



MEDICAID BUDGET

SFY 2012

Department of Vermont Health Access

Mission

Provide leadership for Vermont stakeholders to improve access, quality and cost effectiveness of health care

Assist Medicaid beneficiaries in accessing clinically appropriate health services

Administer Vermont's public health insurance system efficiently and effectively

Collaborate with other health care system entities in bringing evidence-based practices to Vermont Medicaid beneficiaries



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Contact Information

Susan Besio, Ph.D., Commissioner, Department of Vermont Health Access
susan.besio@ahs.state.vt.us

Hunt Blair, Director, Health Care Reform Division
hunt.blair@ahs.state.vt.us

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

Michael Farber, M.D., Medical Director
michael.farber@ahs.state.vt.us

Craig Jones, M.D., Director, Blueprint for Health Division
craig.jones@ahs.state.vt.us

Victoria Loner, Director, Health Services and Managed Care Division
victoria.loner@ahs.state.vt.us

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

Phone

802-879-5900

Fax

802-879-5651

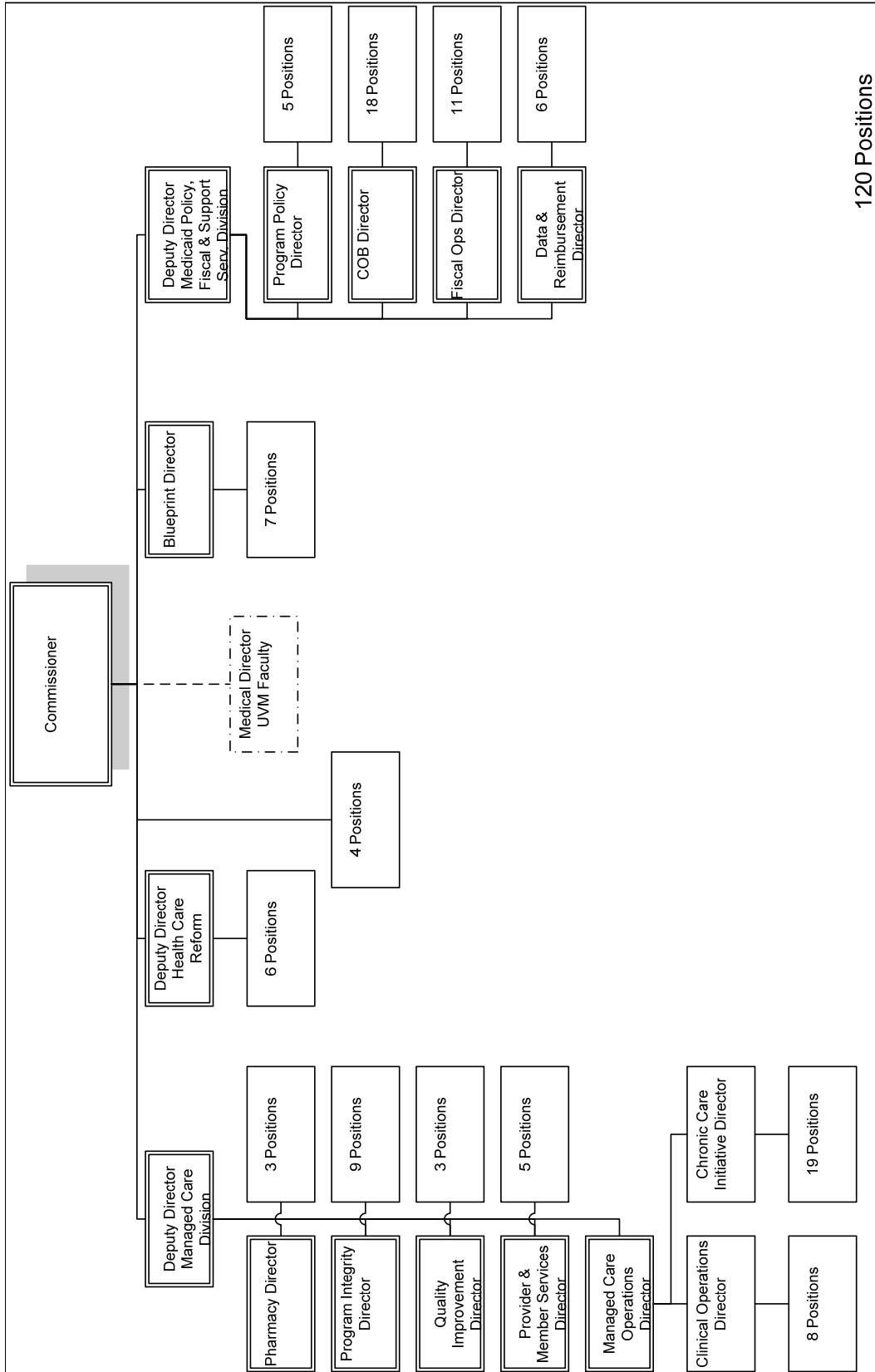
Address

312 Hurricane Lane, Suite 201
Williston, Vermont 05495

Web Sites

Department of Vermont Health Access dvha.vermont.gov
Vermont's Health Care Reform hcr.vermont.gov
Green Mountain Care greenmountaincare.org

Organizational Chart



120 Positions

DVHA Responsibilities and Organization

The Department of Vermont Health Access (DVHA) is responsible for the management of Medicaid, the State Children's Health Insurance Program (SCHIP) and other publicly funded health insurance programs in Vermont.

In 2009, DVHA became the home of state oversight and coordination of Vermont's Health Care Reform initiatives which are designed to increase access, improve quality, and contain the cost of health care for all Vermonters. The Blueprint for Health joined DVHA in 2010 bringing a vision and plan for a statewide partnership to improve the health care system for Vermonters. The Blueprint and the Vermont Chronic Care Initiative (VCCI) provide information, tools and support that Vermonters with chronic conditions and their providers need to better manage their own health. DVHA also is responsible for Vermont's health information technology strategic planning, coordination and oversight.

Staff positions at DVHA currently total 120. The Medical Director is a faculty member of UVM under contract with DVHA and is not included in the 120.

DVHA Leadership & Divisions

In fall 2009, DVHA's organization was re-structured into four distinct Divisions to consolidate like functions, clarify responsibilities, and better reflect organizational goals. DVHA leadership comprises the Commissioner, four Directors and a Medicaid Medical Director. *The DVHA Commissioner* is responsible for all of DVHA's operations, and has been the leader for state and federal health care reform implementation.

DVHA's organizational structure is comprised of four divisions, each with a division director:

- Blueprint for Health
- Health Care Reform
- Health Services and Managed Care
- Policy, Fiscal and Support Services

The new (as of December, 2009) organizational alignment between the Administration's oversight and implementation of Vermont's comprehensive Health Care Reform and DVHA's health care programs and administrative functions has also provided new opportunities for more program integration related to health care reform among the departments within the Agency of Human Service (AHS) initiatives, as well as cross-Agency and Departmental activities outside of AHS.

Blueprint for Health Division

The Blueprint team supports, monitors and manages the state's multi-insurer initiative designed to integrate a system of health care for patients, improve the health of the overall population, and improve control over health care costs by promoting health maintenance, prevention, and care coordination and management at the provider level.

The core components of the Blueprint are payment reforms that include two major components: enhanced payments to primary care practices based on the quality of care they deliver (in addition to fee for service), and shared costs for core Community Health Teams (CHTs) that provide community based multi-disciplinary care support to the primary care practices' patients with chronic conditions and its general population. The combination is designed to assure a general population and high risk subgroups with extraordinary access to routine health maintenance, preventive care, well coordinated health services, and systematic transitions from acute care to thorough preventive care. In addition, a systems-based approach is used to enhance patient self-management and decision support.

Another key is a statewide infrastructure to assure that important information is readily and dependably available, in useful formats and seated in an architecture that supports a continuum of well-coordinated health services. This includes health information exchange (HIE), and data transmission from electronic medical records (EMRs), practice management systems, and hospitals to a centralized registry (DocSite LLC).

Health Care Reform Division

The Health Care Reform Division is responsible for providing oversight and coordination across state government – and with other public and private partners – to foster collaboration, inclusiveness, consistency, and effectiveness in state and federal health care reform. The specific Division functions include:

Overall Policy and Implementation - Ensures that state government activities related to state and federal reform efforts are aligned with the Governor's policy direction; monitors Vermont legislative activity regarding health care reform deliberations. With assistance from DVHA's Commissioner's Office and Policy Unit, the Health Care Reform Division also ensures that information regarding state and federal reforms is distributed to relevant state partners on a timely basis.

Health Care Coverage – Responsible for coordinating the implementation of the Catamount premium assistance program and the Employer-sponsored premium assistance programs created in Vermont Acts 190 and 191 of 2006. Also responsible for marketing and outreach for **Green Mountain Care**, which includes public health insurance options such as Medicaid, Vermont Health Access Plan (VHAP), Dr. Dynasaur, premium assistance programs for Catamount Health and employer-sponsored insurance, and a number of pharmacy assistance programs.

Health Benefits Exchange - In close collaboration with BISHCA, leading Vermont's efforts to plan for a Health Benefits Exchange to be fully operational by December, 2013.

Payment Reform – Responsible for overseeing the development, implementation and evaluation of Payment Reform Pilot Projects as defined in Vermont Act 128 of 2010. These

projects are to be organized around primary care practices, should be aligned with the Blueprint model, should move away from fee-for-service payments, and move toward a system in which all insurers (Medicaid, Medicare, and commercial insurers) pay providers through a single system of payment that provides incentives to reduce health care costs, improve health outcomes and patient satisfaction, and improve the coordination of patient care services. A strategic plan is due to the legislative health care committees no later than February 1, 2011, which will include a description of the required payment reform pilot projects, including a description of the possible organizational model or models for health care providers; a detailed design of the financial model for payment to providers; and an estimate of savings to the health care system resulting from these models.

Health Information Technology - Responsible for Vermont's Health Information Technology (HIT) and Health Information Exchange (HIE) policy, planning and oversight. This includes writing and implementing the State HIT Plan and the State Medicaid HIT Plan, implementing the Medicaid Electronic Health Record (EHR) Provider Incentive program, overseeing the State Health IT Fund, and managing the contract with VITL for HIE operations and HIT expansion. Works with the State Public Health HIT Coordinator at VDH for integration of the Public Health Infrastructure with HIT/HIE. In close collaboration with the AHS CIO, helps to support implementation of Agency Service Oriented Architecture and its integration with HIT/HIE and Health Insurance Exchange systems, including Provider Directory and Enterprise Master Persons Index.

Health Information Technology Fund – Established during the 2008 legislative session in the state treasury, this Fund is used for health care information technology programs and initiatives such as those outlined in the Vermont Health Information Technology Plan. The Fund is financed through an assessment of 0.199 of one percent of all health insurance claims for Vermont members, beginning with quarterly payments in November 2008. This Fund will be utilized to provide resources that can be matched under new federal HIT initiatives. It is overseen by the DVHA Health Care Reform Division, with billing and administrative support from the DVHA Business Office and enforcement through the HCA Division of BISHCA.

Delivery System Reform – Responsible for supporting expansion of the Blueprint for Health in coordination with build out of the statewide HIE network, including integration with public health, mental health and substance abuse providers, long term care, home health, and AHS initiatives including Children's Integrated Services (CIS) and Integrated Family Services (IFS).

Health Services and Managed Care Division

The **Pharmacy Unit** is responsible for managing the pharmacy benefit programs for beneficiaries enrolled in Vermont's publicly funded health care programs. This includes ensuring that beneficiaries receive medically necessary medications in the most cost-effective manner. The Pharmacy Unit routinely analyzes trends in drug utilization and the resulting impact on pharmaceutical costs. Pharmacy Unit staff and MedMetrics Health

Partners, DVHA's contracted Pharmacy Benefit Manager (PBM), work with pharmacies, prescribers and at times beneficiaries to resolve benefit and claims processing issues, as well as to facilitate appeals related to prescription drug coverage within the pharmacy benefit.

In addition, the Pharmacy Unit enforces claims rules in compliance with federal and state laws, implements legislative and operational changes to the pharmacy benefit program, and manages all the state and federal drug rebate programs. Lastly, the Pharmacy Unit manages the activities of the Drug Utilization Review Board, whose members include Vermont physicians and pharmacists. Board members evaluate drugs on the basis of clinical appropriateness and net cost to the state, and make recommendations regarding a drug's clinical management and status on the state's Preferred Drug List (PDL). Board members also review identified utilization events and advise on approaches to management.

The **Quality Improvement (QI) Unit** collaborates with our AHS partners to maintain quality standards as required by the Code of Federal Regulation; prepares for the annual external quality reviews as required under the *Global Commitment to Health Waiver* and state quality audits; provides concurrent review and authorization of psychiatric inpatient admissions; monitors the Intergovernmental Agreements (IGA); maintains the Managed Care Entity (MCE) Quality Plan; and coordinates quality initiatives with the DVHA Managed Care Medical Committee.

The **Program Integrity (PI) Unit** engages in activities to prevent, detect, and investigate Medicaid fraud, waste and abuse by utilizing data mining and analysis, recoupment of provider overpayments, and lock-in programs for overutilization or abuse of the system. PI educates providers about accurate billing and refers cases of abuse to the Attorney General's office (provider fraud) and to DCF (eligibility fraud).

The **Provider and Member Relations (PMR) Unit** assists providers of Medicaid services by acting as a liaison between the providers, and our various DVHA units and fiscal agent, and interacts with provider groups and organizations that represent provider and member interests within Vermont's public health service arena. PMR coordinates assistance for beneficiaries via communications and contracted services (Maximus). PMR staff manages and directly provides daily administration of the Medicaid non-emergency medical transportation (NEMT) program, including 9 transportation brokers/contractors. Other duties include management of additional contracts (eyeglasses; State Dental Clinic), and administration of the DVHA web site dvha.vermont.gov/

The **Managed Care Operations Unit** is responsible for planning and implementation of new program initiatives, best practice guidelines and clinical outcomes. Staff administers clinical policies and procedures, performance improvement projects, and manages external clinical contracts (UVM; APS).

The Managed Care **Clinical Operations Unit** monitors the quality, appropriateness and effectiveness of health care services requested by providers for our beneficiaries. Clinical unit staff ensures requests for services are reviewed and processed efficiently and within time frames outlined in Medicaid Rule, identifies over- and under-utilization of health care services through the Prior Authorization (PA) review process and case tracking, develops clinical criteria for certain established clinical services and new technology and medical treatments and assures correct coding for medical benefits, reviews provider appeals, provides provider education related to specific medical procedures and performs quality improvement activities to enhance medical benefits for enrollees.

The Managed Care **Chronic Care Initiative Unit** identifies and assists Medicaid beneficiaries with chronic health conditions to access clinically appropriate health care information and services; coordinates the efficient delivery of health care to this population by addressing barriers to care, bridging care gaps, and avoiding duplication of services; and educates and empowers this population to eventually self-manage their chronic conditions. This program is fully aligned with the care coordination efforts of the Blueprint for Health.

Policy, Fiscal and Support Division

The **Program Policy Unit** is responsible for coverage rules, fair hearings, grievances and appeals, HIPAA, legislative activities, public record requests, requests for non-covered services, State Plan Amendments, and the State Children's Health Insurance Program (SCHIP). Staff coordinates initiatives resulting from federal health care reform and state legislative sessions and may serve as the primary communicators to Vermont's Congressional Delegation, the media and the Centers for Medicare and Medicaid Services (CMS).

The **Coordination of Benefits (COB) Unit** works with providers, beneficiaries, and other insurance companies to ensure that Medicaid is the payer of last resort. COB also administers the premium assistance programs by performing analyses to ensure beneficiaries are placed in the most cost-effective program.

The **Fiscal Operations Unit** supports, monitors, manages and reports all aspects of fiscal planning and responsibility. Functions include vendor payments, timesheets, expense reports, grants, contracts, purchasing, financial monitoring, budgeting and other relevant practices, procedures and processes.

The **Data Analysis Management & Reimbursement Unit** provides Medicaid data to state agencies, the legislature and other stakeholders as well as providing data for mandatory federal reporting to the Centers for Medicare and Medicaid Services (CMS) and analyses for the budget development process. The Reimbursement side of the unit oversees the claims processing function of the Medicaid program and provides direction, guidance and interpretation of the state plan to our fiscal agent who processes the Medicaid claims. The

team develops projections, implements updates, and analyzes the effect of our myriad pricing reimbursement methodologies.

The above includes major areas of responsibility and is not an all-inclusive listing of responsibilities and duties.

Budget Request SFY 2012

	GF	SF	IdptT	FF	ARRA Fed	Medicaid GCF	Invmnt GCF	Total
FOR FY 2012 DVHA								
Administration - As Passed FY11	1,549,943	3,016,174		12,883,458	-	37,417,425	-	54,867,000
FY11 Challenges for Change:								
3% Payroll Reduction	(1,536)					(118,907)		(120,443)
CURB - Investments						85,000		85,000
IFS - Investments Concurrent Reviewer						85,000		85,000
C4C - Non-AHS - Performance contracting	(633,360)					(633,360)		(633,360)
C4C - Non-AHS - Charter Unit BGS Services	(11,094)							(11,094)
FY11 BAA Subtotal Challenges:	(645,990)					51,093		(594,897)
FY11 Post Challenges	903,953	3,016,174		12,883,458		37,468,518		54,272,103
FY12 Request								
Personal Services:								
Annualization of Salaries - Turnover, Insurance Enrollment etc.	468			1,613		141,599		143,680
Early Retirement Incentive - One-time in SFY11	(15,000)							(15,000)
Increase in Health Insurance	840			2,890		80,210		83,940
Increase in Workers Comp Insurance	29					2,877		2,906
Increase in Retirement Rate	998					138,690		139,688
Subtotal Payact and Related Fringe	(12,665)			4,503		363,376		355,214
1 FTE Palliative Care Nurse Case Manager						85,000		85,000
Increase for HIT and CHIPRA limited service staff (approved by JFO)		27,593		73,219	248,337			349,149
Subtotal New Position Requests	(11,667)	27,593		73,219	248,337	85,000		434,149
Operating Expenses:								
Net Increase in Leases						69,000		69,000
Increase in DII Bandwidth						6,758		6,758
DII Allocation	19,606					33,586		53,192
VISION	33,723					44,237		77,960
Human Resources Allocation	936					92,668		93,604
Fee For Space	(539)					(1,182)		(1,721)
Subtotal Operating Changes	53,726					245,067		298,793
MMIS Procurement (GF moved to capital bill)			3,064,127	27,577,140				30,641,267
VIEWS Procurements (Match in DII capital Appropriations)			1,012,990	9,116,907				10,129,897
Radiology Contract Costs Originally Booked as Netted from Program Savings						685,000		685,000
Blueprint Annualization of Expansion						3,710	96,290	100,000
Change in Blueprint Funding Model						(1,696,710)	1,696,710	-
Hit Matched Federal Grants (APD, IADP etc)		121,015		(785,387)	2,256,707			1,592,335
Transfer to AHS to Fund HIT-Matched GC Expenditures		(1,585,659)				526,186	4,250,568	3,191,095
Increase Contract Costs for Dental Assessment Implementation						200,000		200,000
Contract for AAG Lawsuit						10,000		10,000
Pharmacy Multi-Source Brand Use Criteria						40,000		40,000
Remove Federal Portion of Contractual C4C Reduction								(5,700,240)
Increase in Contract Costs due to Catamount to VHAP Shift						647,324		647,324
Subtotal Grants and Contracts Changes	41,061	(1,464,644)	4,077,117	30,208,420	2,256,707	415,510	6,043,568	41,536,678
FY12 Request	945,014	1,579,123	4,077,117	43,169,600	2,505,044	38,577,471	6,043,568	96,896,937
FY12 Changes								
Personal Services:								
FY12 Subtotal of Legislative Changes								
FY12 As Passed - Dept ID 3410010000	945,014	1,579,123	4,077,117	43,169,600	2,505,044	38,577,471	6,043,568	96,896,937

FOR FY 2012 DVHA	GF	SF	Idpt	FF	ARRA Fed	Medicaid GCF	Invmnt GCF	Total
Program Appropriations - As Passed FY11	96,561,004	-	-	152,296,534	22,351,327	632,073,546	1,730,656	905,013,067
FY11 Challenges for Change:								
Care Coordination - Gross Savings						(652,000)		(652,000)
340B Critical Care Hosp - FOHC Outpatient						(1,000,000)		(1,000,000)
DA Challenge: 340B & Other Collabs with FQHC's & Hospitals						(350,000)		(350,000)
Clinical Utilization Review Board - Gross Savings						(4,085,000)		(4,085,000)
IFS Challenge: Reductions in Inpatient Psychiatric Hospitalization						(600,000)		(600,000)
DA Challenge: Reducing Psychiatric Hospital Length of Stay						(475,000)		(475,000)
IFS Challenge: Additional Inpatient Coordination						(635,000)		(635,000)
IFS Challenge: Reductions in Psychotropic Medication Use						(300,000)		(300,000)
Nursing Home Utilization Reduction	(1,626,000)			(2,936,000)	(438,000)			(5,000,000)
FY11 BAA Subtotal Challenges:	(1,626,000)	-	-	(2,936,000)	(438,000)	(8,097,000)	-	(13,097,000)
FY12 Post Challenges	94,935,004	-	-	149,360,534	21,913,327	623,976,546	1,730,656	891,916,067
FY12 Request								
Grants:								
ARRA-Matched Caseload						23,290,263		23,290,263
Non-ARRA Matched Caseload						(750,151)		(750,151)
Traditional Choices for Care Caseload								
Acute Choices for Care Caseload								
State-Only Pharmacy Caseload	9,324						71,836	9,324
Civil Union Caseload							(2,747)	
HIV Caseload								
SCHIP Caseload	(125,943)			(309,845)				(435,788)
Refugee Caseload				2,615				2,615
Subtotal Caseload Changes	(116,618)	-	-	(307,230)	-	22,540,112	69,089	22,185,352
ARRA-Matched Utilization						5,800,240		5,800,240
Non-ARRA Matched Utilization						686,090		686,090
Traditional Choices for Care Utilization								
Acute Choices for Care Utilization	1,535,270			2,107,991				3,643,261
Change in Non-DVHA CFC Claims Expenditures						(1,028,829)		(1,028,829)
State-Only Pharmacy Utilization	(1,115,451)						(350,625)	(1,115,451)
Civil Union Utilization							7,663	7,663
HIV Utilization								
SCHIP Utilization	249,771			597,126				846,897
Refugee Utilization				(60,593)				(60,593)
Subtotal Utilization Changes	669,590	-	-	2,644,523	-	5,457,501	(342,962)	8,428,653
Change in Buy-In Caseload	(185,485)			(176,039)		(394,859)	(461,060)	(1,217,444)
Change in Clawback	6,277,437			(6,646,867)				6,277,437
Federal Healthcare Reform Changes in Federal Share of Rebates								(6,646,867)
Change in Miscellaneous (Lund Home, PDPs; etc.)						(1,613,220)		(1,613,220)
VPharm Wrap Benefit Not Covered With Waiver Amendment	3,183,320					(3,183,320)		-
Change in Miscellaneous	3,183,320	-	-	-	-	(4,796,540)	-	(1,613,220)
Radiology Contract Costs Originally Booked as Netted from Program Savings						(685,000)		(685,000)
C4C Transfer from DAIL for Personal Care Services Savings						(100,000)		(100,000)
Vet's Home Rate Settlement	337,120			462,880				800,000
TBI Caseload (AHS Net Neutral)	(294,980)			(405,020)				(700,000)
Change in Miscellaneous Programs Managed by DAIL	42,140	-	-	57,860	-	-	-	100,000

	GF	SF	IdptT	FF	ARRA Fed	Medicaid GCF	Invmnt GCF	Total
FOR FY 2012 DVHA								
Transfer to DAIL for USPs						(1,200,000)		(1,200,000)
Transfer Lund Home Funding to DCF						(1,500,000)		(1,500,000)
Transfer Inpatient Rate Funding to DMH						(285,127)		(285,127)
Cost Neutral Transfers to Other Departments						(2,985,127)		(2,985,127)
Change in Federal Financial Participation	23,982,871			(2,069,544)	(21,913,327)			
Cost-Neutral Adj. to CFC Due to Conf. Committee Chgs.	325,597			447,058		(772,655)		
Cost-Neutral Adj. to State Only Due to Conf. Committee Chgs.	1,318,455					(1,398,128)	79,673	
Cost-Neutral Adj. to non-Waiver Due to Conf. Committee Chgs.	34,382			84,588		(118,971)		
Neutral Adjustments Between DVHA Appropriations	1,678,434			531,646		(2,289,754)	79,673	
SUBTOTAL TREND CHANGES	35,531,689			(5,965,651)	(21,913,327)	16,746,334	(655,261)	23,743,784
Cover Legal Immigrant Children & Pregnant Women (Under 5-Year Bar) ~								
CHIPRA	21,773			52,060		10,850		84,683
Increase due to Palliative Care Initiative	7,966			19,046		645,746		672,758
Premium Grace Period Under CHIPRA	44,327			105,985		253,895		404,207
Hospital Rate Increases	150,117			227,979		9,607,158	14,747	10,000,000
Dental Rate Increases	94,729			210,410		5,689,764	5,098	6,000,000
Home Health Rate Increases	32,291			44,579		160,303	131	237,304
Provider Rate Increases	277,136			482,967		15,457,225	19,976	16,237,304
Enhanced Program Integrity Activities	(81,210)			(104,163)		(1,663,385)	(2,763)	(1,851,521)
Limit Coverage for OTC Medication to Preferred List	(7,972)			(2,398)		(114,309)	(322)	(125,000)
Lower Reimbursement Rates for Ltd. Distribution Pharmacies in Network	(1,595)			(479)		(22,862)	(64)	(25,000)
Radiology Tier Authorization'	(8,852)			(15,655)		(715,570)	(1,199)	(741,276)
Growth in 340B Pharmacy Participation	(68,669)			(20,091)		(908,779)	(2,461)	(1,000,000)
Fold Cataamount into VHAP effective 10/1/11						(10,190,556)		(10,190,556)
Maintain \$500 deductible for new VHAP beneficiaries						(1,668,821)		(1,668,821)
Increase new VHAP beneficiary deductible to \$1200						(2,800,999)		(2,800,999)
Cataamount and ESIA Program Conversions to VHAP and VHAP ESIA						(14,660,376)		(14,660,376)
Nursing Home Inflation and Savings from Re-Base	707,804			971,845				1,679,649
Renovations to Woodridge & the Pines	29,820			40,944				70,764
Increase for Special Rates Residents at Crescent Manor Huntington's Unit	132,057			181,321				313,378
Rate Increases for Out-of-State Facilities in NH	66,160			90,840				157,000
Provider Rate Increase	672,369			923,191				1,595,560
Planned Carryover from FY 11 LTC Portion	(632,100)			(867,900)				(1,500,000)
Reduce Instrumental Activities of Daily Living	(1,112,496)			(1,527,504)				(2,640,000)
Reduce Cap on Respite/Companion Services	(1,042,948)			(1,432,012)				(2,474,960)
Implement 10% Discount on Flex Choices Budgets	(131,477)			(180,523)				(312,000)
DAIL Managed Policy Decisions	(1,310,811)			(1,799,798)				(3,110,609)
SUBTOTAL POLICY CHANGES	(1,127,909)			(1,282,527)		(1,717,565)	13,168	(4,114,830)
FY12 Changes	34,403,784			(7,248,178)	(21,913,327)	15,028,768	(642,093)	19,628,954

	GF	SF	IdptT	FF	ARRA Fed	Medicaid GCF	Invmnt GCF	Total
FOR FY 2012 DVHA								
FY12 Request	129,338,788	-	-	142,112,356	-	639,005,314	1,088,563	911,545,021
FY12 Changes								
Grants:								
FY12 Subtotal of Legislative Changes	-	-	-	-	-	-	-	-
FY12 As Passed - Dept ID 34410075000	129,338,788	-	-	142,112,356	-	639,005,314	1,088,563	911,545,021
TOTAL FY11 OVHA Big Bill As Passed	98,110,947	3,016,174	-	165,179,992	22,351,327	669,490,971	1,730,656	959,880,067
TOTAL FY11 OVHA Challenges for Change	(2,271,990)	-	-	(2,936,000)	(438,000)	(8,045,907)	-	(13,691,897)
TOTAL FY12 OVHA Starting Point	95,838,957	3,016,174	-	162,243,992	21,913,327	661,445,064	1,730,656	946,188,170
TOTAL FY12 OVHA Ups & Downs	34,444,844	(1,437,051)	4,077,117	23,037,964	(19,408,283)	16,137,721	5,401,475	62,253,787
TOTAL FY12 OVHA Gov Recommended	130,283,801	1,579,123	4,077,117	185,281,956	2,505,044	677,582,785	7,132,131	1,008,441,957
TOTAL FY12 OVHA Legislative Changes	-	-	-	-	-	-	-	-
TOTAL FY12 OVHA As Passed	130,283,801	1,579,123	4,077,117	185,281,956	2,505,044	677,582,785	7,132,131	1,008,441,957

Budget Considerations SFY 2012

February 10, 2011

The Department of Vermont Health Access (DVHA) budget request includes an increase in administration of \$42,624,834 and in program of \$19,628,953 for a total of \$62,253,787 in new appropriations (i.e., a combination of new funds and new expenditure authority). Please be advised that the SFY '12 budget also reflects a base reduction of \$13,691,897 in the DVHA budget after the SFY '11 Appropriations Act due to Challenges for Change initiatives that were implemented in SFY '11. For reference, these are described at the end of this Budget Narrative section.

The programmatic changes in DVHA's budget are spread across four different covered populations – Global Commitment, Choices for Care, State Only, and Medicaid Matched Non-Waiver. However, the descriptions of the changes are similar across these populations. As such, we are consolidating these items for purposes of testimony and have provided a spreadsheet at the beginning of this narrative that consolidates the official state budget ups and downs to track with our testimony.

