REDUCTION LIST NARRATIVES – BY DEPARTMENT

AHS CO

In order to meet the demanding challenges of the SFY'11, the AHS Secretary's Office is recommending that AHS reduce expenditures by returning to the core mission of the agency of coordinating and directing the policy making decisions for the state. In recent years, the Legislature has appropriated funding for specific operations and directed AHS to manage the grants. Programs have changed over the years and in some instances, the AHS grants have become redundant with operational programs of the departments and we are recommending that the legislative priorities be managed by the operating departments.

Eliminate the Project against Violent Encounters (PAVE) $54,000 Tobacco Funds – This grant supplements activities now funded under the DETER program. DETER in now a fully implemented statewide program. This program supports Bennington Co. exclusively. We will divert the Tobacco Funds for Medicaid related services and supplant General Funds needed for the Global Commitment appropriation.

Lamoille Co. Partnership - $143,000 Tobacco Funds – Supplemental services for Lamoille at-risk children ages birth to twelve with parent who is currently or has previously been incarcerated. Provides case management and referral for health care access including substance abuse and mental health services. One of a kind grant, solely for Lamoille County.

Windham County Homelessness Prevention Grant - $20,000 – General Fund – AHS is increasing a statewide homeless prevention program. This local grant will be reduced from $100,000 to $80,000.

UVM Partnership Grant - $50,000 General Fund – Funds studies on human services outcomes and delivery systems under the direction of the UVM School of Education. There is no impact on direct services to our populations. This is a lower priority activity for AHS when compared to direct client services.

UVM Nursing School Outreach Grant - $63,000 General Fund – Originally granted to expand interest in Nursing as a career plan. Job market conditions have changed and nursing is seen as a preferred career.

Mentoring grants - $80,000 General Fund - The mentoring grant is currently for $250,000 to the Permanent Fund for the Well Being of Vermont Children; the grant would be reduced by $80,000.

Human Services Board Realignment - $2,567 General Fund; $18,284 total funds– Nearly 50% of pending hearings are withdrawn or denied due to lack of follow-up by the

petitioners. We are proposing to tighten processing timelines to reduce backlogs. The HSB is staffed to hear all petitions for possible hearings. Hearing officer services could be contracted on completed hearing reimbursement methodology. Assumes 5% reduction of current operations.

Office of Vermont Health Access

Limit PT/OT/ST Visits to 30 per Year . . . . . $135,572 GC
Currently there are no limits imposed on the number of physical, occupational or speech therapy visits (PT/OT/ST) an individual can receive in a given year. Other state Medicaid programs impose visit limits on these benefits (e.g., Massachusetts, New Hampshire, Wisconsin, and Washington). Likewise, private industry standards in Vermont limit the number of visits to 30 visits per calendar year for combined PT/OT/ST, excluding services provided by home health agencies. Office of Vermont Health Access (OVHA) is proposing to institute this same standard for adult beneficiaries. However, OVHA will monitor PT/OT/ST use to identify beneficiaries that may exceed the combined 30 visit limit. Once a beneficiary has been identified as potentially exceeding the visit limit, OVHA registered nurses and physical therapists in the Clinical Operations Department will work collaboratively with the treating provider to indentify if there are alternative treatment approaches that are in line with evidenced-based guidelines that could be equally or more effective. The combined strategy will be employed with the goals of reducing utilization while concurrently ensuring quality of care.

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

Prior Authorization for Selected Radiology Services . . . . . $2,000,000 GC
Private insurance carriers and other state Medicaid programs (e.g., Alabama, Colorado, Louisiana, Maine, Minnesota, Missouri, New Hampshire, Oklahoma, and Rhode Island) require prior authorization for high cost, high-volume outpatient elective radiology services to facilitate the use of more appropriate or lower cost tests where clinically applicable. Currently no prior authorizations are required by OVHA for these radiology services. Using evidenced-based guidelines and subject matter experts, OVHA proposes to require a prior authorization for:

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

The following will NOT be subject to prior authorization:

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

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

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

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

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

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

Eligibility Determination Quality Control . . . . ($2,563,780)
The Economic Services Division (ESD) of the Department for Children and Families (DCF) conducts all eligibility determinations regarding applications for state-supported financial and health care benefits. There are over 200 eligibility categories for health care programs alone, and as such, the eligibility determination process is very complex. This complexity is augmented by the extremely out-dated ACCESS system that is used for automated eligibility determinations.

