Department of Vermont Health Access

Budget Document

State Fiscal Year 2014

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

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State of Vermont
Agency of Human Services
Department of Vermont Health Access

Budget Document - SFY 2014

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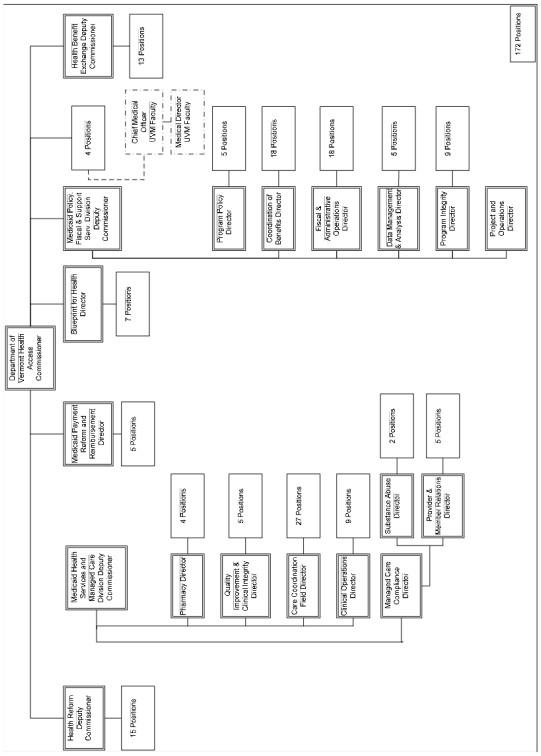
Organization Chart



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Organization and Responsibilities

The Department of Vermont Health Access (DVHA) is the State department responsible for the management of Medicaid, the State Children's Health Insurance Program (SCHIP), and other publicly funded health coverage programs in Vermont. DVHA is Vermont's largest insurer in terms of dollars spent and the second largest in terms of covered lives. As of 2009, DVHA also provides state oversight and coordination of Vermont's expansive Health Care Reform initiatives, which are designed to increase access, improve quality, and contain the cost of health care for all Vermonters. As such, DVHA also is responsible for Vermont's Blueprint for Health and for health information technology strategic planning, coordination and oversight. In addition, DVHA is responsible for the development and implementation of the health benefit exchange, **Vermont Health Connect**, required by the federal Patient Protection and Affordable Care Act (ACA) of 2010 and Vermont's Act 48 of 2011.

The mission for the Department of Vermont Health Access is to

- 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.

Leadership at DVHA consists of the Commissioner and four Deputy Commissioners for the Divisions of

- Medicaid Health Services and Managed Care
- Medicaid Policy, Fiscal and Support Services
- Health Benefit Exchange
- Health Reform.

Additionally, there is a

- Blueprint for Health Director
- Payment Reform and Reimbursement Director
- Chief Medical Officer
- Medicaid Medical Director.

The DVHA Commissioner is responsible for all DVHA's operations and leading state and federal health care reform implementation, and is a member of the Governor's health care leadership team.

The Deputy Commissioner for the Medicaid Health Services and Managed Care Division oversees the following units:

- Vermont Chronic Care Initiative
- Clinical Operations
- Managed Care Compliance
- Substance Abuse
- Provider and Member Relations
- Pharmacy
- Quality Improvement and Clinical Integrity.

The Deputy Commissioner for Medicaid Policy, Fiscal and Support Services Division oversees the following units:

- Coordination of Benefits
- Data Management and Analysis
- Fiscal and Administrative Operations
- Program Integrity
- Program Policy.

The Deputy Commissioner for the Health Reform Division leads the coordination of health reform activities across multiple state stakeholders and has primary responsibility for statewide health information technology (HIT) planning and implementation, including contract and grant management with external HIT partners including the Vermont Information Technology Leaders (VITL).

The Deputy Commissioner for the Health Benefit Exchange Division is responsible for development and implementation of the Vermont health benefit exchange required by the Patient Protection and Affordable Care Act and Vermont Acts 48 of 2011 and 171 of 2012.

The Director of Blueprint for Health oversees the statewide multi-insurer program designed to coordinate 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, care coordination and management at the provider level.

The Director of Payment Reform and Reimbursement is responsible for leading DVHA's payment reform efforts and managing reimbursement operations.

DVHA's budgeted staff positions total 172. The Chief Medical Officer and Medicaid Medical Director positions are faculty members of UVM under contract with DVHA and not included in this staff count.

The DVHA divisions and their units' areas of responsibility and tasks are described below. The descriptions include major areas of responsibility and are not an all-inclusive listing of responsibilities and duties.

Medicaid Health Services and Managed Care Division

DVHA is delegated the responsibility for the administration of the Medicaid program by AHS, the single state entity responsible for the Medicaid program, and operates as a public managed care model. The Medicaid Health Services and Managed Care Division is responsible for health services provided to individuals. The Deputy Commissioner oversees all programs and activities of medical services, including medical management planning and budgeting, and is responsible for overseeing and monitoring many activities related to quality, access to services, measurement and improvement standards, and all utilization management activities. The following units reside in this division:

Vermont Chronic Care Initiative (VCCI)
Identifies and assists Medicaid beneficiaries with chronic health conditions and/or high utilization of medical services 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 conditions. DVHA care coordinators are fully integrated core members of existing Blueprint for Health Community Health Teams and are co-located in provider practices and medical facilities in several communities.

Managed Care Compliance
Responsible for ensuring compliance with all federal and state managed care requirements. The Director also works with AHS and other AHS departments to manage Intergovernmental Agreements (IGAs) that support our healthcare delivery and payment system. This position supervises the Provider and Member Relations Unit and the Substance Abuse Unit.

Clinical Operations
Monitors the quality, appropriateness and effectiveness of health care services requested by providers for beneficiaries. The Clinical Unit 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 and/or adopts clinical criteria for certain established clinical services, new technologies and medical treatments; 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 beneficiaries.

The unit also manages the Clinical Utilization Review Board (CURB) meetings. The CURB is an independent advisory board comprised of ten (10) members with diverse medical experience who are appointed by the governor upon recommendation of the Commissioner of DVHA. CURB examines existing medical services, emerging technologies and relevant evidence-based clinical practice guidelines and makes recommendations to DVHA regarding coverage, unit limitations, place of service, and appropriate medical necessity of services in Vermont's Medicaid programs. The CURB bases its recommendations on medical treatments and devices that are the safest and most effective for beneficiaries. DVHA retains final authority to evaluate and implement the CURB's recommendations.

Pharmacy
Responsible for managing the pharmacy benefit programs for beneficiaries enrolled in Vermont's publicly funded health care programs and ensuring those 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 DVHA's contracted Pharmacy Benefit Manager (PBM) work with pharmacies, prescribers and, at times, beneficiaries to resolve benefit and claims processing issues, and to facilitate appeals related to prescription drug coverage within the pharmacy benefit.

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. The Pharmacy Unit also manages the activities of the Drug Utilization Review (DUR) Board, whose members include Vermont physicians, pharmacists, and a member at large. 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.

Provider and Member Relations
Ensures beneficiaries have access to an adequate provider network to serve their medical needs. The unit is responsible for linking beneficiaries with primary care providers and ensuring beneficiaries are served in accordance with managed care requirements. Staff also oversees provider contracting and enrollment, seven (7) transportation brokers/contractors, the member services contract, and the Vermont State Dental Clinic contract.

Quality Improvement and Clinical Integrity
Collaborates with DVHA's AHS partners to maintain quality standards as required by the Code of Federal Regulations (CFR); prepares for the annual external quality reviews as required under the Global Commitment to Health Waiver as well as state quality audits; maintains the Vermont Medicaid Quality Plan; coordinates quality initiatives with the DVHA Managed Care Medical Committee; and provides concurrent review and authorization of psychiatric inpatient and detoxification admissions. Oversees the Children's Health Insurance Program Re-authorization Act (CHIPRA) Quality Measures grant and will implement the Adult Quality Measures grant recently awarded by the Centers for Medicare and Medicaid Services (CMS) to Vermont.

Substance Abuse
Coordinates the services we offer to members who are recovering from opioid dependence; prior authorizes several medications used for chemical replacement therapy. Administers the Team Care program which links a member to a single prescriber and a single pharmacy. The Team Care program is designed to ensure appropriate care is delivered to members with a history of drug-seeking behavior or other problematic use of prescription drugs.

Medicaid Policy, Fiscal and Support Services Division

The following units are designated in the division that reports to the Deputy Commissioner for Medicaid Policy, Fiscal and Support Services:

Coordination of Benefits (COB)
Works with providers, beneficiaries, and other insurance companies to ensure that Medicaid is the payer of last resort, through coordination of benefits and collections practices. COB currently, through December 31, 2013, administers the Catamount Health and Employer-Sponsored Insurance Assistance programs by performing analyses to ensure beneficiaries are placed in the most cost-effective program.

Data Management and Analysis
Provides data analysis and distribution of Medicaid data extracts such as VHCURES to state agencies, the legislature and other stakeholders and vendors; provides mandatory federal reporting to the Centers for Medicare and Medicaid Services (CMS), annual HEDIS reporting, and other reporting initiatives for federal and state agencies and departments requiring Medicaid data; provides ad hoc data management and analysis for internal DVHA divisions and units including the budget development process.

Fiscal and Administrative Operations
Supports, monitors, manages and reports all aspects of fiscal planning and responsibility. Functions include provider assessment receipts, vendor payments, timesheets, expense reports, grants, contracts, purchasing, financial monitoring, budgeting, human resource support, space and operational duties as well as other relevant practices, procedures and processes.

Program Integrity (PI)
Engages in activities to prevent, detect, and investigate Medicaid fraud, waste and abuse by utilizing data mining and analysis to recoup provider overpayments. The PI Unit educates providers about accurate billing and refers cases of suspected provider fraud to the Attorney General's office and potential beneficiary eligibility fraud to DCF.

Program Policy
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 CMS.

Health Reform Division

Health Reform (HR) became a division within DVHA in 2009, with responsibilities to assist and coordinate state health reform initiatives designed to increase access, improve quality and contain the cost of health care for all Vermonters. DVHA HR is also responsible for Vermont's health information technology (HIT) strategic planning, coordination and oversight.

The Health Reform Division, in partnership with other public and private entities, provides assistance and coordination across state government to foster collaboration, inclusiveness, consistency, and effectiveness in matters related to state and federal health care reform. This includes but is not limited to financial aspects of the Health Services Enterprise and in particular, submission and updating of Federal funding requests and providing the conduit for communication and program milestone checkpoints with CMS.

The HR Division functions include:

Policy Implementation
Helps to ensure that state government activities related to state and federal reform efforts are aligned with the Governor's policy direction. Helps to coordinate "system transformation" efforts associated with the implementation of health reform to ensure state government effectively supports and is aligned with the health reform initiatives being implemented in the private sector.

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, managing the contract with VITL for HIE operations and HIT expansion, and managing the contract for the Statewide clinical data registry (currently with Covisint/DocSite). 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 enable implementation of Agency Service Oriented Architecture (SOA) and its integration with HIT/HIE, Integrated Eligibility system, and Health Benefit Exchange systems, including Provider Directory and Enterprise Master Persons Index. In close collaboration with the Director of Health Care Reform in the Agency of Administration, supports the coordination of efforts associated with the Vermont health information technology project pursuant to 18 V.S.A Chapter 219.

The Health Reform Division, in partnership with other public and private entities, provides assistance and coordination across state government to foster collaboration, inclusiveness, consistency, and effectiveness in matters related to state and federal health care reform.

Health Reform Technology
Vermont brings together coverage reforms, delivery system and process reforms, technical and data advances, administrative simplification, and financing and payment reforms that, in combination, are intended to lead the state to a single system of care and eventually to a single-payer health care system. Building on the strengths of its achievements to date, and further authorized by Act 48, Vermont is leveraging state initiatives with opportunities provided by the ACA and other federal programs supporting health and health reform. Taken together, these provide the opportunity to expand health benefit coverage and to create a fully integrated digital infrastructure for a learning health system to improve care, improve health, and reduce costs.

To create an information ecosystem that supports this vision, the Division, in close collaboration with AHS IT and the Department for Information & Innovation, is leading the State effort to wire the "neural network" of its health care system to provide real time, and close-to-real time, clinical and financial information for the management of the health care system *as a system*. DVHA is leading a systematic and sequential approach for procuring services that support the integration and leveraging of technologies and business processes across the Agency of Human Services (AHS), across programs, initiatives, and systems to support our health care transformation.

Health Information Technology Fund
Established during the 2008 legislative session in the state treasury to further progress on Health IT, 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 is used to provide resources that can be matched under new federal HIT initiatives. Overseen by the DVHA Health Reform Division, billing and administrative support is provided by the DVHA Fiscal and Administrative Operations unit and enforced by the Health Care Administration (HCA) Division of the Department of Financial Regulation (DFR).

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 Benefit Exchange Division

The Health Benefit Exchange (Exchange) Division was added to DVHA in 2011 as a result of the Patient Protection and Affordable Care Act (PPACA) and Vermont Act 48. The Exchange Division is tasked with the creation of a virtual marketplace for the transparent choice and purchase of individual and small group health coverage, interoperability with other state health care programs, and for an active platform for the future universal health care system envisioned in Vermont statute.

Vermont Health Connect will be a marketplace where individuals, families and small businesses in Vermont can compare public and private health plans and select one that fits their needs and budget. Every plan offered through **Vermont Health Connect** must offer basic services which include checkups, emergency care, mental health services and prescriptions. Beginning in October 2013, **Vermont Health Connect** will offer easy-to-understand, side-by-side comparisons of each plan's costs and benefits. **Vermont Health Connect** will simplify the health coverage world for many Vermonters by serving as the one place to access public programs and financial assistance, such as federal tax credits and cost-sharing subsidies. Vermonters will find all the **Vermont Health Connect** information they need online. Those who are uncomfortable with the internet or want personal assistance selecting a health plan can call the Customer Support Center or contact a navigator or broker for in-person assistance.

VERMONT HEALTH CONNECT
Find the plan that's right for you.

More specifically, in 2013, the Exchange team will implement the following components:

- Individual and family eligibility based on qualified health plans (QHP) and modified adjusted gross income (MAGI) determination
- Individual enrollment integration to support operational reconciliation of enrollment data between the State, qualified carriers, and the Federal Data Hub

Plan management for QHPs, connectivity to the System for Electronic Rate and Form Filing (SERFF), and the ability to present plans via **Vermont Health Connect**.

Small business integration to support small group employer eligibility determination, employer plan selection, employee census management, premium aggregation, and Federal reporting requirements

Financial management to enable premium processing for individuals and small businesses, premium remittance to issuers, and reporting

Administrative capabilities to support monitoring and reporting of system performance, audit trails, an operational management of the **Vermont Health Connect**

Business analytics solution that will use a data warehouse for business intelligence and reporting

Noticing by email and paper, based on federal and state mandates and regulations

Web portal with 'friendly' navigation to enable Vermonters to apply for and review benefit options offered through the **Vermont Health Connect**

Customer support call center to assist individuals and small employers in all aspects of the Exchange process, including plan selection

Vermont's Exchange is **Vermont Health Connect**, and the mission is to provide all Vermonters with the knowledge and tools needed to easily compare and choose a quality, affordable, and comprehensive health plan.

Exchange evaluation plan, including consumer satisfaction surveys

Individual and employer responsibility determination process regarding exemptions from complying with the insurance mandate based on lack of minimum essential coverage, lack of an affordable plan, and process to determine whether individual employers are subject to tax penalties for employees who do not have access to minimum essential coverage through the employer

Navigator program to provide grants to qualified individuals and/or organizations to educate and assist individuals and small businesses in enrolling in health coverage through the Exchange

Stakeholder consultation in ongoing meetings with the Medicaid and Exchange Advisory Board

Comprehensive outreach, education and marketing campaigns aimed at consumers and employers, with consideration of individuals with disabilities, limited English proficiency, and other potential barriers to enrollment.

Blueprint for Health

The State of Vermont has demonstrated an intensive commitment to comprehensive health reform that includes the following components: universal coverage, a novel delivery system built on a foundation of medical homes and community health teams, a focus on prevention across the continuum of public health and health care delivery, a statewide health information exchange, and a robust evaluation infrastructure to support ongoing improvement with quality and cost effectiveness as guiding principles. From policy to implementation, Vermont's reforms are designed to provide

access to high quality health care for all of its residents (at the population level and at the individual experience of receiving care), and to improve control of health care costs

The Blueprint is charged with guiding a process that results in sustainable health reform, centered on the needs of patients and families. In effect, the program is intended to bring "system-ness" to a health delivery world that is characterized by independent organizations, segregated services, poor communication within and across organizations, and funding streams that are often not aligned with health related goals.

Guiding legislation calls for a highly coordinated statewide approach to health, wellness, and disease prevention. Vermont's Blueprint for Health is leading this transformation with an Advanced Model of Primary Care statewide. This program includes nationally recognized Patient Centered Medical Homes (PCMHs) supported by Community Health Teams (CHTs), and a health information technology infrastructure that supports guideline based care, population reporting, and health information exchange. Vermont Act 128 of 2010 called for full implementation in every willing primary care practice by October of 2013. Vermont Act 48 of 2011 echoed this commitment. The multi-disciplinary CHTs include members such as nurse coordinators, health educators and counselors who provide support and work closely with clinicians and patients at a local level. Services include individual care coordination, outreach and population management, counseling, and close integration with other social and economic support services in the community. Team-based care is at the core of all Blueprint efforts.

Team-based care is at the core of all Blueprint efforts.

The link from the CHTs to targeted services is essential in order to serve the needs of the spectrum of acuity and intensity in a given site. To that end, the Blueprint is spearheading planning and leveraging federal and state support for such programs as Support and Services at Home (SASH) for at risk Medicare beneficiaries and Medication Assisted Therapy (both methadone and buprenorphine) reorganization for patients with opioid dependence via the "Hub and Spoke" model. Both of the extender-type activities build upon and take advantage of the existing CHT infrastructure locally.

Underlying the Blueprint model is financial reform that aligns fiscal incentives with healthcare goals. All major commercial insurers, Medicare and Vermont Medicaid are participating in financial reform that includes two major components. First, primary care practices receive an enhanced per person per month (PPPM) payment based on the quality of care they provide. The payment is based on the practices' official National Committee for Quality Assurance's recognition program scores and is in addition to their normal fee-for-service or other payments. This provides an incentive for ongoing quality improvement. The salaries of the CHT members, proportional to the participating practices' patient numbers are paid by the insurers as well.

The foundation of patient centered medical homes and CHTs is supported by a robust health information and evaluation infrastructure. This infrastructure includes data sources to evaluate the clinical and financial impacts of the model. Data sources include the following: direct clinical chart

reviews (electronic and paper), analysis of the statewide web-based registry (Covisint DocSite), qualitative assessment of patient, provider and practice experience including a planned statewide survey of patient experience using the CAHPS-PCMH survey, multivariate analysis of existing public health databases, and Vermont's multi-payer claims database (VHCURES) which populated the Blueprint financial impact ("Return on Investment") model. Routine reporting provides a basis for ongoing quality improvement and planning for statewide expansion. Financial sustainability is based on a reduction in unnecessary acute care (specifically a reduction in hospital admissions), and insurers shifting their current expenditures from contracted disease management services to CHTs.

The sustainable targeted payment and system reforms of the Blueprint are serving as a basis for broader reforms being undertaken at the state level. Expansion and refinement will continue as planned in 2013-14.

Medicaid Payment Reform and Reimbursement

The Payment Reform and Reimbursement Unit develops and implements DVHAs value-based payment reform strategy, oversees the provider payments and reimbursement methodologies for Vermont's Medicaid Program including the oversight of Vermont's provider assessment, Disproportionate Share Hospital (DSH) payments, and cost settlement process. This Unit also actively works with the Medicaid providers and other stakeholders to support care delivery reform, improved access and quality of care through implementation of a value based reimbursement system.

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SFY 2013 Initiatives

Last year, the legislature approved several DVHA cost savings proposals. These are listed below along with a status update on the successes or challenges to date.

Outlier Coordination of Benefits Case Resolution ($500,000 expected savings)
The Vermont Supreme Court re: (John Doe case) issued a decision that Vermont Medicaid liens do not have priority over other claims, ruling that federal law prohibits priority. In June 2012, the Attorney General's (AG) office notified DVHA that the Court had amended that decision to applying to pre-2008 amended statute 33 V.S.A.1910. As a result, the amount of DVHA's refund was reduced by the Court and DVHA was notified by the AG's office that a check would be forthcoming in the amount of approximately $144,000. The check was received the first week in January 2013, and the case has been closed.

Require Insurance Companies to Check for Medicaid Eligibility ($100,000 expected savings)
In October 2012, the following information was added to DVHA's website and communicated to the Property and Casualty Insurance (PCI) Vermont Key Contact List and the PCI Claims Committee:

> *Sec. E.307.3.1 IMPLEMENTATION OF INSURERS' OBLIGATIONS*
>
> *(a) The department of Vermont health access shall prepare and distribute an outreach document reminding insurers of their obligations under Sec. E.307.3 of this act. At a minimum, the outreach document will reinforce insurers' obligation to seek out Medicaid liens, and outline reporting requirements, including savings amount achieved. The outreach document may provide examples of areas of concern and department contact information. http://dvha.vermont.gov/budget-legislative/cob-insuror-procedure-for-determining-the-existance-of-medical-liens.pdf*

In November 2012, the Department of Financial Regulation (DFR, formerly BISHCA) provided a link on its website to information on DVHA's website regarding insurers' obligations to check for Medicaid eligibility. DVHA Coordination of Benefits (COB) Casualty Recoveries has received a few calls regarding the statute change, but after 4 months of outreach, has not calculated any measurable savings from this statute change.

Manage High-Risk Pregnancies ($450,000 expected savings)
The two High Risk Pregnancy Care Coordinator positions remain under recruitment. Pending the hire of these positions, the Vermont Chronic Care Initiative (VCCI) will initiate a pilot in Franklin County using a current VCCI staff member with experience in Maternal Child Health who already has been working with high risk substance using pregnant women since 2011. In addition, VCCI and the Vermont Department of Health (VDH) partners are working with Blueprint leadership to assure coordination with the Hub and Spoke case managers being added to Community Health Teams to work with beneficiaries receiving Medication Assisted Therapy (MAT) and their providers. Together, VCCI, VDH and Blueprint are developing a criteria-based, coordinated case management system for high risk pregnant women receiving Suboxone® for opioid dependence. Leadership from

VCCI, VDH Maternal and Child Health (VDH/MCH), Department for Children and Families Children's Integrated Services (DCF/CIS), and the Agency of Human Services IFS staff meet regularly to coordinate the various initiatives for targeted groups within the high risk pregnancy population. DVHA also collaborated closely with VDH on its application for grant funding through the CMS *Strong Start* initiative; award notification is expected in January 2013. Through *Strong Start*, CMS will evaluate different state efforts to reduce pre-term births among women receiving Medicaid. Vermont's proposal builds upon the Blueprint for Health medical home model by working with OB/GYN and other pregnancy care providers to establish pregnancy care homes with enhanced services and supports for pregnant women, and seamless transitions after birth to primary care and pediatric medical homes.

Due to staffing challenges related to state compensation levels and the resulting inability to fully implement the high risk pregnancy program to date, achieving full projected cost savings may be delayed. Once these positions are filled, VCCI anticipates being able to achieve the targeted savings. To improve both recruitment and retention, DVHA revised all nursing position pay grades and also is evaluating the need for a market factor adjustment.

Manage Substance Abuse Services ($690,059 expected savings)
All three (3) staff members (a director and two coordinators) for the new DVHA Substance Abuse Unit have been hired. Effective August 6, 2012, this unit began managing the Team Care services and expanding services to include additional cases. In addition, this unit supports overall system development and enhancements that continue the State's advancement toward a fully integrated system of care (e.g., the Hub and Spoke model). The unit also works with the Medicaid Medical Director on reconsiderations and appeals for all controlled substance authorizations, and collaborates with the Vermont Chronic Care Initiative (VCCI) and the Pharmacy Unit to provide beneficiary outreach and oversight.

Claims are used to identify high risk members for the Team Care program who have demonstrated one or more of the following behavior(s): high ED usage or visits at multiple hospitals; duplication of services received from more than two providers; non-adherence with narcotics contracts; drug screenings that indicate non-adherence with prescribed care; pill counts that indicate inappropriate utilization, and; altered or forged prescriptions. Through addressing these factors, the Substance Abuse Unit expects to meet its savings target. Savings are determined using a six month pre- and post- intervention methodology.

Expand VCCI Initiatives ($1,501,303 expected savings)
The VCCI currently operates out of 20 locations statewide. In addition to 11 AHS work locations, VCCI care coordinators are currently embedded within nine medical facilities, including seven high volume Medicaid provider practice sites and two hospitals. Further expansion of the embedded model to additional hospital and provider sites will occur during 2013: a nurse case manager will be placed at the Community Health Center in Burlington; discussions are occurring with the Springfield FQHC, and; a VCCI nurse will be integrated with the Central Vermont Medical Center case managers/discharge planners. Similarly, the VCCI is establishing a daily presence at FAHC with

access to inpatient nurse case managers/discharge planners. The many benefits of this model include a greater ability by VCCI to connect beneficiaries who visit hospital emergency rooms with a medical home, and enhanced coordination of care transitions from inpatient to outpatient settings. Lastly, the VCCI is receiving hospital inpatient and ED data through secure FTP sites from several hospitals, which facilitates more timely information sharing and supportive outreach to beneficiaries. VCCI is successfully achieving savings through earlier interventions to reduce preventable inpatient and ED utilization and by reducing costs associated with uncoordinated care. Savings are determined by comparing actual costs with those that were expected in the absence of VCCI interventions. Savings are measured for each SFY after a six month claims run out period.

VCCI has continued to confront significant challenges recruiting and retaining qualified nursing candidates due to the classified pay range. DVHA has reclassified all nurse case manager positions to increase the pay to a more competitive level, and a market factor pay adjustment also is under review.

DVHA hired an advanced practice nurse practitioner to support development and lead implementation of the Pediatric Palliative Care Program (PPCP) for children with life limiting diagnoses who are not expected to live beyond the age of 21. Extensive collaboration occurred with internal (DCF/IFS and VDH) and external (UVM, FAHC, Parent-Child Centers, Home Health Agencies and various advocacy groups) partners to develop referral and authorization forms, select a core set of eligible conditions, establish enrollment/eligibility criteria, develop assessment tools and operating manuals, etc. Progressive training roll out to Home Health Agency staff continues and a formal Pediatric End of Life Nursing Education Consortium (ELNAC) training was held in September 2012. The PPCP was launched in September 2012, with implementation completed in Central Vermont and Chittenden, Windsor, Windham, Rutland and Bennington counties. Staff engaged the Act 264 committee and will reconvene the Pediatric Palliative Care Advisory Group in early 2013.

Perform Concurrent Reviews and Discharge Planning for Medical Surgical Extended LOS ($2,000,000 expected savings)
Effective July 1, 2012, DVHA expanded concurrent review to include individuals hospitalized for more than 13 days in an in-state or border facility. A Banner notification was sent in advance of implementation to the facilities and DVHA senior management met in advance with the Vermont Association of Hospitals and Health Systems (VAHHS) to answer questions. DVHA developed a concurrent review process manual that was distributed through VAHHS and posted on DVHA's web site.

One hospital has provided DVHA with access to its electronic medical records system and others will be submitting census information through a dedicated FTP site currently under development. A tracking system has been developed to capture key data points to enable utilization and quality analyses. Collaboration is ongoing with the VCCI and Blueprint for Health to ensure beneficiaries with complex conditions have a medical home and are engaged in health education and care coordination activities.

The Concurrent Review Nurse Case Manager position remained vacant until January 2013, largely due to the classified pay range. DVHA has reclassified all nursing positions to increase the pay to a more competitive level.