ADMINISTRATION \$42,624,834 gross / \$1,618,082 state

PERSONAL SERVICES. \$789,363
\$203,874 state

Payact and Related Fringe \$355,214
\$140,462 state

New Positions \$434,149
\$51,745 state

One of the policy initiatives detailed below implements a Palliative Care initiative. In order to have this be successful, a Nurse Case Manager position is needed \$85,000
\$35,819 state

DVHA has the responsibility to implement Health Insurance Technology and Health Insurance Exchange initiatives which requires an additional 3 FTEs (please see HIT section below for additional detail). \$278,725
\$15,926 state

In addition, the State of Maine and the State of Vermont (DVHA) successfully partnered in applying for a Quality Demonstration Grant offered by the US Department of Health and Human Services (HHS) under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). In total, our partnership was awarded \$11.3 million over 5 years, beginning in summer, 2010. Under the grant agreement, the State of Vermont is a subcontractor with the Muskie School of Public Service and Vermont's share of the award is

\$490,000 over 5 years. The focus of the grant is to improve the quality of health care delivered to children. The grant will allow Vermont to include children in its nationally-recognized *Blueprint for Health*. The cost of one FTE Vermont Project Manager is fully funded through the grant. The Project Manager will play the key role in guiding and facilitating the planning and implementation of the DVHA grant activities. The Project Manager will oversee DVHA's responsibilities as a subcontractor with the Muskie School of Public Service and will interact extensively with both internal and external project staff and stakeholders including MaineCare (Maine's Medicaid Program) and the University of Vermont Child Health Improvement Program (VCHIP). One Limited Service Position (1 FTEs) \$70,424
\$0 state

OPERATING **\$298,793**
(\$156,997 state)

The DVHA 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 '12, it is anticipated that Vision costs for the DVHA will increase by \$77,960 and DII costs by \$59,950. Additionally, it is projected that DVHA will have a \$67,279 increase in space costs and \$93,604 in obligations to the Department of Human Resources.

GRANTS AND CONTRACTS **\$41,536,678**
(\$1,257,212 state plus match funding in Capital bill)

The MOVE Initiative **\$40,771,164**
State match proposed thru state budget neutral source

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

The current ACCESS system was installed in 1983 and provides eligibility functionality for Federal and State financial and health care programs and services. This system was modeled and designed on the Information Technology (IT) rules and processes of the late 1970's. The MMIS, which supports care management tracking and claims, was built in 1992 and last certified by 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; and support and maintenance on these systems is costly and complex. 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.

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. Procurement of these new systems will result in efficiencies for benefits/eligibility determination processing, service delivery, claim adjudication and reporting.

There are three contractual processes associated with receiving federal match for the Eligibility and MMIS projects:

- The technical assistance (TA) contractor is responsible for providing consultative services for the State and assist with planning and development of Center for Medicare and Medicaid Services (CMS) documents (such as funding requests) and Request for Proposal efforts (such as producing the RFP and evaluating the proposals). The State is currently working with a contractor who was hired as the TA vendor for the MMIS project. The TA efforts for the eligibility project have been completed.
- 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. For the MMIS project, this RFP has been released and responses are due in March, 2011. For the Eligibility project, an RFP will be released in February, 2011.
- 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 synch with State and CMS expectations as defined in the RFP and the approved contract. This RFP for the MMIS project is expected to be released in February, 2011, and in agreement and support from CMS this RFP will also procure the IV&V services for the eligibility project.

The costs for the replacement of these two systems are reflected below. Fortunately both of these projects will receive significant financial support from the federal government through Medicaid matching funds (90/10 match rate). State funds for completion of the ACCESS system replacement, called Vermont's Integrated Eligibility Workflow System (VIEWS), and the MMIS system are being requested through a state budget neutral source. As such, request in DVHA's proposed SFY '12 budget is for expenditure authority that reflects both the state fund needs and the significant federal match for these funds.

Movement of Radiology Prior-Authorization from Program \$685,000
\$288,659 state

During the SFY '11 budget testimony, DVHA proposed (and subsequently received approval) to implement a prior authorization process for radiology

services in order to achieve \$2 million in net program savings. This reduction in cost was booked fully in the program appropriations. The initiative, however, involved a contract increase in the administrative appropriation of \$685,000 for the prior authorization management resulting in gross program savings of \$2,685,000.

Annualization of the Blueprint Expansion \$100,000
\$42,140 state

In 2010, the Vermont Blueprint for Health, Vermont’s cutting edge health reform program and public-private partnership, made tremendous progress. Act 128 of 2010 mandated the statewide expansion of the Blueprint’s Advanced Primary Care Practices (APCPs) – a model that includes patient-centered medical homes (PCMHs) and community health teams (CHTs), supported by multi-insurer payment reforms. In order to continue serving Vermonters, all major insurers – including Medicaid - must participate in this model as it is expanded statewide. Evidence of this expansion requires a minimum of two primary care practices in each health service area (HSA) becoming APCPs by July 2011.

There were 3 original APCP pilot communities: St. Johnsbury (July 2008), Burlington (October 2008) and Central Vermont (January 2010). Altogether, in these 3 pilots, 11 APCPs, 58 primary care providers and 3 Community Health Teams take care of 60,000 patients -- or approximately 10 percent of the state’s population. Expansion to the fourth APCP community in the Bennington area occurred in November 2010. These 7 practices now combine with the original pilots to serve a general population of approximately 80,000 patients in 18 APCPs. The expansion is expected to quickly accelerate in the first half of 2011, with 6 more primary care practices in 4 HSAs on or around the first of the year and full Blueprint recognition of at least 2 primary care practices in every HSA in the state by July 2011.

DVHA is requesting a total of \$100,000 (gross) to cover the Medicaid portion of the annualized costs for the statewide expansion of the Community Health Teams.

DVHA also is requesting a cost neutral change in the Global Commitment support of the Blueprint program from the Administrative fund source to the Investment fund source to reflect the fact that not all of the Blueprint Administrative costs are related to Medicaid.

HIT Initiatives \$4,783,430
\$548,280 state

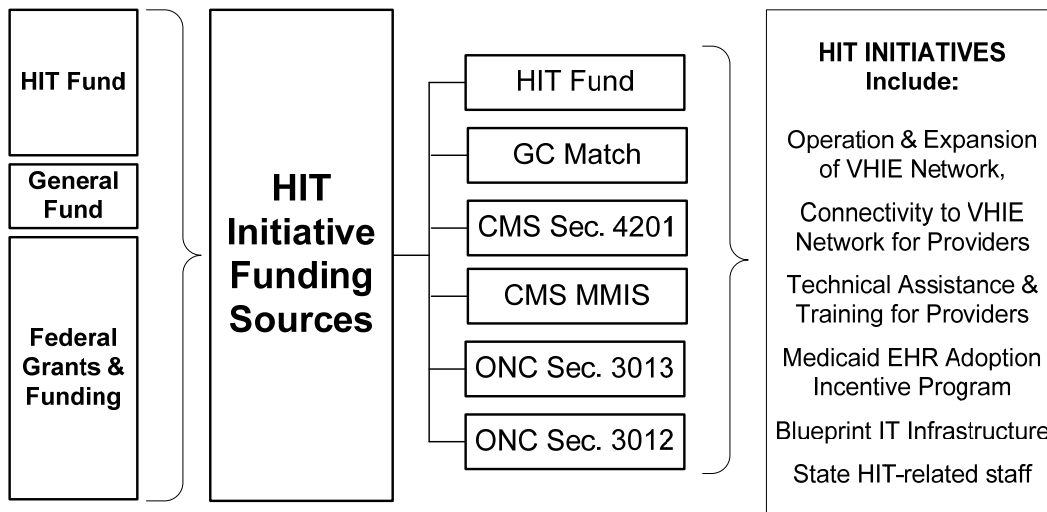
Responsibility for the Health Information Technology (HIT) fund management shifted to DVHA during SFY '10. In order to maximize use of the receipts, a transfer will occur to the AHS Central Office to be used as match for Global Commitment funding. Additionally, the HIT revenues will be used to draw down

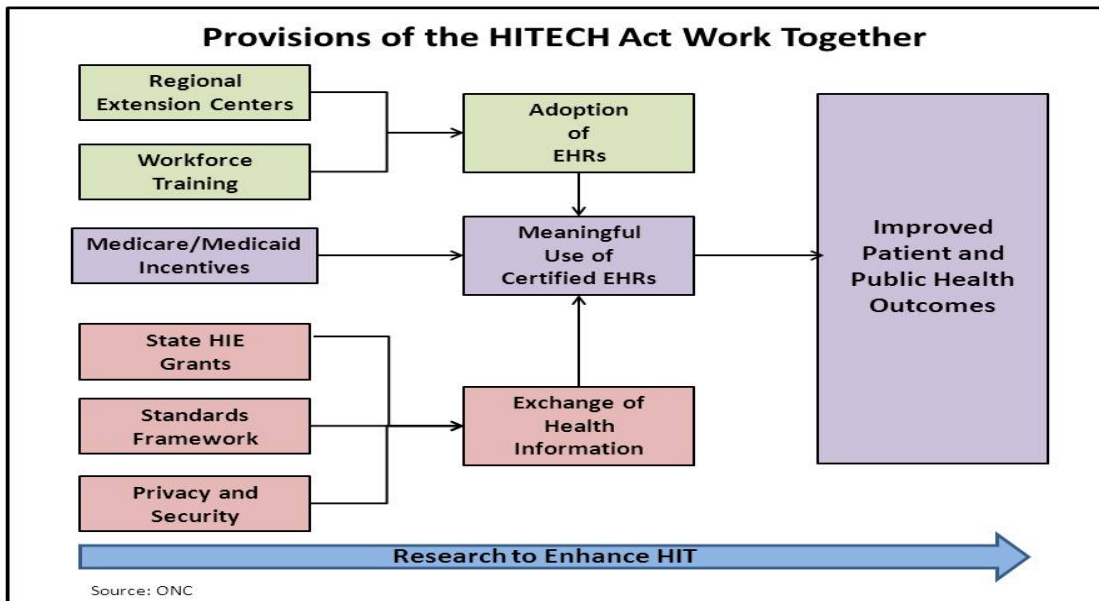
enhanced federal funding available through national healthcare reform opportunities. These enhanced dollars are used to directly fund HIT projects as well as to provide state match for HIT initiatives funded through multiple federal sources.

The federal HITECH Act (a section of the 2009 ARRA stimulus bill) included multi-year funding through both CMS and the federal Office of the National Coordinator of HIT (ONC) for states and health care providers to stimulate the adoption of Electronic Health Record (EHR) systems, development of Health Information Exchange (HIE) networks, and other HIT initiatives including workforce training and HIT research.

Vermont is able to utilize the state HIT Fund to provide the state match for these federal initiatives to provide substantially increased resources for HIT implementation and expansion in the state. DVHA provides grants to support the operation of the Vermont HIE (VHIE) network and state match for federal funding of the Regional HIT Extension Center, both operated by Vermont Information Technology Leaders (VITL), as well as match funding for a federal Health Center Controlled Network grant to Bi-State Primary Care Association and for development of connectivity between public HIT systems and the VHIE.

These resources also support expansion of the Blueprint IT infrastructure and clinical registry, including support for the Medicaid Care Coordination program and secure messaging and care coordination systems that will interface with AHS programs including Integrated Family Services programs. HIT funds also support development of connectivity to the VHIE for providers not eligible for federal EHR incentive payments (including home health, mental health and substance abuse services, and long term care) and provide the majority of funding for DVHA staff working on HIT initiatives.





Miscellaneous Contract Issues (\$4,802,916)
\$378,132 state

As described in the Policy and Revenue sections below, DVHA is undertaking the responsibility for administering a new assessment on dentists. The proposed Appropriation includes \$200,000 (gross) to assist DVHA in implementing and maintaining this new program.

Due to DVHA’s routine involvement in lawsuits, a base appropriation is needed to accommodate expert witness testimony by DVHA consultants involved in the relevant areas (\$10,000 gross).

As described below in the Policy section, one of the new Program Integrity efforts in SFY ’12 is to further promote the use of generics over costlier brand drugs prescribed by physicians by ensuring that they adhere to existing rules regarding this practice. To operationalize this effort, we will need to increase the contract amount for our pharmacy benefit manager vendor by \$40,000 gross.

DVHA’s general fund appropriation was decreased due to the Challenges for Change performance-based contracting initiative. As such, DVHA’s SFY ’12 appropriation must also be reduced by the federal match associated with these contracts (\$5,700,240).

A major policy initiative being proposed is to eliminate the Catamount Health Program and enable Catamount eligibles to enroll in VHAP. While overall this is a very cost effective proposal, it will place an additional burden on several of our contractors (i.e., claims processing, member services, and pharmacy benefit manager), totaling \$647,324 gross.

PROGRAM \$19,628,953 gross / \$40,466,329 state

UPDATED TREND CHANGES \$23,743,784
\$42,312,467 state

Caseload and Utilization Impact \$30,614,003
\$12,235,756 state

Caseload \$22,185,352
\$9,410,899 state

DVHA engages in a consensus caseload estimate process with the Joint Fiscal Office, the Department of Finance and Management, and the Agency of Human Services when projecting caseload growth. When building the SFY '11 budget, the impacts of the down-turning economy were driving enrollment higher than normal historical trends. We are now seeing a leveling off, resulting in a more modest growth rate than what was utilized in the SFY '11 budget build process (see following page):

Medicaid Eligibility Group	SFY '08 Actuals		SFY '09 Actuals		SFY '10 Actuals		SFY '11 Approp.		SFY '11 BAA		SFY '12		12 comp. to BAA		
	#	%	#	%	#	%	#	%	#	%	Gov. Rec.	#	%	#	%
ABD/Medically Needy Adults	11,797	4%	12,550	6%	13,337	6%	13,866	4%	14,081	6%	14,772	907	7%	5%	
Dual Eligibles Adults	14,185	1%	14,753	4%	15,192	3%	15,536	2%	15,806	4%	16,270	734	5%	3%	
General Adults	9,255	-1%	9,847	6%	10,358	5%	10,786	4%	10,852	5%	11,127	341	3%	3%	
VHAP	24,771	11%	28,224	14%	33,249	18%	36,862	11%	37,678	13%	41,240	4,378	12%	9%	
VHAP ESI	276		821	198%	949	16%	1,564	65%	935	-1%	866	(698)	-45%	-7%	
Catamount	1,730		6,350	267%	9,058	43%	11,819	30%	10,922	21%	10,751	(1,067)	-9%	-2%	
ESIA	132		478	262%	682	43%	1,017	49%	808	19%	817	(200)	-20%	1%	
BD/Medically Needy Children	3,487	3%	3,605	3%	3,606	0%	3,771	5%	3,688	2%	3,707	(64)	-2%	1%	
General Children	50,664	-1%	52,224	3%	54,266	4%	55,631	3%	55,427	2%	55,985	355	1%	1%	
Underinsured Children	1,138	-4%	1,212	6%	1,178	-3%	1,282	9%	1,223	4%	1,236	(46)	-4%	1%	
SCHIP	3,278	7%	3,412	4%	3,523	3%	3,966	13%	3,703	5%	3,710	(256)	-6%	0%	
Pharmacy Only Programs	12,737	-2%	12,456	-2%	12,550	1%	12,580	0%	13,088	4%	13,113	533	4%	0%	
Refugee	17	-22%	47	176%	40	-14%	53	31%	47	17%	53	0	1%	13%	
Civil Union	194	34%	197	2%	235	19%	221	-6%	240	2%	252	31	14%	5%	
HIV	101	34%	117	16%	133	14%	167	26%	134	1%	158	(9)	-5%	18%	
Total	133,761	4%	146,291	9%	158,355	8%	169,120	7%	168,633	6%	174,058	4,938	3%	3%	
Total Less New Programs	131,624	2%	138,643	5%	147,667	7%	154,721	5%	155,968	6%	161,624	6,904	4%	4%	

Utilization \$8,428,652

\$2,824,857 state

Utilization impacts are derived by comparing year-over-year changes in per-member per-month (PMPM) costs by category of service, taking into consideration any policy changes that might drive that change (such as rate increases or reductions). An historical picture of category of service costs can be reviewed on insert 4.

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

Medicaid for Adults

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

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

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

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

The following table depicts the caseload and expenditure information by SFY, including the Governor's Recommend for SFY '12 for ABD and/or Medically Needy Adults:

Aged, Blind, & Disabled (ABD) and/or Medically Needy Adults			
SFY	Caseload	Expenditures	P.M.P.M.
SFY '09 Actual	12,550	\$ 82,398,879	\$ 547.15
SFY '10 Actual	13,337	\$ 87,006,993	\$ 543.63
SFY '11 Appropriated	13,866	\$ 97,472,995	\$ 585.82
SFY '11 Budget Adjustment	14,081	\$ 95,860,239	\$ 567.31
SFY '12 Governor's Recommend	14,772	\$ 104,353,401	\$ 588.68

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 '12 for Dual Eligibles:

Dual Eligibles			
SFY	Caseload	Expenditures	P.M.P.M.
SFY '09 Actual	14,753	\$ 38,596,281	\$ 218.02
SFY '10 Actual	15,192	\$ 41,432,987	\$ 227.28
SFY '11 Appropriated	15,536	\$ 45,160,245	\$ 242.24
SFY '11 Budget Adjustment	15,806	\$ 45,181,840	\$ 238.21
SFY '12 Governor's Recommend	16,270	\$ 48,757,915	\$ 249.73

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 '12 for General Adults:

General Adults			
SFY	Caseload	Expenditures	P.M.P.M.
SFY '09 Actual	9,847	\$ 53,060,215	\$ 449.06
SFY '10 Actual	10,358	\$ 58,325,148	\$ 469.26
SFY '11 Appropriated	10,786	\$ 64,639,242	\$ 499.40
SFY '11 Budget Adjustment	10,852	\$ 64,615,245	\$ 496.19
SFY '12 Governor's Recommend	11,127	\$ 69,696,931	\$ 521.96

Vermont Health Access Plan (VHAP)

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

longer do so because they graduated, took a leave of absence, reduced their credits or stopped going to college.

Adults without children can earn up to \$1,382 per month, and parents can make up to \$2,290 per month for a family of two, \$2,876 per month for a family of three, and \$3,462 per month for a family of four and still be eligible.

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

The following table depicts the caseload and expenditure information by SFY, including the Governor's Recommend for SFY '12 for VHAP:

VHAP			
SFY	Caseload	Expenditures	P.M.P.M.
SFY '09 Actual	28,224	\$ 111,730,898	\$ 329.89
SFY '10 Actual	33,249	\$ 130,598,440	\$ 327.32
SFY '11 Appropriated	36,862	\$ 160,445,280	\$ 362.71
SFY '11 Budget Adjustment	37,678	\$ 153,559,727	\$ 339.63
SFY '12 Governor's Recommend	41,240	\$ 172,104,878	\$ 347.77

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 Catamount Health or the VHAP;
- The employee's household income is under \$2,763 a month for one person;
- The employer's plan has comprehensive benefits; and
- The cost of providing premium assistance to enroll in an employer's plan is less than the cost of providing premium assistance to enroll in Catamount Health or the VHAP.

The following tables depict the caseload and expenditure information by SFY, including the Governor's Recommend for SFY '12 for VHAP Employer-Sponsored Insurance (ESI) Premium Assistance:

VHAP ESI			
SFY	Caseload	Expenditures	P.M.P.M.
SFY '09 Actual	821	\$ 1,525,747	\$ 154.95
SFY '10 Actual	949	\$ 1,787,708	\$ 156.97
SFY '11 Appropriated	1,564	\$ 4,234,758	\$ 225.64
SFY '11 Budget Adjustment	935	\$ 2,377,169	\$ 211.86
SFY '12 Governor's Recommend	866	\$ 2,527,600	\$ 243.32

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. Help is also available in paying premiums, based on income. Premium subsidies are available to those who fall at or below 300% of the 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 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-\$526.92 based on income, office visit co-payments are

\$10, prescriptions range from \$10-\$50 and deductibles are \$500 for individuals and \$1000 for families (in network).

The following table depicts the caseload and expenditure information by SFY, including the Governor's Recommend for SFY '12 for Catamount Health (to VHAP):

Catamount Health (to VHAP)			
SFY	Caseload	Expenditures	P.M.P.M.
SFY '09 Actual	6,350	\$ 30,293,232	\$ 397.55
SFY '10 Actual	9,058	\$ 45,210,486	\$ 415.95
SFY '11 Appropriated	11,819	\$ 62,006,808	\$ 437.21
SFY '11 Budget Adjustment	10,922	\$ 57,219,834	\$ 436.59
SFY '12 Governor's Recommend	10,100	\$ 43,231,685	\$ 356.70

Catamount Employer-Sponsored Insurance Premium Assistance

The following tables depict the caseload and expenditure information by SFY, including the Governor's Recommend for SFY '12 for Catamount Employer-Sponsored Insurance (ESI) Premium Assistance (to VHAP ESIA):

ESIA (to VHAP ESIA)			
SFY	Caseload	Expenditures	P.M.P.M.
SFY '09 Actual	478	\$ 688,592	\$ 120.17
SFY '10 Actual	682	\$ 900,029	\$ 110.04
SFY '11 Appropriated	1,017	\$ 2,108,729	\$ 172.80
SFY '11 Budget Adjustment	808	\$ 1,592,434	\$ 164.13
SFY '12 Governor's Recommend	1,468	\$ 2,342,652	\$ 132.95

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 '12 for BD and/or Medically Needy Children:

Blind or Disabled and/or Medically Needy Children			
SFY	Caseload	Expenditures	P.M.P.M.
SFY '09 Actual	3,605	\$ 31,686,636	\$ 732.47
SFY '10 Actual	3,606	\$ 31,605,170	\$ 730.35
SFY '11 Appropriated	3,771	\$ 35,736,828	\$ 789.66
SFY '11 Budget Adjustment	3,688	\$ 33,987,589	\$ 767.93
SFY '12 Governor's Recommend	3,707	\$ 35,473,289	\$ 797.36

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 '12 for General Children:

General Children			
SFY	Caseload	Expenditures	P.M.P.M.
SFY '09 Actual	52,224	\$ 100,299,806	\$ 160.05
SFY '10 Actual	54,266	\$ 108,508,732	\$ 166.63
SFY '11 Appropriated	55,631	\$ 118,920,219	\$ 178.14
SFY '11 Budget Adjustment	55,427	\$ 118,050,440	\$ 177.49
SFY '12 Governor's Recommend	55,985	\$ 128,808,036	\$ 191.73

Underinsured Children

The general eligibility requirements for Underinsured Children are: up to age 18 and up to 300% FPL; designed as part of the original 1115 waiver to Title XIX of the Social Security Act to provide health care coverage for children who would otherwise be underinsured. A family of three can earn up to \$4,663 per month and a family of four can earn up to \$5,613 per month and still be eligible.

The following table depicts the caseload and expenditure information by SFY, including the Governor's Recommend for SFY '12 for Uninsured Children:

Underinsured Children			
SFY	Caseload	Expenditures	P.M.P.M.
SFY '09 Actual	1,212	\$ 721,162	\$ 49.61
SFY '10 Actual	1,178	\$ 812,299	\$ 57.46
SFY '11 Appropriated	1,282	\$ 799,937	\$ 51.98
SFY '11 Budget Adjustment	1,223	\$ 887,676	\$ 60.51
SFY '12 Governor's Recommend	1,236	\$ 988,094	\$ 66.62

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. A family of three can earn up to \$4,663 per month and a family of four can earn up to \$5,613 per month and still be eligible.

The following table depicts the caseload and expenditure information by SFY, including the Governor's Recommend for SFY '12 for the State Children's Health Insurance Program (SCHIP):

SCHIP (Uninsured)			
SFY	Caseload	Expenditures	P.M.P.M.
SFY '09 Actual	3,412	\$ 5,386,841	\$ 131.56
SFY '10 Actual	3,523	\$ 5,629,939	\$ 133.17
SFY '11 Appropriated	3,966	\$ 6,744,663	\$ 141.71
SFY '11 Budget Adjustment	3,703	\$ 6,220,658	\$ 140.00
SFY '12 Governor's Recommend	3,710	\$ 7,690,155	\$ 172.74

Prescription Assistance Pharmacy Only Programs

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

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

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

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

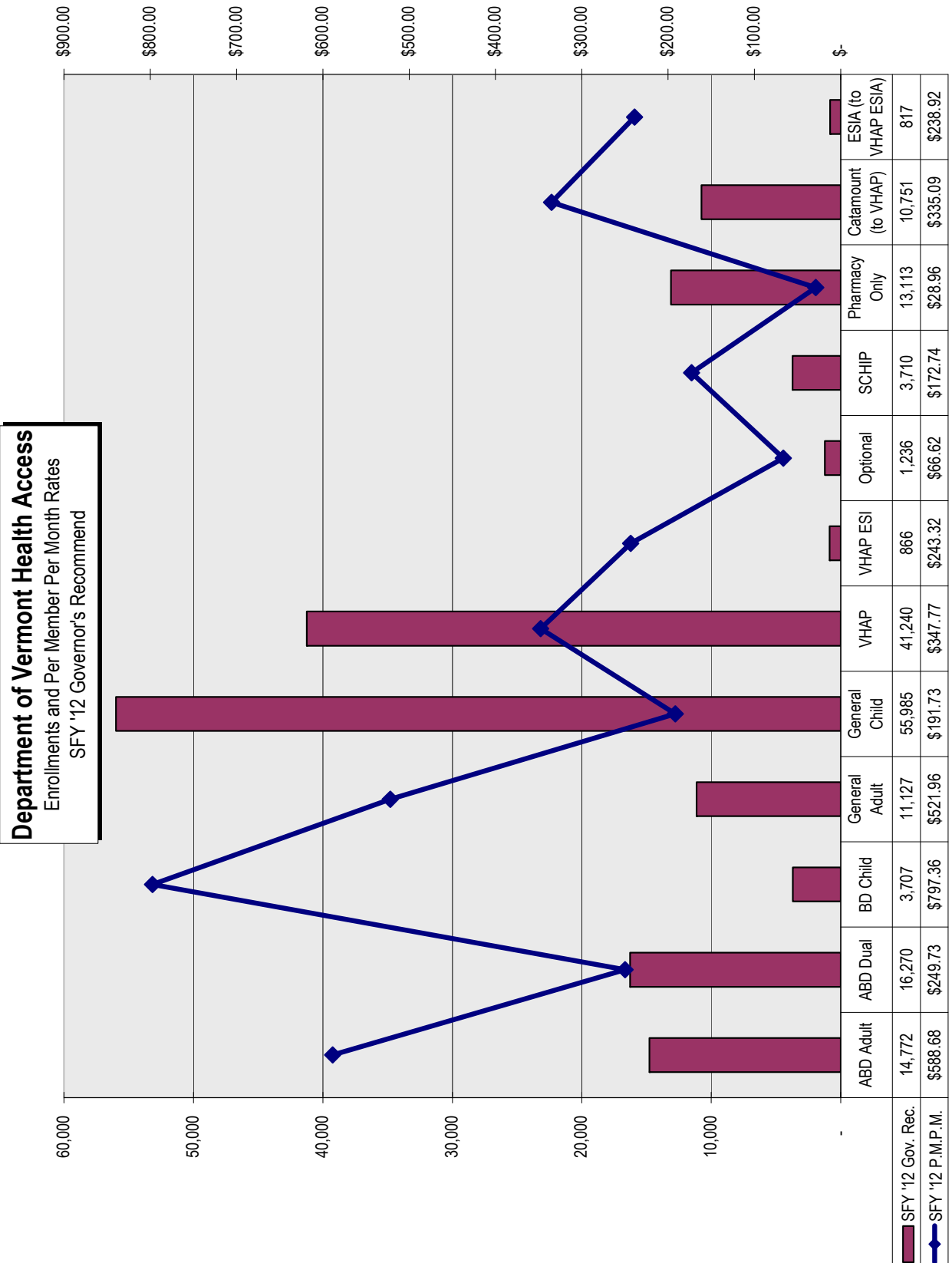
The following table depicts the caseload and expenditure information by SFY, including the Governor's Recommend for SFY '12 for the Pharmacy Programs:

Pharmacy Only Programs			
SFY	Caseload	Expenditures	P.M.P.M.
SFY '09 Actual	12,456	\$ 7,535,743	\$ 50.42
SFY '10 Actual	12,550	\$ 3,929,059	\$ 26.09
SFY '11 Appropriated	12,580	\$ 4,354,351	\$ 28.85
SFY '11 Budget Adjustment	13,088	\$ 4,335,959	\$ 27.61
SFY '12 Governor's Recommend	13,113	\$ 4,557,802	\$ 28.96

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 '12 for the Healthy Vermonters Program:

Healthy Vermonters Program			
SFY	Caseload	Expenditures	P.M.P.M.
SFY '09 Actual	4,843	\$ -	\$ -
SFY '10 Actual	4,753	\$ -	\$ -
SFY '11 Appropriated	4,676	\$ -	\$ -
SFY '11 Budget Adjustment	5,045	\$ -	\$ -
SFY '12 Governor's Recommend	6,115	\$ -	\$ -



Buy-In Adjustment (\$1,217,444)
(\$546,170) state

The federal government allows for states to use Medicaid dollars to “buy-in” to Medicare on behalf of eligible beneficiaries who would otherwise be fully covered by Medicaid programs. Caseload for these programs is coming in less than expected, resulting in a reduced need in our funding.

Increase in Clawback Rates \$6,277,437
\$6,277,437 state

The Medicare Modernization Act (MMA) was signed into law on December 8, 2003. On January 1, 2006, 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. The SFY ’12 increase is further exacerbated by the federal decision to reduce Clawback rates for a limited time when ARRA enhanced match rates were available; as such, these enhanced Vermont revenues go away in SFY ’12.

ACA Federal Reimbursement (\$6,646,867)
(\$0) state

Federal Health Care reform (ACA), which was passed in March, 2010, increased the minimum percent billable by Medicaid to pharmaceutical companies for drug rebates, and the savings from this are required to be 100% refunded to the federal government. As of budget passage last year, it was unclear how to mechanize this obligation. This is the amount that Vermont owes the federal government of the rebates that we collect. The method has subsequently been determined; and we will reduce our federal drawdown in our non-waiver matched Medicaid appropriation. Therefore, we need \$6.6 million less in federal authority.

Change in Misc. Programs. (\$1,613,220)
\$1,162,058 state

In addition to traditional category of service expenditures, DVHA also handles myriad miscellaneous payment streams. The Lund Home (through an arrangement with DCF) and Prescription Drug Plan premium payments are two examples. These two areas were budgeted to experience historical growth patterns that did not come to fruition resulting in \$1.6 million in savings.

Change in VPharm Funding (\$0)
(\$1,841,869) state

The SFY '11 appropriation presumed Global Commitment waiver authority for the 100% VPharm program. The wrap benefit was not accepted as a covered service under the waiver amendment, so there is a gross fund shift of \$3.2 million from the Global Commitment to the state only appropriation.

Radiology Prior Authorization (\$685,000)
(\$288,659) state

As described in the administrative section above, the SFY '11 appropriation originally reflected the program savings for radiology prior authorization as net of the contract cost to provide the authorization service. The cost of this increased contract cost was moved to the administration appropriation; and this reflects the additional savings to bring the gross savings to \$2,685,000.

DAIL Challenges Initiative Impacting DVHA Expenditures (\$100,000)
(\$42,140) state

DAIL and VDH worked collaboratively on an integrated intake and program operations process that would streamline children's services resulting in program savings. Though DAIL manages the children's personal care program, the dollars reside in DVHA appropriations. These are the savings identified for this program.

