanded efforts, it is important to note that savings will not continue to expand each year. Once these efforts are in effect, fraud and abuse should diminish. Savings will come primarily from prevention and cost avoidance as opposed to recouping dollars from fraudulent actions.

Reduce AWP on Drugs Historically Overfunded . . . . . ($3,389,429)
Reimbursement for pharmaceuticals must reflect the true costs of the drugs and not artificially inflated prices.

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

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

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

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

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

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

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

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

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

Example Represents a Brand Drug whose WAC = $ 80

OVHA - Prior to July 15, 2009		OVHA- July 15, 2009		OVHA - After 9/26/09 AWP Rollback		OVHA - After 11/06/09 Removal of Rollback	
WAC	$ 80.00	WAC	$ 80.00	WAC	$ 80.00	WAC	$ 80.00
AWP = WAC x 1.25		AWP = WAC x 1.25		Rollback AWP = WAC x 1.20		Unadjusted AWP = WAC x 1.25	
AWP	$ 100.00	AWP	$ 100.00	RollbackAWP	$ 96.00	Unadjusted AWP	$ 100.00
Discount off AWP	11.90%	Discount off AWP	14.20%	Discount off Rollback AWP	14.20%	Discount off Unadjusted AWP	14.20%
AWP - 11.9 % =	$ 88.10	AWP - 14.2 % =	$ 85.80	Rollback AWP - 14.2 % =	$ 82.37	Unadjusted AWP - 14.2 % =	$ 85.80
Dispensing Fee	$ 4.75	Dispensing Fee	$ 4.75	Dispensing Fee	$ 4.75	Dispensing Fee	$ 4.75
Total to Phmy =	$ 92.85	Total to Phmy =	$ 90.55	Total to Phmy =	$ 87.12	Total to Phmy =	$ 90.55

Estimated Commercial - Prior to 9/26/09						Estimated Commercial - After 9/26/09					
WAC	$ 80.00		WAC	$ 80.00		WAC	$ 80.00		WAC	$ 80.00	
AWP = WAC x 1.25			AWP = WAC x 1.25			Unadjusted AWP = WAC x 1.25			Unadjusted AWP = WAC x 1.25		
AWP	$ 100.00		AWP	$ 100.00		Unadjusted AWP	$ 100.00		Unadjusted AWP	$ 100.00	
Discount off AWP	16.00%	TO	Discount off AWP	17.00%		Discount off Unadjusted AWP	16.00%	TO	Discount off Unadjusted AWP	17.00%	
AWP - 16 % =	$ 84.00		AWP - 16 % =	$ 83.00		Unadjusted AWP - 16 % =	$ 84.00		Unadjusted AWP - 17 % =	$ 83.00	
Dispensing Fee	$ 2.25		Dispensing Fee	$ 2.25		Dispensing Fee	$ 2.25		Dispensing Fee	$ 2.25	
Total to Phmy =	$ 86.25		Total to Phmy =	$ 85.25		Total to Phmy =	$ 86.25		Total to Phmy =	$ 85.25	

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

Expand Health Insurance Premium Program (HIPP). . . . . ($795,000)
Currently there is a limited number (approximately 60) of traditional Medicaid beneficiaries for whom OVHA participates with their employer or private group health insurer (ESI) in order to enroll these individuals into the private healthcare available to them. Under this Health Insurance Premium Program (HIPP), OVHA determines whether it is more cost effective to pay the premium, all other cost cost-sharing, and wrap benefits for their ESI coverage as compared to enrolling them in Medicaid. We are proposing to extend this program to all beneficiaries currently enrolled in all Medicaid programs (other than VHAP and Dual Medicaid/Medicare eligible) that are employed more than 20.5 hours per week and have access to employer-based insurance (estimated at 116 beneficiaries for SFY '11 across all programs). We also are proposing to add one FTE to implement this expansion. Following are examples of how the cost effectiveness tests are applied:

Cost Effectiveness Tests

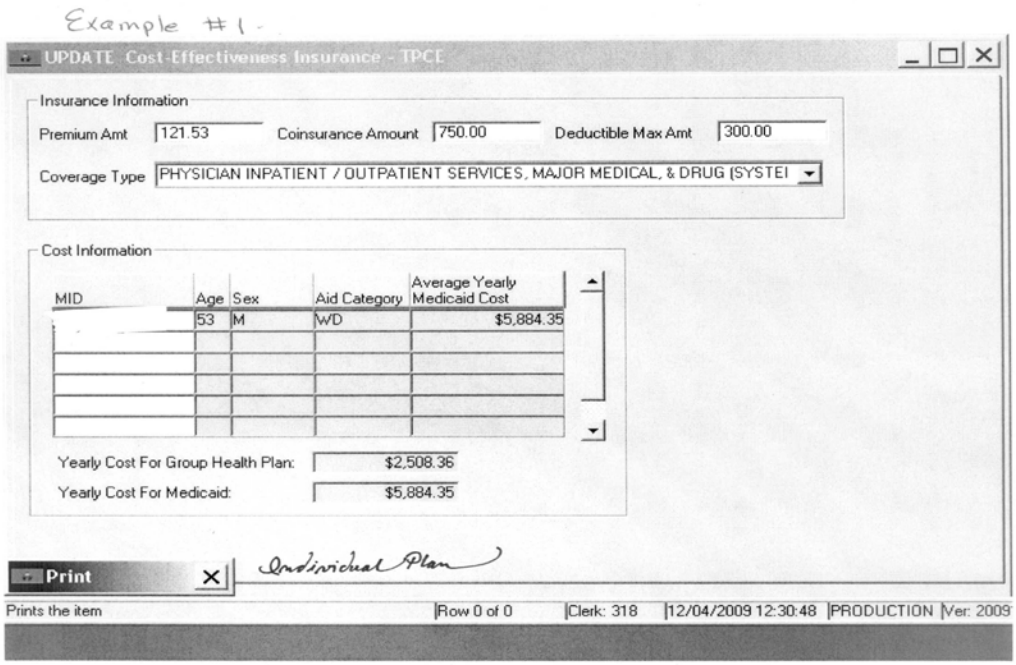
Example #1 - Individual Plan

Premium Amount	$ 121.53
Coinsurance Amount (if any)	$ 750.00
Deductible Max Amount	$ 300.00
Yearly Cost for Group Health Plan:	$ 2,508.36

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

Yearly Cost for Medicaid: $ 5,884.35

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



Example #2 – Family Plan

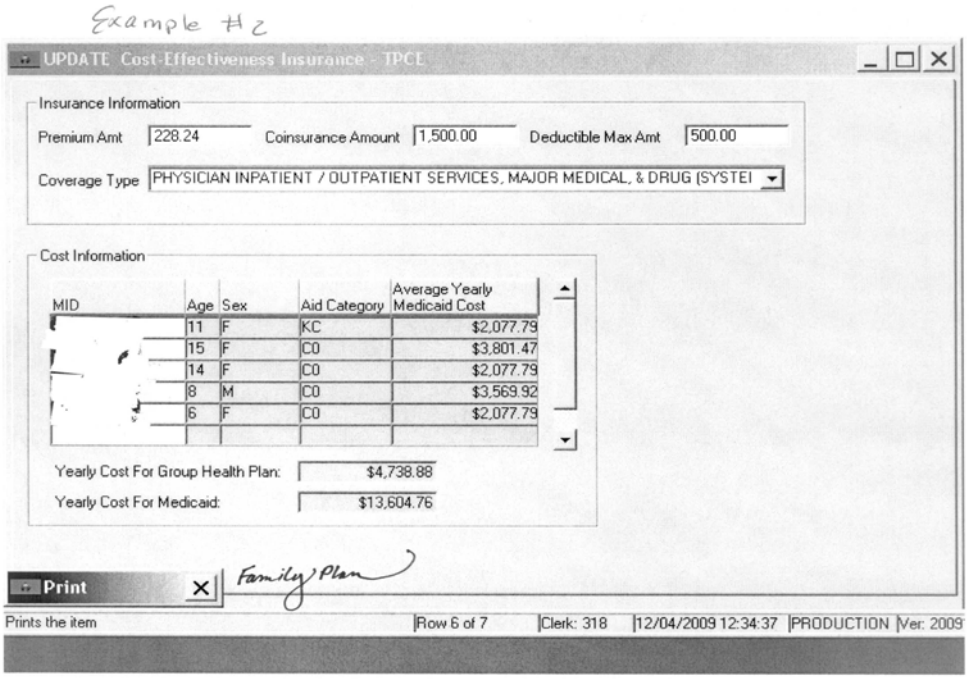
Premium Amount	$ 228.24
Coinsurance Amount (if any)	$ 1,500.00
Deductible Max Amount	$ 500.00

Yearly Cost for Group Health Plan: $ 4,738.88

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

Yearly Cost for Medicaid: $13,604.76

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



Example #3

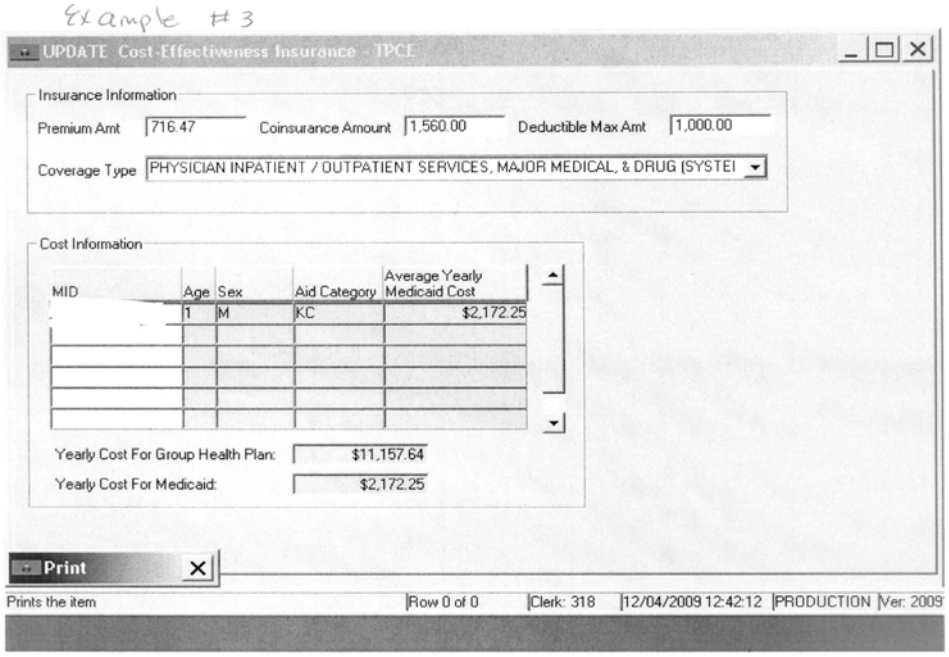
Premium Amount	$ 716.47
Coinsurance Amount (if any)	$ 1,560.00
Deductible Max Amount	$ 1,000.00