Preliminary data analysis (first three months) indicates there has been a decrease in outlier payments, readmissions and average lengths of stay. Based on this very preliminary trend, it appears DVHA is on track to achieve the savings target. However, more months of data and allowing for a six month claims run out period will provide a more accurate estimate.

Co-Pay Restructuring ($384,000 expected savings)
Due to a delay in CMS's approval of the Global Commitment 1115 Demonstration Waiver amendment, DVHA implemented the restructured co-payments effective August 1, 2012, instead of July 1, 2012. Beneficiaries were notified of the change and DVHA implemented a reporting system to track out-of-pocket costs in relation to the 5% and to generate a refund to Medicaid beneficiaries if their cost sharing exceeds the 5%. At the end of the first quarter, 11 households were reimbursed a total of $708.65. Other than the one month delay in implementation, DVHA appears on track to achieve the expected savings.

Perform Concurrent Reviews and Discharge Planning for Mental Health Hospitalizations ($600,000 expected savings)
Effective August 13, 2012, DVHA in collaboration with the Department of Mental Health (DMH) expanded its utilization review functions to all Medicaid primary beneficiaries hospitalized for mental health conditions or detoxification. A Banner notification was sent in advance of implementation to providers regarding the new care management system and implementation of inpatient authorizations. DVHA and DMH jointly visited the designated psychiatric hospitals to include them in developing this system. Prior to implementation, DVHA hired two additional licensed clinical professionals and adopted nationally recognized criteria for the purpose of utilization review. DVHA and DMH continue to collaborate in developing a seamless care management system, with care managers from both departments functioning as a single team.

The two departments also work closely with DVHA's Vermont Chronic Care Initiative (VCCI) care coordinators, DVHA's Substance Abuse unit, Blueprint for Health Community Health Teams (CHTs), Agency of Human Services Field Services Directors and Integrated Family Services (IFS) staff, and the Vermont Department of Health's Division of Alcohol and Drug Abuse Programs (VDH/ADAP) to develop a more coordinated and cohesive system of care for individuals with co-occurring conditions.

Because concurrent review and authorization began August 13, 2012, only three months of data are available, but these data indicate a decrease in the utilization of bed days statewide for DVHA. The utilization reviewers at both DVHA and DMH are assisting the hospitals to access resources for discharge to ensure beneficiaries receive services at the most appropriate level of care. The utilization reviewer/care managers are able to assist hospitals resolve discharge problems, including facilitating communication between the hospital and community providers, which is resulting in decreased lengths of stay.

Transportation Quality Assurance & Coordination ($900,000 expected savings)
Effective July 1, 2012, DVHA transitioned the Non-Emergency Medical Transportation (NEMT) contracts to a per-member per-month (PMPM) payment methodology, which encourages service coordination and efficiencies. After prolonged negotiations, an existing broker discontinued its participation in the NEMT program, requiring DVHA to work with bordering established brokers to provide coverage for the affected service area with no breaks in service for beneficiaries. Letters were mailed to beneficiaries notifying them of the change. Through better case management and coordination between Provider and Member Relations and the Program Integrity unit, DVHA is progressing toward its goals to slow the growth in NEMT costs and improve service quality.

Effective October 1, DVHA also implemented several improvements to the bus pass program. DVHA is partnering with its Member Services contractor Maximus to monitor bus pass use and verify appointments prior to authorizing the services.

Year-to-date transportation program savings are estimated at $400,000. Transition to the PMPM model interrupted direct cost growth but administrative costs were slightly higher than expected during implementation. Stability in the system going forward should allow for additional administrative savings.

Prior Authorization Requirement for Out-of-State Outpatient Office Visits ($275,000 expected savings)
Effective July 1, 2012, prior authorization (PA) requirement for all out-of-state/out-of-network outpatient elective office visits was implemented. Out-of-state/out-of-network providers were sent letters and were also informed through a Banner notification about the PA requirement. Members were notified through the member newsletter.

The DVHA clinical unit initially received a high volume of PA requests for non-urgent medical visits to out-of-state/out-of-network providers. The majority of these requests were from providers in bordering states located in close proximity to Vermont. After careful review, DVHA management decided to exempt these providers from the PA requirement to ensure beneficiary access to primary care services.

Initial data analysis (first three months) shows a decrease in the out-of-network outpatient office visits. Based on this very preliminary trend, it appears DVHA is on track to achieve the savings target. However, more months of data and allowing for a six month claims run out period will provide a more accurate estimate.

Perform Earlier Pediatric PT/OT/ST Utilization Reviews ($100,000 expected savings)
The new Rule went into effect July 1, 2012. A Banner page notification was sent in advance of implementation notifying providers of this requirement, and providers also received training before the change went into effect. The purpose of the change was to ensure appropriate and efficacious treatment, because appropriate care is cost effective care. A “soft start” was implemented to assist providers in the initial phase of the rule change, which was completed by September 1, 2012.

Response from providers has been positive and no complaints or concerns have been received to date from either providers or beneficiaries.

Since implementation, savings have accrued through earlier detection of inappropriate treatment, resulting in more effective care. Referrals to the Program Integrity unit for recoupments have also been reduced. In addition, relationships with providers have become more supportive because DVHA is able to begin collaborating on treatment plans much earlier in the process, contributing to increased provider satisfaction and retention.

Reduce Payments on Contiguous Body Parts ~ Ultrasounds ($165,000 expected savings)
The multiple procedure rate reduction was implemented July 1, 2012. A Provider advisory and a Banner page notification regarding the change were sent to providers in advance of implementation. The reduced payments have been applied to 1,196 claims since implementation. Based on this very preliminary trend, it appears DVHA is on track to achieve the savings target. However, more months of data and allowing for a six month claims run out period will provide a more accurate estimate.

Increase "Pay & Chase"/Cost Avoidance Receipts due to New Pharmacy Data Matching ($2,000,000 expected savings)
On November 1, 2012, DVHA implemented an improvement in the way it processes point-of-sale pharmacy claims that reduces the need for manual post-payment coordination-of-benefits intervention. The program is a new component of the State's contract with its pharmacy benefits manager (PBM). It relies on health insurance enrollment information supplied by insurers to identify and deny claims – at the point of sale – that should be billed to primary insurers before being billed to DVHA, the payer of last resort. In addition to denying the claim, DVHA's return messaging on the denied claim provides the pharmacy with the correct insurance billing information. Gross savings were estimated to be approximately $2,725,000 annually with an increase in administrative costs of $725,000.

While the program was expected to be implemented October 1, 2012, it was delayed until November 1, 2012, due to a delay in the execution of a contract amendment with the PBM. For the first two months of program operations, DVHA's Third Party Liability (TPL) cost-avoidance savings is approximately $595,000, with administrative costs of approximately $27,000, for a net savings of $568,000. This savings includes both annualized and monthly savings figures, and is the result of both operational savings, and updates and improvements to the eligibility feed from the state to the PBM that allow better identification of TPL information.

Program results are based on limited operational data and as the program matures DVHA will continue to monitor and evaluate ways to improve the robustness of the program. However, one major insurer has been unwilling to share TPL data on its members with DVHA, which may impact savings because DVHA has been unable to effectively identify and deny claims at the point of sale for those beneficiaries. DVHA continues to explore alternative ways for the insurer to share this data in a manner the insurer finds acceptable.

Enhance Pharmacy Edits ($125,000 expected savings)
This initiative focuses on avoiding excessive waste in the mandatory 90-day supply (90DS) program for select maintenance drugs. Effective July 1, 2012, DVHA modified the program to allow two initial 30-day fills of maintenance medications, thereby allowing additional time for physicians to titrate patients to desired doses before a 90-day supply is required. This change is expected to save the State $125,000 annually. A limited analysis was performed by the DVHA to evaluate the cost-effectiveness of the 90DS program. For one medication analyzed, a common oral inhaler used to treat asthma and chronic obstructive pulmonary disease (COPD), the net savings of the program was $13,375 annually. Despite occasional changes in therapy and some patients losing eligibility during a 90 day period, the program still achieves substantial cost savings and a savings to waste ratio exceeding 2:1. Allowing an additional 30 day fill will further reduce waste. DVHA continues to review and analyze the cost-effectiveness of this program, and another large class analysis is planned for first quarter SFY 2014.

Contract for Nutritional Supplements ($25,000 expected savings)
Through its participation in the Sovereign States Drug Consortium (SSDC), DVHA attempted to secure preferred pricing on oral nutritional supplements to achieve a projected savings of $25,000. After completing research, analyzing data, and discussing supplemental rebates with the Consortium, DVHA determined this was not a viable approach at this time. One reason for this decision is limited choice of products and manufacturers, particularly for children, who comprise a significant amount of nutritional supplement use; it is important to find supplements for children with an acceptable taste and texture. Also, of the limited number of generics available, many are "store brands," which would limit access within DVHA's network. In addition, for many specialty products such as those used for protein mal-digestion, there are no alternatives and therefore they are only available from a single manufacturer. When DVHA polled the SSDC states, none were interested in pursuing a separate bid process for these products; several states had unsuccessfully attempted this approach in the past. DVHA will continue to monitor the availability of nutritional products in the marketplace and apply clinical criteria through prior authorization to assure appropriate use of these products.

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Measurement and Outcomes

The content of the following pages shows program statements, outcomes and future efforts for some of our initiatives and units.

Blueprint for Health

Coordination of Benefits Unit

Program Integrity Unit

Vermont Chronic Care Initiative

Healthcare Effectiveness Data and Information Set (HEDIS)

Blueprint for Health

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Program Statement

The Vermont Blueprint for Health is a nationally recognized, comprehensive health care reform program supported by DVHA, Blue Cross Blue Shield of Vermont, MVP Health Care, Cigna Health Care, and Medicare. The model consists of:

- Advanced primary care practices (APCPs) throughout the state that are recognized as patient centered medical homes by the National Committee for Quality Assurance (NCQA)
- A multi-disciplinary core community health team and additional specialized care coordinators within each of the state's 14 health service areas (HSAs) which support the APCPs and their patients
- Comprehensive evidence-based self-management programs
- Key targeted payment reforms
- Implementation of health information technology (HIT)
- A robust, multi-faceted evaluation system to determine the program's impact, and
- A Learning Health System that supports continuous quality improvement.

Outcomes

Results of the statewide implementation experience will be published later in 2013, but evaluation of the initial pilots demonstrates the following encouraging trends:

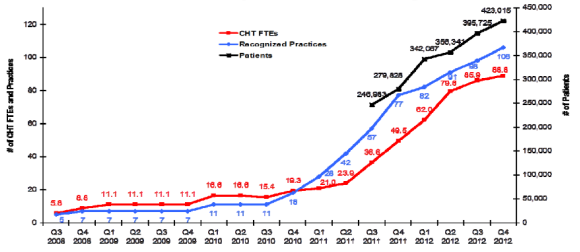
- Between 2009 and 2010, growth rates for emergency room visits and inpatient hospital admissions in participating patients were favorable in spite of this group being older and therefore more likely to have one or more chronic diseases During this period, overall expenditures per capita increased 22% in the Blueprint participants vs. 25% for the control population. In other words, the annual expenditures increases are trending downwards when there was a projected significant increase for the same population ("bending the cost curve").

What's Next?

Future goals of the Blueprint include:

- NCQA recognition of all willing primary care practices as patient-centered medical homes and serving an estimated 500,000 Vermonters by the end of 2013.
- Creating an environment where all Vermonters have access to seamless, effective and preventive health services that improve health care for individuals, improve the health of the population, and improve control of health care costs (the "Triple Aim").
- Achieving community-wide transformation characterized by excellent communication and funding streams aligned with health-related goals, resulting in independent providers working together in ways they never have before.

Blueprint Practices, Patients Served, and Community Health Team Staffing



*Since joining the Blueprint, three practices have combined to form a new practice, one practice has joined an existing practice, and one practice has closed.

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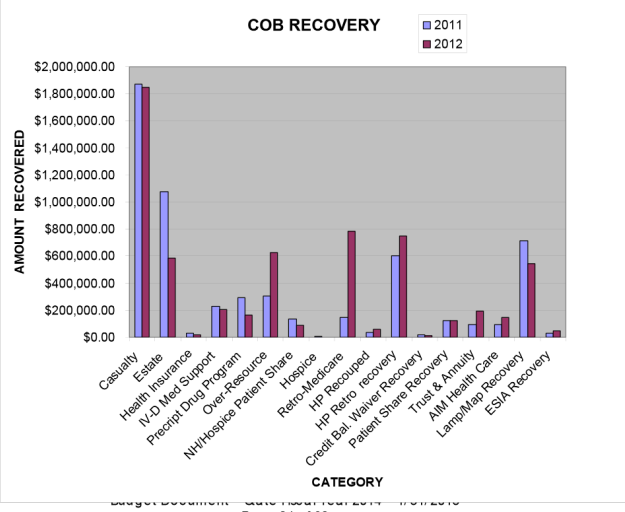
Coordination of Benefits

Program Statement
The Coordination of Benefits (COB) unit works with providers, beneficiaries, probate courts, attorneys, health and liability insurance companies, employers, and Medicare Part D plans to ensure that Medicaid is the payer of last resort, through coordination of benefits and collections practices. COB also administers the Catamount Health and Employer-Sponsored Insurance Assistance (ESIA) programs by performing analyses to ensure beneficiaries are placed in the most cost-effective program.

Outcomes
COB has recovered a total of $6,188,450. in 2012, and $5,789,000. in 2011, through various recovery and recoupment practices as indicated in the chart below.

What's Next?
The COB unit will continue to review Medicaid statutes and rules to strengthen the ability to data-match with health insurance companies. COB will also continue to work with CMS regarding Medicare Dual Eligible. These efforts will help increase cost avoidance and recoveries to ensure that Medicaid is the payer of last resort.

Newly eligible individuals will be enrolled in ESIA until December 2013. The ESIA program will no longer exist as of December 31, 2013 at which time individuals/families and small employers will have an opportunity to shop for and enroll in insurance through the Vermont Health Connect.



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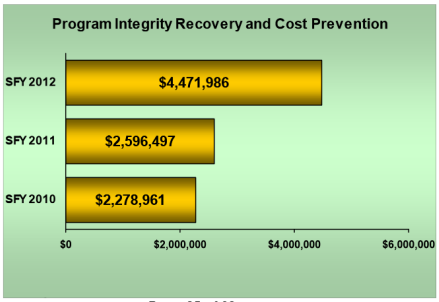
Program Integrity

Program Statement
The Program Integrity Unit works with providers, beneficiaries, our fiscal agents, DVHA units, AHS and other AHS Departments to insure the integrity of services provided and that actual, medically necessary healthcare services for beneficiaries are provided, coded, billed and paid in accordance with federal and state Medicaid rules, regulations, provider agreements and relevant statutes.

Outcomes
The Program Integrity (PI) Unit in DVHA has made significant strides in finding, investigating, and preventing fraud, waste and abuse in the Vermont Medicaid program. During SFY 2011 the legislature approved six (6) new full-time positions to expand the program integrity efforts of DVHA from four (4) FTEs to ten (10) FTEs. The expected annual savings to the State of Vermont was a total of $2.3 million (gross) from PI Unit activities. The PI Unit recovered nearly $2.6 million in recoupment and cost avoidance for SFY 2011. The total recovery in recoupment and cost avoidance for SFY 2012 was $4.47 million and we have recovered $3.5 million in the first six months of SFY 2013.

What's Next
The PI Unit's SFY 2013 Strategic Plan includes the following strategies:

- Work more closely with all units and divisions within DVHA to help identify vulnerabilities when implementing programs
- Work more closely with AHS departments to help identify and prevent fraud, waste and abuse across the entire spectrum of Vermont Medicaid
- Continue to work closely with the Medicaid Fraud and Residential Abuse Unit (MFRAU) in the Office of the Attorney General, to identify and refer potential fraud cases
- Continue to work closely with our fiscal agent, HP Enterprise Solutions (HPES) and our Pharmacy Benefits Manager, Catamaran, Inc. when reviewing and investigating allegations and discovering new cases
- Continue to utilize claims and analysis to detect aberrant billing practices, identify potential findings and perform preliminary investigations
- Continue to work closely with the Medicaid Integrity Institute and our peers in other states to stay up to date with the latest information, methodology, and training.



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Vermont Chronic Care Initiative

Program Statement
Vermont Chronic Care Initiative (VCCI) registered nurses and social workers provide intensive care coordination and case management services to high risk, high utilization, and high cost Medicaid beneficiaries through a holistic approach that addresses physical, mental health, substance abuse, and socioeconomic barriers to health improvement.

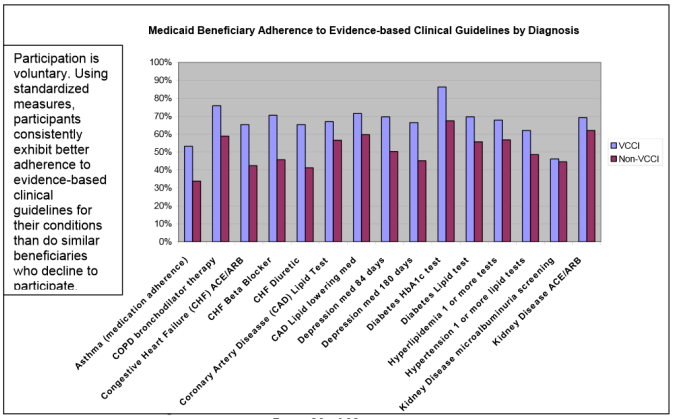
Outcomes
When evaluating VCCI, DVHA tracks hospital utilization and adherence to evidence-based clinical guidelines. In SFY 2011 (the most recent year for which final results are available due to a 6 month claims run out period), both inpatient hospital admissions and emergency room utilization were reduced when compared with the baseline year.

What's Next
In SFY 2012, DVHA obtained a 2:1 Return on Investment performance guarantee from the contractor that provides data and technological support to DVHA's care coordinators. The state of Vermont is guaranteed $2.5 million net savings for SFY 2012.

Reduction in Inpatient Hospital Admissions and Emergency Room Utilization

	Baseline (SFY 2008)	SFY 2011	% Change
Inpatient Admits	188/1000	161/1000	- 14%
ER Use	1145/1000	1030/1000	- 10%

Participation is voluntary. Using standardized measures, participants consistently exhibit better adherence to evidence-based clinical guidelines for their conditions than do similar beneficiaries who decline to participate.



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The Healthcare Effectiveness Data and Information Set (HEDIS)

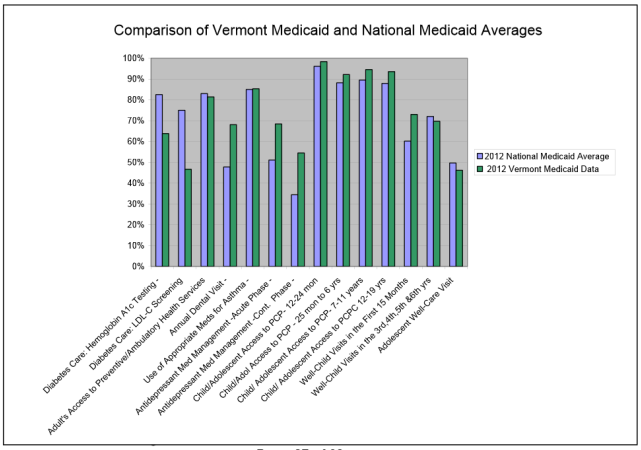
Program Statement

As part of the Quality Program, the Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America's health plans to measure performance on dimensions of care and service. Due to the number of health plans collecting HEDIS data, and because the measures are so specifically defined, HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis.

DVHA uses a vendor certified by the National Committee for Quality Assurance (NCQA) to calculate the measures annually. The measures are reviewed and analyzed by the DVHA Managed Care Medical Committee for accuracy, relevance and consideration for action. Results are used to identify quality improvement initiatives.

Under the terms of the *Global Commitment to Health* waiver, the Department of Vermont Health Access (DVHA) reports on 9 HEDIS measures:

1) Children and Adolescent Access to Primary Care (four age categories: 12 to 24 months, 25 months to 6 years, 7 to 11 years, and 12 to 19 years)
2) Adult Access to Preventive/Ambulatory Health Services
3) Well-Child Visits- First 15 Months
4) Well-Child Visits in 3rd, 4th, 5th and 6th Years
5) Adolescent Well-Care Visits
6) Annual Dental Visits
7) Comprehensive Diabetes Care (ten components)
8) Use of Appropriate Medications for People with Asthma
9) Antidepressant Medication Management (acute and continuation phases)



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Budget Request - State Fiscal Year 2014

FY14 Department Request - DVHA

	GF	SF	IdptT	FF	ARRA Fed	Medicaid GCF	Invmnt GCF	Total
DVHA Administration - As Passed FY13	941,059	1,552,963	4,077,117	79,787,828	76,790	37,855,379	7,372,757	131,663,893
Adjustments:								
								0
Total Adjustments	0	0	0	0	0	0	0	0
Total After FY13 Adjustments	941,059	1,552,963	4,077,117	79,787,828	76,790	37,855,379	7,372,757	131,663,893
FY13 After Adjustments								
Personal Services:								
Annualization of Payact	4,714			171,074	(76,790)	372,422		**471,420**
Increase in benefits - Health	(1,663)	(665)		(39,384)		(142,928)		**(184,638)**
Increase in benefits - Dental	(52)	(21)		(1,231)		(4,468)		**(5,772)**
Increase in benefits - EAP						331		**331**
Increase in benefits - Retirement	113	44		2,688		9,755		**12,601**
FY2014 Worker's Comp Premium						19,742		**19,742**
7 FTE Exchange (HBE) Level 2 Positions				572,244				**572,244**
1 FTE (Net) IAPD Positions - CMS-HIT		4,769		42,918				**47,687**
Blueprint Targeted HCR Investment Evaluation						185,500	314,500	**500,000**
Benefits Administration Contract - Base Adjustment	12,151			26,720		1,176,236		**1,215,107**
Medical Director Increase	2,000			4,398		193,602		**200,000**
Pharmacy Benefits Contract - E-Prescribe	4,600			10,115		445,285		**460,000**
Pharmacy Benefits Contract - E-COB Offset in Program (Net zero)						725,000		**725,000**
Member Services - Transportation services (net zero)	5,000			10,995		484,005		**500,000**
VHCures - MedOregon (provider Link) & Onpoint	4,600			10,115		445,285		**460,000**
ICD-10 & ACA-IAPD Contractual 90/10 funding	203,063			1,827,567				**2,030,630**
Waiver consultation (PHPG)	1,520			3,342		147,138		**152,000**
Re-bid contract for Cost Settlement calculations	500			1,099		48,401		**50,000**
Payment reform consultation	0			0		53,795	91,205	**145,000**
MAPIR Funded in IAPD		34,655		311,899				**346,554**
Match for Healthcare HSE, IE, MMIS ($17.7M total from 7/1 forward)			1,000,000	9,000,000				**10,000,000**

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	GF	SF	IdptT	FF	ARRA Fed	Medicaid GCF	Invmnt GCF	Total
Operating Expenses:								
Building Lease	1,552	2,412	0	323,830				**327,794**
VISION	292			584		28,326		**29,202**
DII Internal Service	896			1,792		86,901		**89,589**
DII Charge On Demand	143			286		13,831		**14,260**
DII Allocation Server/Cloud	765			1,531		74,248		**76,544**
DII Desktop Staff	462			924		44,813		**46,199**
DII Server Staff	1,134			2,268		110,018		**113,420**
FY2014 General Liability Premium	34			68		3,320		**3,422**
FY2014 Commercial Policy Total	(17)			(34)		(1,653)		**(1,704)**
HR Allocation	474			949		46,018		**47,441**
Fee For Space	(9)			(18)		(921)		**(948)**
Grants:								
Eliminate Evidence Based Pratice SF		(400,000)						**(400,000)**
Decrease Provider Incentive Payments ($10,300,000 for SFY'14)				(5,980,000)				**(5,980,000)**
Increase in HIT for SMHP Fair Share Contribution		2,377,464		5,096,418				**7,473,882**
Correct SFY'13 - FMAP for GC-HIT = up in AHS does not need offset		53,810						**53,810**
Change in CHIP FMAP (69.50% to 68.74%)	3,428			(3,428)				**0**
HBE Navigators	400,000					0	0	**400,000**
HBE In Person Assistors						207,760	352,240	**560,000**
Funding changes adjusted based on CAP earnings projections	113,745			(500,223)		(299,302)	685,780	**0**
FY14 Changes	**759,446**	**2,072,469**	**1,000,000**	**10,899,507**	**(76,790)**	**4,472,460**	**1,443,725**	**20,570,817**
FY14 Gov Recommended	**1,700,505**	**3,625,432**	**5,077,117**	**90,687,335**	**0**	**42,327,839**	**8,816,482**	**152,234,710**
FY14 Legislative Changes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	
FY14 Subtotal of Legislative Changes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
FY14 As Passed - Dept ID 3410010000	**1,700,505**	**3,625,432**	**5,077,117**	**90,687,335**	**0**	**42,327,839**	**8,816,482**	**152,234,710**

VERMONT
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	GF	SF	IdptT	FF	ARRA Fed	Medicaid GCF	Invmnt GCF	Total
DVHA Program - As Passed FY13	134,033,397	0	0	139,424,315	0	672,639,153	1,414,929	947,511,794
Adjustments								
Total Adjustments	0	0	0	0	0	0	0	0
FY13 After Adjustments								
Grants:								
Caseload	459,808	0	0	724,477	0	(25,489,183)	(55,752)	**(24,360,650)**
Utilization	(2,964,804)	0	0	(1,562,438)	0	3,480,254	553,044	**(493,944)**
Change in Buy-In	43,889	0	0	75,559	0	(588,287)	(27,469)	**(496,308)**
Change in Clawback	1,691,230							**1,691,230**
Brattleboro Retreat from Medicaid to Investment						(5,225,595)	5,225,595	**0**
Transfer of DVHA funding to other departments for new service delivery	(41,427)	0	0	(90,424)	0	(8,833,523)	0	**(8,965,373)**
Transfer from DVHA to DCF for CIS	(4,458)	0	0	(9,909)	0	(1,238,241)	(958)	**(1,253,566)**
Transfer Family Planning Funding to VDH						(2,000,000)		**(2,000,000)**
Transportation Savings Initiaitve Netted Admin Costs	(56,894)	0	0	(74,200)	0	(368,168)	(738)	**(500,000)**
Pharmacy Savings Initiaitve Netted Admin Costs	(49,186)	0	0	(14,555)	0	(659,076)	(2,185)	**(725,002)**
Annualization of PC Physician Rate Increases	20,245	0	0	116,439	0	3,580,529	5,507	**3,722,721**
Change in Federal Participation	2,599,488			(2,599,488)				**0**
Leahy Bump	(2,213,643)			2,213,643				**0**
Premium Subsidies to 200% FPL						3,343,840		**3,343,840**
Premium Subsidies to 350% FPL						3,242,747		**3,242,747**
Cost Sharing to 350% FPL						3,887,725		**3,887,725**
Begin to Address the Cost Shift						16,113,683		**16,113,683**

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	GF	SF	IdptT	FF	ARRA Fed	Medicaid GCF	Invmnt GCF	Total
Eliminate CFC HCBS - case mgmt - change from 15 minute units with cap of 4	130,680			169,320				**300,000**
Eliminate CFC ERC - eliminate ERC case management	130,680			169,320				**300,000**
Eliminate CFC HCBS - change reimbursement rates from $15/hour to half-day	78,399			101,580				**179,979**
Restore 2% Rate Reduction in ERC	67,954			88,046				**156,000**
Increase wages for self directed personal care	127,597			165,325				**292,922**
Eliminate 2% rate reduction	369,353			478,565				**847,918**
DRS Estimate Nursing Home Statutory Increases	1,306,800			1,693,200				**3,000,000**
NH Utilization Decrease 2.1%	(1,045,440)			(1,354,560)				**(2,400,000)**
Enhance ACCS Rate by $1 (Part of DAIL's Carryforward Usage)	5,786	0	0	8,223	0	335,404	349	**349,761**
Planned Carryforward from FY '13 LTC Portion	(753,579)			(976,400)				**(1,729,979)**
Technical Adj. to CFC Due to Conf. Committee Chgs.	31,356			40,612		(71,968)		**0**
Technical Adj. to State Only Due to Conf. Committee Chgs.	31,668					(37,173)	5,505	**0**
Technical Adj. to non-Waiver Due to Conf. Committee Chgs.	206,635			(139,665)		(66,970)		**0**
FY14 Changes	**172,137**	**0**	**0**	**(777,329)**	**0**	**(10,594,002)**	**5,702,898**	**(5,496,296)**
FY14 Gov Recommended	**134,205,534**	**0**	**0**	**138,646,986**	**0**	**662,045,151**	**7,117,827**	**942,015,498**
FY14 Legislative Changes								
Grants:								
								0
FY14 Subtotal of Legislative Changes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
FY14 As Passed	**134,205,534**	**0**	**0**	**138,646,986**	**0**	**662,045,151**	**7,117,827**	**942,015,498**
TOTAL FY13 DVHA Big Bill As Passed	**134,974,456**	**1,552,963**	**4,077,117**	**219,212,143**	**76,790**	**710,494,532**	**8,787,686**	**1,079,175,687**
TOTAL FY13 DVHA Adjustments	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL FY14 DVHA Starting Point	**134,974,456**	**1,552,963**	**4,077,117**	**219,212,143**	**76,790**	**710,494,532**	**8,787,686**	**1,079,175,687**
TOTAL FY14 DVHA ups & downs	**931,583**	**2,072,469**	**1,000,000**	**10,122,178**	**(76,790)**	**(6,121,542)**	**7,146,623**	**15,074,521**
TOTAL FY14 DVHA Gov Recommended	**135,906,039**	**3,625,432**	**5,077,117**	**229,334,321**	**0**	**704,372,990**	**15,934,309**	**1,094,250,208**
TOTAL FY14 DVHA Legislative Changes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL FY14 DVHA As Passed	**135,906,039**	**3,625,432**	**5,077,117**	**229,334,321**	**0**	**704,372,990**	**15,934,309**	**1,094,250,208**

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Budget Considerations - State Fiscal Year 2014

The Department of Vermont Health Access (DVHA) budget request includes an increase in administration of $20,570,817 and a decrease in program of ($5,496,296) for a total of $15,074,521 in new appropriations (i.e., a combination of new funds and new expenditure authority) compared to our FY13 appropriated spending authority.