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

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

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

Enhancing this capacity could result in savings that can provide support to sustain our health care programs and ensure that Vermonters are getting access to the programs they are eligible for. As such, OVHA and DCF are jointly proposing to add 6 FTEs from the Human Resources position pool to the DCF QC/Fraud Unit.

Reduce Average Wholesale Price (AWP) on Drugs Historically Overfunded . . . . $3,389,429 GC

Reimbursement for pharmaceuticals must reflect the true costs of the drugs and not artificially inflated by an industry publication that was shown to have been inaccurate.

The U.S. District Court for the District of Massachusetts entered a Final Order and Judgment approving a class action settlement that involved two major publishers of drug pricing information, First Databank and Medispan, the most-widely used publishers of prescription drug prices in the United States. First Databank and Medispan were found to

have conspired with McKesson Corp. to fraudulently increase the published price of a third of the most widely used brand-name prescription drugs by 5% since 2002, raising pharmacies' profits.

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

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

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

Enhance Program Integrity Activity. . . . . $1,170,000 GC

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

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

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

- **Decision Support System (DSS)/Profiler**

The Decision Support System (DSS) is a tool that provides the framework for oversight of Medicaid services to ensure they are effective and efficient, adhere to policy, and meet standard of practice and billing compliance. Reports generated by the DSS allow the PIU staff to compare providers with their peers by unique case types. This is a valuable tool for detecting under and over utilization as well as outliers.

- **Medicaid Management Information System (MMIS) and Claim Check / Claim Review**

There are more than 700 various MMIS edits and audits in the MMIS system, which are designed to prevent errors in payment. These edits and audits are pre-payment and are used to analyze claims for clean claims submissions, proper billing, correct coding and adherence to VT Medicaid policy. In addition to the MMIS edits and audits, the OVHA also uses McKesson's ClaimCheck / ClaimReview (CC/CR) software. The CC/CR software is also a pre-payment auditing tool that reflects the American Medical Association guidelines, CMS, specialty society guidelines and industry standards. CC/CR uses a clinical knowledge base to create and ensure clinically valid edits.

- **Ingenix/HWT Post Payment Review**

The OVHA has also contracted with Ingenix to provide post-payment reviews of claims data. Ingenix has created a Program Integrity database consisting of 7 years of Medicaid medical, pharmacy and institutional data, as well as ancillary data sources. Ingenix employs a rules-based algorithmic process of data mining designed to identify specific claims that should not have been paid based upon policy or accepted coding methodologies. The design of the claims data analysis and post payment

review is structured to provide robust and efficient reports valuable to OVHA. These reports are designed utilizing an algorithmic approach to data mining focusing on provider types prioritized by OVHA, such as Physician, Pharmacy, Nurse Practitioner, Durable Medical Equipment (DME) and Hospice. The results of these algorithms can be used to identify aberrant billing patterns and outlier providers resulting in:

- Identification of subject providers for future audits
- Referrals to law enforcement, including the Attorney General's Medicaid Fraud and Residential Abuse Unit
- Direct recoupment of overpaid claims from providers
- Policy and payment system changes that will result in future savings
- Educational opportunities for OVHA and its providers
- Ingenix also has algorithms designed to identify overpayments by all major provider types made as a result of inappropriate billing and coding combinations such as mutually exclusive and inclusive, unbundling and duplicative payments.

- **Recipient Explanation of Benefits (REOMB) process:**

Quarterly, EDS sends a list of billed services to a random sample of beneficiaries to verify that they actually received the services billed by providers.

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

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

With the current staffing, the PIU is only able to respond to referrals and not be proactive. In addition, not having a data person dedicated to the PI Unit limits the ability to look broadly across the spectrum of Medicaid claims to identify trends. As such, OVHA proposes to add three (3) additional staff members to the PI unit to maximize efforts to control fraud, waste and abuse in the Medicaid system, maximize recoupment from providers, and prevent beneficiary fraud, waste and abuse.