Additional DAIL Managed Program Changes \$100,000
\$42,140 state

The funding for the Choices for Care appropriation resides in the DVHA budget; though DAIL is responsible for program management. Two revisions needed to this appropriation relate to a Veteran's Home rate settlement of \$800,000 (an increase in DVHA's budget) and a transfer from this appropriation to DAIL's Traumatic Brain Injury (TBI) appropriation of \$700,000 (a decrease in DVHA's budget), for a net increase of \$100,000 gross.

Cost-Neutral Transfers to Other Departments (\$2,985,127)
(\$1,257,933) state

The DVHA and DAIL have entered into an interdepartmental agreement whereby DAIL will individually wrap beneficiaries who traditionally received Medicaid services. \$1.2 million is being transferred to DAIL for this purpose. Historically DCF has managed the Lund Home program, but costs were paid for through the DVHA appropriation. A mechanism has been developed to allow DCF to pay for the costs directly; therefore, \$1.5 million is being transferred to them for this purpose. In SFY '11, hospital rates were increased by \$20 million. DMH pays for a portion of hospital inpatient costs related to their CRT appropriation. \$285,127 is being transferred from DVHA to DMH due to the rate increase.

Federal Participation Rate Changes and Lost ARRA Funding \$0
\$23,982,871 state

The federal receipts the State receives is dependent upon a funding formula (Federal Medical Assistance Percentage - FMAP) used by the federal government and is based on economic need for each state across the country. Due to the change in the FMAP formula for SFY '12, Vermont loses \$2,069,544 as compared to the FMAP for SFY '11. The balance of lost federal receipts relates to the time-limited financial bailout the federal government provided all states under ARRA. ARRA fully goes away in SFY '12, causing a state fund need of \$21,913,327 for the DVHA budget.

Neutral Adjustments Between DVHA Appropriations \$0
\$747,106 state

During the budget development process, often times the dollars associated with policy decisions are added to or subtracted from the DVHA Global Commitment appropriation. However, these decisions typically impact all appropriations; therefore, funds are being redistributed from the Global Commitment appropriation to the other three program areas. This is a one-time budgeting process adjustment (for SFY '11 BAA and SFY '12 Budget). DVHA will ensure that from this point forward, budget implications due to policy initiatives will be spread across all appropriations, making it clear to the legislature where to appropriately apply impacts.

GOVERNOR'S RECOMMENDED POLICY INITIATIVES (\$4,114,830)
(\$1,846,139) state

Cover Legal Immigrant Children and Pregnant Women \$84,683
\$26,346 state

The Children's Health Insurance Program Reauthorization Act (CHIPRA) provides States with the option to extend Medicaid and SCHIP coverage to qualified alien children and/or pregnant women who are lawful permanent residents in the United States and who have not met the 5-year waiting period or "5-year bar." This waiting period is required under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. These are individuals who otherwise would be eligible for Medicaid or SCHIP coverage, but are not allowed coverage for the first five years of residency. Based on Vermont data from the Department of Homeland Security 2008 Yearbook of Immigration Statistics, we estimate that approximately 18 children and pregnant women will enroll in these programs in SFY '12. (The estimate was factored for age, gender, income, and health insurance coverage to determine the number of pregnant women and children that may be eligible, and who would actually enroll in the first year coverage is available). Providing coverage for this group will reduce the free care provided by hospitals, primary care practices or free clinics, and provide regular preventive care and treatment rather than episodic emergency care to a number of children and pregnant women.

Increase in Cost due to Palliative Care Initiative \$672,758

\$280,083 state

Act 25 (H.435), An Act Relating to Palliative Care, was signed into law in 2009; section 7 of this act required the Agency of Human Services (AHS) to submit a report to the legislature on the programmatic and cost implications of a Medicaid waiver amendment allowing Vermont to provide concurrent palliative and curative care to Medicaid children with life-limiting illnesses. DVHA submitted the report in November 2009, which estimated the cost of such a program to be between \$133,000 and \$1 million per year in GF, depending on the program design. The 2010 legislature included a provision in the SFY' 11 Appropriations Bill requiring AHS to submit a waiver request to CMS, either as part of the Global Commitment for Health waiver renewal or as an amendment following renewal, to allow such a program to be implemented in Vermont.

AHS chose to submit the request as a waiver amendment following renewal of Vermont's Global Commitment for Health waiver, which occurred at the end of December, 2010. If the waiver amendment request is approved, or if after further analysis, we conclude that a waiver amendment is not needed, DVHA will need to hire a nurse trained in pediatric palliative care to develop the program and provide ongoing oversight. In addition, funds will be needed to provide services that are not currently provided to children found eligible to participate in the program (this cost is reflected in the Administration Position Request section above). New services would include case management/care coordination, expressive therapy (such as play or music therapy), bereavement counseling to the child's family, and respite care. We estimate these new services will cost \$672,758 (gross) for SFY '12.

Premium Grace Period Under CHIPRA \$404,207

\$151,318 state

This new provision of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) requires States to grant individuals enrolled in separate child health programs (SCHIP) a 30-day grace period to pay any required premium before enrollment may be terminated. The intent of this CHIPRA provision is to provide help to families that need assistance bridging a short term financial problem. The grace period allows a 30 day period for the beneficiary to make the premium payment before coverage is ended. The grace period would not apply to the first month of coverage, and only applies to the month after a coverage period when a premium was paid. In order to minimize confusion for parents whose children may move between the SCHIP and Medicaid programs within Dr. Dynasaur, we propose to extend this grace period to all Dr. Dynasaur children. Of those children in Dr. Dynasaur that are required to pay a monthly premium, on average between 1.8% and 2.7% lost coverage for failing to pay the premium. This affects an average of 236 children in any month. The benefit of this provision is that children will have uninterrupted coverage.

Provider Rate Increases \$16,237,304
\$6,799,228 state

Provider assessment increases are being proposed (see below) during this difficult budget climate. In order to ensure DVHA beneficiaries continue to have access to needed services, hospital (\$10 million), dental (\$6 million), and home health (\$237,304) rate increases will be provided.

Enhanced Program Integrity Activity (\$1,851,521)
(\$783,324) state

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

The DVHA PIU conducts investigations as a result of program referrals, aberrant or unusual provider submissions/billing, and data mining. PIU coordinates its efforts with the MFRAU in cases where fraud is suspected.

The Vermont Attorney General’s MFRAU is a state-run program, jointly funded by federal (75%) and state (25%) monies. The MFRAU became operational in February 1979 to investigate and prosecute healthcare providers who commit fraud against the Medicaid program and to 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, and therefore relies heavily on the PIU and the Office of Inspector General fraud hotline for referrals of provider fraud cases.

Program Integrity Tools and Referral Sources

The PIU uses the following tools and sources to identify and combat fraud, waste and abuse in the Vermont Medicaid program, and to recoup funds as necessary:

- Decision Support System (DSS)/Profiler: The Decision Support System (DSS) is a tool that compares providers with their peers by unique case types. This is a valuable tool for detecting under and over utilization, as well as identifying outliers for additional investigation.
- Medicaid Management Information System (MMIS) and Claim Check / Claim Review: There are more than 700 various MMIS pre-payment edits and audits in the MMIS system designed to prevent errors in payment. These edits and audits are used to analyze claims for clean claims submissions, proper billing, correct coding and adherence to Vermont Medicaid policy. In addition, the DVHA uses McKesson’s ClaimCheck / ClaimReview (CC/CR) software, which also is a pre-payment auditing tool

and reflects the American Medical Association guidelines, CMS regulations, specialty society guidelines and industry standards. CC/CR uses a clinical knowledge base to create and ensure clinically valid edits, for example, preventing certain all-encompassing procedures from being separated into smaller billing units for potentially greater payment.

- **Ingenix Post Payment Review:** The DVHA has contracted with Ingenix to provide post-payment reviews of claims data. Ingenix has created a Program Integrity database consisting of seven (7) years of Medicaid medical, pharmacy and institutional data, which is used to identify specific claims that should not have been paid based upon policy or accepted coding methodologies. The claims data analysis and post-payment review are designed to provide robust and efficient reports using an algorithmic approach to mine data by provider-type as prioritized by DVHA (e.g., physician, pharmacy, nurse practitioner, durable medical equipment and hospice). Results are used to identify many types of billing errors, aberrant billing patterns, overpayments, inappropriate billing and coding combinations, duplicative payments, and outlier providers, resulting in the following potential actions:
 - Identification of providers for future audits;
 - Referrals to law enforcement, including the Attorney General's MFRAU;
 - Direct recoupment of overpaid claims from providers;
 - Policy and payment system changes that lead to future savings;
 - Educational opportunities for DVHA and its providers.
- **Training:** The PIU and MFRAU jointly presented a statewide fraud, waste, and abuse training on November 4, 2010, for state agencies receiving and distributing Medicaid funds. In addition to educating other state employees and agencies, this training was intended to generate additional referrals. PIU staff continue to attend federally funded trainings provided by the Medicaid Integrity Institute, which are considered essential for new staff, as well as for improving the skills of more experienced staff.
- **Recipient Explanation of Benefits (REOMB) Process:** HP (formally EDS) sends a list of billed services quarterly to a random sample of beneficiaries to verify they actually received the services billed by providers.
- **Medicaid Integrity Contractors (MICs):** The CMS Medicaid Integrity Group (CMS-MIG), in accordance with the Deficit Reduction Act, has engaged Medicaid Integrity Contractors (MICs) to audit Vermont Medicaid claims for overpayments to individuals or entities. These MIC audits began first quarter of CY 2010, and have not yet recouped any Medicaid overpayments.

- **Recovery Audit Contractors (RACs):** A provision in the Affordable Care Act of 2010 requires Medicaid agencies to contract with one or more contingency-based Recovery Audit Contractors (RACs) by April 1, 2011. RAC auditors are expected to coordinate with Medicaid PI units to provide additional recoupment and savings opportunities in areas where the PIU requires specific additional expertise. DVHA will fulfill this requirement by amending its existing contract with Ingenix to include additional services not currently being investigated by PIU staff.
- **Identification of Beneficiary Fraud, Waste and Abuse:** The PIU also focuses on identifying areas where there is high potential for beneficiary misuse of benefits. Examples include identifying beneficiaries who receive transportation for an ineligible service or are deemed ineligible for transport, identifying beneficiaries who are 'doctor shopping' and/or drug diverting, proactively coordinating with primary care providers through the Prescription Monitoring Program, and working closely with the DVHA Clinical Unit and the Chronic Care Initiative to ensure beneficiaries are receiving needed services in the most clinically appropriate and effective manner.

Program Integrity Unit Savings

During the SFY '11 legislative session, the DVHA was approved to hire six (6) new full-time positions to expand the program integrity efforts, with the expectation of saving the State of Vermont a total of \$2.3 million (gross) in SFY '11.

The DVHA has hired the six (6) additional staff and, as required per Section E 306(b) of Act 156 (2010), has developed measures to evaluate the success of these new positions. The six new staff members provide a range of specialty expertise and have quickly learned the Medicaid rules and regulations. DVHA is confident the savings estimates will be realized with the enhanced staffing.

- **SFY '11 Savings:** To date, in SFY '11 the PIU has saved \$1.3 million (gross), the majority from two (2) sources: direct reporting of potential fraud, waste and abuse to the PIU from other state departments, providers, and beneficiaries, and; DVHA's partnership with the Medicaid Fraud and Residential Abuse Unit (MFRAU). Additional savings have been achieved through data mining activities conducted in collaboration with DVHA's contractor Ingenix to identify potential overpayments. The remaining \$1 million (gross) is expected to be saved during the remainder of SFY '11 through similar activities.

It is important to note that of the \$2.3 million expected (gross) savings from PI activities in SFY '11, \$1 million of the savings will be a one time recoupment and \$1.3 million saved in SFY '11 will generate ongoing cost-avoidance savings.

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- SFY '12 Savings: For SFY 2012, DVHA is currently reviewing several areas that will yield additional savings and recoupment, including the following:
 - *Unreasonable Quantities*. Some claims from pharmacies are submitted for drugs in quantities that are not clinically appropriate.
 - *Dispense as Written 1 (DAW 1)*. Vermont state law requires pharmacists to dispense the generic drug when prescriptions are written for a brand name drug with a generic alternative (multi-source brands). However, prescribers can require pharmacists to dispense the brand drug by noting *Dispense as Written* on the prescription. To promote the use of generics over more costly brand drugs (e.g., \$218 average cost of brand vs. \$21 for generic), prescribers will have to provide a clinical rationale for the medical appropriateness of the brand drug, provide documentation of intolerance to the generic, or documentation of unacceptable side effects with the generic.
 - *Dispense as Written 2 (DAW 2)*. Individuals enrolled in Medicare Part D pharmacy benefit plan typically may obtain a brand-name drug, rather than its less-expensive generic counterpart, by agreeing to pay a higher coinsurance amount. This "tiered" benefit design is a common feature in most Part D benefit plans. It is costly to DVHA when beneficiaries with both Medicaid and Medicare Part D choose a higher-cost brand name drug because VPharm pays most of the co-insurance.
 - *Team Care*. The Team Care program, formerly known as the Lock-in Program, is designed to decrease problems associated with beneficiaries who over-utilize, misuse or abuse covered health care services and/or benefits (e.g., drug diversion/abuse, "doctor shopping" to get multiple prescriptions for narcotics, medically unnecessary emergency room visits). Beneficiaries enrolled into DVHA's Team Care program are limited to one provider and one pharmacy for the purpose of Medicaid reimbursement. Beneficiaries in Team Care may also be referred to one of DVHA's Chronic Care Initiative care coordinators for help with coordinating their health care needs. Assuring coordination through one pharmacy and one provider has proven to be effective in decreasing abuse, improving coordination of care and decreasing overall costs in the Medicaid program.
 - *Behavioral Health Codes*. There have been several national and regional alerts issued by PI units in other states regarding behavioral health billing (e.g., group therapy billed for excessive units or excessive visits).
 - *Therapy Services (Physical, Occupational and Speech)*. The PIU has found that some providers are not adhering to Medicaid rules surrounding prior authorization and medical necessity, and are working with DVHA's Clinical

Operations unit to identify and investigate these cases and take appropriate action.

- *Non-Emergency Transportation.* Transportation for medically necessary services is covered by Medicaid. DVHA has received referrals and reports of abuse of this benefit, including the bus pass program. As a result, DVHA has developed a procedure for monitoring the use of bus passes to ensure they are used only for medical appointments.
- *Credit Balances.* Providers (primarily hospitals) can have credit balances that are owed to insurers. Credit balances can accrue when Medicaid or Medicare pays for a service and later discovers the individual had another primary insurer that subsequently paid the claim. Medicare currently has a process to recoup known credit balances from providers and the PIU is creating a form to mirror Medicare’s CMS-838. Providers (primarily hospitals) will be required to return any known credit balances to DVHA, or attest that there are no credit balances.
- *National Correct Coding Initiative (NCCI).* Section 6507 of the Affordable Care Act requires state Medicaid programs to incorporate NCCI methodologies in their claims processing systems for claims received on or after October 1, 2010. The PIU will initially focus on NCCI edits related to “medically unlikely edits” and “unbundling” (e.g., removal of a benign lesion and destruction of a lesion should not be billed together, and surgeries performed on the same day, such as tonsillectomy and adenoidectomy, should be billed as one code and not two separate procedures).

The PIU is constantly looking for other areas to investigate, and now has the additional resources to follow up more efficiently on leads from the DSS Profiler, Ingenix, and other sources.

Limit coverage of over-the-counter (OTC) medications to preferred list in all pharmacy programs (\$125,000)
 (\$56,277) state

DVHA’s pharmacy programs offer very broad coverage of over-the-counter drugs (OTC) with very few restrictions. Many of these OTC drugs have questionable efficacy or side effect profiles (e.g., herbal remedies such as Gingko Biloba; vitamin combinations containing Fish Oil, Echinacea and zinc). In addition, since the DVHA does not specifically manage these OTC products through its Preferred Drug List (PDL), a high level of brand drug use occurs, resulting in higher expenditures. Annualized spending for OTC drugs is approximately \$4 million per year in Medicaid/Global Commitment programs and \$1.3 million per year in DVHA’s Part D wrap benefit on OTC medications.

The DVHA proposes to establish a smaller, more defined list of cost-effective OTC products demonstrated to be clinically safe and appropriate. The result may be fewer choices in OTC coverage, but beneficiaries will continue to have at least one choice in all major medically necessary drug categories (e.g., antihistamines, cough and cold products, select vitamins and minerals, laxatives, etc.). DVHA also proposes implementing additional utilization controls, including quantity limits, day supply limits, promoting generics, and choosing preferred products in select categories of coverage.

These coverage changes would help DVHA ensure that the OTC drugs it covers are safe, effective, medically appropriate, and result in the lowest possible cost. Implementing these changes would result in an estimated \$125,000 (gross) in savings. The operational impact to DVHA resulting from additional prior authorizations and system edits should be minimal.

Establish lower reimbursement rates for limited distribution specialty pharmacies in network (\$25,000)
(\$11,255) state

DVHA currently contracts with two specialty pharmacies for competitive pricing on specific specialty drugs (e.g., Synagis, growth hormones). Specialty drugs are normally high-cost injectable, infused, oral, or inhaled drugs that generally require special storage or handling and close monitoring of the patient's drug therapy. Because of this, drug manufacturers limit distribution of some specialty drugs (e.g., Remodulin for pulmonary arterial hypertension; Prolastin for a rare form of Chronic Obstructive Pulmonary Disease) to particular specialty pharmacies that do a high volume specialty mail order business.

Currently, nine (9) out-of-state pharmacies submit claims to Vermont Medicaid for limited distribution drugs. Although these pharmacies have the purchasing power to obtain products at lower prices, the DVHA does not have competitive pricing contracts with them.

The DVHA proposes to lower reimbursement to these specialty pharmacies for identified limited distribution drugs. Instate pharmacies would not be affected. Since these limited distribution mail order drugs are very expensive, reducing reimbursement could save Vermont Medicaid approximately \$25,000 (gross) per year. In addition, as more drugs fall into the limited distribution category, savings are expected to increase over time.

Radiology tier authorization (\$741,276)
(\$310,898) state

The proposed multiple procedure payment reduction applies to cases in which multiple outpatient radiology imaging services using the same or a similar modality (MRI and MRA; CT and CTA) are performed on the same day by the same provider on contiguous body areas (similar body region) of a beneficiary.

Multiple procedure payment reductions for imaging procedures are used by CMS, as well as Vermont’s commercial insurers.

The multiple procedure payment reduction would apply to the following modalities:

- Computerized Axial Tomography (CT) scans and CT Angiography (CTA);
- Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiogram (MRA).

The reduction will apply only to the technical component of the claims, that is, the performance of the imaging service. Reimbursement for the professional (physician) component will not be affected.

In cases where the multiple procedure payment reduction applies, the procedure with the highest intensity will be reimbursed at 100% of the provider’s fee schedule rate, with subsequent procedures reimbursed at a reduced percentage. If two (2) procedures are performed, the second procedure will be reimbursed at 50%, and if three (3) or more procedures are performed, they will be reimbursed at 25%.

Growth in 340B Pharmacy Participation (\$1,000,000)
(\$452,665) state

The federal drug discount program established under Section 340B of the Public Health Services Act (the “340B Program”) provides the lowest wholesale prescription drug pricing available in the United States, outside of federal contracts for the Department of Defense and the Veterans Administration. 340B wholesale pricing is available to federally designated “Covered Entities,” including Federally Qualified Health Centers (FQHCs), certain Disproportionate Share (DSH) hospitals, and other federal grantees, including family planning, STD, and Ryan White Care Act grantees. The federal Affordable Care Act (ACA) expanded the list of Covered Entities to include outpatient prescriptions for patients of Critical Access and Sole Community Hospitals.

If Covered Entities utilize 340B inventory to fill prescriptions for Medicaid beneficiaries through their in-house or contract pharmacies, they must pass through the discounted price to State Medicaid programs. 340B pricing is lower for Medicaid than the same drug would cost net of the price after factoring in the federal drug rebate programs available to states, so it is to the state’s advantage to encourage eligible Covered Entities to actively participate in 340B.

Historically, Vermont Covered Entities’ 340B utilization has been limited, resulting in very modest savings for Medicaid. However, in SFY ‘11, DVHA began working with the state’s FQHCs and newly eligible Critical Access and

Sole Community Hospitals to increase the state’s benefits from the lower 340B drug pricing. Seven of the twelve Vermont hospitals eligible for participation in 340B were enrolled in the program as of 1/1/11, as were all eight of the state’s FQHCs.

Audit and other operational inventory control requirements make implementation of 340B challenging, especially for small hospitals and independent community pharmacies. DVHA, in collaboration with Vermont’s Covered Entities, has established a reimbursement process to provide a modest dispensing fee to cover administrative costs related to those issues and anticipates 340B utilization for Medicaid beneficiaries ramping up steadily through SFY ‘12. The savings represented here reflect the increased discount available to the state as more Medicaid beneficiaries’ prescriptions are filled by Vermont Covered Entities.

Catamount & ESIA Program Conversions to VHAP Expanded & VHAP ESIA **(\$14,660,376)**
(\$6,177,882) state

VHAP Expanded

Governor Shumlin’s vision for a single-payer health care system provides an excellent framework to guide us this year as we address our fiscal challenges and as we start to discuss the implications of federal reform for our state. This proposed policy initiative moves us towards that vision by converting the privately offered Catamount Health Plans to the VHAP program by expanding VHAP eligibility to 300% of FPL (i.e. VHAP Expanded), and allowing individuals above 300% of FPL purchase VHAP Expanded without premium assistance.

Proposal Assumptions:

- Covered Services of the Catamount Health Plans and VHAP are very similar (see table on following pages).
- Everyone currently enrolled in, and those who would be eligible in the future for, the Catamount Health Plans with Premium Assistance (CHAP) would be able to enroll in VHAP Expanded and would receive existing VHAP benefits, including college students. The existing VHAP eligibility restrictions for College Students would be eliminated.
- Unlike the Catamount Health Plans, VHAP Expanded would not include any coverage limitations due to pre-existing conditions.
- Individuals currently enrolled in Catamount Health Plans at full cost (and individuals eligible in the future) could buy VHAP Expanded at full cost (based on an annualized VHAP Expanded pmpm) which would be significantly lower than current Catamount premiums.

- Current CHAP premiums would remain the same as they are now for all enrollees according to their FPL.
- Other than the deductible, current cost-sharing (co-pays, co-insurance) for Catamount Health Plan enrollees would no longer exist.
- The \$500 deductible within the Catamount Health Plans would change to \$1200 for VHAP Expanded.
- Similar to the existing Catamount Plan, preventive services would not count towards the deductible for VHAP Expanded enrollees.
- ESI and ESIA programs would remain; however, the existing \$500 upper deductible limit would move to \$1200.
- The ESI wrap-around features would remain as they are now: If someone is eligible for VHAP but instead is given premium assistance to enroll in their employer's plan, the state would wrap the benefits that are covered in VHAP but not covered by the employer's. If someone is eligible for VHAP Expanded but instead is given premium assistance to enroll in their employer's plan, the state would wrap chronic care prevention and maintenance benefits that are not provided in the employer's plan.
- The Employer Contribution would remain to help support this program (\$7.6 m annually) and would be adjusted annually based on the change to the annualized VHAP Expanded pmpm.
- The Catamount Fund would be merged into the State Health Care Resource Fund.
- The state would need CMS approval (preliminary indication is supportive).
- The State would need IT lead time, so VHAP Expanded could not be implemented until October 1, 2011.
- While there would be lowered administrative costs for VHAP Expanded as compared to the existing commercial carriers (see 2010 Administrative Cost Effectiveness Report submitted to the Vermont Health Care Reform Commission), an appropriation of \$647,324 is contained in the Administration section of this proposal to cover the expected increased costs for several of our contractors due to higher numbers of public program enrollees (i.e., claims processing, member services, and pharmacy benefit manager), totaling \$647,324 (gross).

- Provider reimbursement would be at the current Medicaid rates (It should be noted that, in order to mitigate any additional impacts of this reimbursement shift, the Governor is not proposing a reduction in non-hospital Medicaid provider rates to address the budget shortfall).

In summary, this proposal would provide equivalent coverage for current and would-be future Catamount enrollees, since the VHAP benefits are quite similar to those provided through Catamount Plans; create more seamless coverage as individuals' incomes change over time; delete almost all cost sharing currently paid by the approximately 12,500 Catamount enrollees other than the deductible (i.e., 20% co-insurance, high pharmacy and office visit co-pays); poise us to take next steps towards the new health care vision; and simultaneously save several million dollars in state funds.

Catamount / VHAP (Managed Care) Comparison

Income	VHAP Managed Care	Catamount Health Assistance Program (CHAP)	
	Monthly Premium	Monthly Premium	
		Single	Two-Person
≤ 50%FPL	None		
> 50% and ≤ 75% FPL	\$7.00 per person		
>75% and ≤ 100% FPL	\$25.00 per person		
> 100% and ≤ 150% FPL	\$33.00 per person		
> 150% and ≤ 185% FPL	\$49.00 per person		
>0 % and ≤ 200%		\$ 60.00	\$120.00
>200% and ≤ 225%		\$124.00	\$248.00
>225% and ≤ 250%		\$152.00	\$304.00
>250% and ≤ 275%		\$180.00	\$360.00
>275% and ≤ 300%		\$208.00	\$416.00
		Catamount Blue	Catamount Choice
> 300%		Single - \$413.84 Two-Person - \$827.67 Family - \$1,239.78	Single – \$526.92 Two-Person – \$1,053.83 Parent with Child(ren) – \$1,001.14 Family – \$1,475.37
Deductible	None	In-Network: \$500 individual/\$1,000 family; Out-Network\$1,000 individual/\$2,000 family	
Co-insurance	None	20% of allowed price	
Pre-Existing Conditions Limitations	None	Yes	

Service	VHAP Managed Care	Catamount	VHAP Managed Care*	Catamount Blue	Catamount Choice
Ambulance	√	√		20% coinsurance	20% coinsurance
Chiropractic	√	√	10 visits per calendar yr; limited to treatment by means of manipulation of the spine to correct subluxation of the spine.	\$10.00 co-pay; limited to 12 visits per yr., unless prior approval. Covered services somewhat broader than VHAP; no coverage out of network	\$10.00 co-pay, no coverage out of network; coverage limited to "subluxations, joint dysfunctions, and neuromuscular and skeletal disorders"
Dental/Dentures	No	No			
Diabetic Supplies	√	√		20% coinsurance unless participating in chronic care management program, then cost sharing waived.	20% coinsurance unless participating in chronic care management program, then cost sharing waived
Durable Medical Equipment	√	√		20% coinsurance	20% coinsurance
Emergency Room	√	√	\$25.00 co-pay per visit	20% coinsurance	20% coinsurance
Eye Exams	√	No	Comprehensive and interim exams are limited to one e every two yrs; refraction exams are covered.		
Eyeglasses/Contacts	No	No			
Family Planning	√	√			
Hearing Aids	No	No			
Home Health Services	√	√		20% coinsurance	20% coinsurance; in network only

Service	VHAP Managed Care	Catamount	VHAP Managed Care*	Catamount Blue	Catamount Choice
Hospice	√	√	Limited to 210 days	20% coinsurance	20% coinsurance; in network only
Immunizations	√	√			
Inpatient Hospital	√	√		20% coinsurance	20% coinsurance
Inpatient mental health or substance abuse	√	√	Limited to 30 days per episode; 60 days per calendar yr.	20% coinsurance; no coverage for services out of network	20% coinsurance; no coverage out of network
Lab Tests/X-Rays/Imaging	√	√	Urine drug testing limited to 8 per calendar month	20% coinsurance	No cost sharing for office lab services; 20% coinsurance for diagnostic lab services
Mental Health & Substance Abuse Services	√	√	Psychiatric admission limit 30 days per episode, 60 days per calendar year	\$10.00 co-pay; no coverage out of network	\$10.00 co-pay; prior authorization required; no coverage out of network
Naturopaths	√	√		\$10.00 co-pay	\$10.00 co-pay
Nurse Practitioners	√	√		\$10.00 co-pay	\$10.00 co-pay
Nutrition Therapy	√	√		Limited to three visits per year, unless part of a chronic care management program	Medical Foods?
PT/OT/ST	√	√	30 combined visits per calendar yr.	20% coinsurance; limited to 30 combined	\$10.00 co-pay in office; 20% coinsurance inpatient; in network only

Service	VHAP Managed Care	Catamount	VHAP Managed Care*	Catamount Blue	Catamount Choice
Ophthalmologist	√	√		\$10.00 co-pay; coverage limited to disease condition of the eye	No coverage for vision correction
Optometrist	√	√		Routine eye care is not covered	No coverage for vision correction
Organ Transplants	√	√		20% coinsurance	20% coinsurance
Orthodontics	No	No			
Outpatient Hospital	√	√		20% coinsurance	20% coinsurance
Podiatry	√	√	Excludes routine foot care	\$10.00 co-pay; palliative foot care excluded	\$10.00 co-pay; limits on foot care
Prescription Drugs	√	√	\$1.00 co-pay ≤\$29.99; \$2.00 co-pay ≥\$30.00; 90-day fill for maintenance drugs	\$10.00 Generic; \$35.00 Brand; \$55.00 non-formulary	\$10.00 Generic; \$35.00 Brand; \$55.00 non-formulary
Primary Care Provider/Physician	√	√	Professional services are limited to 1 visit per day; office visits up to 5 per month; home visits up to 5 per month; nursing facility visits up to 1 per week; hospital visits 1 per day for acute care/1 per month for sub-acute care.	\$10.00 co-pay	\$10.00 co-pay
Preventive Services	√	√		Covered	Covered 100%

Service	VHAP Managed Care	Catamount	VHAP Managed Care*	Catamount Blue	Catamount Choice
				100%	
Skilled Nursing Facility	√	√	Limited to 30 days per episode; limited to 60 days per calendar year	20% coinsurance; limited to 100 days per year	20% coinsurance; in network only; limited to 120 days per year
Surgery	√	√		20% coinsurance	\$10.00 co-pay for outpatient, 20% coinsurance for inpatient
Transportation	No	No			

*Clarifications and additional coverage details available at VHAP – Managed Care Procedures (P-4005 A - P-4005C)

Department of Vermont Health Access
 SFY '12 Budget Proposal to Convert Catamount & ESIA Programs to VHAP & VHAP ESIA
 Friday, January 28, 2011

SFY '12 Cost of Shifting Catamount & ESIA Beneficiaries to VHAP Expanded & VHAP ESIA Expanded @ Existing VHAP Coverage (9-Month Estimate)					
Total Member		Average		Total Cost	
Mos.	Enrollment	Catamount pmpm	VHAP pmpm	VHAP pmpm	Total Cost
97,392	10,821	\$ 447.33	\$ 447.33	\$ 342.70	\$ (10,190,556)
7,400	822	\$ 188.05	\$ 188.05	\$ -	\$ -
Total	104,792	11,644			(10,190,556)
State Fund Savings					(4,294,300)

Uses consensus-based caseload estimates developed by JFO, F&M, AHS, & DVHA as projected by month

SFY '12 Savings Based on Maintaining a \$500 Deductible for VHAP Expanded & VHAP ESIA Expanded Populations				
Total Member		Average		Total Cost
Mos.	Enrollment	pmpm	pmpm	Total Cost
97,392	10,821	\$ (17.14)	\$ (17.14)	\$ (1,668,821)
State Fund Savings				
(703,241)				

Presumes 5% savings based on actuary Catamount modeling (1/8/10)

SFY '12 Savings Based on Increasing Deductible to \$1200					
Total Member		Average		VHAP ESIA	
Mos.	Enrollment	VHAP Expanded pmpm	Expanded pmpm	VHAP Expanded pmpm	Total Cost
7,815	868	\$ 325.56	\$ 325.56	\$ 188.05	\$ (1,074,632)
89,577	9,953	\$ (19.27)	\$ (19.27)	\$ -	\$ (1,726,367)
Total	97,392	10,821			(2,800,999)
State Fund Savings					(1,180,341)

Presumes additional 7% savings based on 1% for every \$100

TOTAL GROSS SAVINGS	(14,660,375)
TOTAL STATE FUND SAVINGS	(6,177,882)

Following are the proposed statutory changes to implement this new initiative:

Sec. 1. VERMONT HEALTH ACCESS PLAN (VHAP); WAIVER AMENDMENT

(a) The commissioner of Vermont health access shall seek an amendment to the Global Commitment to Health Section 1115 waiver (Global Commitment) to provide:

(1) health coverage for individuals with incomes at or below 300 percent of the FPL in the VHAP established in 33 V.S.A. §1973, as amended, and as provided for subsection (c) of this section;

(2) health coverage for individuals with incomes at or below 300 percent of the FPL in the employer-sponsored insurance program established in 33 V.S.A. §1974, as amended;

(3) health coverage for individuals with incomes over 300 percent of the FPL in the VHAP at the full per member per month cost as provided for in subsection (d) of this section; and

(4) a process for transferring current subscribers of Catamount Health and Catamount Health Assistance to the VHAP without applying the 12 month waiting period. For individuals who transfer from Catamount Health Assistance to the VHAP, the premiums shall set as provided for in Sec. 5 of this act, which reflect the most recent, actual premiums paid by individuals.