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 so 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 ..... $20,570,817 gross / $6,409,005 state

PERSONAL SERVICES $933,615
$118,255 state

Payact and Related Fringe $313,684
$113,486 state

Roll-Out of Previously Approved Positions $619,931
$4,769 state

The Department of Vermont Health Access has undertaken several new initiatives that have resulted in significant new federal funding. These new grants were accepted through the Joint Fiscal Committee approval process, and this funding request represents acceptance of the 7 limited service positions to operationalize the Exchange and 1 limited service position to support the Health Information Technology initiatives that were included in the JFC request.

OPERATING $745,219
$184,513 state

Other Department Allocated Costs $418,373
$180,959 state

DVHA receives allocations from the Department of Buildings and General Services (BGS) to cover our share of the Vision system, the Department of Information and Innovation (DII) costs, and the Department of Human Resources (DHR). Departments are notified every year of increases or decreases in their relative share in order to incorporate these changes into budget requests. For SFY '14, it is anticipated that Vision costs for the DVHA will increase by $29,202, DII costs by $340,012, and DHR costs $47,441. Additionally, there are changes year to year in insurance policy liabilities anticipated to be a $1718 increase.

Office Space **$326,846**
$3,554 state

With the addition of the multiple new federally funding initiatives we've undertaken, our number of employees has grown from 120 (appropriated in SFY '12) to 172 as of this budget request. Additionally, there are myriad contractors who must work side by side with our employees to ensure a successful path toward standing up the Exchange by October 1, 2013. It is necessary to acquire additional space in order to accommodate our needs.

GRANTS AND CONTRACTS **$18,891,983**
$6,106,236 state

Again, due to the incredible growth in responsibilities and complexity that DVHA is undertaking, there are multiple changes in our administrative grants and contracts that are necessary (***$7,398,101 gross / 2,728,772 state***).

Blueprint Investment Evaluation . . . . . $500,000 gross/$217,800 state
MMIS Additional Contractual Costs . . . . . $1,215,107 gross/$524,520 state
Medical Director Increase . . . . . $200,000 gross/$86,333 state
Pharmacy Benefits Manager Contract Changes . . . . . $1,185,000 gross/$514,376 state
Member Services/Transportation Mgmt (cost neutral) . . $500,000 gross/$215,833 state
VHCures ~ MedOregon & Onpoint . . . . . $460,000 gross/$198,566 state
ICD-10 & ACA-IAPD Contractual 90/10 Funding . . . $2,030,630 gross/$203,063 state
Waiver Consultation . . . . . $152,000 gross/$65,613 state
Cost Settlement Contract Renegotiation . . . . . $50,000 gross/$21,583 state
Reimbursement Consultation . . . . . $145,000 gross/$63,162 state
MAPIR Funded in IAPD . . . . . $346,554 gross/$34,655 state
Eliminate Evidence-Based Practice Funding . . . . . ($400,000) gross/($400,000) state
Transfer from AHS for HIT Funds Not Needed . . . . . .$53,810 gross/$53,810 state
Change in Federal Participation Match Rate . . . . . $0 gross/$3,428 state
Exchange Navigators and In-Person Assisters . . . . . $960,000 gross/$643,936 state
Funding Changes Based on CAP Earnings Projections . . . . . $0 gross/$282,095 state

Additionally, there have been significant initiatives associated with Healthcare Reform that require myriad contracting and granting supports. These include the State match for federal funding for major healthcare infrastructure and systems (the Health Services Enterprise infrastructure; Integrated Eligibility; and beginning to replace the Medicaid Management Information System). The State also operates a Medicaid incentive payment program for the adoption of Electronic Health Record technology and incentive payments are projected to reduce in 2014 as most hospitals will have received the bulk of their calculated incentive payments by then and other providers receive lower payments after their first year in the program. Finally, the State has access to additional Medicaid funding for Health Information Exchange operations, although at a higher match rate, and that is the

bulk of the increase in HIT for SMHP Fair Share contribution show below. (***$11,493,882 gross / $3,377,464 state***).

Match for Healthcare HSE, IE, MMIS . . . . . $10,000,000 gross/$1,000,000 state
Decrease Provider Incentive Payments . . . . . ($5,980,000) gross/$0 state
Increase in HIT for SMHP Fair Share Contribution. . $7,473,882 gross/$2,377,464 state

PROGRAM . . . . . ($5,496,296) gross /($22,456,155) state

UPDATED TREND CHANGES . . . . . (33,380,892)
($34,602,369) state

Utilization and Caseload Impact . . . . . ($24,854,594)
($30,790,869) state

Utilization . . . . . ($493,944)
($1,207,900) 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). A historical picture of category of service costs can be reviewed on insert 4.

Caseload . . . . . ($24,360,650)
($29,582,970) state

There is significant change in caseload values this year due to the onset of the Affordable Care Act changes. VHAP and Catamount go away in January 2014, and these programs are replaced with either a New Adult benefit package (that expands covered services beyond the VHAP levels to include dental and transportation services) or access to qualified health plan coverage through **Vermont Health Connect** (that includes federal and state premium and cost sharing subsidies). Please note that since this change occurs mid fiscal year, the caseload values for these populations are represented as a point-in-time enrollment estimate as opposed to an average member month value in order to try and depict the expected number of people enrolled when the program is operational.

There will also be a new eligibility test used for determining the benefit level for which traditional Medicaid enrollees will qualify. The ACA changed the financial methodologies that states use to determine household income for many Medicaid groups. The old rules, based on former cash-assistance income methodologies, were replaced with methodologies that are based on modified adjusted gross income (MAGI) as defined in the Internal Revenue Code. The new rules apply to children, pregnant

women, parents and other caregiver relatives, and adults between the ages of 19 and 65. The ACA also eliminated resource standards for individuals whose income eligibility is based on MAGI. The income and resource standards remain unchanged for the elderly and persons with disabilities, among others.

It should also be highlighted that there is a significant change in federal participation in January 2014. Due to Vermont being an expansion state, Senator Leahy was successful in negotiating a discreet federal enhancement for Vermont of 2.2% for two years. Additionally, the New Adult population qualifies for more federal support than our traditional programs of 22.22% which yields an additional $18.9 million of federal revenue in SFY '14 resulting in a lower general fund need.

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.

Please see program descriptions below to view caseload trend data by Medicaid Eligibility Group.

GreenMountainCare
A HEALTHIER STATE OF LIVING

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 age 65 or older. Eligibility is based on income and resources (e.g., cash, bank accounts, etc.).

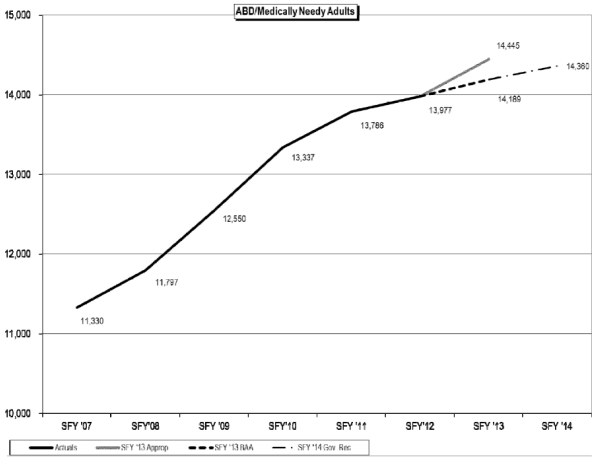
Medicaid programs cover most physical and mental health care services such as doctor visits, hospital care, prescription medicines, vision and dental care, long-term care, physical therapy, medically-necessary transportation and more. Services such as dentures or eyeglasses are not covered, and other services may have limitations.

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 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 '14 for ABD and/or Medically Needy Adults:

Aged, Blind, & Disabled (ABD) and/or Medically Needy Adults					
		DVHA Only		Total	
SFY	Caseload	Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '11 Actual	13,786	$ 88,592,211	$ 535.50	n/a	
SFY '12 Actual	13,977	$ 95,212,717	$ 567.66	$158,495,628	$ 944.96
SFY '13 Appropriated	14,445	$ 100,440,442	$ 579.46	$171,838,251	$ 991.36
SFY '13 Budget Adjustment	14,189	$ 97,260,433	$ 571.21	$168,678,573	$ 990.65
SFY '14 Governor's Recommend	14,360	$ 101,493,654	$ 588.97	$176,742,704	$1,025.64



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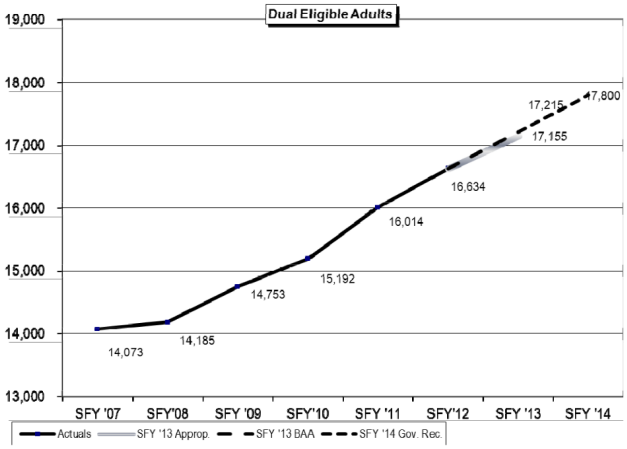
Dual Eligibles

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, and below the protected income level (PIL).

The following table depicts the caseload and expenditure information by SFY, including the Governor's Recommend for SFY '14 for Dual Eligibles:

Dual Eligibles					
		DVHA Only		Total	
SFY	Caseload	Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '11 Actual	16,014	$ 42,746,091	$ 222.44	n/a	
SFY '12 Actual	16,634	$ 43,120,000	$ 216.03	$173,231,075	$ 867.87
SFY '13 Appropriated	17,155	$ 48,138,865	$ 233.84	$194,934,351	$ 946.93
SFY '13 Budget Adjustment	17,215	$ 46,097,874	$ 223.14	$192,935,162	$ 933.93
SFY '14 Governor's Recommend	17,800	$ 48,559,492	$ 227.34	$203,273,214	$ 951.64



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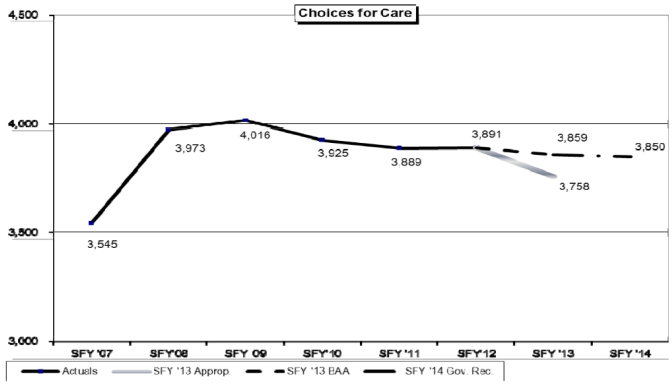
Choices for Care Waiver

Long-Term Care Waiver participants are a subset of the Duals population. These individuals participate in the Choices for Care 1115 demonstration waiver managed by the Department of Disabilities, Aging, and Independent Living (DAIL), in conjunction with the Department of Vermont Health Access (DVHA) and the Department for Children and Families (DCF). The purpose of this waiver is to equalize the entitlement to both home and community based services and nursing home services for all those eligible.

The general eligibility requirements for the waiver are: Vermonters in nursing homes, home-based settings under home and community based services (HCBS) waiver programs, enhanced residential care (ERC), and program for all-inclusive care for the elderly (PACE). Please note that the caseload figures below do not include most moderate-need individuals as they are captured under the Global Commitment waiver program. (Only long-term care services for moderates are included in the dollars below.)

Choices for Care Waiver					
		DVHA Only		Total	
SFY	Caseload	Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '11 Actual	3,889	$ 191,968,507	$4,113.32	n/a	
SFY '12 Actual	3,891	$ 196,477,952	$4,208.14	$ 196,477,952	$4,208.14
SFY '13 Appropriated	3,758	$ 201,312,266	$4,464.65	$ 201,312,266	$4,464.65
SFY '13 Budget Adjustment	3,859	$ 205,732,892	$4,443.09	$ 205,732,892	$4,443.09
SFY '14 Governor's Recommend	3,850	$ 201,375,035	$4,358.45	$ 201,375,035	$4,358.45



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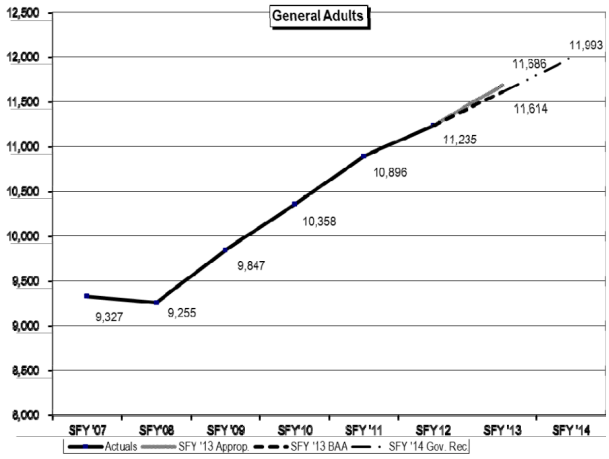
General Adults

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 '14 for General Adults:

General Adults					
		DVHA Only		Total	
SFY	Caseload	Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '11 Actual	10,896	$ 61,424,053	$ 469.78	n/a	
SFY '12 Actual	11,235	$ 61,521,695	$ 456.33	$ 68,112,463	$ 505.22
SFY '13 Appropriated	11,686	$ 71,664,326	$ 511.06	$ 79,100,241	$ 564.08
SFY '13 Budget Adjustment	11,614	$ 65,724,721	$ 471.59	$ 73,162,753	$ 524.96
SFY '14 Governor's Recommend	11,993	$ 69,309,771	$ 481.61	$ 77,146,784	$ 536.07



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Vermont Health Access Plan (VHAP)

VHAP was created by a 1115 waiver to provide low cost, comprehensive health care benefits to adults without children who have a household income below 150% of the federal poverty level (FPL), and adults with children who have a household income below 185% of the federal poverty level.

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

VHAP covers most physical and mental health care services such as doctor visits, hospital care, prescription medicines, physical therapy, and more. It does not cover services such as dental/dentures, eyeglasses or transportation, and other services may have limitations.

The following table depicts the caseload and expenditure information by SFY, including the Governor's Recommend for SFY '14 for VHAP:

VHAP					
		DVHA Only		Total	
SFY	Caseload	Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '11 Actual	36,706	$ 140,821,782	$ 319.71	n/a	
SFY '12 Actual	36,991	$ 144,423,060	$ 325.36	$ 154,655,871	$ 348.41
SFY '13 Appropriated	38,799	$ 161,957,523	$ 347.86	$ 173,502,508	$ 372.65
SFY '13 Budget Adjustment	37,340	$ 148,021,635	$ 330.34	$ 159,569,907	$ 356.12
SFY '14 Governor's Recommend	37,652	$ 86,762,195	$ 342.94	$ 98,929,923	$ 375.36

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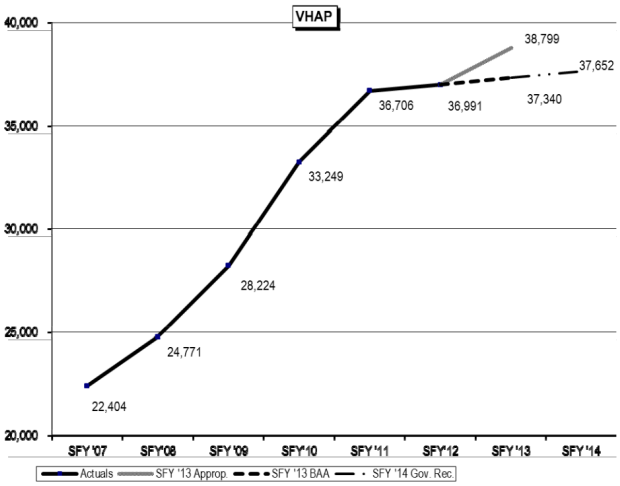

VHAP Employer-Sponsored Insurance Premium Assistance

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
- 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 '14 for VHAP Employer-Sponsored Insurance (ESI) Premium Assistance:

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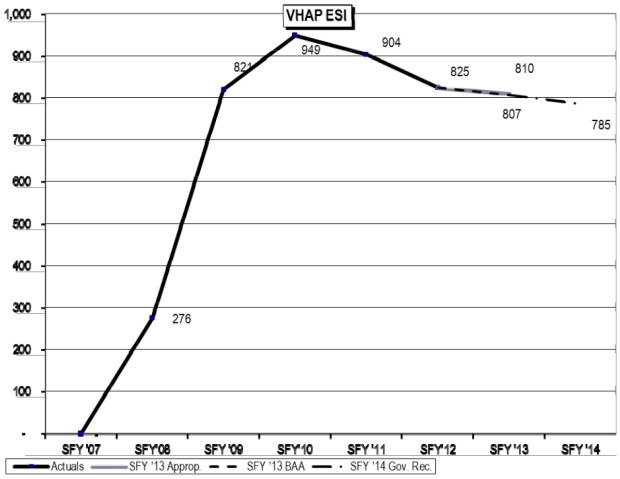
VHAP ESI					
		DVHA Only		Total	
SFY	Caseload	Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '11 Actual	904	$ 1,695,350	$ 156.37	n/a	
SFY '12 Actual	825	$ 1,452,802	$ 146.81	$ 1,452,802	$ 146.81
SFY '13 Appropriated	810	$ 2,006,576	$ 206.35	$ 2,006,576	$ 206.35
SFY '13 Budget Adjustment	807	$ 1,429,801	$ 147.62	$ 1,429,801	$ 147.62
SFY '14 Governor's Recommend	785	$ 713,253	$ 150.76	$ 713,253	$ 150.76



Catamount Health and Premium Assistance

Catamount Health is a health insurance plan offered in cooperation with Blue Cross Blue Shield of Vermont and MVP Health Care. It provides comprehensive, quality health coverage. Assistance also may be available based on income for paying premiums; premium subsidies are available to those who fall at or below 300% of FPL.

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Catamount Health is designed for Vermont residents who meet the following qualifications: age 18 or older; families who are not eligible for existing state-sponsored coverage programs such as Medicaid or Vermont Health Access Plan (VHAP); do not have access to insurance through their employer; 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.

Depending on income, uninsured Vermonters may receive assistance paying their premiums when: access is not available to comprehensive health insurance through their employer as determined by the state; the 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 the employer's plan; or the individual is waiting for the open enrollment period to enroll in their employer's plan.

The following table depicts the caseload and expenditure information by SFY, including the Governor's Recommend for SFY '14 for Catamount Health:

Catamount Health					
		DVHA Only		Total	
SFY	Caseload	Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '11 Actual	9,921	$ 56,831,908	$ 477.36	n/a	
SFY '12 Actual	10,713	$ 52,066,782	$ 405.01	$ 52,066,782	$ 405.01
SFY '13 Appropriated	11,440	$ 62,002,768	$ 451.65	$ 62,002,768	$ 451.65
SFY '13 Budget Adjustment	11,582	$ 59,153,214	$ 425.61	$ 59,153,214	$ 425.61
SFY '14 Governor's Recommend	12,372	$ 30,161,023	$ 411.99	$ 30,161,023	$ 411.99

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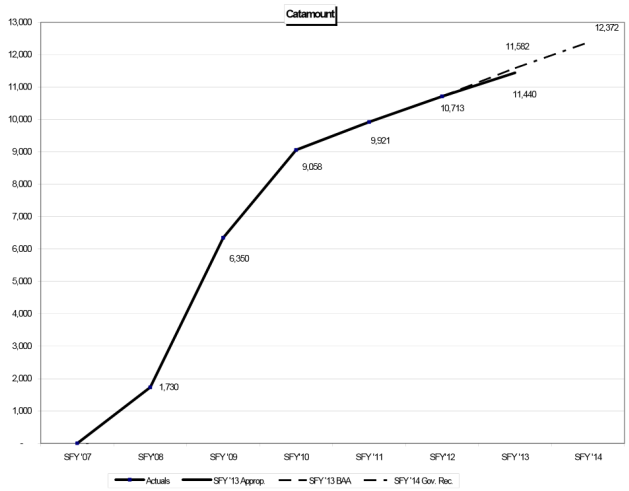

Catamount Employer-Sponsored Insurance Premium Assistance

The State provides premium assistance to eligible uninsured employees to help them enroll in their employer-sponsored health insurance plan if all of the following criteria are met: the employee meets the eligibility criteria to enroll in Catamount Health or the Vermont Health Access Plan (VHAP); the employee's household income is under 300% FPL for one person; the employer's plan has comprehensive benefits; and the cost of providing premium assistance to enroll in an employer's plan is less than the cost of providing premium assistance to enroll in Catamount Health or the VHAP.

The following tables depict the caseload and expenditure information by SFY, including the Governor's Recommend for SFY '14 for Catamount Employer-Sponsored Insurance (ESI) Premium Assistance:

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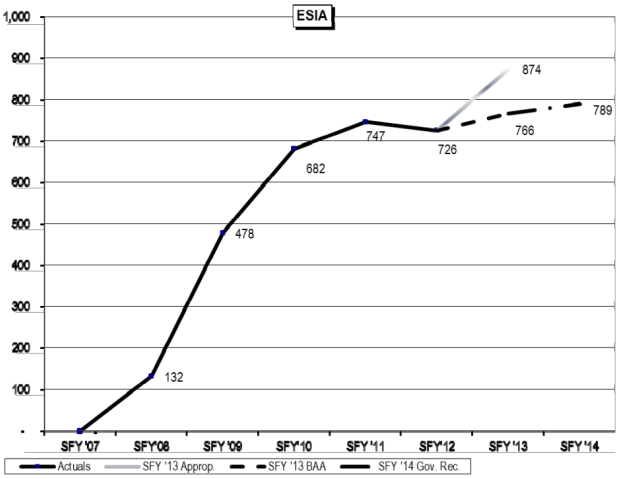
ESIA					
		DVHA Only		Total	
SFY	Caseload	Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '11 Actual	747	$ 1,056,258	$ 117.90	n/a	
SFY '12 Actual	726	$ 954,128	$ 109.54	$ 954,128	$ 109.54
SFY '13 Appropriated	874	$ 2,270,715	$ 216.52	$ 2,270,715	$ 216.52
SFY '13 Budget Adjustment	766	$ 1,000,629	$ 108.80	$ 1,000,629	$ 108.80
SFY '14 Governor's Recommend	789	$ 616,805	$ 130.34	$ 616,805	$ 130.34



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New Adult

Due to Affordable Care Act changes that expanded Medicaid eligibility, adults without children who are at or below 133% of the federal poverty level will now qualify for traditional Medicaid. The chart below depicts anticipated point-in-time enrollment and SFY '14 costs:

New Adult					
		DVHA Only		Total	
SFY	Caseload	Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '11 Actual	-	$ -	$ -	n/a	
SFY '12 Actual	-	$ -	$ -	$ -	$ -
SFY '13 Appropriated	-	$ -	$ -	$ -	$ -
SFY '13 Budget Adjustment	-	$ -	$ -	$ -	$ -
SFY '14 Governor's Recommend	34,490	$ 86,353,450	$ 418.10	$ 86,353,450	$ 418.10

Premium Assistance and Cost Sharing

Individuals with household income over 133% of FPL can choose and enroll in qualified health plans purchased on Vermont Health Connect, Vermont's health benefit exchange. These plans have varying cost sharing and premium levels. There will be federal tax credits to make premiums more affordable for people with incomes less than 400% of FPL and federal subsidies to make out of pocket expenses more affordable for people with incomes below 250% FPL. Despite these federal tax credits and cost sharing subsidies provided by the Affordable Care Act, coverage through these qualified health plans (QHP) will be less affordable than Vermonters have previously experienced under VHAP and Catamount. To address this affordability challenge, the State of Vermont is proposing to further subsidize premiums for enrollees whose income is < 300% and cost sharing where income is < 350%. The charts below reflect point-in-time caseload estimates and SFY '14 costs. A more robust depiction of what these values represent is demonstrated under the Governor's Policy Decision section of this document.

