VERMONT

Agency of Human Services
Department of Vermont Health Access

GreenMountainCare
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Vermont Health Care Innovation Project

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VERMONT Blueprint for Health

Budget Document
State Fiscal year 2017

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DVHA Commissioner's Message

I am pleased to present the Department of Vermont Health Access (DVHA) 2017 Budget Document. Within this year's broadened content are comparisons between Vermont Medicaid spending and other New England states as well as a demonstration of the interconnectivity of the Departments within the Agency of Human Services who jointly deliver Medicaid and Children's Health Insurance Plan (CHIP) services to roughly one-third of the Vermont population. This document focuses on the fiscal pressures, projects, and initiatives aimed at increasing efficiencies and decreasing cost of healthcare delivery such as the expanded eligibility guidelines accounting for a substantial increase in the number of Vermonters served, Vermont's Blueprint and Chronic Care Initiatives, as well as those introduced for 2017.

In State Fiscal Year (SFY) 2015, Vermont Medicaid's expenditures of $1.4 billion accounted for 26% of the total State spend. The average monthly eligible persons under Medicaid rose 18% in SFY 2015 to 212,255, a continuation of the increase in eligible persons driven by Medicaid Expansion. These pressures fuel Vermont's commitment to control Medicaid costs and emphasize the importance on Medicaid delivery reform as captured in the Mission Statement.

The Budget Document highlights a number of new initiatives:

- Implementation of a nationally recognized best practice policy for Vermonters experiencing involuntary inpatient mental health services that prioritizes the health and well-being of the patient.
- Initiation of a special enrollment period for pregnant individuals and their families into any Qualified Health Plan.
- Federal Poverty Limit eligibility alignment, specifically for the expanded pregnant individuals' population.
- Expanded provider assessment to include Primary Care Doctors and Dentists.
- Increased reimbursement rates for both dentists and doctors.
- Data exchange with private insurers for confirmation of enrollees' current coverage status.

In addition to the current and proposed initiatives discussed at length within, I would personally like to note DVHA's excitement at the opportunity to participate in the transition of Vermont's current healthcare model to a quality based All Payer Model. This will shift the focus from individual services rendered (fee for service) to improving patient health.

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FAST FACTS

Category	Description	Data Point
Coverage	Number of covered lives in Vermont's public health insurance coverage programs (SFY2016 BAA)	224,750
	Number of children included in the above (SFY2016 BAA)	71,479
	Percent of Vermont children covered by Green Mountain Care (July 2015)	55%
	Percent of Vermonters enrolled in a public health insurance coverage program (July 2015)	35%
	Average number of covered lives in Vermont Health Connect Qualified Health Plans (SFY 2015)	31,826
Providers	Number of providers enrolled in Green Mountain Care (January 2015)	13,657
	Number of Vermont Medicaid Electronic Health Record Incentive Program eligible providers that have received payment for using Certified EHR systems (CY 2011-2015)	950
	Number of Blueprint Patient Centered Medical Home practices (SFY 2015)	126
Claims	Number of claims processed annually (SFY2015)	5,178,566
	Percent of claims received electronically (SFY2015)	91.80%
	Percent of claims processed within 30 days (SFY2015)	99.17%
	Average number of days from claim receipt to adjudication (SFY2015)	2.04
Customer Support	Average number of VHC calls to Member Services per month (SFY2015)	27,804
	Average number of GMC calls to Member Services per month (SFY2015)	8,629
	Average number of seconds to speak with a live person about VHC (SFY2015)	36.37
	Average number of seconds to speak with a live person about GMC (SFY2015)	48.15
	Average percent of calls answered by a live person within 2 minutes about VHC (SFY2015)	93.39%
	Average percent of calls answered by a live person within 2 minutes about GMC (SFY2015)	92.53%

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CHAPTER ONE: ALL STATE

AGENCIES

The State of Vermont is comprised of myriad agencies and departments. The following is a high-level depiction of such, along with associated mission statements:

Agency of Administration

- **Mission:** To provide responsive and centralized support services to the employees of all agencies and departments of state government so they may deliver services to Vermonters in an efficient, effective and fiscally prudent manner.

Agency of Human Services (AHS)

- **Mission:** To holistically address Vermonters' needs by creating a person-centric system that streamlines management and access to health and human services.

Agency of Agriculture, Food & Market

- **Mission:** To facilitate, support and encourage the growth and viability of agriculture in Vermont while protecting the working landscape, human health, animal health, plant health, consumers and the environment.

Agency of Commerce & Community Development (ACCD)

- **Mission:** The Agency of Commerce and Community Development (ACCD) helps Vermonters improve their quality of life and build strong communities.

Agency of Education

- **Mission:** The State Board of Education and Agency of Education provide leadership, support, and oversight to ensure that the Vermont public education system enables all students to be successful.

Agency of Natural Resources (ANR)

- **Mission:** to protect, sustain, and enhance Vermont's natural resources, for the benefit of this and future generations.

Agency of Transportation (AOT)

- **Mission:** to provide for the safe and efficient movement of people and goods.

Department of Labor

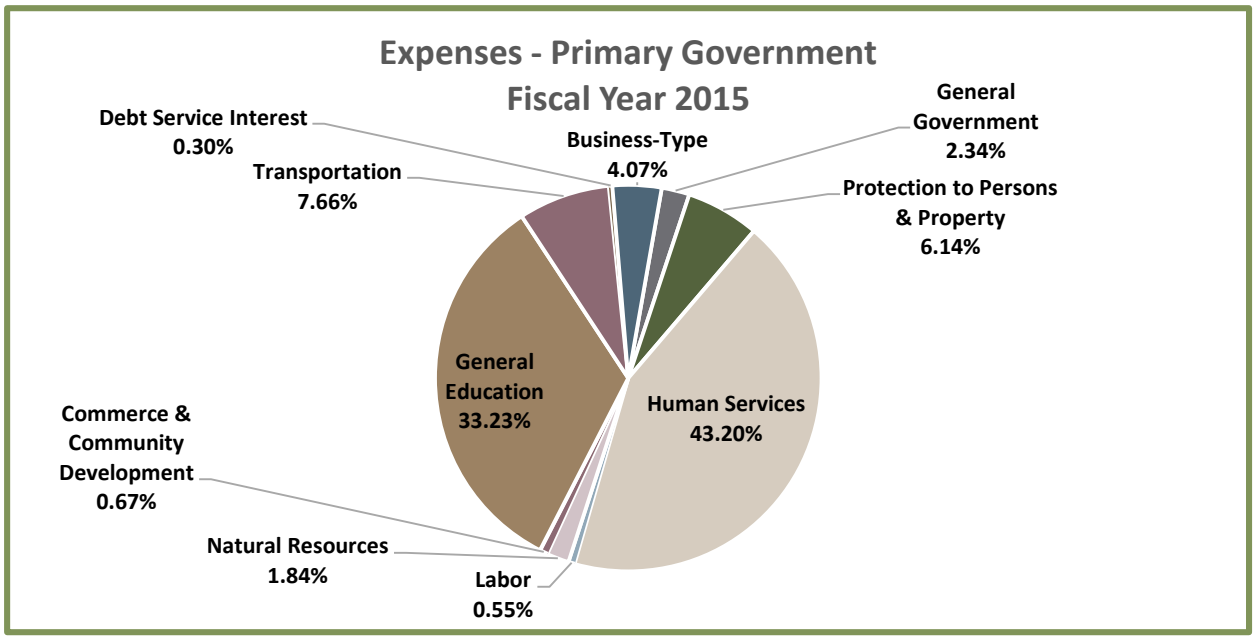
- **Mission:** To promote Vermont's economic strength by assisting employers with job creation, retention and recruitment; coordinating the education and training of our workforce for Vermont's current and future job opportunities; ensuring that Vermont workers have well-paying jobs in safe work environments; administering economic support and reemployment assistance to workers who suffer a job loss or workplace injury; and providing labor market information and analysis to the enable effective planning and decision-making relating to economic, education, labor and employment policies and direction.

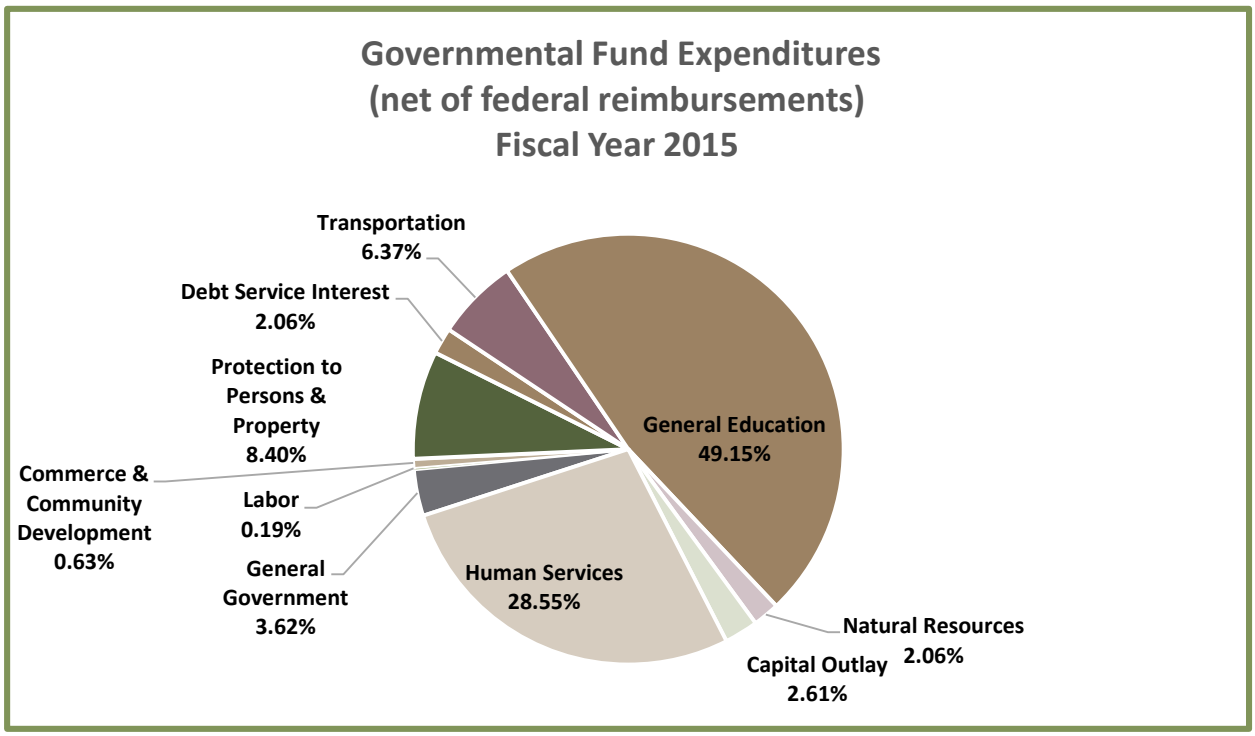
Department of Public Safety

- **Mission:** To promote the detection and prevention of crime, to participate in searches for lost and missing persons, and to assist in cases of statewide or local disasters or emergencies.

AGENCIES' SPEND

One of the Governor's top priorities is to support Vermonters' health through prevention and universal, affordable, and quality healthcare for all, in a manner that supports employers and overall economic growth, and that offers better care. The first chart below depicts the AHS total expenses as a percentage of the total State expenditures. The next chart shows the State fund portion of those expenditures. While AHS is the Agency with the largest expenses, it uses a smaller fraction of state funds than Education.





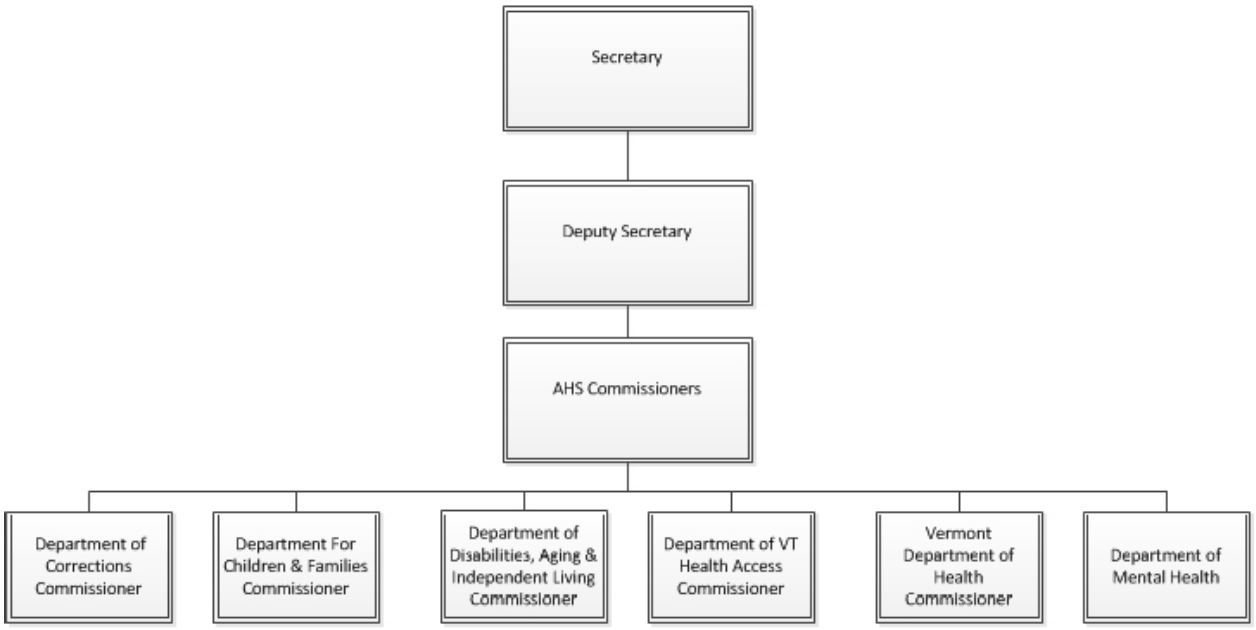
CHAPTER TWO: ALL AHS

MISSION STATEMENT

To holistically address Vermonters' needs by creating a person-centric system that streamlines management and access to health and human services.

ORGANIZATIONAL CHART

Agency of Human Services



DEPARTMENTAL APPROACHES TO MEDICAID

The Agency of Human Services, (AHS), its Departments and the Agency of Education (AoE) oversee and operate numerous programs designed to address the health and wellness needs of Vermont. The AHS' Department of Vermont Health Access manages the State's Medicaid program designed to provide traditional mandatory and optional healthcare services for low-income Vermonters. The remaining AHS Departments and the AoE are responsible for the oversight of specialized healthcare programs within Medicaid. Additional clinical determination may need to be met in order to access other Departments' specialized healthcare programs.

A partial list of Medicaid programs managed by other Departments is below.

Department	Division/Programs
Department of Vermont Health Access (DVHA)	Blueprint for Health Coordination of Benefits (COB) Mental Health and Substance Abuse Program Integrity (PI) Vermont Chronic Care Initiative (VCCI) Quality Reporting Vermont Health Connect (VHC)
Agency of Education (AoE)	School-based Health Services (IEP) Program
Department of Disabilities, Aging and Independent Living (DAIL)	Adult Services Division (ASD) Developmental Disabilities Services (DDS) Program Traumatic Brain Injury Services (TBI) Program
Department for Children and Families (DCF)	Child Development Division (CDD)—Children's Integrated Services (CIS) Program Family Services Division (FSD)—Contracted Treatment Service Programs
Department of Mental health (DMH)	Adult Mental health Division (AMH) Children's Mental Health Division (CMH)
Vermont Department of Health (VDH)	Alcohol and Drug Abuse Program (ADAP) Ladies First Program HIV/AIDS Program

Departmental Approaches to Medicaid Continued

The Departments manage services and programs that are similar, as seen below, but are targeted to unique age groups, disability types, and/or program goals. For example, case management services or service coordination is offered in all programs and almost always involves an assessment, gaining access to and coordination of necessary services across medical, social, educational, or labor domains. The Departments' programs require highly skilled specialized support staff who are capable of providing interventions specifically geared to the target group. Thus, while the services are similar in scope and, in some case, target the same population, these programs have very different coverage policies and reimbursement methodologies.

Service Category	AOE	DVHA	DMH	DDAIL	VDH	DCF
Assessment and Evaluation	x	x	x	x	x	x
Case Management	x	x	x	x		x
Day Services			x	x		
Emergency Services		x	x	x		
Employment			x	x		
Equipment	x		x	x		
Family Supports			x	x		x
Inpatient Hospital		x	x			
Mental Health Skilled Therapy	x	x	x	x		x
Personal Care	x	x		x		
Psychiatric		x	x	x		
Rehabilitation	x	x	x	x	x	x
Residential	x	x	x	x	x	x
Shared Living			x	x		
Transportation		x	x	x		

Secretary's (Central) Office

The Agency of Human Services (AHS) has the widest reach in state government and a critical mission: "To improve the conditions and well-being of Vermonters and protect those who cannot protect themselves." Whether helping a family access healthcare or child care, protecting a young child from abuse, supporting youth and adults through addiction and recovery, providing essential health promotion and disease prevention services, reaching out to elder Vermonters in need of at-home or nursing home assistance, enabling individuals with disabilities to have greater independence, or supporting victims and rehabilitating offenders, AHS serves Vermonters with compassion, dedication and professionalism. For the Medicaid population, AHS manages the development, implementation and monitoring of the Agency's budget to ensure that departmental programs reflect the Governor's priorities and are in compliance with legislative requirements.

Specifically, AHS develops financial status reports and monitors key program performance indicators for each Agency department and:

- Coordinates all federal block grant and statewide single audit functions;
- Develops the AHS indirect rate;
- Updates federal cost allocation plans; and
- Updates the State plan.

The Rate Setting Unit audits and establishes Medicaid payment rates for nursing facilities for the Department of Vermont Health Access (DVHA), intermediate care facilities for people with developmental disabilities for the Department of Disabilities, Aging and Independent Living (DDAIL) and private non-medical institutions for the Department of Children and Family (DCF).

The AHS Healthcare Operations, Compliance, and Improvement Unit manages activities pertaining to Medicaid and associated healthcare operations. It is responsible for integrated planning, policy development, regulatory compliance and funding. These initiatives require cross-departmental (and intra-governmental) operations for successful implementation and outcomes. Activities include but are not limited to: federal negotiations relative to changes in the AHS Medicaid structure; oversight of the DVHA and AHS operations of the Vermont Global Commitment to Health Medicaid Waiver; quality assurance, improvement and performance measurements of program activities; providing technical assistance to departments; overseeing AHS Consumer Information and Privacy Standards; and federal Health Information Portability and Accountability Act (HIPAA) requirements.

The following table depicts the average Medicaid caseload for all of AHS as a percentage of the total estimated State of Vermont population.

	VT Population Estimate[1]	Green Mountain Care Enrollment	Percent of Population Enrolled
SFY2015	626,562	212,255	33.88%
SFY2014	626,855	184,372	29.41%
SFY2013	626,138	180,265	28.79%
SFY2012	626,450	178,192	28.44%
SFY2011	625,792	175,211	28.00%

1. *Annual estimates of the Resident Population: April 1, 2010 to July 1, 2014*, U.S. Census Bureau, Population Division, Release Date: December 2014

DEPARTMENT FOR CHILDREN AND FAMILIES (DCF)

Mission Statement: To foster the healthy development, safety, well-being, and self-sufficiency of Vermonters. We are passionate about prevention and will:

- Reduce poverty and homelessness;
- Improve the safety and well-being of children and families;
- Create permanent connections for children and youth; and
- Provide timely and accurate financial supports for children, individuals, and families.

Vision: Vermont is a place where people prosper; children and families are safe and have strong, loving connections; and individuals have the opportunity to fully develop their potential.

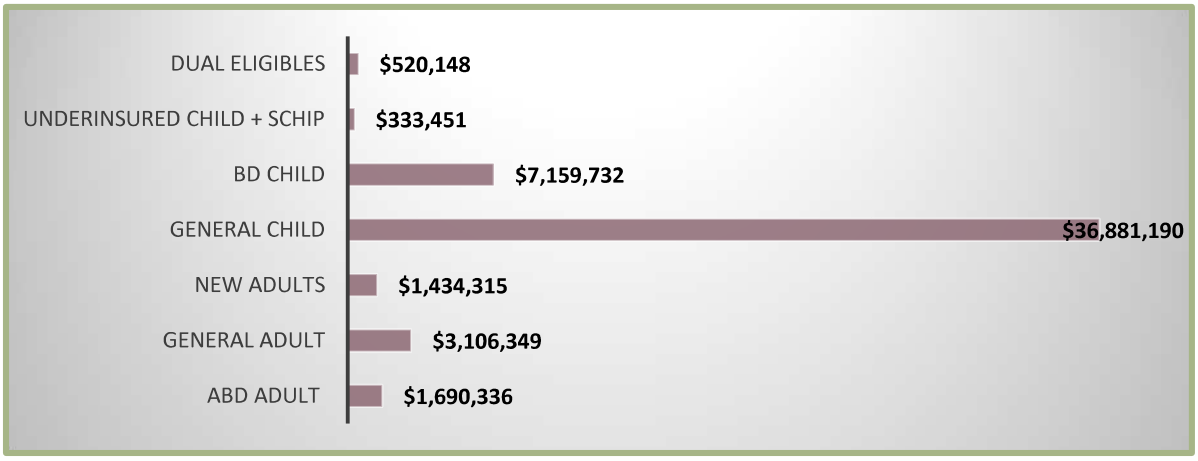
The Department for Children and Families, (DCF) has six programmatic divisions that administer the department's major programs.

1. Child Development Division
2. Economic Services Division
3. Family Support Division
4. Office of Child Support
5. Office of Disability Determinations
6. Office of Economic Opportunity

Healthcare Eligibility Determination Services: Economic Services Division determines and maintains eligibility for Vermonters who are eligible for healthcare coverage. The division processes applications from applicants seeking coverage. The complexity of eligibility determinations results from the combination of Vermont's broad range of healthcare programs and the use of an antiquated computer system. DCF has proposed to move this unit to the Department of Vermont Health Access in SFY17.

SFY 2015 DCF Medicaid & CHIP Spend

$51,125,521



Department of Corrections (DOC)

Mission Statement: In partnership with the community, we support safe communities by providing leadership in crime prevention, repairing the harm done, addressing the needs of crime victims, ensuring offender accountability for criminal acts and managing the risk posed by offenders. This is accomplished through a commitment to quality services and continuous improvement while respecting diversity, legal rights, human dignity and productivity.

Vision: To be valued by the citizens of Vermont as a partner in prevention, research, control and treatment of criminal behavior.

Generally Medicaid is unavailable for incarcerated individuals; however individuals admitted to a hospital, nursing facility, juvenile psychiatric facility, or intermediate care facility may be covered through DVHA, as long as they remain otherwise Medicaid eligible.

Department of Disabilities, Aging and Independent Living (DDAIL)

Mission Statement: The mission of the Department of Disabilities, Aging, and Independent Living is to make Vermont the best state in which to grow old or to live with a disability with dignity, respect, and independence.

DDAIL provides a variety of services to Vermonters who are over the age of 60 or who have a disability. Services are delivered by regional area Agencies on Aging, traumatic brain injury providers, home health agencies, residential care facilities, adult day programs, personal emergency response and self-directed care providers. Within the Department, there are four divisions, each responsible for different areas of service:

- Division for the Blind and Visually Impaired,
- Division of Licensing and Protection,
- Division of Disability and Aging Services,
- Division of Vocational Rehabilitation.

SFY 2015 DDAIL Medicaid & CHIP Spend

$176,160,018

DEPARTMENT OF MENTAL HEALTH (DMH)

Mission Statement: It is the mission of the Vermont Department of Mental Health to promote and improve the mental health of Vermonters.

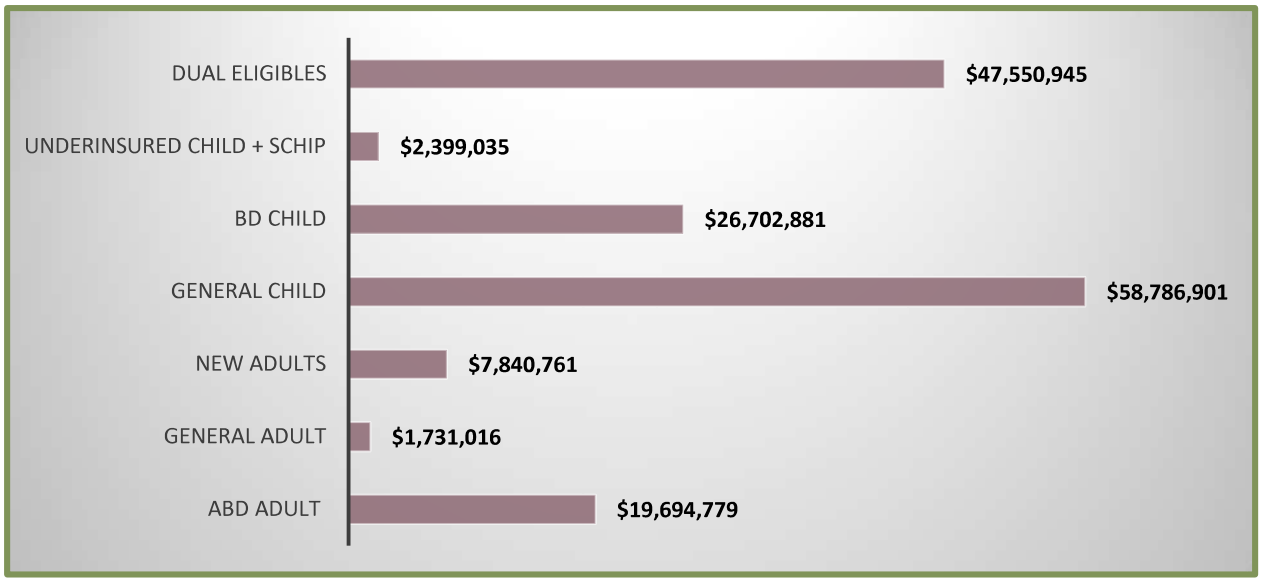
Vision: Mental health will be a cornerstone of health in Vermont. People will live in caring communities with compassion for, and a determination to respond effectively and respectfully to the mental health needs of all citizens. Vermonters will have access to effective prevention, early intervention and mental health treatment and supports as needed to live, work, learn and participate fully in their communities.

The Department of Mental Health (DMH) consists of two programmatic divisions: Adult and Child, Adolescent, and Family Mental Health Units.

Direct services are provided by private, non-profit service providers called Designated Agencies (DAs), and Specialized Service Agencies (SSAs) located throughout the state. The Department of Mental Health designates one Designated Agency (DA) in each geographic region of the state as responsible for ensuring needed services are available through local planning, service coordination, and monitoring outcomes within their region.