(b) If necessary, the commissioner shall seek an amendment to Global Commitment to allow college students to be eligible for the Vermont health access program to the same extent as college students are currently eligible for Catamount Health. If a waiver amendment is not required by the Centers for Medicare and Medicaid Services (CMS), the commissioner shall amend the rules for the Vermont health access program to make this eligibility change.

(c) The commissioner shall create by rule a deductible of \$1200.00 per month in the VHAP for individuals with incomes greater than 150 percent of the FPL who do not have children and for parents of minor children with incomes greater than 185 percent of the FPL.

(d)(1) The commissioner shall create by rule a process for individuals with incomes over 300 percent of the FPL to purchase the VHAP at full per member per month cost.

(2) For individuals purchasing VHAP at full per member per month cost, there shall be a \$1200.00 deductible for health services. The cost-sharing shall be the same as currently provided for by rule for individuals with incomes at or below 150 percent of FPL.

Sec. 2. 33 V.S.A. § 1973 is amended to read:

§ 1973. Vermont health access plan

(a) The agency of human services or its designee shall establish the VHAP pursuant to a waiver of federal Medicaid law. The plan shall remain in effect as long as a federal Section 1115 demonstration

* * *

~~(d) An individual who has been enrolled in Catamount Health, with or without premium assistance, shall not be subject to a 12-month waiting period before becoming eligible for the Vermont health access plan.~~

~~(e)(d)~~ An individual who is or becomes eligible for Medicare shall not be eligible for the VHAP.

~~(f)(e)~~ For purposes of this section, "uninsured" means:

* * *

~~(4) Notwithstanding any other provision of law, when an individual is enrolled in Catamount Health solely under the high deductible standard outlined in 8 V.S.A. § 4080f(a)(9), the individual shall not be eligible for the Vermont health access plan for the 12-month period following the date of enrollment in Catamount Health.~~

Sec. 3. 33 V.S.A. §1974 is amended to read:

§ 1974. Employer-sponsored insurance, premium assistance

(a) No later than October 1, 2007, subject to approval by the Centers for Medicare and Medicaid Services, the agency of human services shall establish a premium assistance program to assist individuals eligible for or enrolled in the VHAP and ~~uninsured individuals with incomes under 300 percent of the federal poverty guidelines and their dependents~~ to purchase an approved employer-sponsored insurance plan if offered to those individuals by an employer. The agency shall determine whether to include children who are eligible for Medicaid or Dr. Dynasaur in the premium assistance program at their parent's option. The agency shall not mandate participation of children in employer-sponsored insurance.

(b) VHAP-eligible premium assistance for individuals with lower incomes.

(1) For individuals enrolled in or who apply for enrollment in the VHAP on or after October 1, 2007 who have access to an approved employer-sponsored insurance plan and who have income at or below 150 percent of the FPL for adults without children or at or below 185 percent of FPL for parents with minor children the premium assistance program shall provide:

(A) A subsidy of premiums or cost-sharing amounts based on the household income of the eligible individual to ensure that the individual is obligated to make out-of-pocket expenditures for premiums and cost-sharing amounts which are substantially equivalent to or less than the premium and cost-sharing obligations on an annual basis under the VHAP.

(B) Supplemental benefit coverage equivalent to the benefits offered by the VHAP.

* * *

~~(3) The agency shall determine whether it is cost effective to the state to enroll an individual in an approved employer-sponsored insurance plan with the premium assistance under this subsection as compared to enrolling the~~

~~individual in the Vermont health access plan. If the agency determines that it is cost-effective, the individual shall be required to enroll in the approved employer-sponsored plan as a condition of continued assistance under this section or coverage under the Vermont health access plan, except that dependents who are children of eligible individuals shall not be required to enroll in the premium assistance program. Notwithstanding this requirement, an individual shall be provided benefits under the Vermont health access plan until the next open enrollment period offered by the employer or insurer. The agency shall not consider the medical history, medical conditions, or claims history of any individual for whom cost-effectiveness is being evaluated.~~

~~(4) An individual who is or becomes eligible for Medicare shall not be eligible for premium assistance under this subsection.~~

~~(5) Decisions regarding plan approval and cost-effectiveness are matters fully within the agency's discretion. On appeal pursuant to 3 V.S.A. § 3091, the human services board may overturn the agency's decision only if it is arbitrary or unreasonable.~~

~~(6) Notwithstanding any other provision of law, when an individual is enrolled in Catamount Health solely under the high deductible standard outlined in 8 V.S.A. § 4080f(a)(9), the individual shall not be eligible for premium assistance for the 12-month period following the date of enrollment in Catamount Health.~~

~~(c) Uninsured individuals; premium assistance. VHAP-eligible premium assistance for individuals with higher incomes.~~

~~(1) For the purposes of this subsection:~~

~~(A) "Chronic care" means health services provided by a health care professional for an established clinical condition that is expected to last a year or more and that requires ongoing clinical management attempting to restore the individual to highest function, minimize the negative effects of the condition, and prevent complications related to chronic conditions. Examples of chronic conditions include diabetes, hypertension, cardiovascular disease, cancer, asthma, pulmonary disease, substance abuse, mental illness, spinal cord injury, and hyperlipidemia.~~

~~(B) "Uninsured" means an individual who does not qualify for Medicare, Medicaid, the Vermont health access plan, or Dr. Dynasaur and had no private insurance or employer-sponsored coverage that includes both hospital and physician services within 12 months prior to the month of application, or lost private insurance or employer-sponsored coverage during the prior 12 months for the following reasons:~~

~~(i) the individual's private insurance or employer-sponsored coverage ended because of:~~

~~(l) loss of employment, including a reduction in hours that results in ineligibility for employer-sponsored coverage, unless the employer has terminated its employees or reduced their hours for the primary purpose of~~

~~discontinuing employer sponsored coverage and establishing their eligibility for Catamount Health;~~

~~(II) death of the principal insurance policyholder;~~

~~(III) divorce or dissolution of a civil union;~~

~~(IV) no longer receiving coverage as a dependent under the plan of a parent or caretaker relative; or~~

~~(V) no longer receiving COBRA, VIPER, or other state continuation coverage.~~

~~(ii) College or university sponsored health insurance became unavailable to the individual because the individual graduated, took a leave of absence, decreased enrollment below a threshold set for continued coverage, or otherwise terminated studies.~~

~~(iii)(I) The individual lost health insurance as a result of domestic violence. The individual shall provide the agency of human services with satisfactory documentation of the domestic violence. The documentation may include a sworn statement from the individual attesting to the abuse, law enforcement or court records, or other documentation from an attorney or legal advisor, member of the clergy, or health care provider, as defined in 18 V.S.A. § 9402. Information relating to the domestic violence, including the individual's statement and corroborating evidence, provided to the agency shall not be disclosed by the agency unless the individual has signed a consent to disclose form. In the event the agency is legally required to release this information without consent of the individual, the agency shall notify the individual at the time the notice or request for release of information is received by the agency and prior to releasing the requested information.~~

~~(II) Subdivision (I) of this subdivision (B)(iii) shall take effect upon issuance by the Centers for Medicare and Medicaid Services of approval of an amendment to the waiver set forth in subsection (f) of this section allowing for a domestic violence exception to the premium assistance program waiting period.~~

~~(C) "Vermont resident" means an individual domiciled in Vermont as evidenced by an intent to maintain a principal dwelling place in Vermont indefinitely and to return to Vermont if temporarily absent, coupled with an act or acts consistent with that intent.~~

~~(2) An individual is eligible for premium assistance under this subsection if the individual:~~

~~(A) is an uninsured Vermont resident;~~

~~(B) has income less than or equal to 300 percent of the federal poverty level;~~

~~(C) has access to an approved employer sponsored insurance plan; and~~

~~(D) is 18 or over and is not claimed on a tax return as a dependent of a resident of another state.~~

~~(3) The premium assistance program under this subsection For individuals enrolled in or who apply for enrollment in the VHAP on or after October 1, 2011 who have access to an approved employer-sponsored~~

insurance plan and have incomes over 150 percent of the FPL for adults without children and over 185 percent of FPL for parents with minor children, the premium assistance program shall provide a subsidy of premiums or cost-sharing amounts based on the household income of the eligible individual, with greater amounts of financial assistance provided to eligible individuals with lower household income and lesser amounts of assistance provided to eligible individuals with higher household income. Until an approved employer-sponsored plan is required to meet the standard in ~~subdivision (4)(B)(ii) of this subsection~~ subsection (e) of this section, the subsidy shall include premium assistance and assistance to cover cost-sharing amounts for chronic care health services covered by the VHAP that are related to evidence-based guidelines for ongoing prevention and clinical management of the chronic condition specified in the blueprint for health in 18 V.S.A. § 702. ~~Notwithstanding any other provision of law, when an individual is enrolled in Catamount Health solely under the high deductible standard outlined in 8 V.S.A. § 4080f(a)(9), the individual shall not be eligible for premium assistance for the 12-month period following the date of enrollment in Catamount Health.~~

~~(4)(2)~~ (2) In consultation with the department of banking, insurance, securities, and health care administration, the agency shall develop criteria for approving employer-sponsored health insurance plans to ensure the plans provide comprehensive and affordable health insurance when combined with the assistance under this section. At minimum, an approved employer-sponsored insurance plan shall include:

~~(A) covered benefits to be substantially similar, as determined by the agency, to the benefits covered under Catamount Health~~ coverage for the following services:

(i) Physician visits;
(ii) Inpatient care;
(iii) Outpatient services, including diagnostics, physical therapy, and surgery;

(iv) Prescription drugs;
(v) Emergency room services;
(vi) Ambulance services;
(vii) Mental health and substance abuse treatment;
(viii) Medical equipment and supplies; and
(ix) Maternity care; and

~~(B)(i) until January 1, 2009 or when statewide participation in the Vermont blueprint for health is achieved, appropriate coverage of chronic conditions in a manner consistent with statewide participation by health insurers in the Vermont blueprint for health, and in accordance with the standards established in 18 V.S.A. § 702;~~

(ii) after statewide participation is achieved, coverage of chronic conditions substantially similar to Catamount Health.

~~(5) The agency shall determine whether it is cost effective to the state to require the individual to purchase the approved employer sponsored insurance plan with premium assistance under this subsection instead of Catamount Health established in 8 V.S.A. § 4080f with assistance under subchapter 3a of chapter 19 of this title. If providing the individual with assistance to purchase Catamount Health is more cost effective to the state than providing the individual with premium assistance to purchase the individual's approved employer sponsored plan, the state shall provide the individual the option of purchasing Catamount Health with assistance for that product. An individual may purchase Catamount Health and receive Catamount Health assistance until the approved employer sponsored plan has an open enrollment period, but the individual shall be required to enroll in the approved employer sponsored plan in order to continue to receive any assistance. The agency shall not consider the medical history, medical conditions, or claims history of any individual for whom cost effectiveness is being evaluated.~~

~~(6) Decisions regarding plan approval and cost effectiveness are matters fully within the agency's discretion. On appeal pursuant to 3 V.S.A. § 3091, the human services board may overturn the agency's decision only if it is arbitrary or unreasonable.~~

~~(d)(1) Participation in an approved employer-sponsored insurance plan with premium assistance under this section or Catamount Health shall not disqualify an individual from the VHAP if an approved employer-sponsored insurance plan or Catamount Health is no longer available to that individual.~~

~~(2) An individual who has been enrolled in Medicaid, VHAP, Dr. Dynasaur, or any other health benefit plan authorized under Title XIX or Title XX of the Social Security Act shall not be subject to a 12-month waiting period before becoming eligible for premium assistance to purchase an approved employer-sponsored insurance plan.~~

~~(3) Enrollment in Catamount Health, with or without premium assistance, shall not disqualify an individual for premium assistance in connection with an approved employer-sponsored insurance plan.~~

~~(e) If the emergency board determines that the funds appropriated for either of the premium assistance programs under this section are insufficient to meet the projected costs of enrolling new program participants into the appropriate program, the emergency board shall suspend new enrollment in that program or restrict enrollment to eligible lower income individuals. This subsection does not affect eligibility for the Vermont health access plan or purchase of Catamount Health. The agency shall determine whether it is cost-effective to the state to enroll an individual in an approved employer-sponsored insurance plan with the premium assistance under this section as compared to enrolling the individual in the VHAP. If the agency determines that it is cost-effective, the individual shall be required to enroll in the approved employer-sponsored plan as a condition of continued assistance under this section or coverage under the VHAP, except that dependents who are children of eligible individuals shall not~~

be required to enroll in the premium assistance program. Notwithstanding this requirement, an individual shall be provided benefits under the VHAP until the next open enrollment period offered by the employer. Insurers shall provide an open enrollment period as provided for in 8 V.S.A. 4080. The agency shall not consider the medical history, medical conditions, or claims history of any individual for whom cost-effectiveness is being evaluated.

~~(f) The agency of human services shall request federal approval for an amendment to the Global Commitment for Health Medicaid Section 1115 waiver for the premium assistance program authorized by this section. An individual who is or becomes eligible for Medicare shall not be eligible for premium assistance under this section.~~

~~(g)(1) Of the amount appropriated in No. 215 of the Act of the 2005 Adj. Sess. (2006) for the employer-sponsored insurance premium assistance program established by this section, no more than \$250,000.00 may be expended for start-up and initial administrative expenses until the report as required by subdivision (2) of this subsection has been received and approved.~~

~~(2) No additional amounts appropriated in No. 215 of the Act of the 2005 Adj. Sess. (2006) for the employer-sponsored premium assistance program may be made after November 15, 2006 without approval of a majority of the combined membership of the joint fiscal committee and the health access oversight committee at a joint meeting upon receipt of a report from the agency, which must include the following:~~

~~(A) a plan for the additional expenditures;~~

~~(B) a survey to determine whether and how many individuals currently enrolled in VHAP, including those eligible as caretakers, are potentially eligible for employer-sponsored premium assistance under this section;~~

~~(C) the sliding-scale premium and cost-sharing assistance amounts provided under the premium assistance program to individuals;~~

~~(D) a description and estimate of benefits offered by the Vermont health access plan that are likely to be provided as supplemental benefits for the employer-sponsored premium assistance program enrollees;~~

~~(E) a plan for covering dependent children through the premium assistance program; and~~

~~(F) the anticipated budgetary impact of an employer-sponsored insurance premium assistance program for fiscal year 2008, including savings attributable to enrolling current VHAP enrollees in the premium assistance program established under this section, the start-up and administrative costs of the program, and the cost of providing the subsidy to these enrollees. Decisions regarding plan approval and cost-effectiveness are matters fully within the agency's discretion. On appeal pursuant to 3 V.S.A. § 3091, the human services board may overturn the agency's decision only if it is arbitrary or unreasonable.~~

~~(h) The agency shall report monthly to the joint fiscal committee, the health access oversight committee, and the commission on health care reform with~~

the number of individuals enrolled in the premium assistance program, and the income levels of the individuals, ~~a description of the range and types of employer-sponsored plans that have been approved, the percentage of premium and cost sharing amounts paid by employers whose employees participate in the premium assistance program, and the net savings or cost of the program.~~

~~(i)(h)~~ The health access oversight committee shall monitor the development, implementation, and ongoing operation of the employer-sponsored premium assistance program under this section.

~~(j)~~ The premium contributions for individuals shall be as follows:

~~(1) Monthly premiums for each individual who is eligible for premium assistance under subsection (b) of this section shall be the same as charged in the Vermont health access plan.~~

~~(2) Monthly premiums for each individual who is not eligible for the Vermont health access plan shall be the same as the premiums established in subsections 1984(b) and (c) of this title.~~

Sec. 4. EMPLOYER-SPONSORED INSURANCE; COMPARISON

The commissioner of Vermont health access shall modify the deductible amount from \$500.00 to \$1200.00 per individual for the benefits comparison in the employer-sponsored insurance program for adults without children with incomes over 150 percent of the FPL and for adults with minor children with incomes over 185 percent of the FPL as provided for in 33 V.S.A. §1974.

Sec. 5. Sec. 147(d) of No. 66 of the Acts of 2003, as amended by Sec. 129 of No. 122 of the Acts of the 2003 Adj. Sess. (2004), Sec. 279 of No. 71 of the Acts of 2005, and Sec. 11 of No. 191 of the Acts of 2005 (Adj. Sess.), is further amended to read:

~~(d) VHAP, premium-based.~~ and employer-sponsored insurance premium assistance.

* * *

(2) The agency shall establish per individual premiums for ~~the VHAP Uninsured program~~ for the following brackets of income ~~for the VHAP group~~ as a percentage of FPL:

(A) Income greater than 50 percent and less than or equal to 75 percent of FPL: \$7.00 per month.

(B) Income greater than 75 percent and less than or equal to 100 percent of FPL: \$25.00 per month.

(C) Income greater than 100 percent and less than or equal to 150 percent of FPL: \$33.00 per month.

(D) Income For parents with minor children, income greater than 150 percent and less than or equal to 185 percent of FPL: \$49.00 per month.

(E) Except as provided for in (D), income greater than 150 percent and less than or equal to 200 percent of FPL: \$60.00 per month.

(F) Income greater than 200 percent and less than or equal to 225 percent of FPL: \$124.00 per month.

(G) Income greater than 225 percent and less than or equal to 250 percent of FPL: \$152.00 per month.

(H) Income greater than 250 percent and less than or equal to 275 percent of FPL: \$180.00 per month.

(I) Income greater than 275 percent and less than or equal to 300 percent of FPL: \$208.00 per month.

(J) Income greater than 300 percent of FPL: the full per member per month cost.

Sec. 6. 21 V.S.A. §2003 is amended to read:

§2003. Health care fund contribution assessment

* * *

(b) For any quarter in fiscal years 2007 and 2008, the amount of the health care fund contribution shall be \$91.25 for each full-time equivalent employee in excess of eight. For each fiscal year after fiscal year 2008, the number of excluded full-time equivalent employees shall be adjusted in accordance with subsection (a) of this section, and the amount of the health care fund contribution shall be adjusted by a percentage equal to any percentage change in premiums for ~~Catamount Health~~ per member per month amount in the VHAP for that fiscal year; provided, however, that to the extent that ~~Catamount Health~~ the Vermont health access premiums decrease due to changes in benefit design or deductible amounts, the health care fund contribution shall not be decreased by the percentage change attributable to such benefit design or deductible changes.

* * *

(d) Revenues from the health care fund contributions collected shall be deposited into the ~~Catamount Fund~~ state health care resources fund established under 33 V.S.A. § ~~1981~~1901d for the purpose of financing health care coverage under ~~Catamount Health~~ assistance, as provided under ~~subchapter 3a~~ of chapter 19 of Title 33.

Sec. 7. 33 V.S.A. § 1901d(b)(1) is amended to read:

(1) all revenue from the tobacco products tax and ~~84.5 percent of the revenue~~ from the cigarette tax levied pursuant to chapter 205 of Title 32;

Sec. 8. FUND TRANSFER

Any funds remaining in the Catamount Fund after the termination of Catamount Health Assistance shall be transferred to the state health care resources fund.

Sec. 9. EMERGENCY RULES

In order to administer Secs. 1-6 of this act relating to consolidating Catamount Health and Catamount Health Assistance into the Vermont health access program, the agency of human services shall be deemed to have met the standard for adoption of emergency rules as required by 3 V.S.A. § 844(a).

Sec. 10. REPEAL

33 V.S.A. chapter 19, subchapter 3a (Catamount Health Assistance) and 8 V.S.A. 4080f (Catamount Health) is repealed on September 30, 2011 for the purposes of enrolling new individuals. The agency may continue to operate the Catamount Health and Catamount Health Assistance until the individuals enrolled in those programs transition to the VHAP or terminate their participation.

Sec. 11. EFFECTIVE DATES

(a) Secs.2-8 (Catamount Health and VHAP related changes) of this act shall become effective on October 1, 2011 or upon completion of the rules provided for in Sec. 9, whichever is later.

(b) Secs. 1 (Waiver), 9 (Emergency Rules for VHAP), 10 (Repeals) and this section shall become effective upon passage.

DAIL Managed Policy Decisions (\$3,110,609)
(\$1,310,811) state

As described earlier in this document, DVHA pays for the Choices for Care expenditures, but DAIL is responsible for managing the long-term care component of such. They are implementing the following changes in the program and will provide documentation in support of their decisions during their budget testimony:

- Nursing home inflation & savings from re-base: \$1,679,649 (\$707,804 state)
- Renovations to Woodridge & the Pines: \$70,764 (\$29,820 state)
- Special rates increase @ Crescent Manor: \$313,378 (\$132,057 state)
- Out-of-state NH rate increases: \$157,000 (\$66,160 state)
- NH rate increase due to assessment going to 6%: \$1,595,560 (\$672,369 state)
- Planned carryover from SFY '11 LTC portion: (\$1,500,000) ((\$632,100) state)
- Reduce instrumental activities of daily living: (\$2,640,000) ((\$1,112,496) state)
- Reduce cap on respite/companion services: (\$2,474,960) ((\$1,042,948) state)
- Implement 10% discount on flex choices budgets: (\$312,000) ((\$131,477) state)

REVENUE IMPLICATIONS \$29,624,638
\$29,624,638 state

Increase most provider assessments to 6% as of 10/1/11 \$9,642,690
\$9,642,690 state

The provider assessment rate cap historically was 6% of gross revenues. The federal government reduced this to 5.5% as of January 1, 2008 with an end

date to the temporary reduction of 9/30/11. By increasing the rate back up to the former threshold, DVHA would be able to draw in an additional estimated \$6,823,604 from hospitals, \$4,959 from the ICF-MR, and \$2,814,127 from nursing homes. (See Table on following pages for overview of provider assessments)

Hospital assessment increase due to annual revenue growth . . . \$5,940,339
\$5,940,339 state

Annually, we see an increase in hospital provider assessment revenues due to the growth in their revenues from the previous year.

Home health agency assessment changes \$237,304
\$237,304 state

As of 10/01/11, home health agency assessments will increase from 17.69% to 19.30% of net operating revenues for core health care services, excluding revenues for services provided under Title XVIII of the federal Social Security Act (i.e., Medicare). In addition, annually, we see an increase in home health agency assessment revenues due to growth in their revenues from the previous year. Combined, these changes are expected to yield an increase of \$237,304 for SFY '12.

Move basis used to establish hospital assessment from most recently audited data to current budget year \$4,634,752
\$4,634,752 state

Hospital provider assessment calculations are currently done on the most recently audited financial statements. This proposal would revise that basis to use the most current year's budget information available through BISHCA.

Institute new Managed Care & Dental provider assessments . \$16,000,000
\$16,000,000 state

An opportunity afforded to all states but not utilized thus far by Vermont is the ability to assess both (1) managed care organizations and (2) dental providers.

(1) For every 1.33% assessment charged to managed care organizations, \$10 million in new state funds would be available to support healthcare programs. One of the goals of this new initiative would be to have these organizations negotiate new rates of reimbursement with the hospitals, reducing their commitment by the same amount of the tax. Concurrently, DVHA could increase rates (to the extent funding is available) to start to address cost-shifting issues \$10,000,000
\$10,000,000 state

(2) Dental provider assessments are proposed as a manner by which to access additional funding to support the Medicaid program. \$6,000,000
\$6,000,000 state

Provider Assessments

Health Care Provider	Current Methodology	SFY '11 Generated Revenue	Proposed Methodology	SFY '12 Generated Revenue
Hospitals 33 V.S.A. § 1953	Hospitals are assessed <u>5.5%</u> of net patient revenues (less chronic, skilled and swing bed revenues). The assessment is based on data from the hospital's most recent full fiscal year for which data has been reported to BISCHA.	\$94,139,184	Hospitals are assessed <u>5.5%</u> of net patient revenues (less chronic, skilled and swing bed revenues). The assessment is based on data from the hospital's most recent full fiscal year for which data has been reported to BISCHA. As of 10/01/11, hospitals are assessed 6%. The assessment is based on the hospitals most current year's budget information available through BISCHA.	\$111,537,339
Nursing Homes 33 V.S.A. § 1954	Nursing homes are assessed <u>\$3,962.66 per licensed bed</u> . The assessment for each licensed bed is prorated for the number of days during which the bed was actually licensed. As more people choose to remain in the community rather than nursing homes, the number of licensed beds is likely to decrease.	\$13,060,927	Nursing homes are assessed <u>\$4,509.57 per licensed bed for 7/1/11 through 9/30/11</u> (this is equivalent to 5.5% of gross revenues). As of 10/1/11, nursing homes are assessed <u>\$4,919.93 per licensed bed</u> (this is equivalent to 6% of gross revenues). The assessment for each licensed bed is prorated for the number of days during which the bed was actually licensed. As more people choose to remain in the community rather than nursing homes, the number of licensed beds is likely to decrease.	\$15,875,054
ICF/MR (Intermediate Care Facilities for Persons with Mental Retardation) 33 V.S.A. § 1955	Each ICF/MR is assessed <u>5.5%</u> of their total annual direct and indirect expense for the most recently settled ICF/MR audit.	\$66,002	Each ICF/MR is assessed <u>5.5%</u> of their total annual direct and indirect expense for the most recently settled ICF/MR audit. As of 10/1/11, ICF/MRs are assessed 6%.	\$70,961

Health Care Provider	Current Methodology	SFY '11 Generated Revenue	Proposed Methodology	SFY '12 Generated Revenue
Home Health 33 V.S.A. § 1955a	Each home health agency is assessed 17.69% of net operating revenues from core home health care services, excluding revenues for services provided under Title XVIII of the federal Social Security Act. The assessment is based on the agency's most recent audited financial statements at the time of submission (which are provided to the state on or before December 1 of each year).	\$4,088,575	Each home health agency is assessed 17.69% of net operating revenues (this is equivalent to 3.8% of gross revenues) from core home health care services, excluding revenues for services provided under Title XVIII of the federal Social Security Act. As of 10/1/11, each home health agency is assessed <u>19.30% of net operating revenues</u> (this is equivalent to 3.9% of gross revenues) from core home health care services, excluding revenues for services provided under Title XVIII of the federal Social Security Act. The assessment is based on the agency's most recent audited financial statements at the time of submission (which are provided to the state on or before December 1 of each year).	\$4,325,879
Pharmacy 33 V.S.A. § 1955b	Each pharmacy is assessed \$0.10 for each prescription filled or refilled. Pharmacies submit their assessment payments monthly. N/A	\$800,000	Each pharmacy is assessed \$0.10 for each prescription filled or refilled. Pharmacies submit their assessment payments monthly. As of 7/1/11, managed care organizations are assessed 1.33% of all health insurance premiums paid to the managed care organization by its Vermont members in the previous fiscal year ending 6/30.	\$800,000
Managed Care Organization (MCO)	N/A	\$0	As of 7/1/11, managed care organizations are assessed 1.33% of all health insurance premiums paid to the managed care organization by its Vermont members in the previous fiscal year ending 6/30.	\$10,000,000

Health Care Provider	Current Methodology	SFY '11 Generated Revenue	Proposed Methodology	SFY '12 Generated Revenue
Dental	N/A	\$0	As of 7/1/11, each practicing dentist's assessment shall be 3% of the dentist's gross revenues from performing dental and other healthcare services. The amount of the tax shall be determined annually by the Commissioner based on the practicing dentist's calendar year gross revenues as reported to DVHA. The annual assessment for SFY '12 shall be based on each practicing dentist's 2010 gross revenues as reported to the Department on or before July 30, 2011. Each succeeding year's assessment will be based upon the calendar year's gross revenue as reported to the department no later than March 1.	\$6,000,000

Following is the proposed language in order for DVHA to implement the new MCO and Dental assessment initiatives:

Sec. XXX. 33 V.S.A. § 1951 is amended to read:

§ 1951. DEFINITIONS

As used in this subchapter:

(1) "Assessment" means a tax levied on a health care provider pursuant to this chapter.

(2) "Core home health care services" means those medically-necessary skilled nursing, home health aide, therapeutic, and personal care attendant services, provided exclusively in the home by home health agencies. Core home health services do not include private duty nursing, hospice, homemaker or physician services, or services provided under early periodic screening, diagnosis, and treatment (EPSDT), traumatic brain injury (TBI), high technology programs, or services provided by a home for the terminally ill as defined in subdivision 7102(10) of this title.