Enhance Quality Control on Transportation Services . . . . . $575,000 GC
Non-Emergency Medical Transportation (NEMT) is a service available to Medicaid and Dr. Dynasaur beneficiaries under certain conditions such as when transportation is not

otherwise available, when transportation is to/from a necessary (covered) medical service, and to a medical service that is generally available to and used by other members of the community in which the beneficiary is located (i.e., travel beyond 30 miles or out-of-state requires an out-of-area/state request). The mode (e.g., van, taxi, volunteer, bus pass) of transportation is determined based on the least costly mode suitable to the medical needs of the beneficiary. Prior authorization is required. In SFY '09, 11,169 beneficiaries received non-emergency medical transportation services for a total expenditure of $11,694,573.

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

OVHA believes that $575,000 (net) in savings can be gained in transportation services by implementing controls and optimizing efficiencies in areas such as reimbursement, utilization, and trip coordination, and by enhancing reliance on least costly mode of transportation, increasing the volunteer network, and management of high utilizers and no-show cases

Improve eligibility assessment for Children's Personal Care Services (CPCS) . . . . $1,000,000 GC

1) Savings will be realized through use of a standardized, norm-tested assessment which will yield better information. This information will result in more appropriate allocations of CPCS. While it is not anticipated that populations of children will no longer qualify for CPCS, it is anticipated that better information will result in an aggregate savings in CPCS costs.
2) CPCS/DAIL intends to train and certify assessors in administering the assessment to ensure quality and standardization. Annual (periodic) training will be provided as well as on-going technical assistance related to CPCS program (intent, use, etc).
3) CPCS/DAIL intends to verify primary diagnoses of all participants at time of reassessment and of all new applicants at time of application as part of eligibility determination. Verification will ensure that all participants carry a confirmed diagnosis of a disability or health condition versus a rule-out, exhibiting "symptoms", etc.

Reduce FQHC Reimbursement Rate . . . . . $138,526 GC

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

- Not denying requested health care services, regardless of ability to pay;
- Not limiting the number of patients whose services are paid for by Medicare, Medicaid, or Children's Health Insurance Program (CHIP);

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

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

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

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

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

Reductions in the Choices for Care Program. . . . . $4,333,224 (GF)
Detail testimony about these proposed reductions will be provided by the Department of Disabilities, Aging and Independent Living (DDAIL). In summary, savings will be achieved by: (1) modifying rules to change reimbursement for the Moderate Need Group case management from 15 minute units to a monthly rate of $50; (2) reducing the home health agency-directed Personal Care Attendant rate from $26.15/hr to $22/hr; (3)

modifying rules to change reimbursement from 15 minute units to $110 monthly rate for HB case management services; (4) modifying rules to tighten personal care variances and maintain variances in service hours for respite and companion services; (5) changing procedures in the Flexible Choices option to reduce authorized budgets and actual expenditures by 10% and eliminating annual carryover of unspent funds; and (7) modifying regulations to reduce case management for Enhanced Residential Care participants to 3 hours/year, and (8) reducing the weight assigned to the hour lowest case mix scores used in nursing home reimbursement by 50%. . .

CATAMOUNT II . . . . ($11,482,134 GC)
The Catamount Health Plans, Catamount Health Assistance Program (CHAP) and Employer-Sponsored Insurance Assistance Programs (ESIA) that began in the fall of 2007 have been successful in providing insurance for over 12,000 uninsured Vermonters. The Governor and his Administration are strongly committed to continuing support for these important programs. However, given that there is a projected deficit of $7.7 million in the Catamount Fund for SFY '11, we must find ways to make these programs more sustainable as we move toward federal health care reform. As such, we are proposing to change the generous cost-sharing benefits in the existing Catamount Health Plans to a new Catamount II plan for all new CHAP enrollees as of July 1, 2010, and in which all current CHAP enrollees would be enrolled on their 12 month anniversary date.

Department of Health:

AHEC Program Support: $250,000 GC:
This represents a reduction of 50% of the program support that the Department of Health provides to Area Health Education Centers.