SFY 2015 DMH Medicaid & CHIP Spend

$164,706,391



DEPARTMENT OF HEALTH (VDH)

Mission Statement: To protect and promote optimal health for all Vermonters.

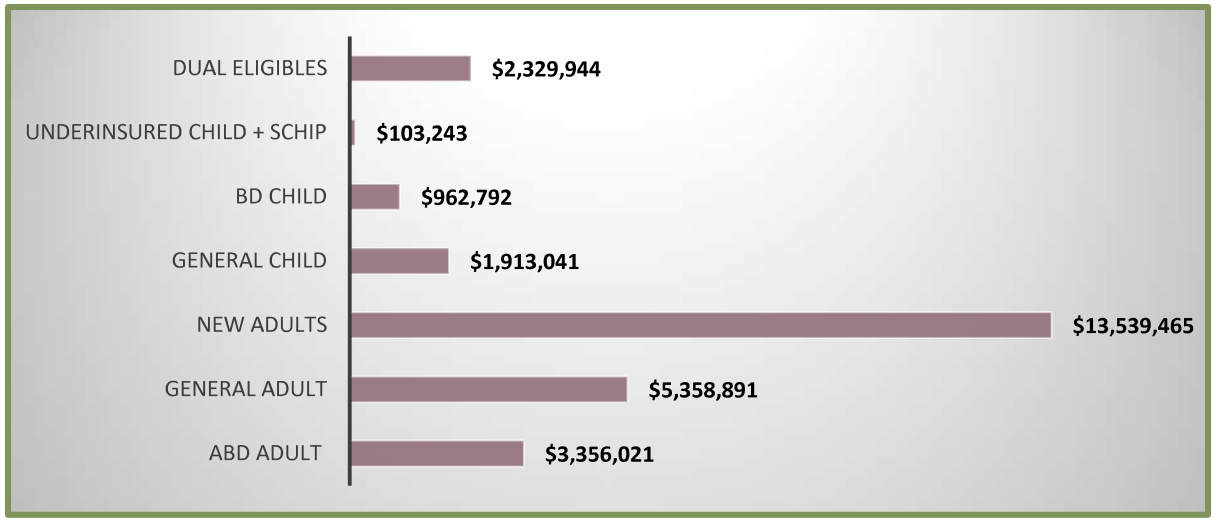
Vision: Healthy Vermonters living in healthy communities.

VDH is divided into individual divisions, each with the goal of promoting safety and health throughout the state. Those divisions are as follows: the Environmental Health Division, Health Promotion and Disease Prevention Division, Health Surveillance Division, The Office of Local Health, Maternal and Child Health Division, Office of Public Health Preparedness and Emergency Medical Services, The Board of Medical Practice, and the Alcohol and Drug Abuse Programs Division (ADAP).

ADAP helps Vermonters prevent, reduce, and/or eliminate alcohol and other drug related problems. ADAP manages and evaluates a comprehensive system of substance abuse treatment, prevention, and recovery services throughout Vermont. The substance abuse Care Alliance (termed "Hub and Spoke") is a joint effort administered by both VDH and the DVHA's Blueprint for Health program. The Ladies First program is administered by VDH and provides women with breast, cervical, and heart health screenings. VDH also provides several specific programs for persons living with AIDS. These care programs are federally funded through the HRSA Ryan White Act and the CDC HIV Surveillance System.

SFY 2015 VDH Medicaid & CHIP Spend

$27,563,398



AGENCY OF EDUCATION (AOE)

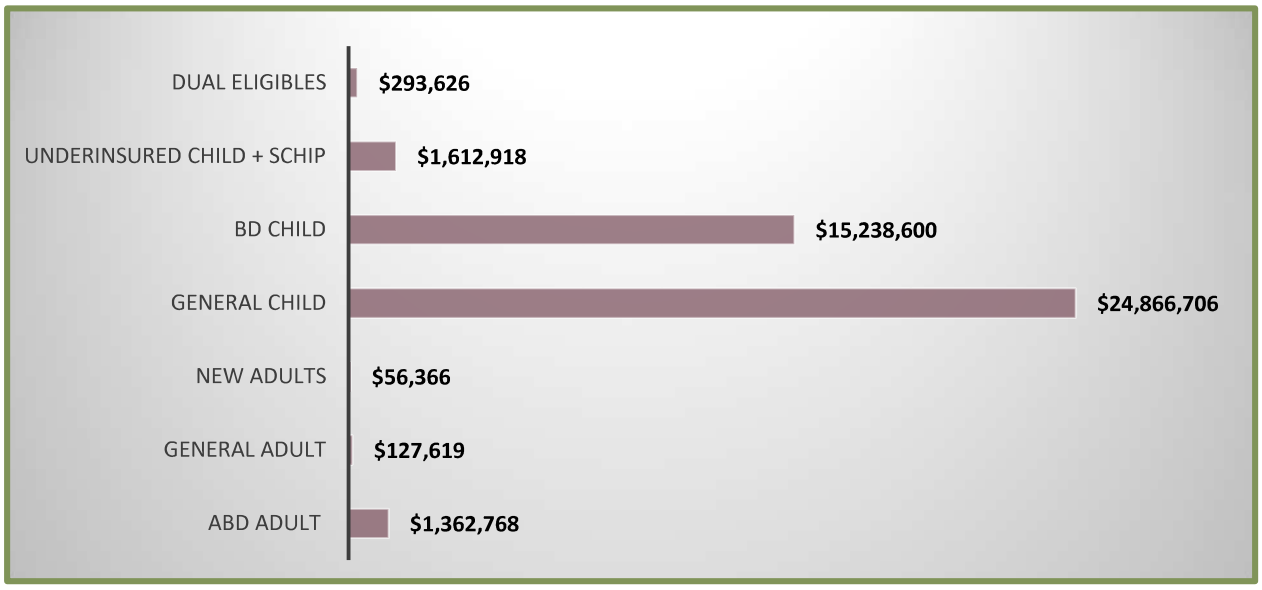
Mission Statement: The State Board of Education and Agency of Education provide leadership, support, and oversight to ensure that the Vermont public education system enables all students to be successful.

Vision: Every learner completes his or her public education with the knowledge and skills necessary for success in college, continuing education, careers, and citizenship. The public education system provides flexible learning environments rich with 21st century tools that promote self-development, academic achievement, and active engagement in learning. It operates within a framework of high expectations for every learner with support from educators, families and the community.

The Agency of Education works with the Department of Vermont Health Access on the School-based Health Services Program which allows schools to generate Medicaid reimbursement for the health-related services provided to special education students who are enrolled in Medicaid and receive eligible services in accordance with their individualized education plans (IEPs).

SFY 2015 AoE Medicaid & CHIP Spend

$43,558,603



Please note: the dollars depicted above are the federal fund only. General fund is in the Agency of Education's direct appropriation.

DEPARTMENT OF VERMONT HEALTH ACCESS (DVHA)

The Department of Vermont Health Access (DVHA) is responsible for the oversight, implementation, and management of Vermont's publicly funded health coverage programs. These programs include Medicaid and the Children's Health Insurance Program, collectively branded Green Mountain Care (GMC); as well as the State's health insurance marketplace, Vermont Health Connect (VHC). DVHA also oversees many of Vermont's expansive Healthcare Reform initiatives, designed to increase access, improve quality, and contain the cost of healthcare for all Vermonters, including the federally funded Vermont Healthcare Innovation Project (VHCIP), Vermont's Blueprint for Health, and health information technology strategic planning, coordination and oversight. DVHA acts as a Managed Care Organization under the Global Commitment to Healthcare waiver.

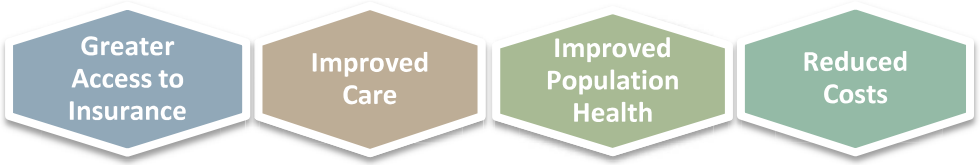
DVHA's Commissioner is a member of the Governor's healthcare leadership team. He is responsible for all of DVHA's operations as well as leading state and federal healthcare reform implementations. DVHA has a total of 316 budgeted classified staff positions. This includes 208 direct DVHA staff and a proposed 108 Health Access Eligibility Unit staff who currently report to DCF.

The Commissioner's Senior Management Team consists of division directors overseeing operations and projects as well as key support services. Their core divisions are: Medicaid Health Services and Managed Care; Medicaid Policy, Fiscal and Support Services; Payment Reform and Reimbursement; Vermont Health Connect; and the Blueprint for Health. Additional members of the Senior Leadership Team are the Chief Medical Officer General Counsel, Financial Director, Principal Assistant, and Health Reform Deputy Commissioner.

DVHA's work serves the State of Vermont's high level health reform goals:

- Reduce healthcare costs and cost growth.
- Assure that all Vermonters have access to and coverage for high quality healthcare.
- Improve the health of Vermont's population.
- Assure greater fairness and equity in how we pay for healthcare.

The Department's diverse and complementary health reform activities have the following objectives:



In support of the objectives outlined above, DVHA's successful Blueprint for Health and the Vermont Chronic Care Initiative (VCCI) have been working hand-in-hand with the federally-funded State Innovation Model (SIM) project, labeled the Vermont Healthcare Innovation Project (VHCIP). The Blueprint for Health team oversees the statewide multi-insurer program designed to coordinate a system of healthcare for patients, improve the health of the overall population, and improve control over healthcare costs by promoting health maintenance, prevention, care coordination, and management at the provider level. In support of these delivery system reforms, the team leads the coordination of health reform activities across multiple state stakeholders and has primary responsibility for statewide health information technology (HIT) strategic planning and implementation. The Blueprint team provides HIT coordination and oversight including contract and grant management with external HIT partners such as the Vermont Information Technology Leaders (VITL).

The specific goals for the Vermont Healthcare Innovation Project (VHCIP) are: to increase the level of accountability for cost and quality outcomes among provider organizations; to create a health information network that supports the best possible care management and assessment of cost and quality outcomes and informs opportunities to improve care; to establish payment methodologies across all payers that encourage the best cost and quality outcomes; to ensure accountability for outcomes from both the public and private sectors; and to create commitment to change and synergy between public and private cultures, policies and behaviors. To address the project aims and goals described above, the VHCIP has three main focus areas: payment models—implementing provider payments that move away from straight fee-for-service and incorporate value measurement, care models—creating a more integrated system of care management and care coordination for Vermonters, and health information technology/health information exchange (HIT/HIE)—building an interoperable system that allows for sharing of health information to support optimal care delivery and population health management.

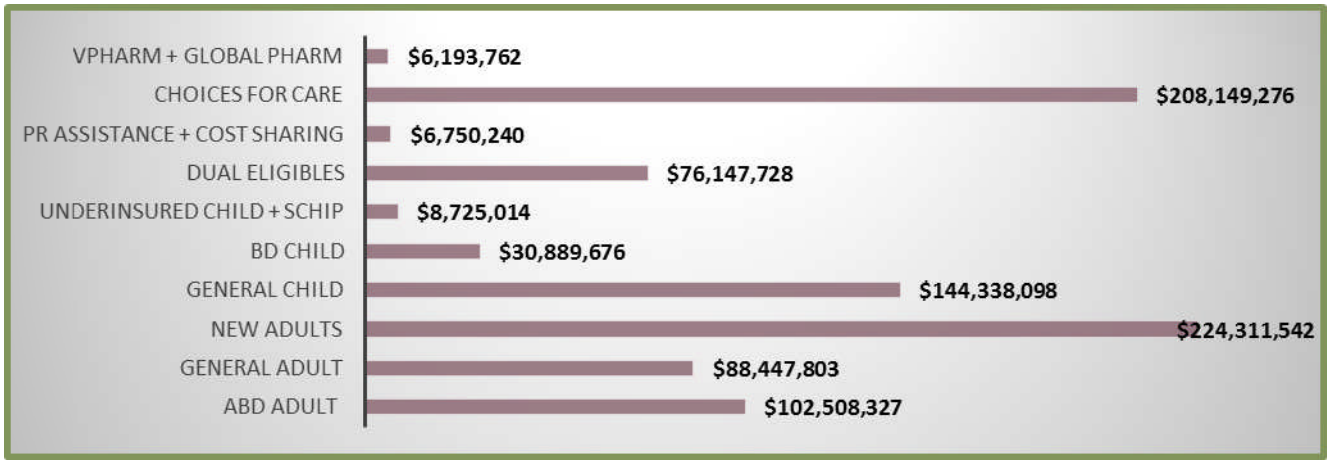
The Vermont Chronic Care Initiative continues to partner with the pilot Medicaid Accountable Care Organization (ACO) delivery model to assure integrated, non-duplicative service delivery for VCCI-eligible, high risk members. VCCI is a healthcare reform strategy which supports Medicaid members with chronic health conditions and/or high utilization of medical services in accessing clinically appropriate healthcare information and services; coordinates the efficient delivery of healthcare to these members by addressing barriers to care, gaps in evidence-based treatment, and reducing duplication of services; and educates and empowers members to eventually self-manage their conditions. VCCI case managers/care coordinators are field based and embedded in AHS district offices and high volume hospital and provider practice sites to support communication, referrals, and transitions in care. They partner with providers and ACO clinical teams, are members of the Blueprint for Health community health teams (CHT), and work with partners across AHS to facilitate a holistic approach for addressing the

socioeconomic barriers to health for at risk members. The VCCI also operates at a population level by identifying panels of patients with gaps in evidence-based care and associated utilization to share with treating providers and ACO partners. Eligible members are identified via predictive modeling and risk stratification, supplemented by referrals from providers and local care teams. VCCI receives census reports from several hospitals and has staff who act as liaisons with partner hospitals to support early case identification and transitions of care.

Vermont and DHVA have long been leaders in healthcare coverage expansion and maintenance. Two of DVHA's most successful coverage expansion programs – the Vermont Health Access Plan (VHAP) and Catamount – came to an end in 2014, and eligible individuals were moved into the expanded Medicaid program or onto a new qualified health plans (QHPs) in Vermont Health Connect. DVHA serves approximately 212,255 Vermonters clinically and/or financially, and an additional 14,711 Vermonters (individuals and families) are enrolled in Vermont Health Connect qualified health plans with no financial subsidy. DVHA's divisions work closely and collaboratively with the Economic Services Division of the Department for Children and Families.

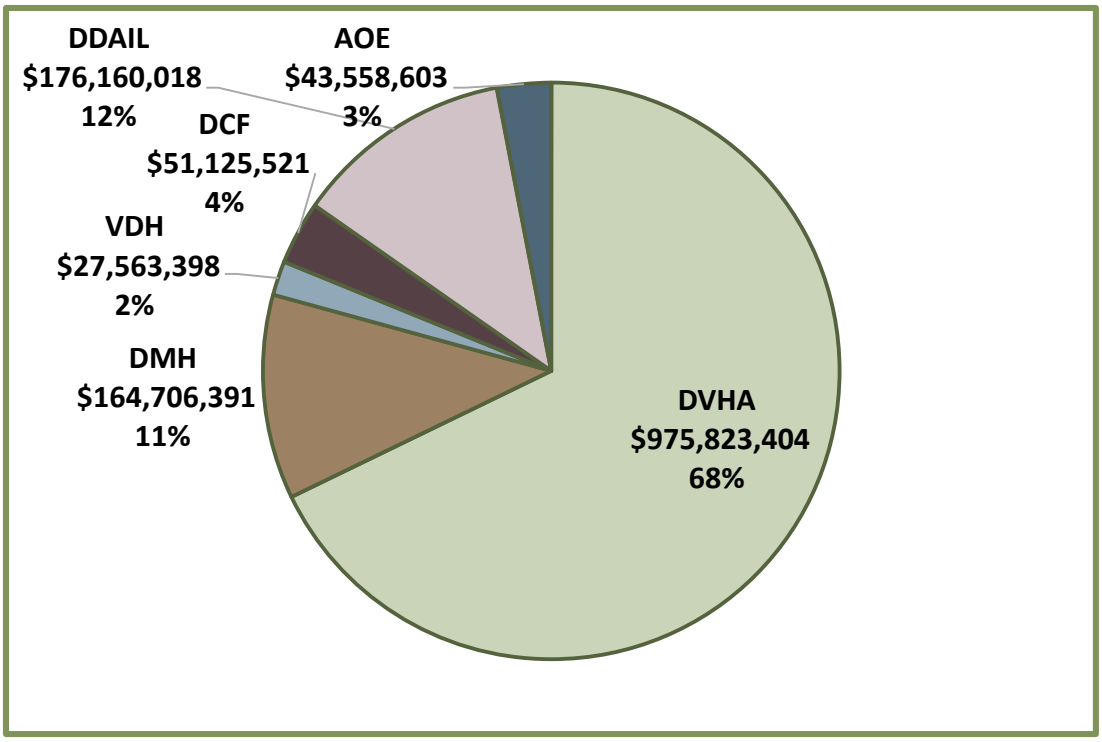
SFY 2015 DVHA Program Spend

$975,823,404

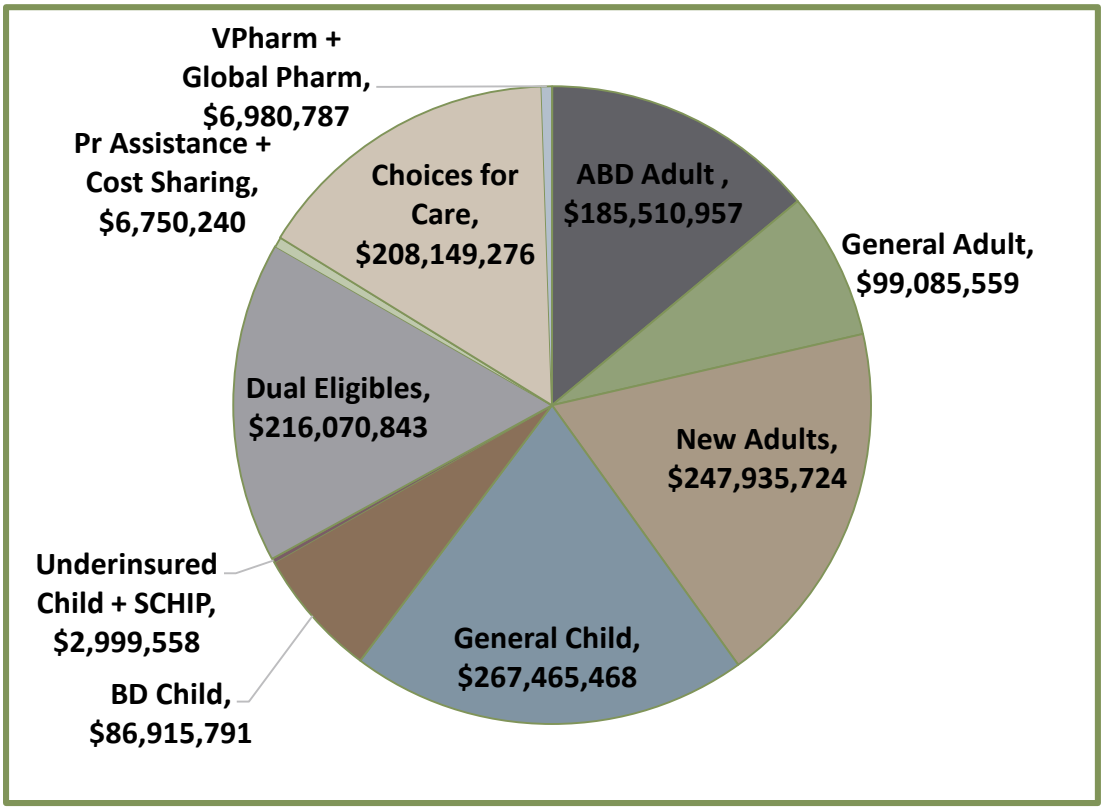


CROSS-DEPARTMENTAL MEDICAID COMPARISON

Departmental Medicaid Spend $ 1,438,937,334



All AHS Spend by Medicaid Eligibility Group



CROSS-DEPARTMENTAL MEDICAID COMPARISON CONTINUED

SFY 2015 Medicaid Spend - Global Commitment, CHIP, & CFC - BY CATEGORY OF SERVICE

Category of Service	DVHA	DMH	VDH	DCF	DAIL	AOE	Total AHS
Inpatient	$ 138,984,965	$ 1,947,087	$ -	$ -	$ -	$ -	$ 140,932,052
Outpatient	$ 128,812,484	$ -	$ -	$ -	$ -	$ -	$ 128,812,484
Physician	$ 98,448,617	$ -	$ -	$ -	$ -	$ 241,342	$ 98,689,959
Pharmacy	$ 185,563,094	$ -	$ -	$ -	$ -	$ -	$ 185,563,094
Nursing Home	$ 122,245,567	$ -	$ -	$ -	$ (7,291)	$ -	$ 122,238,276
ICF/MR Private	$ -	$ -	$ -	$ -	$ 1,347,733	$ -	$ 1,347,733
Mental Health Facility	$ 890,779	$ (460,125)	$ -	$ -	$ -	$ -	$ 430,654
Dental	$ 27,087,323	$ -	$ -	$ -	$ -	$ -	$ 27,087,323
MH Clinic	$ 140,474	$ 99,909,520	$ -	$ -	$ 553,332	$ -	$ 100,603,327
Independent Lab/Xray	$ 14,408,861	$ -	$ -	$ -	$ -	$ -	$ 14,408,861
Home Health	$ 6,724,784	$ -	$ -	$ -	$ -	$ -	$ 6,724,784
Hospice	$ 3,880,096	$ -	$ -	$ -	$ -	$ -	$ 3,880,096
FQHC & RHC	$ 31,443,105	$ -	$ -	$ -	$ -	$ -	$ 31,443,105
Chiropractor	$ 1,226,933	$ -	$ -	$ -	$ -	$ -	$ 1,226,933
Nurse Practitioner	$ 960,950	$ -	$ -	$ -	$ -	$ -	$ 960,950
Skilled Nursing	$ 2,814,854	$ -	$ -	$ -	$ -	$ -	$ 2,814,854
Podiatrist	$ 319,363	$ -	$ -	$ -	$ -	$ -	$ 319,363
Psychologist	$ 24,591,328	$ -	$ -	$ -	$ -	$ -	$ 24,591,328
Optometrist/Optician	$ 2,254,446	$ -	$ -	$ -	$ -	$ -	$ 2,254,446
Transportation	$ 12,491,480	$ -	$ -	$ -	$ -	$ -	$ 12,491,480
Therapy Services	$ 4,964,124	$ -	$ -	$ -	$ -	$ -	$ 4,964,124
Prosthetic/Ortho	$ 3,137,112	$ -	$ -	$ -	$ -	$ -	$ 3,137,112
Medical Supplies & DME	$ 10,328,593	$ -	$ -	$ -	$ -	$ -	$ 10,328,593
H&CB Services	$ 55,893,564	$ -	$ -	$ -	$ -	$ -	$ 55,893,564
H&CB Services Mental Service	$ 669,119	$ 1,465,296	$ -	$ -	$ -	$ -	$ 2,134,415
H&CB Services Development Services	$ 849	$ -	$ -	$ -	$ 164,871,253	$ -	$ 164,872,102
TBI Services	$ -	$ 329,962	$ -	$ -	$ 4,744,613	$ -	$ 5,074,575
Enhanced Resident Care	$ 8,135,081	$ -	$ -	$ -	$ -	$ -	$ 8,135,081
Personal Care Services	$ 16,727,437	$ -	$ -	$ -	$ 1,477,213	$ -	$ 18,204,650
Targeted Case Management (Drug)	$ 67,433	$ 4,662,669	$ -	$ -	$ 1,782,614	$ -	$ 6,512,716
Assistive Community Care	$ 14,140,393	$ 4,471,242	$ -	$ 12,166,037	$ -	$ -	$ 30,777,672
Day Treatment MHS	$ -	$ 51,865,566	$ -	$ -	$ 2,213,144	$ -	$ 54,078,710
OADAP Families in Recovery	$ 2,685,214	$ -	$ 25,546,957	$ -	$ -	$ -	$ 28,232,170
Rehabilitation	$ 598,985	$ -	$ -	$ -	$ -	$ -	$ 598,985
D & P Dept of Health	$ 224,794	$ 587,520	$ 2,030,686	$ 36,190,488	$ -	$ 43,398,926	$ 82,432,413
PcPlus Case Mgmt and Special Program Payments	$ 3,537,462	$ -	$ -	$ -	$ -	$ -	$ 3,537,462
Blue Print & CHT Payments	$ 8,683,861	$ -	$ -	$ -	$ -	$ -	$ 8,683,861
PDP Premiums	$ 1,138,775	$ -	$ -	$ -	$ -	$ -	$ 1,138,775
VPA Premiums	$ 5,757,910	$ -	$ -	$ -	$ -	$ -	$ 5,757,910
Ambulance	$ 4,329,354	$ -	$ -	$ -	$ -	$ -	$ 4,329,354
Dialysis	$ 1,567,530	$ -	$ -	$ -	$ -	$ -	$ 1,567,530
ASC	$ 66,585	$ -	$ -	$ -	$ -	$ -	$ 66,585
Total Other Expenditures	$ 122,162,149	$ (66,557)	$ (8,728)	$ 2,768,996	$ (792,064)	$ (81,664)	$ 123,982,133
Total Offsets	$ (92,282,426)	$ (5,789)	$ (5,516)	$ -	$ (30,529)	$ -	$ (92,324,261)
Total All Program Expenditures	$ 975,823,404	$ 164,706,391	$ 27,563,398	$ 51,125,521	$ 176,160,018	$ 43,558,603	$ 1,438,937,334

Mental Health and Substance Abuse

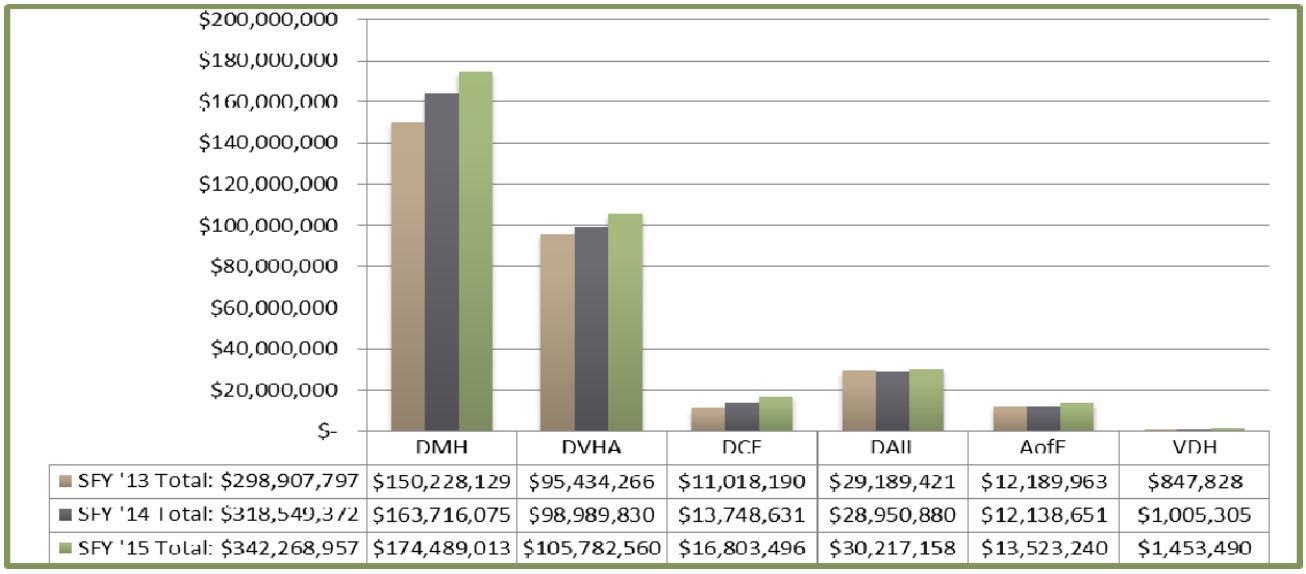
Vermont Medicaid is the chief source of coverage for low-income Vermonters with mental health and substance abuse treatment needs. Given the prevalence of these concerns within our population, the high level of Medicaid spending, and the impact to the overall physical health of the population, DVHA is highly focused on steps toward the integration of mental health delivery and the coordination of care within the Departments. Medicaid mental health services across AHS programs amounted to over $342 million in SFY 2015. Focus is on both setting expectations for better outcomes and reducing costs for those with comorbid conditions. An important step in this process is in the identification of all of a patient's healthcare needs regardless of which program within the Agency the member entered the system; a person-centric care coordination approach is critical.