Premium Assistance For Exchange Enrollees < 300%					
		DVHA Only		Total	
SFY	Caseload	Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '11 Actual	-	$ -	$ -	n/a	
SFY '12 Actual	-	$ -	$ -	$ -	$ -
SFY '13 Appropriated	-	$ -	$ -	$ -	$ -
SFY '13 Budget Adjustment	-	$ -	$ -	$ -	$ -
SFY '14 Governor's Recommend	40,748	$ 6,586,587	$ 26.94	$ 6,586,587	$ 13.47

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Cost Sharing For Exchange Enrollees < 350%					
		DVHA Only		Total	
SFY	Caseload	Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '11 Actual	-	$ -	$ -	n/a	
SFY '12 Actual	-	$ -	$ -	$ -	$ -
SFY '13 Appropriated	-	$ -	$ -	$ -	$ -
SFY '13 Budget Adjustment	-	$ -	$ -	$ -	$ -
SFY '14 Governor's Recommend	44,954	$ 3,887,724	$ 14.41	$ 3,887,724	$ 7.21

Dr. Dynasaur

Dr. Dynasaur encompasses all health care 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; those 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 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 '14 for BD and/or Medically Needy Children:

Blind or Disabled and/or Medically Needy Children					
		DVHA Only		Total	
SFY	Caseload	Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '11 Actual	3,696	$ 34,724,216	$ 783.01	n/a	
SFY '12 Actual	3,712	$ 33,805,689	$ 759.03	$ 85,167,021	$1,912.23
SFY '13 Appropriated	3,614	$ 35,654,068	$ 822.18	$ 93,601,570	$2,158.44
SFY '13 Budget Adjustment	3,727	$ 29,244,275	$ 653.96	$ 87,208,278	$1,950.14
SFY '14 Governor's Recommend	3,740	$ 28,520,439	$ 635.44	$ 89,593,664	$1,996.17

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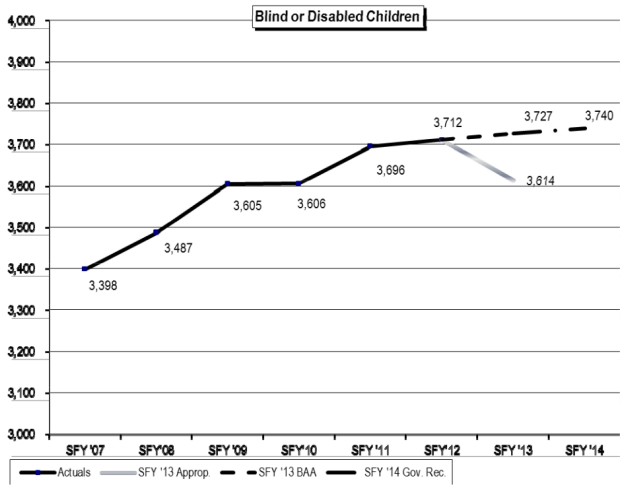

General Children
The general eligibility requirements for General Children are: under age 21 and below the protected income level (PIL), categorized as those eligible for cash assistance including Reach Up (Title V) and foster care payments (Title IV-E).

The following table depicts the caseload and expenditure information by SFY, including the Governor's Recommend for SFY '14 for General Children:

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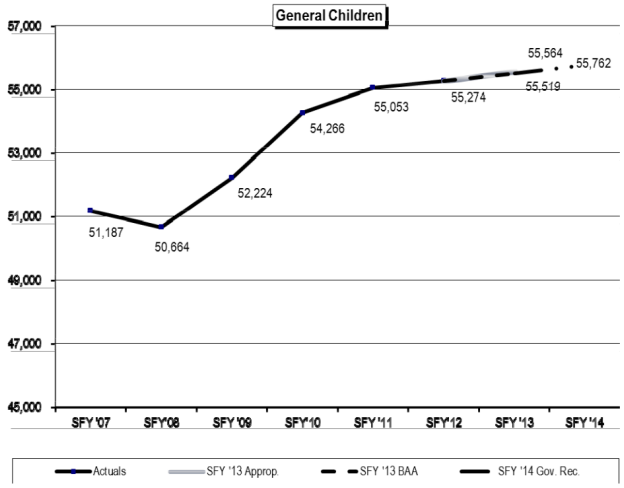
General Children					
		DVHA Only		Total	
SFY	Caseload	Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '11 Actual	55,053	$ 111,924,219	$ 169.42	n/a	
SFY '12 Actual	55,274	$ 117,381,607	$ 176.97	$211,056,955	$ 318.20
SFY '13 Appropriated	55,564	$ 123,109,797	$ 184.64	$228,797,327	$ 343.14
SFY '13 Budget Adjustment	55,519	$ 120,354,228	$ 180.65	$226,071,854	$ 339.33
SFY '14 Governor's Recommend	56,762	$ 120,211,081	$ 179.65	$231,599,461	$ 346.11



Underinsured Children

The general eligibility requirements for Underinsured Children are: up to age 18 and up to 300% FPL. This program was 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.

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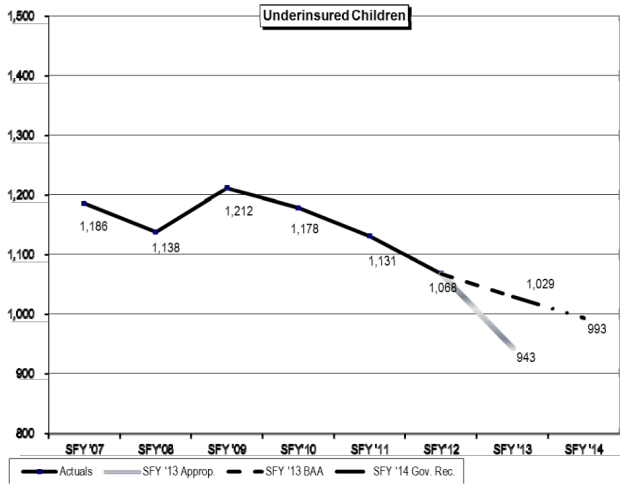
The following table depicts the caseload and expenditure information by SFY, including the Governor's Recommend for SFY '14 for Uninsured Children:

Underinsured Children					
		DVHA Only		Total	
SFY	Caseload	Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '11 Actual	1,131	$ 806,332	$ 59.43	n/a	
SFY '12 Actual	1,068	$ 766,013	$ 59.78	$ 2,016,045	$ 157.33
SFY '13 Appropriated	943	$ 677,890	$ 59.91	$ 2,088,216	$ 184.56
SFY '13 Budget Adjustment	1,029	$ 690,513	$ 55.91	$ 2,101,240	$ 170.14
SFY '14 Governor's Recommend	993	$ 633,974	$ 53.21	$ 2,120,373	$ 177.96



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

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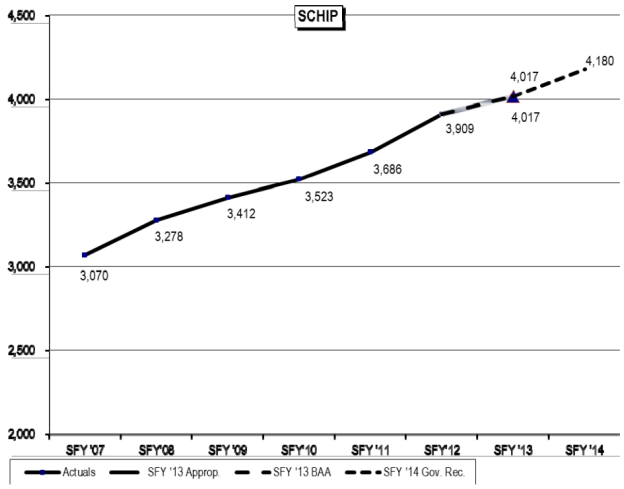
The following table depicts the caseload and expenditure information by SFY, including the Governor's Recommend for SFY '14 for the State Children's Health Insurance Program (SCHIP):

SCHIP (Uninsured)					
		DVHA Only		Total	
SFY	Caseload	Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '11 Actual	3,686	$ 6,295,264	$ 142.34	n/a	
SFY '12 Actual	3,909	$ 6,873,629	$ 146.52	$ 9,320,022	$ 198.67
SFY '13 Appropriated	4,017	$ 7,598,806	$ 157.64	$ 10,358,905	$ 214.90
SFY '13 Budget Adjustment	4,017	$ 6,528,240	$ 135.42	$ 9,289,125	$ 192.69
SFY '14 Governor's Recommend	4,180	$ 6,878,275	$ 137.14	$ 9,787,255	$ 195.14



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Prescription Assistance Pharmacy Only Programs

Vermont provides prescription assistance programs to help Vermonters pay for prescription medicines based on income, disability status and age. There is a monthly premium based on income and co-pays based on the cost of the prescription.

VPharm assists Vermonters enrolled in Medicare Part D with paying for prescription medicines. Those eligible include people age 65 and older and Vermonters of all ages with disabilities with household incomes up to 225% FPL.

VHAP-Pharmacy assists Vermonters age 65 and older and people with disabilities who are not enrolled in Medicare and who have household incomes up to 150% FPL pay for eye exams and prescription medicines for short-term and long-term medical problems. Please note that this program goes away effective 1/1/14.

VScript assists Vermonters age 65 and older and people of all ages with disabilities who are not enrolled in Medicare and who have household incomes between 150% and 225% FPL pay for prescription medicines for long-term medical problems. . Please note that this program goes away effective 1/1/14.

Vscript Expanded helps Vermonters 65 and older and people of all ages with disabilities who are not enrolled in Medicare and who have household incomes between 175% and 225% FPL, pay for prescription and over the counter maintenance drugs. . Please note that this program goes away effective 1/1/14.

The following table depicts the caseload and expenditure information by SFY, including the Governor's Recommend for SFY '14 for the Pharmacy Programs:

Pharmacy Only Programs					
		DVHA Only		Total	
SFY	Caseload	Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '11 Actual	12,751	$ 4,427,164	$ 28.93	n/a	
SFY '12 Actual	12,655	$ (1,421,868)	$ (9.36)	$ (1,421,868)	$ (9.36)
SFY '13 Appropriated	12,698	$ 4,777,918	$ 31.36	$ 4,777,918	$ 31.36
SFY '13 Budget Adjustment	12,565	$ (440,929)	$ (2.92)	$ (440,929)	$ (2.92)
SFY '14 Governor's Recommend	12,669	$ 2,629,328	$ 17.29	$ 2,629,328	$ 17.29

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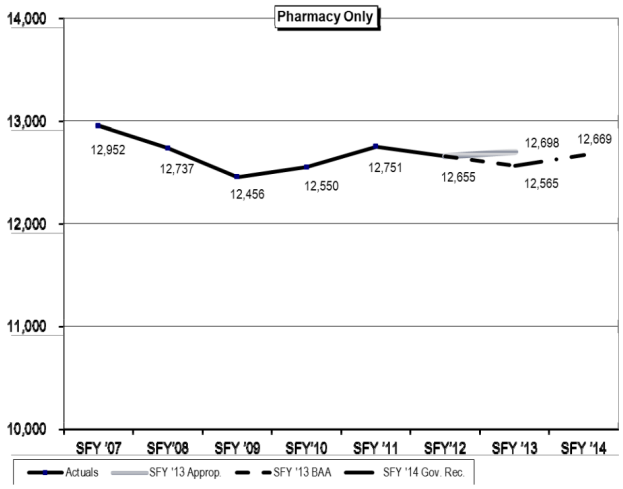

Healthy Vermonters provides a discount on short-term and long-term prescription medicines for individuals not eligible for other pharmacy assistance programs with household incomes up to 350% and 400% FPL if they are aged or disabled. There is no cost to the state for this program.

The following table depicts the caseload and expenditure information by SFY, including the Governor's Recommend for SFY '14 for the Healthy Vermonters Program:

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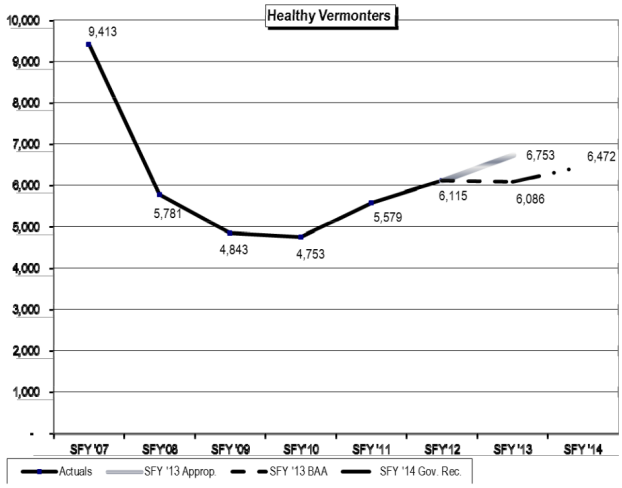
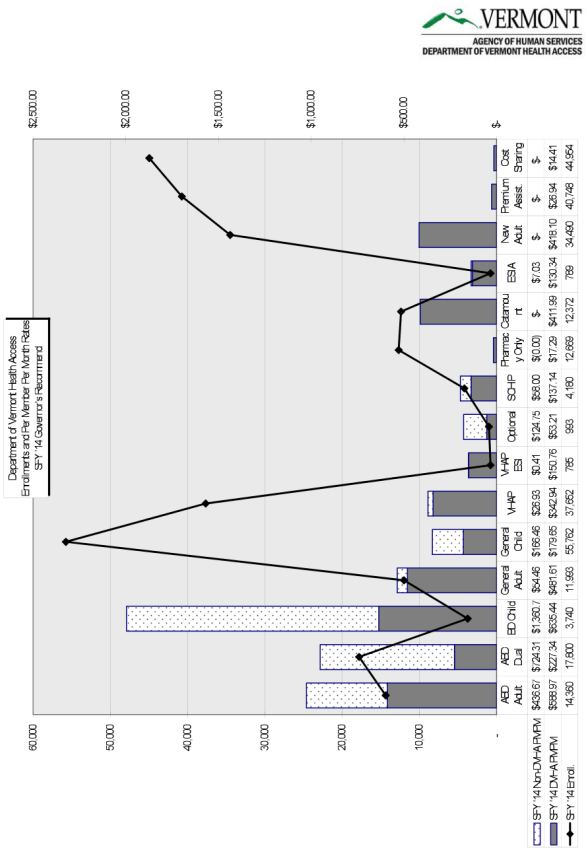
Healthy Vermonters Program					
		DVHA Only		Total	
SFY	Caseload	Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '11 Actual	5,579	$ -	n/a	n/a	
SFY '12 Actual	6,115	$ -	n/a	$ -	n/a
SFY '13 Appropriated	6,753	$ -	n/a	$ -	n/a
SFY '13 Budget Adjustment	6,086	$ -	n/a	$ -	n/a
SFY '14 Governor's Recommend	6,472	$ -	n/a	$ -	n/a

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Department of Vermont Health Access
Enrollment and Per Member Per Month Rates
SFY '14 Governor's Recommend
$2,500.00
$2,000.00
$1,500.00
$1,000.00
$500.00
$-
60,000
50,000
40,000
30,000
20,000
10,000
-
AED Adult
AED Dual
ED/Child
General Adult
General Child
VHAP
VHAP ESI
Optional
SCHIP
Pharmacy Only
Catamount
ESIA
New Adult
Premium Assist.
Cost Sharing
SFY '14 Non-DM-ARMPM
SFY '14 DM-ARMPM
SFY '14 Enrol.

Buy-In Adjustment . . . . . (($496,308)
($224,335) 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 and member month costs vary from year to year.

Increase in Clawback $1,691,230
$1,691,230 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.

Brattleboro Retreat Adjustment $0
$0 state

Brattleboro Retreat inpatient services have historically been considered cost-effective treatment for our citizens. Because of this, Vermont has considered these Medicaid eligible (even though the Retreat is an IMD – Institute for Mental Disease). CMS disagreed with our position. Therefore, services that were historically Medicaid eligible must now be paid for with MCO investment dollars.

Transfer of DVHA Funding to DMH for New Service Delivery . . . . . ($8,965,375)
($3,889,309) state

With the use of the new evaluation tool in Children's Personal Care Services (CPCS) some children that previously qualified for personal care will no longer qualify or will qualify for less. However we recognize that there is still a need. That need may be a combination of several services and supports and may include targeted case management/specialized rehabilitation (skills work, collateral contact, supportive counseling and service coordination), respite, or childcare/supervision. In order to support the Designated Agencies (DAs) in providing appropriate services and supports to more families, AHS diverted funding from the CPCS budget line and asked each DA to plan for the provision of additional services to families in a non-categorical manner regardless of MH or DS diagnosis.

Transfer of DVHA Funding to DCF for CIS . . . . . (($1,253,566)
($544,253) state

DVHA has also worked with DCF on funding a more cohesive program for children's integrated services (CIS). This resulted in a need to transfer funding to DCF in order to allow DCF to pay for services previously covered by DVHA.

Transfer of DVHA Family Planning Funding to VDH . . . . . ($2,000,000)
($871,200) state

In our SFY '13 budget submission, DVHA proposed to implement a birth control plus option initiative that offered individuals (men and women) - who were previously ineligible for Medicaid - family planning services and supplies. Due to information technology challenges, we are not able to operationalize the program as originally designed until a new eligibility system is in place. In the interim, the services are being provided through a grant with existing providers within VDH.

Cost Neutral Transfer from Program to Admin . . . . . ($1,225,000)
($554,820) state

DVHA proposed two approaches for cost savings (better transportation management and multiple pharmacy changes) in the SFY '13 budget that required some administrative support. This increase in administrative costs is offset by savings in our program costs (a budget-neutral change). This moves the funding from program to administration.

Annualization of PC Physician Rate Increases $3,722,721
$0 state

One of the initiatives offered under the Affordable Care Act was an increase in primary care physician (PCP) rates, and the federal government will pick up the costs of those increases for two years. These rate increases went into effect January 1, 2013. This request annualizes the effect of the rate change.

Federal Participation Rate Changes and Leahy Bump $0
$385,845 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 '14, Vermont loses $2,599,488 as compared to the FMAP for SFY '13. As mentioned earlier, however, Senator Leahy was able to negotiate a 2.2% rate increase for two years for Vermont. Some of this general fund impact is represented in the caseload and utilization data above (as it relates to Global Commitment components). The Choices for Care program also benefits from this bump offsetting the loss of federal participation associated with the FMAP change by $2,213,643.

Neutral Adjustments Between DVHA Appropriations $0
$195,344 state

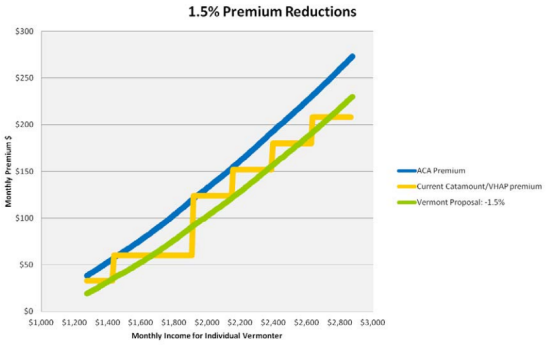
During the budget development process, often times the dollars associated with policy decisions are added to or subtracted from the DVHA Global Commitment appropriation. However, these decisions typically impact all DVHA appropriations; therefore, funds are being redistributed from the Global Commitment appropriation to the other three DVHA program areas.

GOVERNOR'S RECOMMENDED INITIATIVES $27,884,596
$12,146,214 state

Premium and Cost Sharing Subsidies for Exchange Enrollees $10,474,312
$4,562,610 state

As referred to earlier in this document, Catamount and VHAP will end on December 31, 2013. Single adults with incomes less than 133% FPL will qualify for Medicaid services in the New Adult program. People with incomes greater than 300% will qualify to choose qualified health plans through Vermont Health Connect. Despite federal tax credits and cost sharing subsidies provided by the ACA, the affordability standard set by the ACA is not as generous as the standard offered in the existing VHAP and Catamount programs. Therefore, the Governor is proposing to offer state based premium and cost sharing subsidies. Following are charts that demonstrate what is in our request:

Premium Assistance Proposals



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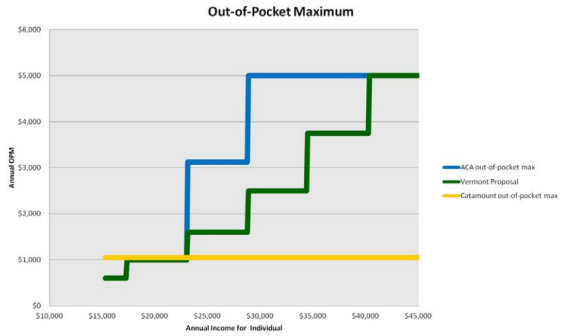

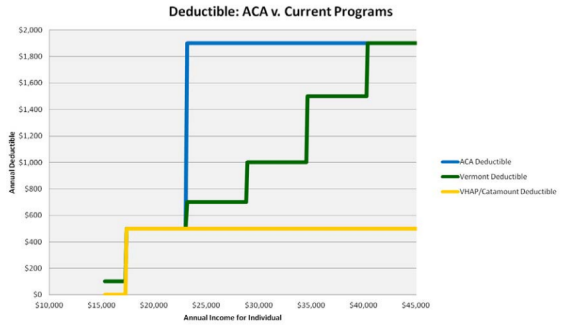

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	Medical Deductible		
FPL	ACA	ACA Subsidized	Vermont Proposal
133-150%	$1,900	$100	$100
150-200%	$1,900	$500	$500
200-250%	$1,900	$1,900	$700
250-300%	$1,900	$1,900	$1,000
300-350%	$1,900	$1,900	$1,500

	Medical OPM		
FPL	ACA	ACA Subsidized	Vermont Proposal
133-150%	$5,000	$600	$600
150-200%	$5,000	$1,000	$1,000
200-250%	$5,000	$3,200	$1,600
250-300%	$5,000	$5,000	$2,500
300-350%	$5,000	$5,000	$3,750

Begin to Address the Cost Shift $16,113,683
$7,019,120 state

It is a fairly well-known fact that Medicaid rates of reimbursement have not kept up with the rate of inflation. In order for providers to cover their costs, they have had to negotiate disproportionately higher rates of reimbursement with other insurers resulting in a cost shift. In an effort to begin to mitigate this effect, we are proposing to increase provider rates beginning October 1, 2013. While we are expecting providers to receive roughly an additional 3% overall, the manner in which the payments will be adjusted will be a combination of a straight rate increase and a quality incentive component. The Green Mountain Care Board can assure that this investment results in relief for private ratepayers, rather than increased health care costs.

DAIL Managed Policy Decisions $1,296,601
$564,483 state

DVHA pays for the Choices for Care (CFC) expenditures, but DAIL is responsible for managing the long-term care component. DAIL is implementing the following changes in the program and will provide documentation in support of their decisions during their budget testimony:

Eliminate CFC Home and Community Based Services (HCBS) - case mgmt - change from 15 minute units with cap of 48 hours/year to monthly rate of $110: $300,000 ($130,680 state)
Eliminate CFC Enhanced Residential Care (ERC) - eliminate ERC case management: $300,000 ($130,680 state)

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Eliminate CFC HCBS - change reimbursement rates from $15/hour to half-day and full-day rates: $179,979 ($78,399 state)
Restore 2% Rate Reduction in ERC: $156,000 ($67,954 state)
Increase wages for self-directed personal care: $292,922 ($127,597 state)
Eliminate 2% rate reduction: $847,918 ($369,353 state)
DRS Estimate Nursing Home (NH) Statutory Increases: $3,000,000 ($1,306,800 state)
NH Utilization Decrease 2.1%: ($2,400,000) ($1,045,440 state)
Enhance ACCS Rate by $1: $349,761 ($152,040 state)
Planned Carry-forward from FY '13 LTC Portion: ($1,729,979) ($753,579 state)

Reference

Materials

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Overview of Green Mountain Care Programs as of 1/1/13
Created by Vermont Legal Aid's Office of Health Care Ombudsman
1-800-917-7787

PROGRAM	WHO IS ELIGIBLE	BENEFITS	COST-SHARING
Medicaid[1] **PIL[2]** **Medicaid Working Disabled 250% FPL[3]**	• Aged, blind, disabled • Parents or caretaker relatives of a dependent child • Youth ages 18-20 Disabled working adults	• 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.	• 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. • $1/$2/$3 DME copay.
Dr. Dynasaur 200% FPL	Pregnant women	Same as Medicaid, but with full dental for both children and adults over 21.	• 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.	• 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	• Same as Medicaid except: **no** dental or transportation. • If covered by employer-sponsored insurance, VHAP wraps ESI coverage as secondary.	• 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. • $25/ER visit; $3/outpatient hospital visit; $1/$2/$3 prescription and DME copay.
Catamount-ESIA (Employer Sponsored Insurance Assistance) 150%/185%-300% FPL	Uninsured adults (some exceptions) with access to approved ESI	Covered by employer-sponsored insurance; State provides premium assistance.	• Coverage/cost-sharing by ESI. • Wrap-around benefits for some chronic care. • $60-$205/person/mo thru employer.
CHAP (Catamount Health Premium Assistance Program) 150%/185%-300% FPL	Uninsured adults (some exceptions) WITHOUT access to approved ESI	Covered by BCBS Catamount Blue.	• Cost sharing according to plan. • $60-$208/person/mo paid to State.
Catamount Health (no state assistance)	Same as directly above except income over 300% FPL (some exceptions)	Covered by BCBS Catamount Blue.	• 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	• VHAP Pharmacy: acute and maintenance Medicaid drugs, diabetic supplies, eye exams. • VS & VS Expanded cover maintenance drugs and diabetic supplies only.	• 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	• 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.	• 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 $5000/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	• 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).	• 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 exhausted or has no prescription coverage	• Discount on medications. (NOT INSURANCE)	Beneficiary pays the Medicaid rate for all prescriptions.