Yearly Cost for Group Health Plan: $11,157.64

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

Yearly Cost for Medicaid: $ 2,172.25

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



Example #4

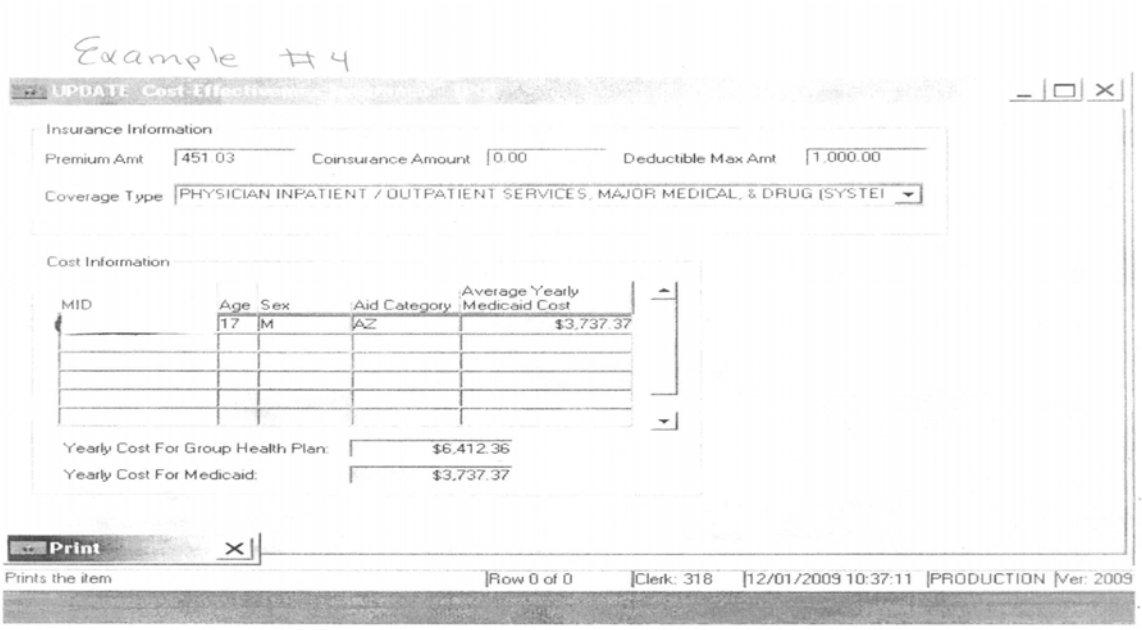
Premium Amount	$ 451.03
Coinsurance Amount (if any)	$ 0.00
Deductible Max Amount	$1,000.00

Yearly Cost for Group Health Plan: $6,412.36

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

Yearly Cost for Medicaid $3,737.37

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



Limit Emergency Room Services to 12 per Year . . . . . (.....) ($301,530)
The Emergency Medical Treatment and Labor Act (EMTALA) prevents limiting access to the emergency room (ER) – the ER is required by law to perform a screening exam (99281-99283) to rule out an emergency and then may either request permission to provide treatment or, if an emergency, must stabilize the patient before calling the provider or insurer. Both Rhode Island and New Hampshire Medicaid programs limit ER visits to 12 per year for situations where a Medicaid beneficiary is not admitted or transferred to another inpatient facility as a result of the emergency room visit. Under this proposal, OVHA will not reimburse for more than 12 emergency room visits per year in this same manner. However, OVHA registered nurses and social workers in the Chronic Care Program are proactively beginning to reach out to the 180 beneficiaries and their selected primary care physicians that have been identified as having >12 non-emergent ER visits in SFY '09 to offer case management services. Additionally, on a quarterly basis the OVHA will monitor non-emergent ER use to identify beneficiaries that may exceed the 12 visit limit to initiate case management services. As such, these individuals will be contacted and supported by care coordinators to better assist them to avoid emergency room use. This will increase the quality of care for these beneficiaries and also limit any liability hospitals may incur due to unreimbursed emergency room visits by OVHA beneficiaries.

Enhance Program Integrity Activity. . . . . ($1,170,000)
Improper provider payments waste scarce health care resources. Two VT agencies, the Program Integrity Unit (PIU) of the Office of VT Health Access (OVHA) and the Medicaid Fraud and Residential Abuse Unit (MFRAU) of the Office of the Attorney General, are committed to combating provider fraud and abuse in the VT Medicaid program.

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

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

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

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

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

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

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

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

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

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

State	Medicaid Beneficiaries	Medicaid Expenditures	PI Staffing (FTE)
Vermont	141,922	$1.26B	4
Connecticut	400,000	$4.1B	25
Nevada	166,437	$1.2B	13
New Hampshire	111,591	$1.22B	8 + 1 admin
Delaware	105,800	$1B	24
Maine	225,000	$3B	12
Maryland	250,000	$2B	14

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

Enhance Quality Control on Transportation Services . . . . . ($575,000)
Non-Emergency Medical Transportation (NEMT) is a service available to Medicaid and Dr. Dynasaur beneficiaries under certain conditions such as when transportation is not otherwise available, when transportation is to/from a necessary (covered) medical service, and to a medical service that is generally available to and used by other members of the community in which the beneficiary is located (i.e., travel beyond 30 miles or out-of-state requires an out-of-area/state request). The mode (e.g., van, taxi, volunteer, bus pass) of transportation is determined based on the least costly mode suitable to the medical needs of the beneficiary. Prior authorization is required. In SFY '09, 11,169 beneficiaries received non-emergency medical transportation services for a total expenditure of $11,694,573.

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

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

Tighten Eligibility for Children's Personal Care Services . . . . . ($1,000,000)
Detail testimony about these proposed reductions will be provided by the Department of Disabilities, Aging and Independent Living (DDAIL).

Reduce FQHC Reimbursement Rate . . . . . ($138,526)
Federally-funded Federally-Qualified Health Centers (FQHCs) must meet the following federal health center grant requirements and are required to report administrative, clinical and other information to the federal Bureau of Primary Health Care, HRSA:

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

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

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

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

Adult Dental Cap Decrease ($495 to $200) . . . . . ($ 1,476,501)
Adult dental benefits are currently provided for beneficiaries enrolled in Medicaid/Dr. Dynasaur programs, with an annual cap of $495. Allowable charges within this cap include an exam and cleaning 2 times per year and endodontic limited to 3 teeth per lifetime. Crowns, bridges, orthodontia and periodontal services are not covered. In addition, individuals who need emergency dental care for bleeding, pain or infection can access General Assistance (GA) Vouchers for procedures related to these conditions (i.e., exams, incisions, drainage, and minor procedures). If the individual is a Medicaid beneficiary, the claims associated with these GA voucher services are paid by OVHA.

Given current fiscal realities, we are proposing to reduce the annual cap from $495 to $200. In FY09, there were 13,213 adults who accessed dental benefits, and 6,682 of these individuals would have been impacted by this proposed change. As such, the estimated savings for this proposal assumes that OVHA will experience a 10% increase in claims associated with the use of GA vouchers by Medicaid beneficiaries for these emergency dental procedures.

Changes in DDAIL Rates and Rules . . .. ($4,333,224)
Detail testimony about these proposed reductions will be provided by the Department of Disabilities, Aging and Independent Living (DDAIL). In summary, savings will be achieved by: (1) modifying rules to change reimbursement from 15 minute units to a monthly rate of $50; (2) reducing the home health agency-directed Personal Care Attendant rate from $26.15/hr to $22/hr; (3) modifying rules to change reimbursement from 15 minute units to $110 monthly rate for HB case management services; (4) modifying rules to tighten personal care variances and maintain variance in service hours for respite and companion services; (5) changing procedures to reduce authorized budgets and actual expenditures by 10% and eliminating annual carryover of unspent funds; and (7) modifying regulations to reduce case management for Enhanced Residential Care participants to 3 hours/year.

CATAMOUNT II . . . . . (($11,482,134)

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

CATAMOUNT II Design

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

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

Model Assumptions:

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

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

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

Catamount and ESIA Beneficiary Premium Schedule

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

Office of Vermont Health Access

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

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

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

Office of Vermont Health Access

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

CATAMOUNT II

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

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

Office of Vermont Health Access

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

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

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

REVENUE IMPLICATIONS $8,951,019

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

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

Premiums

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

Federal		58.03%	$ 7,872,529		$ 10,163,201	$ 2,290,672
ARRA		6.30%	$ 624,162		$ 835,685	
GF		35.67%	$ 6,153,184		$ 7,680,924	**$ 1,739,263**
Total			$ 14,649,875		$ 18,679,810	$ 4,029,935

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

Vermont Medicaid Premium History Through SFY '11

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

* Per family per month
** Per individual for 6 months
*** Per individual per month
**** Implementation of Pharmacy Premiums 1/1/2004 replacing cost sharing

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

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

	FY08 Actual	FY09 Actual	FY10 As Passed	FY10 BAA	FY11 Gov. Rec.
General Hospitals	61,686,261	66,413,401	74,396,881	72,285,982	81,722,693
Psych. Hospitals	876,955	885,672	848,818	848,590	858,760
Nursing Homes	14,559,205	13,004,774	13,816,171	13,536,996	13,060,927
Home Health	4,426,736	3,864,347	4,062,099	4,101,901	4,088,575
ICF-MR	61,104	62,059	61,666	66,002	66,002
Pharmacy - $0.10/script	603,986	835,186	800,000	800,000	800,000
-	82,214,247	85,065,439	93,985,635	91,639,471	100,596,957

7,325,812 Increase Over Appropriated

9,436,711 Increase Over Actual SFY 10 Tax Basis

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

POLICY CHANGES . . . . . $ 0

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

  18 VSA § 4474c(b) is amended to read:
  (b) This chapter shall not be construed to require that coverage or reimbursement for the use of marijuana for symptom relief be provided by:
  (1) a health insurer as defined by section 9409 of this title, or any insurance company regulated under Title 8;
  (2) Medicaid, Vermont health access plan, and any other public health care assistance program;
  (3) an employer; or
  ~~(3)~~ (4) for purposes of workers' compensation, an employer as defined in subdivision 601 (3) of Title 21.