AHEC Loan Repayment: $300,000GC:
This represents a 34% reduction in funding for the AHEC loan repayment program. Vermont recently experienced a significant expansion in loan repayment opportunities through the National Health Service Corps. This could offset the reduction of the loan repayment program.

Patient Safety Program: $60,000 GC:
The Patient Safety program requires hospitals to report to the Department of Health on reportable adverse events. This reduction eliminates the Department's involvement with patient safety reporting. Hospitals will continue to comply with regulatory reporting requirements but will no longer send these and other adverse events reports to the Department of Health. This reduction will require the repeal or suspension of 18 V.S.A. Ch. 43A.

Coalition of Clinics for the Uninsured: $50,000 GC:

This represents a reduction of 7.5% of the total amount of funding that is provided to VCCU.

FQHC Look-Alike Funding $100,000GC:
This represents a 90% reduction in the funding allocated to FQHC Look Alikes and FQHC development. There are currently no FQHC look likes in Vermont and there are approximately one or two FQHCs under development in any given year. Limited financial support would continue to be provided for FQHC development.

AIDS Service Program $135,000 GF:
This reduction will limit support for food, housing, transportation, and emergency financial aid for persons living with HIV/AIDS. Vermonters in need are eligible for a range of services and it is expected that dedicated federal drug rebates will off set this reduction.

Children with Special Health Needs (CSHN) Support of Persons: $170,000 GF:
We will institute the following measures to reduce financial assistance program costs: limit assistance to non-Medicaid families only, require Medicaid applications as a prerequisite for CSHN assistance, cap financial assistance at 400% of the FPL, cap maximum per-family assistance at $15,000 per year and bring deductibles in line with income and inflation.

CSHN Clinics $82,000 GF:
CSHN clinics services will be altered. Changes under consideration include reducing child development clinic sites and capping the age for new referrals to CDC, as well as redirecting focus from specialty clinic-based services to more inclusive care coordination services.

CSHN Respite Program $95,000 GF
Savings will be realized by implementing the following measures: restrict payments for a higher allocation level and require an annual renewal application for all families.

Kidney Association Grant $15,000 GC:
This reduction eliminates a grant that contributes to the Kidney Association's Renal Patient Fund.

Youth Continence Grant $12,000 GC:
Continence services provided by a nurse would not be available.

Syringe Exchange Program $50,000 GF:
This represents a 50% reduction in the syringe exchange program. It is expected the some CDC prevention funds may be available to support some part of this program.

Lamoille County Partnership $53,000 GC:
This reduction eliminates a nurse/care coordinator working with young people in a court diversion program in Lamoille County only.

Coordinated Healthy Activity, Motivation, and Prevention Programs **(CHAMPPS)**
Community Prevention Grants: $255,000 GC:
Funding to support community coalition efforts to improve physical activity, nutrition, and access to preventive services will be reduced by 42%.

Poison Control Program $50,000 GC:
The Department of Health contracts with a regional poison control center in Maine. VDH will attempt to negotiate a contract that has more limited poison control services in order to achieve savings.

Addison Parent Child Center (PCC) Grant $32,800 GF:
This reduction eliminates a grant that contributes to the Addison County Parent to Child Center. This is the only PCC in the state that receives this funding.

ADAP Residential - $1.5M GC gross reduction; $500k needed for reinvestment
This reduction reflects purchasing adolescent residential treatment services at the market rate and not continuing to purchase unused capacity.

<u>Department of Mental Health:</u>

Consumer and Family Support Programs $7,472 GC
The proposed reductions represent a 5% decrease in funds for non-direct services activities such as education and training activities provided by consumer and family support programs. These programs are; Vermont Association of Mental Health, National Alliance on Mental Illness, Vermont Psychiatric Survivors, and the Vermont Federation of Families. **Direct services funding to these organizations is unchanged in these reductions.**
Detail:

- **National Alliance for Mental Illness – Vermont - $1,796 GC:**

Training and education for service providers on mental illness and family experience. This represents an overall reduction of 1 % in total funding.