Coverage Groups Premium	FPL[3]	1	2 Household	3	4
Medicaid PIL outside Chittenden County	NA	$975.00[2]	$975.00[2]	$1175.00[2]	$1333.00[2]
Medicaid PIL inside Chittenden County	NA	$1058.00[2]	$1058.00[2]	$1250.00[2]	$1408.00[2]
Medicaid Working Disabled	<250%	$2394.00	$3232.00	$4069.00	$4907.00
VHAP-ESIA or VHAP (if no ESI)	<185%				
≤50% FPL No fee	50%	$479.00	$647.00	$814.00	$982.00
>50% but ≤75% FPL $7/person/month	75%	$719.00	$970.00	$1221.00	$1472.00
>75% but ≤100% FPL $25/person/month	100%	$958.00	$1293.00	$1628.00	$1963.00
>100% but ≤150% FPL $33/person/month	150%	$1437.00	$1939.00	$2442.00	$2944.00
>150% but ≤185% FPL * $49/person/month	185%	$1772.00	$2392.00	$3011.00	$3631.00
*families with dependent children only					
VPharm1/ VHAP Pharmacy $15/person/mo	<150%	$1437.00	$1939.00	$2442.00	$2944.00
VPharm2/ VScript $20/person/mo	<175%	$1676.00	$2262.00	$2849.00	$3435.00
VPharm3/ VScript Expanded $50/person/mo	<225%	$2155.00	$2909.00	$3662.00	$4416.00
Dr. Dynasaur (kids up to 18 & pregnant women)	<300% kids/ <200% women				
Kids ≤185% FPL No Fee					
Pregnant women ≤ 200% FPL $15/family/month					
Kids >185% but ≤ 225% FPL $15/family/month	185%	$1772.00	$2392.00	$3011.00	$3631.00
Kids >225% but ≤ 300% FPL $20/family/month	200%	$1915.00	$2585.00	$3255.00	$3925.00
If otherwise uninsured, $60/family/month	225%	$2155.00	$2909.00	$3662.00	$4416.00
	300%	$2873.00	$3878.00	$4883.00	$5888.00
Catamount-ESIA	150%-300%				
>150% but ≤ 200% FPL $60/person/month	200%	$1915.00	$2585.00	$3255.00	$3925.00
>200% but ≤ 225% FPL $122/person/month	225%	$2155.00	$2909.00	$3662.00	$4416.00
>225% but ≤ 250% FPL $149/person/month	250%	$2394.00	$3232.00	$4069.00	$4907.00
>250% but ≤ 275% FPL $177/person/month	275%	$2634.00	$3555.00	$4476.00	$5397.00
>275% but ≤ 300% FPL $205/person/month	300%	$2873.00	$3878.00	$4883.00	$5888.00
Catamount ESIA premium rates may change at start of each calendar yr.					
CHAP-Catamount Blue	150%-300%				
>150% but ≤ 200% FPL $60/person/month	200%	$1915.00	$2585.00	$3255.00	$3925.00
>200% but ≤ 225% FPL $124/person/month	225%	$2155.00	$2909.00	$3662.00	$4416.00
>225% but ≤ 250% FPL $152/person/month	250%	$2394.00	$3232.00	$4069.00	$4907.00
>250% but ≤ 275% FPL $180/person/month	275%	$2634.00	$3555.00	$4476.00	$5397.00
>275% but ≤ 300% FPL $208/person/month	300%	$2873.00	$3878.00	$4883.00	$5888.00
>300% FPL: $455.56 individual/$911.12 2-person/$1366.68 family					
Medicare Savings Programs: QMB	<100%	$958.00	$1293.00		
SLMB	<120%	$1149.00	$1551.00	N/A	N/A
QI-1	<135%	$1293.00	$1745.00		
Healthy Vermonters (any age)	<350%	$3352.00	$4524.00	$5697.00	$6869.00
Healthy Vermonters (aged, disabled)	<400%	$3830.00	$5170.00	$6510.00	$7850.00
Prescription discount if uninsured or if prescription benefits exhausted					

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

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

Percentage of Federal Poverty Level (FPL) Guidelines 01/01/13-12/31/13

Monthly

	Percentage of Federal Poverty Income Guidelines (PIL) - Effective January 1, 2013												
Group Size	75%	100%	120%	135%	150%	175%	185%	200%	225%	250%	300%	350%	400%
1	719	958	1149	1293	1437	1676	1772	1915	2155	2394	2873	3352	3830
2	970	1293	1551	1745	1939	2262	2392	2585	2909	3232	3878	4524	5170
3	1221	1628	1953	2198	2442	2849	3011	3255	3662	4069	4883	5697	6510
4	1472	1963	2355	2650	2944	3435	3631	3925	4416	4907	5888	6869	7850
5	1724	2298	2757	3102	3447	4021	4251	4595	5170	5744	6893	8042	9190
6	1975	2633	3159	3554	3949	4607	4871	5265	5924	6582	7898	9214	10530
7	2226	2968	3561	4007	4452	5194	5490	5935	6677	7419	8903	10387	11870
8	2477	3303	3963	4459	4954	5780	6110	6605	7431	8257	9908	11559	13210
9	2729	3638	4365	4911	5457	6366	6730	7275	8185	9094	10913	12732	14550
10	2980	3973	4767	5363	5959	6952	7350	7945	8939	9932	11918	13904	15890
11	3231	4308	5169	5816	6462	7539	7969	8615	9692	10769	12923	15077	17230
12	3482	4643	5571	6268	6964	8125	8589	9285	10446	11607	13928	16249	18570
13	3734	4978	5973	6720	7467	8711	9209	9955	11200	12444	14933	17422	19910
14	3985	5313	6375	7172	7969	9297	9829	10625	11954	13282	15938	18594	21250
15	4236	5648	6777	7625	8472	9884	10448	11295	12707	14119	16943	19767	22590

Annually

	Percentage of Federal Poverty Income Guidelines (PIL) - Effective January 1, 2013												
Group Size	75%	100%	120%	135%	150%	175%	185%	200%	225%	250%	300%	350%	400%
1	8628	11496	13788	15516	17244	20112	21264	22980	25860	28728	34476	40224	45960
2	11640	15516	18612	20940	23268	27144	28704	31020	34908	38784	46536	54288	62040
3	14652	19536	23436	26376	29304	34188	36132	39060	43944	48828	58596	68364	78120
4	17664	23556	28260	31800	35328	41220	43572	47100	52992	58884	70656	82428	94200
5	20688	27576	33084	37224	41364	48252	51012	55140	62040	68928	82716	96504	110280
6	23700	31596	37908	42648	47388	55284	58452	63180	71088	78984	94776	110568	126360
7	26712	35616	42732	48084	53424	62328	65880	71220	80124	89028	106836	124644	142440
8	29724	39636	47556	53508	59448	69360	73320	79260	89172	99084	118896	138708	158520
9	32748	43656	52380	58932	65484	76392	80760	87300	98220	109128	130956	152784	174600
10	35760	47676	57204	64356	71508	83424	88200	95340	107268	119184	143016	166848	190680
11	38772	51696	62028	69792	77544	90468	95628	103380	116304	129228	155076	180924	206760
12	41784	55716	66852	75216	83568	97500	103068	111420	125352	139284	167136	194988	222840
13	44808	59736	71676	80640	89604	104532	110508	119460	134400	149328	179196	209064	238920
14	47820	63756	76500	86064	95628	111564	117948	127500	143448	159384	191256	223128	255000
15	50832	67776	81324	91500	101664	118608	125376	135540	152484	169428	203316	237204	271080

VERMONT
AGENCY OF HUMAN SERVICES
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Premiums

Program	% FPL	'13 Steady State Enroll	'13 Steady State Premium	'13 Steady State Premiums	'13 BAA Enroll	'13 BAA Premium	'13 BAA Premiums	'14 Steady State Enroll	'14 Steady State Premium	'14 Steady State Premiums
AbD Adults	FPL	14,445	$ -	$ -	14,189	$ -	$ -	14,360	$ -	
AbD Dual Eligible Adults	FPL	17,155	$ -	$ -	17,215	$ -	$ -	17,800	$ -	
Choices for Care Adults	FPL	3,758	$ -	$ -	3,859	$ -	$ -	3,850	$ -	
ANFC Adults	FPL	11,686	$ -	$ -	11,614	$ -	$ -	11,993	$ -	
		47,043		$ -	46,877		$ -	48,003		$ -
Dr. Dynasaur	0-185%	54,622	$ -	$ -	54,685	$ -	$ -	54,922	$ -	$ -
Dr. Dynasaur	185-225%	4,556	$ 15.00	$ 512,501	4,561	$ 15.00	$ 513,088	4,581	$ 15.00	$ 515,315
Dr. D *with ins.*	225-300%	943	$ 20.00	$ 141,431	1,029	$ 20.00	$ 154,377	993	$ 20.00	$ 148,933
Dr. D *without ins.*	225-300%	4,017	$ 60.00	$ 1,801,592	4,017	$ 60.00	$ 1,801,771	3,740	$ 60.00	$ 1,683,106
Dr. D Total		64,137		$ 2,461,524	64,292		$ 2,469,236	64,236		$ 2,347,354
VHAP	0-50%	13,366	$ -	$ -	12,872	$ -	$ -	17,710	$ -	$ -
VHAP	50-75%	4,787	$ 7.00	$ 402,091	4,610	$ 7.00	$ 387,251	27,831	$ 7.00	$ 194,817
VHAP	75-100%	5,548	$ 25.00	$ 1,664,445	5,343	$ 25.00	$ 1,603,018	32,258	$ 25.00	$ 806,441
VHAP	100-150%	12,761	$ 33.00	$ 5,053,533	12,290	$ 33.00	$ 4,867,032	74,197	$ 33.00	$ 2,448,492
VHAP	150-185%	3,147	$ 49.00	$ 1,850,534	3,031	$ 49.00	$ 1,782,240	49,893	$ 49.00	$ 2,444,773
VHAP Total		39,609		$ 8,970,603	38,147		$ 8,639,542	261,888		$ 5,894,524
VPharm 1 & VHAP Pharmacy	0-150%	7,921	$ 15.00	$ 1,425,731	7,838	$ 15.00	$ 1,410,820	7,903	$ 15.00	$ 1,422,517
VPharm 2 & VScript	150-175%	2,816	$ 20.00	$ 675,825	2,786	$ 20.00	$ 668,757	2,810	$ 20.00	$ 674,302
VPharm 3 & VScript Expanded	175-225%	1,961	$ 50.00	$ 1,176,805	1,941	$ 50.00	$ 1,164,498	1,957	$ 50.00	$ 1,174,153
Pharmacy Total		12,698		$ 3,278,362	12,565		$ 3,244,075	12,669		$ 3,270,971
Catamount Health	0-150%	1,591	$ 60.00	$ 1,145,238	1,668	$ 60.00	$ 1,668	10,460	$ 60.00	$ 627,583
Catamount Health	150-175%	2,411	$ 60.00	$ 1,735,981	2,528	$ 60.00	$ 1,820,065	15,855	$ 60.00	$ 951,306
Catamount Health	175-200%	4,187	$ 60.00	$ 3,014,930	4,390	$ 60.00	$ 3,160,962	27,536	$ 60.00	$ 1,652,162
Catamount Health	200-225%	2,463	$ 124.00	$ 3,665,307	2,851	$ 124.00	$ 4,242,122	18,264	$ 124.00	$ 2,264,743
Catamount Health	226-250%	438	$ 152.00	$ 798,479	507	$ 152.00	$ 924,137	3,246	$ 152.00	$ 493,369
Catamount Health	251-275%	197	$ 180.00	$ 424,581	227	$ 180.00	$ 491,398	1,457	$ 180.00	$ 262,343
Catamount Health	276-300%	153	$ 208.00	$ 383,002	178	$ 208.00	$ 443,276	1,138	$ 208.00	$ 236,652
Catamount Total		11,440		$ 11,167,519	12,348		$ 11,083,627			$ 6,488,159
TOTAL		174,928		$ 25,878,008	174,230		$ 25,442,479			$ 18,001,008
Federal				$ 13,451,728			$ 13,220,493			$ 8,982,189
GF				$ 12,426,281			$ 12,221,986			$ 9,018,819
Total				$ 25,878,008			$ 25,442,479			$ 18,001,008

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

Federal Match Rates

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

Federal Fiscal Year

FFY	From	To	Federal Share w/o hold harmless	ARRA including hold harmless	Total Federal Share	State Share
	07/01/73	09/30/75	65.38%			34.62%
	07/01/75	09/30/77	69.82%			30.18%
	10/01/77	09/30/79	68.02%			31.98%
	10/01/79	09/30/81	68.40%			31.60%
	10/01/81	09/30/83	68.54%			31.46%
	10/01/83	09/30/85	69.37%			30.63%
	10/01/85	09/30/86	67.06%			32.94%
	10/01/86	09/30/87	67.37%			32.63%
	10/01/87	09/30/88	66.23%			33.77%
	10/01/88	09/30/89	63.92%			36.08%
1990	10/01/89	09/30/90	62.77%			37.23%
1991	10/01/90	09/30/91	61.97%			38.03%
1992	10/01/91	09/30/92	61.37%			38.63%
1993	10/01/92	09/30/93	59.88%			40.12%
1994	10/01/93	09/30/94	59.55%			40.45%
1995	10/01/94	09/30/95	60.82%			39.18%
1996	10/01/95	09/30/96	60.87%			39.13%
1997	10/01/96	09/30/97	61.05%			38.95%
1998	10/01/97	09/30/98	62.18%			37.82%
1999	10/01/98	09/30/99	61.97%			38.03%
2000	10/01/99	09/30/00	62.24%			37.76%
2001	10/01/00	09/30/01	62.40%			37.60%
2002	10/01/01	09/30/02	63.06%			36.94%
2003	10/01/02	09/30/03	62.41%			37.59%
fiscal relief	04/01/03	09/30/03	66.01%			33.99%
		Per TANA...applies only to Title XIX (excluding DSH pymts)				
2004	10/01/03	09/30/04	61.34%			38.66%
fiscal relief	10/01/03	09/30/04	65.36%			34.64%
		Per TANA...applies only to Title XIX (excluding DSH pymts)				
2005	10/01/04	09/30/05	60.11%	n/a	60.11%	39.89%
2006	10/01/05	09/30/06	58.49%	n/a	58.49%	41.51%
2007	10/01/06	09/30/07	58.93%	n/a	58.93%	41.07%
2008	10/01/07	09/30/08	59.03%	n/a	59.03%	40.97%
2009	10/01/08	09/30/09				
	Non-ARRA		59.45%	n/a	59.45%	40.55%
	ARRA e-FMAP		59.45%	9.38%	68.83%	31.17%
2010	10/01/09	09/30/10				
	Non-ARRA		58.73%	n/a	58.73%	41.27%
	ARRA e-FMAP		58.73%	11.23%	69.96%	30.04%
2011	10/01/10	09/30/11				
	Non-ARRA		58.71%	n/a	58.71%	41.29%
	ARRA e-FMAP (consensus)		58.71%	6.55%	65.26%	34.74%
2012	10/01/11	09/30/12				
	Non-ARRA		57.58%	n/a	57.58%	42.42%
2013	10/01/12	09/30/13	56.04%	n/a	56.04%	43.96%
2014 proj.	10/01/13	09/30/14	55.11%	n/a	55.11%	44.89%

State Fiscal Year

SFY	From	To	Federal Share w/o hold harmless	ARRA including hold harmless	Total Federal Share	State Share
1986	7/1/1985	6/30/1986	67.64%	32.36%		
1987	7/1/1986	6/30/1987	67.29%	32.71%		
1988	7/1/1987	6/30/1988	66.52%	33.48%		
1989	7/1/1988	6/30/1989	64.50%	35.50%		
1990	7/1/1989	6/30/1990	63.06%	36.94%		
1991	7/1/1990	6/30/1991	62.17%	37.83%		
1992	7/1/1991	6/30/1992	61.52%	38.48%		
1993	7/1/1992	6/30/1993	60.25%	39.75%		
1994	7/1/1993	6/30/1994	59.63%	40.37%		
1995	7/1/1994	6/30/1995	60.50%	39.50%		
1996	7/1/1995	6/30/1996	60.86%	39.14%		
1997	7/1/1996	6/30/1997	61.01%	38.99%		
1998	7/1/1997	6/30/1998	61.90%	38.10%		
1999	7/1/1998	6/30/1999	62.02%	37.98%		
2000	7/1/1999	6/30/2000	62.17%	37.83%		
2001	7/1/2000	6/30/2001	62.36%	37.64%		
2002	7/1/2001	6/30/2002	62.90%	37.10%		
2003	7/1/2002	6/30/2003	62.57%	37.43%		
		fiscal relief - Title XIX only:	63.47%	36.53%		
		no adj for DSH				
2004	7/1/2003	6/30/2004	61.61%	38.39%		
		fiscal relief - Title XIX only:	65.52%	34.48%		
		no adj for DSH				
2005	7/1/2004	6/30/2005	60.42%	n/a	60.42%	39.58%
2006	7/1/2005	6/30/2006	58.90%	n/a	58.90%	41.10%
2007	7/1/2006	6/30/2007	58.82%	n/a	58.82%	41.18%
2008	7/1/2007	6/30/2008	59.01%	n/a	59.01%	40.99%
2009	7/1/2008	6/30/2009				
	Non-ARRA		59.35%	n/a	59.35%	40.65%
	ARRA e-FMAP		59.35%	6.76%	66.10%	33.90%
2010	7/1/2009	6/30/2010				
	Non-ARRA		58.91%	n/a	58.91%	41.09%
	ARRA e-FMAP		58.91%	11.05%	69.96%	30.04%
2011	7/1/2010	6/30/2011				
	Non-ARRA		58.72%	n/a	58.72%	41.28%
	ARRA e-FMAP (consensus)		58.72%	9.35%	68.07%	31.93%
2012	7/1/2011	6/30/2012				
	Non-ARRA		57.88%	n/a	57.88%	42.14%
2013	7/1/2012	6/30/2013	56.43%	n/a	56.43%	43.57%
2014 proj.	7/1/2013	6/30/2014	55.34%	n/a	55.34%	44.66%

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

Federal Fiscal Year

FFY	From	To	Federal Share	State Share
1999	10/01/98	09/30/99	73.38%	26.62%
2000	10/01/99	09/30/00	73.57%	26.43%
2001	10/01/00	09/30/01	73.68%	26.32%
2002	10/01/01	09/30/02	74.14%	25.86%
2003	10/01/02	09/30/03	73.69%	26.31%
2004	10/01/03	09/30/04	72.94%	27.06%
2005	10/01/04	09/30/05	72.08%	27.92%
2006	10/01/05	09/30/06	70.94%	29.06%
2007	10/01/06	09/30/07	71.25%	28.75%
2008	10/01/07	09/30/08	71.32%	28.68%
2009	10/01/08	09/30/09	71.62%	28.38%
2010	10/01/09	09/30/10	71.11%	28.89%
2011	10/01/10	09/30/11	71.10%	28.90%
2012	10/01/11	09/30/12	70.31%	29.69%
2013	10/01/12	09/30/13	69.23%	30.77%
2014 proj.	10/01/13	09/30/14	68.58%	31.42%

State Fiscal Year

SFY	From	To	Federal Share	State Share
1999	7/1/1998	9/30/1999	73.38%	26.62%
2000	7/1/1999	9/30/2000	73.52%	26.48%
2001	7/1/2000	6/30/2001	73.65%	26.35%
2002	7/1/2001	6/30/2002	74.03%	25.97%
2003	7/1/2002	6/30/2003	73.80%	26.20%
2004	7/1/2003	6/30/2004	73.13%	26.87%
2005	7/1/2004	6/30/2005	72.30%	27.71%
2006	7/1/2005	6/30/2006	71.23%	28.78%
2007	7/1/2006	6/30/2007	71.17%	28.83%
2008	7/1/2007	6/30/2008	71.30%	28.70%
2009	7/1/2008	6/30/2009	71.56%	28.45%
2010	7/1/2009	6/30/2010	71.24%	28.76%
2011	7/1/2010	6/30/2011	71.10%	28.90%
2012	7/1/2011	6/30/2012	70.51%	29.49%
2013	7/1/2012	6/30/2013	69.50%	30.50%
2014 proj.	7/1/2013	6/30/2014	68.74%	31.26%

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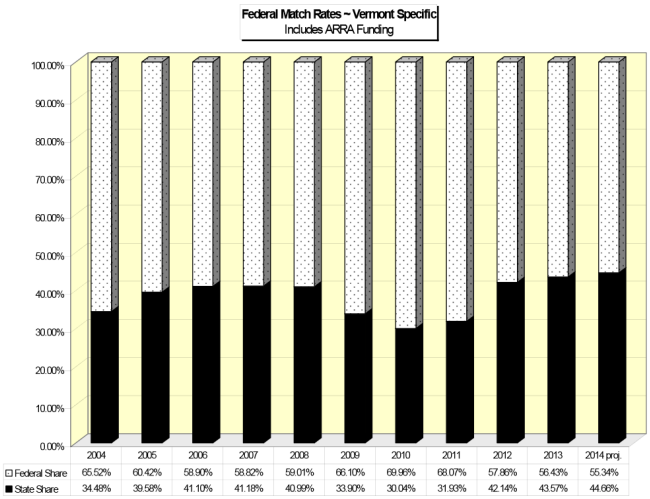
Federal Match Rates ~ Vermont Specific



	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014 proj.
Federal Share	65.52%	60.42%	58.90%	58.82%	59.01%	66.10%	69.96%	68.07%	57.86%	56.43%	55.34%
State Share	34.48%	39.58%	41.10%	41.18%	40.99%	33.90%	30.04%	31.93%	42.14%	43.57%	44.66%

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MCO Investment Expenditures

Department	Criteria	Investment Description	SFY06 Actuals - 3/4 SFY	SFY07 Actuals	SFY08 Actuals	SFY09 Actuals	SFY10 Actuals	SFY11 Actuals	SFY12 Actuals
DOE	2	School Health Services	$ 6,397,319	$ 8,956,247	$ 8,956,247	$ 8,956,247	$ 8,956,247	$ 4,478,124	$ 11,027,579
AOA	4	Blueprint Director	$ -	$ -	$ 70,000	$ 68,879	$ 179,284	$ -	$ -
GMCB	4	Green Mountain Care Board	$ -	$ -	$ -	$ -	$ -	$ -	$ 789,437
BISHCA	2	Health Care Administration	$ 983,637	$ 914,629	$ 1,340,728	$ 1,871,651	$ 1,713,959	$ 1,898,342	$ 1,897,997
DII	4	Vermont Information Technology Leaders	$ 266,000	$ 105,000	$ 105,000	$ 339,500	$ -	$ -	$ -
VVH	2	Vermont Veterans Home	$ 747,000	$ 913,047	$ 913,047	$ 881,043	$ 837,225	$ 1,410,956	$ 1,410,956
VSC	2	Health Professional Training	$ 283,154	$ 391,698	$ 405,407	$ 405,407	$ 405,407	$ 405,407	$ 405,407
UVM	2	Vermont Physician Training	$ 2,798,070	$ 3,870,682	$ 4,006,152	$ 4,006,156	$ 4,006,152	$ 4,006,156	$ 4,006,156
VAAFM	3	Agriculture Public Health Initiatives	$ -	$ -	$ -	$ -	$ -	$ -	$ 90,278
AHSCO	2	Designated Agency Underinsured Services	$ -	$ -	$ -	$ -	$ -	$ 2,510,099	$ 5,401,947
AHSCO	4	2-1-1 Grant	$ -	$ -	$ -	$ 415,000	$ 415,000	$ 415,000	$ 415,000
VDH	2	Emergency Medical Services	$ 174,482	$ 436,642	$ 626,728	$ 427,056	$ 425,870	$ 333,488	$ 274,417
VDH	2	AIDS Services/HIV Case Management	$ 152,945	$ -	$ -	$ -	$ -	$ -	$ -
VDH	2	TB Medical Services	$ 27,052	$ 29,129	$ 15,872	$ 28,359	$ 41,313	$ 36,284	$ 39,173
VDH	3	Epidemiology	$ 326,708	$ 427,075	$ 416,932	$ 204,646	$ 241,932	$ 315,135	$ 329,380
VDH	3	Health Research and Statistics	$ 276,673	$ 403,244	$ 404,431	$ 217,178	$ 254,828	$ 289,420	$ 439,742
VDH	2	Health Laboratory	$ 1,369,982	$ 1,908,982	$ 2,012,252	$ 1,522,578	$ 1,875,487	$ 1,912,034	$ 1,293,671
VDH	4	Tobacco Cessation: Community Coalitions	$ 938,058	$ 1,647,129	$ 1,144,713	$ 1,016,685	$ 535,573	$ 94,089	$ 371,646
VDH	3	Statewide Tobacco Cessation	$ -	$ -	$ -	$ 230,985	$ 484,998	$ 507,543	$ 450,804
VDH	2	Family Planning	$ 365,320	$ 122,961	$ 169,392	$ 300,876	$ 300,876	$ 275,803	$ 420,823
VDH	4	Physician/Dentist Loan Repayment Program	$ 810,716	$ 439,140	$ 930,000	$ 1,516,361	$ 970,000	$ 900,000	$ 970,000
VDH	2	Renal Disease	$ 15,000	$ 7,601	$ 16,115	$ 15,095	$ 2,053	$ 13,689	$ 1,752
VDH	2	Newborn Screening	$ 74,899	$ 166,795	$ 136,577	$ -	$ -	$ -	$ -
VDH	2	WIC Coverage	$ 161,804	$ 1,165,699	$ 562,446	$ 86,882	$ -	$ 36,959	$ -
VDH	4	Vermont Blueprint for Health	$ 92,049	$ 1,975,940	$ 753,087	$ 1,395,135	$ 1,417,770	$ 752,375	$ 454,813
VDH	4	Area Health Education Centers (AHEC)	$ -	$ 35,000	$ 310,000	$ 565,000	$ 725,000	$ 500,000	$ 540,094
VDH	4	Community Clinics	$ -	$ -	$ -	$ 640,000	$ 468,154	$ 640,000	$ 600,000
VDH	4	FQHC Lookalike	$ -	$ -	$ 30,000	$ 105,650	$ 81,500	$ 87,900	$ 102,545
VDH	4	Patient Safety - Adverse Events	$ -	$ -	$ 190,143	$ 100,509	$ 44,573	$ 16,829	$ 25,081
VDH	4	Coalition of Health Activity Movement Prevention Program (CHAMPPS)	$ -	$ 100,000	$ 291,298	$ 496,466	$ 412,043	$ 290,661	$ 318,806
VDH	2	Substance Abuse Treatment	$ 1,466,732	$ 2,514,963	$ 2,744,787	$ 2,997,668	$ 3,000,335	$ 1,693,198	$ 2,928,773
VDH	4	Recovery Centers	$ 171,153	$ 287,374	$ 329,215	$ 713,576	$ 716,000	$ 648,350	$ 771,100
VDH	2	Immunization	$ -	$ -	$ -	$ 726,264	$ -	$ -	$ 23,903
VDH	2	DMH Investment Cost in CAP	$ -	$ -	$ -	$ 64,843	$ -	$ 752	$ 140
VDH	4	Poison Control	$ -	$ -	$ -	$ -	$ 176,340	$ 115,710	$ 213,150
VDH	4	Challenges for Change: VDH	$ -	$ -	$ -	$ -	$ -	$ -	$ 309,645
VDH	3	Fluoride Treatment	$ -	$ -	$ -	$ -	$ -	$ -	$ 43,483
VDH	4	CHIP Vaccines	$ -	$ -	$ -	$ -	$ -	$ -	$ 196,868
DMH	2	Special Payments for Treatment Plan Services	$ 101,230	$ 131,309	$ 113,314	$ 164,356	$ 149,068	$ 134,791	$ 132,021
DMH	2	MH Outpatient Services for Adults	$ 775,899	$ 1,393,395	$ 1,293,044	$ 1,320,521	$ 864,815	$ 522,595	$ 974,854
DMH	2	Mental Health Elder Care	$ 38,563	$ 37,682	$ 38,970	$ -	$ -	$ -	$ -
DMH	4	Mental Health Consumer Support Programs	$ 451,606	$ 546,987	$ 673,160	$ 707,976	$ 802,579	$ 582,397	$ 67,285
DMH	2	Mental Health CRT Community Support Services	$ 2,318,668	$ 602,186	$ 807,539	$ 1,124,728	$ -	$ 1,935,344	$ 1,886,140
DMH	2	Mental Health Children's Community Services	$ 1,561,396	$ 3,066,774	$ 3,341,602	$ 3,597,662	$ 2,569,759	$ 1,775,120	$ 2,785,090
DMH	2	Emergency Mental Health for Children and Adults	$ 1,885,014	$ 1,988,548	$ 2,016,348	$ 2,165,648	$ 1,797,605	$ 2,309,810	$ 4,395,885
DMH	2	Respite Services for Youth with SED and their Families	$ 385,581	$ 485,586	$ 502,237	$ 412,920	$ 516,677	$ 543,635	$ 541,707
DMH	2	CRT Staff Secure Transportation	$ -	$ -	$ 52,242	$ -	$ -	$ -	$ -
DMH	2	Recovery Housing	$ -	$ -	$ 235,267	$ -	$ 332,635	$ 512,307	$ 562,921
DMH	2	Transportation - Children in Involuntary Care	$ 4,768	$ 1,075	$ -	$ -	$ -	$ -	$ -
DMH	2	Vermont State Hospital Records	$ -	$ -	$ -	$ -	$ 19,590	$ -	$ -
DMH	4	Challenges for Change: DMH	$ -	$ -	$ -	$ -	$ -	$ 229,512	$ 945,051
DMH	2	Seriously Functionally Impaired	$ -	$ -	$ -	$ -	$ -	$ 68,713	$ 160,560
DMH	2	Acute Psychiatric Inpatient Services	$ -	$ -	$ -	$ -	$ -	$ -	$ 12,603,067
DVHA	4	Vermont Information Technology Leaders/HIT/HIE	$ -	$ -	$ -	$ -	$ 339,500	$ 646,220	$ 1,425,017
DVHA	4	Vermont Blueprint for Health	$ -	$ -	$ -	$ -	$ -	$ 2,616,211	$ 1,841,690
DVHA	1	Buy-In	$ 4,594	$ 314,376	$ 419,951	$ 248,537	$ 200,868	$ 50,605	$ 24,000
DVHA	1	Vscript Expanded	$ 1,695,246	$ -	$ -	$ -	$ -	$ -	$ -
DVHA	1	HIV Drug Coverage	$ 31,172	$ 42,347	$ 44,524	$ 48,711	$ 38,904	$ 39,176	$ 37,462
DVHA	1	Civil Union or Marriage	$ 373,175	$ 543,986	$ 671,941	$ 556,811	$ 627,976	$ 999,084	$ 1,215,109
DVHA	1	Vpharm	$ -	$ -	$ -	$ 278,934	$ 210,796	$ -	$ -
DVHA	4	Hospital Safety Net Services	$ -	$ -	$ 281,973	$ -	$ -	$ -	$ -
DVHA	2	Patient Safety Net Services	$ -	$ -	$ -	$ -	$ -	$ 36,112	$ 73,487
DCF	2	Family Infant Toddler Program	$ -	$ 199,064	$ 326,424	$ 335,235	$ 81,086	$ 624	$ -
DCF	2	Medical Services	$ 69,893	$ 91,569	$ 120,494	$ 65,278	$ 45,216	$ 64,496	$ 47,720
DCF	2	Residential Care for Youth/Substitute Care	$ 9,181,386	$ 10,536,996	$ 10,110,441	$ 9,392,213	$ 8,033,068	$ 7,853,100	$ 9,629,289
DCF	2	AABD Admin	$ 988,557	$ -	$ -	$ -	$ -	$ -	$ -
DCF	2	AABD	$ 2,415,100	$ -	$ -	$ -	$ -	$ -	$ -
DCF	2	Aid to the Aged, Blind and Disabled CCL Level III	$ 96,000	$ 2,617,350	$ 2,615,023	$ 2,591,613	$ 2,827,617	$ 2,661,246	$ 2,563,226
DCF	2	Aid to the Aged, Blind and Disabled Res Care Level III	$ -	$ 143,975	$ 170,117	$ 172,173	$ 137,356	$ 136,466	$ 137,833
DCF	2	Aid to the Aged, Blind and Disabled Res Care Level IV	$ 210,989	$ 312,815	$ 349,887	$ 366,161	$ 299,488	$ 265,812	$ 273,662
DCF	2	Essential Person Program	$ 542,382	$ 675,860	$ 614,974	$ 620,052	$ 485,536	$ 736,479	$ 775,278
DCF	2	GA Medical Expenses	$ 254,154	$ 339,928	$ 298,207	$ 380,000	$ 583,080	$ 492,079	$ 352,451
DCF	2	CUPS/Early Childhood Mental Health	$ -	$ -	$ 52,825	$ 499,143	$ 166,429	$ 112,619	$ 165,016
DCF	2	VCRHYP/Vermont Coalition for Runaway and Homeless Youth Program	$ -	$ -	$ 1,764,400	$ -	$ -	$ -	$ -
DCF	2	HBKF/Healthy Babies, Kids & Families	$ -	$ -	$ 318,321	$ 63,921	$ -	$ -	$ -
DCF	1	Catamount Administrative Services	$ -	$ -	$ -	$ 339,894	$ -	$ -	$ -
DCF	2	Therapeutic Child Care	$ -	$ -	$ -	$ 978,886	$ 577,259	$ 570,493	$ 596,406
DCF	2	Lund Home	$ -	$ -	$ -	$ 325,516	$ 175,378	$ 196,159	$ 354,528
DCF	2	GA Community Action	$ -	$ -	$ -	$ -	$ -	$ 199,762	$ 338,275
DCF	3	Prevent Child Abuse Vermont: Shaken Baby	$ -	$ -	$ -	$ -	$ -	$ 44,119	$ 74,250
DCF	3	Prevent Child Abuse Vermont: Nurturing Parent	$ -	$ -	$ -	$ -	$ -	$ -	$ 107,184
DCF	4	Challenges for Change: DCF	$ -	$ -	$ -	$ -	$ -	$ 50,622	$ 196,378
DCF	2	Strengthening Families	$ -	$ -	$ -	$ -	$ -	$ -	$ 465,343
DCF	2	Lamoille Valley Community Justice Project	$ -	$ -	$ -	$ -	$ -	$ -	$ 162,000
DDAIL	2	Elder Coping with MMA	$ 441,234	$ -	$ -	$ -	$ -	$ -	$ -
DDAIL	2	Mobility Training/Other Svcs.-Elderly Visually Impaired	$ 187,500	$ 250,000	$ 250,000	$ 250,000	$ 245,000	$ 245,000	$ 245,000
DDAIL	2	DS Special Payments for Medical Services	$ 394,055	$ 192,111	$ 880,797	$ 522,058	$ 469,770	$ 757,070	$ 1,498,083
DDAIL	2	Flexible Family/Respite Funding	$ 1,086,291	$ 1,135,213	$ 1,341,698	$ 1,364,896	$ 1,114,898	$ 1,103,748	$ 1,103,749
DDAIL	4	Quality Review of Home Health Agencies	$ -	$ 77,467	$ 186,664	$ 126,306	$ 90,227	$ 103,598	$ 128,399
DDAIL	4	Support and Services at Home (SASH)	$ -	$ -	$ -	$ -	$ -	$ -	$ 773,192
DOC	2	Intensive Substance Abuse Program (ISAP)	$ 382,230	$ 299,602	$ 310,610	$ 200,000	$ 591,004	$ 591,000	$ 458,485
DOC	2	Intensive Sexual Abuse Program	$ 72,439	$ 46,078	$ 85,542	$ 88,523	$ 68,350	$ 70,002	$ 60,585
DOC	2	Intensive Domestic Violence Program	$ 109,692	$ 134,663	$ 230,353	$ 229,166	$ 173,938	$ 174,000	$ 164,218
DOC	2	Women's Health Program (Tapestry)	$ 460,130	$ 487,344	$ 487,231	$ 527,956	$ -	$ -	$ -
DOC	2	Community Rehabilitative Care	$ 1,038,114	$ 1,982,456	$ 2,031,408	$ 1,997,499	$ 2,190,924	$ 2,221,448	$ 2,242,871
DOC	2	Return House	$ -	$ -	$ -	$ 51,000	$ -	$ -	$ -
DOC	2	Northern Lights	$ -	$ -	$ -	$ -	$ 40,000	$ 40,000	$ -
DOC	4	Challenges for Change: DOC	$ -	$ -	$ -	$ -	$ -	$ -	$ 687,166
			$ 45,455,809	$ 55,495,719	$ 59,918,097	$ 62,419,988	$ 55,554,314	$ 56,275,877	$ 89,836,470