(3) "Commissioner" means the commissioner of Vermont health access.

(4) "Department" means the department of Vermont health access.

(5) "Gross revenue" means a practicing dentist's gross charges for performing dental and other health care services including any separate charges for drugs, medicines, and other substances administered or provided to a patient as part of the dental or other health care services delivered to the patient. "Gross revenue" also includes any separate charges for prosthetic devices, including dental prostheses, that are part of the dental or other health care services delivered to patients.

(6) "Fund" means the state health care resources fund consisting in part of assessments from health care providers under this subchapter.

~~(5)~~(7) "Health care provider" means any hospital, nursing home, intermediate care facility for the mentally retarded, home health agency, practicing dentist, or retail pharmacy.

~~(6)~~ (8) "Home health agency" means an entity that has received a certificate of need from the state to provide home health services or is certified to provide services pursuant to 42 U.S.C. § 1395x(o).

~~(7)~~ (9) "Hospital" means a hospital licensed under chapter 43 of Title 18.

~~(8)~~ (10) "Intermediate Care Facility for the Mentally Retarded" ("ICF/MR") means a facility which provides long-term health related care to residents with mental retardation pursuant to subdivision 1902(a)(31) of the Social Security Act (42 U.S.C. § 1396a(a)(31)).

(11) "Managed care organization" shall have the same meaning as in 18 V.S.A. § 9402(14).

~~(9)~~(12) "Mental hospital" or "psychiatric facility" means a hospital as defined in 18 V.S.A. § 1902(1)(B) or (H), but does not include psychiatric units of general hospitals.

~~(10)~~(13) "Net operating revenues" means a provider's gross charges less any deductions for bad debts, charity care, contractual allowances, and other payer discounts.

~~(11)~~(14) "Nursing home" means a health care facility licensed under chapter 71 of this title.

~~(12) "Department" means the department of Vermont health access.~~

~~(13)~~(15) "Pharmacy" means a Vermont drug outlet licensed by the Vermont state board of pharmacy pursuant to chapter 36 of Title 26 in which prescription drugs are sold at retail.

(16) "Practicing dentist" means a person, licensed in Vermont, practicing dentistry as defined in 26 V.S.A. § 721.

~~(14)~~(17) "Secretary" means the secretary of the agency of human services.

Sec. XXX. 33 V.S.A. §1952(f) is amended to read:

~~(f)~~(1) If a health care provider fails to pay its assessments under this subchapter according to the schedule or a variation thereof adopted by the commissioner, the commissioner may, after notice and opportunity for hearing, deduct these assessment arrears and any late-payment penalties from Medicaid payments otherwise due to the provider. The deduction of these assessment arrears may be made in one or more installments on a schedule to be determined by the commissioner.

(2) If any managed care organization fails to pay the assessment established in section 1955c of this title within 45 days after notice from the commissioner, the commissioner, or designee, shall notify the commissioner of banking,

insurance, securities, and health care administration of the failure to pay. In addition to any other remedy or sanction provided for by law, if the commissioner of banking, insurance, securities, and health care administration finds, after notice and an opportunity to be heard, that the managed care organization has violated this section or any rule or order adopted or issued pursuant to this section, the commissioner of banking, insurance, securities, and health care administration may take any one or more of the following actions:

(A) Assess an administrative penalty on the managed care organization of not more than \$1,000.00 for each violation and not more than \$10,000.00 for each willful violation;

(B) Order the managed care organization to cease and desist in further violations; or

(C) Order the managed care organization to remediate the violation, including the payment of assessmentss in arrears and payment of interest on assessments in arrears at the rate of 12 percent per annum.

Sec. 4. 33 V.S.A. §1955c is added to read:

§ 1955c. Practicing dentist assessment.

Practicing dentists shall be subject to an annual assessment as follows:

(1) Beginning July 1, 2011, each practicing dentist's assessment shall be 3 percent of the dentist's gross revenues from performing dental and other health care services. The amount of the tax shall be determined annually by the commissioner based on the practicing dentist's calendar year gross revenues as reported to the department. The annual assessment for state fiscal year 2012 shall be based on each practicing dentist's 2010 gross revenues as reported to the department on or before July 30, 2011. Each succeeding year's assessment will be based upon the calendar year's gross revenue as reported to the department no later than March 1.

(2) Each practicing dentist shall be notified in writing by the department of the assessment made pursuant to this section. If no practicing dentist submits a request for reconsideration under section 1958 of this title, the assessment shall be considered final.

(3) Each practicing dentist shall submit its assessment to the department according to a payment schedule adopted by the commissioner. Variations in

payment schedules shall be permitted as deemed necessary by the commissioner.

(4) Any practicing dentist that fails to make a payment to the department on or before the specified schedule, or under any schedule for delayed payments established by the commissioner, shall be assessed not more than \$1,000.00 in penalty fees. The commissioner may waive this late payment assessment provided for in this subsection for good cause shown.

Sec. 5. 33 V.S.A. §1955d is added to read:

§ 1955d. MANAGED CARE ORGANIZATION ASSESSMENT

Beginning July 1, 2011 and annually thereafter, each managed care organization shall pay an assessment in the amount of 1.33 percent of all health insurance premiums paid to the managed care organization by its Vermont members in the previous fiscal year ending June 30. The annual assessment shall be paid monthly.

Sec. 6. 33 V.S.A. § 1956 is amended to read:

§ 1956. PROCEEDS FROM ASSESSMENTS

All assessments, including late-payment assessments, from health care providers and managed care organizations under this subchapter shall be deposited in the state health care resources fund established in section 1901d of this title. No provision of this subchapter shall permit the state to reduce the level of state funds expended on the nursing home Medicaid program in any fiscal year below the level expended in fiscal year 1991 from the general fund for the nursing home Medicaid program.

Other Requested Statutory Changes \$ 0

DVHA requests the following change to statute governing the Health IT Fund:

32 V.S.A. chapter 241 § 10301 is amended to read:

§ 10301. HEALTH IT-FUND

(g) The secretary of administration or his or her designee shall submit an annual report on the receipts, expenditures, and balances in the health IT-fund to the joint fiscal committee at its September meeting and to the commission on health care reform by October 1. The report shall include information on the results of an annual ~~independent~~ study of the effectiveness of programs and initiatives funded through the health IT-fund, with reference

to a baseline, benchmarks, and other measures for monitoring progress and including data on return on investments made.

Justification: When the Health IT Fund was originally created, there was no Division of Health Care Reform at DVHA with responsibility for oversight and coordination of State Health Information Technology policy, planning, and implementation, so it made sense to have an independent evaluator; there was not a place in state government to perform the function. However, with enactment of 18 V.S.A. § 9351, we have the infrastructure to complete this work internally without incurring the \$25,000 annual cost of an external entity doing the work. The baseline has been established by the independent study completed last year, with benchmarks and other measures for monitoring progress established that can now be completed by DVHA staff going forward.

Hospital assessments:

Due to changes in the hospital assessment base, the following language change is required:

33 V.S.A. § 1953. Hospital assessment

§ 1953. Hospital assessment

(a) Hospitals shall be subject to an annual assessment as follows:

(1) Each hospital's annual assessment, except for hospitals assessed under subdivision (2) of this subsection, shall be 5.5 through September 30, 2011 percent of its net patient revenues (less chronic, skilled, and swing bed revenues). ~~for the hospital's fiscal year as determined annually by the commissioner of Vermont health access from the hospital's financial reports and other data filed with the department of banking, insurance, securities, and health care administration. Beginning October 1, 2011, each hospital's assessment, except for hospitals assessed under subdivision (2) of this subsection, shall be 6.00 percent of its net patient revenues~~ (less chronic, skilled, and swing bed revenues). The annual assessment shall be based on data from a hospital's most recent budgeted fiscal year for which data has been reported to the department of banking, insurance, securities, and health care administration.

(2) Beginning July 1, 2004, each mental hospital or psychiatric facility's annual assessment shall be 4.21 percent through September 30, 2011, provided that the United States Department of Health and Human Services grants a waiver to the uniform assessment rate, pursuant to 42 C.F.R. § 433.68(e). If the United States Department of Health and Human Services fails to grant a waiver, mental hospitals and psychiatric facilities shall be assessed under subdivision (1) of this subsection. The annual assessment shall be based on data from the mental hospital's or psychiatric facility's most recent full fiscal year for which data has been provided to the Department of Vermont Health Access. Beginning October 1, 2011, each mental hospital or psychiatric facility assessment shall be 6.0 percent.

(b) Each hospital shall be notified in writing by the department of the assessment made pursuant to this section. If no hospital submits a request for reconsideration under section 1958 of this title, the assessment shall be considered final.

(c) Each hospital shall submit its assessment to the department according to a payment schedule adopted by the commissioner. Variations in payment schedules shall be permitted as deemed necessary by the commissioner.

(d) Any hospital that fails to make a payment to the department on or before the specified schedule, or under any schedule for delayed payments established by the commissioner, shall be assessed not more than \$1,000.00. The commissioner may waive this late payment assessment provided for in this subsection for good cause shown by the hospital. (Added 1991, No. 94, § 1; amended 1993, No. 56, § 1, eff. June 3, 1993; 1995, No. 5, § 26, eff. March 3, 1995; No. 14, § 2, eff. April 12, 1995; 1997, No. 59, §§ 69, 70, eff. June 30, 1997; 1999, No. 49, § 199; 2001, No. 65, § 13; 2003, No. 66, § 306; see effective date note set out below; 2003, No. 163 (Adj. Sess.), § 7; 2005, No. 71, § 285; 2007, No. 190 (Adj. Sess.), § 47, eff. June 6, 2008; 2009, No. 156 (Adj. Sess.), § E.309.4.)

Premium indexing and surcharge:

The SFY11 budget bill in Section E.309.3 states the following:

Sec. E.309.3 SUSPENSION OF AUTOMATIC PREMIUM INCREASES; MAINTENANCE OF ELIGIBILITY REQUIREMENTS

(a) It is the intent of the general assembly to ensure compliance with Section 5001(f) of the American Recovery and Reinvestment Act of 2009, Public Law 111-5 and Section 2001 of the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (maintenance of eligibility) by maintaining the premiums at levels due on June 15, 2008 for individuals enrolled in health benefit plans or premium assistance funded by Medicaid. By maintaining the premiums and eligibility for programs included in Global Commitment to Health and Choices for Care, the state will remain eligible for funds available for Medicaid and Medicaid-waiver programs.

(b) Notwithstanding 33 V.S.A. §§ 1974(j) and 1984(b), individuals receiving Catamount Health premium assistance or employer-sponsored premium assistance shall not have the premiums automatically indexed.

(c) This section of this act shall supersede any agency rules establishing premium amounts above the amounts due on June 15, 2008.

This language was added on the assumption that CMS would interpret all premium increases as a violation of the maintenance-of-eligibility (MOE) requirements in ARRA and health care reform law; however, we posed this question to CMS and have received their response that indexing beneficiary premiums to increases in the underlying private insurance premiums does not violate the MOE requirement. As such, **if the Policy**

proposal to eliminate Catamount Health and allow individuals to enroll in VHAP up to 300% FPL is not accepted, this section should be deleted because we need to be able to continue to index CHAP and ESIA premiums to the increase in cost of the underlying product, and we need to retain our ability to charge CHAP beneficiaries enrolled in the higher-cost plan the difference between that plan and the lower-cost plan.

Language elimination needed for VHAP eligibility back to date of application:

Section 103 of Act 4 (H.232) amends Sec. 2(c) of No. 71 of the Acts of 2007 as amended by Sec. 5.903 of No. 192 of the Acts of 2008 to delay the implementation until October 1, 2011, of the provision to grant VHAP back to the date of application (if approved by CMS). This change is still not slated to occur due to budget implications.

State Children's Health Insurance Program (SCHIP) and other Medicaid programs covering children premium grace period language change:

The federal Affordable Care Act (ACA) allows for a grace period for late payment of premiums for health care programs funded under CHIPRA. This language brings our SCHIP and other Medicaid programs covering children program into compliance with federal law.

Sec. E.309.19 is added to read: SCHIP AND OTHER MEDICAID PROGRAMS COVERING CHILDREN PREMIUM GRACE PERIOD

The commissioner shall make such changes in the billing and collection process as are necessary to achieve state compliance with the premium grace period and notice requirements of section 504 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (42 U.S.C. § 1397cc(e)(3)(C)). These changes shall:

(a) Afford children enrolled in the state's SCHIP and other Medicaid programs covering children, a grace period of at least 30 days from the beginning of a new coverage period to make premium payments before coverage may be terminated. The new coverage period will begin the month immediately following the last month for which a premium was paid.

(b) Inform affected enrollees, not later than seven days after the first day of such grace period:

- (1) that failure to make a required premium payment within the grace period will result in termination of coverage; and
- (2) of the individual's right to challenge the proposed termination pursuant to applicable rules.

(c) Provide this same grace period and notice for each coverage period for which a premium has not been received.

Depreciation and self-employment exception to the 12-month waiting period:

Section 22 of Act 61 (H.444), which passed in 2009, required the Agency to pursue a waiver amendment that would:

- Allow depreciation as a business expense in the income determination process for CHAP, ESIA, and VHAP
- Create a new exception to the waiting period for these same programs for self-employed individuals who lose their insurance coverage in the individual market due to the closing of their business.

Section 23 of this act required the Agency to submit a report no later than January 15, 2010, on the fiscal impact of implementing the depreciation change.

On August 18, 2009, the Joint Fiscal Committee rescinded the funding to support these two changes.

DVHA submitted the waiver amendment to CMS on 8/25/09. On 12/23/09 the Agency received a response from CMS that addressed the depreciation/self-employment change, as well as the issues included in the waiver amendment request submitted on 3/5/09 (extending CHAP and ESIA from 200% to 300% FPL, extending pharmacy benefits from 175% to 225%, covering cost-sharing for people enrolled in the Part D pharmacy programs, changing the waiting period from 12 to 6 months, and adding domestic violence as an exception to the waiting period). CMS approved these changes, except for the requests to cover cost-sharing for the pharmacy programs and the depreciation and self-employment changes. For depreciation and self-employment, CMS said that “the appropriate course of action is to wait until the legislature restores funding to these areas before an Amendment is considered.”

On January 6, 2010, DVHA submitted a report estimating the cost of the depreciation change to be \$81,000 GF in SFY10 and \$266,400 GF in SFY ‘11. The cost of this change is not included in our budget, and therefore we believe this language should be eliminated.

Department Deputies:

3 V.S.A. Sec. 3051 is amended to read:

Sec. 3051. Commissioners; deputy commissioners; appointment; term (a) The secretary, with the approval of the governor, shall appoint a commissioner of each department, who shall be the chief executive and administrative officer and shall serve at the pleasure of the secretary.

(b) For the department of health, the secretary, with the approval of the governor, shall appoint deputy commissioners for the following divisions of the department:

- (1) public health;
- (2) substance abuse.

(c) For the department for children and families, the secretary, with the approval of the governor, shall appoint deputy commissioners for the following divisions of the department:

- (1) economic services;
- (2) child development;
- (3) family services.

(d) For the department of Vermont health access, the secretary, with the approval of the governor, shall appoint deputy commissioners for the following divisions of the department:

- (1) health services and managed care;
- (2) policy, fiscal and support services;
- (3) Healthcare reform.

(e) Deputy commissioners shall be exempt from the classified service. Their appointments shall be in writing and shall be filed with the office of the secretary of state.

EXPLANATION: The Office of Vermont Health Access became a Department in 2010 Act 156 Secs 1.1 to 1.79, and its lead changed from Director to Commissioner. The three (exempt) Division Directors should correspondingly be changed to Deputy Commissioners.

Challenges for Change Initiatives Implemented. \$13,691,897

Administrative Challenges (\$594,897)
(\$624,459) state

Appropriation adjustments made under this section included the impact of the 3% payroll reduction (\$120,443)
(\$51,643) state

Two of the programmatic C4C initiatives required additional staffing support resulting in an increase to this appropriation. The specific initiatives are psychiatric inpatient hospital coordination and Clinical Utilization Review Board (CURB) reviews. (The savings associated with these new staffing investments are described below.) \$170,000
\$71,638 state

One of the statewide C4C initiatives was achieving savings associated with performance-based contracting. Many of DVHA's major contracts already had performance measures as part of the contractor's deliverables; however, we are optimistic that we can cover the general fund target assigned to DVHA (\$633,360)
(\$633,360) state

BGS has been tasked with finding their own administrative efficiencies which would, in turn, result in a reduction in charge to DVHA. An example of one such efficiency was their negotiating a lower shipping cost with UPS than the previously agreed upon amounts with FedEx. DVHA's costs are scheduled to be reduced by their efforts. (\$11,094)
(\$11,094) state

Program Challenges (\$13,097,000)
(\$5,038,076) state

CARE COORDINATION CHALLENGE:

The Care Coordination Unit at DVHA is charged with helping the most costly beneficiaries better manage their care by working with both the individual and the myriad providers they see. This unit added six FTEs cost neutrally through a reduction to the APS contract; and additional savings are expected to be achieved. (\$652,000)
(\$74,753) state

340B CRITICAL CARE HOSPITAL (FQHC) PRICING CHALLENGE:

This initiative charges DVHA with encouraging Vermont’s eight Critical Access and three Sole Community Hospitals (who are newly eligible to participate in the federal 340B discount pharmacy program) to enroll with the federal Office of Pharmacy Affairs (OPA) as eligible Covered Entities and then to “carve in” Medicaid to ensure the state benefits from lower drug pricing. In addition, DVHA is working with already enrolled Covered Entities (Federally Qualified Health Centers and Fletcher Allen Health Care) to increase their 340B utilization and pass through the savings to Medicaid. (\$1,000,000)
(\$421,400) state

DA CHALLENGE TO COLLABORATE WITH FQHCs FOR 340B PRICING:

DMH has a C4C initiative focused on alignment between Covered Entities and the Designated Agencies (DAs) to achieve the same end as above: increased utilization of 340B for Medicaid beneficiaries who are clients of the DA’s. (\$350,000)
(\$147,490) state

CLINICAL UTILIZATION REVIEW BOARD (CURB) CHALLENGE:

A Clinical Utilization Review Board (CURB) has been established to look at existing benefits and payment methodologies as well as emerging clinical practices to determine whether there are more cost effective strategies that could be considered that would result in better outcomes and lower costs. An administrative position (identified above) was added to support this initiative . . . (\$4,085,000)
(\$1,721,419) state

INPATIENT HOSPITALIZATION INITIATIVES:

There are three separate C4C initiatives identified that are aimed at reducing inpatient costs. The first involves more direct oversight of children’s psychiatric hospitalization stays, ensuring they comply with best practice. DVHA is working with all inpatient facilities on reducing lengths of stay; and the Designated Agencies are charged with reducing the number of children admitted (\$600,000)
(\$252,840) state

The second charge is to reduce the length of stay for adult inpatient services and is being performed by DMH staff. (\$475,000)
(\$200,165) state

The third initiative is aimed at further reducing the length of children's stays as well as better coordinating inpatient detoxification stays and requires an additional position as identified above. (\$635,000)

(\$267,589) state

REDUCE PSYCHOTROPIC MEDICATION USE CHALLENGE:

The DMH, in collaboration with the DVHA's Drug Utilization Review (DUR) Board has been charged with developing evidence-based protocols representing best practices for prescribing multiple psychiatric drugs for adults and psychotropic drugs for children. Savings be achieved by better managing the use of low-dose Seroquel (an anti-psychotic medication). (\$300,000)

(\$126,420) state

NURSING HOME UTILIZATION REDUCTION CHALLENGE:

DAIL manages the Choices for Care, long-term care services although the funding resides in the DVHA budget. DAIL is working on an initiative to reduce nursing home utilization. (\$5,000,000)

(\$1,626,000) state

Overview of Green Mountain Care Programs as of 1/5/11
Created by Vermont Legal Aid's Office of Health Care Ombudsman
1-800-917-7787

PROGRAM	WHO IS ELIGIBLE	BENEFITS	COST-SHARING
Medicaid¹ PIL² Medicaid Working Disabled 250% FPL³	<ul style="list-style-type: none"> • Aged, blind, disabled • Parents or caretaker relatives of a dependent child • Youth ages 18-20 Disabled working adults	<ul style="list-style-type: none"> • Covers physical and mental health, dental (\$495 cap/yr), prescriptions, chiro (limited), transportation (limited). • Not covered: eyeglasses (except youth 18-20); dentures. • Additional benefits listed under Dr. Dynasaur (below) covered for youth 18-20. • Covers excluded classes of Medicare Part D drugs for dual-eligible individuals. 	<ul style="list-style-type: none"> • No monthly premium. • \$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 dual-eligible individuals. • \$3 dental co-pay • \$3/outpatient hospital visit • \$75/inpatient admission
Dr. Dynasaur 200% FPL	Pregnant women	Same as Medicaid.	<ul style="list-style-type: none"> • Up to 185% FPL: no premium • Up to 200% FPL: \$15/family/month • No prescription co-pays.
Dr. Dynasaur 300% FPL	Children up to age 18	Same as Medicaid but covers eyeglasses, full dental, & additional benefits.	<ul style="list-style-type: none"> • Up to 185% FPL: no premium • Up to 225% FPL: \$15/family/month • Up to 300% FPL: \$20/family/month (\$60/family/mo. w/out other insurance) • No prescription co-pays.
VHAP (Vermont Health Access Plan) -or- VHAP-ESIA (Employer Sponsored Insurance Assistance) 150% FPL/ 185% if have dependent child	Uninsured adults (some exceptions) WITHOUT access to approved ESI Uninsured adults with access to approved ESI	<ul style="list-style-type: none"> • Same as Medicaid except: no dental or transportation. • If covered by employer-sponsored insurance, VHAP wraps ESI coverage as secondary. 	<ul style="list-style-type: none"> • Up to 50% FPL: no premium • Up to 75% FPL: \$7/person/month • Up to 100% FPL: \$25/person/month • Up to 150% FPL: \$33/person/month • Up to 185% FPL (adults w/child only): \$49/person/month • Only cost-sharing is \$25 ER visit; \$1/\$2 script co-pay if income > 100%.
Catamount-ESIA (Employer Sponsored Insurance Assistance) 150%-300% FPL	Uninsured adults (some exceptions) with access to approved ESI	Covered by employer-sponsored insurance; State provides premium assistance.	<ul style="list-style-type: none"> • Coverage/cost-sharing by ESI. • Wrap-around benefits for some chronic care. • \$60-\$321/person/mo pd. to State.
CHAP (Catamount Health Premium Assistance Program) 150%-300% FPL	Uninsured adults (some exceptions) WITHOUT access to approved ESI	Covered by BCBS Catamount Blue -OR- MVP Catamount Choice.	<ul style="list-style-type: none"> • Cost sharing according to plan. • \$60-\$321/person/mo paid to State.
Catamount Health (no state assistance)	Same as directly above except income over 300% FPL (some exceptions)	Covered by BCBS Cat. Blue or MVP Catamount Choice.	<ul style="list-style-type: none"> • Cost sharing according to plan. • Full premium costs; family plans available.
VHAP Pharmacy 150% FPL VScript 175% FPL VScript Expanded 225% FPL	Aged or disabled, not eligible for Medicare, and has no script coverage	<ul style="list-style-type: none"> • VHAP Pharmacy: acute and maintenance Medicaid drugs, diabetic supplies, eye exams. • VS & VS Expanded cover maintenance drugs and diabetic supplies only. 	<ul style="list-style-type: none"> • VHAP Pharmacy: \$15/person/month • VScript: \$20/person/month • VS Expanded: \$50/person/month • \$1/\$2 prescription co-pays • VS Expanded only: manufacturer must sign supplemental agreement w/State.
VPharm1 150% FPL VPharm2 175% FPL VPharm3 225% FPL	Medicare Part D beneficiaries	<ul style="list-style-type: none"> • VPharm1 covers Part D cost-sharing & excluded classes of Part D meds, diabetic supplies, eye exams. • VPharm 2&3 cover maintenance meds & diabetic supplies only. 	<ul style="list-style-type: none"> • VPharm1: \$15/person/mo. pd to State • VPharm2: \$20/person/mo. pd to State • VPharm3: \$50/person/mo. pd to State • \$1/\$2 prescription co-pays. • VPharm1 must apply for Part D Limited Income Subsidy.

¹ Medicaid is the only program w/resource limits: \$2000/person, \$3000/couple (MWD is \$4000/person, \$6000/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

Medicare Savings Programs: QMB 100% FPL Qualified Medicare Beneficiaries SLMB 120% FPL Specified Low-Income Beneficiaries QI-1 135% FPL Qualified Individuals	<ul style="list-style-type: none"> • QMB & SLMB: Medicare beneficiaries w/ Part A • QI-1: Medicare bens. who are not on other fed. med. benefits e.g. Medicaid (LIS for Part D OK). 	<ul style="list-style-type: none"> • QMB covers Medicare Part B (and A if not free) premiums; Medicare A & B cost-sharing. • SLMB and QI-1 cover Medicare Part B premiums only. 	No cost / no monthly premium.
Healthy Vermonters 350% FPL/ 400% FPL if aged or disabled	Anyone who has no/has exhausted script coverage	<ul style="list-style-type: none"> • Discount on medications. (NOT INSURANCE) 	Beneficiary pays the Medicaid rate for all prescriptions.

Coverage Groups	Premium	FPL ³	1	2	3	4
				Household		
Medicaid PIL outside Chittenden County Medicaid PIL inside Chittenden County Medicaid Working Disabled		NA NA <250%	\$925.00 ² \$1000.00 ² \$2303.00	\$925.00 ² \$1000.00 ² \$3094.00	\$1116.00 ² \$1183.00 ² \$3886.00	\$1258.00 ² \$1333.00 ² \$4678.00
VHAP-ESIA or VHAP (if no ESI) ≤50% FPL No fee >50% but ≤75% FPL \$7/person/month >75% but ≤100% FPL \$25/person/month >100% but ≤150% FPL \$33/person/month >150% but ≤185% FPL * \$49/person/month *families with dependent children only		<185% 50% 75% 100% 150% 185%	\$460.50 \$690.75 \$921.00 \$1382.00 \$1704.00	\$619.00 \$928.50 \$1238.00 \$1857.00 \$2290.00	\$777.50 \$1166.25 \$1555.00 \$2332.00 \$2876.00	\$935.50 \$1403.20 \$1871.00 \$2807.00 \$3462.00
VPharm1/ VHAP Pharmacy \$15/person/mo VPharm2/ VScript \$20/person/mo VPharm3/ VScript Expanded \$50/person/mo		<150% <175% <225%	\$1382.00 \$1612.00 \$2072.00	\$1857.00 \$2166.00 \$2785.00	\$2332.00 \$2720.00 \$3497.00	\$2807.00 \$3274.00 \$4210.00
Dr. Dynasaur (kids up to 18 & pregnant women) Kids ≤185% FPL No Fee Pregnant women ≤ 200% FPL \$15/family/month Kids >185% but ≤ 225% FPL \$15/family/month Kids >225% but ≤ 300% FPL \$20/family/month If uninsured, \$60/family/month		<300% kids/ <200% women 185% 200% 225% 300%	\$1704.00 \$1842.00 \$2072.00 \$2763.00	\$2290.00 \$2475.00 \$2785.00 \$3713.00	\$2876.00 \$3109.00 \$3497.00 \$4663.00	\$3462.00 \$3742.00 \$4210.00 \$5613.00
Catamount-ESIA >150% but ≤ 200% FPL \$60/person/month >200% but ≤ 225% FPL \$124/person/month >225% but ≤ 250% FPL \$152/person/month >250% but ≤ 275% FPL \$180/person/month >275% but ≤ 300% FPL \$208/person/month Catamount ESIA bens' premium rates may change at start of each calendar yr.		150%-300% 200% 225% 250% 275% 300%	\$1842.00 \$2072.00 \$2303.00 \$2532.75 \$2763.00	\$2475.00 \$2785.00 \$3094.00 \$3404.50 \$3713.00	\$3109.00 \$3497.00 \$3886.00 \$4276.25 \$4663.00	\$3742.00 \$4210.00 \$4678.00 \$5145.25 \$5613.00
CHAP-Catamount Blue >150% but ≤ 200% FPL \$60/person/month >200% but ≤ 225% FPL \$122*/\$124**/person/month >225% but ≤ 250% FPL \$149*/\$152**/person/month >250% but ≤ 275% FPL \$177*/\$180**/person/month >275% but ≤ 300% FPL \$205*/\$208**/person/month * Premium for policies w/start date before 4/1/10. **Premium for policies w/start date 4/1/10 or after. CHAP premium rates may change at start of beneficiary's policy anniversary.		150%-300% 200% 225% 250% 275% 300%	\$1842.00 \$2072.00 \$2303.00 \$2532.75 \$2763.00	\$2475.00 \$2785.00 \$3094.00 \$3404.50 \$3713.00	\$3109.00 \$3497.00 \$3886.00 \$4276.25 \$4663.00	\$3742.00 \$4210.00 \$4678.00 \$5145.25 \$5613.00
CHAP-MVP Catamount Choice >150-≤ 200% FPL \$60*/ \$60** /\$70***/ \$96****/ \$173*****p/m >200-≤225% FPL \$122*/\$124**/\$134***/\$160****/\$237*****p/m >225-≤250% FPL \$149*/\$152**/\$162***/\$188****/\$265*****p/m >250-≤ 275% FPL \$177*/\$180**/\$190***/\$216****/\$293*****p/m >275-≤ 300% FPL \$205*/\$208**/\$218***/\$244****/\$321*****p/m *Policies w/start date before 4/1/10. **Policies w/ start date 4/1/10 through 6/30/10. ***Policies w/ start date 7/1/10 through 9/30/10. ****Policies w/ start date 10/1/10 through 12/31/10. *****Policies w/start date 1/1/11 or after. CHAP premium rates may change at start of beneficiary's policy anniversary.		150%-300% 200% 225% 250% 275% 300%	\$1842.00 \$2072.00 \$2303.00 \$2532.75 \$2763.00	\$2475.00 \$2785.00 \$3094.00 \$3404.50 \$3713.00	\$3109.00 \$3497.00 \$3886.00 \$4276.25 \$4663.00	\$3742.00 \$4210.00 \$4678.00 \$5145.25 \$5613.00
Medicare Savings Programs: QMB SLMB QI-1		<100% <120% <135%	\$921.00 \$1105.00 \$1244.00	\$1238.00 \$1485.00 \$1671.00	N/A	N/A
Healthy Vermonters (any age) Healthy Vermonters (aged, disabled)		<350% <400%	\$3223.00 \$3684.00	\$4332.00 \$4950.00	\$5440.00 \$6217.00	\$6548.00 \$7484.00