- **Vermont Psychiatric Survivors – Counterpoint $2,052 GC**

Supports the publication of a newsletter which serves as a voice for news and the arts by psychiatric survivors, ex-patients, and consumers of mental health services, and their families and friends. This represents an overall reduction of 0.5% in total funding for VPS.

- **Vermont Association for Mental Health $3,124 GC**

Education and advocacy to heighten understanding of mental health issues that concern all Vermonters. This represents an overall reduction of 4% in total funding.

- **Vermont Federation of Families $500 GC**

Administrative costs to maintain a statewide, family-run, support and advocacy organization. This represents an overall reduction of 5% in total funding.

Department for Children and Families

DCF Admin: 3% reduction on Grants – Food Stamp Outreach & Girl Scouts $19,371 GF:
Reduction matches reduction of state employees and reflects reduced cost of living-- Food Stamps Outreach is adequately covered by other funding sources -- Girl Scouts grant is a special grant that cannot be maintained in this difficult environment.

Adoption Subsidy -$100
This is not a policy cut; it is recognition of a caseload downward trend.

Family Services: 3% reduction on grants, residential, adoption, trmnt payments $378,139 GF; $511,038 Fed Funds; $782,103 GC
Reduction matches reduction for state employees and reflects reduced cost of living

CDD: Community Childcare Support Agency (CCSA) Restructuring reduced grants $200,000 GF
This reduction is associated with moving financial eligibility determination for child care over to the Economic Services Division—part of modernization—increased accuracy and efficiency

Child Development Division (CDD): 3% reduction on grants (FITP, CUPS, HBKF, others) $33,324 GF; $165,591 FF: $151,436 GC:
Reduction matches reduction for state employees and reflects reduced cost of living.

General assistance: Cap Payment to funeral homes $150,000 GF:
Would cap DCF payment for public burials at cremation rate.

General assistance reduction/restructure $500,000 GF
+$500k Homelessness Prevention would require - $500k within GA

Full Family Sanctions: $1,001,341 GF/$1,251,677 GROSS
These reductions remove families from the caseload who are not in compliance with meeting program standards. This is approximately 80% of the current sanctioned families in the caseload as there is an expectation that 20% would come off sanctions and participate in work activities.

Eliminate SSI Disregard $1,320,000 GF/$1,650.000 GROSS
This would result in counting the first $125 of SSI income for determining Reach Up (RU) eligibility. The RU benefit would be reduced by that amount, but by doing so, the Supplemental Nutrition Assistance Program (SNAP) benefit for these same recipients would increase by $40 resulting for a net loss of $85. The savings are based upon a caseload of 1100 @ $125/month.

Eliminate paying for sanctioned recipients over 60 months $76,800 GF/$96,000 GROSS
The savings above are based upon 3 months at the 20% GF level due to ARRA funding.

Eliminate Reach Ahead $440,000 GF/$550,000 GROSS
This reduces the one year support for food for exiting Reach Up recipients. This leaves more of a cliff for leaving participants.

Eliminate Case Management Support for the PSE Program $300,000 GF AND GROSS
This eliminates the case management support provided by the Community College of Vermont and Champlain College. These counselors provide guidance services for Post Secondary Education students. Case Managers connected to higher education have been important to the success of many students.

REDUCE Temporary Aid to Needy Families (TANF) Support Services $467,432 GF
Currently we spend $2.3 million on various support services to help people prepare for and get to work. This would reduce the total funding for these services from an average of $442 per household to 308 per household. The actual expenditures vary widely depending on needs and where people are in their programs.

RU Increase in Program Int/Wage Match/Fraud $184,865 GF – add 1 staff
We believe that increased QC and pursuit of fraud will have a significant impact on errors and abuse.

Eliminate Individual Development Accounts (IDA'S) $135,300 GF:
This is an excellent program for helping people move out of poverty. However, it serves a relatively small number of people and cannot be afforded in the current environment.

Allow Magistrates to Establish Presumption of Parentage $25,160 GF/$74,000GROSS
This would allow the Family Court magistrates to establish parentage where presumption exists. This would reduce the OCS Attorney requirements and would also save the court money. Reduce 1 FTE.