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Strategic Plan

Plan Period: 2011 - 2015

Mission

Provide leadership for Vermont stakeholders to improve access, quality and cost effectiveness in health care reform.
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.

Statutory Guidance

Title 33: Human Services, Chapter 18: Public-Private Universal Health Care System
33 V.S.A. § 1803, Vermont health benefit exchange
Act 48: An act relating to a universal and unified health system
Title 33, Human Services Chapter 19 Medical Assistance

Planning Process

The Department of Vermont Health Access' (DVHA) Strategic Plan is the result of the collective input from all of DVHA's staff, DVHA management, and the Medicaid Advisory Board. DVHA's Strategic Plan is informed by the Governor's priorities and the State Health Care Strategic Plan. This plan is also guided by the Legislative Act 48 which creates Green Mountain Health Care to contain costs and to provide comprehensive, affordable, high-quality, publicly financed health care coverage for all Vermont residents. This Plan is a tool to assist DVHA in improving its performance and focusing its attention on key priorities. DVHA created a core team to develop the Plan using input from the above mentioned resources to guide the process. The team considered the current driving forces in Vermont and the various strengths, weaknesses and opportunities for the Department. As a result, this Plan identifies the overall accomplishments the DVHA should achieve.

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Goal 1: Reduce health care costs and cost growth

A. Statewide Priority: Affordable Health Care
Support Vermonters in the maintenance of their health through prevention and through affordable quality health care for all in a manner that supports small employers and overall economic growth, and that gets us better care.

B. Goal 1 Performance Measures

Measure 1A: Annual incremental growth in total cost of care per eligibility group
Measure 1B: Actual vs. projected growth rates in total cost of care per eligibility group
Measure 1C: Impact of health reforms on rates of utilization and related costs for Medicaid beneficiaries
Measure 1D: Impact of health reforms on shifting high risk Medicaid beneficiaries from patterns of acute episodic care to patterns of preventive care
Measure 1E: (%) of Medicaid beneficiaries with access to Blueprint integrated health services model, including Patient Centered Medical Homes and Community Health Teams
Measure 1F: (%) of primary care providers in Vermont participating in the Blueprint for Health
Measure 1G: (%) of applicable new contracts/grants and renewals of existing contracts that have performance based metrics
Measure 1H: (%) of cost avoidance in Medicaid expenditures

C. Goal 1 Strategies *(Projects, programs, and/or activities designed to implement the goal and achieve its measures)*

Implement simplifications and process efficiencies that reduce administrative costs within Vermont's public health care programs.

Implement innovations that will reduce the cost of care with Vermont's public health care programs.

Develop and maintain a state health care budgeting process that recognizes savings and investments.

Transition Vermonters' public health care programs toward payment methods that reward quality outcomes, value and promote integration of care.

Provide better coordination of health care services for all populations, particularly for high cost and high utilization populations.

Evaluate and continuously improve DVHA's efforts by developing a "learning health system."

Evaluate and ensure accurate and appropriate claim payments to prevent and reduce fraud, waste and abuse.

Develop a system for benefit determination based on clinical effectiveness and cost effectiveness.

Support Vermonters' personal health care decision-making through increased information and education.

Develop a health care system that supports a more flexible use of resources.

Goal 2: Assure that all Vermonters have access to and coverage for high-quality health care (health care includes mental health, physical health and substance abuse treatment)

A. Statewide Priority: Affordable Health Care

Support Vermonters in the maintenance of their health through prevention and through affordable quality health care for all in a manner that supports small employers and overall economic growth, and that gets us better care.

B. Goal 2 Performance Measures

Measure 2A: (%) of Vermonters who qualify for Medicaid/VHAP who are enrolled

Measure 2B: (%) of Green Mountain Care beneficiaries with coverage gaps greater than 29 days

Measure 2C: By October 2013, Vermonters can begin accessing the Health Benefit Exchange

Measure 2D: By January 1, 2014, Vermonters can begin purchasing qualified health plans through the Health Benefit Exchange

Measure 2E: (%) of Medicaid beneficiaries with access to Blueprint integrated health services model, including Patient Centered Medical Homes and Community Health Teams

C. Goal 2 Strategies *(Projects, programs, and/or activities designed to implement the goal and achieve its measures)*

Create more efficient enrollment processes in Vermont's public health care programs for Vermonters who qualify.

Implement federally required health insurance exchange.

Coordinate public health care programs and the state employees' health plans where possible.

Implement efficiencies and best practices in Vermonters' enrollment and retention in coverage to reduce churn between coverage options.

Goal 3: Reduce the complexities of health care interactions and transactions

A. Statewide Priority: Vermont's Infrastructures

Support modernization and improvements to Vermont's infrastructures, including our electric grid, road network, telecommunications system, and waste and storm water systems, to ensure Vermont's long-term economic and environmental sustainability.

B. Goal 3 Performance Measures

Measure 3A: (%) of expenditures based on rewarding value and promoting integration of care
Measure 3B: By October 2013, Vermonters can begin accessing the Health Benefit Exchange
Measure 3C: By January 1, 2014, Vermonters can begin purchasing qualified health plans through the Health Benefit Exchange

C. Goal 3 Strategies *(Projects, programs, and/or activities designed to implement the goal and achieve its measures)*

Allow for a single point of eligibility determination and enrollment for public care and private health insurance programs.

Transition Vermonters' public health care programs toward payment methods that reward value and promote integration of care.

Create an integrated system for health care claims processing.

Analyze payment structures for equity and cost-effectiveness.

Eliminate the cost shift between public health care and private health insurance programs.

Offer enrollment solutions that are real-time and user friendly.

Upgrade and implement the Medicaid Enterprise Solution (MES).

Goal 4: Support improvement in the health of Vermont's population.

A. Statewide Priority: Affordable Health Care
Support Vermonters in the maintenance of their health through prevention and through affordable quality health care for all in a manner that supports small employers and overall economic growth, and that gets us better care.

B. Goal 4 Performance Measures

Measure 4A: (%) of beneficiaries receiving direct care management services through Vermont's Chronic Care Initiative (VCCI)
Measure 4B: (#) of emergency room visits per 1000 Medicaid beneficiaries
Measure 4C: Impact of health reforms on shifting high risk Medicaid beneficiaries from patterns of acute episodic care to patterns of preventive care
Measure 4D: (%) of Medicaid beneficiaries receiving age and gender appropriate health maintenance and preventive healthcare services

Measure 4E: (%) of Medicaid beneficiaries receiving guideline based care for chronic conditions
Measure 4F: (%) of Medicaid beneficiaries at risk for poor health outcomes who are provided access to enhanced self-management support services
Measure 4G: (%) of dental providers enrolled as Vermont Medicaid providers

C. Goal 4 Strategies *(Projects, programs, and/or activities designed to implement the goal and achieve its measures)*

Maintain a network of providers that is sufficient in number, mix and geographic distribution to meet the health care needs of Vermonters.
Assure an appropriate range of preventive, primary care and specialty services to meet the health care needs of Vermonters.
Improve Vermonters' access to medically necessary dental care.
Improve Vermonters' access to medically necessary vision care.
Improve Vermonters' access to integrated mental health and substance abuse services.
Assure access to Blueprint integrated health services model for all Vermonters.
Conduct comparative effectiveness research and promote engagement in ongoing learning health systems activities.

Goal 5: Improve customer and provider satisfaction

A. Statewide Priority: State Government and Employees
Improve the effectiveness of state government by support of a motivated and healthy workforce and through greater accountability, performance measurement, and focus on customer service.

B. Goal 5 Performance Measures

Measure 5A: (%) of beneficiaries who, on DVHA's satisfaction survey, rate their overall health plan on a scale from 0 to 10 as an 8, 9 or10 (0 is the worst health plan possible and 10 is the best health plan possible)
Measure 5B: (%) of beneficiaries who, on DVHA's satisfaction survey, respond "usually" or "always" to easy access to care, tests, or treatment
Measure 5C: (%) of beneficiaries who, on DVHA's satisfaction survey, respond "usually" or "always" to easy access to a specialist
Measure 5D: (%) of beneficiaries who, on DVHA's satisfaction survey, respond "usually" or "always" to access to care as soon as needed
Measure 5E: (%) of providers who, on the HP Annual Provider Survey, rate their experience in all categories with the provider services help desk/call center as satisfied or very satisfied
Measure 5 F: (%) of providers who, on the HP Annual Provider Survey, rate their experience in all categories with the provider relations field representatives as satisfied or very satisfied

C. Goal 5 Strategies *(Projects, programs, and/or activities designed to implement the goal and achieve its measures)*

Improve involvement of stakeholders in Department policy development.
Reduce overly burdensome administrative procedures for both customers and providers.
Create an electronic system that allows beneficiaries access to their benefit accounts.
Improve beneficiary self-serve options by allowing certain changes via the web.
Improve oversight of the grievance and appeals procedures and compliance by end of 4th quarter, SFY 2012.

Goal 6: Establish an infrastructure that assures professional workforce competency and staff satisfaction.

A. Statewide Priority: State Government and Employees
Improve the effectiveness of state government by support of a motivated and healthy workforce and through greater accountability, performance measurement, and focus on customer service.

B. Goal 6 Performance Measures

Measure 6A: (%) of staff satisfaction surveys indicating an overall positive sense of job accomplishments.
Measure 6B: (%) of staff performance evaluations completed on time
Measure 6C: (%) of staff satisfaction surveys indicating manager's or direct supervisor's support of professional development.

C. Goal 6 Strategies *(Projects, programs, and/or activities designed to implement the goal and achieve its measures)*

Create a positive, healthy and supportive workplace environment.
Assure adequate supply and distribution of a high quality workforce.
Promote idea sharing for work process improvements.
Support and encourage employee development.
Develop training requirements for new staff.
Create workforce incentives for healthy lifestyles.
Reduce overly burdensome administrative procedures.
Enhance workforce competency and diminish reliance on contracted expertise.
Maintain performance management practices to create accountability, goals to success, and efficient and effective workflow achievements.

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Acronyms

AAA ..... Area Agency on Aging
AABD..... Aid to the Aged, Blind & Disabled
AAG ..... Assistant Attorney General
AAP ..... American Academy of Pediatrics
ABAWD..... Able-Bodied Adults without Dependents
ABD..... Aged, Blind and Disabled
ACA..... Affordable Care Act
ACCESS..... The computer software system used by DCF and DVHA to track program eligibility information
ACF ..... Administration for Children & Families
ACO..... Accountable Care Organization
ADA ..... American Dental Association
ADAP..... Alcohol and Drug Abuse Programs
AEP ..... Annual Enrollment Period
AGA ..... Adult General Assessment
AHCPR..... Agency for Health Care Policy & Research
AHEC..... Area Health Education Center
AHRQ Agency for Healthcare Research & Quality
AHS ..... Agency of Human Services
AIM®..... Advanced Information Management system (see MMIS)
AIRS..... Automated Information and Referral System
A/I/U Adopt/Implement/Upgrade
ALS ..... Advanced Life Support
AMA..... American Medical Association
AMAP ..... Aids Medication Assistance Program
AMP ..... Average Manufacturer Price
ANFC..... Aid to Needy Families with Children
AOA ..... Agency of Administration
APA ..... Administrative Procedures Act
APC ..... Ambulatory Payment Classification
APCP..... Advanced Primary Care Practice
APD ..... Advance Planning Document
APS..... Adult Protective Services
APS..... APS Healthcare
APTC..... Advanced Premium Tax Credit
ARRA..... American Recovery and Reinvestment Act of 2009
ASD..... Administrative Services Division
AWP ..... Average Wholesale Price
BAFO ..... Best & Final Offer
BC/BS..... Blue Cross/Blue Shield
BCCT..... Breast and Cervical Cancer Treatment Program
BD ..... Blind & Disabled
BHP ..... Basic health Plan
BISHCA..... Banking, Insurance, Securities, & Health Care Administration (now Financial Regulation) (Department of)
BP Blueprint for Health
BPM Business Process Management
BPS..... Benefits Programs Specialist
BROC..... Bennington-Rutland Opportunity Council
CAD Coronary Artery Disease
CAHPS..... Consumer Assessment of Health Plans Survey
CALT Collaborative Application Lifecycle Tool
CAP..... Community Action Program
CC..... Committed Child
CCB..... Change Control Board
CCI ..... Chronic Care Initiative
CCIIO Center for Consumer Information & Insurance Oversight (CMS)
CCMP..... Chronic Care Management Program
CCTA..... Chittenden County Transportation Authority
CF..... Crisis Fuel
CFR ..... Code of Federal Regulations
CHAP..... Catamount Health Assistance Program
CHF..... Congestive Heart Failure
CHIPRA..... Children's Health Insurance Program Re-authorization Act of 2009
CHPR ..... Center for Health Policy and Research
CHT..... Community Health Team
CIO..... Chief Information Office
CIS..... Children's Integrated Services
CM..... Case Management or Configuration Management
CMN..... Certification of Medical Necessity
CMS..... Centers for Medicare & Medicaid Services (formerly HCFA)
CMSO..... Center for Medicaid & State Operations
CNM Certified Nurse Midwife
COA..... Council on Aging
COB..... Coordination of Benefits
COB-MAT... Coordination of Office Based Medication Assisted Therapy
COLA..... Cost of Living Adjustment
CON..... Certificate of Need
ConOps..... Concept of Operations
COPD..... Chronic Obstructive Pulmonary Disease
COPS..... Computer Operations and Problem Solving
COS ..... Categories of Service
COTS..... Commercial Off-The-Shelf

CPH ..... Community Public Health
CPI..... Center for Program Integrity
CPT..... Common Procedural Terminology
CPTOD. Capitated Program for the Treatment of Opiate Dependency
CRT ..... Community Rehabilitation & Treatment
CSBG..... Community Services Block Grant
CSC ..... Customer Support Center
CSD..... Computer Services Division
CSHN ..... Children with Special Health Needs
CSME..... Coverage & Services Management Enhancement
CSR ..... Customer Service Request or Cost Sharing Reductions
CURB ..... Clinical Utilization Review Board
CY ..... Calendar Year
DAD..... Department of Aging & Disabilities (see DAIL)
DAIL..... Department of Disabilities, Aging and Independent Living
DCA Dept. of Cost Allocation (federal)
DCF..... Department for Children and Families
DDI..... Design, Development & Implementation
DDMHS..... Department of Developmental & Mental Health Services
DDS..... Disability Determination Services (part of DCF)
DHHS..... Department of Health & Human Services (United States)
DII..... Department of Information & Innovation
DIS..... Detailed Implementation Schedule
DME ..... Durable Medical Equipment
DMC ..... Disease Management Coordinators
DMH..... Department of Mental Health
DO..... District Office
DOA..... Date of Application
DOB..... Date of Birth
DOC..... Department of Corrections
DOE..... Department of Education
DOH ..... Department of Health (see VDH)
DOL..... Department of Labor
DOS ..... Date of Service
DR..... Desk Review
DRA..... Deficit Reduction Act
DR ..... Disaster Recovery
DR. D..... Dr. Dynasaur Program
DRG..... Diagnosis Related Grouping
DSH..... Disproportionate Share Hospital
DSW..... Department of Social Welfare (see PATH)
DUR..... Drug Utilization Review (Board)
DVHA ..... Department of Vermont Health Access
EA..... Emergency Assistance
EAC..... Estimated Acquisition Cost
EBT ..... Electronic Benefit Transfer
ECS..... Electronic Claims Submission
EDI..... Electronic Data Interchange
EDS ..... Electronic Data Systems Corporation, now HP Enterprise Services
EFT..... Electronic Funds Transfer
EGA..... Estimated Gestational Age
EHB ..... Essential Health Benefits
EHR..... Electronic Health Record
EHRIP ..... EHR Incentive Program
EITC ..... Earned Income Tax Credit
EOMB..... Explanation of Medicare (or Medicaid) Benefits
EP..... Essential Person
EPSDT..... Early & Periodic Screening, Diagnosis & Treatment
EQR..... External Quality Review
ER..... Emergency Room
ERA..... Electronic Remittance Advice
ERC ..... Enhanced Residential Care
ESD..... Economic Services Division (of the DCF)
ESI..... Employer Sponsored Insurance
ESRD..... End Stage Renal Disease
EST..... Eastern Standard Time
EVAH..... Enhanced VT Ad Hoc (query & reporting system)
EVS ..... Eligibility Verification System
FA..... Fiscal Agent
FADS..... Fraud Abuse & Detection System
FDA ..... Food & Drug Administration
FEIN..... Federal Employer's Identification Number
FFP ..... Federal Financial Participation
FFS ..... Fee for Service
FFY..... Federal Fiscal Year
FH..... Fair Hearing
FICA..... Federal Insurance Contribution Act
FMAP..... Federal Medical Assistance Percentage
FMB Financial Measurement Baseline
FMP Financial Management Plan
FPL..... Federal Poverty Level
FPO Family Planning Option
FQHC..... Federally Qualified Health Centers
FSA Flexible Spending Account
FTE Fulltime Equivalent
FTI Federal Tax Information
FUL ..... Federal Upper Limit (for pricing & payment of drug claims)
GA ..... General Assistance
GAO ..... General Accounting Office
GC ..... Global Commitment
GCR..... Global Clinical Record (application of the MMIS)

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GF..... General Fund
GMC..... Green Mountain Care
GMCB Green Mountain Care Board
GME Graduate Medical Education
HAEU..... Health Access Eligibility Unit
HATF..... Health Access Trust Fund
HBE..... Health Benefit Exchange
HCBS..... Home and Community Based Services
HCERA Health Care & Education Reconciliation Act of 2010
HCFA..... Health Care Finance Administration (now CMS)
HCPCS..... HCFA Common Procedure Coding System
HCR Health Care Reform
HEDIS..... Healthcare Effectiveness Data & Information Set
HHA..... Home Health Agency
HHS..... Health and Human Services (U.S. Department of)
HIE..... Health Information Exchange
HIR..... Hire into Range
HIX Health Insurance Exchange
HIFA..... Health Insurance Flexibility and Accountability
HIPAA..... Health Insurance Portability & Accountability Act
HIPP..... Health Insurance Premium Program
HIT..... Health Information Technology
HITECH HIT for Economic & Clinical Health
HIX Health Information Exchange
HP..... HP Enterprise Services, formerly EDS
HPIU Health Programs Integration Unit
HCR Health Care Reform
HR..... Health Reform
HRA..... Health Risk Assessment or Health Reimbursement Account
HRAP Health Resource Allocation Plan
HRSA..... Health Resources and Services Administration
HSA Health Savings Account or Health Service Area
HSB..... Human Services Board
HVP..... Healthy Vermonters Program
IAPD..... Implementation Advance Planning Document
IBNR ..... Incurred But Not Reported
IC..... Individual Consideration
ICD..... International Classification of Diseases
ICEHR Integrated Care Electronic Health Record
ICF/MR..... Intermediate Care Facility for the Mentally Retarded
ICM Integrated Care Management
ICN..... Internal Control Number
ICU..... Intensive Care Unit
ID..... Identification
IDN..... Integrated Delivery Network
IEP..... Individual Education Plan
IEVS..... Income Eligibility Verification System
IGA..... Intergovernmental Agreements
IHI..... Institute for Healthcare Improvement
IRS..... Internal Revenue Service
ISRA..... Information Security Risk Assessment
IT..... Information Technology
ITF..... Integrated Test Facility
IV & V..... Internal Validation & Verification
IVS..... Intervention Services
JCL..... Job Control Language
JFO..... Joint Fiscal Office
LAMP..... Legal Aid Medicaid Project
LAN..... Local Area Network
LC..... Legislative Council
LECC..... Legally Exempt Child Care
LIHEAP..... Low-Income Home Energy Assistance Program
LIS..... Low-Income Subsidy
LIT..... Local Interagency Team
LTC..... Long-Term Care
LUPA..... Low Utilization Payment Adjustment
MA..... Medicare Advantage – Medicare Part C in VT
MAB..... Medicaid Advisory Board
MAC..... Maximum Allowable Cost (refers to drug pricing)
MAGI Modified Adjusted Gross Income
MAPIR Medicaid Assistance Provider Incentive Repository
MARS..... Management & Administrative Reporting
MAT..... Medication Assisted Therapy
MCE..... Managed Care Entity
MCH..... Maternal and Child Health
MCMC..... Managed Care Medical Committee
MCO..... Managed Care Organization
MCP..... Managed Care Plan
MDB..... Medicare Database
MEQC..... Medicaid Eligibility Quality Control
MES..... Medicaid Enterprise Solution
MFP..... Money Follows the Person
MFRAU..... Medicaid Fraud & Residential Abuse Unit
MID..... Beneficiary Medicaid Identification Number (see UID)
MIC..... Medicaid Integrity Contractor
MIG Medicaid Integrity Group
MIP Medicaid Integrity Program
MIS..... Management Information System
MITA..... Medicaid Information Technology Architecture