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

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

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

  Specifically, repealing the following language is proposed:

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

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

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

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

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

PROGRAM	WHO IS ELIGIBLE	BENEFITS	COST-SHARING
Medicaid[1] **PIL[2]** **Medicaid Working Disabled 250% FPL[3]**	• Aged, blind, disabled • Parents or caretaker relatives of a dependent child • Children up to age 21 • Disabled working adults	• Covers: physical and mental health, dental ($495 cap/yr), prescriptions, chiro (limited). • Not covered: dentures, eyeglasses. • Covers excluded classes of Medicare Part D drugs for dual-eligible individuals. • <21 same as Dr. Dynasaur	• No program fee. Some co-pays age 18-21. • $1/$2/$3 prescription co-pay if no Medicare Part D coverage. • $1.10 -$6.30 co-pays if have Part D. Medicare Part D is primary prescription coverage for Medicaid/Medicare recipients. • $3 dental co-pay • $3/outpatient hospital visit • $75/inpatient admission
Dr. Dynasaur 200% FPL	Pregnant women	• Same as Medicaid.	• Up to 185% FPL: No fee • Up to 200% FPL: $15/family/month • $1/$2/$3 prescription co-pays.
Dr. Dynasaur 300% FPL	Children up to age 18	• Same as Medicaid but covers eyeglasses, full dental, & additional benefits.	• Up to 185% FPL: no fee • Up to 225% FPL: $15/family/month • Up to 300% FPL: $20/family/month ($60/family/month without other insurance) • $1/$2/$3 prescription copays.
VHAP (Vermont Health Access Plan) 150% FPL **-or-** **VHAP-ESIA (Employer Sponsored Insurance Assistance)**	Uninsured adults Uninsured adults with access to approved ESI	• Same as Medicaid except: **no** dental or transportation. • Covered by employer sponsored insurance; VHAP wraps coverage as secondary	• Up to 50%FPL: $0 • Up to 75% FPL: $7/person/ month • Up to100% FPL: $25/person/ month • Up to 150% FPL: $33/ person/ month • Only costsharing is: $25 ER visit/ $60 if not medically necessary ; $1/$2 script copay.
VHAP -or- **VHAP-ESIA 185% FPL**	Uninsured adults with dependent children (with or w/o access to ESI)	• Same as directly above	• $49/person/month, otherwise same as VHAP without dependent children.
Catamount-ESIA (Employer Sponsored Insurance Assistance) 150%-300% FPL	Uninsured adults (some exceptions) w/access to approved ESI	• Covered by employer sponsored insurance; provides premium assistance	• Wrap-around benefits for chronic care as per Blueprint • Cost sharing according to ESI • Premiums $60-$205 per person
CHAP (Catamount Health Premium Assistance Program) 150%-300% FPL	Uninsured adults (some exceptions) WITHOUT access to approved ESI	Covered by: BCBS Catamount Blue -OR- MVP Catamount Choice	• Cost sharing according to plan • Premiums $60-$205 per person
Catamount Health (no state assistance)	Same as directly above income over 300% FPL	Covered by BCBS or MVP plans above	• Cost sharing according to plan • Full premium costs; family plans available
VHAP Pharmacy 150% FPL	Aged or disabled, not eligible for Medicare Part A or B, and has no other insurance that covers any portion of prescription cost	• Same prescriptions covered by Medicaid • Diabetic supplies • Eye exams	• $15/person/month • $1/$2 prescription copays.
VScript 175% FPL **VScript Expanded 225% FPL**	Same as directly above Same as directly above	• Maintenance medication • Diabetic supplies • Maintenance medication • Diabetic supplies	• $20/person/month;$1/$2 script copays. • $50/person/month; $1/$2 script copays. • Manufacturer has to sign supplemental rebate agreement with the state.

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

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

[3] FPL: Federal Poverty Level

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

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

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

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

Monthly

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

Annual

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

FEDERAL MATCH RATES

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

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

Federal Fiscal Year

FFY	From	To	Federal Share w/o hold harmless	ARRA including hold harmless	Total Federal Share	State Share
	07/01/73	06/30/75	65.38%			34.62%
	07/01/75	09/30/77	69.82%			30.18%
	10/01/77	09/30/79	68.02%			31.98%
	10/01/79	09/30/81	68.40%			31.60%
	10/01/81	09/30/83	68.54%			31.46%
	10/01/83	09/30/85	69.37%			30.63%
	10/01/85	09/30/86	67.06%			32.94%
	10/01/86	09/30/87	67.37%			32.63%
	10/01/87	09/30/88	66.23%			33.77%
	10/01/88	09/30/89	63.92%			36.08%
1990	10/01/89	09/30/90	62.77%			37.23%
1991	10/01/90	09/30/91	61.97%			38.03%
1992	10/01/91	09/30/92	61.37%			38.63%
1993	10/01/92	09/30/93	59.88%			40.12%
1994	10/01/93	09/30/94	59.55%			40.45%
1995	10/01/94	09/30/95	60.82%			39.18%
1996	10/01/95	09/30/96	60.87%			39.13%
1997	10/01/96	09/30/97	61.05%			38.95%
1998	10/01/97	09/30/98	62.18%			37.82%
1999	10/01/98	09/30/99	61.97%			38.03%
2000	10/01/99	09/30/00	62.24%			37.76%
2001	10/01/00	09/30/01	62.40%			37.60%
2002	10/01/01	09/30/02	63.06%			36.94%
2003	10/01/02	09/30/03	62.41%			37.59%
fiscal relief	**04/01/03**	**09/30/03**	**66.01%**			**33.99%**
		Per TRRA...applies only to Title XIX (excluding DSH pymts)				
2004	10/01/03	09/30/04	61.34%			38.66%
fiscal relief	**10/01/03**	**06/30/04**	**65.36%**			**34.64%**
		Per TRRA...applies only to Title XIX (excluding DSH pymts)				
2005	10/01/04	09/30/05	60.11%	n/a	60.11%	39.89%
2006	10/01/05	09/30/06	58.49%	n/a	58.49%	41.51%
2007	10/01/06	09/30/07	58.93%	n/a	58.93%	41.07%
2008	10/01/07	09/30/08	59.03%	n/a	59.03%	40.97%
2009	10/01/08	09/30/09				
	Non-ARRA		59.45%	n/a	59.45%	40.55%
	ARRA-increased		**59.45%**	**9.38%**	**68.83%**	**31.17%**
2010	10/01/09	09/30/10				
	Non-ARRA		58.73%	n/a	58.73%	41.27%
	ARRA-increase - consensus		**58.73%**	**11.23%**	**69.96%**	**30.04%**
2011 Proj.	10/01/10	09/30/11				
	Non-ARRA		58.71%	n/a	58.71%	41.29%
	ARRA-increase - consensus		**58.71%**	**2.81%**	**61.52%**	**38.48%**

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

State Fiscal Year

SFY	From	To	Federal Share w/o hold harmless	ARRA including hold harmless	Total Federal Share	State Share
		1986	67.64%	32.36%		
		1987	67.29%	32.71%		
		1988	66.52%	33.49%		
		1989	64.50%	35.50%		
1990	7/1/1989	6/30/1990	63.06%	36.94%		
1991	7/1/1990	6/30/1991	62.17%	37.83%		
1992	7/1/1991	6/30/1992	61.52%	38.48%		
1993	7/1/1992	6/30/1993	60.25%	39.75%		
1994	7/1/1993	6/30/1994	59.63%	40.37%		
1995	7/1/1994	6/30/1995	60.50%	39.50%		
1996	7/1/1995	6/30/1996	60.86%	39.14%		
1997	7/1/1996	6/30/1997	61.01%	38.99%		
1998	7/1/1997	6/30/1998	61.90%	38.10%		
1999	7/1/1998	6/30/1999	62.02%	37.98%		
2000	7/1/1999	6/30/2000	62.17%	37.83%		
2001	7/1/2000	6/30/2001	62.36%	37.64%		
2002	7/1/2001	6/30/2002	62.90%	37.10%		
2003	7/1/2002	6/30/2003	62.57%	37.43%		
		fiscal relief - Title XIX only:	63.47%	36.53%		
			no adj for DSH			
2004	7/1/2003	6/30/2004	61.61%	38.39%		
		fiscal relief - Title XIX only:	65.52%	34.48%		
			no adj for DSH			
2005	7/1/2004	6/30/2005	60.42%	n/a	60.42%	39.58%
2006	7/1/2005	6/30/2006	58.90%	n/a	58.90%	41.10%
2007	7/1/2006	6/30/2007	58.82%	n/a	58.82%	41.18%
2008	7/1/2007	6/30/2008	59.01%	n/a	59.01%	40.99%
2009	7/1/2008	6/30/2009				
	Non-ARRA		59.35%	n/a	59.35%	40.65%
	ARRA-increased		**59.35%**	**6.76%**	**66.10%**	**33.90%**
2010	7/1/2009	6/30/2010				
	Non-ARRA		58.91%	n/a	58.91%	41.09%
	ARRA-increase - consensus		**58.91%**	**11.05%**	**69.96%**	**30.04%**
2011 Proj	7/1/2010	6/30/2011				
	Non-ARRA		58.72%	n/a	58.72%	41.28%
	ARRA-increase - consensus		**58.72%**	**5.62%**	**64.33%**	**35.67%**

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

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

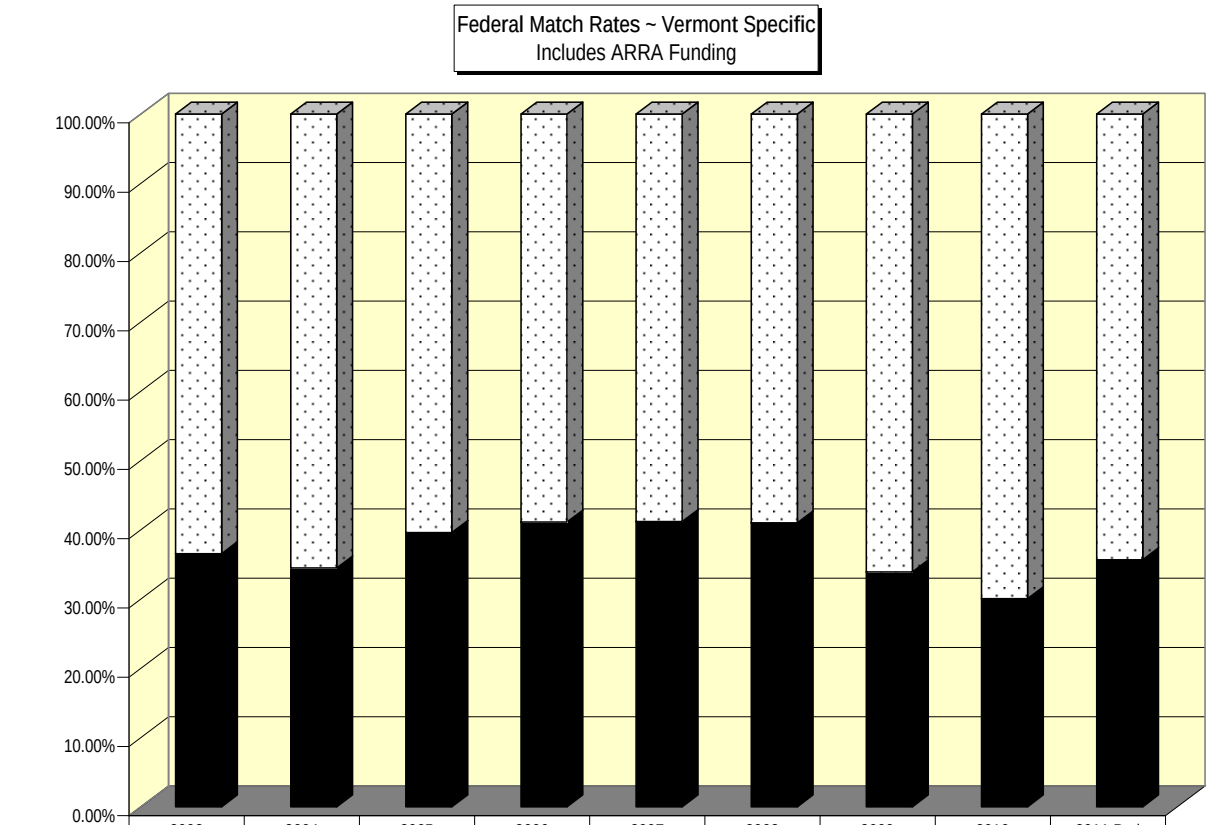
Federal Fiscal Year

FFY	From	To	Federal Share	State Share
2005	10/01/04	09/30/05	72.08%	27.92%
2006	10/01/05	09/30/06	70.94%	29.06%
2007	10/01/06	09/30/07	71.25%	28.75%
2008	10/01/07	09/30/08	71.32%	28.68%
2009	10/01/08	09/30/09	71.62%	28.38%
2010	10/01/09	09/30/10	71.11%	28.89%
2011 Proj.	10/01/10	09/30/11	71.10%	28.90%