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

Federal Poverty Level (FPL) Guidelines 01/01/11-12/31/11

Monthly		Household Size							
		1	2	3	4	5	6	7	8
Percent of FPL	50%	460.50	614.00	777.50	935.50	1,094.00	1,252.50	1,410.50	1,569.00
	75%	690.75	921.00	1,166.25	1,403.25	1,641.00	1,878.75	2,115.75	2,353.50
	100%	921.00	1,228.00	1,555.00	1,871.00	2,188.00	2,505.00	2,821.00	3,138.00
	125%	1,151.25	1,535.00	1,943.75	2,338.75	2,735.00	3,131.25	3,526.25	3,922.50
	133%	1,224.93	1,633.24	2,068.15	2,488.43	2,910.04	3,331.65	3,751.93	4,173.54
	150%	1,382.00	1,857.00	2,332.00	2,807.00	3,282.00	3,757.00	4,232.00	4,707.00
	175%	1,612.00	2,166.00	2,720.00	3,274.00	3,829.00	4,383.00	4,937.00	5,491.00
	185%	1,704.00	2,290.00	2,876.00	3,462.00	4,047.00	4,633.00	5,219.00	5,805.00
	200%	1,842.00	2,475.00	3,109.00	3,742.00	4,375.00	5,009.00	5,642.00	6,275.00
	225%	2,072.00	2,785.00	3,497.00	4,210.00	4,922.00	5,635.00	6,347.00	7,060.00
	250%	2,303.00	3,094.00	3,886.00	4,678.00	5,469.00	6,261.00	7,053.00	7,844.00
	275%	2,532.75	3,377.00	4,276.25	5,145.25	6,017.00	6,888.75	7,757.75	8,629.50
	300%	2,763.00	3,713.00	4,663.00	5,613.00	6,563.00	7,513.00	8,463.00	9,413.00
350%	3,223.00	4,332.00	5,440.00	6,548.00	7,657.00	8,765.00	9,873.00	10,982.00	
400%	3,684.00	4,950.00	6,217.00	7,484.00	8,750.00	10,017.00	11,284.00	12,550.00	

Annual		Household Size							
		1	2	3	4	5	6	7	8
Percent of FPL	50%	5,526.00	7,368.00	9,330.00	11,226.00	13,128.00	15,030.00	16,926.00	18,828.00
	75%	8,289.00	11,052.00	13,995.00	16,839.00	19,692.00	22,545.00	25,389.00	28,242.00
	100%	11,052.00	14,736.00	18,660.00	22,452.00	26,256.00	30,060.00	33,852.00	37,656.00
	125%	13,815.00	18,420.00	23,325.00	28,065.00	32,820.00	37,575.00	42,315.00	47,070.00
	133%	14,699.16	19,598.88	24,817.80	29,861.16	34,920.48	39,979.80	45,023.16	50,082.48
	150%	16,584.00	22,284.00	27,984.00	33,684.00	39,384.00	45,084.00	50,784.00	56,484.00
	175%	19,344.00	25,992.00	32,640.00	39,288.00	45,948.00	52,596.00	59,244.00	65,892.00
	185%	20,448.00	27,480.00	34,512.00	41,544.00	48,564.00	55,596.00	62,628.00	69,660.00
	200%	22,104.00	29,700.00	37,308.00	44,904.00	52,500.00	60,108.00	67,704.00	75,300.00
	225%	24,864.00	33,420.00	41,964.00	50,520.00	59,064.00	67,620.00	76,164.00	84,720.00
	250%	27,636.00	37,128.00	46,632.00	56,136.00	65,628.00	75,132.00	84,636.00	94,128.00
	275%	30,393.00	40,524.00	51,315.00	61,743.00	72,204.00	82,665.00	93,093.00	103,554.00
	300%	33,156.00	44,556.00	55,956.00	67,356.00	78,756.00	90,156.00	101,556.00	112,956.00
350%	38,676.00	51,984.00	65,280.00	78,576.00	91,884.00	105,180.00	118,476.00	131,784.00	
400%	44,208.00	59,400.00	74,604.00	89,808.00	105,000.00	120,204.00	135,408.00	150,600.00	

Federal Match Rates

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

Federal Fiscal Year								State Fiscal Year							
FFY	From	To	Federal	ARRA	Total Federal Share	State Share		SFY	From	To	Federal	ARRA	Total Federal Share	State Share	
			Share w/o hold harmless	including hold harmless							Share w/o hold harmless	including hold harmless			
	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%		1986	7/1/1985	6/30/1986	67.64%	32.36%			
	10/01/86	09/30/87	67.37%			32.63%		1987	7/1/1986	6/30/1987	67.29%	32.71%			
	10/01/87	09/30/88	66.23%			33.77%		1988	7/1/1987	6/30/1988	66.52%	33.49%			
	10/01/88	09/30/89	63.92%			36.08%		1989	7/1/1988	6/30/1989	64.50%	35.50%			
1990	10/01/89	09/30/90	62.77%			37.23%		1990	7/1/1989	6/30/1990	63.06%	36.94%			
1991	10/01/90	09/30/91	61.97%			38.03%		1991	7/1/1990	6/30/1991	62.17%	37.83%			
1992	10/01/91	09/30/92	61.37%			38.63%		1992	7/1/1991	6/30/1992	61.52%	38.48%			
1993	10/01/92	09/30/93	59.88%			40.12%		1993	7/1/1992	6/30/1993	60.25%	39.75%			
1994	10/01/93	09/30/94	59.55%			40.45%		1994	7/1/1993	6/30/1994	59.63%	40.37%			
1995	10/01/94	09/30/95	60.82%			39.18%		1995	7/1/1994	6/30/1995	60.50%	39.50%			
1996	10/01/95	09/30/96	60.87%			39.13%		1996	7/1/1995	6/30/1996	60.86%	39.14%			
1997	10/01/96	09/30/97	61.05%			38.95%		1997	7/1/1996	6/30/1997	61.01%	38.99%			
1998	10/01/97	09/30/98	62.18%			37.82%		1998	7/1/1997	6/30/1998	61.90%	38.10%			
1999	10/01/98	09/30/99	61.97%			38.03%		1999	7/1/1998	6/30/1999	62.02%	37.98%			
2000	10/01/99	09/30/00	62.24%			37.76%		2000	7/1/1999	6/30/2000	62.17%	37.83%			
2001	10/01/00	09/30/01	62.40%			37.60%		2001	7/1/2000	6/30/2001	62.36%	37.64%			
2002	10/01/01	09/30/02	63.06%			36.94%		2002	7/1/2001	6/30/2002	62.90%	37.10%			
2003	10/01/02	09/30/03	62.41%			37.59%		2003	7/1/2002	6/30/2003	62.57%	37.43%			
fiscal relief	04/01/03	09/30/03	66.01%			33.99%					fiscal relief - Title XIX only:	63.47%	36.53%		
			Per TRRA...applies only to Title XIX (excluding DSH pymts)									no adj for DSH			
2004	10/01/03	09/30/04	61.34%			38.66%		2004	7/1/2003	6/30/2004	61.61%	38.39%			
fiscal relief	10/01/03	06/30/04	65.36%			34.64%					fiscal relief - Title XIX only:	65.52%	34.48%		
			Per TRRA...applies only to Title XIX (excluding DSH pymts)									no adj for DSH			
2005	10/01/04	09/30/05	60.11%	n/a	60.11%	39.89%		2005	7/1/2004	6/30/2005	60.42%	n/a	60.42%	39.58%	
2006	10/01/05	09/30/06	58.49%	n/a	58.49%	41.51%		2006	7/1/2005	6/30/2006	58.90%	n/a	58.90%	41.10%	
2007	10/01/06	09/30/07	58.93%	n/a	58.93%	41.07%		2007	7/1/2006	6/30/2007	58.82%	n/a	58.82%	41.18%	
2008	10/01/07	09/30/08	59.03%	n/a	59.03%	40.97%		2008	7/1/2007	6/30/2008	59.01%	n/a	59.01%	40.99%	
2009	10/01/08	09/30/09						2009	7/1/2008	6/30/2009					
	Non-ARRA		59.45%	n/a	59.45%	40.55%			Non-ARRA		59.35%	n/a	59.35%	40.65%	
	ARRA e-FMAP		59.45%	9.38%	68.83%	31.17%			ARRA e-FMAP		59.35%	6.76%	66.10%	33.90%	
2010	10/01/09	09/30/10						2010	7/1/2009	6/30/2010					
	Non-ARRA		58.73%	n/a	58.73%	41.27%			Non-ARRA		58.91%	n/a	58.91%	41.09%	
	ARRA e-FMAP		58.73%	11.23%	69.96%	30.04%			ARRA e-FMAP		58.91%	11.05%	69.96%	30.04%	
2011	10/01/10	09/30/11						2011	7/1/2010	6/30/2011					
	Non-ARRA		58.71%	n/a	58.71%	41.29%			Non-ARRA		58.72%	n/a	58.72%	41.28%	
	ARRA e-FMAP (consensus)		58.71%	6.25%	64.96%	35.04%			ARRA e-FMAP (consensus)		58.72%	9.05%	67.77%	32.23%	
2012 Proj.	10/01/11	09/30/12						2012 Proj	7/1/2011	6/30/2012					
	Non-ARRA		57.58%	n/a	57.58%	42.42%			Non-ARRA		57.86%	n/a	57.86%	42.14%	

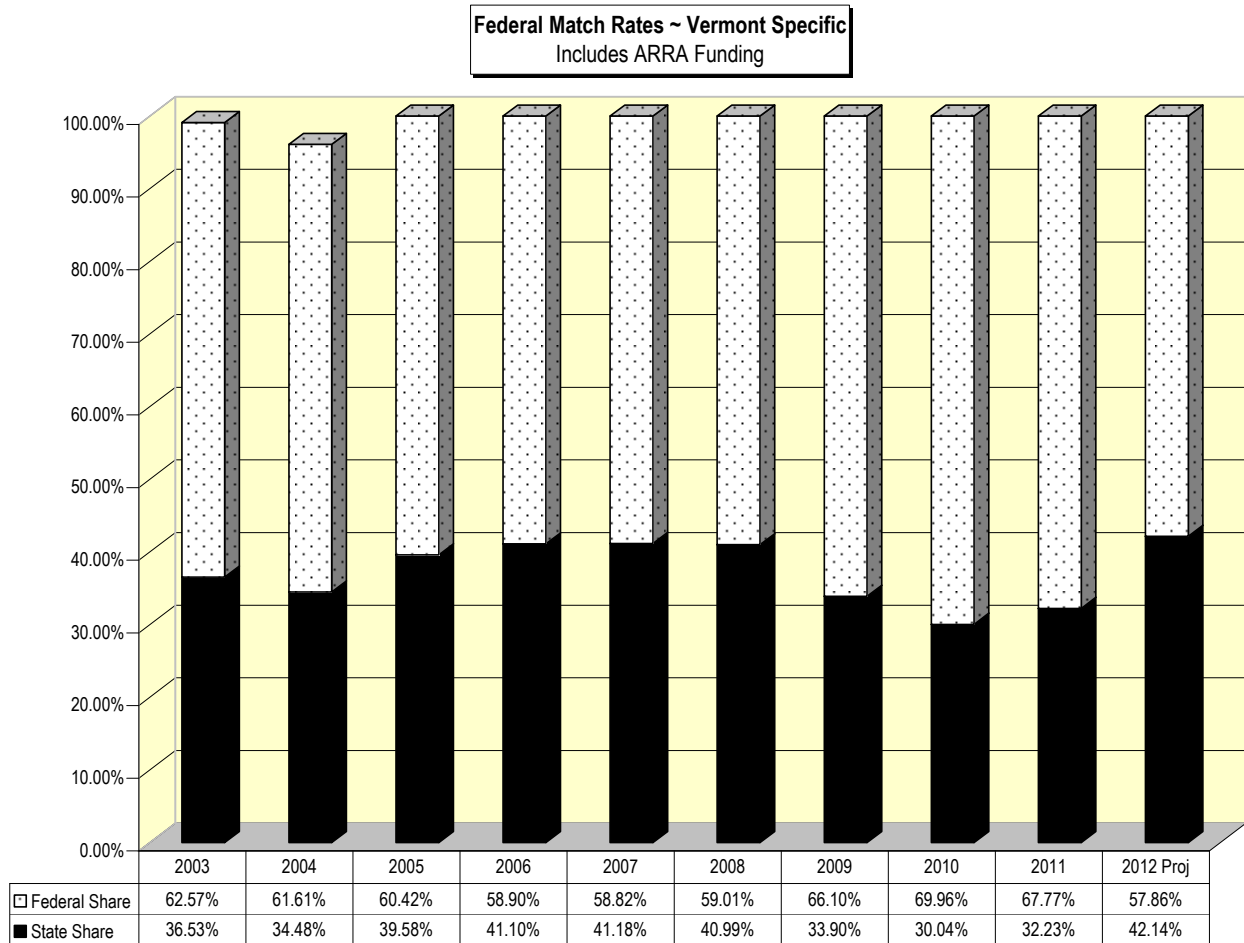
down rate. FY12 reflects FFIS projection.

enhancement at stepped-down rate. FY12 reflects FFIS projection.

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

Federal Fiscal Year					State Fiscal Year				
FFY	From	To	Federal Share	State Share	SFY	From	To	Federal Share	State Share
1999	10/01/98	09/30/99	73.38%	26.62%	1999	07/01/98	06/30/99	73.38%	26.62%
2000	10/01/99	09/30/00	73.57%	26.43%	2000	07/01/99	06/30/00	73.52%	26.48%
2001	10/01/00	09/30/01	73.68%	26.32%	2001	07/01/00	06/30/01	73.65%	26.35%
2002	10/01/01	09/30/02	74.14%	25.86%	2002	07/01/01	06/30/02	74.03%	25.97%
2003	10/01/02	09/30/03	73.69%	26.31%	2003	07/01/02	06/30/03	73.80%	26.20%
2004	10/01/03	09/30/04	72.94%	27.06%	2004	07/01/03	06/30/04	73.13%	26.87%
2005	10/01/04	09/30/05	72.08%	27.92%	2005	07/01/04	06/30/05	72.30%	27.71%
2006	10/01/05	09/30/06	70.94%	29.06%	2006	07/01/05	06/30/06	71.23%	28.78%
2007	10/01/06	09/30/07	71.25%	28.75%	2007	07/01/06	06/30/07	71.17%	28.83%
2008	10/01/07	09/30/08	71.32%	28.68%	2008	07/01/07	06/30/08	71.30%	28.70%
2009	10/01/08	09/30/09	71.62%	28.38%	2009	07/01/08	06/30/09	71.55%	28.45%
2010	10/01/09	09/30/10	71.11%	28.89%	2010	07/01/09	06/30/10	71.24%	28.76%
2011	10/01/10	09/30/11	71.10%	28.90%	2011	07/01/10	06/30/11	71.10%	28.90%
2012 Proj.	10/01/11	09/30/12	70.31%	29.69%	2012 Proj	07/01/11	06/30/12	70.51%	29.49%

Federal Match Rates - Vermont Specific



MCO Investment Expenditures

Department	Investment Description	SFY06 Actuals -				
		3/4 SFY	SFY07 Actuals	SFY08 Actuals	SFY09 Actuals	SFY10 Actuals
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	\$ 179,284
BISHCA	Health Care Administration	\$ 983,637	\$ 914,629	\$ 1,340,728	\$ 1,871,651	\$ 1,713,959
DII	Vermont Information Technology Leaders (moved to DVHA in SFY10)	\$ 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	\$ 4,006,152
AHSCO	2-1-1 Grant	\$ -	\$ -	\$ -	\$ 415,000	\$ 415,000
VDH	Emergency Medical Services	\$ 174,482	\$ 436,642	\$ 626,728	\$ 427,056	\$ 425,870
VDH	AIDS Services/HIV Case Management	\$ 152,945	\$ -	\$ -	\$ -	\$ -
VDH	TB Medical Services	\$ 27,052	\$ 29,129	\$ 15,872	\$ 28,359	\$ 41,313
VDH	Epidemiology	\$ 326,708	\$ 427,075	\$ 416,932	\$ 204,646	\$ 241,932
VDH	Health Research and Statistics	\$ 276,673	\$ 403,244	\$ 404,431	\$ 217,178	\$ 254,828
VDH	Health Laboratory	\$ 1,369,982	\$ 1,908,982	\$ 2,012,252	\$ 1,522,578	\$ 1,875,487
VDH	Tobacco Cessation: Community Coalitions	\$ 938,056	\$ 1,647,129	\$ 1,144,713	\$ 1,016,685	\$ 535,573
VDH	Statewide Tobacco Cessation	\$ -	\$ -	\$ -	\$ 230,985	\$ 484,998
VDH	Family Planning	\$ 365,320	\$ 122,961	\$ 169,392	\$ 300,876	\$ 300,876
VDH	Physician/Dentist Loan Repayment Program	\$ 810,716	\$ 439,140	\$ 930,000	\$ 1,516,361	\$ 970,000
VDH	Renal Disease	\$ 15,000	\$ 7,601	\$ 16,115	\$ 15,095	\$ 2,053
VDH	Newborn Screening	\$ 74,899	\$ 166,795	\$ 136,577	\$ -	\$ -
VDH	WIC Coverage	\$ 161,804	\$ 1,165,699	\$ 562,446	\$ 86,882	\$ -
VDH	Vermont Blueprint for Health	\$ 92,049	\$ 1,975,940	\$ 753,087	\$ 1,395,135	\$ 1,417,770
VDH	Area Health Education Centers (AHEC)	\$ -	\$ 35,000	\$ 310,000	\$ 565,000	\$ 725,000
VDH	Community Clinics	\$ -	\$ -	\$ -	\$ 640,000	\$ 468,154
VDH	FQHC Lookalike	\$ -	\$ -	\$ 30,000	\$ 105,650	\$ 81,500
VDH	Patient Safety - Adverse Events	\$ -	\$ -	\$ 190,143	\$ 100,509	\$ 44,573
VDH	Coalition of Health Activity Movement Prevention Program (CHAMPPS)	\$ -	\$ 100,000	\$ 291,298	\$ 486,466	\$ 412,043
VDH	Substance Abuse Treatment	\$ 1,466,732	\$ 2,514,963	\$ 2,744,787	\$ 2,997,668	\$ 3,000,335
VDH	Recovery Centers	\$ 171,153	\$ 287,374	\$ 329,215	\$ 713,576	\$ 716,000
VDH	Immunization	\$ -	\$ -	\$ -	\$ 726,264	\$ -
VDH	DMH Investment Cost in CAP	\$ -	\$ -	\$ -	\$ 64,843	\$ -
VDH	Poison Control	\$ -	\$ -	\$ -	\$ -	\$ 176,340
DMH	Special Payments for Treatment Plan Services	\$ 101,230	\$ 131,309	\$ 113,314	\$ 164,356	\$ 149,068
DMH	MH Outpatient Services for Adults	\$ 775,899	\$ 1,393,395	\$ 1,293,044	\$ 1,320,521	\$ 864,815
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	\$ 802,579
DMH	Mental Health CRT Community Support Services	\$ 2,318,668	\$ 602,186	\$ 807,539	\$ 1,124,728	\$ -
DMH	Mental Health Children's Community Services	\$ 1,561,396	\$ 3,066,774	\$ 3,341,602	\$ 3,597,662	\$ 2,569,759
DMH	Emergency Mental Health for Children and Adults	\$ 1,885,014	\$ 1,988,548	\$ 2,016,348	\$ 2,165,648	\$ 1,797,605
DMH	Respite Services for Youth with SED and their Families	\$ 385,581	\$ 485,586	\$ 502,237	\$ 412,920	\$ 516,677
DMH	CRT Staff Secure Transportation	\$ -	\$ -	\$ 52,242	\$ -	\$ -
DMH	Recovery Housing	\$ -	\$ -	\$ 235,267	\$ -	\$ 332,635
DMH	Transportation - Children in Involuntary Care	\$ 4,768	\$ 1,075	\$ -	\$ -	\$ -
DMH	Vermont State Hospital Records	\$ -	\$ -	\$ -	\$ -	\$ 19,590
DVHA	Vermont Information Technology Leaders (moved from DII in SFY10)	\$ -	\$ -	\$ -	\$ -	\$ 339,500
DVHA	Buy-In	\$ 4,594	\$ 314,376	\$ 419,951	\$ 248,537	\$ 200,868
DVHA	Vscript Expanded	\$ 1,695,246	\$ -	\$ -	\$ -	\$ -
DVHA	HIV Drug Coverage	\$ 31,172	\$ 42,347	\$ 44,524	\$ 48,711	\$ 38,904
DVHA	Civil Union	\$ 373,175	\$ 543,986	\$ 671,941	\$ 556,811	\$ 627,976
DVHA	Vpharm	\$ -	\$ -	\$ -	\$ 278,934	\$ 210,796
DVHA	Hospital Safety Net Services	\$ -	\$ -	\$ 281,973	\$ -	\$ -
DCF	Family Infant Toddler Program	\$ -	\$ 199,064	\$ 326,424	\$ 335,235	\$ 81,086
DCF	Medical Services	\$ 69,893	\$ 91,569	\$ 120,494	\$ 65,278	\$ 45,216
DCF	Residential Care for Youth/Substitute Care	\$ 9,181,386	\$ 10,536,996	\$ 10,110,441	\$ 9,392,213	\$ 8,033,068
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	\$ 2,827,617
DCF	Aid to the Aged, Blind and Disabled Res Care Level III	\$ -	\$ 143,975	\$ 170,117	\$ 172,173	\$ 137,356
DCF	Aid to the Aged, Blind and Disabled Res Care Level IV	\$ 210,989	\$ 312,815	\$ 349,887	\$ 366,161	\$ 299,488
DCF	Essential Person Program	\$ 542,382	\$ 675,860	\$ 614,974	\$ 620,052	\$ 485,536
DCF	GA Medical Expenses	\$ 254,154	\$ 339,928	\$ 298,207	\$ 380,000	\$ 583,080
DCF	CUPS/Early Childhood Mental Health	\$ -	\$ -	\$ 52,825	\$ 499,143	\$ 166,429
DCF	VCRHYP/Vermont Coalition for Runaway and Homeless Youth Program	\$ -	\$ -	\$ 1,764,400	\$ -	\$ -
DCF	HBKF/Healthy Babies, Kids & Families	\$ -	\$ -	\$ 318,321	\$ 63,921	\$ -
DCF	Catamount Administrative Services	\$ -	\$ -	\$ -	\$ 339,894	\$ -
DCF	Therapeutic Child Care	\$ -	\$ -	\$ -	\$ 978,886	\$ 577,259
DCF	Lund Home	\$ -	\$ -	\$ -	\$ 325,516	\$ 175,378
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	\$ 469,770
DDAIL	Flexible Family/Respite Funding	\$ 1,086,291	\$ 1,135,213	\$ 1,341,698	\$ 1,364,896	\$ 1,114,898
DDAIL	Quality Review of Home Health Agencies	\$ -	\$ 77,467	\$ 186,664	\$ 126,306	\$ 90,227
DOC	Intensive Substance Abuse Program (ISAP)	\$ 382,230	\$ 299,602	\$ 310,610	\$ 200,000	\$ 591,004
DOC	Intensive Sexual Abuse Program	\$ 72,439	\$ 46,078	\$ 85,542	\$ 88,523	\$ 68,350
DOC	Intensive Domestic Violence Program	\$ 109,692	\$ 134,663	\$ 230,353	\$ 229,166	\$ 173,938
DOC	Women's Health Program (Tapestry)	\$ 460,130	\$ 487,344	\$ 487,231	\$ 527,956	\$ -
DOC	Community Rehabilitative Care	\$ 1,038,114	\$ 1,982,456	\$ 2,031,408	\$ 1,997,499	\$ 2,190,924
DOC	Return House	\$ -	\$ -	\$ -	\$ 51,000	\$ -
DOC	Northern Lights	\$ -	\$ -	\$ -	\$ -	\$ 40,000
		\$ 45,455,809	\$ 55,495,719	\$ 59,918,097	\$ 62,419,988	\$ 55,554,314

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Acronyms

AAA.....	Area Agency on Aging	BISHCA.....	Banking, Insurance, Securities, & Health Care Administration (Department of)
AABD	Aid to the Aged, Blind & Disabled	BP	Blueprint for Health
AAG.....	Assistant Attorney General	BPM	Business Process Management
AAP	American Academy of Pediatrics	BPS.....	Benefits Programs Specialist
ABAWD	Able-Bodied Adults without Dependents	BROC.....	Bennington-Rutland Opportunity Council
ABD.....	Aged, Blind and Disabled	CAHPS.....	Consumer Assessment of Health Plans Survey
ACA.....	Affordable Care Act	CAP.....	Community Action Program
ACCESS.....	The computer software system used by DCF and DVHA to track program eligibility information	CC.....	Committed Child
ACF.....	Administration for Children & Families	CCI	Chronic Care Initiative
ACO.....	Accountable Care Organization	CCMP.....	Chronic Care Management Program
ADA.....	American Dental Association	CCTA.....	Chittenden County Transportation Authority
ADAP.....	Alcohol and Drug Abuse Programs	CF.....	Crisis Fuel
AEP	Annual Enrollment Period	CFR.....	Code of Federal Regulations
AGA.....	Adult General Assessment	CHAP.....	Catamount Health Assistance Program
AHCPR.....	Agency for Health Care Policy & Research	CHF.....	Congestive Heart Failure
AHEC.....	Area Health Education Center	CHIPRA.....	Children's Health Insurance Program Re-authorization Act of 2009
AHRQ	Agency for Healthcare Research & Quality	CHPR	Center for Health Policy and Research
AHS.....	Agency of Human Services	CIO	Chief Information Office
AIM®.....	Advanced Information Management system (see MMIS)	CIS	Children's Integrated Services
AIRS.....	Automated Information and Referral System	CM.....	Case Management
A/I/U	Adopt/Implement/Upgrade	CMN.....	Certification of Medical Necessity
ALS	Advanced Life Support	CMS.....	Centers for Medicare & Medicaid Services (formerly HCFA)
AMA	American Medical Association	CMSO.....	Center for Medicaid & State Operations
AMAP.....	Aids Medication Assistance Program	CNM	Certified Nurse Midwife
AMP	Average Manufacturer Price	COA.....	Council on Aging
ANFC.....	Aid to Needy Families with Children	COB	Coordination of Benefits
AOA.....	Agency of Administration	COB-MAT.....	Coordination of Office Based Medication Assisted Therapy
APA	Administrative Procedures Act	CON.....	Certificate of Need
APC.....	Ambulatory Payment Classification	COPD	Chronic Obstructive Pulmonary Disease
APD	Advance Planning Document	COPS.....	Computer Operations and Problem Solving
APS	Adult Protective Services	COS	Categories of Service
APS.....	APS Healthcare	CPH.....	Community Public Health (of the VDH)
ARRA.....	American Recovery and Reinvestment Act of 2009	CPI.....	Center for Program Integrity
ASD.....	Administrative Services Division	CPT.....	Common Procedural Terminology
AWP.....	Average Wholesale Price	CPTOD.	Capitated Program for the Treatment of Opiate Dependency
BAFO	Best & Final Offer	CRT.....	Community Rehabilitation & Treatment
BC/BS.....	Blue Cross/Blue Shield	CSBG	Community Services Block Grant
BCCT.....	Breast and Cervical Cancer Treatment Program	CSD.....	Computer Services Division
BD	Blind & Disabled	CSHN	Children with Special Health Needs
		CSME.....	Coverage & Services Management Enhancement

CSR	Customer Service Request	EP.....	Essential Person
CURB	Clinical Utilization Review Board	EPSDT.....	Early & Periodic Screening, Diagnosis & Treatment
CY	Calendar Year	EQR	External Quality Review
DAD.....	Department of Aging & Disabilities (see DAIL)	ER	Emergency Room
DAIL.....	Department of Disabilities, Aging and Independent Living	ERA	Electronic Remittance Advice
DCF.....	Department for Children and Families	ERC.....	Enhanced Residential Care
DDI.....	Design, Development & Implementation	ESD.....	Economic Services Division (of the DCF)
DDMHS.....	Department of Developmental & Mental Health Services	ESL.....	Employer Sponsored Insurance
DDS.....	Disability Determination Services (part of DCF)	ESRD	End Stage Renal Disease
DHHS.....	Department of Health & Human Services (United States)	EST.....	Eastern Standard Time
DIL.....	Department of Information & Innovation	EVAH.....	Enhanced VT Ad Hoc (query & reporting system)
DIS	Detailed Implementation Schedule	EVS	Eligibility Verification System
DME.....	Durable Medical Equipment	FA	Fiscal Agent
DMC	Disease Management Coordinators	FADS.....	Fraud Abuse & Detection System
DMH.....	Department of Mental Health	FDA	Food & Drug Administration
DO.....	District Office	FEIN.....	Federal Employer's Identification Number
DOA.....	Date of Application	FFP.....	Federal Financial Participation
DOB	Date of Birth	FFS.....	Fee for Service
DOC.....	Department of Corrections	FFY.....	Federal Fiscal Year
DOE	Department of Education	FH.....	Fair Hearing
DOH	Department of Health (see VDH)	FICA.....	Federal Insurance Contribution Act
DOL	Department of Labor	FMAP.....	Federal Medical Assistance Percentage
DOS.....	Date of Service	FPL	Federal Poverty Level
DR.....	Desk Review	FQHC.....	Federally Qualified Health Centers
DRA	Deficit Reduction Act	FUL.....	Federal Upper Limit (for pricing & payment of drug claims)
DR. D.....	Dr. Dinosaur Program	GA	General Assistance
DRG	Diagnosis Related Grouping	GAO	General Accounting Office
DSH.....	Disproportionate Share Hospital	GC.....	Global Commitment
DSW.....	Department of Social Welfare (see PATH)	GCR.....	Global Clinical Record (application of the MMIS)
DUR	Drug Utilization Review (Board)	GF.....	General Fund
DVHA.....	Department of Vermont Health Access	GMC.....	Green Mountain Care
EA	Emergency Assistance	HAEU.....	Health Access Eligibility Unit
EAC.....	Estimated Acquisition Cost	HATF.....	Health Access Trust Fund
EBT.....	Electronic Benefit Transfer	HBE	Health Benefit Exchange
ECS.....	Electronic Claims Submission	HCBS.....	Home and Community Based Services
EDI.....	Electronic Data Interchange	HCERA	Health Care & Education Reconciliation Act of 2010
EDS	Electronic Data Systems Corporation, now HP Enterprise Services	HCFA.....	Health Care Finance Administration (now CMS)
EFT	Electronic Funds Transfer	HCPCS.....	HCFA Common Procedure Coding System
EGA	Estimated Gestational Age	HCR	Health Care Reform
EHR.....	Electronic Health Record	HEDIS.....	Healthcare Effectiveness Data & Information Set
EITC.....	Earned Income Tax Credit	HHA.....	Home Health Agency
EOMB.....	Explanation of Medicare (or Medicaid) Benefits		