MMA ..... Medicare Modernization Act
MMIS..... Medicaid Management Information System
MNF ..... Medical Necessity Form
MOE..... Maintenance of Effort
MOE ..... Maintenance of Eligibility
MOU..... Memorandum of Understanding
MOVE..... Modernization of Vermont's Enterprise
MSIS..... Medicaid Statistical Information
MSP ..... Medicare Savings Programs
MTM ..... Medication Therapy Management
MU..... Meaningful Use
MVP ..... Mohawk Valley Physicians
NAMI ..... National Association for Mental Illness
NCBD..... National CAHPS Benchmarking Database
NCCI National Correct Coding Initiative
NCQA National Committee for Quality Assurance
NDC..... National Drug Code
NEKCA..... Northeast Kingdom Community Action
NEMT Non-Emergency Medical Transportation
NGA ..... National Governors Association
NP..... Nurse Practitioner or Naturopathic Physician
NPA ..... Non-Public Assistance
NPF..... National Provider File
NPI..... National Provider Identifier
OADAP..... Office of Alcohol & Drug Abuse Programs
OASDI..... Old Age, Survivors, Disability Insurance
OASIS Organization for the Advancement of Structured Information Standards
OCIIO Office of Consumer Information and Insurance Oversight (CMS)
OCS ..... Office of Child Support
ODAP ..... Office of Drug & Alcohol Prevention
OEO..... Office of Economic Opportunity
OHRA..... Oral Health Risk Assessment
OLTP ..... Online Transaction Processing
ONC..... Office of National Coordinator for HIT
OPS..... Operations
OPPS..... Outpatient Prospective Payment System
OTC ..... Over the Counter
OVHA... Office of Vermont Health Access (now department (DVHA)
PA..... Prior Authorization or Public Assistance or Physician Assistant or Payment Authorization
PACE..... Program for All-Inclusive Care for the Elderly
PAPD Planning Advanced Planning Document (CMS)
PARIS..... Public Assistance Reporting Information System
PATH..... Department of Prevention, Assistance, Transition, & Health Access (now DCF)
PBA/PBM... Pharmacy Benefits Administrator / Pharmacy Benefits Manager
PC Plus ..... VT Primary Care Plus
PCCM..... Primary Care Case Management
PCIP..... Pre-existing Condition Insurance Plan
PCMH..... Patient-Centered Medical Home
PCP ..... Primary Care Provider
PDF..... Portable Document File
PDL ..... Preferred Drug List
PDP..... Prescription Drug Plan
PDSA..... Plan Do Study Act
PEP ..... Proposal Evaluation Plan or Principal Earner Parent
PERM ..... Payment Error Rate Measurement
PES ..... Provider Electronic Solutions
PHI..... Protected Health Information
PHO ..... Physician Hospital Organization
PI ..... Program Integrity
PII ..... Personally Identifiable Information
PIL ..... Protected Income Level or Poverty Income Guidelines
PIP ..... Performance Improvement Project
PIRL ..... Plan Information Request Letter
PIA..... Privacy Impact Statement
PM ..... Project Manager
PMP ..... Project Management Plan
PMPM ..... Per Member Per Month
PNMI..... Private Non-Medical Institution
POC ..... Plan of Care or
..... Public Oversight Commission
POS..... Point of Sale or Point of Service
PP&D..... Policy, Procedures and Development (Interpretive Rule Memo)
PPA Project Process Agreement
PPACA Patient Protection & Affordable Care Act
PPPM..... Per Patient Per Month
PPR..... Planning, Policy and Regulation
PRO ..... Peer Review Organization
PRWORA.... Personal Responsibility & Work Opportunity Reconciliation Act
PSE ..... Post-Secondary Education
PSTG ..... Private Sector Technology Group
QC ..... Quality Control
QHP..... Qualified Health Plan
QI Qualified Individual or Quality Improvement
QIAC..... Quality Improvement Advisory Committee
QMB..... Qualified Medicare Beneficiary

QWDI ..... Qualified Working Disabled Individual
RA ..... Remittance Advice
RAC..... Recovery Audit Contractor
RAM..... Responsibility Assignment Matrix
RBC..... Risk Based Capital
RBRVS..... Resource-Based Relative Value Scale
RBUC ..... Reported But Unpaid Claims
REVS..... Recipient Eligibility Verification System
RFI..... Request for Information
RFP..... Request for Proposals
RMP..... Risk Management Plan
RN ..... Registered Nurse
RO ..... Regional Office
ROB..... Rules of Behavior
ROI ..... Return on Investment
RR..... Railroad Retirement
RTM ..... Requirements Traceability Matrix
RU..... Reach Up program
RVU..... Relative Value Units
SAMHSA... Substance Abuse and Mental Health Services Administration
SAS..... Statement on Auditing Standards
SASH..... Support and Services at Home
SBC ..... Summary of Benefits & Coverage
SBE..... State Health Benefit Exchange
SCHIP..... State Children's Health Insurance Program
SDMP System Development Management Plan
SDO ..... Standards Development Organization
SDX..... State Data Exchange System
SE ..... Systems Engineer
SEP ..... Special Enrollment Periods
SF..... Supplemental Fuel
SFY..... State Fiscal Year
SGF..... State General Fund
SHOP..... Small Business Health Options Program
SILC ..... Statewide Independent Living Council
SLA ..... Service Level Agreement
SLHIE..... State Level HIE Consensus Project
SLMB..... Specified Low-Income Medicare Beneficiary
SMDL State Medicaid Directors Letter
SMHP State Medicaid HIT Plan
SMM..... State Medicaid Manual
SNAP..... State Nutritional Assistance Program
SNF..... Skilled Nursing Facility
SOA ..... Service Oriented Architecture
SOR ..... System of Records
SORN ..... System of Record Notice
SOW..... Statement of Work
SPA..... State Plan Amendment
SPAP..... State Pharmacy Assistance Program
SPR..... Safeguard Procedures Report
SRS..... Social & Rehabilitative Services (Department of)
SSA..... Social Security Administration or ..... State Self Assessment
SSBG..... Social Services Block Grant
SSI ..... Supplemental Security Income
SSN..... Social Security Number
SSO..... Standards Setting Organization
SSP ..... Systems Security Plan
SUR ..... Surveillance & Utilization Review
TAD..... Turnaround Documents
TANF..... Temporary Assistance for Needy Families (Reach Up in VT)
TARB ..... Technical Architecture Review Board
TBI..... Traumatic Brain Injury
TIN ..... Taxpayer Identification Number
TM..... Transitional Medicaid
TPA ..... Third Party Administrator
TPL..... Third Party Liability
UC ..... Unemployment Compensation
UCR..... Usual & Customary Rate
UCUM ..... Unified Code for Units of Measure
UI..... Unemployment Insurance
UIB..... Unemployment Insurance Benefits
UID..... Unique Identification Number
UM..... Utilization Management
UMLS..... Unified Medical Language System
UR ..... Utilization Review
UVM..... University of Vermont
VA ..... Veterans Administration
VAB..... VT Association for the Blind
VAHHA..... VT Assembly of Home Health Agencies
VAHHS..... VT Association of Hospital & Health Systems
VCCI..... Vermont Chronic Care Initiative
VCIL Vermont Center for Independent Living
VDH..... VT Department of Health
VDHA ..... VT Dental Hygienists Association
VHAP... ....VT Health Access Plan
VHAP-Rx..... VT Health Access Plan Pharmacy Program
VHC Vermont Health Connect
VHCURES VT Healthcare Claims Uniform Reporting & Evaluation System
VIEWS Vermont's Integrated Eligibility Workflow System
VIP..... VT Independence Project
VISION ..... VT's Integrated Solution for Information and Organizational Needs (the statewide accounting system)
VIT..... VT Interactive Television
VITL..... VT Information Technology Leaders
VLA..... VT Legal Aid
VMS ..... VT Medical Society

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VNA .....Visiting Nurses Association
VPHARM....VT Pharmacy Benefits Program
VPQHC .....VT Program for Quality in Health Care
VPTA.....Vermont Public Transportation Agency
VR.....Vocational Rehabilitation
VRS .....Voice Response System
VSA.....VT Statutes Annotated
VSAC……VT Student Assistance Corporation
VScript.....VT Pharmacy Benefits Program
VSDS.....VT State Dental Society
VSEA.....VT State Employees Association
VSECU.....VT State Employees Credit Union
VSH.....VT State Hospital
VSHA.....VT State Housing Authority
VT.....State of Vermont
VTD.....VT Part D as Primary
VTM.....VT Medicaid as Primary
VUL.....VT Upper Limit
WAC.....Wholesale Acquisition Cost
WBS .....Work Breakdown Structure
WIC .....Women, Infants & Children
WTW.....Welfare to Work

Title XIX State Plan Groups			
Mandatory; Categorically Needy (Global Commitment Demonstration Population 1)			
Population Description	**Green Mountain Care Group**	**Standards and Methodologies**	**Benefit Package**
Section 1931 low-income families with children	Commonly referred to as Medicaid (for adults) and Dr. Dynasaur (for children)	AFDC standard and methodologies	Inpatient hospital services Outpatient hospital services Rural health clinic services Federally qualified health center services Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services Laboratory and X-ray services Family planning services Physician services and Medical and Surgical Services of a Dentist Home health services Nurse Midwife services Nursing facility services Certified Pediatric and Family Nurse Practitioner Services Other Medical/Remedial Care Provided by Licensed Practitioners and Recognized under State Law (chiropractor, podiatrist, optometrist, licensed social worker, licensed mental counselor or licensed marriage and family therapist, psychologist, optician, hi-tech nursing, nurse practitioner, licensed lay midwife) Clinical Services Prescription drugs Diagnostic, Screening, Preventive and Rehabilitative Services Private duty nursing services Other Aids to Vision Dental Services Prosthetic Devices Physical and Occupational therapies, and services for Individuals with Speech, hearing and language disorder services Inpatient Hospital/Nursing Facility/ICF Services for Individuals 65 and Older in IMD ICF/MR Services Inpatient Psychiatric Services for Individuals Under 21 Personal Care Services Case Management Respiratory Care for Ventilator Dependent Individuals Primary Care Case Management Hospice Transportation Services Nursing Facility Services for Individuals Under Age 21 Emergency Hospital Services Critical Access Hospital Traumatic Brain Injury; HCBS waiver –like services Mental Illness Under 22; HCBS waiver-like services Community Rehabilitation and Treatment; HCBS waiver-like services Developmental Services; HCBS waiver-like services
Children receiving IV-E payments (IV-E foster care or adoption assistance)		AFDC standard and methodologies	
Individuals who lose eligibility under §1931 due to employment		AFDC standard and methodologies	
Individuals who lose eligibility under §1931 because of child or spousal support		AFDC standard and methodologies	
Individuals participating in a work supplementation program who would otherwise be eligible under §1931		AFDC standard and methodologies	
Individuals receiving SSI cash benefits		SSI standard and methodologies	
Disabled children no longer eligible for SSI benefits because of a change in definition of disability		SSI standard and methodologies	
Qualified severely impaired individuals (as defined in §1905(q))		SSI standard and methodologies	
Individuals under age 21 eligible for Medicaid in the month they apply for SSI		SSI standard and methodologies	
Qualified pregnant women		AFDC standard and methodologies	
Qualified children		AFDC standard and methodologies	
Poverty level pregnant women		Income ≤ to 185% of the FPL	
Poverty level infants		Income ≤ to 185% of the FPL	
Qualified family members		AFDC standard and methodologies	
Poverty level children under age six		Family income ≤ to 133% of FPL	
Poverty level children under age 19, who are born after September 30, 1983 (or, at State option, after any earlier date)		Family income ≤ to 100% of FPL	
Disabled individuals whose earnings exceed SSI substantial gainful activity level		SSI standard and methodologies	
Disabled individuals whose earnings are too high to receive SSI cash benefits		SSI standard and methodologies	
Pickle amendment: individuals who would be eligible for SSI if Title II COLAs were deducted from income (§503 of Public Law 94-566)		SSI standard and methodologies	
Disabled widows and widowers		SSI standard and methodologies	
Disabled adult children		SSI standard and methodologies	
Early widows/widowers		SSI standard and methodologies	
Individuals who would be eligible for AFDC except for increased OASDI income under P.L. 92-336 (July 1, 1972)		AFDC standards and methodologies	
Individuals receiving mandatory State supplements		SSI standard and methodologies	
Individuals eligible as essential spouses in December 1973		SSI standard and methodologies	
Institutionalized individuals who were eligible in December 1973		SSI standard and methodologies	
Blind and disabled individuals eligible in December 1973		SSI standard and methodologies	
Individuals who would be eligible except for the increase in OASDI benefits under Public Law 92-336		SSI standard and methodologies	
Individuals who become eligible for cash assistance as a result of OASDI cost-of- living increases received after April 1977		SSI standard and methodologies	
Individuals who become eligible for cash assistance as a result of OASDI cost-of- living increases received after April 1977		SSI standard and methodologies	
Newborns deemed eligible for one year			
Pregnant women who lose eligibility receive 60 days coverage for pregnancy-related & post partum services			Pregnancy related and post partum services under the State Plan
Pregnant women losing eligibility because of a change in income remain eligible 60 days post partum			Pregnancy related and post partum services under the State Plan
Poverty level infants and children receiving inpatient services who lose eligibility because of age must be covered through an inpatient stay			Inpatient hospital services
Qualified Medicare Beneficiaries	Commonly referred to as QMBs	Medicare beneficiaries with income equal to 100% of the FPL	Payment of Medicare premiums, coinsurance, deductibles, and copayment except Part D copayment
Qualified Disabled and Working Individuals	Commonly referred to as QDWIs	Medicare beneficiaries with income equal to 200% of the FPL and not eligible for Medicaid	Payment of Medicare Part A premiums
Specified Low-Income Medicare Beneficiaries	Commonly referred to as SLMBs	Medicare beneficiaries with income between 100 and 120% of the FPL	Payment of Medicare Part B premiums
Qualifying Individuals	Commonly referred to as QIs	Medicare beneficiaries with income equal to 120% but < 135% of the FPL and not eligible for Medicaid	Payment of Medicare Part B premiums

* This is not an exhaustive list of mandatory groups covered under the Vermont title XIX State plan. For a complete list, refer to the Vermont approved title XIX State plan.

Optional; Categorically Needy (Global Commitment Demonstration Population 2)			
Population Description	**Green Mountain Care Group**	**Standards and Methodologies**	**Benefit Package**
Individuals who are eligible for but not receiving IV-A, SSI or State supplement cash assistance	Commonly referred to as Medicaid (for adults) and Dr. Dynasaur (for children)		Same comprehensive benefit package as Global Commitment Demonstration Population 1
Individuals who could be eligible for IV-A cash assistance if State did not subsidize child care			
Individuals who are eligible for Title IV-A if State AFDC plan were as broad as allowed			
Individuals who would have been eligible for IV-A cash assistance, SSI, or State supplement if not in a medical institution			
Special income level group: individuals who are in a medical institution for at least 30 consecutive days with gross income that does not exceed 300% of the SSI income standard, or state-specified standard			
Individuals who are terminally ill, would be eligible if they were in a medical institution, and will receive hospice care			
Children under 21 (or at State option 20, 19, or 18) who are under State adoption agreements			
Poverty level pregnant women not mandatorily eligible			
Poverty level infants not mandatorily eligible			
Individuals receiving only an optional State supp. payment more restrictive than the criteria for an optional State supplement under title XVI			
Katie Beckett children			
Individuals under 18 who would be mandatorily categorically eligible except for income and resources			
Pregnant women who lose eligibility receive 60 days coverage for pregnancy-related and post partum services			
Blind and disabled individuals eligible in December 1973			
All individuals under 21 or at State option 20, 19, or 18 or reasonable classifications who would not be covered under mandatory medically needy group of individuals under 18			
Specified relatives of dependent children who are ineligible as categorically needy			
Aged individuals who are ineligible as categorically needy			
Blind individuals who are ineligible as categorically needy but meet the categorically needy definition of blindness			
Disabled individuals who are ineligible as categorically needy that meet the categorically needy definition of blindness			
Individuals receiving HCBS who would only be eligible for Medicaid under the State Plan if they were in a medical institution; individuals who were previously covered under a separate 1915(c) Demonstration. 1. TBI (traumatic brain injury) 2. MI under 22 (Children's mental Health) 3. MR/DD (Mental Retardation/Developmental Disabilities)			
Pregnant women who would be categorically eligible except for income and resources			Pregnancy-related and Post-Partum Services under the State Plan

Expansion Populations			
VHAP Expansion Populations (Global Commitment Demonstration Populations 3-8)			
Population Description	**Medicaid Eligibility Group**	**Standards and Methodologies**	**Benefit Package**
Underinsured children with income between 225% and including 300% of FPL who are not eligible for Medicaid or CHIP	Commonly referred to as Medicaid (for adults) and Dr. Dynasaur (for children)	Children with income between 225% and up to and including 300% of FPL (with other insurance)	Same comprehensive benefit package as Global Commitment Demonstration Population 1 only if not covered by primary insurer.
Adults with children with income between 150% and up to and including 185% of the FPL	Commonly referred to as VHAP	Income between 150% and up to and including 185% of the FPL	Inpatient hospital services Outpatient hospital services Rural health clinic services Federally qualified health center services Laboratory and X-ray services Family Planning Services and Supplies Physician Services and Medical and Surgical Service of a Dentist Home health services Certified Pediatric and Family Nurse Practitioner services Other Medical/Remedial Care Provided by Licensed Practitioners and Recognized under State Law (chiropractor, podiatrist, optometrist, licensed social worker, licensed mental counselor or licensed marriage and family therapist, psychologist, optician, hi-tech nursing, nurse practitioner, licensed lay midwife) Clinical Services Prescriptions Drugs Diagnostic, Screening, Preventive and Rehabilitative Services Physical and Occupational Therapies, and Services for Individuals with Speech, Hearing, and Language Disorders Primary Care Case Management Emergency Hospital Services Critical Access Hospital Nursing facility services Nurse Midwife services Respiratory care services Hospice
Adults with income up to and including 150% of the FPL	Commonly referred to as VHAP	Income up to and including 150% of the FPL	
Medicare beneficiaries and non-Medicare individuals who are 65 years or older or have a disability with income at or below 150% of the FPL	Prescription Assistance Pharmacy Only Program	Income at or below 150 percent of the FPL	Medicaid Prescriptions, eyeglasses and related eye exams
Medicare beneficiaries and non-Medicare individuals who are 65 years or older or have a disability with income above 150% and ≤ 225% of the FPL	Prescriptions Assistance Pharmacy Only Program	Income below 225 percent of the FPL	Maintenance Drugs
Individuals with persistent mental illness with income up to and including 150% of the FPL		Income up to and including 150 percent of the FPL	Day services, diagnosis and evaluation services, emergency care, psychotherapy, group therapy, chemotherapy, specialized rehabilitative services
Premium Assistance Expansion Populations (Global Commitment Demonstration Population 9 and 10) ESI Premium Assistance**			
Adults with children with income between 185% and up to and including 300% of the FPL	Commonly referred to as ESI Premium Assistance	Income between 185% and up to and including 300% of the FPL	Premium assistance to purchase ESI. The benefits covered by the plan must be substantially similar to the benefits offered by the Catamount Health Premium Assistance.
Childless adults with income between 150% and up to and including 300% of the FPL	Commonly referred to as ESI Premium Assistance	Income between 150% and up to and including 300% of the FPL	Premium assistance to purchase ESI. The benefits covered by the plan must be substantially similar to the benefits offered by the Catamount Health Premium Assistance.
Catamount Health Premium Assistance			
Adults with children with income between 185% and up to and including 300% FPL	Commonly referred to as Catamount Health	Income between 185% and up to and including 300% of the FPL	Premium assistance to purchase the Catamount Health. Comprehensive benefit as prescribed in Catamount State statute
Childless adults with income between 150% and up to and including 300% of the FPL	Commonly referred to as Catamount Health	Income between 150% and up to and including 300% of FPL	Premium assistance to purchase Catamount Health. Comprehensive benefit as prescribed in Catamount State statute

Population Description	Medicaid Eligibility Group	Standards and Methodologies	Benefit Package
Individuals covered under the Vermont Section 1115 Choices for Care Demonstration not receiving CRT services	Subset of Medicaid for Long-Term Care Services	See Department of Aging and Independent Living	See Department of Aging and Independent Living
Children's Health Insurance Program (CHIP)	Commonly referred to as Dr. Dynasaur	Income from 225% and up to and including 300% of FPL	Same comprehensive benefit package as Global Commitment Demonstration Population 1

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Program Cost Comparison SFY 2007 through SFY 2014 Governor's Recommend

PROGRAM EXPENDITURES

	SFY '07 Actuals			SFY '08 Actuals			SFY '09 Actuals		
Adults	Enrollment	Expenses	PMPM	Enrollment	Expenses	PMPM	Enrollment	Expenses	PMPM
Aged, Blind, or Disabled (ABD)/Medically Needy	11,330	$ 68,586,463	$ 504.46	11,797	$ 72,515,067	$ 512.24	12,550	$ 82,398,879	$ 547.15
Dual Eligibles	14,073	$ 37,371,558	$ 221.30	14,185	$ 35,614,807	$ 209.23	14,753	$ 38,596,281	$ 218.02
General	9,327	$ 41,239,463	$ 368.44	9,255	$ 43,797,118	$ 394.36	9,847	$ 53,060,215	$ 449.06
VHAP	22,404	$ 79,795,246	$ 296.80	24,771	$ 89,891,925	$ 302.40	28,224	$ 111,730,898	$ 329.89
VHAP ESI	-	$ -	$ -	276	$ 571,218	$ 172.63	821	$ 1,525,747	$ 154.95
Catamount	-	$ -	$ -	1,730	$ 7,995,765	$ 385.12	6,350	$ 30,293,232	$ 397.55
ESIA	-	$ -	$ -	132	$ 168,977	$ 106.81	478	$ 688,592	$ 120.17
New Adult									
Premium Assistance For Exchange Enrollees < 300%									
Cost Sharing For Exchange Enrollees < 350%									
Subtotal Adults	57,134	$ 226,992,729	$ 331.08	62,146	$ 250,554,876	$ 335.98	73,021	$ 318,293,843	$ 363.24
Children									
Blind or Disabled (BD)/Medically Needy	3,398	$ 28,299,312	$ 693.95	3,487	$ 27,775,036	$ 663.78	3,605	$ 31,686,636	$ 732.47
General	51,187	$ 85,115,012	$ 138.57	50,664	$ 90,807,988	$ 149.36	52,224	$ 100,299,806	$ 160.05
Underinsured	1,186	$ 846,736	$ 59.51	1,138	$ 742,529	$ 54.39	1,212	$ 721,162	$ 49.61
SCHIP (Uninsured)	3,070	$ 4,189,850	$ 113.73	3,278	$ 4,462,004	$ 113.42	3,412	$ 5,386,841	$ 131.56
Subtotal Children	58,841	$ 118,450,910	$ 167.76	58,567	$ 123,787,557	$ 176.13	60,452	$ 138,094,446	$ 190.36
Pharmacy Only Programs	12,952	$ 9,285,897	$ 55.24	12,737	$ 8,052,596	$ 47.88	12,456	$ 7,535,743	$ 50.42
Choices for Care									
Nursing Home, Home & Community Based, ERC	3,545	$ 148,714,078	$ 3,496.19	3,973	$ 166,375,075	$ 3,489.85	4,016	$ 172,372,731	$ 3,576.72
Acute-Care Services ~ DVHA	3,545	$ 18,015,671	$ 423.54	3,973	$ 20,041,562	$ 420.39	4,016	$ 22,925,258	$ 475.70
Acute-Care Services ~ Other Depts.	3,545	$ 627,528	$ 14.75	3,973	$ 1,097,788	$ 23.03	4,016	$ 284,592	$ 5.91
Buy-In		$ 2,198,479			$ 2,228,171			$ 2,371,707	
Subtotal Choices for Care*	3,545	$ 169,555,756	$ 3,986.17	3,973	$ 189,742,595	$ 3,980.00	4,016	$ 197,954,288	$ 4,107.53
Subtotal Direct Services	132,472	$ 524,285,291	$ 329.81	137,422	$ 572,137,623	$ 346.95	149,946	$ 661,878,320	$ 367.84
Miscellaneous Program									
GC to CFC Funding Reallocation		$ (627,528)			$ (1,097,788)			$ (284,592)	
Refugee	22	$ 93,315	$ 357.53	17	$ 68,304	$ 334.83	47	$ 222,863	$ 395.15
ACA Rebates		$ -			$ -			$ -	
HIV	110	$ 49,468	$ 37.55	101	$ 43,914	$ 36.23	117	$ 44,976	$ 32.10
Civil Unions	185	$ 1,006,036	$ 452.61	194	$ 1,010,764	$ 434.18	197	$ 839,480	$ 355.11
Underinsured									
DSH		$ 59,377,729			$ 49,003,898			$ 35,648,781	
Clawback		$ 19,142,150			$ 20,339,254			$ 20,779,093	
Buy-In ~ GC		$ 21,744,731			$ 21,063,422			$ 21,306,607	
Buy-In ~ State Only (MCO Invest.)		$ 314,376			$ 419,951			$ 248,537	
Buy-In ~ Federal Only		$ 2,489,407			$ 3,123,135			$ 2,730,326	
Legal Aid		$ 564,937			$ 476,832			$ 547,983	
Misc. Pymts. (incl. family planning option)		$ 2,470,780			$ 2,237,253			$ 2,788,183	
Healthy Vermonters Program	9,413	$ -	n/a	5,781	$ -	n/a	4,843	$ -	n/a
Subtotal Miscellaneous Program	9,730	$ 106,625,402		6,093	$ 96,688,940		5,203	$ 84,872,236	
TOTAL PROGRAM EXPENDITURES	142,202	$ 630,910,693		143,515	$ 668,826,563		155,149	$ 746,750,556	

	SFY '10 Actuals			SFY '11 Actuals			SFY '12 Actuals		
Adults	Enrollment	Expenses	PMPM	Enrollment	Expenses	PMPM	Enrollment	Expenses	PMPM
Aged, Blind, or Disabled (ABD)/Medically Needy	13,337	$ 87,006,993	$ 543.63	13,786	$ 88,592,211	$ 535.50	13,977	$ 95,212,717	$ 567.66
Dual Eligibles	15,192	$ 41,432,987	$ 227.28	16,014	$ 42,746,091	$ 222.44	16,634	$ 43,120,000	$ 216.03
General	10,358	$ 58,325,148	$ 469.26	10,896	$ 61,424,053	$ 469.78	11,235	$ 61,521,695	$ 456.33
VHAP	33,249	$ 130,598,440	$ 327.32	36,706	$ 140,821,782	$ 319.71	36,991	$ 144,423,060	$ 325.36
VHAP ESI	949	$ 1,787,708	$ 156.97	904	$ 1,695,350	$ 156.37	825	$ 1,452,802	$ 146.81
Catamount	9,058	$ 45,210,486	$ 415.95	9,921	$ 56,831,908	$ 477.36	10,713	$ 52,066,782	$ 405.01
ESIA	682	$ 900,029	$ 110.04	747	$ 1,056,258	$ 117.90	726	$ 954,128	$ 109.54
New Adult									
Premium Assistance For Exchange Enrollees < 300%									
Cost Sharing For Exchange Enrollees < 350%									
Subtotal Adults	82,824	$ 365,261,791	$ 367.51	88,973	$ 393,167,654	$ 368.24	91,101	$ 398,751,184	$ 364.75
Children									
Blind or Disabled (BD)/Medically Needy	3,606	$ 31,605,170	$ 730.35	3,696	$ 34,724,216	$ 783.01	3,712	$ 33,805,689	$ 759.03
General	54,266	$ 108,508,732	$ 166.63	55,053	$ 111,924,219	$ 169.42	55,274	$ 117,381,607	$ 176.97
Underinsured	1,178	$ 812,299	$ 57.46	1,131	$ 806,332	$ 59.43	1,068	$ 766,013	$ 59.78
SCHIP (Uninsured)	3,523	$ 5,629,939	$ 133.17	3,686	$ 6,295,264	$ 142.34	3,909	$ 6,873,629	$ 146.52
Subtotal Children	62,573	$ 146,556,139	$ 195.18	63,565	$ 153,750,031	$ 201.57	63,963	$ 158,826,938	$ 206.93
Pharmacy Only Programs	12,550	$ 3,929,059	$ 26.09	12,751	$ 4,427,164	$ 28.93	12,655	$ (1,421,868)	$ (9.36)
Choices for Care									
Nursing Home, Home & Community Based, ERC	3,925	$ 170,312,343	$ 3,616.05	3,889	$ 165,981,446	$ 3,556.49	3,891	$ 171,257,632	$ 3,667.97
Acute-Care Services ~ DVHA	3,925	$ 20,549,664	$ 436.31	3,889	$ 21,883,931	$ 468.91	3,891	$ 21,310,228	$ 456.42
Acute-Care Services ~ Other Depts.	3,925	$ 1,300,771	$ 27.62	3,889	$ 1,423,289	$ 30.50	3,891	$ 1,298,408	$ 27.81
Buy-In		$ 2,455,358			$ 2,679,842			$ 2,611,685	
Subtotal Choices for Care*	3,925	$ 194,618,136	$ 4,132.11	3,889	$ 191,968,507	$ 4,113.32	3,891	$ 196,477,952	$ 4,208.14
Subtotal Direct Services	161,872	$ 710,365,126	$ 365.70	169,179	$ 743,313,356	$ 366.14	171,610	$ 752,634,207	$ 365.48
Miscellaneous Program									
GC to CFC Funding Reallocation		$ (1,300,771)			$ (1,423,289)			$ (1,298,408)	
Refugee	40	$ 154,500	$ 319.21	46	$ 242,581	$ 438.66	68	$ 283,439	$ 346.08
ACA Rebates		$ -			$ (4,698,058)			$ (4,784,914)	
HIV	133	$ 38,904	$ 24.38	123	$ 39,176	$ 26.60	91	$ 37,452	$ 34.31
Civil Unions	235	$ 838,772	$ 297.44	285	$ 1,045,654	$ 306.28	308	$ 1,438,940	$ 389.22
Underinsured									
DSH		$ 37,448,781			$ 37,448,782			$ 37,448,781	
Clawback		$ 13,332,383			$ 17,684,471			$ 23,784,030	
Buy-In ~ GC		$ 23,415,644			$ 27,334,803			$ 26,993,495	
Buy-In ~ State Only (MCO Invest.)		$ 200,868			$ 50,605			$ 24,000	
Buy-In ~ Federal Only		$ 3,125,212			$ 3,556,352			$ 3,392,297	
Legal Aid		$ 547,983			$ 547,993			$ 502,318	
Misc. Pymts. (incl. family planning option)		$ 2,147,266			$ 29,590			$ (15,196)	
Healthy Vermonters Program	4,753	$ -	n/a	5,579	$ -	n/a	6,115	$ -	n/a
Subtotal Miscellaneous Program	5,161	$ 79,949,542		6,033	$ 81,858,661		6,582	$ 87,806,235	
TOTAL PROGRAM EXPENDITURES	167,033	$ 790,314,667		175,211	$ 825,172,016		178,192	$ 840,440,442	