State Fiscal Year

SFY	From	To	Federal Share	State Share
2005	7/1/2004	6/30/2005	72.30%	27.71%
2006	7/1/2005	6/30/2006	71.23%	28.78%
2007	7/1/2006	6/30/2007	71.17%	28.83%
2008	7/1/2007	6/30/2008	71.30%	28.70%
2009	7/1/2008	6/30/2009	71.55%	28.46%
2010	7/1/2009	6/30/2010	71.24%	28.76%
2011 Proj	7/1/2010	6/30/2011	71.10%	28.90%

FEDERAL MATCH RATES – VERMONT SPECIFIC



	2003	2004	2005	2006	2007	2008	2009	2010	2011 Proj
Federal Share	63.47%	65.52%	60.42%	58.90%	58.82%	59.01%	66.10%	69.96%	64.33%
State Share	36.53%	34.48%	39.58%	41.10%	41.18%	40.99%	33.90%	30.04%	35.67%

VERMONT

COPAY HISTORY SFY 2002 THROUGH SFY 2011

Program	% FPL	Cost per Prescription	SFY 2002 Co-Pay	SFY 2003 Co-Pay	SFY 2004 Co-Pay	SFY 2005 Co-Pay	SFY 2006 Co-Pay	SFY 2007 Co-Pay	SFY 2008 Co-Pay	SFY 2009 Co-Pay	SFY 2010 Co-Pay	SFY 2011 Co-Pay
Traditional Medicaid (*Does not apply to children <18 (effective 1/1/2007 <21), pregnant women, or LTC Patients)	0-185%	$29.99 or Less	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00
		$30.00 - $49.99	$2.00	$2.00	$2.00	$2.00	$2.00	$2.00	$2.00	$2.00	$2.00	$2.00
		$50.00 or more	$3.00	$3.00	$3.00	$3.00	$3.00	$3.00	$3.00	$3.00	$3.00	$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	N/A	N/A	N/A
		$30.00 - $49.99										
		$50.00 or more										
VHAP	50-75%	$29.99 or Less			N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		$30.00 - $49.99										
		$50.00 or more										
VHAP	75-100%	$29.99 or Less			N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		$30.00 - $49.99										
		$50.00 or more										
VHAP	100-150%	$29.99 or Less			N/A	N/A	N/A	N/A	N/A	N/A	$1.00	$1.00
		$30.00 - $49.99									$2.00	$2.00
		$50.00 or more									$2.00	$2.00
VHAP	150-185%	$29.99 or Less			N/A	N/A	N/A	N/A	N/A	N/A	$1.00	$1.00
		$30.00 - $49.99									$2.00	$2.00
		$50.00 or more									$2.00	$2.00
			11/1/2001	11/1/2002	1/1/2004							
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	N/A	$1.00	$1.00
		$30.00 - $49.99	$2.00	$3.00 Generic/$6.00 Brand ** $50.00 per beneficiary per quarter maximum $2.00 Diabetic Supply							$2.00	$2.00
		$50.00 or more	$3.00	$3.00 Generic/$6.00 Brand ** $50.00 per beneficiary per quarter maximum $3.00 Diabetic Supply							$2.00	$2.00
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	N/A	$1.00	$1.00
		$30.00 - $49.99	$4.00								$2.00	$2.00
		$50.00 or more									$2.00	$2.00
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	N/A	$1.00	$1.00
		$30.00 - $49.99									$2.00	$2.00
		$50.00 or more									$2.00	$2.00
			11/1/2001	11/1/2002	1/1/2004							
VPharm 1	0-150%	$29.99 or Less	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$1.00	$1.00
		$30.00 - $49.99									$2.00	$2.00
		$50.00 or more									$2.00	$2.00
VPharm 2	150-175%	$29.99 or Less	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$1.00	$1.00
		$30.00 - $49.99									$2.00	$2.00
		$50.00 or more									$2.00	$2.00
VPharm 3	175-225%	$29.99 or Less	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$1.00	$1.00
		$30.00 - $49.99									$2.00	$2.00
		$50.00 or more									$2.00	$2.00
						Effective 1/1/06						

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

HISTORY OF HOSPITAL DSH PAYMENTS

DSH Calculations
State Fiscal Years vs. Federal Fiscal Years

State Fiscal Year Impact				
State Fiscal Year '07 (7/1/06 thru 6/30/07)	State Fiscal Year '08 (7/1/07 thru 6/30/08)	State Fiscal Year '09 (7/1/08 thru 6/30/09)	State Fiscal Year '10 (7/1/09 thru 6/30/10)	State Fiscal Year '11 (7/1/10 thru 6/30/11)
59,377,728	49,003,898	35,648,781	37,448,781	37,448,781

Federal Fiscal Year Impact					
Federal Fiscal Year '06 (10/1/05 thru 9/30/06)	Federal Fiscal Year '07 (10/1/06 thru 9/30/07)	Federal Fiscal Year '08 (10/1/07 thru 9/30/08)	Federal Fiscal Year '09 (10/1/08 thru 9/30/09)	Federal Fiscal Year '10 (10/1/09 thru 9/30/10)	Federal Fiscal Year '11 (10/1/10 thru 9/30/11)
36,233,886	35,902,422	36,245,420	35,648,781	37,448,781	37,448,781

MCO INVESTMENT EXPENDITURES

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

PALLIATIVE CARE FOR CHILDREN

Report to:
Senate Appropriations Committee
Senate Health and Welfare Committee
House Appropriations Committee
House Human Services Committee

Office of Vermont Health Access
Agency of Human Services

November 16, 2009

Executive Summary

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

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

Introduction

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

Palliative vs. Curative Care

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

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

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

Services currently available to Medicaid and SCHIP children in Vermont

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

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

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

Additional services under a waiver amendment

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

These services could include:

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

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

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

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

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

Waiver amendment process

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

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

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

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

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

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

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

Pediatric palliative care programs in other states

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Children with life-limiting illnesses

	M	**F**	**Total**
Age			
0 to 5	8	7	15
6 to 12	39	25	64
13 to 17	29	16	45
18 to 20	16	13	29
21+ *	11	6	17
Total	**103**	**67**	**170**

***These children were included because they were under 21 on the date of service for the claims included in this analysis.

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

Diseases and Conditions by Number Of Children

Disease	**Number of children**
Leukemia	43
Other cancers	65
Muscular Dystrophy	23
Chronic liver disease	14
Other*	25
Total	**170**

*Includes cerebral palsy, Werdnig-Hoffmann disease, Patau's Syndrome, congenital heart disease, aplastic anemia, Fragile X Syndrome

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

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

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

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

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

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

Financial impact of a waiver amendment

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

- Although all of the 170 children had at least one life-limiting diagnosis, many of the children had very few claims submitted under that diagnosis code, indicating that the illness was probably in an early stage or in remission, in which case palliative services may not yet be necessary.

- It is likely that there would not be an expectation of death before age 21 for at least some of the 170 children, in which case they would not qualify for hospice-like services under this program.

- Other states that have implemented similar programs are serving a relatively small number of children. For example, Florida has 468 children in its palliative care program out of a population of Medicaid children of 1,095,400 (as of 2008), or .04%. Colorado has 85 children out of a population of 232,500, or .037%. The 29 children in the low-cost estimate would represent .05% of Vermont's Medicaid children enrolled in 2008.

- Some of the children are receiving services through other state programs, such as Developmental Disability Services and Children's Personal Care Services, both programs administered by the Department of Disabilities, Aging, and Independent Living (DAIL). To the extent that other programs are providing case management, care coordination, home supports, respite care, crisis services, and other types of services, these same services would not be add-ons to the palliative care program. Both the high- and low-cost estimates do subtract personal care services from the additional costs, since the provision of personal care services would reduce the added cost for respite care.

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

Conclusions

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

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

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

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Attachment 1

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

(a) No later than October 1, 2009, the secretary of human services shall submit to the house committees on appropriations and on human services and the senate committees on appropriations and on health and welfare a report on the programmatic and cost implications of a Medicaid and a State Children's Health Insurance Program (SCHIP) waiver amendment allowing Vermont to provide its Medicaid- and SCHIP-eligible children who have life-limiting illnesses with concurrent palliative services and curative care.

(b) For purposes of this section:

  (1) "Life-limiting illness" means a medical condition that, in the opinion of the child's treating health care provider, has a prognosis of death that is highly probable before the child reaches adulthood.

  (2) "Palliative services" means personal care, respite care, hospice-like services, and counseling.

Attachment 2

COMPARISON OF PEDIATRIC PALLIATIVE CARE PROGRAM IN THREE STATES

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

Attachment 3: ADDITIONAL PALLIATIVE CARE COSTS--HIGH ESTIMATE

COSTS

Type of service		Max units/child	# Children[4]	Units/child	Cost/unit[5]	Gross cost/year
Family training/counseling		98 hours[1]				
	High need		35	98	$70.56	$242,020.80
	Medium need		49	49	$70.56	$169,414.56
	Low need		86	24	$70.56	$145,635.84
In-home respite care		720 hours[1]				
Skilled	High need		35	720	$40.68	$1,025,136.00
Unskilled						
	Medium need		49	360	$23.08	$407,131.20
	Low need		86	180	$23.08	$357,278.40
Expressive therapy		39 hours[1]				
	High need		35	39	$46.96	$64,100.40
	Medium need		49	20	$46.96	$46,020.80
	Low need		86	10	$46.96	$40,385.60
Bereavement counseling		26 hours[2]	5	26	$70.56	$9,172.80
Care coordination/case mgt.		2 positions[3]		2	$77,625.00	$155,250.00
GROSS COSTS						**$2,661,546.40**
Minus personal care[6]						**$473,314.83**
ADJUSTED COSTS						**$2,188,231.57**

SAVINGS[7]

Type of service	Claims cost	Reduction	Gross savings
Inpatient claims	$942,920.53	20%	$188,584.11
Outpatient claims	$387,319.55	10%	$38,731.96
GROSS SAVINGS			**$227,316.06**
NET COSTS			**$2,434,230.34**
STATE SHARE[8]			**$1,005,093.71**

[1]Maximum units are based on Colorado's program.

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

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

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

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

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

[6]46 of the 170 children were receiving personal care services equivalent to respite care, so these would not be additional costs.

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

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

Attachment 4

ADDITIONAL PALLIATIVE CARE COSTS--LOW ESTIMATE

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

SAVINGS[6]			
Type of service	**Claims cost**	**Reduction**	**Gross savings**
Inpatient claims	$708,726.49	20%	$141,745.30
Outpatient claims	$191,233.88	10%	$19,123.39
GROSS SAVINGS			**$160,868.69**
NET COSTS			**$322,351.27**
STATE SHARE			**$133,098.84**

[1]Maximum units are based on Colorado's program.