The Departments of Mental Health and Vermont Health Access have developed a plan for unified service and financial allocation for publicly funded mental health services as part of an integrated healthcare system. Details on this plan can be found in Appendix C of this document.

Today, mental health services are managed throughout the Agency, each focusing on the individual goals of their respective programs.

DVHA	DMH	Other Departments
Independent Practices, Clinics and Hospital Inpatient	DA/SSA	Disability Specific Mental Health Services
Medication Management	Hospital Inpatient	Agency of Education IEP related Mental Health Claims
Vermont Chronic Care Initiative	Children's Services	

Mental Health Expenditures by Department

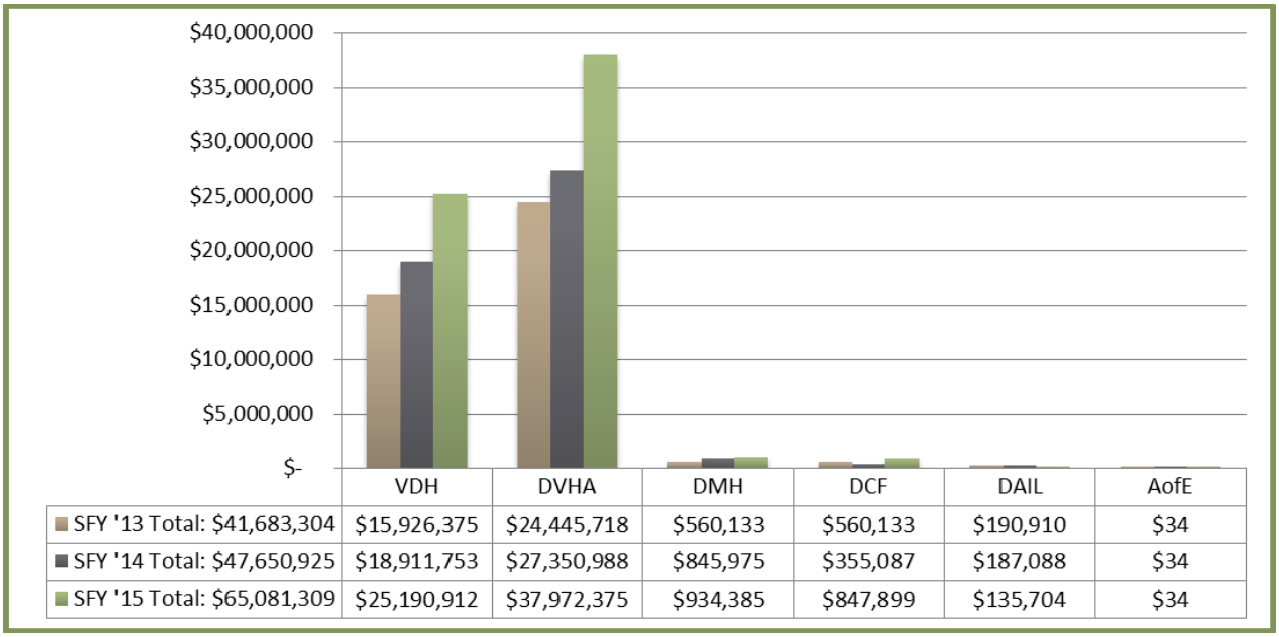


	DMH	DVHA	DCF	DAIL	AofF	VDH
SFY '13 Total: $298,907,797	$150,228,129	$95,434,266	$11,018,190	$29,189,421	$12,189,963	$847,828
SFY '14 Total: $318,549,372	$163,716,075	$98,989,830	$13,748,631	$28,950,880	$12,138,651	$1,005,305
SFY '15 Total: $342,268,957	$174,489,013	$105,782,560	$16,803,496	$30,217,158	$13,523,240	$1,453,490

Integration of Substance Abuse Prevention & Treatment Delivery

DVHA	VDH	OTHER DEPTS.
Care Coordination through Community Health Teams/Blueprint & VCCI	Community, School-based Services, High Risk populations targeting prevention	DCF – Reach Up
Medication Assisted Treatment (MAT) within HUB & Spoke and Outpatient Physician Services	Methadone Treatment in HUB setting	AHS – Integrated Family Services
Utilization Review – Residential Services	Recovery Services, Peer Support	DOC – Screening & Therapeutic Communities
Laboratory & Transportation Services	Preferred Provider Outpatient, Intensive Outpatient Services	DMH – Elder Care Clinicians
Outpatient Therapy & Hosp. Detoxification	Halfway/Transitional Housing	DDAIL - Screening

Substance Abuse Expenditures by Department



	VDH	DVHA	DMH	DCF	DAIL	AofE
SFY '13 Total: $41,683,304	$15,926,375	$24,445,718	$560,133	$560,133	$190,910	$34
SFY '14 Total: $47,650,925	$18,911,753	$27,350,988	$845,975	$355,087	$187,088	$34
SFY '15 Total: $65,081,309	$25,190,912	$37,972,375	$934,385	$847,899	$135,704	$34

Substance Abuse Provider Network

ADAP manages a Preferred Provider Network in which Medicaid members can obtain preventative, intervention, treatment, and recovery services.

DVHA in accordance with the Medicaid State Plan manages the Medicaid Provider Network. Providers within this network can provide crisis, preventative, intervention, treatment, & recovery services to eligible members in accordance with the Provider's licensure.

MCO Investments

Vermont uses Managed Care invested funds as authorized in the Global Commitment to Health waiver to pay for a number of optional programs and services that vary widely between the departments. Each department is summarized below to show their total MCO Investment spend by year. To see the individual programs, populations served, and the related expenditures, please see Appendix A.

MCO Investment Expenditures Summary

Dept.	SFY09 Actuals	SFY10 Actuals	SFY11 Actuals	SFY12 Actuals	SFY13 Actuals	SFY14 Actuals	SFY15 Prelim.
AHSCO	$ 415,000	$ 415,000	$ 2,925,099	$ 5,816,947	$ 6,647,517	$ 7,683,876	$ 7,393,872
AOA	$ 68,879	$ 179,284	$ -	$ -	$ -	$ -	$ 639,239
DCF	$ 16,130,085	$ 13,411,513	$ 13,384,076	$ 16,238,819	$ 16,962,997	$ 17,885,475	$ 16,876,280
DDAIL	$ 2,263,260	$ 1,919,895	$ 2,209,416	$ 3,748,423	$ 5,221,080	$ 6,832,417	$ 4,028,224
DFR	$ 1,871,651	$ 1,713,959	$ 1,898,342	$ 1,897,997	$ 659,544	$ 165,946	$ -
DII	$ 339,500	$ -	$ -	$ -	$ -	$ -	$ -
DMH	$ 9,493,811	$ 7,052,728	$ 8,614,224	$ 25,054,581	$ 40,521,446	$ 39,043,497	$ 42,080,184
DOC	$ 3,094,144	$ 3,064,215	$ 3,096,450	$ 3,613,324	$ 5,726,775	$ 5,308,263	$ 5,117,606
DOE	$ 8,956,247	$ 8,956,247	$ 4,478,124	$ 11,027,579	$ 9,741,252	$ 10,454,116	$ 10,029,809
DVHA	$ 1,132,993	$ 1,418,044	$ 4,387,408	$ 4,616,757	$ 14,922,410	$ 15,879,646	$ 15,999,879
GMCB	$ -	$ -	$ -	$ 789,437	$ 1,450,717	$ 2,360,462	$ 2,517,516
UVM	$ 4,006,156	$ 4,006,152	$ 4,006,156	$ 4,006,156	$ 4,006,156	$ 4,006,156	$ 4,046,217
VAAFM	$ -	$ -	$ -	$ 90,278	$ 90,278	$ 90,278	$ 90,278
VDH	$ 13,361,812	$ 12,174,645	$ 9,460,219	$ 11,119,809	$ 15,903,347	$ 16,576,934	$ 19,285,337
VSC	$ 405,407	$ 405,407	$ 405,407	$ 405,407	$ 405,407	$ 405,407	$ 409,461
VVH	$ 81,043	$ 837,225	$ 1,410,956	$ 1,410,956	$ 1,410,956	$ 410,986	$ 410,986
Total	$ 2,419,988	$ 55,554,314	$ 56,275,877	$ 89,836,470	$ 123,669,882	$ 127,103,459	$128,924,888

VERMONT MEDICAID TRENDS - A NATIONAL & REGIONAL COMPARISON

Through review of analyses completed by federal agencies, academia, and organizations such as Kaiser Family Foundation and a comprehensive look at the trends in Vermont spending, DVHA finds that State Medicaid spending trends can be influenced by a number of causes such as: State and/or Federal policy changes, demographic shifts such as an aging population, and other economic drivers within the overall healthcare system. This section provides insight to drivers as well as a comparison between Vermont Medicaid and the nation with a focus on our region.

The United States has been experiencing decades of rising healthcare costs. These increases are partly a result of recognized inefficiencies in the overall healthcare system, and partly the result of the development of treatments which can vastly improve health outcomes but may be costly. In recent years, the national rate of growth has decreased. Examination of the per member per month (PMPM) trends seen in Medicaid (see the Caseload, Utilization, & Expenditures section of this report for further information) illustrates that this trend has generally held true in Vermont as well. A number of different explanations for this have been theorized including the recession and subsequent sluggish recovery; drops in some prescription drug costs brought about by the expiration of patents on several costly medications which are now available in low-cost generic versions; and the Affordable Care Act (ACA) changes to Medicare reimbursement policies. Vermont has also focused on quality of care and curbing healthcare costs through initiatives such as VCCI and Blueprint. This has curtailed the rate of growth in the PMPM, however other factors contribute to the rise in overall Vermont Medicaid expenditures as described below.

Medicaid Expansion

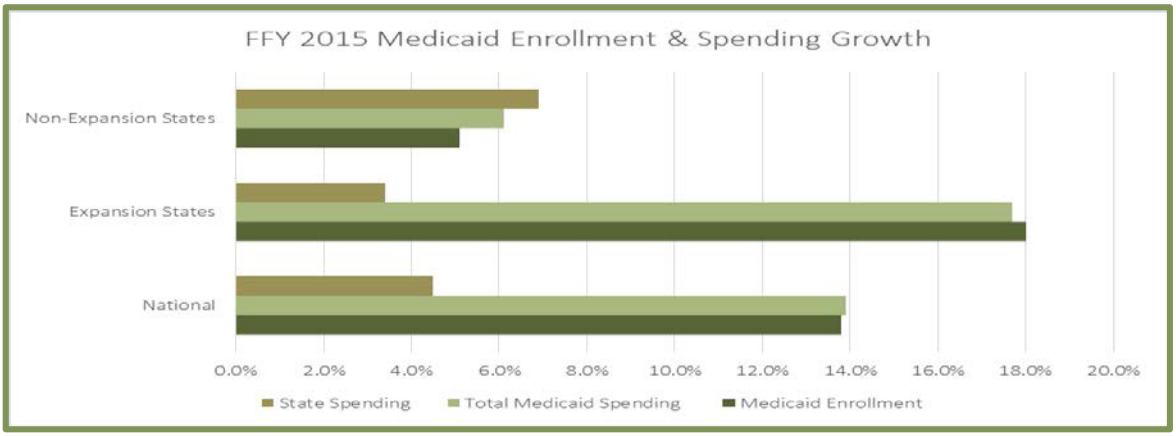
The ACA has driven significant increases to States' Medicaid enrollment and overall Medicaid spending including allowing for the inclusion of most adults up to a poverty level of 138% (FPL). Additionally, the ACA required all states to implement new streamlined and coordinated application, enrollment, and renewal processes, including transitioning to a new income standard (Modified Adjusted Gross Income or MAGI) to determine Medicaid financial eligibility for non-elderly, non-disabled populations.

Some of the changes in eligibility guidelines are:

- No longer requiring a 12 month uninsured period for those Vermonters who lost previous insurance voluntarily;
- No requirement for students to take school insurance;
- No premiums;
- Eligibility granted retroactively to the first of the application month;
- No resource test;
- Expanded income considerations such as depreciation, worker's compensation payments, child support, and expanded tax deductions.

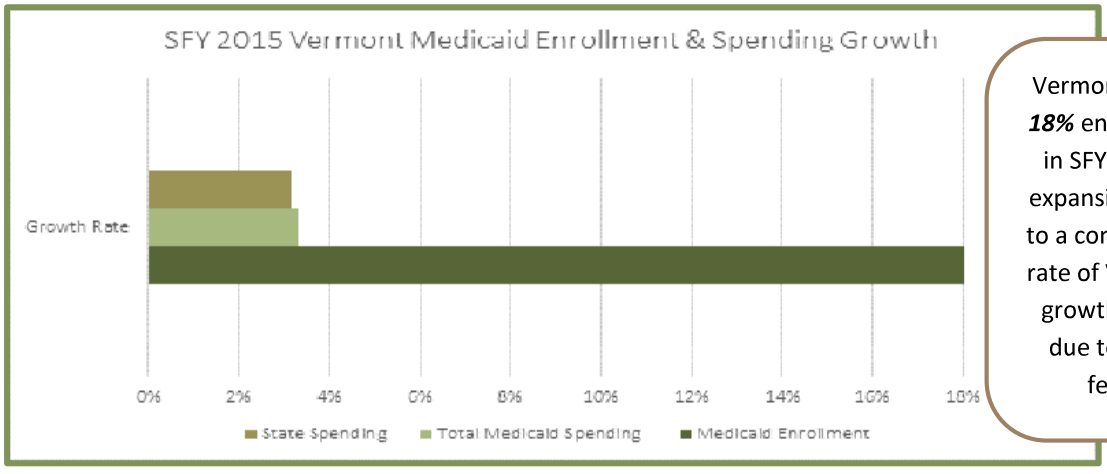
VERMONT MEDICAID TRENDS - A NATIONAL & REGIONAL COMPARISON CONTINUED

In the Federal Fiscal Year (FFY) 2015, enrollment and total spend in the 29 states that implemented the Medicaid expansion provisions of the ACA exceeded the rate of growth in the States that opted to not. For those 29 states, enrollment increased faster than anticipated; however, the PMPM cost for those individuals came in under projections. For states that are newly expanding Medicaid, the federal government paid 100 percent of Medicaid costs of those newly eligible for calendar years 2014-2016. The federal share will phase down to 95 percent in 2017, 94 percent in 2018, 93 percent in 2019 and 90 percent in 2020 and thereafter; well above traditional Federal Medical Assistance Percentage (FMAP) rates in every state. For the states that expanded Medicaid prior to the ACA effectuation, such as Vermont, federal reimbursement will increase to 90% for the same cohort by 2018. Thus, while the enrollment and total costs for the expansion states far exceeded non-expansion, the state share of spending growth was lower. The chart below depicts the FFY 2015 Medicaid enrollment and spending growth, as well as the state share.



Source: http://kff.org/medicaid/issue-brief/medicaid-enrollment-spending-growth-fy-2015-2016/

Vermont had provided expanded coverage through the VHAP, CHAP, and ESIA programs when the ACA was implemented. As a result, Vermont benefits from a Special Match rate of up to approximately 90% by 2018. The population growth and overall state spend is comparable to other expansion states.



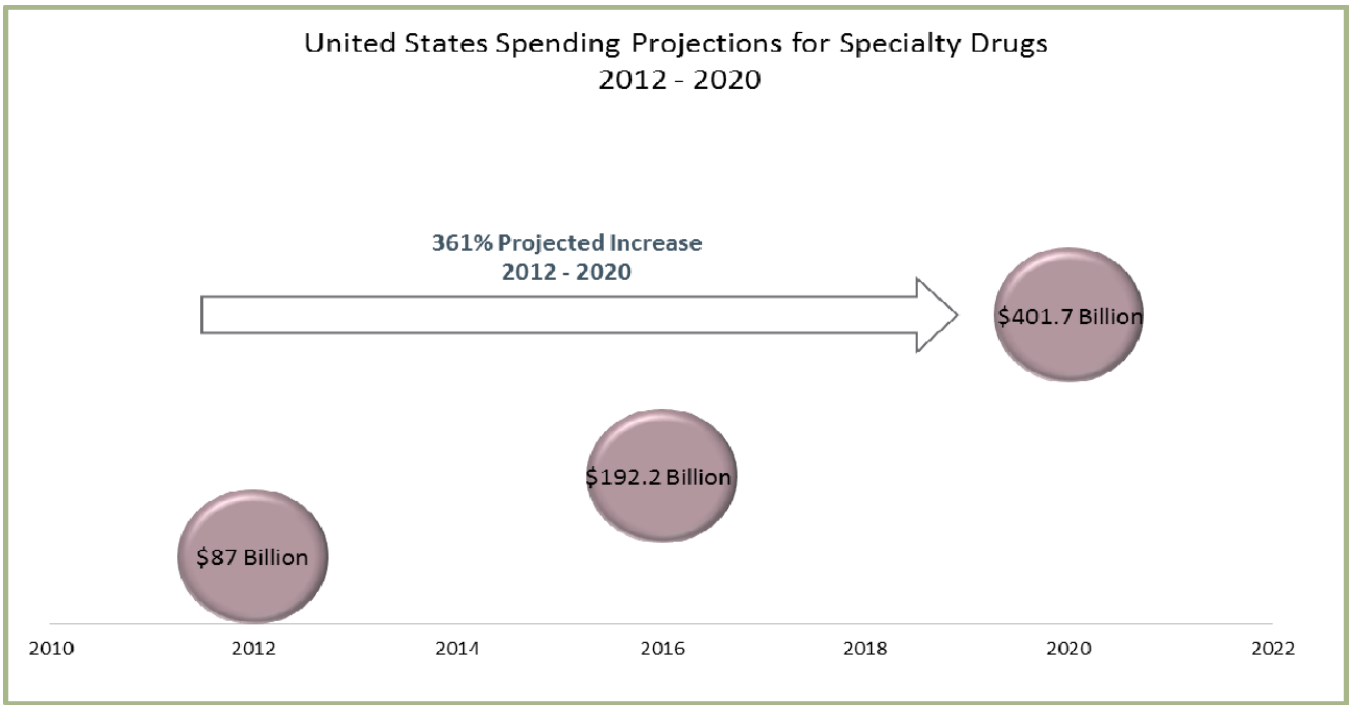
Vermont experienced an ***18%*** enrollee growth rate in SFY 2015. Like most expansion States, this led to a comparatively slower rate of Vermont spending growth - ***less than 4%*** - due to the increase in federal match.

Prescription Services

In Vermont, DVHA saw an 18.35% increase in drug spend (before rebates) between SFY 2014 and 2015. This increase is due to a 9.5% increase in unit cost while utilization was marginally negative. The increase in unit cost can be traced back mainly to increases in specialty drugs. The pricing power of manufacturers continues to be immediate concern to DVHA; specifically the relatively high price the US market – and Medicaid as the largest purchaser of drugs – incurs as compared to other nations. Prices remain high even as the products are widely used and thus broadly diffusing the initial efforts in research and development.

Some studies have found that up to 50% of all spending on prescription medication by 2018 will be for specialty drugs, which are complex pharmaceuticals that require special handling, administration, and monitoring by healthcare

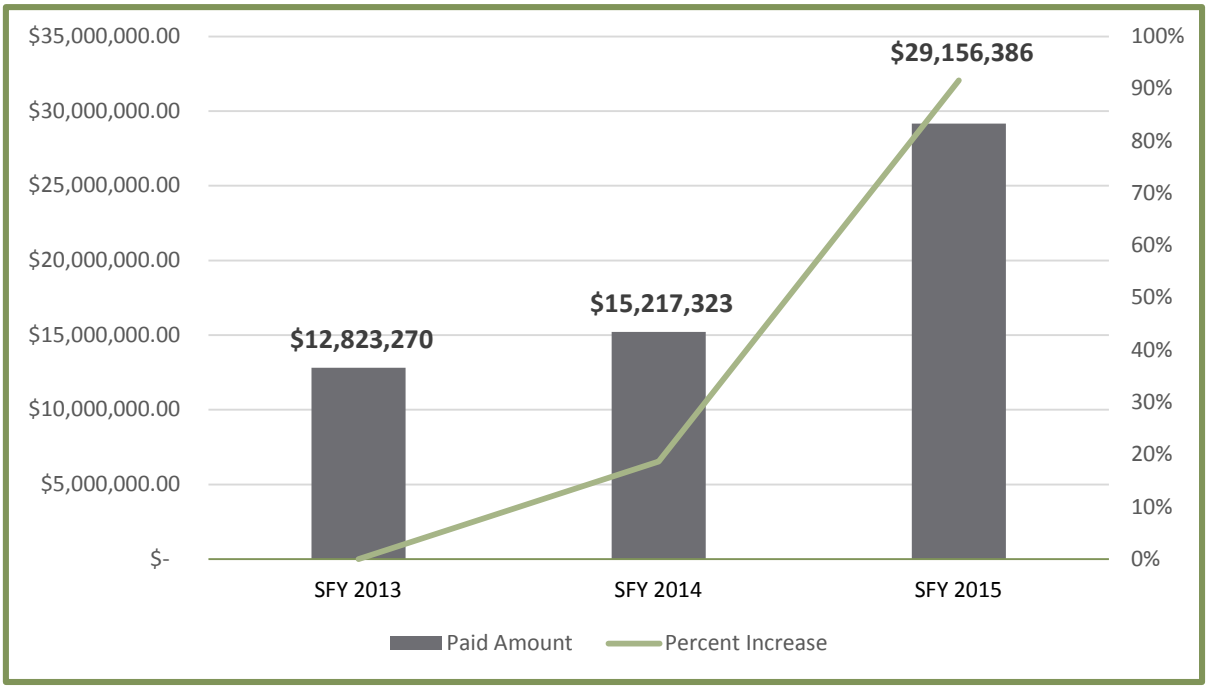
National spending on specialty medications increased in 2015, due almost entirely to increases in unit cost. Although generic availability in some of these classes exist, changes to drug formulation are needed to address mutations in virus strains that cause resistance to drugs. Additionally, some medications which have generic versions available, older HIV drugs for example, must be used in combination with other, newer and more costly, medications.



Source: http://content.healthaffairs.org/content/33/10/1736.full.pdf+html

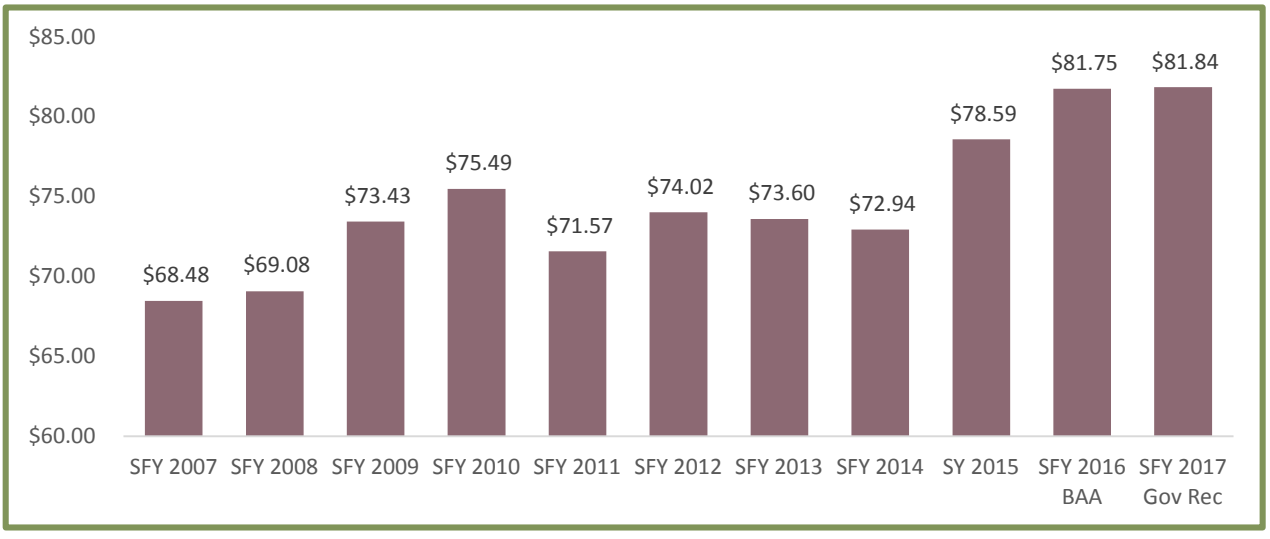
In SFY 2015, DVHA spent $29,156,386 on specialty drugs. This is a 92% increase over SFY 2014, when specialty drug costs were $15,217,323.

Vermont Medicaid Specialty Drug Cost Increases SFY 2013 - SFY 2015



The average cost per specialty drug prescription is $5,830, an increase of 48% over SFY 2014 when the average specialty prescription cost was $3,939. These increases in specialty pharmaceuticals are one of the main contributing factors to the overall increase in PMPM – an increase that diverges from the overall trend in PMPM as seen in the Caseload, Utilization and Expenditure section of this document.