DCF Admin: Reduce S.13 Prevention Grants One-Time Grants – Curricula Development $100,000 GF
DCF was awarded a one-time $100,000 to develop prevention strategies related to Act 1. Those strategies will be implemented by June 30.

DCF Admin: DCF - DOL Match pre eligibility net 1.1M - 5 staff
We believe that increased QC and pursuit of fraud will have a significant impact on errors and abuse. Also see OVHA.

<u>Department of Disabilities, Aging, and Independent Living</u>

Eliminate Housing and Supportive Services (HASS) grants $351,390 GF:
Method: Eliminate 100% of funds remaining in 14 grants.
Impact: Eliminate funding for residents in 22 housing sites that provides supportive services to improve residents' ability to age in place and enhance their quality of life. Greater reliance on housing staff, family members, other services.

Eliminate Cathedral Square Corporation grant $100,000 GF:
Eliminate 100% of grant funds. CSC will need to seek alternative funding.

Eliminate Adult Day Services GF Grants $109,995 GF:
Eliminate 100% of remaining grant funds. Funds support the ADC and not directly tied to individual support. Reduction in revenue to individual providers. Greater reliance on Medicaid funding.

Eliminate Adult Day Services GF Emergency Fund $23,655 GF:
Eliminate 100% of emergency funds. If providers have a financial emergency, funds will not be available from Division of Disability and Aging Services (DDAS).

Area Agencies on Aging (AAA) - $146,698 GF:
Reduce grant funds by 3%. AAA use funds to support a variety of services including case management, information/referral/assistance, home delivered and congregate meals, family caregiver support services and contracts/grants to support local community agencies serving older adults and family caregivers.

Eliminate VT Kidney Association Grant $30,000 GF:
Eliminate 100% of grant funds. End support for approximately 1,600 one-way trips per year to and from End Stage Renal Disease (ESRD) treatments. Increased reliance on other transportation including family resources, Medicaid transportation, and Federal Transportation Agency (FTA) funded public transportation.

Eliminate Foster Grandparent Grant: $41,064 GF:
Eliminate 100% of grant funds. Program funds are used to support Foster Grandparent services benefitting older volunteers, community programs and sites served by the program, and young people who directly benefit from Foster Grandparent services. Reduced stipends for volunteers, reduced services for children and youth. If other sources of funding cannot be found, services may end.

Eliminate Senior Companion Grant: $74,500 GF:
Eliminate 100% of grant funds. Funds are granted to Central Vermont Council on Aging to operate the Senior Companion Program to provide support, personal care and friendly visiting assistance to seniors. Provides eligible seniors with the opportunity to participate as either stipended or non-stipended volunteers. Reduced stipends for volunteers, reduced services for seniors. State funding is used to match federal funding. If other sources of funds cannot be found, services may be reduced or end.

Reduce Long Term Care (LTC) Ombudsman Grant funding: $29,042 GF and $98,388 GC:
Reduce grant funding. Fewer ombudsman staff and volunteers available to assist long term care consumers with complaints and concerns. Reduced individual and systems advocacy for community based LTC services.

Caregiver Registry - Eliminate funding $40,000 GC:
Eliminate 100% of funding. Funding for contractor to maintain a Vermont specific web-based Direct Care Worker Registry. Registry is used by direct care workers seeking work, families and employers seeking direct care workers. Workers and employers will rely on other means including newspapers and craigslist. Additional delays in finding caregivers may increase risk to some consumers' health and safety.

Redesign GF Attendant Services Program (ASP) (assets/income): $1,000,000 GF:
Method: redesign the General Fund portion of the Attendant Services Program to limit participation to those otherwise-eligible individuals who also meet certain financial criteria established by regulation.
Impact: Some current participants will no longer be eligible and will have to use their own resources to purchase care. Once those resources are used, they could apply for Choices for Care or ASP Medicaid-funded option.

Eliminate Neighbor to Neighbor grant $120,000 GF:
Elimination of grant to lead agency, Central Vermont Council on Aging (CVCOA). CVCOA subcontracts with three additional Area Agencies on Aging to provide services. Neighbor to Neighbor Americorp funds are used as match to a federal grant to support older adults and people with disabilities to live as independently as possibly. Activities include implementation of successful aging practices, provision of volunteer supportive services and collaboration with organizational partners and the community-at-large in the improvement of service networks. This will likely result in the inability of CVCOA will need to secure necessary match for federal grant if this program is to continue.