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

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

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

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

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

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

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

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

January 15, 2010

Summary

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

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

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

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

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

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

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

Background

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

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

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

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

Methodology used to develop the cost estimate

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

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

Results of sample evaluation

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

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

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

Below is a breakdown of the costs for each category:

Active cases

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

Healthy Vermonters

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

Closed cases

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

Denied cases

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

TOTAL

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

ACRONYMS

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

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

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

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

OFFICE of VERMONT HEALTH ACCESS

MISSION

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

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

OVERVIEW

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

VERMONT
AGENCY OF HUMAN SERVICES

INSERT #1

Mandatory & Optional Coverage Groups & Services

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

Medicaid Eligibility Group	Description of Population			Mandatory Services	Optional Services
Mandatory Population					
• ANFC Children • ANFC Adults	Traditional Medicaid: mandatory groups under Title XIX of Social Security Act	0%-100% FPL	Children • Children who meet §1931 criteria (1996 ANFC financial test) • Children receiving Reach Up • Newborns up to 12 months • Children ages 1 through 5 • Children 6 or older, born after 9/30/83 • Children under 19, born after 9/30/83 • Transitional Medicaid (first 12 months) Pregnant Women Parents & Caretaker Relatives	Inpatient hospital (excl. inpatient svs. in IMDs) Outpatient hospital including FQHCs Other laboratory and x-ray Certified pediatric and family nurse practitioners Nursing facility svs. for beneficiaries age 21+ EPSDT for children under age 21 Family planning services and supplies Physicians' services Medical and surgical services of a dentist Home health svs. for those entitled to nursing facility svs. Home health aides Intermittent or part-time nursing services provided by home health agency or by a registered nurse when there is no home health agency in the area Medical supplies and appliances for use in the home Nurse mid-wife services Pregnancy related services Prenatal and delivery services RHCs and FQHCs Post partum services for those under age 18 who are entitled to institutional and ambulatory services	Podiatrists Optometrists Psychologists Physician Directed Clinic Services Home Health Audiology Therapy Dental Physical Therapy Occupational Therapy Speech & Language Therapy Prescribed Drugs Prosthetic Devices Screening Services Preventive Services Mental Health Stabilization Rehab Mental Health Other Inpatient Hosp., NH, ICF/MR Inpatient Psych. For under 21 Personal Care Services Targeted Case Mgmt. Primary Care Case Mgmt. Hospice Care Respiratory Care for Ventilator Dependent PACE Transportation Nursing Facility for Under 21 Emergency Hospital for Non-MCare Particip. Eyeglasses Orthotics ADAP Dialysis Ambulance HCBS (Children's Waiver?? DS Waiver??)
• ABD Adults • ABD Duals • BD Children	Traditional Medicaid: Mandatory Groups (SSI-Related)		• SSI cash recipients • Individuals receiving state supplemental payments (AABD) • Disabled children eligible under §4913 • Disabled adult children • Individuals determined eligible under the Pickle amendment • Disabled widows and widowers • Early widows and widowers • Essential spouses eligible in December 1973 • Institutionalized individuals eligible in 1973 • Disabled individuals eligible in 1973		

Medicaid Eligibility Group	Description of Population			Mandatory Services	Optional Services
Optional Population					
• ANFC Children • ANFC Adults	Traditional Medicaid: optional groups under Title XIX of Social Security Act	up to 185% FPL	• Transitional Medicaid (month 12-36) up to 185% FPL • Children under age 21 (PIL) • Individuals receiving child care services • Special needs adoption under 21 • Committed Children - SRS adoption assistance • Committed Children – SRS foster care • ANFC-related medically needy (PIL) • Pregnant women to 200% FPL • Caretaker relatives up to 150% FPL	Inpatient hospital (excl. inpatient svs. in IMDs) Outpatient hospital including FQHCs Other laboratory and x-ray Certified pediatric and family nurse practitioners Nursing facility svs. for beneficiaries age 21+ EPSDT for children under age 21 Family planning services and supplies Physicians' services Medical and surgical services of a dentist Home health svs. for those entitled to nursing facility svs. Intermittent or part-time nursing services provided by home health agency or by a registered nurse when there is no home health agency in the area Home health aides Medical supplies and appliances for use in the home Pregnancy related services Prenatal and delivery services Post partum services for those under age 18 who are entitled to institutional and ambulatory services Nurse mid-wife services RHCs and FQHCs	Podiatrists Optometrists Psychologists Physician Directed Clinic Services Home Health Audiology Therapy Dental Physical Therapy Occupational Therapy Speech & Language Therapy Prescribed Drugs Prosthetic Devices Screening Services Preventive Services Mental Health Stabilization Rehab Mental Health Other Inpatient Hosp., NH, ICF/MR Inpatient Psych. For under 21 Personal Care Services Targeted Case Mgmt. Primary Care Case Mgmt. Hospice Care Respiratory Care for Ventilator Dependent PACE Transportation Nursing Facility for Under 21 Emergency Hospital for Non-MCare Particip. Eyeglasses Orthotics ADAP Dialysis Ambulance HCBS (Children's Waiver?? DS Waiver??)
• VHAP • Underinsured Children • VPharm1 • VPharm2 • VPharm3 • VHAP Pharmacy • VScript • VScript Expanded • Healthy Vermonters	VHAP: expansion groups under §1115 of Social Security Act	up to 225% FPL	• Children with other insurance over 225% FPL • Premiums for pregnant women between 185% - 200% FPL • Parents & caretaker relatives between 150%-185% FPL • Health insurance coverage for single adults up to 150% FPL who are ineligible for Medicare and Medicaid • Traumatic Brain Injury • Kids Mental Health • Developmentally Disabled • Pharmacy groups – (VPharm 1,2, & 3) • VHAP Pharmacy • VScript • VScript expanded • Healthy Vermonters • Health insurance coverage for CRT enrolled adults whose earnings place them over 150% FPL and are ineligible for Medicaid		
• Catamount Health • Employer-Sponsored Insurance	Premium Assistance Coverage Groups: under §1115 of Social Security Act	up to 300% FPL	• CHAP (0-300% FPL) - premium assistance for those without access to ESI • ESIA (0-300% FPL) – premium assistance for those with access to employer sponsored insurance • VHAP + ESIA (0-150/185% FPL)		
• Choices for Care Waiver Enrollees • Qualified Individuals (Qis) • ABD Adults (working) • Ladies First	Traditional Medicaid: optional groups (SSI Related)		• Hospice care • Working Disabled • Individuals eligible for but not receiving SSI or AABD cash benefits • Breast & Cervical Cancer • Disabled Children in Home Care (Katie Beckett) • Special needs adoption under 21 • Choices for Care – home based special income group • Choices for Care – long-term care medically needy • SSI-related medically needy – community Medicaid • Earnings too high to receive SSI cash (§1619(a)(b)) • Qualified Medicare Beneficiaries (QMB) • Qualified Disabled Working Individuals (QDWI) • Specified Low-Income Medicare Beneficiaries (SLMB) • Qualified Individuals (QI-1)		
• Civil Union			• Qualify for Services through MCO Investments		
• HIV			• Qualify for Services through MCO Investments		
• SCHIP	SCHIP: under Title XXI of Social Security Act	up to 300% FPL	• Children without other insurance		