Vermont Pharmacy PMPM Trend



Regional Comparisons

This section will illustrate the variations in spend in New England states and attempt to provide insight into the differences. States design and administer their own Medicaid programs within federal requirements. States and the federal government finance these programs jointly. Each state is required by federal law to cover specified "mandatory" services in Medicaid. They can also elect to cover many services designated as "optional" (see table below). These benefits apply to adults eligible for Medicaid under pre-ACA eligibility rules. The Medicaid benefit package for children, known as EPSDT (Early and Periodic Screening, Diagnosis, and Treatment), is uniquely comprehensive, addressing children's developmental as well as healthcare needs, and includes many services that are critical for children with special healthcare needs.

Mandatory Benefits	Optional Benefits
• Inpatient hospital services • Outpatient hospital services • EPSDT: Early and Periodic Screening, Diagnostic, and Treatment Services • Nursing Facility Services • Home Health Services • Physician Services • Rural health clinic services • Federally qualified health center services • Laboratory and X-ray services • Family Planning Services • Nurse Midwife services • Certified Pediatric and Family nurse Practitioner services • Freestanding Birth Center Services (when licensed or otherwise recognized by the state) • Transportation to medical care • Tobacco cessation counseling for pregnant women	• Prescription Drugs • Clinic Services • Physical therapy • Occupational therapy • Speech, hearing and language disorder services • Respiratory care services • Other diagnostic, screening, preventative and rehabilitative services • Podiatry services • Optometry service's • Dental services • Dentures • Prosthetics • Eyeglasses • Chiropractic services • Other practitioner services • Private duty nursing services • Personal care • Hospice • Case Management • Service for Individuals Age 65 or Older in an Institute for Mental Disease (IMD) • Services in an intermediate care facility for individuals with intellectual Disability • State Plan Home and Community Based Services-1915(i) • Self-Directed Personal Assistance Services-1915 (j) • Community First Choice Option-1915 (k) • TB Related Services • Inpatient psychiatric services for individuals under age 21 • Other services approved by the Secretary • Health home for Enrollees with Chronic Conditions-Section 1945

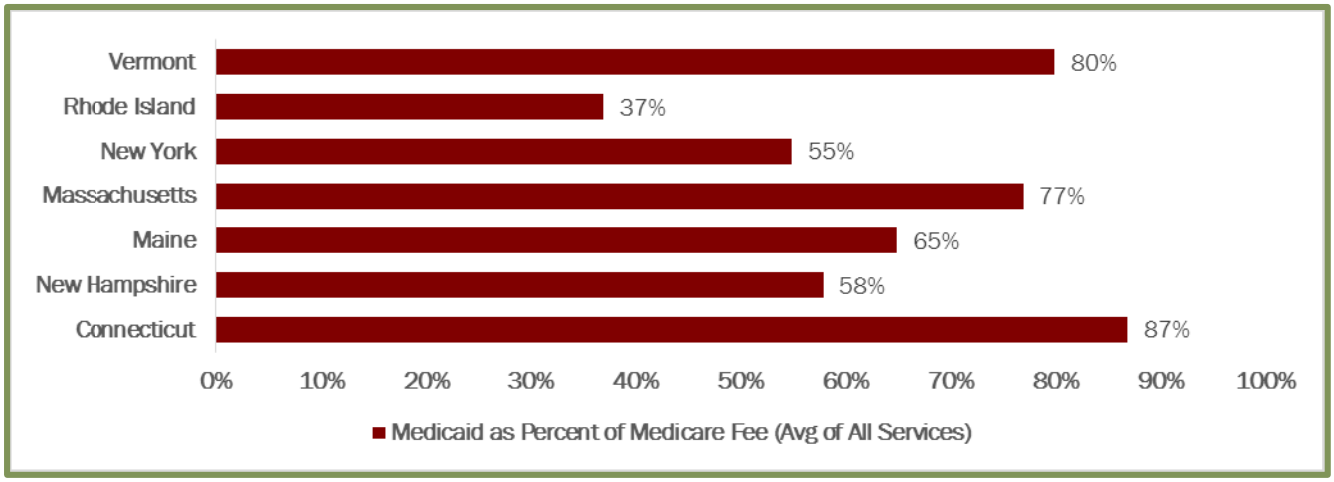
VERMONT MEDICAID TRENDS - A NATIONAL & REGIONAL COMPARISON CONTINUED

Medicaid policy decisions including eligibility levels, adoption of optional benefits, payment and delivery system choices as well as demand for public services will contribute to Medicaid spending variations from state to state. Providing optional services is thought to reduce the overall cost of mandatory services.

State	Number of Medicaid & CHIP enrollees July 2014	Acute Care	PMPY Acute Care Estimate	Long-Term Care	PMPY LTC Estimate	DSH Payments	Total	Total PMPY
Connecticut	753,927	$4,194,040,934	$5,563	$2,888,126,680	$3,831	$149,024,544	$7,231,192,158	$9,591.37
Maine	280,241	$1,590,280,368	$5,675	$827,567,260	$2,953	$39,328,950	$2,457,176,578	$8,768.08
Massachusetts	1,639,259	$10,333,520,762	$6,304	$4,269,201,576	$2,604	$0	$14,602,722,338	$8,908.12
New Hampshire	181,182	$555,436,277	$3,066	$678,967,270	$3,747	$109,314,773	$1,343,718,320	$7,416.40
New York	6,452,876	$35,605,322,810	$5,518	$15,232,267,682	$2,361	$3,366,485,105	$54,204,075,597	$8,399.99
Rhode Island	276,028	$2,069,517,652	$7,497	$240,416,400	$871	$138,322,435	$2,448,256,487	$8,869.59
Vermont	185,242	$1,369,634,401	$7,394	$127,690,959	$689	$37,448,781	$1,534,774,141	$8,285.24

Sources: MACStats: Medicaid and CHIP Data Book, December 2015 & http://kff.org/medicaid/issue-brief/medicaid-per-enrollee-spending-variation-across-states/

In addition to the State's decisions concerning services available to Medicaid enrollees, Medicaid reimbursement rates have an obvious impact to the spending level. The table below illustrates how Vermont compares to the region based on the 2012 Medicaid rate as a percentage of the 2012 Medicare rate.



Source: http://kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/

Under EPSDT, children up to age 21 are entitled to all medically necessary Medicaid services, including optional services, even if the state does not cover them for adults. Please see Glossary for benefits definitions.

The following table depicts the differences across states on providing optional services to their Medicaid populations.

Medicaid Optional Services New England + NY	VT	CT	MA	ME	NH	NY	RI
Physical Therapy	Yes	Yes	Yes	Yes	Yes	Yes	No
Occupational Therapy	Yes	No	Yes	Yes	Yes	Yes	No
Speech, hearing and language disorder services	Yes	Yes	Yes	Yes	Yes	Yes	No
Podiatry services	Yes	Yes	Yes	Yes	Yes	No	Yes
Dentures	No	Yes	Yes	Yes	No	Yes	Yes
Eyeglasses	No	Yes	Yes	Yes	Yes	Yes	Yes
Chiropractic Services	Yes	Yes	Yes	Yes	No	No	No
Private duty nursing services	Yes	No	Yes	Yes	Yes	Yes	No
Personal Care	Yes	No	Yes	Yes	Yes	Yes	Yes
Hospice	Yes	No	No	Yes	No	No	No
Self-Directed Personal Assistance Services- 1915(j)	Yes	No	No	No	No	*Data not available*	No
Tuberculosis (TB) Related Services	No	No	No	No	No	*Data not available*	Yes
Health Homes for Enrollees with Chronic Conditions – Nursing services, home health aides and medical supplies/equipment	Yes	No	No	Yes	No	Yes	Yes

Source: http://kff.org/health-reform/issue-brief/medicaid-moving-forward/

Beyond the ability for each State to design and administer their Medicaid programs, States also have the flexibility to set limitations on the number and duration of services, as well as requiring prior authorization for services. One specific area of remarkable variation is in Mental Health and Substance Abuse treatment services. This is especially relevant as one in six low income adults are estimated to have a severe mental health disorder with many more having less severe mental health needs. Medicaid members with mental health disorders are likely to need access to prescription services, therapy services, inpatient hospital, and other residential treatment programs. Access to assistive community supports and care management are usually also needed for those with persistent, severe mental health and/or substance abuse issues. Vermont's Blueprint efforts to improve integration of mental health and substance abuse disorders are designed to improve outcomes given the high rates of comorbidity between mental health and physical health. The primary-care based health home is recognized as having great potential for the early identification and treatment of mental health and substance abuse disorders such as depression.

Location	Service Limitation
Connecticut	10 days/occurrence in approved Alcohol Abuse Treatment Center for acute and evaluation phase of treatment
Maine	Substance abuse services limited to 30 weeks
Massachusetts	Substance abuse counseling limited to 24 sessions per recipient per calendar year. MassHealth does not reimburse for nonmedical MH services such as community outreach services and vocational rehab.
New Hampshire	Community mental health care limited to $1,800/year unless specified criteria met, low service utilizer with severe or persistent mental illness limited to $4,000/year; ambulatory detox services for substance abuse are not covered
New York	Beneficiary Specific Utilization Thresholds apply to mental health services
Rhode Island	MH/SA limits of 30 outpatient counseling sessions, 60 days treatment, and 60 consecutive days of residential treatment per calendar year. Beyond this requires prior authorization.
Vermont	1 group psychotherapy per day and three per week; Limit of 12 family psychotherapy sessions per year without patient; No psychiatric inpatient limitation

It has proven difficult to obtain a full picture of current mental health and substance abuse spending information for individual states due to various delivery mechanisms within states. For example, some states utilize behavioral health managed care organizations and others put waivers in place to provide community based services. The following table provides a comparison of spending for State Mental Health Agencies (SMHAs) only for FFY 2013. This is only part of the overall Medicaid mental health delivery system. However, it does illustrate the per person spend.

Location	SMHA Expenditures FFY 2013	Number of Enrollees July 2014	PMPY Estimate
United States	$ 38,000,000,000	67,147,446	$ 566
Connecticut	$ 777,700,000	753,927	$ 1,032
Maine	$ 458,270,000	280,241	$ 1,635
Massachusetts	$ 737,800,000	1,639,259	$ 450
New Hampshire	$ 182,970,000	181,182	$ 1,010
New York	$ 5,100,000,000	6,452,876	$ 790
Rhode Island	$ 111,130,000	276,028	$ 403
Vermont	$ 182,600,000	185,242	$ 986

Source: http://kff.org/other/state-indicator/smha-expenditures-per-capita/

State Medicaid plans typically cover the following mental health services: psychiatric hospital visits, case management, day treatment, psycho-social rehabilitation, psychiatric evaluation and testing, medication management, individual/group and family therapy, inpatient detoxification, methadone maintenance, smoking and tobacco cessation services.

Nationally, the spending for all Medicaid enrollees with mental health diagnoses in 2011 was $131.18 billion. The 20% of enrollees with mental health diagnoses accounted for 48% of Medicaid costs. The PMPY cost for an enrollee with a mental health diagnosis was $13,303 as compared to $3,564 without. Vermont, in comparison, spent $342 million in SFY 2015 on 71,854 unique Medicaid/CHIP enrollees. In other words, 30% of the total population comprised 49% of the total cost.

Demographic Comparison

Certain national, regional, demographic, and economic factors will have an impact on the cost drivers for any State. In aggregate as a population ages, the health needs become more complex and the health spending increases. States with more of their population living in poverty are going to experience an increase in Medicaid enrollment.

Below are two tables offering insight into the demographic data of each state. The first expands on the population information by breaking it into age distribution, the second by relationship to the Federal Poverty Level (FPL).

Population Distribution by Age CY 2014							
Location	Children 0-18	Adults 19-25	Adults 26-34	Adults 35-44	Adults 45-54	Adults 55-64	65+
Connecticut	24%	9%	12%	12%	16%	15%	14%
Maine	21%	7%	9%	13%	16%	15%	19%
Massachusetts	23%	10%	13%	12%	13%	14%	16%
New Hampshire	21%	10%	10%	12%	16%	15%	16%
New York	23%	10%	13%	12%	14%	13%	15%
Rhode Island	22%	11%	11%	12%	15%	15%	15%
Vermont	20%	8%	13%	12%	14%	16%	16%

Source: http://kff.org/other/state-indicator/distribution-by-age/

It is worth noting, as seen below; roughly 24% of the Vermont population is below 200% of the FPL, and 56% is under the ACA threshold for subsidies of 400%.

Distribution of Total Population by Federal Poverty Level CY 2014				
Location	Under 100%	100-199%	200-399%	400%+
Connecticut	9%	13%	26%	52%
Maine	15%	16%	32%	37%
Massachusetts	13%	15%	21%	51%
New Hampshire	8%	13%	26%	53%
New York	14%	20%	26%	40%
Rhode Island	12%	16%	29%	43%
Vermont	10%	14%	32%	44%

Source: http://kff.org/other/state-indicator/distribution-by-fpl/

In conclusion, variation in State spending has many causes, including state discretion in policy and program benefits. New technologies and pharmacological advancements have proven both necessary for better health outcomes and are expensive. Social problems within a state such as opiate dependency will impact states' Medicaid budgets. Differences in reimbursement rates, methodologies, and amounts of services used direct Medicaid spend. Demographic and economic indicators of each State will determine the need of the population to access Medicaid and healthcare services.

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CHAPTER THREE: DVHA INTERNAL

MISSION STATEMENT

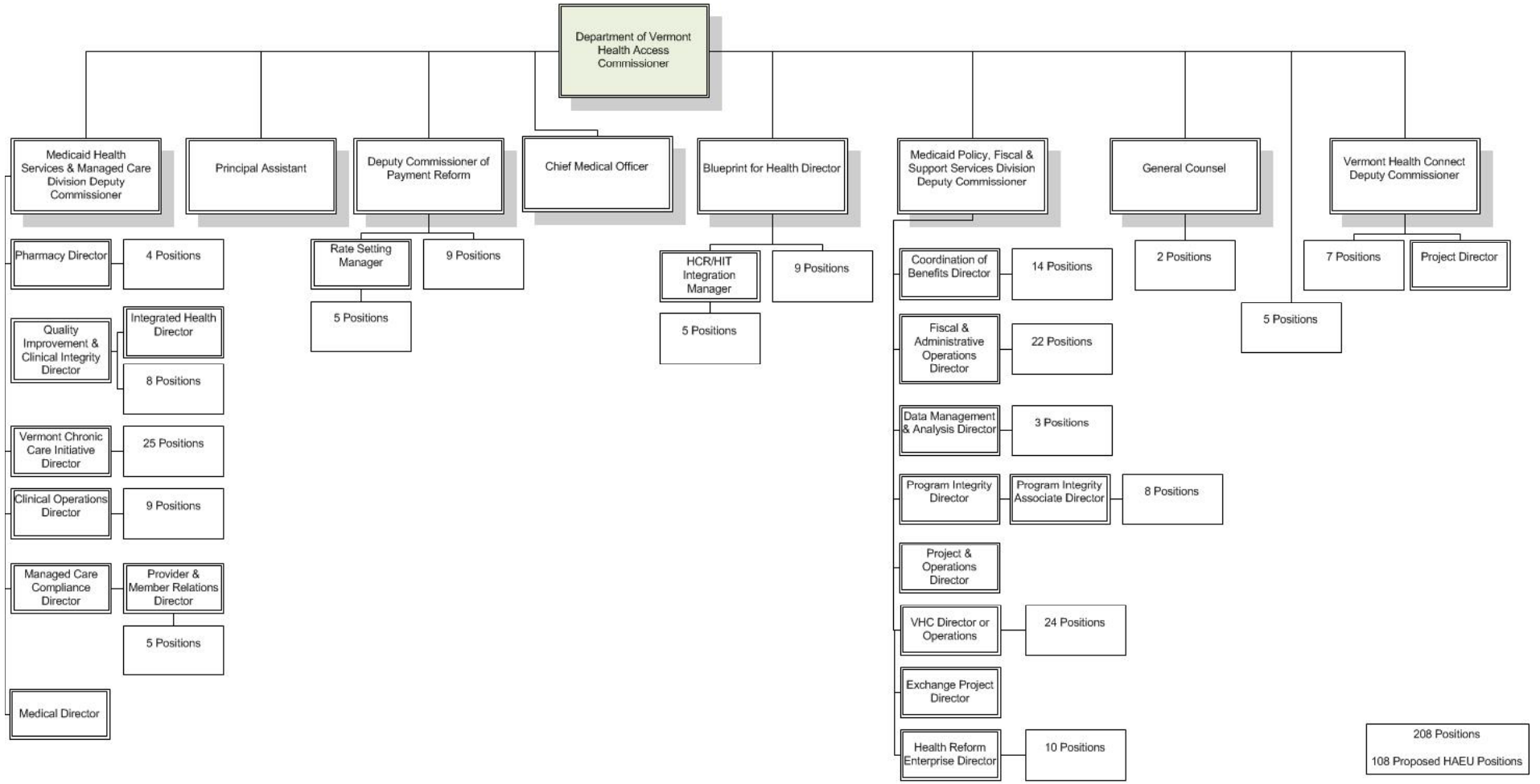
Provide leadership for Vermont stakeholders to improve access, quality and cost-effectiveness of healthcare.

Assist Medicaid beneficiaries in accessing clinically appropriate health services.

Administer Vermont's public health insurance system efficiently and effectively.

Collaborate with other healthcare system entities in bringing evidence-based practices to Vermont Medicaid beneficiaries.

DVHA ORGANIZATIONAL CHART



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UNIT RESPONSIBILITIES

DVHA is comprised of the following Divisions:

- *Medicaid Health Services and Managed Care*
- *Medicaid Policy, Fiscal, and Support Services*
- *Medicaid Payment Reform and Reimbursement*
- *Blueprint for Health*
- *Vermont Health Connect*

MEDICAID HEALTH SERVICES AND MANAGED CARE

The Medicaid Health Services and Managed Care Division is responsible for health services provided to members, medical management planning, and the oversight of all activities related to quality, access to services, measurement and improvement standards, and utilization review. The following units comprise this division:

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

CLINICAL OPERATIONS

The Clinical Operations unit (COU) monitors the quality, appropriateness, and effectiveness of healthcare services requested by providers for members. The unit ensures that requests for services are reviewed and processed efficiently and within timeframes outlined in Medicaid Rule; identifies over- and under-utilization of healthcare 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; offers provider education related to specific Medicaid policies and procedures; and performs quality improvement activities to enhance medical benefits for members.

The unit also manages the Clinical Utilization Review Board (CURB), an advisory board comprised of ten (10) members with diverse medical experience appointed by the Governor upon recommendation of the Commissioner of DVHA. The 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 members. DVHA retains final authority to evaluate and implement the CURB's recommendations.

The COU has been involved in the ICD-9 to ICD-10 (International Classification of Diseases) implementation project, a national change mandated by the federal Department of Health and Human Services (HHS) which was successfully completed on October 1, 2015. ICD-10 is a more robust classification system which provides more detailed information on diagnoses and procedures; and is expected to improve healthcare management as well as reporting and analytics.

Because this is a major transition, both DVHA and Hewlett Packard Enterprise, as DVHA's fiscal agent:

- Monitored provider claims closely in real time from October 1, 2015 until December 2015;
- Conducted system monitoring and tracking via Early Warning Indicators to identify system issues;
- Address any issues that arose with efficiency, and provided claims processing guidance and support to providers.

PHARMACY

The pharmacy benefit for members enrolled in Vermont's publicly funded healthcare programs is managed by the Pharmacy unit. Responsibilities include ensuring members receive medically necessary medications in the most timely, cost-effective manner.

Pharmacy unit staff and DVHA's contracted pharmacy benefit manager (PBM) work with pharmacies, prescribers, and members to resolve benefit and claims processing issues, and to facilitate appeals related to prescription drug coverage within the pharmacy benefit. The unit enforces claims rules in compliance with federal and state laws, implements legislative and operational changes to the pharmacy benefit programs, and oversees all the state, federal, and supplemental drug rebate programs. In addition, the unit and its PBM partner manage DVHA's preferred drug list (PDL), pharmacy utilization management programs, a local provider call center/help desk, and drug utilization review activities focused on promoting rational prescribing and alignment with evidence-based clinical guidelines.

The Pharmacy unit also manages the activities of the Drug Utilization Review (DUR) Board, an advisory board with membership that includes Vermont physicians, pharmacists, and a community health practitioner. Board members evaluate drugs based on clinical appropriateness and net cost to the state, and make recommendations regarding a drug's clinical management and status on the state's PDL. Board members also review identified utilization events and advise on approaches to management.

DVHA successfully launched a new and modernized prescription benefit management (PBM) system, including a new claims processing platform, on January 1, 2015.

The new PBM system consists of a suite of software and services designed to improve the delivery of prescription benefit services to Vermont's publicly-funded benefits programs.

The new system will allow the State to more effectively manage pharmacy and medical costs. Enhanced services include a local Call Center/Helpdesk staffed by Vermont pharmacists and pharmacy technicians and a new provider portal giving pharmacists and prescribers access to a secure, web-based application that offers features such as responses to pharmacy and member queries, electronic submission of prior authorizations (PA), uploading of clinical documentation into a document management system, and status updates for submitted PA requests. More information about pharmacy services can be found on the DVHA website.

QUALITY IMPROVEMENT AND CLINICAL INTEGRITY

The Quality Improvement & Clinical Integrity unit collaborates with AHS partners to develop a culture of continuous quality improvement. The unit maintains the Vermont Medicaid Quality Plan and Work Plan; coordinates quality initiatives throughout DVHA in collaboration with AHS partners; oversees DVHA's formal performance improvement projects as required by the Global Commitment to Health Waiver; coordinates the production of standard performance measure sets including *Global Commitment to Health* measures, Healthcare Effectiveness Data and Information Set (HEDIS) measures, CMS Adult and Children's Core Quality measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey measures; and is the DVHA lead unit for the Results Based Accountability (RBA) methodology for performance improvement; and produces the DVHA RBA Scorecards.

The unit is coordinating the wrap up of two performance improvement projects – Breast Cancer Screening & Initiation and Engagement in Alcohol & Other Substance Abuse Treatment. The Quality unit staff also led and participated in a new medical record review (MRR) process in 2015 that allows us to produce more accurate performance data for measures that require a hybrid of data collection methodologies making use of both claim and medical records. The unit also leads a formal performance improvement project – validated by our External Quality Review Organization (EQRO) and submitted to CMS annually – that consists of AHS-wide representation and is focused on Follow Up After Hospitalization for Mental Illness (FUH). The DVHA Quality unit leads the Agency Improvement Model (AIM) and supports DVHA staff with process improvement by providing ongoing AIM training and representation on the AHS AIM Steering Committee.

The unit houses the Clinical Utilization Review (UR) team responsible for the utilization management of mental health and substance abuse services. The team works toward the integration of services provided to Vermont Medicaid members with substance abuse and mental health needs with their primary care. The team performs utilization management activities including concurrent review and authorization of mental health and substance abuse services and facilitates access to care for members. In an effort to further support a member-centric approach and coordinated management of mental health/substance abuse services, the DVHA Quality unit and the Division of Alcohol and Drug Abuse Programs (ADAP) moved the utilization review responsibilities for substance abuse residential services from ADAP to the DVHA Behavioral Health Team in April of 2015.

In state fiscal year 2015, the UR team authorized and performed concurrent reviews for 433 child/adolescent psychiatric inpatient admissions, 970 withdrawal management inpatient admissions, 982 adult psychiatric inpatient admissions and 558 residential treatment admissions. The team supported active discharge planning, especially with the child/adolescent

population, by requesting and/or participating in regular case conferences with all involved parties for the purpose of ensuring successful outpatient transitions. With the knowledge of statewide systems of care, the team has been able to provide hospital and residential discharge planners with resource information and assistance with difficult cases to support the best possible outcomes for members. The team continues to work closely with the Department of Mental Health, the Vermont Department of Health's Division of Alcohol and Drug Abuse Program, the Care Alliance for Opioid Addiction (also referred to as "Hub and Spoke"), the Vermont Chronic Care Initiative, and the DVHA Pharmacy and Clinical Operations units.

The UR team also administers the Team Care program, which locks a member to a single prescriber and a single pharmacy. This program ensures appropriate care is delivered to members who have a history of drug-seeking behavior or other problematic uses of prescription drugs. The unit continues to explore opportunities to identify additional supports for members in lieu of lock-in to better meet members' needs and to enhance coordination with the VCCI in supporting members to move from high ER use to utilizing their primary care.

Throughout fiscal year 2015, Quality Unit staff, in collaboration with the AHS Policy Unit, researched best practices and benefit design for the provision of Applied Behavioral Analysis (ABA) services in the public and private sectors throughout the country. The Medicaid Policy unit and the Quality unit brought together the AHS sister departments to provide feedback on the proposed benefit design for ABA services and also solicited feedback from stakeholders and the public. The benefit became active on July 1, 2015 and is managed by the UR team.

VERMONT CHRONIC CARE INITIATIVE (VCCI)

As indicated earlier, VCCI is a healthcare reform strategy to support Medicaid members with chronic health conditions and/or high utilization of medical services to access clinically appropriate healthcare information and services; coordinate the efficient delivery of healthcare to these members by addressing barriers to care, gaps in evidence-based treatment and duplication of services; and to educate and empower members to eventually self-manage their conditions. Management of depression continues to be an area of primary focus for the VCCI population, as there is high prevalence of this condition, along with other co-morbidities among members who account for the highest cost of care (the top 5%). Helping members to manage depression is indicated prior to addressing any other chronic healthcare conditions. VCCI also offers case management for at-risk pregnant women (Medicaid Obstetrical and Maternal Supports (MOMS), including women with substance use/abuse and mental health disorders; and those with a prior history of premature delivery. Studies have suggested that these conditions in pregnancy put the pregnant individual and infants at greater risk and generate higher associated cost of delivery and Neonatal Intensive Care Unit costs (NICU), which may be positively impacted by proactive care management by VCCI field based staff.

VERMONT CHRONIC CARE INITIATIVE (VCCI) CONTINUED

The MOMS service within VCCI currently relies on referrals from internal Agency partners, private physicians, and other social service partners throughout the state and is successfully working to improve quality of care, health outcomes, and containment of associated healthcare costs. Efforts to support the collaboration have included development and administration of a training curriculum by the MOMS lead care manager. Recipients of these trainings have included VCCI field staff, ADAP colleagues and their "Hub" leadership team; the DVHA Blueprint/hospital based project managers and CHT (Community Health Team) "Spoke" staff working with pregnant women receiving Medication Assisted Therapy (MAT); and DMH.