Eliminate South Burlington Community Housing Grant $10,300 GF:
Cancellation of grant. Grant provides funding for services at Cathedral Square Corporation's South Burlington Community Housing project. Majority of residents receive services through the Choices for Care Program, primarily provided/managed by the Visiting Nurses Association (VNA) of Chittenden & GI Counties. No identified impact on consumers.

Eliminate Other Housing grants $29,700 GF:
Each year, some DAIL funds were used to provide grants to innovative housing with supportive services planning projects. Funds will not be available in the future.

Eliminate Vermont Center for Independent Living (VCIL) home access and modification grant $100,000 GF:
Funds are used to help individuals with disabilities maintain their independence in their homes by building ramps, widening doorways for wheelchair access and modifying

bathrooms. Consumers will have to rely on funding provided through the Housing Conservation Board and the VCIL Sue Williams Freedom Fund.

Reduce case services – Division of Blind and Visually Impaired (DBVI) $31,745 GF:
Reduce funding available to DBVI Clients. Counselors will manage services with fewer case service dollars. Will likely result in requests for employers to pick-up the cost of accommodations, e.g. for specialized hardware and software and/or reducing costs by deciding not to financially support a work experience and requiring the business to pick-up the associated costs instead.

Eliminate set aside for van purchases and modifications VR $175,000 GF:
Two to three individuals per year with severe physical disabilities will be unable to access modified vans. The cost of a modified van is very high ($80,000 to $90,000), well out of the reach of most working Vermonters. The affected Vermonters will be unable to work because they lack transportation. All participants are in self-sustaining employment and if they lost their jobs, they will be forced to depend on state/federal benefits to support themselves.

Eliminate funds dedicated to self employment start up VR $25,000 GF:
Ten to fifteen individuals with disabilities will lose start up funds for small business ventures. Most will lack the resources to establish their businesses and the opportunity to become entrepreneurs.

Eliminate funds dedicated to meeting home modification needs VR $15,000 GF:
Two to three individuals with severe physical disabilities will not receive necessary home modifications to allow them to leave home and go to work. These are individuals who are employed and are not eligible for other sources of funding for home modifications. As a result most will have to stop working because they would not be able to get to their jobs.

Eliminate funds dedicated to special testing TBI VR $10,000 GF:
Five to six individuals annually will not be able to access neuropsychological assessments to determine appropriate services.

Reduce the Case Service Contingency Fund for high cost services VR $35,475 GF
DVR maintains a contingency fund for consumers with high cost needs. Typically these funds are used for durable medical equipment or high cost assistive technology necessary for individuals to gain or maintain employment. This will further reduce DVR capacity to serve individuals with the most severe disabilities.

Reduce DS Flexible Family Funding 43% $475,705 GC:
Method: Grants to eligible families will be reduced.
Impact: These are flexible supports for approximately 989 eligible children and adults with developmental disabilities who live with their families. Families receive a maximum of $1000 based on a sliding scale to purchase services and supports that

address the specific needs of the individual and family (including respite, assistive technology, equipment and goods that meet individual and household needs).

Eliminate remaining DS State-funded Respite Homes $160,000 GC:
Eliminate respite services for approximately 20 families. Service has been underutilized for some time.

Eliminate DS Medicaid Targeted Case Management (TCM) (DA's Only) $596,518 GC
Method: Eliminate 100% of funding. Eliminate targeted case management (TCM) service for approximately 380 children and adults with developmental disabilities, receiving an average of about 27 hours per year. TCM is often the only service that individuals receive, and can help avoid the need for more costly or comprehensive services. Impact on individuals includes the reduction or loss of supports for individuals to live independently and reduction or loss of support to families to coordinate multiple services for their children. Loss of revenue to provider agencies.

Department of Corrections:

Seven Million dollars ($7,000,000) in net General Fund savings as part of PSG Challenge.