INSERT #2

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

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

PROGRAM EXPENDITURES

	SFY '07 Actuals			SFY '08 Actuals			SFY '09 Actuals			SFY '10 Appropriated			SFY '10 BAA			SFY '11 Gov. Rec.		
Adults	Enrollment	Expenses	PMPM	Enrollment	Expenses	PMPM	Enrollment	Expenses	PMPM	Enrollment	Expenses	PMPM	Enrollment	Expenses	PMPM	Enrollment	Expenses	PMPM
Aged, Blind, or Disabled (ABD)/Medically Needy	11,330	$ 68,586,463	$ 504.46	11,797	$ 72,515,067	$ 512.24	12,550	$ 82,398,879	$ 547.15	12,400	$ 87,391,435	$ 587.32	13,184	$ 80,842,468	$ 510.97	13,866	$ 88,506,243	$ 531.93
Dual Eligibles	14,073	$ 37,371,558	$ 221.30	14,185	$ 35,614,807	$ 209.23	14,753	$ 38,596,281	$ 218.02	14,681	$ 42,783,829	$ 242.85	15,111	$ 42,040,322	$ 231.85	15,536	$ 43,787,312	$ 234.88
General	9,327	$ 41,239,463	$ 368.44	9,255	$ 43,797,118	$ 394.36	9,847	$ 53,060,215	$ 449.06	9,333	$ 51,435,872	$ 459.27	10,297	$ 55,295,379	$ 447.51	10,786	$ 59,173,662	$ 457.17
VHAP	22,404	$ 79,795,246	$ 296.80	24,771	$ 89,891,925	$ 302.40	28,224	$ 111,730,898	$ 329.89	30,023	$ 118,932,948	$ 330.12	32,429	$ 122,905,750	$ 315.83	36,862	$ 148,458,099	$ 335.62
VHAP ESI	-	$ -	$ -	276	$ 571,218	$ 172.63	821	$ 1,525,747	$ 154.95	1,215	$ 3,146,430	$ 215.84	1,195	$ 2,389,512	$ 166.61	1,564	$ 4,172,221	$ 222.30
Catamount	-	$ -	$ -	1,730	$ 7,995,765	$ 385.12	6,350	$ 30,293,232	$ 397.55	9,277	$ 50,124,827	$ 450.27	9,081	$ 44,329,429	$ 406.79	10,379	$ 49,765,094	$ 399.57
ESIA	-	$ -	$ -	132	$ 168,977	$ 106.81	478	$ 688,592	$ 120.17	630	$ 1,095,532	$ 144.99	710	$ 1,247,392	$ 146.50	2,413	$ 4,512,365	$ 155.82
Subtotal Adults	57,134	$ 226,992,729	$ 331.08	62,146	$ 250,554,876	$ 335.98	73,021	$ 318,293,843	$ 363.24	77,558	$ 354,910,872	$ 381.34	82,007	$ 349,050,253	$ 354.69	91,406	$ 398,374,998	$ 363.19
Children																		
Blind or Disabled (BD)/Medically Needy	3,398	$ 28,299,312	$ 693.95	3,487	$ 27,775,036	$ 663.78	3,605	$ 31,686,636	$ 732.47	3,660	$ 33,942,009	$ 772.74	3,680	$ 31,709,593	$ 718.12	3,771	$ 33,052,202	$ 730.34
General	51,187	$ 85,115,012	$ 138.57	50,664	$ 90,807,988	$ 149.36	52,224	$ 100,299,806	$ 160.05	51,037	$ 105,463,098	$ 172.20	53,863	$ 103,396,604	$ 159.97	55,631	$ 111,652,406	$ 167.25
Underinsured	1,186	$ 846,736	$ 59.51	1,138	$ 742,529	$ 54.39	1,212	$ 721,162	$ 49.61	1,170	$ 894,887	$ 63.74	1,248	$ 696,455	$ 46.50	1,282	$ 755,915	$ 49.12
SCHIP (Uninsured)	3,070	$ 4,189,850	$ 113.73	3,278	$ 4,462,004	$ 113.42	3,412	$ 5,386,841	$ 131.56	3,559	$ 5,523,528	$ 129.34	3,721	$ 5,648,299	$ 126.50	3,966	$ 6,421,696	$ 134.93
Subtotal Children	58,841	$ 118,450,910	$ 167.76	58,567	$ 123,787,557	$ 176.13	60,452	$ 138,094,446	$ 190.36	59,426	$ 145,823,521	$ 204.49	62,512	$ 141,450,951	$ 188.57	64,651	$ 151,882,219	$ 195.77
Pharmacy Only Programs	12,952	$ 9,285,897	$ 55.24	12,737	$ 8,052,596	$ 47.88	12,456	$ 7,535,743	$ 50.42	12,498	$ 6,513,896	$ 43.43	12,659	$ 1,399,166	$ 9.21	12,580	$ 5,637,397	$ 37.34
Choices for Care																		
Nursing Home, Home & Community Based, ERC	3,545	$ 148,714,078	$ 3,496.19	3,973	$ 166,375,075	$ 3,489.85	4,010	$ 172,372,731	$ 3,582.14	4,010	$ 173,314,853	$ 3,601.72	4,010	$ 174,214,875	$ 3,620.43	4,010	$ 175,487,571	$ 3,646.87
Acute-Care Services ~ OVHA	3,545	$ 18,015,671	$ 423.54	3,973	$ 20,041,562	$ 420.39	4,010	$ 22,925,258	$ 476.42	4,010	$ 26,041,957	$ 541.19	4,010	$ 21,856,882	$ 454.22	4,010	$ 24,238,964	$ 503.72
Acute-Care Services ~ Other Depts.	3,545	$ 627,528	$ 14.75	3,973	$ 1,097,788	$ 23.03	4,010	$ 284,592	$ 5.91	4,010	$ 1,268,632	$ 26.36	4,010	$ 287,519	$ 5.98	4,010	$ 300,140	$ 6.24
Buy-In	-	$ 2,198,479	$ -	-	$ 2,228,171	$ -	-	$ 2,371,707	$ -	-	$ 2,679,815	$ -	-	$ 2,875,797	$ -	-	$ 3,071,780	$ -
Subtotal Choices for Care*	3,545	$ 169,555,756	$ 3,986.17	3,545	$ 189,742,595	$ 4,460.75	3,545	$ 197,954,288	$ 4,653.81	3,545	$ 203,305,257	$ 4,779.60	3,545	$ 199,235,074	$ 4,683.92	3,545	$ 203,098,454	$ 4,774.74
Subtotal Direct Services	132,472	$ 524,285,291	$ 329.81	136,994	$ 572,137,623	$ 348.03	149,475	$ 661,878,320	$ 369.00	153,026	$ 710,553,546	$ 386.94	160,723	$ 691,135,443	$ 358.35	172,181	$ 758,993,068	$ 367.34
Miscellaneous Program																		
GC to CFC Funding Reallocation	-	$ (627,528)	$ -	-	$ (1,097,788)	$ -	-	$ (284,592)	$ -	-	$ (1,268,632)	$ -	-	$ (287,519)	$ -	-	$ (300,140)	$ -
Refugee	22	$ 93,315	$ 357.53	17	$ 68,304	$ 334.83	47	$ 222,863	$ 395.15	162	$ 75,939	$ 39.07	48	$ 230,678	$ 402.43	53	$ 271,411	$ 427.13
HIV and Civil Unions	220	$ 1,055,504	$ 399.21	295	$ 1,054,678	$ 297.48	314	$ 884,456	$ 234.54	299	$ 993,560	$ 277.12	350	$ 953,892	$ 226.81	388	$ 1,117,244	$ 240.04
DSH	-	$ 59,377,729	$ -	-	$ 49,003,898	$ -	-	$ 35,648,781	$ -	-	$ 37,448,781	$ -	-	$ 37,448,781	$ -	-	$ 37,448,781	$ -
Clawback	-	$ 19,142,150	$ -	-	$ 20,339,254	$ -	-	$ 20,779,093	$ -	-	$ 23,113,134	$ -	-	$ 23,113,134	$ -	-	$ 24,414,748	$ -
Buy-In ~ GC	-	$ 21,744,731	$ -	-	$ 21,063,422	$ -	-	$ 21,306,607	$ -	-	$ 25,016,468	$ -	-	$ 26,846,000	$ -	-	$ 28,675,532	$ -
Buy-In ~ State Only (MCO Invest.)	-	$ 314,376	$ -	-	$ 419,951	$ -	-	$ 248,537	$ -	-	$ 516,704	$ -	-	$ 554,485	$ -	-	$ 592,264	$ -
Buy-In ~ Federal Only	-	$ 2,489,407	$ -	-	$ 3,123,135	$ -	-	$ 2,730,326	$ -	-	$ 3,503,500	$ -	-	$ 3,759,721	$ -	-	$ 4,015,941	$ -
Legal Aid	-	$ 564,937	$ -	-	$ 476,832	$ -	-	$ 547,983	$ -	-	$ 506,142	$ -	-	$ 547,983	$ -	-	$ 547,983	$ -
Misc. Pymts.	-	$ 2,470,780	$ -	-	$ 2,237,253	$ -	-	$ 2,788,183	$ -	-	$ 4,443,598	$ -	-	$ 3,495,288	$ -	-	$ 4,981,021	$ -
Healthy Vermonters Program	9,413	$ -	n/a	5,781	$ -	n/a	4,843	$ -	n/a	9,211	$ -	n/a	4,782	$ -	n/a	4,676	$ -	n/a
Subtotal Miscellaneous Program	9,655	$ 106,625,402		6,094	$ 96,688,940		5,204	$ 84,872,236		9,672	$ 94,349,196		5,180	$ 96,662,443		5,117	$ 101,764,785	
TOTAL PROGRAM EXPENDITURES	142,127	$ 630,910,693		143,088	$ 668,826,564		154,678	$ 746,750,556		162,698	$ 804,902,742		165,903	$ 787,797,886		177,297	$ 860,757,857	

ADMINISTRATIVE EXPENDITURES

	SFY '07 Actuals			SFY '08 Actuals			SFY '09 Actuals			SFY '10 Appropriated			SFY '10 BAA			SFY '11 Gov. Rec.		
		Expenses			Expenses			Expenses			Expenses			Expenses			Expenses	
Contract																		
Claims Processing	-	$ 9,928,717	$ -	-	$ 9,938,968	$ -	-	$ 9,433,393	$ -	-	$ 9,535,000	$ -	-	$ 9,685,000	$ -	-	$ 10,695,522	$ -
Member Services	-	$ 2,808,807	$ -	-	$ 2,913,852	$ -	-	$ 3,117,187	$ -	-	$ 2,913,852	$ -	-	$ 2,947,800	$ -	-	$ 2,913,852	$ -
Pharmacy Benefits Manager	-	$ 2,112,158	$ -	-	$ 2,704,233	$ -	-	$ 2,538,847	$ -	-	$ 2,964,993	$ -	-	$ 2,964,993	$ -	-	$ 2,964,993	$ -
Chronic Care Initiative	-	$ 1,257,191	$ -	-	$ 3,562,406	$ -	-	$ 4,249,583	$ -	-	$ 5,035,184	$ -	-	$ 5,034,497	$ -	-	$ 4,749,294	$ -
Catamount Outreach	-	$ 664,427	$ -	-	$ 1,697,182	$ -	-	$ 500,000	$ -	-	$ 500,000	$ -	-	$ 392,000	$ -	-	$ 500,000	$ -
Miscellaneous	-	$ 2,970,277	$ -	-	$ 1,892,349	$ -	-	$ 2,179,530	$ -	-	$ 4,724,851	$ -	-	$ 3,949,589	$ -	-	$ 3,053,723	$ -
Health Information Technology	-	$ -	$ -	-	$ -	$ -	-	$ -	$ -	-	$ -	$ -	-	$ 3,587,101	$ -	-	$ 3,655,674	$ -
MITA/MOVE	-	$ -	$ -	-	$ 1,184,745	$ -	-	$ 926,779	$ -	-	$ 1,950,000	$ -	-	$ 1,950,000	$ -	-	$ 13,100,000	$ -
Operating/Personnel Services	-	$ 5,509,561	$ -	-	$ 7,152,358	$ -	-	$ 7,067,735	$ -	-	$ 8,036,369	$ -	-	$ 7,203,038	$ -	-	$ 8,170,601	$ -
Total Administrative Expenses		$ 25,251,238			$ 31,046,091			$ 30,013,053			$ 35,660,249			$ 37,714,018			$ 49,803,659	
TOTAL ALL EXPENDITURES	142,252	$ 656,161,931		146,717	$ 699,872,655		154,678	$ 776,763,609			$ 840,562,990			$ 825,511,904			$ 910,561,516	
53rd week														12,083,044			5,835,000	
total trend, etc. including 53rd week														837,594,948			916,396,516	

*

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

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

PROGRAM EXPENDITURES

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

ADMINISTRATIVE EXPENDITURES

	SFY '10 Appropriated		SFY '10 BAA		SFY '11 Gov. Rec.		
	Gross Expenses	State Funds	Gross Expenses	State Funds	Gross Expenses	State Funds	
Contract							
Claims Processing	$ 9,535,000	$ 2,864,314	$ 9,685,000	$ 2,909,374	$ 10,695,522	$ 3,815,093	Most admin. expenses are funded with: Global Commitment funds ~ g.f. @ 35.67%, traditional federal @ 58.72%, and ARRA @ 5.61%(ARRA not available for expansion population administration so g.f. = 41.28%) and Title XXI funds (28.90% g.f. and 71.10%)
Member Services	$ 2,913,852	$ 875,321	$ 2,947,800	$ 885,519	$ 2,913,852	$ 1,039,371	
Pharmacy Benefits Manager	$ 2,964,993	$ 890,684	$ 2,964,993	$ 890,684	$ 2,964,993	$ 1,057,613	
Chronic Care Initiative	$ 5,035,184	$ 1,512,569	$ 5,034,497	$ 1,512,363	$ 4,749,294	$ 1,694,073	
Catamount Outreach	$ 500,000	$ 150,200	$ 392,000	$ 117,757	$ 500,000	$ 178,350	
Miscellaneous	$ 4,724,851	$ 1,419,345	$ 3,949,589	$ 1,186,457	$ 3,053,723	$ 1,089,263	
Health Information Technology	$ -	$ -	$ 3,587,101	$ -	$ 3,655,674	$ -	$2.4m special fund; $.55m MCO Invest. as described above; balance 100% federal
MITA/MOVE	$ 1,950,000	$ 195,000	$ 1,950,000	$ 195,000	$ 13,100,000	$ 1,310,000	10% g.f.; 90% federal
Operating/Personnel Services	$ 8,036,369	$ 2,414,125	$ 7,203,038	$ 2,163,793	$ 8,170,601	$ 2,454,449	
Total Administrative Expenses	$ 35,660,249	$ 10,321,559	$ 37,714,018	$ 9,860,946	$ 49,803,659	$ 12,638,211	
TOTAL ALL EXPENDITURES	$ 840,562,990	$ 279,029,334	$ 825,511,904	$ 270,380,818	$ 910,561,516	$ 337,428,164	
			12,083,044	3,629,746	5,835,000	2,081,345	
			837,594,948	274,010,565	916,396,516	339,509,508	