The 2013 Behavioral Risk Factor Surveillance System (BRFSS) data indicates that 34% of Medicaid beneficiaries are obese. It is well documented that obesity directly contributes to an increase in chronic conditions and associated costs to the healthcare system. In 2015, the new VCCI nutrition/obesity specialist worked to embed Body Mass Index (BMI) documentation in the case management workflow and establish BMI as a "vital sign" for chronic disease management. Healthy living action plans and a motivational interviewing tool to assess ambivalence and motivation for change in members who are overweight and obese were developed and disseminated.

MANAGED CARE COMPLIANCE

The Managed Care Compliance unit is responsible for ensuring DVHA's adherence to all state and federal Medicaid managed care requirements. This unit also manages DVHA's Inter-Governmental Agreements (IGA) with other AHS departments and coordinates audits aimed at evaluating the compliance and quality of managed care activities and programs. If a compliance issue is identified, the Compliance unit is responsible for creating and managing a corrective action plan, which is reviewed and monitored by the Managed Care Compliance Committee.

Each year, the unit coordinates a managed care compliance audit, which is conducted by an auditor designated by CMS as an External Quality Review Organization (EQRO). As these auditors review insurance plans across the United States, the annual EQRO audit is an opportunity to see how Vermont compares to other systems and to learn about best practices. This audit has helped DVHA programs to improve over the years, resulting in recent audit scores between 97% and 100%. For more information, see the Report Card for Quality Reporting.

The Compliance unit works closely with the Quality unit to maintain continuity between compliance and quality improvement activities.

PROVIDER AND MEMBER RELATIONS (PMR)

PMR ensures members have access to appropriate healthcare for their medical, dental, and mental health needs. The unit monitors the adequacy of the Green Mountain Care (GMC) network of providers and ensures that members are served in accordance with managed care requirements. The Green Mountain Care Member Support Center contractor is the point of initial contact for members' questions and concerns.

Unit responsibilities relating to providers include provider enrollment, screening, and revalidation. Credentialing of providers and monitoring of the network helps prevent Medicaid fraud and abuse. In conjunction with the State's fiscal agent, PMR currently has 13,000 providers enrolled in the Vermont Medicaid program. For exceptional circumstances, PMR pursues the enrollment of providers for members' prior authorized out-of-state medical needs or if members need emergency healthcare services while out of state.

The PMR Non-Emergency Medical Transportation (NEMT) group ensures that Medicaid members without access to transportation get rides to and from medical appointments including treatment for opioid addiction. In addition to contract management and quality review of the eight statewide transportation broker/providers, PMR staff process authorizations for out-of-area transportation and transportation related medical exemption applications.

PMR is responsible for outreach and communication including: Medicaid policy education; provider manuals and newsletters; member handbooks and newsletters; the Green Mountain Care member website; the Department of Vermont Health Access website; and other communications. Additionally, PMR serves as liaison to the Medicaid Exchange Advisory Board (MEAB).

MEDICAID POLICY, FISCAL, AND SUPPORT SERVICES

The following units comprise this division:

- *Coordination of Benefits*
- *Data Management and Analysis*
- *Fiscal and Administrative Operations*
- *Information Technology*
- *Program Integrity*
- *Projects and Operations*
- *Vermont Medicaid Management Information System Program*

Coordination Of Benefits (COB)

The COB unit works to coordinate benefit and collection practices with providers, members, and other insurance companies to ensure that Medicaid is the payer of last resort. COB is responsible for Medicare Part D casework including claims processing assistance, coverage verification, and issue resolution. The unit also works diligently to recover funds from third parties where Medicaid should not have been solely responsible. Those efforts include estate recovery, absent parent medical support recovery, casualty recovery, patient liability recovery, Medicare recovery, Medicare prescription recovery, special needs recovery, and trust recovery. The unit has been able to increase Third Party Liability (TPL) cost avoidance dollars, a direct result of ensuring that correct TPL insurance information is in the payment systems and being used appropriately.

Data Management and Analysis

The Data Management and Analysis unit provides data analysis, distribution of Medicaid data extracts, reporting to state agencies, the legislature, and other stakeholders and vendors. It also delivers mandatory federal reporting to the Centers for Medicare and Medicaid Services (CMS), develops the annual Healthcare Effectiveness Data and Information Sets (HEDIS) for reporting, and provides ad hoc data analysis for internal DVHA divisions and other AHS departments and state agencies.

AHS and DVHA initiatives around performance measures, performance improvement projects, and pay-for-performance initiatives are supported by the unit. DVHA successfully implemented three hybrid measures for the HEDIS 2015 season: Comprehensive Diabetes Care (CDC), Controlling High Blood Pressure (CBP), and Prenatal and Postpartum Care (PPC). The unit continues to support the AHS Central Office monitoring of the Designated Agencies (DAs) by running the annual DA Master Grant Performance Measures and providing AHS with a multi-year span of results for nine measures to track progress and monitor continued improvements. The unit is actively engaged in Performance Improvements Projects (PIP) aimed at improving three HEDIS measures: Breast Cancer Screening (BCS), Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET), and Follow-Up After Hospitalization for Mental Illness (FUH). Analysts working on these projects analyze claims records while designing, developing, and implementing change processes to encourage beneficiary and provider coordination and cooperation.

In collaboration with the Payment Reform Team, the unit provides monthly detailed data runs, which are the basis for algorithms to attribute Medicaid beneficiaries into Accountable Care Organization (ACO) groups.

Fiscal and Administrative Operations

The Fiscal and Administrative Operations unit supports, monitors, manages and reports all aspects of fiscal planning and responsibility. The unit includes Accounts Payable/Accounts Receivable (AP/AR), Grants and Contracts, Business Administration, Fiscal Analytics, and Programmatic Accounting and Compliance.

AP/AR is responsible for provider and drug manufacturer assessment billing and receipts, vendor payments, drug rebate receipts, internal expense approvals, and administration appropriation financial monitoring. The Grants and Contracts team oversee procurement, maintenance, and compliance for all DVHA funded grants and contracts. Business Administration ensures DVHA staff is supported with facilities, equipment, Human Resources liaison, purchasing, and other internal administrative tasks. Fiscal Analytics formulates and performs analysis of the programmatic budget, periodic financial reporting, and ad-hoc research requests providing analytic support for the remainder of the Fiscal and Administrative Operations unit. Programmatic Accounting and Compliance monitors the program operations in order to determine financial impact, assist with programmatic budget preparation, and ensure financial reporting alignment with federal and state regulations. The unit is also responsible for researching, developing and implementing relevant administrative processes, procedures and practices.

Information Technology (IT)

The Information Technology unit provides direction, assistance, and support for all aspects of information technology planning, implementation, and governance. In conjunction with AHS IT and Department of Information and Innovation (DII), the unit is responsible for researching, developing, and implementing relevant administrative processes, procedures, and practices related to computer systems and applications operations management.

The functions of DVHA IT include applications development (in-house build), procurement, or framework configuration determinations. This includes hardware and software procurement, requests for proposal, and contract development in association with the Fiscal and Administrative Operations unit and DII. Some of these activities are related to system account administration, system audit coordination, and security and privacy.

The unit also assists with coordination of projects requiring cross-functional involvement within the Agency, CMS, and DII such as ICD10, Transformed Medicaid Statistical Information Systems (T-MSIS), and the Affordable Care Act (ACA). The unit oversees remediation of outsourced systems to meet regulatory compliance and other needs, in particular related to the Medicaid Management Information Systems (MMIS). The unit worked to prepare Vermont's MMIS for ICD-10 in collaboration with clinical operations and ensured system remediation work was completed. DVHA is working on monitoring impacts post the October 1st implementation with Hewlett Packard Enterprise and Agency sister departments to promote and devise assistive

methods for each of their programs' provider communities. DVHA, in collaboration with the other insurers in Vermont, conducted meetings with state medical associations, and appeared at several conferences presenting ICD-10 awareness and roadmap guidelines. The unit has also conducted provider and clearinghouse surveys to identify non-compliant providers and promote readiness.

PROGRAM INTEGRITY (PI)

The Program Integrity unit works to establish and maintain integrity within the Medicaid Program. The unit engages in activities to prevent, detect, and investigate Medicaid provider fraud, waste, and abuse. Data mining and analytics, along with referrals received, are used to identify and support the appropriate resolution of incorrect payments made to providers.

The PI unit works with other Medicaid program units to facilitate changes in policies, procedures, and program logic to help ensure the integrity of the program. In addition, the PI unit provides education to our Medicaid providers when deficiencies and incorrect billing practices are identified.

Cases with credible allegations of provider fraud are referred to the Office of the Attorney General's Medicaid Fraud and Residential Abuse Unit (MFRAU). Cases of suspected enrollee eligibility fraud are referred to the Department for Children and Families (DCF)'s Member Fraud unit.

PROJECTS AND OPERATIONS

The Projects and Operations unit is responsible for operationalizing select new program initiatives and ongoing projects in particular those requiring cross-functional involvement. Responsibilities include the MMIS Care Management project – which is part of the Agency of Human Services' Health and Human Services Enterprise (HSE) – the Graduate Medical Education (GME) Program, and Medicaid Health Home initiatives and State Plan Amendments (SPAs).

Key accomplishments for the Projects and Operations unit during the past year include: ensuring quarterly GME payments and fulfillment of quality reporting requirements; determining 2017 GME funding and enhanced reporting requirements for UVM Medical Center; developing a proposal to CMS for Vermont's Opioid Dependence Health Homes' quality reporting strategy and capabilities; negotiating and implementing a contract with the selected Care Management vendor; and initiating system development and onboarding with the first phase of the care management project, the Vermont Chronic Care Initiative.

VERMONT MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) PROGRAM

The Vermont Medicaid Management Information System (MMIS) program team continues to evolve. The MMIS program is a core element of the AHS HSE vision, aligning Vermont's MMIS with new federal and state regulations stemming from the federal Affordable Care Act and Vermont's healthcare reform law, Act 48. The new MMIS will integrate with a Service Oriented Architecture (SOA), creating a configurable, interoperable system, and it will also be compliant with the CMS Seven Standards and Conditions. When operational, this new system will efficiently and securely share appropriate data with Vermont agencies, providers, and other stakeholders involved in a member's case and care.

Multiple procurements comprise the MMIS Program:

Pharmacy Benefit Management Solution (PBM): the PBM contract with Goold Health Systems (GHS) was effective May, 2014. Phase 1 (Point of Sale) was implemented January, 2015. Phase 2 will be fully implemented in March, 2016 with features including a Provider Portal and a Data Analytic Tool.

Care Management (CM): the CM contract with eQHealth Solutions was effective May, 2015. Phase 1 will replace the current vendor contract, supporting the work of the Vermont Chronic Care Initiative (VCCI) clinicians in the field and leading to expanded care management efforts across AHS. Phase 2 will address Children's Integrated Services (CIS) and is expected in July, 2016.

Specialized Program Projects (SPP): the SPP contracts with Berry Dunn McNeil & Parker (BD) and Pacific Health Policy Group (PHPG) were effective February, 2015. This work provides an opportunity to streamline and standardize reporting requirements, funding streams, reimbursement rates, and provider qualifications. Currently these functions operate under several different specialized systems of care.

Independent Verification and Validation (IV&V): the IV&V contract with CSG Government Solutions (CSG) was effective April, 2015. CSG provides independent, detailed review of MMIS Program deliverables to assess the quality, alignment with objectives, fidelity to state and federal requirements and adherence to the plan.

MMIS Core: will provide full claims processing, program integrity and fiscal agent services supporting the Vermont's HSE. CMS has mandated and fully supported this procurement, which is currently in the final procurement phase of the implementation timeline.

MEDICAID PAYMENT REFORM AND REIMBURSEMENT

The following units reside in this division:

- *Medicaid Reimbursement*
- *Medicaid Payment Reform*

MEDICAID REIMBURSEMENT

The DVHA Medicaid Reimbursement unit oversees rate setting, pricing, provider payments and reimbursement methodologies for a large array of services provided under Vermont's Medicaid Program. The unit works with Medicaid providers and other stakeholders to support equitable, transparent, and predictable payment policy in order to ensure efficient and appropriate use of Medicaid resources. The Reimbursement unit is primarily responsible for implementing and managing prospective payment reimbursement methodologies developed to align with CMS Medicare methodologies for outpatient, inpatient and professional fee services. While these reimbursement streams comprise the majority of payment through DVHA, the Unit also oversees a complementary set of specialty fee schedules including but not limited to durable medical equipment, ambulance, clinical labs, blood, physician administered drugs, dental, and home health. The Reimbursement unit also manages the Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) payment process as well as supplemental payment administration such as the Disproportionate Share Hospital (DSH) program. The unit is involved with addressing the individual and special circumstantial needs of members by working closely with clinical staff from within DVHA and partner agencies to ensure that needed services are provided in an efficient and timely manner. The Reimbursement unit works closely and collaboratively on reimbursement policies for specialized programs with AHS sister departments, including the Department of Disabilities, Aging, and Independent Living (DDAIL), the Vermont Department of Health (VDH), the Vermont Department of Mental Health (DMH), Integrated Family Services (IFS), and Children's Integrated Services (CIS).

In calendar year 2015, the Reimbursement unit had many accomplishments including: assisting in the implementation of ICD-10; bringing the unit concept for group psychotherapy into compliance with national correct coding guidelines; and implementing new payment methodologies for our physician administered drug and clinical laboratory fee schedules. Additionally, the Reimbursement unit continues to work with FQHCs and RHCs as well as Home Health Agencies in developing new Value Based Prospective Payment Systems.

MEDICAID PAYMENT REFORM

The Payment Reform Team supports the Vermont Healthcare Innovation Project (VHCIP), a program developed from a three year, 45 million dollar State Innovation Model (SIM) grant awarded to the State of Vermont by the Centers for Medicare and Medicaid Innovation (CMMI). The grant, jointly implemented by DVHA and the Green Mountain Care Board, is focused on three primary outcomes: 1) an integrated system of value-based provider payment; 2) an integrated system of care coordination and care management; and 3) an integrated system of electronic medical records.

The primary areas of focus for Medicaid payment reform are to support the design, implementation, and evaluation of innovative payment initiatives, including an accountable care organization (ACO); shared savings program (SSP); and an Episode of Care (EOC) program for Medicaid. The payment reform team supports an array of payment reform and integration activities; ensures consistency across multiple program areas; develops fiscal analysis, data analysis, and reimbursement models; engages providers in testing models; and ensures the models encourage higher quality of care and are supported by robust monitoring and evaluation plans. Members of the payment reform team are also responsible for staffing VHCIP multi-stakeholder work groups to facilitate overall program decision-making.

In 2015, Vermont has maintained operation of commercial and Medicaid ACO Shared Savings Programs. The Medicaid ACO program currently boasts over 75,000 members attributed through two participating ACOs (OneCare Vermont and Community Health Accountable Care). There has also been a focus on planning for implementation of a Medicaid Episodes of Care program in 2016. During the next year, the Medicaid payment reform team will continue to support VHCIP activities, focusing on ongoing implementation and evaluation of the ACO SSPs, along with the launch of additional payment reform models to complement initiatives that are already underway.

The following units comprise this division:

- *Blueprint for Health*
- *Vermont Health Connect*

BLUEPRINT FOR HEALTH

The Vermont Blueprint for health is a state-led, nationally-recognized initiative transforming the way primary care and comprehensive health services are delivered and reimbursed. The foundation of this transformation is quality improvement inside healthcare organizations. Participating organizations are then incentivized to work together with other health and human services organizations to create and reinforce an integrated system of care. The result is whole-person care that's more evidence-based, patient and family centered, and cost effective.

The Blueprint model includes coaching and support for primary care practices becoming patient centered medical homes (PCMHs), locally directed community health teams (CHTs) that provide multi-disciplinary support services for PCMH patients, and health information technology (HIT) infrastructure including a statewide clinical registry that enables comparative reporting to inform continuous improvement activities.

Patient Centered Medical Homes (PCMH)

Vermont's primary care practices are supported by Blueprint in the process of achieving and maintaining recognition at Patient Centered Medical Homes (PCMHs) under the National Committee for Quality Assurance (NCQA) standards.

Community Health Teams (CHT)

Local community partners plan and develop CHTs that provide multidisciplinary support for PCMHs and their patients. CHT members are functionally integrated with the practices in proportion to the number of patients served by each practice. 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. In addition to core CHT services, CHT extenders provide targeted services including Support and Services at Home (SASH) for at-risk Medicare members, the Vermont Chronic Care Initiative (VCCI) for high utilizing Medicaid beneficiaries, and the Care Alliance for Opioid Addiction for patients receiving medication assisted therapy for opioid addiction. Extender-type activities build upon, and take advantage of, the existing CHT infrastructure locally and have been substantially implemented in the last year.

Payment Reforms

Underlying the Blueprint model is financial reform. Vermont Medicaid, Medicare, and all major commercial insurers in Vermont are participating in financial reform that includes three major components:

1) Primary care practices receive a per person per month (PPPM) payment based on the quality of care they provide. To receive the payment, a practice must be recognized as a Patient Centered Medical Home (PCMH) and (beginning January 2016) must also participate in their area's Community Collaborative.

2) Funding for CHT staff is provided in proportion to participating practices' patient numbers.

3) A new performance payment, the details of which are being finalized, will begin in January 2016. The basis of the proposed payments is community level outcomes on Accountable Care Organization (ACO) quality measures, outcomes that will be translated into scores and then payment amounts due to each practice.

Health Information Technology

The Blueprint Health Information Technology Team is responsible for Vermont's Health Information Technology (HIT) and Health Information Exchange (HIE) policy, planning and oversight. Activities include writing and implementing the state HIT Plan and the state Medicaid HIT Plan, implementing the Medicaid Electronic Health Record Provider Incentive program (EHRIP), overseeing expenditures from 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. The team also works with the State Public Health HIT Coordinator at Vermont Department of Health (VDH) for integration of the public health infrastructure with HIT/HIE. In close collaboration with the AHS CIO, the team helps to enable implementation of the Health Services Enterprise (HSE) that consists of Service Oriented Architecture (SOA) and its integration with HIT/HIE, Integrated Eligibility system, Medicaid Management Information System (MMIS) and Vermont Health Connect (VHC).

Community Health System Collaboratives

The foundation of improvement in PCMHs and CHTs is supported statewide data systems and comparative evaluation. Data and analytic sources include: a web-based registry, CAHPS-PCMH survey of the patient experience, a network analysis of the culture change in the Blueprint HSAs, and Vermont's multi-payer claims database (VHCURES). Combined data analytics from these sources demonstrate current healthcare utilization, cost, and quality trends in Vermont and populate the Blueprint financial impact (Return on Investment) model. Regular reports, in the Practice, Health Service Area (HSA), and Organization Profiles are being used by local

communities to organize and grow multi-stakeholder workgroups – Community Collaboratives – to guide medical home expansion, coordination of community health team operations, implementation of new service models and service improvements, and setting performance goals.

VERMONT HEALTH CONNECT (VHC)

Vermont Health Connect (VHC) is Vermont's health insurance marketplace, created as a result of the federal Affordable Care Act and Vermont Act 48. VHC integrates Medicaid and private health insurance eligibility, enrollment, and case management.

VHC coordinates a range of quality health plans available to individuals, families, and small businesses and, for many individuals and families, access to financial help to pay for coverage. Every plan offered through Vermont Health Connect must offer basic services that include checkups, emergency care, mental health services and prescriptions. VHC serves as a place for Vermonters to determine whether they qualify for Medicaid for Children and Adults (MCA) or private health insurance with financial help, such as federal Advanced Premium Tax Credits (APTCs), Vermont premium assistance (VPA), and state and federal cost-sharing reductions (CSR). Vermonters can find information they need online, and those who are uncomfortable with the internet or who want personal assistance selecting a health plan can call the toll-free Customer Support Center or contact a local Assister for in-person assistance.

VHC launched in October 2013. As was the case with the federal marketplace and marketplaces in other states across the country, the rollout followed a tight timeline that was marked by technological challenges, performance issues, and significant operational backlogs. Despite these challenges, VHC was successful in connecting Vermonters to quality health coverage. By the end of 2014, the state's uninsured rate was just over half what it was two years earlier. Vermont now has the second lowest uninsured rate in the nation.

VHC changed contractors in October 2014 and made steady progress throughout 2015 in delivering core functionality, clearing operational backlogs, and improving the customer service experience.

VHC delivers customer service through an outsourced Level 1 call center, and a Level 2 call center run by a matrixed Health Eligibility and Enrollment team consisting of staff from both DVHA and the Department for Children and Families' Economic Services Division (DCF-ESD) that address escalated issues. The Level 1 call center provides a range of services for customers including: answering questions related to healthcare coverage, taking insurance applications over the phone, accepting credit card payments, handling password resets, and processing changes of circumstance and other special handling requests. The Level 2 call center addresses escalated issues, including eligibility issues, change of circumstance, appeals, paper applications, escalated billing and premium issues, access to care needs, and more.

VHC also supports outreach and education efforts and an Assister Program for professionals who assist Vermonters with health insurance literacy and enrollment in communities across the state. “Assisters” is an umbrella term encompassing trained and certified Navigators, Certified Application Counselors, and Brokers. Navigators are supported by DVHA-funded grants and ensure that free, in-person help is available in every county in the state. Certified Application Counselors are funded by host organizations, such as hospitals and health centers that share VHC’s goal of connecting Vermonters to health insurance. Brokers are funded by customers and often have a long-running history of assisting these customers with a wide range of benefits and services. All Assisters receive training and support.

The Affordable Care Act charged health insurance marketplaces with offering coverage to small businesses as well as to individuals. For 2014 through 2016 coverage years, with the permission of VHC’s federal partners at CMS, Vermont’s small businesses enrolled in VHC’s qualified health plans directly through Blue Cross Blue Shield of Vermont and MVP Healthcare. In 2016, VHC will pursue a solution to facilitate 2017 small business enrollment through the marketplace.

VHC continues to be developed as an integral part of the State’s overall Health and Human Services Enterprise (HSE) program, an integrated system of policies, processes, and information systems that form the foundation of Vermont’s strategic healthcare vision. In addition to delivering ACA-mandated capabilities, VHC provides a set of reusable platform components and common services that will form the basis for related solutions in the areas of Integrated Eligibility (IE) and Medicaid Management Information System (MMIS).

VHC’s developments also aim to help the marketplace achieve its goal of a smooth customer experience, while continuing to help Vermont lead the nation in connecting its citizens to the health and peace of mind that comes from having quality insurance coverage.

STATUS OF SFY '16 INITIATIVES

Addressing the Cost Shift

Medicaid reimbursement rates are the lowest among payers for the majority of medical services. This disparity results in providers and facilities shifting costs to private insurance for businesses and individuals who pay more on average in order to sustain the health system, acting as a hidden tax. This is known as the cost shift. The Green Mountain Care Board estimates the cost shift results in $150 million in private premium inflation every single year. Lower Medicaid reimbursement rates also mean that the State is not using significant dollars in matching federal funds available to the Medicaid program.

While the Governor had a bold proposal to address the cost shift by implementing focused rate increases including Outpatient Services, Primary Care, Professional Services, Blueprint Home Health Expansion and a specific increase for Dartmouth Hitchcock, the legislature ultimately passed the following appropriations:

Primary Care services: $1,000,676 was appropriated for the purpose of increasing reimbursement rates beginning July 1, 2015. DVHA utilized this appropriation to reinstate a fraction of the Enhanced Primary Care Payments program, which provides increased payments to primary care providers who fall within the criteria set forth by CMS.

Independent Mental Health and Substance Abuse Treatment Professionals: $111,185 was appropriated for the purpose of increasing reimbursement rates beginning July 1, 2015 to mental health and substance abuse professionals not affiliated with a designated agency. DVHA utilized this appropriation to increase reimbursement for services provided by PhD Psychologists. Given the limited amount of the appropriation, the total amount was targeted to a single provider type in order to maximize the impact of the appropriation.

Home and Community Based Services: $175,818 was appropriated for the purpose of increasing home and community-based services in the Global Commitment and Choices for Care programs beginning July 1, 2015. Of that total, approximately $35,900 was applied to Global Commitment and $139,900 to the Choices for Care program. DVHA utilized the Global Commitment appropriation to increase the reimbursement rate for Long Term Residential services without room and board.

DVHA implemented the changes as directed by the legislature; though due to the total funding appropriated, the changes were not substantive enough to begin to address the cost shift.

Autism Spectrum Disorder - Applied Behavior Analysis (ABA): In SFY2016 DVHA developed a comprehensive Medicaid Applied Behavior Analysis (ABA) benefit for children with Autism spectrum disorders (ASD). The Clinical unit has oversight for the clinical practice and prior authorization, working closely with the Central Office Policy unit. DVHA submitted a State Plan Amendment to CMS to allow Medicaid to receive federal financial participation for the reimbursement of ABA providers. DVHA has finalized the interim clinical guidance that was disseminated to the DAs in SFY2015. As recommended by DVHA's Managed Care Medical Committee (MCMC), an ABA Clinical Practice Guideline was developed and the draft guideline was distributed to internal partners for review. Currently, the draft has progressed to being reviewed by external providers. The MCMC plans to review provider feedback on the draft guidelines and then have a finalized draft of the guidelines to recommend to DVHA leadership in early 2016.