HHS.....	Health and Human Services (U.S. Department of)	MA.....	Medicare Advantage – Medicare Part C in VT
HIE.....	Health Information Exchange	MAB.....	Medicaid Advisory Board
HIFA.....	Health Insurance Flexibility and Accountability	MAC.....	Maximum Allowable Cost (refers to drug pricing)
HIPAA.....	Health Insurance Portability & Accountability Act	MAPIR	Medicaid Assistance Provider Incentive Repository
HIPP.....	Health Insurance Premium Program	MARS.	Management & Administrative Reporting
HIT.....	Health Information Technology	MAT.....	Medication Assisted Therapy
HITECH	HIT for Economic & Clinical Health	MCE.....	Managed Care Entity
HP.....	HP Enterprise Services, formerly EDS	MCH.....	Maternal and Child Health
HPIU	Health Programs Integration Unit	MCMC.....	Managed Care Medical Committee
HRA.....	Health Risk Assessment	MCO.....	Managed Care Organization
HRAP	Health Resource Allocation Plan	MCP.....	Managed Care Plan
HRSA.....	Health Resources and Services Administration	MDB.....	Medicare Database
HSB.....	Human Services Board	MEQC.....	Medicaid Eligibility Quality Control
HVP.....	Healthy Vermonters Program	MES.....	Medicaid Enterprise Solution
IAPD.....	Implementation Advance Planning Document	MFP.....	Money Follows the Person
IBNR.....	Incurred But Not Reported	MFRAU.....	Medicaid Fraud & Residential Abuse Unit
IC.....	Individual Consideration	MID.....	Beneficiary Medicaid Identification Number (see UID)
ICD.....	International Classification of Diseases	MIC.....	Medicaid Integrity Contractor
ICEHR	Integrated Care Electronic Health Record	MIG	Medicaid Integrity Group
ICF/MR.....	Intermediate Care Facility for the Mentally Retarded	MIP	Medicaid Integrity Program
ICM	Integrated Care Management	MIS.....	Management Information System
ICN.....	Internal Control Number	MITA.....	Medicaid Information Technology Architecture
ICU.....	Intensive Care Unit	MMA.....	Medicare Modernization Act
ID.....	Identification	MMIS.....	Medicaid Management Information System
IDN.....	Integrated Delivery Network	MNF.....	Medical Necessity Form
IEP.....	Individual Education Plan	MOE.....	Maintenance of Effort
IEVS.....	Income Eligibility Verification System	MOE.....	Maintenance of Eligibility
IGA.....	Intergovernmental Agreements	MOVE.....	Modernization of Vermont’s Enterprise
IHI.....	Institute for Healthcare Improvement	MSIS.....	Medicaid Statistical Information
IRS.....	Internal Revenue Service	MSP.....	Medicare Savings Programs
IT.....	Information Technology	MU.....	Meaningful Use
ITF.....	Integrated Test Facility	MVP.....	Mohawk Valley Physicians
IVS.....	Intervention Services	NAMI.....	National Association for Mental Illness
JCL.....	Job Control Language	NCBD.....	National CAHPS Benchmarking Database
LAMP.....	Legal Aid Medicaid Project	NCCI	National Correct Coding Initiative
LAN.....	Local Area Network	NDC.....	National Drug Code
LC.....	Legislative Council	NEKCA.....	Northeast Kingdom Community Action
LECC.....	Legally Exempt Child Care	NEMT	Non-Emergency Medical Transportation
LIHEAP.....	Low-Income Home Energy Assistance Program	NGA.....	National Governors Association
LIS.....	Low-Income Subsidy	NP.....	Nurse Practitioner or Naturopathic Physician
LIT.....	Local Interagency Team		
LTC.....	Long-Term Care		
LUPA.....	Low Utilization Payment Adjustment		


NPA	Non-Public Assistance	PP&D.....	Policy, Procedures and Development (Interpretive Rule Memo)
NPF	National Provider File	PPACA	Patient Protection & Affordable Care Act
NPI.....	National Provider Identifier	PPR.....	Planning, Policy and Regulation
OADAP.....	Office of Alcohol & Drug Abuse Programs	PRO	Peer Review Organization
OASDI.....	Old Age, Survivors, Disability Insurance	PRWORA.....	Personal Responsibility & Work Opportunity Reconciliation Act
OASIS	Organization for the Advancement of Structured Information Standards	PSE.....	Post-Secondary Education
OCS.....	Office of Child Support	PSTG	Private Sector Technology Group
ODAP	Office of Drug & Alcohol Prevention	QC	Quality Control
OEO	Office of Economic Opportunity	QI.....	Qualified Individual
OHRA.....	Oral Health Risk Assessment	QIAC.....	Quality Improvement Advisory Committee
OLTP.....	Online Transaction Processing	QMB	Qualified Medicare Beneficiary
OPS	Operations	QWDI.....	Qualified Working Disabled Individual
OPPS.....	Outpatient Prospective Payment System	RA.....	Remittance Advice
OTC.....	Over the Counter	RAC.....	Recovery Audit Contractor
OVHA	Office of Vermont Health Access (DVHA as of 07/01/2010)	RBC.....	Risk Based Capital
PA.....	Prior Authorization or Public Assistance	RBUC	Reported But Unpaid Claims
PA	Physician Assistant	REVS	Recipient Eligibility Verification System
PACE.....	Program for All-Inclusive Care for the Elderly	RFI	Request for Information
PARIS.....	Public Assistance Reporting Information System	RFP	Request for Proposals
PATH.....	Department of Prevention, Assistance, Transition, & Health Access (now DCF)	RN	Registered Nurse
PBA/PBM...	Pharmacy Benefits Administrator / Pharmacy Benefits Manager	RO.....	Regional Office
PC Plus	VT Primary Care Plus	RR.....	Railroad Retirement
PCCM	Primary Care Case Management	RU.....	Reach Up program
PCIP	Pre-existing Condition Insurance Plan	RVU	Relative Value Units
PCMH.....	Patient-Centered Medical Home	SAMHSA...	Substance Abuse and Mental Health Services Administration
PCP	Primary Care Provider	SAS	Statement on Auditing Standards
PDF	Portable Document File	SCHIP	State Children's Health Insurance Program
PDL.....	Preferred Drug List	SDO	Standards Development Organization
PDP	Prescription Drug Plan	SDX.....	State Data Exchange System
PDSA	Plan Do Study Act	SE.....	Systems Engineer
PEP.....	Proposal Evaluation Plan or Principal Earner Parent	SEP.....	Special Enrollment Periods
PERM.....	Payment Error Rate Measurement	SF.....	Supplemental Fuel
PES	Provider Electronic Solutions	SFY.....	State Fiscal Year
PHO	Physician Hospital Organization	SGF	State General Fund
PI.....	Program Integrity	SILC.....	Statewide Independent Living Council
PIL.....	Protected Income Level	SLHIE.....	State Level HIE Consensus Project
PIRL	Plan Information Request Letter	SLMB.....	Specified Low-Income Medicare Beneficiary
PM.....	Project Manager	SMDL	State Medicaid Directors Letter
PMPM.....	Per Member Per Month	SMHP	State Medicaid HIT Plan
PNMI.....	Private Non-Medical Institution	SMM.....	State Medicaid Manual
POC.....	Plan of Care	SNAP.....	State Nutritional Assistance Program
POS	Point of Sale or Point of Service	SNF.....	Skilled Nursing Facility
		SOA	Service Oriented Architecture
		SPA.....	State Plan Amendment

SPAP..... State Pharmacy Assistance Program	VCIL Vermont Center for Independent Living
SRS Social & Rehabilitative Services (Department of)	VDH.....VT Department of Health
SSA..... Social Security Administration or State Self Assessment	VDHAVT Dental Hygienists Association
SSBG Social Services Block Grant	VHAP... ..VT Health Access Plan
SSI Supplemental Security Income	VHAP-Rx.....VT Health Access Plan Pharmacy Program
SSN Social Security Number	VIPVT Independence Project
SSO..... Standards Setting Organization	VISIONVT's Integrated Solution for Information and Organizational Needs (the statewide accounting system)
SUR..... Surveillance & Utilization Review	VIT.....VT Interactive Television
TAD Turnaround Documents	VITLVT Information Technology Leaders
TANF Temporary Assistance for Needy Families (Reach Up in VT)	VLA.....VT Legal Aid
TARB Technical Architecture Review Board	VMS.....VT Medical Society
TBI..... Traumatic Brain Injury	VNA Visiting Nurses Association
TIN..... Taxpayer Identification Number	VPHARMVT Pharmacy Benefits Program
TM..... Transitional Medicaid	VPQHCVT Program for Quality in Health Care
TPA Third Party Administrator	VPTA.....Vermont Public Transportation Agency
TPL..... Third Party Liability	VR.....Vocational Rehabilitation
UC Unemployment Compensation	VRS.....Voice Response System
UCR.....Usual & Customary Rate	VSA.....VT Statutes Annotated
UCUM Unified Code for Units of Measure	VSAC.....VT Student Assistance Corporation
UI.....Unemployment Insurance	VScript.....VT Pharmacy Benefits Program
UIB.....Unemployment Insurance Benefits	VSDSVT State Dental Society
UID Unique Identification Number	VSEA.....VT State Employees Association
UM..... Utilization Management	VSECU.....VT State Employees Credit Union
UMLS..... Unified Medical Language System	VSH.....VT State Hospital
UR Utilization Review	VSHA.....VT State Housing Authority
UVM University of Vermont	VTState of Vermont
VA Veterans Administration	VTD.....VT Part D as Primary
VAB..... VT Association for the Blind	VTMVT Medicaid as Primary
VAHHA VT Assembly of Home Health Agencies	VULVT Upper Limit
VAHHS..... VT Association of Hospital & Health Systems	WAC.....Wholesale Acquisition Cost
VCCI.....VT Chronic Care Initiative	WAM.....Welfare Assistance Manual
	WICWomen, Infants & Children
	WTW.....Welfare to Work

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State of Vermont**Department of Vermont Health Access**
312 Hurricane Lane, Suite 201
Williston VT 05495-2807
dvha.vermont.gov[Phone] 802-879-5900
[Fax] 802-879-5651*Agency of Human Services*

TO: Senator Claire Ayer, Chair, Senate, Health and Welfare Committee
Representative Mark Larson Chair, House Health Care Committee

FROM: Susan Besio, Commissioner 

DATE: January 13, 2011

SUBJECT: Required Annual Report on Implementation of the Clinical Utilization review Board

This memo is to serve as the required annual report per Section C34 of Act 146 of 2010:

The department shall conduct comprehensive evaluations of the board's success in improving clinical and utilization outcomes using claims data and a survey of health care professional satisfaction. The department shall report annually by January 15 to the house committee on health care and the senate committee on health and welfare regarding the results of the most recent evaluation or evaluations and a summary of the board's activities and recommendations since the last report.

Annual Report

The Clinical Utilization Review Board (CURB) was created by the Department of Vermont Health Access (DVHA) as a Challenges for Change Initiative for SFY '11. The purpose of the CURB is to examine existing medical services, emerging technologies, and relevant evidence-based clinical practice guidelines and make recommendations to the DVHA regarding coverage, unit limitations, place of service, and appropriate medical necessity of services for the Vermont Medicaid program.

By statute, the board is comprised of 10 members with diverse medical expertise appointed by the governor upon the recommendation of the commissioner of DVHA. The medical director of DVHA serves as state liaison and moderator for the CURB. During spring and summer of 2010, the DVHA medical director sought input to board member selection from the Vermont Medical Society, the University of Vermont Office of the Dean, and other state and public stakeholders. Due to the desire to ensure that the membership was represented by a range of medical professions and by geographic diversity, it took longer than originally anticipated to conclude the Governor appointments; as such the CURB was not fully formed until early October 2010.

Following is a list of the CURB members:

Michel Benoit, MD, UVM, Orthopedic Surgeon, Hand Surgery, Shelburne
Patricia Berry, MPH, UVM, VCHIP, Burlington
Delores Burroughs-Biron, MSN, MD, Family Medicine
David Butsch, MD, General Surgeon, Barre
Molly Hastings, MD, Ophthalmologist, Williston
Adam Kunin, MD, UVM, Cardiologist, Shelburne
William Minsinger, MD, Orthopedic Surgeon, Randolph
Paul Penar, MD, UVM, Neurosurgeon, Shelburne
Norman Ward, MD, UVM, Family Medicine, Burlington

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January 13, 2011

The CURB convened for its first meeting on October 20, 2010, and has met monthly for a total of three meetings through 2010. The CURB duties and responsibilities include identifying opportunities to improve quality, efficiency, and adherence to evidence-based clinical practice guidelines, and making recommendations to the commissioner of DVHA regarding the most appropriate mechanism to implement the recommended utilization controls for provision of evidence-based clinical practice guidelines. DVHA provides CURB members per diem compensation for each meeting and food service for dinner before the meeting. DVHA filled one full-time position to provide data support to the CURB to start in January, 2011. In the interim, DVHA has responded to the CURB requests for data through currently employed data analysts.

Over the past three meetings, the DVHA medical director presented the CURB an overview of the guiding principles of Medicaid coverage, a review of utilization controls, and a review of program costs for medical services. The clinical unit director presented the steps for evaluation of prior authorization requests, exception requests, appeals, requests for non-covered services, and pharmacy authorizations and DVHA use of proprietary sources for medical criteria and coding manuals. The CURB members have provided suggestions regarding transportation services, emergency room services, services provided by geographic area, use of case management, reduction of administration barriers, provider incentives to increase participation, ambulance services, and personal care services.

The CURB members also requested data regarding out-of-state services. Currently DVHA only requires prior authorization for inpatient services out-of-state. The CURB was presented data on total number of outpatient services provided out-of-state, services provided and reimbursed to each state, the composite list of services provided to beneficiaries by specific coded service, and the specific providers for each state. The board members provided suggestions to ensure appropriate use of out-of-state services which will be summarized and presented by DVHA at the January 19, 2011, meeting. The CURB also has begun discussions on the use of the negative pressure wound closure system for Vermont Medicaid beneficiaries and mechanisms to ensure that evidence-based clinical practice guidelines are followed by providers.

Given the delay in the start of the CURB meetings, DVHA is still assessing whether the projected \$4 million in net gross savings can be achieved for SFY11. However, while the savings specific to this initiative may not be fully recognized in SFY '11 due to the project delays, DVHA's overall spending levels this year are such that we can cover the overall targets for this Challenge initiative.

cc: Michael Farber, MD
Doug A. Racine
Patrick Flood
Jim Giffin

MEMORANDUM

TO: Representative Mark Larson, Chair, House Committee on Health Care
Representative Ann Pugh, Chair, House Committee on Human Services
Senator Claire Ayer, Chair, Senate Committee on Health & Welfare

FROM: Hunt Blair, Director, Division of Health Care Reform

DATE: January 13, 2011

RE: Report on Hospital-sited Primary Care Clinics Challenges for Change Initiative

Section C32 of Act 146 of 2010, the legislation implementing the Challenges for Change initiatives, includes a short section asking the Department to explore development of hospital-sited primary care clinics that would help to divert patients with non-emergency level of care needs from hospital Emergency Departments (ED) to primary care sites located on or near the hospital campus.

Sec. C32. EXPANSION OF HEALTH CLINICS; FQHCS

The department of Vermont health access shall collaborate with the federally qualified health centers and other interested parties to create urgent care clinics to ensure that nonemergency health services are available outside emergency departments in hospitals, especially during evenings and weekends. The department may apply or may assist the FQHCs in applying for federal grants funds available for clinics, including nurse-managed health clinics. By January 15, 2011, the department shall provide a progress report on this initiative, with any recommendations, to the house committees on health care and on human services and the senate committee on health and welfare.

The anticipated benefit of this initiative would be to reduce overall costs to the health care system by helping to ensure that patients seeking primary care through EDs have access to alternative, less costly settings. There was not a state expenditure savings target associated with this Challenge initiative, because Vermont Medicaid does not typically pay for non-emergency level services delivered in an ED and because other Challenge initiatives focus on reducing inappropriate utilization of hospital EDs by Medicaid beneficiaries.

Unfortunately, the timing of this initiative as it relates to Federally Qualified Health Center (FQHC) expansion in the state was less than propitious. No testimony was taken prior to inclusion of the initiative in the Challenges legislation, but DVHA's targeted partners in the initiative, the state's community health centers, already had planning well underway for an array of expansion efforts.

2010 was a banner year for increased funding of the FQHC program (\$11 billion over five years) in the Affordable Care Act (ACA), following on the heels of significantly increased funding (\$2 billion) through the American Recovery and Reinvestment Act (ARRA) in 2009. Indeed, thanks in large measure to the advocacy of Vermont Senator Bernie Sanders for provisions included in both of the bills, there has never been a time when more federal resources were available to expand FQHCs.

This has proven to be of substantial benefit for existing Vermont FQHCs seeking “satellite expansions” and communities aspiring to develop “new start” health centers, as well a bringing in funding for capital expenditures on new or renovated facilities. Vermont FQHCs have received a total of \$25 million in program and construction funding since passage of ARRA.

In addition, seven applications for additional FQHC development were submitted in December 2010. These include:

- A community group in Bristol that is seeking to convert an independent family practice into an FQHC, serving northeastern Addison County.
- A community group in Arlington seeking to convert an existing Rural Health Clinic into an FQHC, serving northern Bennington County.
- Gifford Hospital, which is submitting an application to convert its primary care practices into the FQHC model, serving primarily Orange County. Gifford is using this New Access Point funding opportunity as a learning experience.
- The Northern Tier Center for Health (NoTCH) is submitting an application to establish a new satellite site in Fairfax, to serve southern Franklin County.
- Community Health Center of Burlington (CHCB) is proposing to convert a Rural Health Clinic in South Hero into an FQHC satellite site, to serve southern Grand Isle County.
- Northern Counties Health Care (NCHC) is applying to convert a Rural Health Clinic currently owned and operated by North Country Hospital, into a satellite site of the FQHC.
- Community Health Centers of the Rutland Region (CHCRR) is seeking to establish a new satellite site in Shoreham, to serve southern Addison County.

Planning for all of these projects pre-dated Act 146, and given the work done by the health centers to develop the applications and the intense work required to prepare the 200 page proposals to the federal Health Resources and Services Administration (HRSA), Bureau of Primary Health Care (BPHC), it was not practical for Vermont FQHCs to shift their focus to hospital-sited clinics over the past six months.

DVHA has conducted an assessment of the environment from the hospital perspective (see Table on page 3). Five of the 13 community hospitals currently operate a walk-in or urgent care clinic, in most cases located adjacent to their Emergency Departments, which serve as diversion points for the ED, but none operate a full service primary care clinic on the hospital campus. The model that comes closest to that, while not located on the hospital campus, is the new FQHC location being developed in downtown Springfield that will actively seek patients who would otherwise utilize the hospital ED.

Senator Sanders has requested that the Government Accountability Office (GAO) compile an inventory of models from around the country that currently exist where FQHCs play a role in ED diversion. The report is due in the spring, when the Senator plans to hold hearings, and his staff indicates that the Senator would be interested in convening Vermont hospital and health center stakeholders to discuss how the models iterated in the GAO report might be replicated in Vermont.

The Department will ensure copies of the GAO report are made available to your committees and can provide an update on the outcome of the stakeholder meeting. Those steps may be adequate; it may be that no further action is required by the legislature or the administration to move this initiative forward.

Vermont Hospitals with Walk-in or Urgent Care Facilities:

Hospital Name	Location	Walk-in or Urgent Care Center?
Brattleboro Memorial Hospital	Brattleboro	No
Central Vermont Medical Center	Berlin	Yes
Copley Hospital	Morrisville	No
Fletcher Allen Health Care	Burlington	Yes – at Fanny Allen campus
Gifford Medical Center	Randolph	No
Grace Cottage Hospital	Townshend	No
Mt. Ascutney Hospital & Health Center	Windsor	No
North Country Hospital	Newport	No
Northeastern Vermont Regional Hospital	St. Johnsbury	Yes
Northwestern Medical Center	St. Albans	Yes
Porter Medical Center	Middlebury	No
Rutland Regional Medical Center	Rutland	Yes
Southwestern Vermont Health Care	Bennington	No

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MEMORANDUM

TO: Senator Jane Kitchel, Chair, Senate Appropriations Committee
 Representative Martha Heath, Chair, House Appropriations Committee
 Representative Mark Larson, Chair, House Healthcare Committee

FROM: Susan Besio, Ph.D. Commissioner, Department of Vermont Health Access *Susan Besio*

DATE: January 20, 2011

RE: Catamount Health and Employer Sponsored Insurance Assistance Premium Indexing

Catamount Health and Employer Sponsored Insurance Assistance was implemented in SFY '07. One of the facets of this program included indexing beneficiary premiums correlating with carrier premium increases.

In June of 2008, the American Recovery and Reinvestment Act was passed (ARRA) which included a Maintenance of Eligibility (MOE) requirement that premiums not be increased for Medicaid enrollees. (ARRA ends June 30, 2010.) In March of 2010, the Federal Affordable Care Act (ACA) was passed and included similar MOE conditions.

Catamount beneficiaries enrolled in Medicaid when ARRA was passed included only those < 200% FPL. Therefore, premium indexing continued for the > 200% population. The > 200% cohort was approved for inclusion in the Global Commitment to Health Waiver (and subsequently eligible for Medicaid match) on January 1, 2010.

DVHA engaged in conversation with CMS regarding the indexing concept to discern whether or not they considered indexing contrary to either ARRA or ACA MOE requirements. We were advised by CMS that, in fact, indexing was allowed under both ARRA and ACA.

Because CMS guidance was not available at the time of budget passage, the SFY '11 Appropriations Act included language to suspend indexing. Following is what was included in the act:

**Sec. E.309.3 SUSPENSION OF AUTOMATIC PREMIUM INCREASES;
 MAINTENANCE OF ELIGIBILITY REQUIREMENTS**

(a) It is the intent of the general assembly to ensure compliance with Section 5001(f) of the American Recovery and Reinvestment Act of 2009, Public Law 111-5 and Section 2001 of the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (maintenance of eligibility) by maintaining the premiums at levels due on June 15, 2008 for individuals enrolled in health benefit plans or premium assistance funded by Medicaid. By maintaining the premiums and eligibility for programs included in Global Commitment to Health and Choices for Care, the state will remain eligible for funds available for Medicaid and Medicaid-waiver programs.

(b) Notwithstanding 33 V.S.A. §§ 1974(j) and 1984(b), individuals receiving Catamount Health premium assistance or employer-sponsored premium assistance shall not have the premiums automatically indexed.

(c) This section of this act shall supersede any agency rules establishing premium amounts above the amounts due on June 15, 2008.

DVHA's SFY '11 Budget Adjustment Testimony included a request to strike this language due to the fact that CMS deemed indexing appropriate under both ARRA and ACA. Moreover, the language as written has DVHA out of compliance with this requirement due to indexing that occurred for the > 200% population up until April 1, 2010. In addition, the reference to premium amounts as of June 15, 2008, is incorrect, since premiums for the > 200% population were increased by legislative action effective July 1, 2009.

The House Healthcare Committee has significant concern regarding deleting these words but is amenable to amending the language to ensure consistency between language and practice. Therefore, DVHA (in working with legislative counsel) proposes the following:

(c) This section of this act shall supersede any agency rules establishing premium amounts above the amounts in effect for new Catamount premium assistance applicants on April 1, 2010.

Please be advised that this request relates only to the SFY '11 budget adjustment timeline. Additional consideration will need to be given during the SFY '12 budget process.

cc: Jim Reardon, Commissioner, Finance and Management
Douglas A. Racine, Secretary, Agency of Human Services
Jim Giffin, Financial Director, Agency of Human Services
Nolan Langweil, Fiscal Analyst, Joint Fiscal Office
Stephanie Barrett, Associate Fiscal Analyst, Joint Fiscal Office
Matt Riven, Director, Budget and Management, Finance and Management

State of Vermont
Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston VT 05495-2807
dvha.vermont.gov

Agency of Human Services

[Phone] 802-879-5900
[Fax] 802-879-5651

TO: Rep. Martha Heath, Chair, House Appropriations Committee
Sen. Jane Kitchel, Chair, Senate Appropriations Committee

CC: Rep. Mark Larson, Chair, House Health Care Committee
Sen. Claire Ayer, Chair, Senate Health and Welfare Committee

FROM: Susan Besio, PhD, Commissioner, Department of Vermont Health access

DATE: January 21, 2011

RE: Legislative report: 2010 Act 156 Sec. 306(b); Program Integrity Measures

During the SFY 2011 legislative session, the Department of Vermont Health Access (DVHA) proposed adding three (3) additional full-time positions to its Program Integrity (PI) unit to maximize efforts to control fraud, waste, and abuse in the Medicaid system. Ultimately, the legislature approved six (6) new full-time positions to expand the program integrity efforts, with the expectation of saving the State of Vermont a total of \$2.3 million (gross) in SFY 2011 from PI activities.

The DVHA has now hired the six additional staff and, as required per Section E 306(b) of Act 156 (2010), has developed measures to evaluate the success of these new positions. Included in this summary report are the evaluation activities developed to measure the projected savings for SFY 2011. The PI unit is confident of realizing the savings expectations.

To date, the PI unit has saved \$1.3 million (gross). The majority of savings has been achieved through two sources: direct reporting of potential fraud, waste and abuse to the PI unit from other state departments, providers, and beneficiaries; and DVHA's partnership with the Medicaid Fraud and Residential Abuse Unit (MFRAU). Additional savings have been achieved through data mining activities conducted in collaboration with DVHA's contractor, Ingenix, to identify potential overpayments in the following areas:

- *Pharmacy Kits.* Some pharmacy medications are sold in kits containing multiple units; units in kits are less expensive than when sold individually. Instead of billing for the kit, some pharmacies have continued to bill for the number of individual units in the kit (e.g., Imitrex, a migraine medication, is packaged in quantities of two (2) syringes; some pharmacies continue to bill for each of the two syringes instead of for the kit).
- *Pharmacy Billing Codes.* Some drugs require Prior Authorization (PA) from the primary insurer, such as the Medicare Part D Plan (PDP). However, rather than obtaining a PA from the primary insurer, pharmacies sometimes put an override code into the system which allows the claim to be paid through Medicaid as the primary. As a result, Medicaid pays significantly more than the portion it would have paid if the primary insurer had authorized and paid its portion of the costs first.

- *Therapy Services (Physical, Occupational, and Speech)*. Some providers have not adhered to Medicaid Prior Authorization requirements for these services.
- *Non-Emergency Transportation Services*. Some beneficiaries may attempt to use transportation services to access non-medical services, which are not covered through the Medicaid program.

In addition, DVHA is reviewing the following areas and expects them to yield an additional \$1 million savings in SFY 2011:

- *Correct Coding Initiative*. Identifying defined code pairs that should never be billed together (e.g., removal of a benign lesion and destruction of a lesion should not be billed together).
- *Ambulance Transport for Inpatient Beneficiaries*. Identifying inappropriately billed ambulance transports during an inpatient hospital stay.
- *Rounding Errors*. Drug packages may contain units in a size other than a whole number. When pharmacies round the unit size up to the next whole number before multiplying by the number of units in the package, Medicaid is billed for more of the drug than is actually dispensed. (e.g., nebulizer solutions, vaccines, and other solutions that are packaged in decimal quantities such as 2.5ml which are then rounded up to 3ml, or 8 oz bottles that are rounded up from 237ml to 240ml).
- *Unreasonable Medication Quantities*. Identifying drugs that are billed in quantities that are not clinically indicated or appropriate.
- *Team Care*. Reducing prescription drug abuse by restricting certain beneficiaries to one pharmacy and/or one provider will result in savings through reduced drug diversion and improved coordination of care.
- *Behavioral Health Codes*. Reviewing medical necessity and appropriate billing of certain behavioral health codes (e.g., group therapy billed for excessive units or excessive visits).
- *Credit Balances*. Creating a procedure similar to Medicare's in which providers are requested to return any known credit balances and/or attest none exists.
- *Pharmacy Reimbursement for Renal Dialysis*. Identifying when pharmacy services billed by dialysis providers are paid a percent of charges instead of at the fee schedule rate, resulting in overpayments.
- *Physician Assistant Reimbursement Logic*. Identifying when physician assistants are reimbursed at the MD level instead of at 90% of the MD level.

It also is important to note that of the \$2.3 million expected (gross) savings from PI activities in 2011, \$1 million of the savings will be a one time recoupment and \$1.3 million saved in 2011 will generate ongoing cost-avoidance savings. However, we anticipate that our on-going work in SFY 12 will generate savings to continue the \$1 million so it can be considered an on-going (i.e., base) savings into the future.

If you have any questions regarding this report, please contact Ron Clark, Director of Program Integrity, at (802) 879-5652.