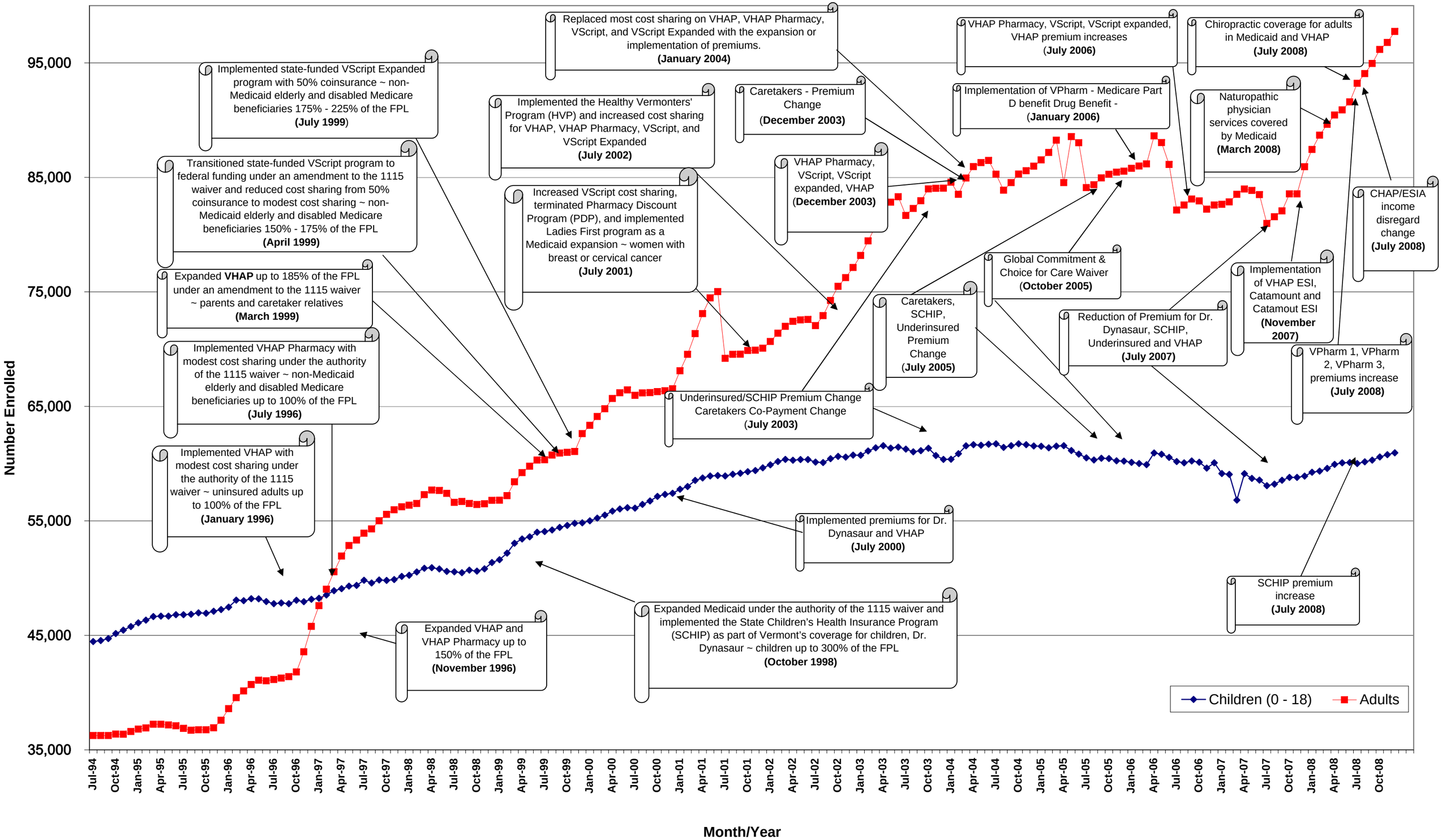
*

INSERT #3

Categories of Service (COS)