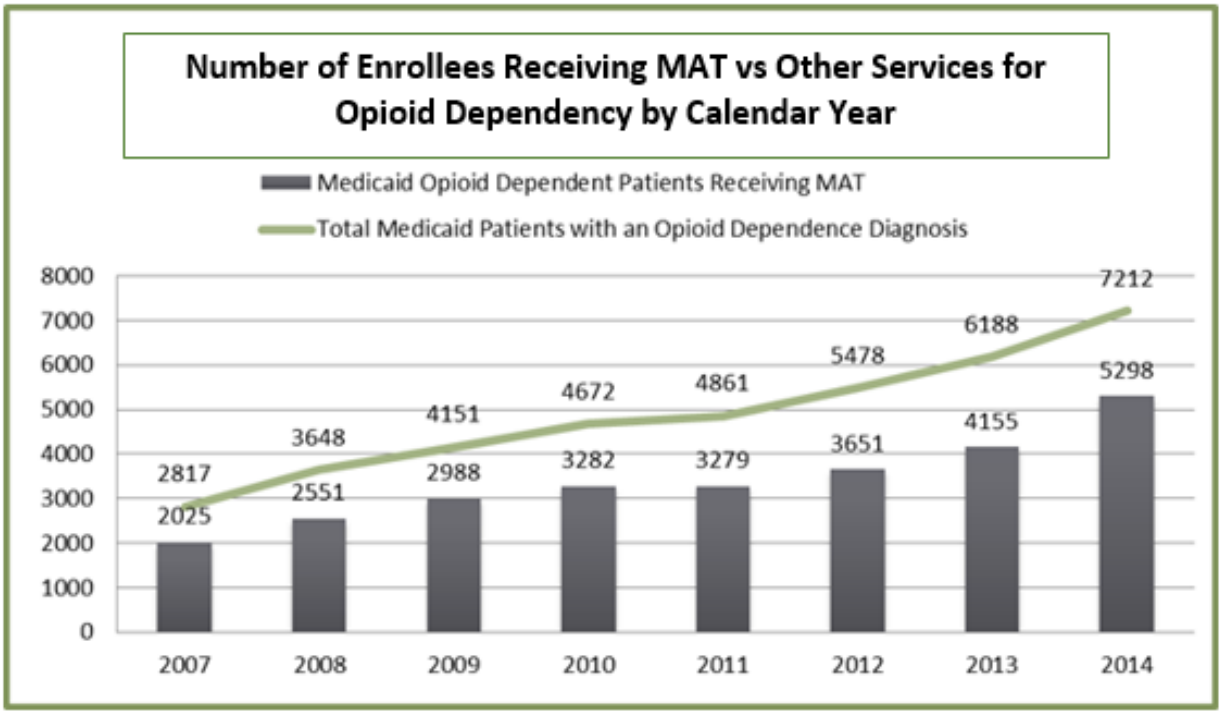
Opioid Treatment

Act 137 was enacted with the intention of establishing a regional system of opioid treatment in Vermont. Three partnering entities – DVHA's Health Services and Managed Care Division; the Blueprint for Health Unit; and the Vermont Department of Health Division of Alcohol and Drug Abuse Programs – in collaboration with local health, addictions, and mental health providers – implemented a statewide treatment program in 2013. Grounded in the principles of Medication Assisted Treatment (MAT), the Blueprint's healthcare reform framework, and the Health Home concept in the Affordable Care Act, the partners have created the Care Alliance for Opioid Addiction initiative, also known as "Hub and Spoke." The addition of the Rutland Hub in 2014 has been a great success and has operationally excelled. In addition, it enhances Methadone treatment programs (Hubs) by augmenting the programming to include Health Home Services to link with the primary care and community services; provide buprenorphine for clinically complex patients; provide consultation support to primary care and specialists prescribing buprenorphine; and embed new clinical staff in the form of a nurse and a Master's prepared, licensed clinician, in physician practices that prescribe buprenorphine (Spokes) through the Blueprint Community Health Teams (CHTs) to provide Health Home services, including clinical and care coordination supports to individuals receiving buprenorphine. Spoke staff (nurses and licensed counselors) have been recruited and deployed statewide to all willing physician practices that prescribe buprenorphine. To date, nearly 40 full time nurses and addictions counselors have been hired and deployed to over sixty different practices. Additionally, DVHA expanded practice coverage to neighboring states with three (3) locations enrolled in the Summer/Fall of 2015. Through collaboration with ADAP and the Federally Qualified Healthcare Centers (FQHC), providers have increased their panels to accept patients needing Opioid Replacement Therapy. In November 2015 United Counseling Services in Bennington Country, in collaboration with Hawthorne Recovery made available additional MAT services which

included observed dosing. The number of patients served in the first year will be up to 30 with expansion opportunities expected after the first year.

In collaboration with ADAP, DVHA has worked with Rutland, Chittenden and Saint Albans areas to expand the use of a new medication that has shown promise in the treatment of alcoholism and some opioid dependent population. Vivitrol Intramuscular Injection is a new delivery method for Naltrexone. Vivitrol is a valuable addition to the recovery toolbox, along with methadone and buprenorphine. It blocks other opioids from acting on the receptors in the brain and can also help ease drug cravings. By blocking the effects of other opioids it takes away the pleasurable effect, which can help with preventing relapse. Vivitrol, like any other medication for opioid dependence, must be accompanied by a firm commitment to recovery, including substance abuse counseling, outpatient programs and support systems. Vermont Medicaid has added this treatment option for certain patients with an Opioid Addiction. Over the course of this next year, ADAP and DVHA will continue to monitor the use and effects of this medication.

As the chart below demonstrates, approximately 73% of Medicaid requests with an Opioid dependency diagnosis receive MAT (Hub and Spoke).



MEASUREMENTS AND OUTCOMES

DVHA programs and staff strive toward excellence and value in serving Vermonters effectively. Asking the questions – *how much did we do, how well did we do it, is anyone better off* – DVHA works toward the most powerful results possible. The following pages highlight some of these initiatives and units. Each provides the program statement, annual outcomes with data, and plans to ensure continued success.

- *Blueprint for Health*
- *Coordination of Benefits*
- *Program Integrity*
- *Vermont Chronic Care Initiative*
- *Quality Reporting*
- *Mental Health and Substance Abuse*

BLUEPRINT FOR HEALTH REPORT CARD

Program Statement:

The Vermont Blueprint for Health is transforming the way primary care and comprehensive health services are delivered and paid for, with a model that consists of:

- A steady increase of primary care practices throughout the state that are recognized as Patient Centered Medical Homes (PCMHs) by the National Committee for Quality Assurance (NCQA) currently totaling 126 practices and comprehensive evidence-based self-management programs
- Multi-disciplinary core Community Health Teams (CHTs) in each of the state's 14 health service areas; plus additional specialized care coordinators to support the PCMHs and their patients
- All-insurer payment reforms that support PCMHs and community health teams
- Implementation of health information technology (HIT) and a multi-faceted evaluation system to determine the program's impact
- A Learning Health System that supports continuous quality improvement

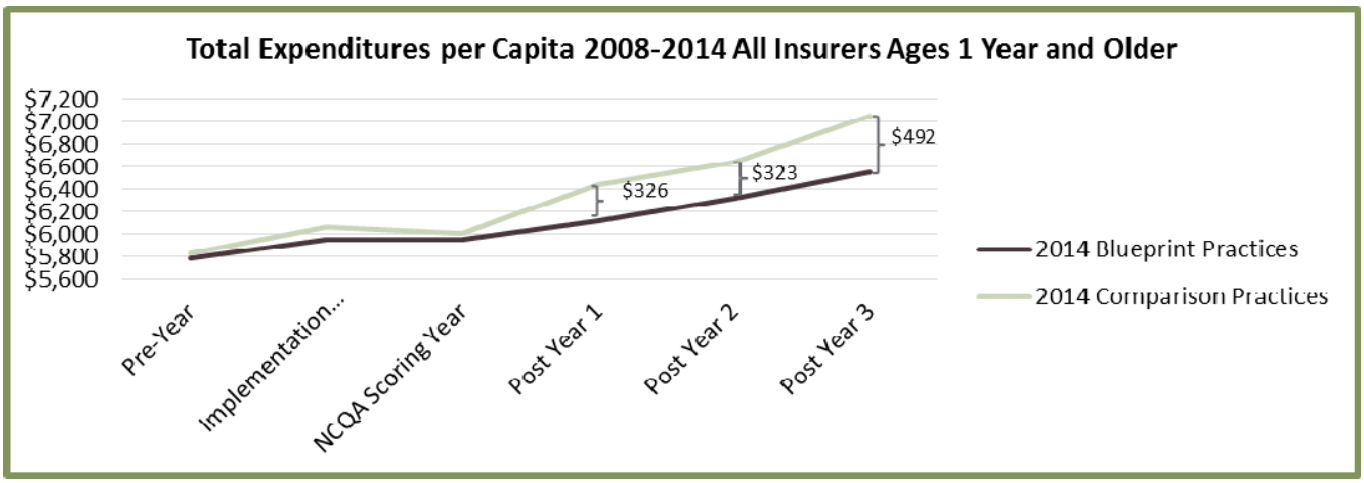
Outcomes:

The Blueprint for Health's intensive program evaluation includes results recently published in the peer-reviewed journal *Population Health Management*. The article "Vermont's Community-Oriented All-Payer Medical Home Model Reduces Expenditures and Utilization While Delivering High-Quality Care" demonstrates that patients participating in the Blueprint, by receiving care at one of Vermont's PCMHs, incur less healthcare spending than non-participants.

- As the Blueprint program matures, healthcare expenditures for patients receiving the majority of their care at a Blueprint PCMHs cost $482 less per year than expenditures for patients receiving care in non-PCMHs, primarily because of fewer in-and-outpatient hospital visits.
- At the same time that their healthcare expenditures decreased, Medicaid patients receiving the majority of their care at a Blueprint PCMH saw a corresponding increase in expenditures for dental, social, and community-based support services, suggesting that PCMHs – likely through their Community Health Teams – are better at connecting patients with non-medical community and social supports.

What's Next?

- The Community Collaboratives, in which Blueprint and ACO workgroups come together with homecare, mental health, and other service providers to deliver shared governance targeted at improving healthcare utilization, quality, and coordination of care.
- Continued advancement of analytics and reporting in collaboration with ACOs and other provider groups to provide comparative information that can guide continued improvement in Vermont's community oriented learning health system. A key component is the Blueprint Registry (formerly Docsite), where statewide claims and clinical databases are combined and used to produce profiles that span insurers and health systems, offering community-level outcomes reporting in order to spur community-based solutions.
- Implementation of performance payments to Blueprint PCMHs. These new payments will be based on community level outcomes on ACO quality measures and regularly adjusted to incentivize communities to work together to improve utilization and care quality.



COORDINATION OF BENEFITS (COB) REPORT CARD

Program Statement:

The Coordination of Benefits (COB) Unit works with providers, beneficiaries, probate courts, attorneys, health and liability insurance companies, employers, and Medicare Parts A, B, C & D plans to ensure that Medicaid is the payer of last resort, through coordination of benefits and collections practices.

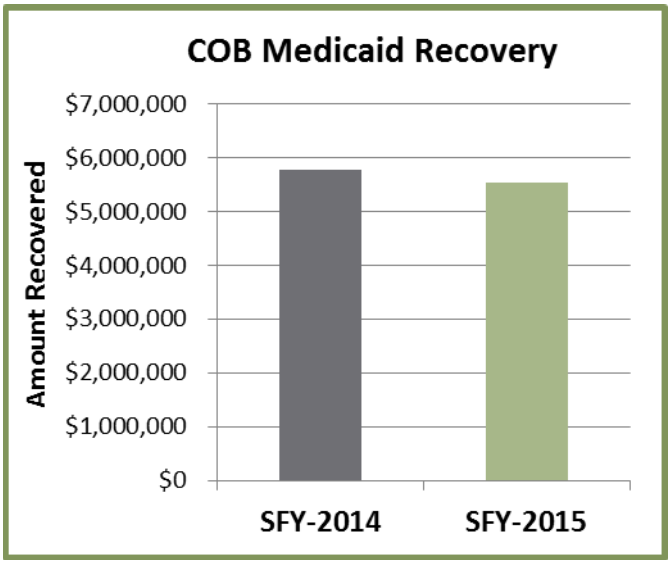
Outcomes:

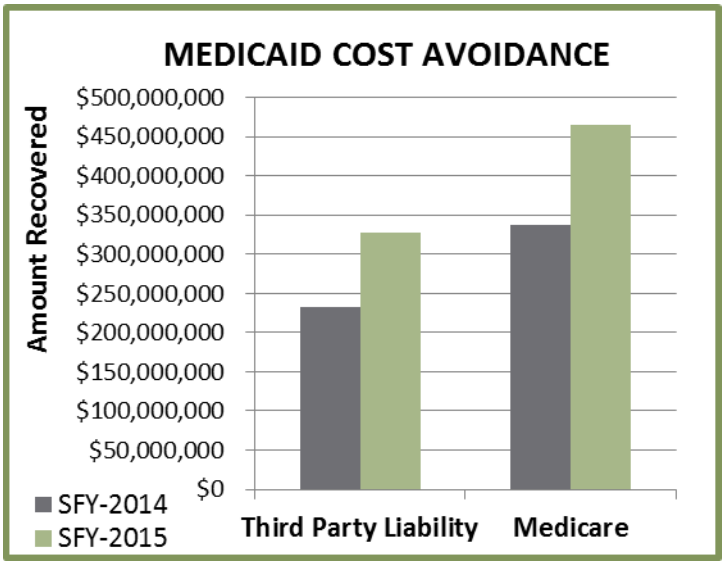
COB Medicaid Recovery totaled $5,546,150 in SFY2015, the result of various recovery and recoupment practices.

Correct information from beneficiaries and data matching efforts with insurance companies ensures that accurate insurance billing information is identified and recorded in Medicaid systems. This decreases Medicaid costs, since the correct insurer pays, leaving Medicaid as payer of last resort identified as Medicaid Cost Avoidance. The Medicaid Third Party Liability cost avoidance increased in the past year, in part due to increased focus on maintaining an updated eligibility system with other health information for Medicaid recipients.

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 beneficiaries.
- These efforts will help increase cost avoidance and recoveries to ensure that Medicaid is the payer of last resort.





PROGRAM INTEGRITY (PI) REPORT CARD

Program Statement:

The Program Integrity Unit works with providers, beneficiaries, DVHA's fiscal agents, DVHA units, AHS departments and the CMS Medicaid Integrity Contractors (MIC) to ensure the integrity of services provided and that medically necessary healthcare services for beneficiaries are provided, coded, billed and paid in accordance with federal and state Medicaid rules, regulations, provider contracts and relevant statutes.

Outcomes:

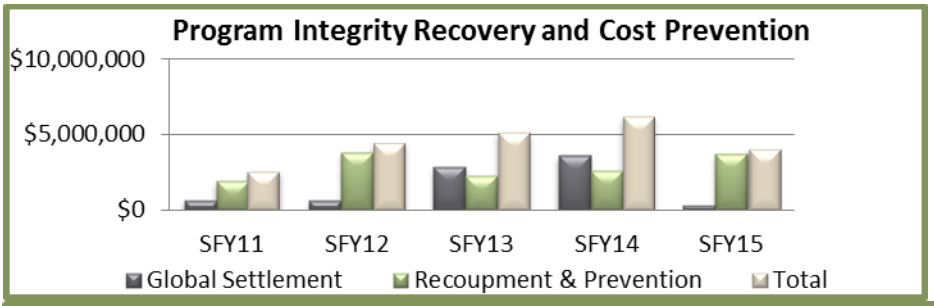
The PI Unit has made significant strides in detecting, investigating, and preventing fraud, waste and abuse in the Vermont Medicaid program. Program Integrity auditing and investigating is a very specialized field and as such, CMS and the Department of Justice, through the Medicaid Integrity Institute (MII) supported the creation of the Certified Program Integrity Professional (CPIP) designation. This designation is recognized by the National Healthcare Anti-Fraud Association, the Association of Certified Fraud Examiners, and the American Academy of Professional Coders. To date, half of the VT Program Integrity staff members have achieved this certification.

The PI Unit works closely with the Medicaid Fraud and Residential Abuse Unit (MFRAU) and participates in many training opportunities to educate staff, providers, and beneficiaries about healthcare fraud, waste and abuse. PI also works very closely with other Medicaid States' Program Integrity Units and OIG offices across the country on a regular basis.

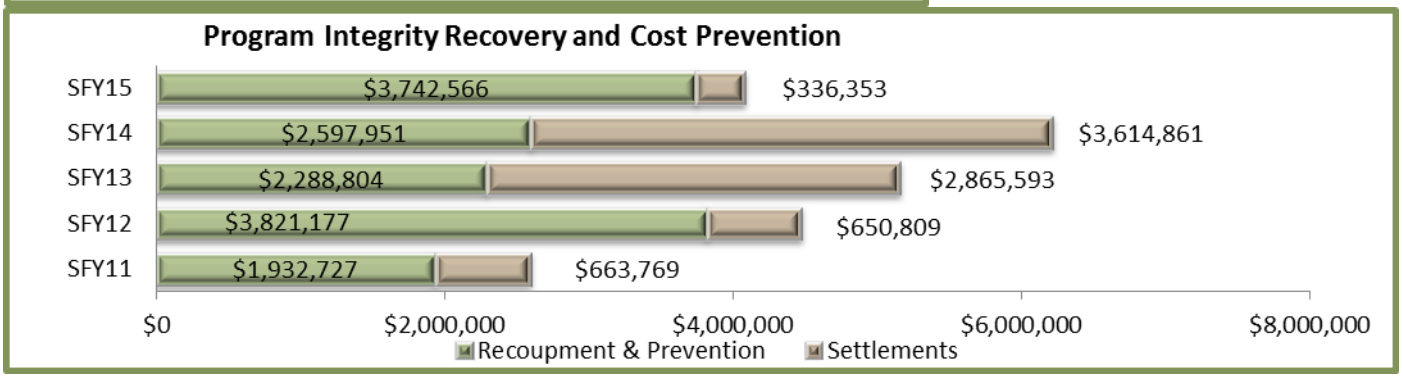
The total recovery and savings to the State of Vermont in SFY2014 was $4.08 million. In the last five years, the Program Integrity Unit has reported combined Medicaid program savings and recoveries in excess of $22.5 million (including settlements).

What's Next?

- New collaboration with CMS "Boots on the Ground" to enhance and improve the quality of patient care, health outcomes, and reducing healthcare costs.
- Proactive desk audits of high risk and high cost program areas to evaluate for the correct and appropriate billing of medically necessary services provided to VT beneficiaries.
- Evaluation of known vulnerabilities, deficiencies and outliers to ensure compliance and adherence to policies.
- Creation of new algorithms and data analytics to enhance fraud, waste and abuse detection and prevention.
- Continued education and training of PI staff, MFRAU staff, other state staff, providers, and beneficiaries to increase awareness of fraud, waste and abuse schemes for earlier detection and reporting.



A global settlement settles all the claims against one defendant in a single settlement rather than individual ones. May involve medical or product liability within Vermont or nationally.



VERMONT CHRONIC CARE INITIATIVES (VCCI) REPORT CARD

Program Statement:

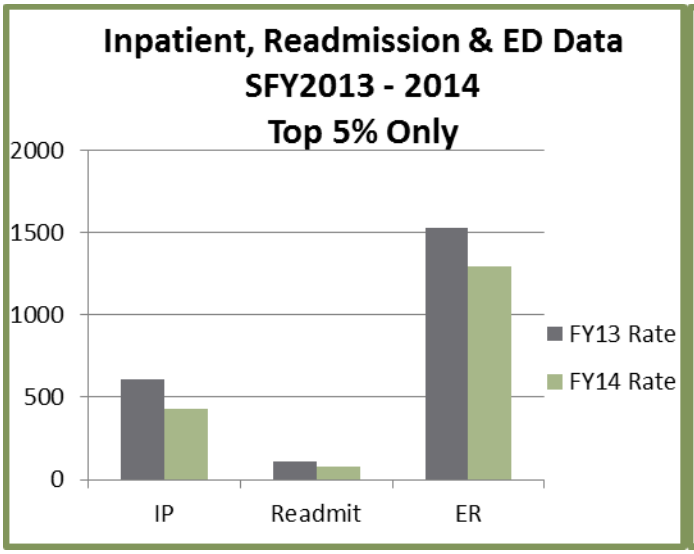
Vermont Chronic Care Initiative (VCCI) case managers - registered nurses and licensed alcohol and drug abuse counselors provide intensive case management and care coordination services to high risk, high utilization, and high cost Medicaid beneficiaries (top 5%) through a holistic approach that addresses complex physical and behavioral health needs, health literacy, and socioeconomic barriers to healthcare and health improvement. VCCI collaborates with statewide healthcare reform partners centrally and locally to assure seamless integration of intensive field-based case management services to achieve common goals.

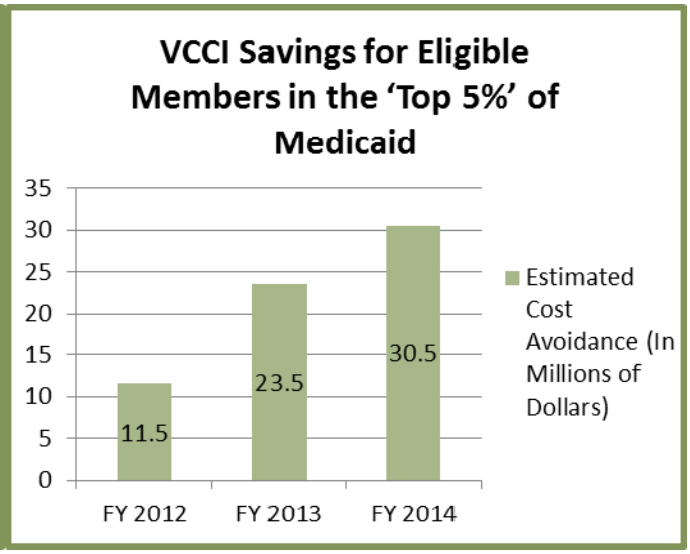
Outcomes:

In SFY2014 VCCI documented $30.5 million in net savings among the eligible top 5% utilizers, who account for roughly 39% of Medicaid expenditures. When evaluating VCCI, DVHA tracks adherence to evidence-based clinical guidelines as well as ambulatory care sensitive hospital utilization; and in 2014, measured return on investment (ROI) via a risk-based contract. In SFY2014 (the most recent year for which final results are available due to a 6 month claims run out period and the sun-setting of the current vendor contract), VCCI demonstrated significant improvement on important clinical measures, such as treatment of depression, which was an area of focus due to prevalence among high risk/cost members. VCCI also focused on utilization measures with documented reductions in all areas, including for ambulatory care sensitive (ACS) inpatient hospital admissions (- 30%) readmissions (- 31%) and emergency department use (-15%) as compared to 2013 data. Staff are embedded in multiple high-volume hospital and primary care practice sites to support care transitions as well as direct referrals for high risk/cost members. As indicated, the MOMS service was also launched statewide in 2015 and the VCCI nutrition/obesity specialist supported BMI as a vital sign and related tools to address member engagement and health literacy on BMI.

What's Next?

- VCCI will continue to be an integral component of healthcare reform efforts given the initiative's focus on holistic case management and the required expertise in human services necessary for successful case management and care coordination of a high complexity population, including those with significant social support needs and associated cost. reduction/containment efforts.
- The Unit has taken a leadership role in the enterprise level MMIS/Care Management system design and development and is scheduled as the first program to 'go live' in the new system, with an anticipated launch date of mid SFY 2016.
- VCCI has developed strong relationships with contracted Medicaid ACO partners and clinical leaders, including data sharing to prevent redundancies and to support collaboration and direct referral, as well as care transitions.
- The VCCI will continue strategic efforts to leverage limited resources toward common goals. Inherent in this, VCCI is active with the VHCIP 'learning collaborative.'





VERMONT CHRONIC CARE INITIATIVES (VCCI) SCORECARD

Below is an overview of the VCCI Scorecard, as required of this Budget Document. See the full contents of the VCCI Scorecard in Appendix B.

P DVHA Medicaid's Vermont Chronic Care Initiative (VCCI)

What We Do

The 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. DVHA care coordinators are fully integrated core members of existing Community Health Teams and are co-located in provider practices and medical facilities in several communities. The population are the top 5% utilizers of the healthcare system, accounting for 39% of healthcare costs.

How We Impact

VCCI is focused on utilization measures with documented reductions in all areas, including for ambulatory care sensitive (ACS) inpatient hospital admissions, readmissions and emergency department use. Staff are embedded in multiple high-volume hospital and primary care practice sites to support care transitions as well as direct referrals for high risk/cost members. The VCCI continues to receive national recognition for its model and results including by CMS and the National Academy for State Health Policy (NASHP).

Budget Information

Total Program Budget FY 2017: $2,608,703.46

Action Plan

VCCI will continue to be an integral component of healthcare reform efforts given the initiative's focus on holistic case management and the required expertise in human services necessary for successful case management and care coordination of a high complexity population, including those with significant social needs. The Unit has taken a leadership role in the enterprise level MMIS/Care Management system procurement process, with an anticipated go live date of early SFY 2016. VCCI has developed collaborative relationships with contracted Medicaid ACO partners and will continue strategic efforts to leverage limited resources toward common goals. Inherent in this, VCCI is active on the payment reform Care Management and Care Models (CMCM) workgroup and has a leadership role in the care management learning collaborative planning and implementation to assure service integration.