	SFY '13 Appropriated			SFY '13 BAA			SFY '14 Gov. Rec.		
Adults	Enrollment	Expenses	PMPM	Enrollment	Expenses	PMPM	Enrollment	Expenses	PMPM
Aged, Blind, or Disabled (ABD)/Medically Needy	14,445	$ 100,440,442	$ 579.46	14,189	$ 97,260,433	$ 571.21	14,360	$ 101,493,654	$ 588.97
Dual Eligibles	17,155	$ 48,138,865	$ 233.84	17,215	$ 46,097,874	$ 223.14	17,800	$ 48,559,492	$ 227.34
General	11,686	$ 71,664,326	$ 511.06	11,614	$ 65,724,721	$ 471.59	11,993	$ 69,309,771	$ 481.61
VHAP	38,799	$ 161,957,523	$ 347.86	37,340	$ 148,021,635	$ 330.34	37,652	$ 86,762,195	$ 342.94
VHAP ESI	810	$ 2,006,576	$ 206.35	807	$ 1,429,801	$ 147.62	785	$ 713,253	$ 150.76
Catamount	11,440	$ 62,002,768	$ 451.65	11,582	$ 59,153,214	$ 425.61	12,372	$ 30,161,023	$ 411.99
ESIA	874	$ 2,270,715	$ 216.52	766	$ 1,000,629	$ 108.80	789	$ 616,805	$ 130.34
New Adult							34,490	$ 86,353,450	$ 418.10
Premium Assistance For Exchange Enrollees < 300%							40,748	$ 6,586,587	$ 26.94
Cost Sharing For Exchange Enrollees < 350%							44,954	$ 3,887,724	$ 14.41
Subtotal Adults	95,209	$ 448,481,216	$ 392.54	93,514	$ 418,688,306	$ 373.11	95,751	$ 434,443,954	$ 378.10
Children									
Blind or Disabled (BD)/Medically Needy	3,614	$ 35,654,068	$ 822.18	3,727	$ 29,244,275	$ 653.96	3,740	$ 28,520,439	$ 635.44
General	55,564	$ 123,109,797	$ 184.64	55,519	$ 120,354,228	$ 180.65	55,762	$ 120,211,081	$ 179.65
Underinsured	943	$ 677,890	$ 59.91	1,029	$ 690,513	$ 55.91	993	$ 633,974	$ 53.21
SCHIP (Uninsured)	4,017	$ 7,598,806	$ 157.64	4,017	$ 6,528,240	$ 135.42	4,180	$ 6,878,275	$ 137.14
Subtotal Children	64,137	$ 167,040,562	$ 217.03	64,292	$ 156,817,256	$ 203.26	64,675	$ 156,243,769	$ 201.32
Pharmacy Only Programs	12,698	$ 4,777,918	$ 31.36	12,565	$ (440,929)	$ (2.92)	12,669	$ 2,629,328	$ 17.29
Choices for Care									
Nursing Home, Home & Community Based, ERC	3,758	$ 174,812,771	$ 3,876.95	3,859	$ 180,677,907	$ 3,902.00	3,850	$ 175,759,611	$ 3,804.05
Acute-Care Services ~ DVHA	3,758	$ 22,137,306	$ 490.96	3,859	$ 21,155,529	$ 456.88	3,850	$ 21,547,054	$ 466.35
Acute-Care Services ~ Other Depts.	3,758	$ 1,704,031	$ 37.79	3,859	$ 1,309,365	$ 28.28	3,850	$ 1,309,457	$ 28.34
Buy-In		$ 2,658,158			$ 2,590,091			$ 2,758,913	
Subtotal Choices for Care*	3,758	$ 201,312,266	$ 4,464.65	3,859	$ 205,732,892	$ 4,443.09	3,850	$ 201,375,035	$ 4,358.45
Subtotal Direct Services	175,802	$ 821,611,963	$ 389.46	174,230	$ 780,797,524	$ 373.45	176,946	$ 794,692,086	$ 374.26
Miscellaneous Program									
GC to CFC Funding Reallocation		$ (1,704,031)			$ (1,309,365)			$ (1,309,457)	
Refugee	77	$ 438,734	$ 473.69	88	$ 393,999	$ 373.13	109	$ 493,016	$ 377.02
ACA Rebates		$ (5,026,587)			$ (4,873,376)			$ (4,963,473)	
HIV	70	$ 39,937	$ 47.64	99	$ 40,003	$ 33.65	80	$ 32,304	$ 33.65
Civil Unions	342	$ 1,319,265	$ 321.71	316	$ 1,604,584	$ 422.56	326	$ 1,826,165	$ 467.12
Underinsured					$ 5,225,595			$ 5,225,595	
DSH		$ 37,448,781			$ 37,448,781			$ 37,448,781	
Clawback		$ 25,755,735			$ 25,968,463			$ 27,446,965	
Buy-In ~ GC		$ 30,964,845			$ 27,666,237			$ 30,376,557	
Buy-In ~ State Only (MCO Invest.)		$ 61,232			$ 32,386			$ 33,763	
Buy-In ~ Federal Only		$ 4,048,016			$ 3,703,861			$ 4,066,709	
Legal Aid		$ 547,983			$ 593,658			$ 547,993	
Misc. Pymts. (incl. family planning option)		$ 32,005,915			$ 29,984,804			$ 46,098,487	
Healthy Vermonters Program	6,753	$ -	n/a	6,086	$ -	n/a	6,472	$ -	n/a
Subtotal Miscellaneous Program	7,242	$ 125,899,825		6,589	$ 126,479,630		6,987	$ 147,323,406	
TOTAL PROGRAM EXPENDITURES	183,044	$ 947,511,788		180,819	$ 907,277,154		183,933	$ 942,015,492	

ADMINISTRATIVE EXPENDITURES

	SFY '07 Actuals	SFY '08 Actuals	SFY '09 Actuals	SFY '10 Actuals	SFY '11 Actuals	SFY '12 Actuals	SFY '13 Appropriated	SFY '13 BAA	SFY '14 Gov. Rec.
	Expenses	Expenses	Expenses	Expenses	Expenses	Expenses	Expenses	Expenses	Expenses
Contract									
Claims Processing	$ 9,928,717	$ 9,938,968	$ 9,433,393	$ 9,678,287	$ 10,684,000	$ 11,134,619	$ 11,059,656	$ 10,374,656	$ 11,589,763
Member Services	$ 2,808,807	$ 2,913,852	$ 3,117,187	$ 2,947,753	$ 2,843,945	$ 3,049,591	$ 2,576,436	$ 3,076,436	$ 3,076,436
Pharmacy Benefits Manager	$ 2,112,158	$ 2,704,233	$ 2,538,847	$ 2,566,106	$ 2,310,247	$ 2,404,369	$ 2,975,343	$ 3,750,343	$ 4,210,343
Care Coordination & Chronic Care Management	$ 1,257,191	$ 3,562,406	$ 4,249,583	$ 6,334,904	$ 2,323,852	$ 2,759,477	$ 2,670,032	$ 2,670,032	$ 2,670,032
Catamount Outreach	$ 664,427	$ 1,697,182	$ 500,000	$ 500,000	$ 500,000	$ 500,000	$ 500,000	$ 500,000	$ 500,000
Miscellaneous	$ 2,970,277	$ 1,892,349	$ 2,179,530	$ 1,406,227	$ 2,202,319	$ 3,318,525	$ 4,384,644	$ 3,959,644	$ 6,452,274
IT Enterprise Solution	$ -	$ 1,184,745	$ 926,779	$ 2,374,283	$ 8,446,108	$ 21,312,323	$ 86,283,445	$ 87,460,111	$ 100,459,357
Blueprint & Payment Reform	$ -	$ -	$ -	$ -	$ 2,264,887	$ 2,870,383	$ 4,009,932	$ 4,009,932	$ 4,509,932
Operating/Personnel Services	$ 5,509,662	$ 7,152,358	$ 7,067,735	$ 4,647,392	$ 11,019,698	$ 12,097,553	$ 17,204,405	$ 17,159,929	$ 18,766,575
Total Administrative Expenses	$ 25,251,238	$ 31,046,091	$ 30,013,053	$ 30,454,952	$ 42,595,056	$ 59,446,840	$ 131,663,893	$ 132,961,083	$ 152,234,712
TOTAL ALL EXPENDITURES	142,252 $ 656,161,931	146,717 $ 699,872,654	155,149 $ 776,763,609	167,033 $ 820,769,619	175,211 $ 867,767,072	178,192 $ 899,887,282	183,044 $ 1,079,175,681	180,819 $ 1,040,238,237	183,933 $ 1,094,250,204

Insert 2

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

Program Expenditures SFY 2013 & SFY 2014 Governor's Recommend w/ Funding Description

PROGRAM EXPENDITURES

	SFY '13 Appropriated		SFY '13 BAA		SFY '14 Gov. Rec.		SFY '14 Funding Description
Adults	Gross Expenses	State Funds	Gross Expenses	State Funds	Gross Expenses	State Funds	
Aged, Blind, or Disabled (ABD)/Medically Needy	$ 100,440,442	$ 43,761,901	$ 97,260,433	$ 42,145,611	$ 101,493,654	$ 43,633,871	
Dual Eligibles	$ 48,138,865	$ 20,974,103	$ 46,097,874	$ 19,977,455	$ 48,559,492	$ 20,884,103	
General	$ 71,664,326	$ 31,224,147	$ 65,724,721	$ 28,406,161	$ 69,309,771	$ 29,616,219	Global Commitment funded (GC) ~ g.f. @44.66% less 2.2% for 1/2 year due to Leahy Bump less PC Physician rate bump at 100% federal
VHAP	$ 161,957,523	$ 69,564,893	$ 148,021,635	$ 64,282,764	$ 86,762,195	$ 37,793,612	
VHAP ESI	$ 2,006,576	$ 874,265	$ 1,429,801	$ 622,618	$ 713,253	$ 309,827	
Catamount	$ 62,002,768	$ 27,014,606	$ 59,153,214	$ 25,773,055	$ 30,161,023	$ 13,138,142	
ESIA	$ 2,270,715	$ 989,351	$ 1,000,629	$ 435,974	$ 616,805	$ 268,680	
New Adult					$ 86,353,450	$ 18,174,625	GC ~ g.f. @44.66% less 2.2% for 1/2 year less PC rate incr. less 22.22% enhancement
Premium Assistance For Exchange Enrollees < 300%					$ 6,596,587	$ 2,941,570	GC ~ g.f. @44.66%
Cost Sharing For Exchange Enrollees < 350%					$ 3,887,724	$ 1,736,256	
Subtotal Adults	$ 448,481,216	$ 194,403,266	$ 418,688,306	$ 181,643,638	$ 434,443,954	$ 168,496,906	
Children							
Blind or Disabled (BD)/Medically Needy	$ 35,654,068	$ 15,534,478	$ 29,244,275	$ 12,702,651	$ 28,520,439	$ 12,325,825	
General	$ 123,109,797	$ 53,209,688	$ 120,354,228	$ 52,059,563	$ 120,211,081	$ 51,417,229	Global Commitment funded (GC) ~ g.f. @44.66% less 2.2% for 1/2 year due to Leahy Bump less PC Physician rate bump at 100% federal
Underinsured	$ 677,890	$ 295,357	$ 690,513	$ 300,856	$ 633,974	$ 276,159	
SCHIP (Uninsured)	$ 7,598,806	$ 2,317,636	$ 6,528,240	$ 1,972,065	$ 6,878,275	$ 2,115,460	Title XXI ~ g.f. @31.26% and federal @68.74%
Subtotal Children	$ 167,040,562	$ 71,357,158	$ 156,817,256	$ 67,035,135	$ 156,243,769	$ 66,134,673	
Pharmacy Only Programs	$ 4,777,918	$ 3,288,401	$ (440,929)	$ (197,792)	$ 2,629,328	$ 1,131,139	Predominantly all GC as detailed above
Choices for Care							
Nursing Home, Home & Community Based, ERC	$ 174,812,771	$ 75,165,924	$ 180,677,907	$ 78,721,364	$ 175,759,611	$ 76,660,887	
Acute-Care Services ~ DVHA	$ 22,137,308	$ 9,645,224	$ 21,155,529	$ 9,188,889	$ 21,547,054	$ 9,314,477	Global Commitment funded (GC) ~ g.f. @44.66% less 2.2% for 1/2 year due to Leahy Bump less PC Physician rate bump at 100% federal
Acute-Care Services ~ Other Depts.	$ 1,704,031	$ 742,446	$ 1,309,365	$ 570,490	$ 1,309,457	$ 570,400	
Buy-In	$ 2,658,158	$ 1,158,159	$ 2,590,091	$ 1,128,503	$ 2,758,913	$ 1,201,782	
Subtotal Choices for Care*	$ 201,312,266	$ 86,711,754	$ 205,732,892	$ 89,609,246	$ 201,375,035	$ 87,647,545	
Subtotal Direct Services	$ 821,611,963	$ 355,760,579	$ 780,797,524	$ 338,090,228	$ 794,692,086	$ 323,410,263.57	
Miscellaneous Program							
GC to CFC Funding Reallocation	$ (1,704,031)	$ (742,446)	$ (1,309,365)	$ (570,490)	$ (1,309,457)	$ (570,400)	GC funded as detailed above
Refugee	$ 438,734	$ -	$ 393,999	$ -	$ 493,016	$ -	100% federally reimbursed
ACA Rebates	$ (5,026,587)	$ -	$ (4,873,376)	$ -	$ (4,963,473)	$ -	100% federally reimbursed
HIV	$ 39,937	$ 17,401	$ 40,003	$ 17,429	$ 32,304	$ 14,072	MCO Investments ~ matched like GC above
Civil Unions	$ 1,319,265	$ 574,804	$ 1,604,584	$ 699,117	$ 1,826,165	$ 795,477	MCO Investments ~ matched like GC above
Underinsured			$ 5,225,595	$ 2,276,792	$ 5,225,595	$ 2,276,269	MCO Investments ~ matched like GC above
DSH	$ 37,448,781	$ 16,316,434	$ 37,448,781	$ 16,316,434	$ 37,448,781	$ 16,724,626	44.88% g.f. 55.11% federal
Clawback	$ 25,755,735	$ 25,755,735	$ 25,968,463	$ 25,968,463	$ 27,446,965	$ 27,446,965	100% general fund
Buy-In ~ GC	$ 30,964,845	$ 13,491,383	$ 27,666,237	$ 12,054,179	$ 30,376,557	$ 13,566,170	GC funded as detailed above
Buy-In ~ State Only (MCO Invest.)	$ 61,232	$ 26,679	$ 32,386	$ 14,111	$ 33,763	$ 14,707	MCO Investments ~ matched like GC above
Buy-In ~ Federal Only	$ 4,048,016	$ -	$ 3,703,861	$ -	$ 4,095,709	$ -	100% federally reimbursed
Legal Aid	$ 547,983	$ 238,756	$ 593,658	$ 258,657	$ 547,993	$ 244,734	GC funded as detailed above
Misc. Pymts.	$ 32,005,915	$ 13,944,977	$ 29,984,804	$ 13,064,379	$ 46,098,487	$ 20,587,585	GC funded ~ g.f. @44.66%
Healthy Vermonters Program	$ -	n/a	$ -	n/a	$ -	n/a	
Subtotal Miscellaneous Program	$ 125,899,825	$ 69,623,722	$ 126,479,630	$ 70,099,070	$ 147,323,406	$ 81,100,205	
TOTAL PROGRAM EXPENDITURES	$ 947,511,788	$ 425,384,301	$ 907,277,154	$ 408,189,298	$ 942,015,492	$ 404,510,468	

ADMINISTRATIVE EXPENDITURES

	SFY '13 Appropriated		SFY '13 BAA		SFY '14 Gov. Rec.		SFY '14 Funding Description
Contract	Gross Expenses	State Funds	Gross Expenses	State Funds	Gross Expenses	State Funds	
Claims Processing	$ 11,059,666	$ 4,818,692	$ 10,374,666	$ 3,655,957	$ 11,589,763	$ 5,089,621	
Member Services	$ 2,576,436	$ 1,122,553	$ 3,076,436	$ 476,123	$ 3,076,436	$ 1,381,215	
Pharmacy Benefits Manager	$ 2,975,343	$ 1,296,357	$ 3,750,343	$ 1,634,024	$ 4,210,343	$ 1,834,025	Most admin. expenses are funded with: Global Commitment funds as stated above and Title XXI funds (31.26% g.f. and 68.74% federal)
Care Coordination & Chronic Care Management	$ 2,670,032	$ 1,163,333	$ 2,670,032	$ 1,163,333	$ 2,670,032	$ 1,163,096	
Catamount Outreach	$ 500,000	$ 217,850	$ 500,000	$ 217,850	$ 500,000	$ 217,800	
Miscellaneous	$ 4,384,644	$ 1,933,129	$ 3,959,644	$ 1,725,217	$ 6,452,274	$ 2,810,611	
IT Enterprise Solution	$ 86,283,445	$ 7,947,070	$ 87,460,111	$ 8,746,011	$ 100,459,357	$ 10,045,936	Blended based on federal programs ~ match GF, SF, IDT
Blueprint & Payment Reform	$ 4,009,932	$ 1,747,127	$ 4,009,932	$ 1,747,127	$ 4,509,932	$ 1,964,526	
Operating/Personnel Services	$ 17,204,405	$ 6,030,925	$ 17,159,929	$ 7,476,581	$ 18,766,575	$ 8,174,720	GC funded as detailed above
Total Administrative Expenses	$ 131,663,893	$ 26,277,037	$ 132,961,083	$ 26,842,224	$ 182,234,712	$ 32,681,520	
TOTAL ALL EXPENDITURES	$ 1,079,175,681	$ 451,661,337	$ 1,040,238,237	$ 435,031,522	$ 1,094,250,204	$ 437,191,988	

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VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

Categories of Service (COS)

COS	Description of Service	BAA SFY '13	2013 BAA-2012 Act. % Change	Gov. Rec. SFY '14	2014 Rec-2013 BAA % Change	5-Yr. Avg. Growth % Chg.	5-Yr. Total Change	10-Yr. Avg. Growth % Chg.	10-Yr. Total Change
01-00	Inpatient	129,106,528	3.3%	134,756,978	4.4%	9.7%	40,187,606	9.8%	75,352,790
02-00	Outpatient	104,614,915	8.2%	107,931,053	3.2%	8.1%	21,707,071	7.8%	43,411,236
03-00	Physician	87,611,260	5.4%	91,228,968	4.1%	3.3%	7,702,588	6.2%	32,605,842
04-00	Pharmacy	140,915,054	-0.4%	146,401,757	3.9%	3.2%	9,085,607	0.9%	(21,130,844)
05-00	Nursing Home	120,001,920	3.4%	118,444,941	-1.3%	-0.1%	3,070,264	1.5%	13,956,988
07-00	Mental Health Facility	476,395	2.9%	491,668	3.2%	32.8%	222,935	5.3%	425,603
08-00	Dental	21,264,019	3.1%	23,694,195	11.4%	4.4%	2,133,832	5.7%	8,955,077
09-01	MH Clinic	127,146	1.7%	130,883	2.9%	176.3%	1,650	108.7%	86,547
10-00	Independent Laboratory	4,657,661	1.6%	4,784,851	2.7%	-3.7%	(1,530,986)	13.9%	2,521,531
11-00	Home Health	6,929,273	5.5%	7,018,094	1.3%	1.4%	716,396	-0.3%	(780,240)
12-00	RHC & FQHC	25,350,453	8.9%	27,794,029	9.6%	11.2%	8,942,379	10.7%	16,847,168
13-00	Hospice	1,180,276	2.3%	1,208,790	2.4%	0.8%	(713,328)	12.2%	658,698
15-00	Chiropractor	817,126	1.5%	840,703	2.9%	-2.5%	19,781	175.5%	785,578
16-00	Nurse Practitioners	914,999	4.9%	965,149	5.5%	14.5%	233,365	5.8%	423,795
17-00	Skilled Nursing	3,457,516	0.7%	3,486,525	0.8%	1.6%	335,270	-2.2%	(1,144,686)
18-00	Podiatrist	431,497	9.9%	477,734	10.7%	14.3%	206,973	11.8%	265,744
19-00	Psychologist	19,584,420	4.6%	20,624,233	5.3%	6.5%	3,533,649	11.0%	8,302,263
20-00	Optometrist	1,285,142	5.8%	1,368,946	6.5%	7.4%	437,597	7.1%	562,915
21-00	Optician	225,265	0.6%	226,814	0.7%	-2.9%	(21,533)	4.5%	24,555
22-00	Transportation	9,211,132	-11.5%	10,728,551	16.5%	-1.2%	84,086	6.3%	1,304,067
23-00	OT/PT/ST Services	2,750,905	-0.3%	2,878,369	4.6%	4.6%	182,700	13.3%	1,408,968
24-00	Prosthestic/Orthro	3,015,910	8.5%	3,279,742	8.7%	12.1%	1,262,802	6.8%	1,635,334
25-00	Medical Supplies & DME (26-00)	8,727,837	2.0%	8,945,151	2.5%	2.4%	57,566	5.3%	1,925,648
27-00	H&CB Services	51,203,283	15.3%	47,897,793	-6.5%	1.0%	1,968,139	6.3%	15,063,129
27-02	H&CB Mental Health Services	694,005	0.5%	698,154	0.6%	5.5%	137,653	-2.7%	(112,489)
27-03	H&CB Mental Retardation	11,100	0.7%	11,580	4.3%	1.0%	11,580	-12.5%	(4,905)
27-17	Enhanced Resident Care	6,563,826	-0.9%	6,563,826	0.0%	2.8%	764,206	11.9%	3,198,751
29-00	Personal Care Services	15,973,865	-31.6%	13,566,485	-15.1%	-5.3%	(7,969,800)	3.9%	(2,844,834)
30-00	Target Case Management	44,700	1.5%	45,593	2.0%	525.3%	42,212	499.6%	42,824
33-04	Assistive Community Care Services	13,400,386	4.4%	13,256,579	-0.8%	2.6%	1,279,763	7.6%	5,044,451
34-01	Day Treatment (MHS)	19,982	1.1%	20,604	3.1%	-18.5%	(65,296)	-6.4%	(45,106)
35-07	AUA/Families in Recovery	168,291	1.9%	173,229	2.9%	(0.9%)	136,480	64.1%	160,939
37-01	Rehabilition/D&P Dept. of Health	564,682	-68.7%	579,965	2.7%	-25.7%	(3,262,356)	47.2%	(2,783,182)
38-03	PC+ Case Management Fees	6,175,943	1.0%	6,289,184	1.8%	3.5%	365,973	2.5%	(67,984
	Blueprint & CHT	5,515,908	0.0%	7,173,210	0.0%	635.4%	7,173,210	635.4%	7,173,210
05 & 36	Pace Capitation	4,507,974	-16.6%	4,507,974	0.0%	7.5%	952,845	7.5%	4,507,974
40-00	Ambulance	4,032,905	7.4%	4,351,976	7.9%	6.7%	935,152	8.6%	1,843,679
41-00	Dialysis	1,466,548	1.9%	1,497,497	2.1%	-9.1%	(194,087)	46.4%	991,855
42-00	ASC	46,282	1.6%	47,569	2.8%	98.8%	(3,541)	52.1%	42,475
43-00	Outpatient Rehab	-	0.0%	-	0.0%	-20.0%	-	-22.7%	(290,361)
39-06	PDP Premium Payments	-	0.0%	-	0.0%	-40.0%	(1,187)	-21.9%	(2,287,779)
39-10	New Premium Payments	61,360,675	13.1%	41,822,004	-31.8%	9.1%	(5,961,925)	32.0%	41,822,004
45-00	Miscellaneous	29,870,547	-22150.3%	45,982,263	53.9%	4644.1%	46,480,488	-2234.4%	44,685,836
	Total	894,277,520	7.5%	912,233,597	2.0%	5.1%	140,638,178	5.8%	305,401,032
Other Expenditures									
	DSH	37,448,781	0.0%	37,448,781	0.0%	1.0%	(0)	4.9%	2,243,458
	Clawback	25,968,463	9.2%	27,446,965	5.7%	9.2%	14,114,581	23.2%	20,568,788
	Insurance Premium Payouts	2,078,057	0.1%	2,087,200	0.9%	259.7%	(2,868)	50.5%	1,863,633
	HIV Insurance Fund F	40,003	6.8%	32,304	-19.2%	-5.9%	(6,600)	-2.9%	(8,632)
	Lund Home Family Ctr Retro PNMI	-	0.0%	-	0.0%	-16.4%	(1,806,291)	3.6%	(430,854)
	Legal Aid	583,658	18.2%	547,993	-7.7%	0.4%	10	5.2%	54,173
	Rate Setting	-	0.0%	-	0.0%	0.0%	-	-7.6%	(644,746)
	CMS Refugee Resettlement Adjustment	-	0.0%	-	0.0%	0.0%	-	0.0%	-
	Interdeptl GF Transfer	-	0.0%	-	0.0%	0.0%	-	-20.0%	(1,403,112)
	Misc	-	0.0%	-	0.0%	0.0%	-	0.0%	-
	Buy In	33,992,575	2.9%	37,235,943	9.5%	7.1%	8,038,862	13.1%	17,697,891
	Total Other	100,121,537	3.4%	104,809,186	4.7%	4.2%	20,337,693	11.2%	39,930,598
Offsets									
	Drug Rebates	(72,093,429)	0.5%	(61,262,408)	-15.0%	12.0%	(7,515,861)	9.8%	(10,637,094)
	ACA Rebates	(4,873,376)	1.8%	(4,963,473)	1.8%	1.1%	(4,963,473)	0.6%	(4,963,473)
	Drug Rebate Interest	-	-100.0%	-	0.0%	-38.2%	-	-38.2%	-
	Supplemental Drug Rebates	(6,825,491)	-31.2%	(6,028,956)	-11.7%	2.2%	1,501,047	186.0%	4,380,863
	TPL	(5,262,257)	29.1%	(4,730,333)	-10.1%	1.5%	1,569,533	4.9%	1,889,696
	Costs Settlements	1,932,651	1.1%	1,957,880	1.3%	-28.6%	103,708	-30.5%	9,659,644
	Total Offsets	(87,121,902)	-1.7%	(75,027,291)	-13.9%	8.6%	(9,275,046)	10.2%	329,636
Net Expenditures		907,277,154	8.0%	942,015,492	3.8%	4.8%	151,700,825	5.9%	345,661,267

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