Mandatory & Optional Coverage Groups & Services (Insert 1)

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

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

Program Cost Comparison SFY 2008 through SFY 2012 Governor's Recommend (Insert 2)

State of Vermont
Agency of Human Services
Department of Vermont Health Access
Medicaid Budget SFY 2012

PROGRAM EXPENDITURES																		
Adults	SFY '08 Actuals			SFY '09 Actuals			SFY '10 Actuals			SFY '11 Appropriated			SFY '11 BAA			SFY '12 Requested		
	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	11,797	\$ 72,515,067	\$ 512.24	12,550	\$ 82,398,879	\$ 547.15	13,337	\$ 87,006,993	\$ 543.63	13,866	\$ 97,472,995	\$ 585.82	14,081	\$ 95,860,239	\$ 567.31	14,772	\$ 104,353,401	\$ 588.68
Dual Eligibles	14,185	\$ 35,614,807	\$ 209.23	14,753	\$ 38,596,281	\$ 218.02	15,192	\$ 41,432,987	\$ 227.28	15,536	\$ 45,160,245	\$ 242.24	15,806	\$ 45,181,840	\$ 238.21	16,270	\$ 48,757,915	\$ 249.73
General	9,255	\$ 43,797,118	\$ 394.36	9,847	\$ 53,060,215	\$ 449.06	10,358	\$ 58,325,148	\$ 469.26	10,786	\$ 64,639,242	\$ 499.40	10,852	\$ 64,615,245	\$ 496.19	11,127	\$ 69,696,931	\$ 521.96
VHAP	24,771	\$ 89,891,925	\$ 302.40	28,224	\$ 111,730,898	\$ 329.89	33,249	\$ 130,598,440	\$ 327.32	36,862	\$ 160,445,280	\$ 362.71	37,678	\$ 153,559,727	\$ 339.63	41,240	\$ 172,104,878	\$ 347.77
VHAP ESI	276	\$ 571,218	\$ 172.63	821	\$ 1,525,747	\$ 154.95	949	\$ 1,787,708	\$ 156.97	1,564	\$ 4,234,758	\$ 225.64	935	\$ 2,377,169	\$ 211.86	866	\$ 2,527,600	\$ 243.32
Catamount (to VHAP)	1,730	\$ 7,995,765	\$ 385.12	6,350	\$ 30,293,232	\$ 397.55	9,058	\$ 45,210,486	\$ 415.95	11,819	\$ 62,006,808	\$ 437.21	10,922	\$ 57,219,834	\$ 436.59	10,751	\$ 43,231,685	\$ 335.09
ESIA (to VHAP ESIA)	132	\$ 168,977	\$ 106.81	478	\$ 688,592	\$ 120.17	682	\$ 900,029	\$ 110.04	1,017	\$ 2,108,729	\$ 172.80	808	\$ 1,592,434	\$ 164.13	817	\$ 2,342,652	\$ 238.92
Subtotal Adults	62,146	\$ 250,554,876	\$ 335.98	73,021	\$ 318,293,843	\$ 363.24	82,824	\$ 365,261,791	\$ 367.51	91,449	\$ 436,068,058	\$ 397.37	91,083	\$ 420,406,488	\$ 384.64	95,843	\$ 443,015,062	\$ 385.19
Children																		
Blind or Disabled (BD)/Medically Needy	3,487	\$ 27,775,036	\$ 663.78	3,605	\$ 31,686,636	\$ 732.47	3,606	\$ 31,605,170	\$ 730.35	3,771	\$ 35,736,828	\$ 789.66	3,688	\$ 33,987,589	\$ 767.93	3,707	\$ 35,473,289	\$ 797.36
General	50,664	\$ 90,807,988	\$ 149.36	52,224	\$ 100,299,806	\$ 160.05	54,266	\$ 108,508,732	\$ 166.63	55,631	\$ 118,920,219	\$ 178.14	55,427	\$ 118,050,440	\$ 177.49	55,985	\$ 128,808,036	\$ 191.73
Underinsured	1,138	\$ 742,529	\$ 54.39	1,212	\$ 721,162	\$ 49.61	1,178	\$ 812,299	\$ 57.46	1,282	\$ 799,937	\$ 51.98	1,223	\$ 887,676	\$ 60.51	1,236	\$ 988,094	\$ 66.62
SCHIP (Uninsured)	3,278	\$ 4,462,004	\$ 113.42	3,412	\$ 5,386,841	\$ 131.56	3,523	\$ 5,629,939	\$ 133.17	3,966	\$ 6,744,663	\$ 141.71	3,703	\$ 6,220,658	\$ 140.00	3,710	\$ 7,690,155	\$ 172.74
Subtotal Children	58,567	\$ 123,787,557	\$ 176.13	60,452	\$ 138,094,446	\$ 190.36	62,573	\$ 146,556,139	\$ 195.18	64,651	\$ 162,201,649	\$ 209.07	64,040	\$ 159,146,363	\$ 207.09	64,639	\$ 172,959,575	\$ 222.98
Pharmacy Only Programs	12,737	\$ 8,052,596	\$ 47.88	12,456	\$ 7,535,743	\$ 50.42	12,550	\$ 3,929,059	\$ 26.09	12,580	\$ 4,354,351	\$ 28.85	13,088	\$ 4,335,959	\$ 27.61	13,113	\$ 4,557,802	\$ 28.96
Choices for Care																		
Nursing Home, Home & Community Based, ERC	3,973	\$ 166,375,075	\$ 3,489.85	4,010	\$ 172,372,731	\$ 3,582.14	3,925	\$ 170,312,343	\$ 3,616.05	4,010	\$ 178,547,346	\$ 3,710.46	4,010	\$ 173,396,917	\$ 3,603.43	4,010	\$ 170,536,737	\$ 3,543.99
Acute-Care Services ~ OVHA	3,973	\$ 20,041,562	\$ 420.39	4,010	\$ 22,925,258	\$ 476.42	3,925	\$ 20,549,664	\$ 436.31	4,010	\$ 25,398,299	\$ 527.81	4,010	\$ 27,390,174	\$ 569.21	4,010	\$ 28,245,416	\$ 586.98
Acute-Care Services ~ Other Depts.	3,973	\$ 1,097,788	\$ 23.03	4,010	\$ 284,592	\$ 5.91	3,925	\$ 1,300,771	\$ 27.62	4,010	\$ 300,140	\$ 6.24	4,010	\$ 1,328,969	\$ 27.62	4,010	\$ 1,328,969	\$ 27.62
Buy-In		\$ 2,228,171			\$ 2,371,707			\$ 2,455,358			\$ 3,071,780			\$ 2,541,959			\$ 2,631,615	
Subtotal Choices for Care*	3,973	\$ 189,742,595	\$ 3,980.00	4,010	\$ 197,954,288	\$ 4,113.76	3,925	\$ 194,618,136	\$ 4,132.11	4,010	\$ 207,317,565	\$ 4,308.35	4,010	\$ 204,658,018	\$ 4,253.08	4,010	\$ 202,742,736	\$ 4,213.27
Subtotal Direct Services	137,422	\$ 572,137,623	\$ 346.95	149,940	\$ 661,878,320	\$ 367.86	161,872	\$ 710,365,126	\$ 365.70	172,689	\$ 809,941,622	\$ 390.85	172,222	\$ 788,546,829	\$ 381.56	177,605	\$ 823,275,175	\$ 386.29
Miscellaneous Program																		
GC to CFC Funding Reallocation		\$ (1,097,788)			\$ (284,592)			\$ (1,300,771)			\$ (300,140)			\$ (1,328,969)			\$ (1,328,969)	
Refugee	17	\$ 68,304	\$ 334.83	47	\$ 222,863	\$ 395.15	40	\$ 154,500	\$ 319.21	53	\$ 277,247	\$ 436.31	47	\$ 186,593	\$ 329.82	53	\$ 225,114	\$ 350.96
ACA Rebates		\$ -			\$ -			\$ -			\$ -			\$ (6,000,000)			\$ (6,646,867)	
Civil Unions	194	\$ 1,010,764	\$ 434.18	197	\$ 839,480	\$ 355.11	235	\$ 838,772	\$ 297.44	221	\$ 1,167,101	\$ 440.08	240	\$ 786,673	\$ 273.15	252	\$ 901,479	\$ 298.11
HIV	101	\$ 43,914	\$ 36.23	117	\$ 44,976	\$ 32.03	133	\$ 38,904	\$ 24.38	167	\$ 50,964	\$ 25.43	134	\$ 50,964	\$ 31.69	158	\$ 55,880	\$ 29.47
DSH		\$ 49,003,898			\$ 35,648,781			\$ 37,448,781			\$ 37,448,781			\$ 37,448,781			\$ 37,448,781	
Clawback		\$ 20,339,254			\$ 20,779,093			\$ 13,332,383			\$ 17,614,748			\$ 18,041,154			\$ 23,892,185	
Buy-In ~ GC		\$ 21,063,422			\$ 21,306,607			\$ 23,415,644			\$ 28,675,532			\$ 25,733,444			\$ 28,280,673	
Buy-In ~ State Only (MCO Invest.)		\$ 419,951			\$ 248,537			\$ 200,868			\$ 592,264			\$ 162,341			\$ 131,204	
Buy-In ~ Federal Only		\$ 3,123,135			\$ 2,730,326			\$ 3,125,212			\$ 4,015,941			\$ 3,577,210			\$ 4,094,581	
Legal Aid		\$ 476,832			\$ 547,983			\$ 547,983			\$ 547,983			\$ 547,983			\$ 547,983	
Misc. Pymts.		\$ 2,237,253			\$ 2,788,183			\$ 2,147,266			\$ 4,981,021			\$ 643,140			\$ 667,801	
Healthy Vermonters Program	5,781	\$ -	n/a	4,843	\$ -	n/a	4,753	\$ -	n/a	4,676	\$ -	n/a	5,045	\$ -	n/a	6,115	\$ -	n/a
Subtotal Miscellaneous Program	6,093	\$ 96,688,940		5,204	\$ 84,872,236		5,161	\$ 79,949,542		5,117	\$ 95,071,441		5,466	\$ 79,849,315		6,578	\$ 88,269,845	
TOTAL PROGRAM EXPENDITURES	143,515	\$ 668,826,563		155,144	\$ 746,750,556		167,032	\$ 790,314,667		177,806	\$ 905,013,063		177,688	\$ 868,396,144		184,183	\$ 911,545,021	

ADMINISTRATIVE EXPENDITURES																		
Contract	SFY '08 Actuals			SFY '09 Actuals			SFY '10 Actuals			SFY '11 Appropriated			SFY '11 BAA			SFY '12 Requested		
	Expenses			Expenses			Expenses			Expenses			Expenses			Expenses		
Claims Processing	\$	9,938,968		\$	9,433,393		\$	9,678,287		\$	10,695,522		\$	11,380,522		\$	11,771,672	
Member Services	\$	2,913,852		\$	3,117,187		\$	2,947,753		\$	2,913,852		\$	2,913,852		\$	2,932,427	
Pharmacy Benefits Manager	\$	2,704,233		\$	2,538,847		\$	2,566,106		\$	2,964,993		\$	2,964,993		\$	3,205,195	
Care Coordination & Chronic Care Management	\$	3,562,406		\$	4,249,583		\$	6,334,904		\$	4,749,294		\$	4,269,908		\$	2,670,032	
Catamount Outreach	\$	1,697,182		\$	500,000		\$	500,000		\$	500,000		\$	500,000		\$	500,000	
Miscellaneous	\$	1,892,349		\$	2,179,530		\$	1,406,227		\$	3,053,723		\$	2,289,107		\$	3,503,226	
Health Information Technology/Healthcare Reform	\$	-		\$	-		\$	2,307,983		\$	3,655,674		\$	7,109,567		\$	8,379,691	
MITA/MOVE	\$	1,184,745		\$	926,779		\$	66,300		\$	13,100,000		\$	13,100,000		\$	47,537,564	
Blueprint & Payment Reform	\$	-		\$	-		\$	-		\$	4,823,341		\$	5,042,244		\$	4,149,932	
Operating/Personnel Services	\$	7,152,358		\$	7,067,735		\$	4,647,392		\$	8,410,601		\$	7,742,923		\$	12,247,198	
Total Administrative Expenses	\$	31,046,091		\$	30,013,053		\$	30,454,952		\$	54,867,000		\$	57,313,116		\$	96,896,937	
TOTAL ALL EXPENDITURES	146,717	\$ 699,872,655		155,144	\$ 776,763,609		\$	820,769,619		\$	959,880,063		\$	925,709,259		\$	1,008,441,958	

Program Expenditures SFY 2011 & SFY 2012 Governor's Recommend w/ Funding Description (Insert 3)

State of Vermont
Agency of Human Services
Dept. of Vermont Health Access
Medicaid Budget SFY 2012

PROGRAM EXPENDITURES							
	SFY '11 Appropriated		SFY '11 BAA		SFY '12 Gov. Rec.		SFY '12 Funding Description
	Gross Expenses	State Funds	Gross Expenses	State Funds	Gross Expenses	State Funds	
Adults							
Aged, Blind, or Disabled (ABD)/Medically Needy	\$ 97,472,995	\$ 34,768,617	\$ 95,860,239	\$ 34,193,347	\$ 104,353,401	\$ 43,974,523	Global Commitment funded ~ g.f. @ 42.14%, federal @ 57.86%
Dual Eligibles	\$ 45,160,245	\$ 16,108,660	\$ 45,181,840	\$ 16,116,362	\$ 48,757,915	\$ 20,546,586	Global Commitment funded ~ g.f. @ 42.14%, federal @ 57.86%
General	\$ 64,639,242	\$ 23,056,818	\$ 64,615,245	\$ 23,048,258	\$ 69,696,931	\$ 29,370,287	Global Commitment funded ~ g.f. @ 42.14%, federal @ 57.86%
VHAP	\$ 160,445,280	\$ 57,230,831	\$ 153,559,727	\$ 54,774,755	\$ 172,104,878	\$ 72,524,996	Global Commitment funded ~ g.f. @ 42.14%, federal @ 57.86%
VHAP ESI	\$ 4,234,758	\$ 1,510,538	\$ 2,377,169	\$ 847,936	\$ 2,527,600	\$ 1,065,131	Global Commitment funded ~ g.f. @ 42.14%, federal @ 57.86%
Catamount	\$ 62,006,808	\$ 23,051,524	\$ 57,219,834	\$ 21,276,082	\$ 43,231,685	\$ 18,217,832	Global Commitment funded ~ g.f. @ 42.14%, federal @ 57.86%
ESIA	\$ 2,108,729	\$ 778,675	\$ 1,592,434	\$ 593,057	\$ 2,342,652	\$ 987,194	Global Commitment funded ~ g.f. @ 42.14%, federal @ 57.86%
Subtotal Adults	\$ 436,068,058	\$ 156,505,663	\$ 420,406,488	\$ 150,849,798	\$ 443,015,062	\$ 186,686,547	
Children							
Blind or Disabled (BD)/Medically Needy	\$ 35,736,828	\$ 12,747,327	\$ 33,987,589	\$ 12,123,373	\$ 35,473,289	\$ 14,948,444	Global Commitment funded ~ g.f. @ 42.14%, federal @ 57.86%
General	\$ 118,920,219	\$ 42,418,842	\$ 118,050,440	\$ 42,108,592	\$ 128,808,036	\$ 54,279,706	Global Commitment funded ~ g.f. @ 42.14%, federal @ 57.86%
Underinsured	\$ 799,937	\$ 285,338	\$ 887,676	\$ 316,634	\$ 988,094	\$ 416,383	Global Commitment funded ~ g.f. @ 42.14%, federal @ 57.86%
SCHIP (Uninsured)	\$ 6,744,663	\$ 1,949,208	\$ 6,220,658	\$ 1,797,770	\$ 7,690,155	\$ 2,267,827	Title XXI ~ g.f. @ 29.49% and federal @ 70.51%
Subtotal Children	\$ 162,201,649	\$ 57,400,714	\$ 159,146,363	\$ 56,346,369	\$ 172,959,575	\$ 71,912,360	
Pharmacy Only Programs	\$ 4,354,351	\$ 3,601,026	\$ 4,335,959	\$ 2,732,758	\$ 4,557,802	\$ 3,145,333	100% g.f. for +/- 66% of program; balance is Global Commitment as described above
Choices for Care							
Nursing Home, Home & Community Based, ERC	\$ 178,547,346	\$ 63,687,838	\$ 173,396,917	\$ 61,850,680	\$ 170,536,737	\$ 71,864,181	Global Commitment funded ~ g.f. @ 42.14%, federal @ 57.86%
Acute-Care Services ~ OVHA	\$ 25,398,299	\$ 9,059,573	\$ 27,390,174	\$ 9,770,075	\$ 28,245,416	\$ 11,902,618	Global Commitment funded ~ g.f. @ 42.14%, federal @ 57.86%
Acute-Care Services ~ Other Depts.	\$ 300,140	\$ 107,060	\$ 1,328,969	\$ 474,043	\$ 1,328,969	\$ 560,027	Global Commitment funded ~ g.f. @ 42.14%, federal @ 57.86%
Buy-In	\$ 3,071,780	\$ 1,095,704	\$ 2,541,959	\$ 906,717	\$ 2,631,615	\$ 1,108,962	Global Commitment funded ~ g.f. @ 42.14%, federal @ 57.86%
Subtotal Choices for Care*	\$ 207,317,565	\$ 73,950,175	\$ 204,658,018	\$ 73,001,515	\$ 202,742,736	\$ 85,435,789	
Subtotal Direct Services	\$ 809,941,622	\$ 291,457,580	\$ 788,546,829	\$ 282,930,441	\$ 823,275,175	\$ 347,180,029	
Miscellaneous Program							
GC to CFC Funding Reallocation	\$ (300,140)	\$ (107,060)	\$ (1,328,969)	\$ (474,043)	\$ (1,328,969)	\$ (560,027)	Global Commitment funded ~ g.f. @ 42.14%, federal @ 57.86%
Refugee	\$ 277,247	\$ -	\$ 186,593	\$ -	\$ 225,114	\$ -	100% federally reimbursed
ACA Federal Rebate	\$ -	\$ -	\$ (6,000,000)	\$ -	\$ (6,646,867)	\$ -	100% federally reimbursed
Civil Unions	\$ 1,167,101	\$ 416,305	\$ 786,673	\$ 280,606	\$ 901,479	\$ 379,883	MCO Investments ~ g.f. @ 42.14%, federal @ 57.86%
HIV	\$ 50,964	\$ 18,179	\$ 50,964	\$ 18,179	\$ 55,880	\$ 23,548	MCO Investments ~ g.f. @ 42.14%, federal @ 57.86%
DSH	\$ 37,448,781	\$ 15,458,857	\$ 37,448,781	\$ 15,387,704	\$ 37,448,781	\$ 15,458,857	42.14% g.f. and 57.86% federal
Clawback	\$ 17,614,748	\$ 17,614,748	\$ 18,041,154	\$ 18,041,154	\$ 23,892,185	\$ 23,892,185	100% g.f.
Buy-In ~ GC	\$ 28,675,532	\$ 10,228,562	\$ 25,733,444	\$ 9,179,120	\$ 28,280,673	\$ 8,644,553	Global Commitment funded ~ g.f. @ 42.14%, federal @ 57.86%
Buy-In ~ State Only (MCO Invest.)	\$ 592,264	\$ 211,261	\$ 162,341	\$ 57,907	\$ 131,204	\$ 40,105	MCO Investments ~ g.f. @ 42.14%, federal @ 57.86%
Buy-In ~ Federal Only	\$ 4,015,941	\$ -	\$ 3,577,210	\$ -	\$ 4,094,581	\$ -	100% federally reimbursed
Legal Aid	\$ 547,983	\$ 195,466	\$ 547,983	\$ 195,466	\$ 547,983	\$ 167,502	Global Commitment funded ~ g.f. @ 42.14%, federal @ 57.86%
Misc. Pymts.	\$ 4,981,021	\$ 1,776,730	\$ 643,140	\$ 229,408	\$ 667,801	\$ 204,127	Global Commitment funded ~ g.f. @ 42.14%, federal @ 57.86%
Healthy Vermonters Program	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Subtotal Miscellaneous Program	\$ 95,071,441	\$ 45,813,047	\$ 79,849,315	\$ 42,915,500	\$ 88,269,845	\$ 48,250,732	
TOTAL PROGRAM EXPENDITURES	\$ 905,013,063	\$ 337,270,626	\$ 868,396,144	\$ 325,845,941	\$ 911,545,021	\$ 395,430,762	

ADMINISTRATIVE EXPENDITURES							
	SFY '11 Appropriated		SFY '11 BAA		SFY '12 Gov. Rec.		
	Gross Expenses	State Funds	Gross Expenses	State Funds	Gross Expenses	State Funds	
Contract							
Claims Processing	\$ 10,695,522	\$ 3,815,093	\$ 11,380,522	\$ 4,059,432	\$ 11,771,672	\$ 4,960,583	Most admin. expenses are funded with: Global Commitment funds ~ g.f. @ 42.14%, federal @ 57.86% and Title XXI funds (29.49% g.f. and 70.51% federal)
Member Services	\$ 2,913,852	\$ 1,039,371	\$ 2,913,852	\$ 1,039,371	\$ 2,932,427	\$ 1,235,725	
Pharmacy Benefits Manager	\$ 2,964,993	\$ 1,057,613	\$ 2,964,993	\$ 1,057,613	\$ 3,205,195	\$ 1,350,669	
Care Coordination & Chronic Care Management	\$ 4,749,294	\$ 1,694,073	\$ 4,269,908	\$ 1,523,076	\$ 2,670,032	\$ 1,125,151	
Catamount Outreach	\$ 500,000	\$ 178,350	\$ 500,000	\$ 178,350	\$ 500,000	\$ 210,700	
Miscellaneous	\$ 3,053,723	\$ 1,089,263	\$ 2,289,107	\$ 816,525	\$ 3,503,226	\$ 1,476,259	
Health Information Technology/Healthcare Reform	\$ 3,655,674	\$ -	\$ 7,109,567	\$ -	\$ 8,379,691	\$ -	
MITA/MOVE	\$ 13,100,000	\$ 1,310,000	\$ 13,100,000	\$ 1,310,000	\$ 47,537,564	\$ 4,753,756	
Blueprint & Payment Reform	\$ 4,823,341	\$ 1,720,486	\$ 5,042,244	\$ 1,798,568	\$ 4,149,932	\$ 1,748,781	
Operating/Personnel Services	\$ 8,410,601	\$ 3,000,061	\$ 7,742,923	\$ 2,761,900	\$ 12,247,198	\$ 5,160,969	
Total Administrative Expenses	\$ 54,867,000	\$ 14,904,310	\$ 57,313,116	\$ 14,544,836	\$ 96,896,937	\$ 22,022,594	
TOTAL ALL EXPENDITURES	\$ 959,880,063	\$ 352,174,936	\$ 925,709,259	\$ 340,390,777	\$ 1,008,441,958	\$ 417,453,356	

*

Categories of Service (COS) (Insert 4)

State of Vermont
Agency of Human Services
Department of Vermont Health Access
Medicaid Budget SFY 2012

COS	Description of Service	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	Actual SFY '10	2009 Act.-2010 Act. % Change	Appropriated SFY '11	2010 Act-2011 Approp % Chg	BAA SFY '11	2010 Act.-2011 BAA. % Change	Requested SFY '12	2011 BAA-2012 SS % Change
01-00	Inpatient	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%	94,569,282	9.7%	121,184,643	7.0%	119,561,791	26.4%	140,360,752	17.4%
02-00	Outpatient	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%	86,223,982	17.2%	88,987,277	3.2%	92,443,733	7.2%	102,605,937	11.0%
03-00	Physician	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%	83,526,380	7.2%	96,784,364	15.9%	88,652,321	6.1%	102,490,419	15.6%
04-00	Pharmacy	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%	137,316,150	9.2%	139,848,098	1.8%	146,536,487	6.7%	167,719,326	14.5%
05-00	Nursing Home	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%	115,374,677	-3.3%	120,254,147	4.2%	116,103,718	0.6%	116,030,498	-0.1%
07-00	Mental Health Facility	346,914	292.5%	(216,883)	-162.5%	66,065	-130.5%	200,938	204.2%	242,458	20.7%	137,992	-43.1%	268,734	94.7%	248,460	-7.5%	279,639	4.1%	288,144	3.0%
08-00	Dental	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%	21,560,363	11.6%	24,508,866	13.7%	23,922,277	-2.4%	32,389,922	35.4%
09-01	MH Clinic	18,420	-61.4%	37,525	103.7%	44,333	18.1%	133,264	200.6%	55,163	-58.6%	14,754	-73.3%	129,230	775.9%	51,397	-60.2%	142,166	10.0%	167,447	17.8%
10-00	Independent Laboratory	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%	6,315,537	6.2%	8,427,926	33.4%	5,423,818	-14.1%	6,255,172	15.3%
11-00	Home Health	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%	6,301,698	-4.2%	7,413,985	17.7%	6,585,409	-4.5%	7,159,687	8.7%
12-00	RHC & FQHC	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%	18,851,650	15.1%	22,775,251	20.8%	22,324,652	-1.9%	27,387,719	22.7%
13-00	Hospice	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%	1,922,116	44.5%	1,929,200	0.4%	2,008,495	4.5%	2,094,779	4.3%
15-00	Chiropractor	88,164	-42.9%	84,868	-3.7%	55,125	-35.0%	48,784	-11.5%	50,357	3.2%	964,128	1814.6%	820,922	-14.9%	787,311	-4.1%	898,364	9.4%	1,052,225	17.1%
16-00	Nurse Practitioners	598,020	64.1%	617,187	3.2%	541,354	-12.3%	566,198	4.6%	507,683	-10.3%	509,254	0.3%	731,784	43.7%	656,718	-10.3%	823,089	12.5%	950,311	15.5%
17-00	Skilled Nursing	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%	3,151,255	-2.4%	3,550,320	12.7%	3,550,320	0.0%	3,615,836	1.8%
18-00	Podiatrist	161,904	22.0%	211,724	30.8%	211,990	0.1%	218,769	3.2%	238,065	8.8%	246,648	3.6%	270,761	9.8%	334,456	23.5%	295,988	-9.3%	336,155	13.6%
19-00	Psychologist	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%	17,090,584	13.3%	17,457,891	2.1%	19,009,790	11.2%	21,804,845	14.7%
20-00	Optometrist	706,214	5.4%	821,836	16.4%	786,030	-4.4%	814,027	3.6%	873,743	7.3%	970,695	11.1%	931,349	-4.1%	1,146,733	23.1%	1,034,530	-11.1%	1,179,899	14.1%
21-00	Optician	151,077	-38.2%	187,424	24.1%	202,259	7.9%	225,809	11.6%	237,305	5.1%	262,905	10.8%	248,348	-5.5%	295,804	19.1%	277,370	-11.7%	305,510	10.1%
22-00	Transportation	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%	10,644,485	-9.0%	12,675,143	19.1%	11,582,849	-8.8%	12,552,070	8.4%
23-00	OT/PT/ST Services	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%	2,695,670	16.1%	3,584,006	33.0%	3,462,262	-3.4%	4,590,807	32.6%
24-00	Prosthetic/Ortho	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%	2,016,941	7.2%	2,306,696	14.4%	2,223,706	-3.4%	2,490,358	12.0%
25-00	Medical Supplies & DME (26-00)	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%	8,887,585	11.0%	9,207,795	3.6%	9,714,525	5.5%	10,746,432	10.6%
27-00	H&CB Services	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%	45,939,654	-0.8%	49,869,850	8.6%	49,869,850	0.0%	47,082,918	-5.6%
27-02	H&CB Mental Health Services	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%	560,501	-2.5%	608,162	8.5%	526,963	-6.0%	533,859	1.3%
27-03	H&CB Mental Retardation	24,184	57.2%	-	-100.0%	16,486	0.0%	34,556	109.6%	20,846	-39.7%	-	-100.0%	-	-	26,562	0.0%	-	0.0%	-	0.0%
27-17	Enhanced Resident Care	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%	5,799,620	1.2%	7,655,491	32.0%	7,655,491	0.0%	7,655,491	0.0%
29-00	Personal Care Services	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%	21,536,285	11.7%	21,267,855	-1.2%	22,075,767	2.5%	22,287,924	1.0%
30-00	Target Case Management	1,658	-27411.2%	8,196	394.4%	2,768	-66.2%	1,914	0.1%	4,770	-30.9%	5,100	2072.2%	3,380	-91.9%	2,604	-23.0%	3,687	9.1%	4,417	19.8%
33-04	Assistive Community Care Services	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%	12,016,816	2.8%	13,298,940	10.7%	13,298,940	0.0%	13,562,204	2.0%
34-01	Day Treatment (MHS)	80,050	103.0%	56,415	-29.5%	65,710	16.5%	75,895	15.5%	58,122	-23.4%	86,781	49.3%	85,870	-1.0%	115,685	34.7%	99,847	-16.3%	129,970	30.2%
35-07	ADAP Families in Recovery	122,782	127.6%	303,097	146.9%	12,290	-95.9%	33,820	175.2%	79,764	135.8%	19,425	-75.6%	36,749	89.2%	95,145	158.9%	38,382	-4.4%	40,821	6.4%
37-01	Rehabilitation/D&P Dept. of Health	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%	3,842,321	-0.2%	4,490,906	16.9%	4,483,934	-0.2%	4,537,436	1.2%
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	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
38-03	PC+ Case Management Fees	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%	5,923,211	11.2%	6,350,676	7.2%	7,875,913	33.0%	8,862,767	12.5%
05 & 38	Pace Capitation	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
40-00	Ambulance	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%	3,555,128	12.7%	3,400,278	-4.4%	3,400,278	0.0%	3,400,278	0.0%
41-00	Dialysis	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%	1,691,583	-43.8%	3,293,318	94.7%	3,293,318	0.0%	3,429,125	4.1%
42-00	ASC	9,899	-78.7%	6,277	-36.6%	5,084	-19.0%	3,530	-30.6%	6,097	72.7%	8,563	40.4%	51,100	496.8%	9,608	-81.2%	55,187	8.0%	62,364	13.0%
43-00	Outpatient Rehab	240,341	31.1%	298,602	24.2%	290,361	-2.8%	203,595	-29.9%	158,647	-22.1%	5,826	-96.3%	-	-100.0%	174,285	0.0%	-	0.0%	-	0.0%
39-10	New Premium Payments	-	0.0%	-	0.0%	-	0.0%	-	0.0%	8,593,929	0.0%	32,210,646	274.8%	47,783,930	48.3%	67,756,149	41.8%	61,097,950	-10.3%	20,642,883	-66.2%
45-00	Miscellaneous	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%	(498,223)	-1108.6%	165,130	-133.1%	165,130	0.0%	174,776	5.8%
	Total	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%	771,595,419	8.1%	867,235,860	12.4%	854,725,602	-1.4%	901,573,900	5.5%
	Total w/o Catamount	-	-	-	-	-	-	559,005,383	-	604,890,785	8.2%	681,331,831	12.6%	723,811,490	6.2%	799,479,710	10.5%	793,627,652	-0.7%	880,931,017	11.0%
	Other Expenditures	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	0.0%	37,448,781	0.0%	37,448,781	0.0%
	Clawback	-	0.0%	-	0.0%	6,888,177	0.0%	19,142,150	177.9%	20,339,254	6.3%	20,779,093	2.2%	13,332,383	-35.8%	17,614,748	32.1%	18,041,154	35.3%	23,892,185	32.4%
	Insurance Premium Payouts	237,224	41.1%	283,304	19.4%	233,567	-17.6%	66,307	-71.6%	(31,616)	-147.7%	150,307	-575.4%	2,100,069	1297.2%	3,473,211	65.4%	2,664,666	-26.9%	2,669,043	0.2%
	HIV Insurance Fund F	46,108	-17.1%	46,738	1.4%	40,936	-12.4%	49,468	20.8%	43,914	-11.2%	44,976	2.4%	38,904	-13.5%	50,964	31.0%	50,964	0.0%	55,880	9.6%
	Lund Home Family Ctr Retro PNMI	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%	1,806,291	18.1%	2,328,139	28.9%	-	-100.0%	-	0.0%
	Legal Aid	361,229	62.3%	481,377	33.3%	493,820	2.6%	564,937	14.4%	476,832	-15.6%	547,983									

History of Program Expansions July 1994 – December 2008

(Insert 5)