Performance Measures	Time Period	Actual Value	Target Value	Current Trend	Baseline %Change
PM VCCI # of Medicaid Beneficiaries Enrolled in the Vermont Chronic Care Initiative	SFY 2015	1,657	2,000	↘ 2	-5% ↓
PM VCCI % of Eligible High Cost/High Risk Medicaid Beneficiaries Enrolled in the Vermont Chronic Care Initiative	SFY 2015	21%	25%	↘ 2	-7% ↓
PM VCCI 30 Day Hospital Readmission Rate Among VCCI-eligible Medicaid Beneficiaries (#/1000)	SFY 2014	49	–	↘ 3	-44% ↓
PM VCCI # of ER visits by Medicaid beneficiaries Eligible for VCCI	SFY 2014	1,299	–	↘ 1	-15% ↓
PM VCCI # of Inpatient Admissions by Medicaid beneficiaries Eligible for VCCI	SFY 2014	429	–	↘ 1	-30% ↓
PM VCCI Net Savings over Anticipated Expense (in millions of dollars) for VCCI Eligible Members	SFY 2014	$30.5	–	↗ 2	165% ↑

Our Work Helps Turn These Indicators	Time Period	Actual Value	Target Value	Current Trend	Baseline %Change
O VAHS Vantage Vermonters are healthy					

Quality Reporting Report Card

Program Statement:

The DVHA Quality Improvement (QI) and Clinical Integrity Unit strives to improve the quality of care to Medicaid members by identifying and monitoring quality measures and performance improvement projects, performing utilization management and improving internal processes. Performance measures are indicators or metrics that are used to gauge program performance. 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. Under the terms of the Global Commitment to Health Waiver, DVHA reports on fourteen (14) HEDIS measures. These measures represent a wide range of health conditions that DVHA and the Agency of Human Services have determined are important to Vermonters:

1. Adolescent Well-Care Visits
2. Adults' Access to Preventive/Ambulatory Health Services
3. Annual Dental Visits
4. Antidepressant Medication Management
5. Breast Cancer Screening
6. Children and Adolescent Access to Primary Care (four age categories: 12-24 months, 25 months - 6 years, 7-11 years, and 12-19 years)
7. Chlamydia Screening in Women
8. Controlling High Blood Pressure
9. Follow-Up After Hospitalization for Mental Illness
10. Initiation and Engagement in Alcohol and Other Substance Dependence Treatment
11. Prenatal and Postpartum Care
12. Use of Appropriate Medications for People with Asthma
13. Well-Child Visits First 15 Months
14. Well-Child Visits in 3rd, 4th, 5th and 6th Years

Outcomes:

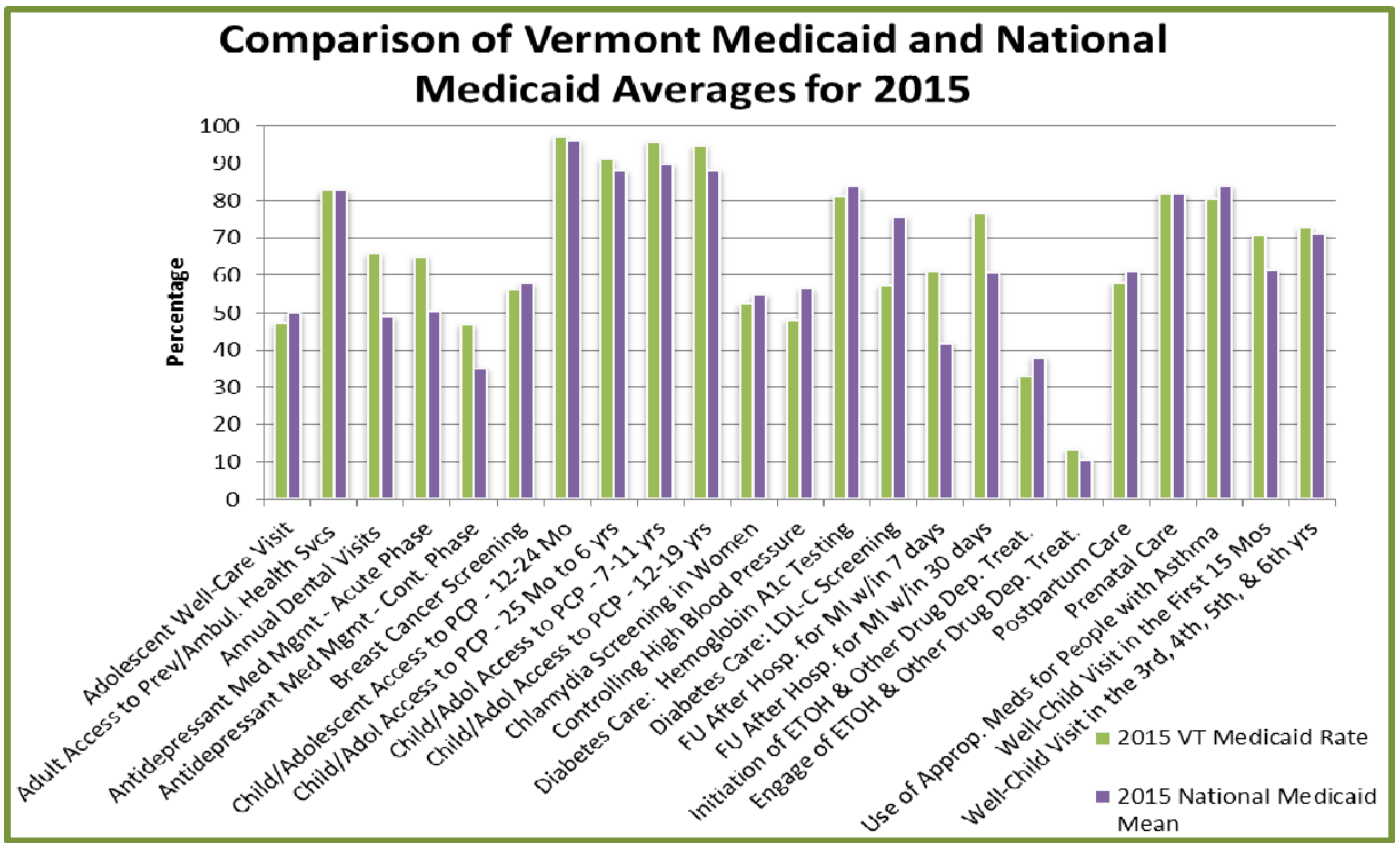
The QI Unit works closely with the Data Unit to ensure the internal capacity to produce valid performance measure results. DVHA then uses a vendor certified by the National Committee for Quality Assurance (NCQA) to calculate the measures annually.

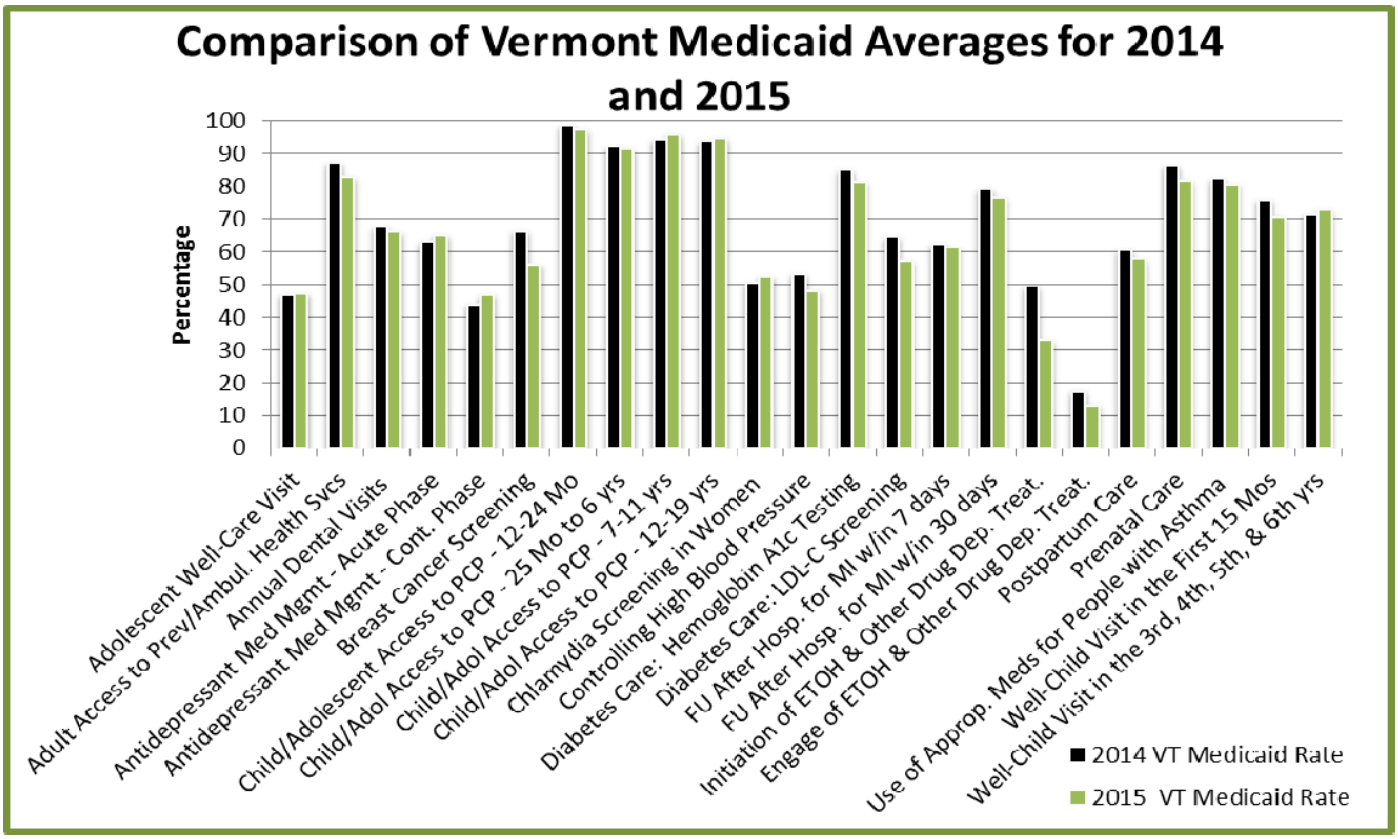
The first chart, (Comparison of Vermont Medicaid and National Medicaid Averages for 2015), compares Vermont Medicaid's performance on this core set of *Global Commitment to Health* measures against the national mean for other state Medicaid plans for 2015. It shows that Vermont's rates are higher than or comparable to the nation mean on most measures. This means, as an example: of Vermont Medicaid enrollees who are recommended to receive an Adolescent Well-Care visit, approximately 50% actually do, which is comparable to the national average. The *Initiation and Engagement in Alcohol and Other Substance Dependent Treatment* measure is one of the lowest performing measures in the set, both for Vermont and nationally. Based on this data along with Vermont's growing and well documented opioid addiction problem, DVHA is involved in multi-faceted improvement initiatives. The Hub and Spoke, is one such initiative. DVHA is also currently working on a performance improvement project related to the treatment of alcohol abuse.

The next chart (Comparison of Vermont Medicaid Rates for 2014 and 2015), shows Vermont Medicaid's performance on these measures in 2014 compared against performance in 2015. It displays steady performance across most of these measures. The most significant change in reported rates is seen again in the *Initiation of Alcohol and other Drug Dependence Treatment within 7 days*. Not only is this an indication of the continuing problem of addiction, but as a unit, we also continue to learn about our data collection efforts through claims and how other initiatives underway within the State may impact our overall HEDIS rates (e.g. bundled payments via the Hubs or early intervention services provided through grants that then do not generate a claim).

What's Next?

HEDIS is just one of a variety of healthcare quality measure sets being tested and reported out on nationally by health plans, including Vermont Medicaid. The QI Unit continues to develop the internal capacity to report on all measure sets as accurately as possible. Coordination and analysis of these measure sets also helps DVHA target efforts for improvement in the quality of care provided to Medicaid beneficiaries. Multiple performance improvement projects are underway within Vermont Medicaid at all times.


Comparison of Vermont Medicaid and National Medicaid Averages for 2015
Percentage
100
90
80
70
60
50
40
30
20
10
0
Adolescent Well-Care Visit
Adult Access to Prev/Ambul. Health Svcs
Annual Dental Visits
Antidepressant Med Mgmt - Acute Phase
Antidepressant Med Mgmt - Cont. Phase
Breast Cancer Screening
Child/Adolescent Access to PCP - 12-24 Mo
Child/Adol Access to PCP - 25 Mo to 6 yrs
Child/Adol Access to PCP - 7-11 yrs
Child/Adol Access to PCP - 12-19 yrs
Chlamydia Screening in Women
Controlling High Blood Pressure
Diabetes Care: Hemoglobin A1c Testing
Diabetes Care: LDL-C Screening
FU After Hosp. for MI w/in 7 days
FU After Hosp. for MI w/in 30 days
Initiation of ETOH & Other Drug Dep. Treat.
Engage of ETOH & Other Drug Dep. Treat.
Postpartum Care
Prenatal Care
Use of Approp. Meds for People with Asthma
Well-Child Visit in the First 15 Mos
Well-Child Visit in the 3rd, 4th, 5th, & 6th yrs
2015 VT Medicaid Rate
2015 National Medicaid Mean


Comparison of Vermont Medicaid Averages for 2014 and 2015
Percentage
100
90
80
70
60
50
40
30
20
10
0
Adolescent Well-Care Visit
Adult Access to Prev/Ambul. Health Svcs
Annual Dental Visits
Antidepressant Med Mgmt - Acute Phase
Antidepressant Med Mgmt - Cont. Phase
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Child/Adolescent Access to PCP - 12-24 Mo
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Child/Adol Access to PCP - 7-11 yrs
Child/Adol Access to PCP - 12-19 yrs
Chlamydia Screening in Women
Controlling High Blood Pressure
Diabetes Care: Hemoglobin A1c Testing
Diabetes Care: LDL-C Screening
FU After Hosp. for MI w/in 7 days
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Initiation of ETOH & Other Drug Dep. Treat.
Engage of ETOH & Other Drug Dep. Treat.
Postpartum Care
Prenatal Care
Use of Approp. Meds for People with Asthma
Well-Child Visit in the First 15 Mos
Well-Child Visit in the 3rd, 4th, 5th, & 6th yrs
2014 VT Medicaid Rate
2015 VT Medicaid Rate

MENTAL HEALTH AND SUBSTANCE ABUSE REPORT CARD

Program Statement:

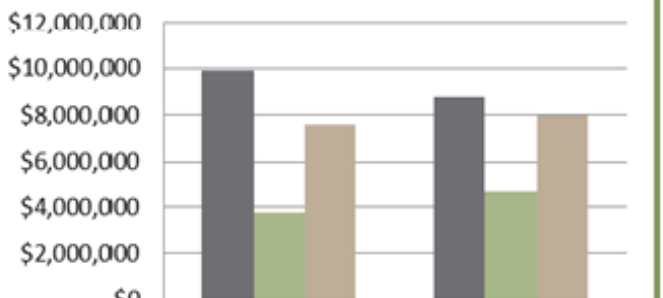
The Quality Improvement and Clinical Integrity unit (QI) is responsible for utilization management of one of Vermont Medicaid's most intensive and high-cost services, inpatient psychiatric hospitalization. Inpatient psychiatric services, which include detoxification, are paid on a per-day basis, unlike hospitalization on traditional medical inpatient units. This per-day payment methodology has the potential to create a disincentive for providers to make efficient use of this high cost, most restrictive level of care. The QI staff performs concurrent reviews to ensure that Vermont Medicaid pays only for medically necessary services and reviews claims data to verify that reimbursement is only provided for the authorized services and rates.

Outcomes:

The State has experienced a number of challenges that impact the ability of the QI utilization management program to successfully bend the cost curve for inpatient mental health and substance abuse costs, including the flooding of the Vermont State Psychiatric Hospital and subsequent move to a de-centralized mental health inpatient system, an increase in opiate addiction and resulting need for services which has led to inpatient level of care being used in place of medically necessary lower levels of care, and a slow economic recovery which strained both resources and already vulnerable beneficiaries. However, without the utilization management program, history has indicated that costs and average lengths of stay would have grown even more exponentially.

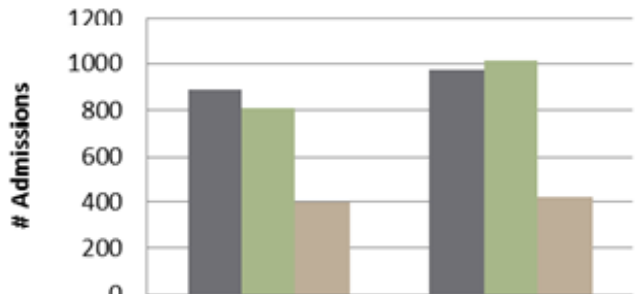
What's Next?

- The Quality unit will continue to perform utilization review activities on all inpatient stays on psychiatric floors to ensure Medicaid is only paying for medically necessary services.
- The Quality unit is working with HPE to improve the edits and PA process in the MMIS system to ensure that only inpatient services on psychiatric floors require PA and that claims are paid correctly and timely according to what was authorized.
- The Quality unit will assume responsibilities for prior authorization of individual therapy services in excess of 24 sessions annually.



SFY14-16 DVHA Total Paid Inpatient Psychiatric Hospitalizations

	SFY14	SFY15
Adult	$9,910,203	$8,741,419
Detox	$3,744,270	$4,636,608
Children	$7,559,073	$8,004,966



SFY14-16 DVHA Total # Inpatient Admissions

	SFY14	SFY15
Adult	886	971
Detox	811	1015
Children	395	420

MENTAL HEALTH AND SUBSTANCE ABUSE SCORECARD

Below is an overview of the Mental Health and Substance Abuse Scorecard, as required of this Budget Document. See the full contents of the Mental Health and Substance Abuse Scorecard in Appendix B.

DVHA Programmatic Performance Budget (FY17)

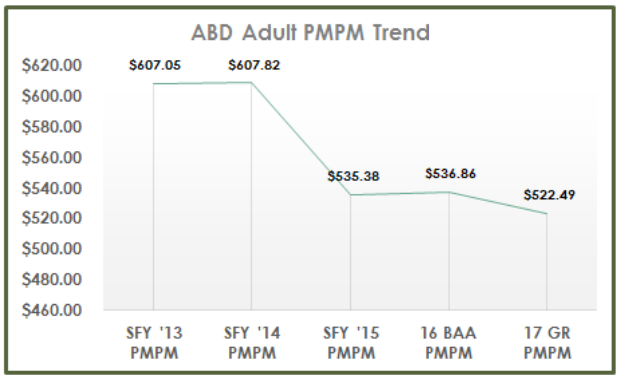
		Time Period	Actual Value	Forecast Value	Current Trend
O DVHA	Vermonters Receive Appropriate Care				
P DVHA	Medicaid Inpatient Psychiatric and Detoxification Utilization				
	Budget Information				
	Total Program Budget FY 2017: $960,728.86				
PM DVHA	# of Children's Mental Health Inpatient Admissions per 1000 Members	Jun 2015	0.53	–	↘ 1
PM DVHA	# of Adult Mental Health Inpatient Admissions per 1000 Members	Jun 2015	0.57	–	↘ 2
PM DVHA	# of Detoxification Admissions per 1000 Members	Jun 2015	0.84	–	↗ 1
PM DVHA	Average Length of Stay - Children's Mental Health Inpatient Admissions	Jun 2015	16.30	–	↗ 1
PM DVHA	Average Length of Stay - Adult Mental Health Inpatient Admissions	Jun 2015	5.90	–	↘ 2
PM DVHA	Average Length of Stay - Detox. Admissions	Jun 2015	4.80	–	↗ 1
PM DVHA	Paid Claims - Children's Mental Health Inpatient Admissions	Jun 2015	698,247	–	↘ 4
PM DVHA	Paid Claims - Adult Mental Health Inpatient Admissions	Jun 2015	602,255	–	↘ 2
PM DVHA	Paid Claims - Detox. Admissions	Jun 2015	521,263	–	↗ 1
P DVHA	Medicaid's Vermont Chronic Care Initiative (VCCI)				
	Budget Information				
	Total Program Budget FY 2017: $2,608,703.46				
PM VCCI	# of Medicaid Beneficiaries Enrolled in the Vermont Chronic Care Initiative	SFY 2015	1,657	–	↘ 2
PM VCCI	% of Eligible High Cost/High Risk Medicaid Beneficiaries Enrolled in the Vermont Chronic Care Initiative	SFY 2015	21%	–	↘ 2
PM VCCI	30 Day Hospital Readmission Rate Among VCCI-eligible Medicaid Beneficiaries (#/1000)	SFY 2014	49	–	↘ 3
PM VCCI	# of ER visits by Medicaid beneficiaries Eligible for VCCI	SFY 2014	1,299	–	↘ 1
PM VCCI	# of Inpatient Admissions by Medicaid beneficiaries Eligible for VCCI	SFY 2014	429	–	↘ 1
PM VCCI	Net Savings over Anticipated Expense (in millions of dollars) for VCCI Eligible Members	SFY 2014	$30.5	–	↗ 2

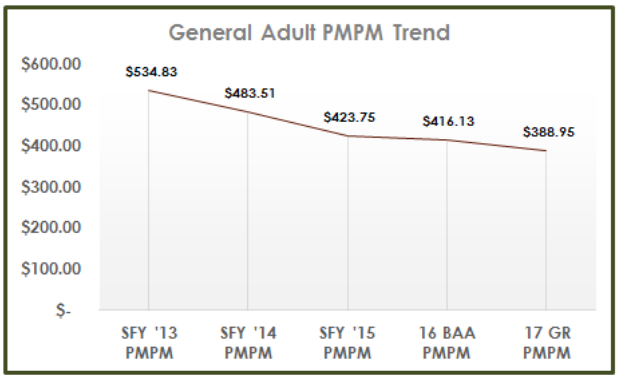
GreenMountainCare
A HEALTHIER STATE OF LIVING

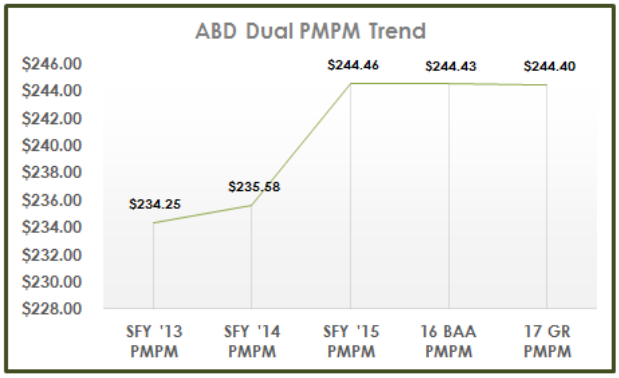
Green Mountain Care is the umbrella name for the state-sponsored family of low-cost and free health coverage programs for uninsured Vermonters. Offered by the State of Vermont and its partners, **Green Mountain Care** programs offer access to quality, comprehensive healthcare coverage at a reasonable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

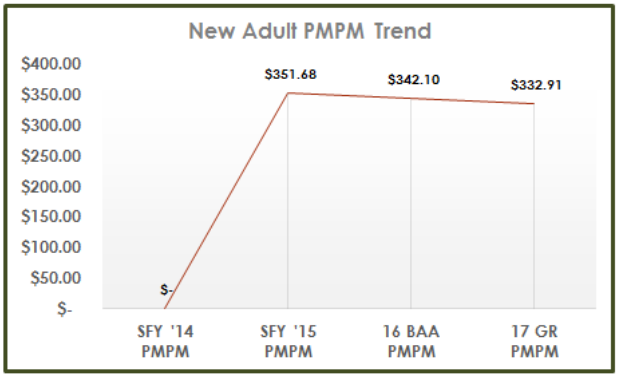
Medicaid for Adults

The below section distinguishes each population group and compares DVHA PMPMs for each year since SFY 2013.



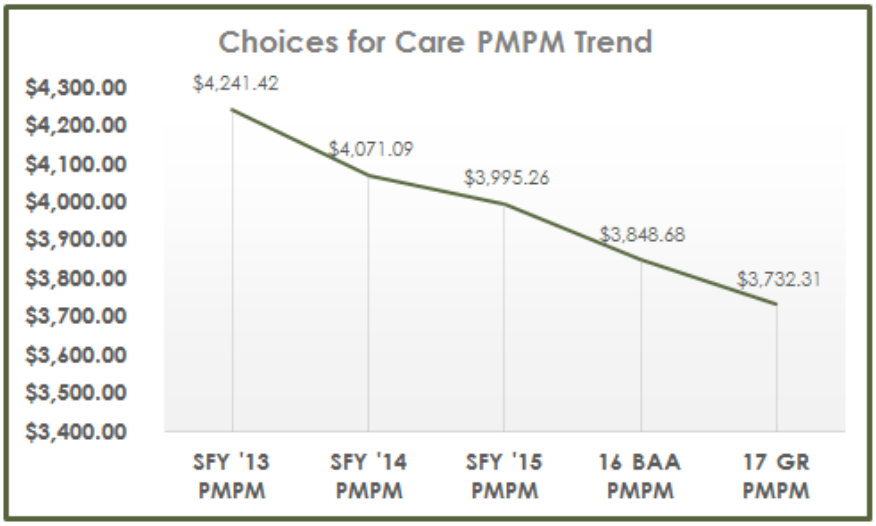






Medicaid for Adults Continued

The below chart depicts the CFC DVHA PMPMs for each year since SFY 2013.



As noted in the Vermont Medicaid in Comparison section of this budget document, the trend of lower PMPMs is quite evident in nearly all of the population groups on the previous page. This would indicate that efficiencies and improvements are being made so that Vermont Medicaid programs may serve more Vermonters, at the least possible cost. Medicaid programs for adults provide low-cost or free coverage for low-income parents, childless adults, pregnant individuals, caretaker relatives, people who are blind or disabled, and those ages 65 or older. Eligibility is based on various factors including income, and, in certain cases, resources (e.g., cash, bank accounts, etc.).

Medicaid programs cover most physical and mental healthcare services such as doctor's 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.

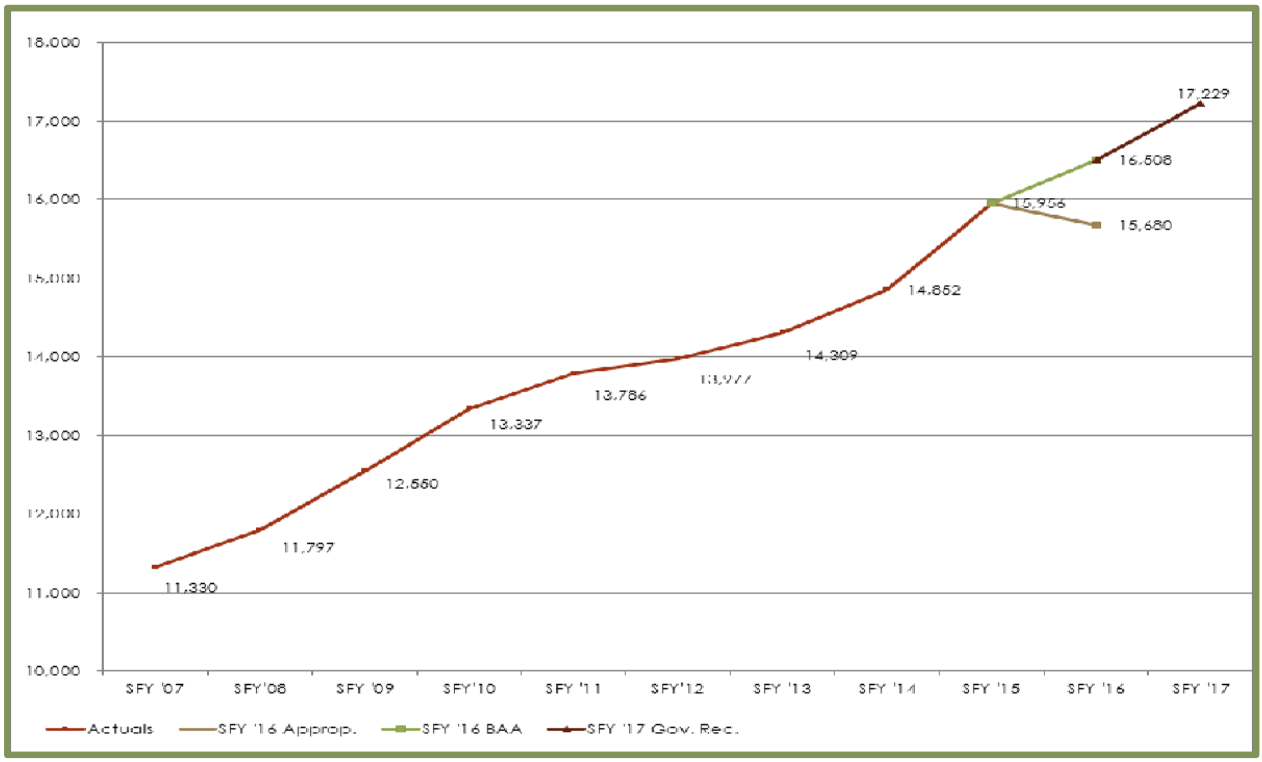
Aged, Blind, or Disabled (ABD) and/or Medically Needy Adults

The general eligibility requirements for the ABD and/or Medically Needy Adults are: age 19 and older; determined 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.