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

COS	Description of Service	Actual SFY '03	2002- 2003 % Change	Actual SFY '04	2003-2004 % Change	Actual SFY '05	2004-2005 % Change	Actual SFY '06	2005-2006 % Change	Actual SFY '07	2006-2007 % Change	Actual SFY '08	2007-2008 % Change	Actual SFY '09	2008 Act-2009 Est. % Change	Approp. SFY '10	2009 Act.-2010 Approp. %	BAA SFY '10	2009 Act.-2010 BAA. % Change	Gov. Rec. SFY '11	2010 BAA-2011 SS % Change
01-00	Inpatient	40,929,353	6.8%	55,423,636	35.4%	59,916,830	8.1%	59,404,188	-0.9%	57,668,408	-2.9%	64,635,263	12.1%	86,235,838	33.4%	88,216,968	2.3%	97,563,269	13.1%	101,759,643	4.3%
02-00	Outpatient	43,429,952	6.8%	51,810,009	19.3%	59,256,286	14.4%	64,519,817	8.9%	62,005,623	-3.9%	67,819,155	9.4%	73,572,880	8.5%	80,823,904	9.9%	81,323,558	10.5%	88,987,277	9.4%
03-00	Physician	47,157,888	6.4%	51,268,594	8.7%	61,369,027	19.7%	58,623,126	-4.5%	61,235,508	4.5%	68,710,405	12.2%	77,883,797	13.4%	80,371,477	3.2%	87,327,788	12.1%	96,784,364	10.8%
04-00	Pharmacy	125,291,458	8.2%	152,886,158	22.0%	191,397,999	25.2%	167,532,601	-12.5%	109,065,993	-34.9%	112,406,224	3.1%	125,709,817	11.8%	124,720,305	-0.8%	134,165,876	6.7%	140,889,206	5.0%
05-00	Nursing Home	95,547,013	1.2%	102,673,295	7.5%	105,538,644	2.8%	104,487,943	-1.0%	109,236,612	4.5%	115,642,835	5.9%	119,361,580	3.2%	117,947,659	-1.2%	116,073,123	-2.8%	117,194,372	1.0%
07-00	Mental Health Facility	88,376	-66.8%	346,914	292.5%	(216,883)	-162.5%	66,065	-130.5%	200,938	204.2%	242,458	20.7%	137,992	-43.1%	248,460	80.1%	248,460	80.1%	248,460	0.0%
08-00	Dental	13,651,738	-7.7%	14,090,596	3.2%	15,938,630	13.1%	14,739,118	-7.5%	15,125,710	2.6%	15,980,470	5.7%	19,319,401	20.9%	21,507,700	11.3%	22,165,962	14.7%	23,032,365	3.9%
09-01	MH Clinic	47,771	-221.6%	18,420	-61.4%	37,525	103.7%	44,333	18.1%	133,264	200.6%	55,163	-58.6%	14,754	-73.3%	51,397	248.4%	51,397	248.4%	51,397	0.0%
10-00	Independent Laboratory	2,200,561	27.1%	1,981,035	-10.0%	3,394,475	71.3%	2,263,320	-33.3%	2,934,505	29.7%	3,467,612	18.2%	5,945,785	71.5%	4,864,983	-18.2%	7,539,863	26.8%	8,427,926	11.8%
11-00	Home Health	7,972,483	2.6%	7,651,902	-4.0%	7,633,288	-0.2%	7,798,335	2.2%	5,668,194	-27.3%	6,313,071	11.4%	6,576,435	4.2%	7,469,575	13.6%	7,053,492	7.3%	7,413,985	5.1%
12-00	RHC & FQHC	8,414,816	9.4%	10,121,951	20.3%	10,830,725	7.0%	10,946,861	1.1%	12,064,368	10.2%	14,434,537	19.6%	16,381,379	13.5%	19,127,472	16.8%	19,388,703	18.4%	22,636,725	16.8%
13-00	Hospice	353,237	-5.3%	524,835	48.6%	576,137	9.8%	550,093	-4.5%	942,007	71.2%	1,321,956	40.3%	1,330,036	0.6%	1,719,329	29.3%	1,632,495	22.7%	1,929,200	18.2%
15-00	Chiropractor	154,279	-51.2%	88,164	-42.9%	84,868	-3.7%	55,125	-35.0%	48,784	-11.5%	50,357	3.2%	964,128	1814.6%	735,000	-23.8%	735,000	-23.8%	787,311	7.1%
16-00	Nurse Practitioners	364,337	-7.8%	598,020	64.1%	617,187	3.2%	541,354	-12.3%	566,198	4.6%	507,683	-10.3%	509,254	0.3%	572,795	12.5%	574,694	12.9%	656,718	14.3%
17-00	Skilled Nursing	4,174,255	-4.3%	4,656,432	11.6%	4,755,608	2.1%	4,631,221	-2.6%	4,135,104	-10.7%	2,903,558	-29.8%	3,230,347	11.3%	3,213,236	-0.5%	3,365,417	4.2%	3,550,320	5.5%
18-00	Podiatrist	132,681	11.0%	161,904	22.0%	211,724	30.8%	211,990	0.1%	218,769	3.2%	238,065	8.8%	246,648	3.6%	281,274	14.0%	285,423	15.7%	334,456	17.2%
19-00	Psychologist	6,696,605	27.0%	7,653,452	14.3%	11,105,331	45.1%	12,321,970	11.0%	12,780,061	3.7%	13,650,779	6.8%	15,078,858	10.5%	15,299,971	1.5%	16,281,591	8.0%	17,457,891	7.2%
20-00	Optometrist	669,818	-27.7%	706,214	5.4%	821,836	16.4%	786,030	-4.4%	814,027	3.6%	873,743	7.3%	970,695	11.1%	945,145	-2.6%	1,053,695	8.6%	1,146,733	8.8%
21-00	Optician	244,641	-47.7%	151,077	-38.2%	187,424	24.1%	202,259	7.9%	225,809	11.6%	237,305	5.1%	262,905	10.8%	269,552	2.5%	281,985	7.3%	295,804	4.9%
22-00	Transportation	5,339,085	16.9%	6,287,195	17.8%	6,722,540	6.9%	9,424,484	40.2%	9,900,218	5.0%	10,663,296	7.7%	11,694,573	9.7%	12,193,527	4.3%	12,635,938	8.0%	12,675,143	0.3%
23-00	OT/PT/ST Services	600,657	41.0%	939,926	56.5%	1,481,146	57.6%	1,469,402	-0.8%	1,516,267	3.2%	1,630,481	7.5%	2,322,326	42.4%	2,179,098	-6.2%	2,875,954	23.8%	3,519,006	22.4%
24-00	Prosthestic/Orthro	1,667,329	26.6%	1,767,709	6.0%	1,732,815	-2.0%	1,644,408	-5.1%	1,522,775	-7.4%	1,784,140	17.2%	1,881,035	5.4%	2,348,755	24.9%	2,084,440	10.8%	2,306,696	10.7%
25-00	Medical Supplies & DME (26-00)	4,658,025	20.0%	5,469,602	17.4%	6,178,377	13.0%	7,019,503	13.6%	6,825,297	-2.8%	6,827,517	0.0%	8,009,175	17.3%	7,275,113	-9.2%	8,638,821	7.9%	9,207,795	6.6%
27-00	H&CB Services	23,228,773	20.5%	27,058,997	16.5%	32,160,154	18.9%	32,834,665	2.1%	36,078,707	9.9%	44,727,273	24.0%	46,321,622	3.6%	48,774,675	5.3%	49,674,070	7.2%	49,869,850	0.4%
27-02	H&CB Mental Health Services	951,432	424.1%	1,138,960	19.7%	1,157,853	1.7%	810,643	-30.0%	534,055	-34.1%	594,391	11.3%	575,154	-3.2%	667,937	16.1%	595,990	3.6%	608,162	2.0%
27-03	H&CB Mental Retardation	15,389	-20.2%	24,184	57.2%	-	-100.0%	16,486	0.0%	34,556	109.6%	20,846	-39.7%	-	-100.0%	51,313	0.0%	24,064	0.0%	26,562	10.4%
27-13	TBI Services	(14,251)	-100.7%	(60)	-99.6%	-	-100.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
27-17	Enhanced Resident Care	2,156,820	21.8%	2,429,162	12.6%	2,723,956	12.1%	3,365,075	23.5%	4,775,636	41.9%	6,896,341	44.4%	5,731,482	-16.9%	7,803,435	36.2%	7,655,449	33.6%	7,655,491	0.0%
29-00	Personal Care Services	8,165,126	42.9%	10,615,921	30.0%	13,131,328	23.7%	16,411,319	25.0%	16,832,388	2.6%	16,839,209	0.0%	19,276,508	14.5%	20,907,852	8.5%	20,523,685	6.5%	20,267,855	-1.2%
30-00	Target Case Management	(6)	-100.1%	1,658	-27411.2%	8,196	394.4%	2,768	-66.2%	2,770	0.1%	1,914	-30.9%	41,580	2072.2%	2,491	-94.0%	2,491	-94.0%	2,604	4.5%
33-04	Assistive Community Care Services	5,216,479	17.1%	6,487,940	24.4%	7,696,713	18.6%	8,252,128	7.2%	9,825,397	19.1%	11,046,374	12.4%	11,691,935	5.8%	13,183,825	12.8%	12,697,393	8.6%	13,298,940	4.7%
34-01	Day Treatment (MHS)	39,432	-26.1%	80,050	103.0%	56,415	-29.5%	65,710	16.5%	75,895	15.5%	58,122	-23.4%	86,781	49.3%	69,316	-20.1%	96,673	11.4%	115,685	19.7%
35-07	ADAP Families in Recovery	53,936	0.0%	122,782	127.6%	303,097	146.9%	12,290	-95.9%	33,820	175.2%	79,764	135.8%	19,425	-75.6%	87,043	348.1%	87,043	348.1%	95,145	9.3%
37-01	Rehabilition/D&P Dept. of Health	30,022	-63.1%	543,437	1710.2%	3,736,272	587.5%	3,363,147	-10.0%	4,720,375	40.4%	3,713,914	-21.3%	3,850,941	3.7%	4,160,291	8.0%	4,203,399	9.2%	4,490,906	6.8%
38-01	Capitation Fee Health Plans	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
38-01	Health Care Risk Pool	-	-100.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
38-03	PC+ Case Management Fees	4,976,410	4.6%	5,075,010	2.0%	5,127,135	1.0%	5,521,200	7.7%	4,475,263	-18.9%	5,084,590	13.6%	5,326,311	4.8%	5,404,870	1.5%	5,788,475	8.7%	6,350,676	9.7%
05 & 38	Pace Capitation	-		-		-		-		-		-		2,720,223		1,000,000		1,442,234	-47.0%	3,400,278	135.8%
40-00	Ambulance	1,664,640	17.9%	1,972,634	18.5%	2,348,739	19.1%	2,508,296	6.8%	2,287,713	-8.8%	2,514,402	9.9%	3,144,232	25.0%	3,555,663	13.1%	3,666,959	16.6%	4,238,728	15.6%
41-00	Dialysis	206,113	110.0%	294,592	42.9%	391,569	32.9%	505,642	29.1%	692,408	36.9%	569,685	-17.7%	3,012,489	428.8%	916,313	-69.6%	3,186,732	5.8%	3,293,318	3.3%
42-00	ASC	46,492	102.7%	9,899	-78.7%	6,277	-36.6%	5,084	-19.0%	3,530	-30.6%	6,097	72.7%	8,563	40.4%	6,871	-19.8%	9,058	5.8%	9,608	6.1%
43-00	Outpatient Rehab	183,367	4.5%	240,341	31.1%	298,602	24.2%	290,361	-2.8%	203,595	-29.9%	158,647	-22.1%	5,826	-96.3%	174,285	2891.4%	174,285	2891.4%	174,285	0.0%
39-06	PDP Premium Payments	-	0.0%	-	0.0%	-	0.0%	2,287,779	0.0%	2,421,626	5.9%	1,888,168	-22.0%	1,829,725	-3.1%	1,211,842	-33.8%	1,927,714	5.4%	2,064,912	7.1%
39-10	New Premium Payments	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	8,593,929	0.0%	32,210,646	274.8%	53,969,635	67.6%	47,648,152	47.9%	57,936,476	21.6%
45-00	Miscellaneous	64,270	-177.0%	219,599	241.7%	2,624,357	1095.1%	1,296,427	-50.6%	1,173,211	-9.5%	294,974	-74.9%	49,398	-83.3%	165,130	234.3%	165,130	234.3%	165,130	0.0%
	Total	456,770,799	6.8%	533,592,148	16.8%	621,342,200	16.4%	606,832,565	-2.3%	559,005,383	-7.9%	613,484,713	9.7%	713,542,478	16.3%	754,495,480	5.7%	782,915,939	9.7%	835,357,405	6.7%
	Total w/o Catamount												0.0%		0.0%		0.0%		0.0%		0.0%
			0.0%		0.0%		0.0%		0.0%		0.0%		0.0%		0.0%		0.0%		0.0%		
Other Expenditures			0.0%		0.0%		0.0%		0.0%		0.0%		0.0%		0.0%		0.0%		0.0%		
	DSH	28,868,690	8.9%	29,259,141	1.4%	34,793,164	18.9%	35,205,323	1.2%	59,377,729	68.7%	49,003,898	-17.5%	35,648,781	-27.3%	37,448,781	5.0%	37,448,781	5.0%	37,448,781	0.0%
	Clawback	-	0.0%	-	0.0%	-	0.0%	6,888,177	0.0%	19,142,150	177.9%	20,339,254	6.3%	20,779,093	2.2%	23,113,134	11.2%	23,113,134	11.2%	24,414,748	5.6%
	Insurance Premium Payouts	168,124	-6.4%	237,224	41.1%	283,304	19.4%	233,567	-17.6%	66,307	-71.6%	(31,616)	-147.7%	150,307	-575.4%	-	-100.0%	160,844	7.0%	172,291	7.1%
	HIV Insurance Fund F	55,638	42.0%	46,108	-17.1%	46,738	1.4%	40,936	-12.4%	49,468	20.8%	43,914	-11.2%	44,976	2.4%	44,495	-1.1%	47,578	5.8%	50,964	7.1%
	Lund Home Family Ctr Retro PNMI	917,207	36.6%	686,755	-25.1%	523,624	-23.8%	430,854	-17.7%	684,813	58.9%	1,120,262	63.6%	1,529,624	36.5%	743,598	-51.4%	1,871,552	22.4%	2,328,139	24.4%
	Legal Aid	222,514	-50.8%	361,229	62.3%	481,377	33.3%	493,820	2.6%	564,937	14.4%	476,832	-15.6%	547,983	14.9%	506,142	-7.6%	547,983	0.0%	547,983	0.0%
	Rate Setting	538,489	0.9%	595,244	10.5%	418,452	-29.7%	644,746	54.1%	-	-100.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
	CMS Refugee Resettlement Adjustment	180,056	0.0%	-	-100.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
	Interdept'l GF Transfer	337,785	-43.7%	(262,215)	-177.6%	-	-100.0%	1,403,112	0.0%	-	-100.0%	-	0.0%	-	0.0%	2,000,000	0.0%	-	0.0%	-	0.0%
	Misc.	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	301,003	0.0%	1,236,007	310.6%
	Buy In	10,721,974	9.3%	11,646,455	8.6%	14,204,050	22.0%	19,538,052	37.6%	26,746,994	36.9%	26,834,679	0.3%	26,657,177	-0.7%	31,716,488	19.0%	34,036,003	27.7%	36,355,517	6.8%
	Total Other	42,010,477	8.3%	42,569,940	1.3%	50,750,709	19.2%	64,878,587	27.8%	106,632,399	64.4%	97,787,223	-8.3%	85,357,941	-12.7%	95,572,638	12.0%	97,526,878	14.3%	102,554,430	5.2%
			0.0%		0.0%		0.0%		0.0%		0.0%		0.0%		0.0%		0.0%		0.0%		
Offsets			0.0%		0.0%		0.0%		0.0%		0.0%		0.0%		0.0%		0.0%		0.0%		
	Drug Rebates	(28,818,077)	13.4%	(33,160,742)	15.1%	(46,999,074)	41.7%	(50,625,315)	7.7%	(27,352,725)	-46.0%	(30,496,900)	11.5%	(37,550,730)	23.1%	(34,349,469)	-8.5%	(79,795,015)	112.5%	(63,344,490)	-20.6%
	Supplemental Drug Rebates	(7,099)	0.0%	(288,860)	3969.1%	(5,423,825)	1777.7%	(10,409,819)	91.9%	(4,742,390)	-54.4%	(5,318,443)	12.1%	(6,489,711)	22.0%	(5,085,529)	-21.6%	(6,119,537)	-5.7%	(6,600,102)	7.9%
	TPL	(5,893,729)	37.8%	(6,079,776)	3.2%	(5,756,542)	-5.3%	(6,620,029)	15.0%	(2,881,618)	-56.5%	(5,761,948)	100.0%	(5,052,217)	-12.3%	(5,730,379)	13.4%	(5,730,379)	13.4%	(6,138,219)	7.1%
	Costs Settlements	(370,906)	-41.6%	(2,832,049)	663.5%	(3,804,148)	34.3%	(7,701,764)	102.5%	249,645	-103.2%	(868,083)	-447.7%	(3,057,205)	252.2%	-	-100.0%	(1,000,000)	-67.3%	(1,071,172)	7.1%
	Total Offsets	(35,089,811)	15.7%	(42,361,427)	20.7%	(61,983,590)	46.3%	(75,356,927)	21.6%	(34,727,089)	-53.9%	(42,445,373)	22.2%	(52,149,863)	22.9%	(45,165,377)	-13.4%	(92,644,931)	77.7%	(77,153,983)	-16.7%
			0.0%		0.0%		0.0%		0.0%		0.0%		0.0%		0.0%		0.0%		0.0%		
Net Expenditures		463,691,465	6.3%	533,800,661	15.1%	610,109,320	14.3%	596,354,225	-2.3%	630,910,693	5.8%	668,826,564	6.0%	746,750,556	11.7%	804,902,742	7.8%	787,797,886	5.5%	860,757,852	9.3%

History of Program Expansions
July 1994 – December 2008

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