ABD Caseload, Expenditure, and PMPM Comparison by State Fiscal Year

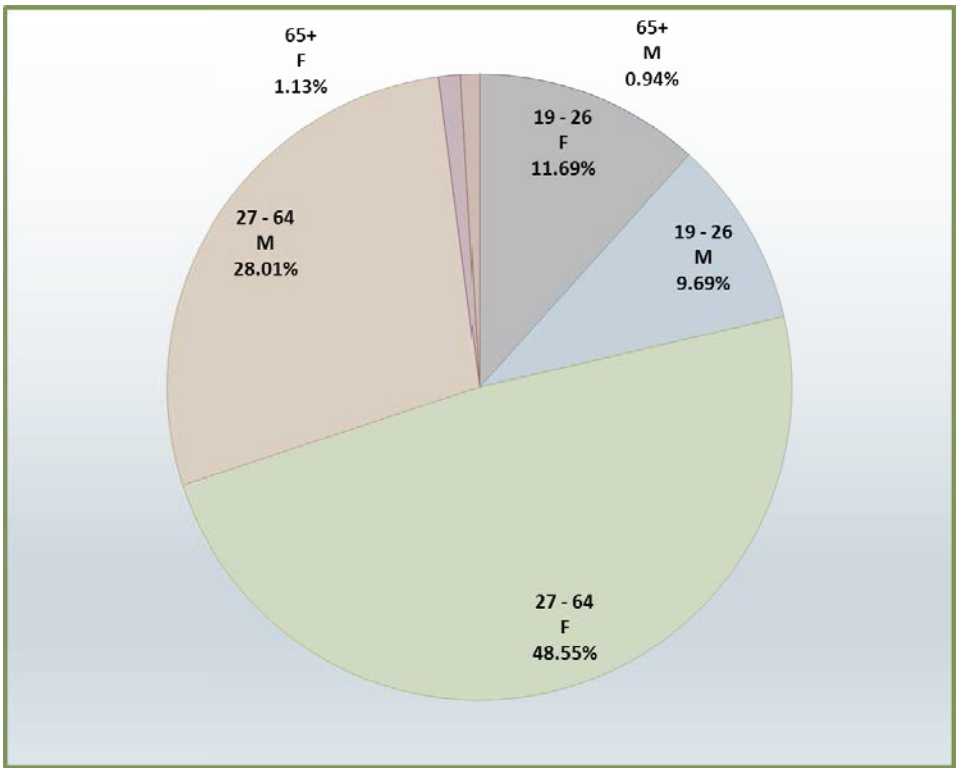
Aged, Blind, & Disabled (ABD) and/or Medically Needy Adults					
		DVHA Only		Total	
SFY	Caseload	Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '14 Actual	14,852	$108,329,783	$ 607.82	$ 188,835,438	$ 1,059.52
SFY '15 Actual	15,956	$102,508,327	$ 535.38	$ 185,718,082	$ 969.96
SFY '16 Appropriated	15,680	$113,165,353	$ 601.43	$ 191,779,487	$ 1,019.23
SFY '16 Budget Adjustment	16,508	$106,347,928	$ 536.86	$ 187,692,043	$ 947.49
SFY '17 Governor's Recommend	17,229	$108,022,293	$ 522.49	$ 187,950,791	$ 909.09

ABD Caseload Comparison by State Budget Cycle

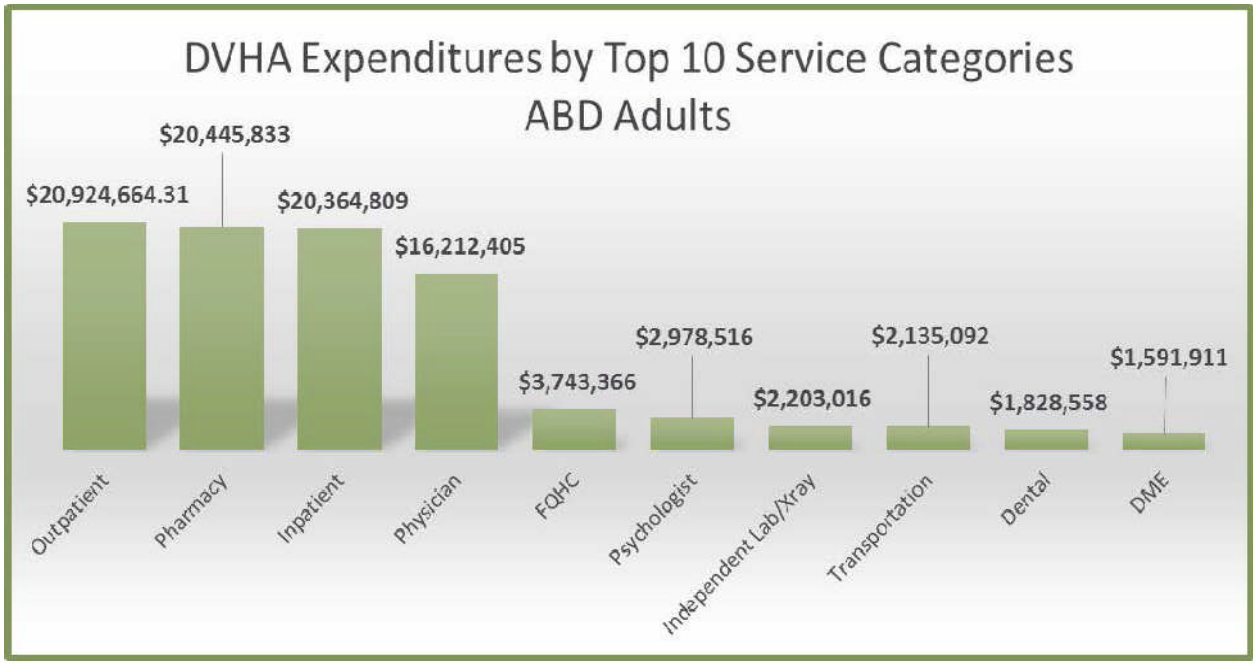


Aged, Blind, or Disabled (ABD) and/or Medically Needy Adults Continued

ABD Adult SFY 2015 Average Enrollment Breakout by Age and Gender



For adults with disabilities, pharmacy, outpatient, inpatient, and professional services accounted for the majority of the $102,508,327 total expenditure for ABD Adults. Please note pharmacy expenditures are net of drug rebates.



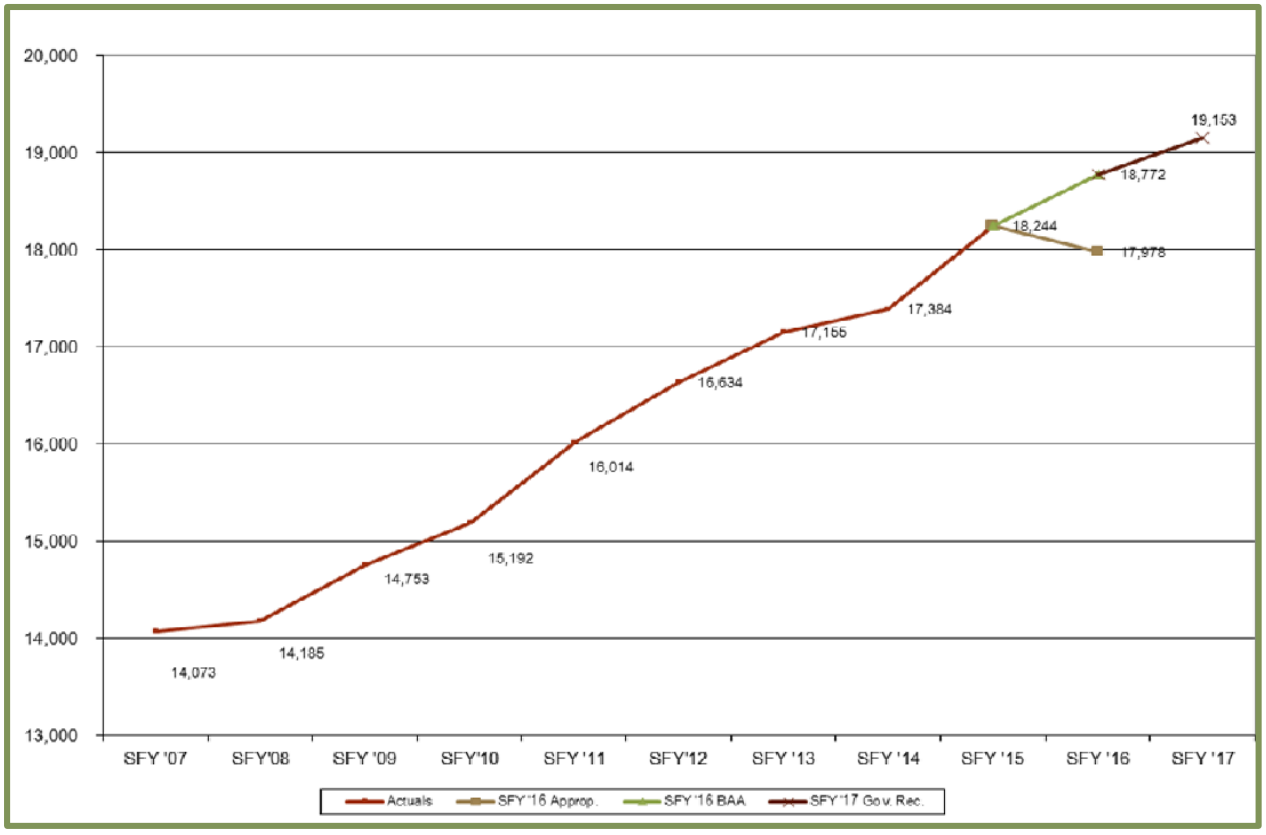
Dual Eligibles

Dual Eligibles are enrolled in both Medicare and Medicaid. Medicare eligibility is either due to being at least 65 years of age or determined blind, or disabled.

Dual Eligibles Caseload, Expenditure, and PMPM Comparison by State Fiscal Year

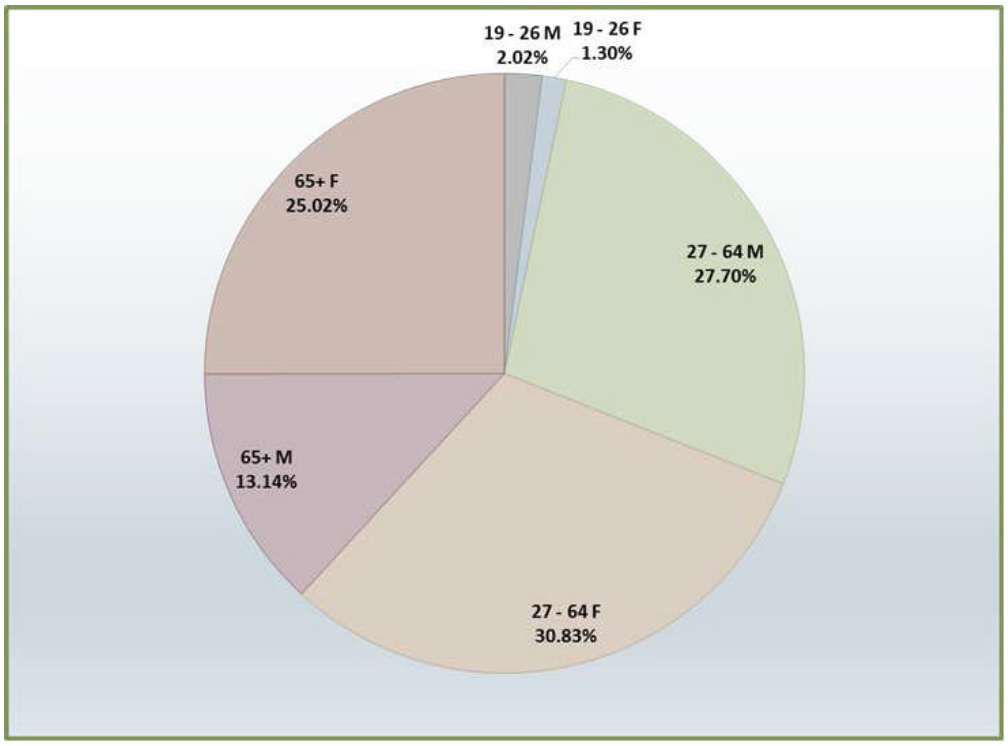
Dual Eligibles					
		DVHA Only		Total	
SFY	Caseload	Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '14 Actual	17,384	$ 49,143,760	$ 235.58	$ 201,968,814	$ 968.19
SFY '15 Actual	18,244	$ 53,518,538	$ 244.46	$ 216,083,619	$ 987.00
SFY '16 Appropriated	17,978	$ 50,051,552	$ 232.01	$ 204,746,363	$ 949.08
SFY '16 Budget Adjustment	18,772	$ 55,062,284	$ 244.43	$ 213,880,708	$ 949.46
SFY '17 Governor's Recommend	19,153	$ 56,172,024	$ 244.40	$ 210,957,910	$ 917.84

Dual Eligibles Caseload comparison by State Budget Cycle

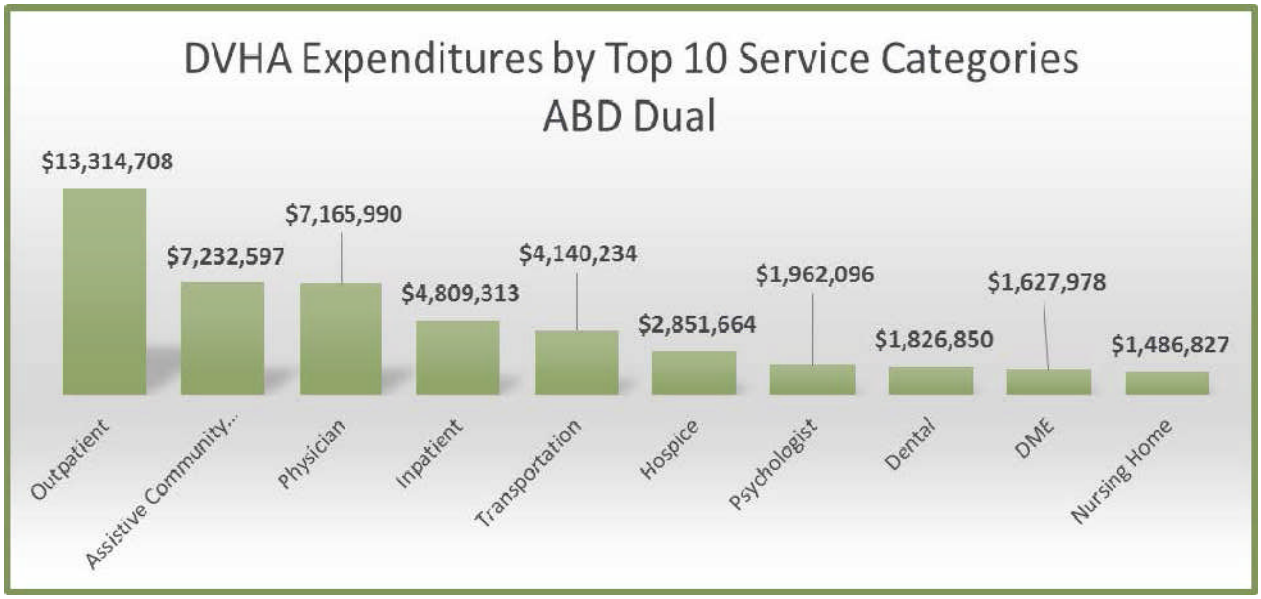


Dual Eligibles Continued

Dual Eligibles SFY 2015 Average Enrollment Breakout by Age and Gender



For the Dual Eligible population, outpatient, assistive community supports, inpatient, and professional services accounted for the majority of the $53,518,538 spend in SFY 2015. This population is covered by Medicare as primary insurer, and Medicaid pays for co-insurance and deductible, as well wrapping certain services not covered by Medicare.



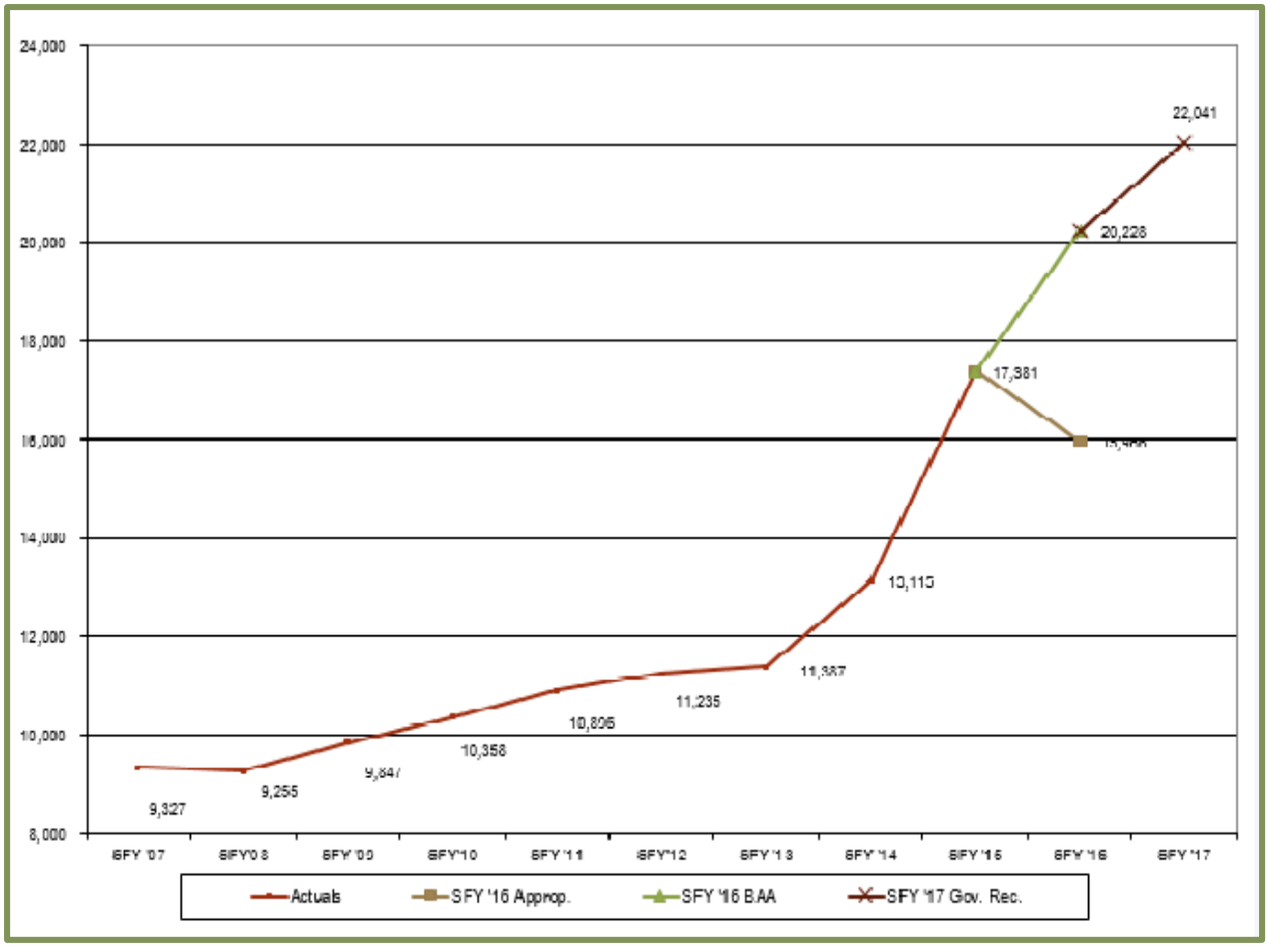
General Adults

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, whose income is below the protected income level (PIL).

General Adults Caseload, Expenditure, and PMPM Comparison by State Fiscal Year

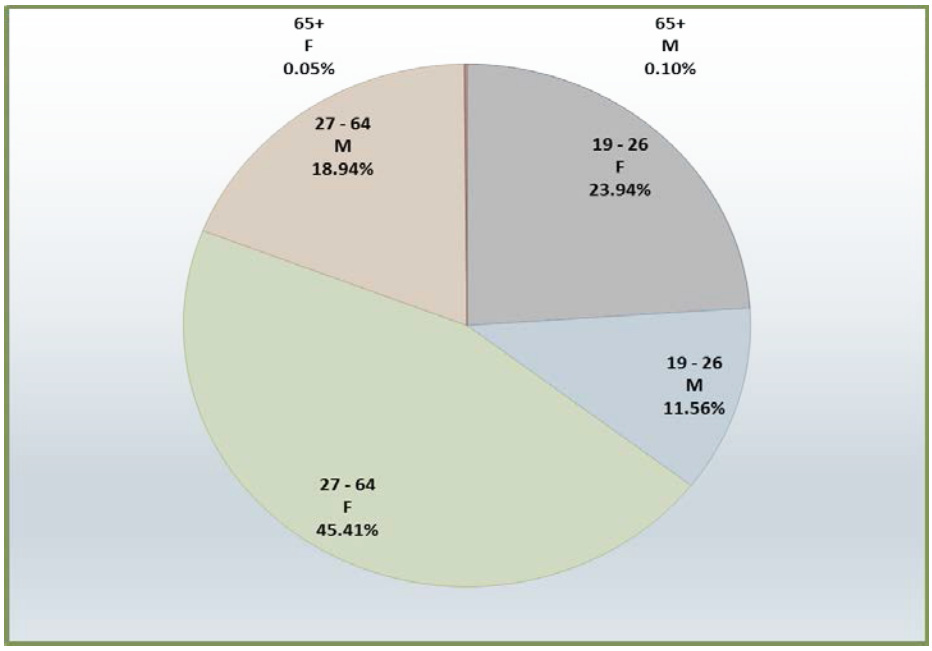
General Adults					
		DVHA Only		Total	
SFY	Caseload	Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '14 Actual	13,115	$ 76,094,174	$ 483.51	$ 84,532,839	$ 537.13
SFY '15 Actual	17,381	$ 88,383,933	$ 423.75	$ 98,968,224	$ 474.49
SFY '16 Appropriated	15,966	$ 90,450,192	$ 472.09	$ 99,955,443	$ 521.71
SFY '16 Budget Adjustment	20,228	$101,008,816	$ 416.13	$ 111,212,344	$ 458.16
SFY '17 Governor's Recommend	22,041	$102,873,429	$ 388.95	$ 118,910,060	$ 449.58

General Adults Caseload Comparison by State Budget Cycle



General Adults Continued

General Adults SFY 2015 Average Enrollment Breakout by Age and Gender



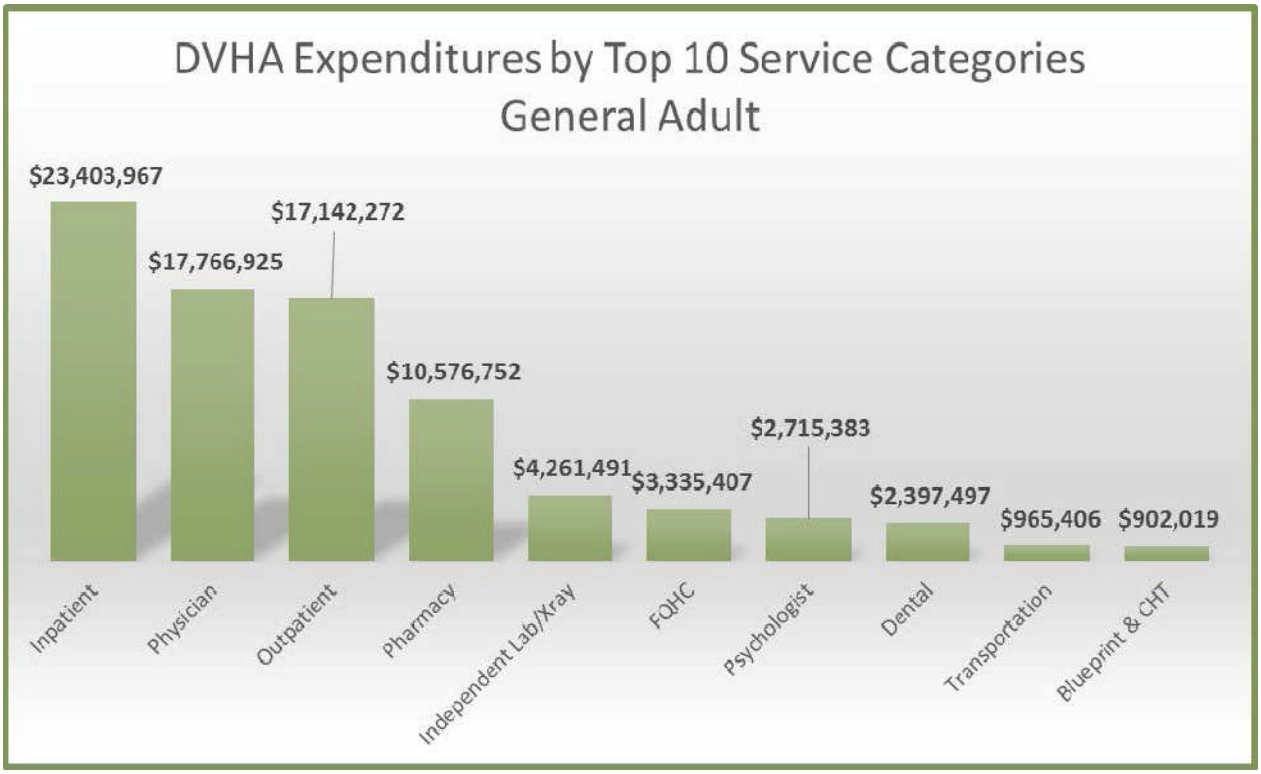
The General Adult population saw a 32.76% increase between SFY 2014 and SFY 2015. Much of this increase can be explained through the Medicaid Expansion activities of the Affordable Care Act. The reason for this is two-fold. First, the changes in MAGI eligibility would have allowed more enrollees to qualify through the income disregard. Second, it can be assumed some enrollees were only made aware of their eligibility when applying for QHP benefits. The table below demonstrates the new enrollees into General Adult since the implementation of Medicaid Expansion.

		New Enrollees - General Adults									
Category	Demographic	QE Mar 2014	QE Jun 2014	QE Sept 2014	QE Dec 2014	QE Mar 2015	QE June 2015	QE Sept 2015	QE Dec 2015	Medicaid Expansion New Enrollees	New Enrollees Trendline
General Adult	Female 19 - 26	120	109	101	111	102	49	32	56	680	
General Adult	Female 27 - 64	437	189	231	212	251	129	143	148	1,740	
General Adult	Male 19 - 26	25	16	10	13	17	6	8	14	109	
General Adult	Male 27 - 64	346	123	107	147	130	67	43	53	1,016	
General Adult		928	437	449	483	500	251	226	271	3,545	

Definition: Has not had Medicaid/VHAP/VPHARM/CAT/ESIA Coverage in 3 years prior to month of enrollment. May have had GA Voucher or Healthy Vermonters Discounted Pharmacy

General Adult Continued

Inpatient, physician, outpatient, and pharmacy (net of drug rebates) accounted for the majority of the $88,383,933 SFY 2015 spend.



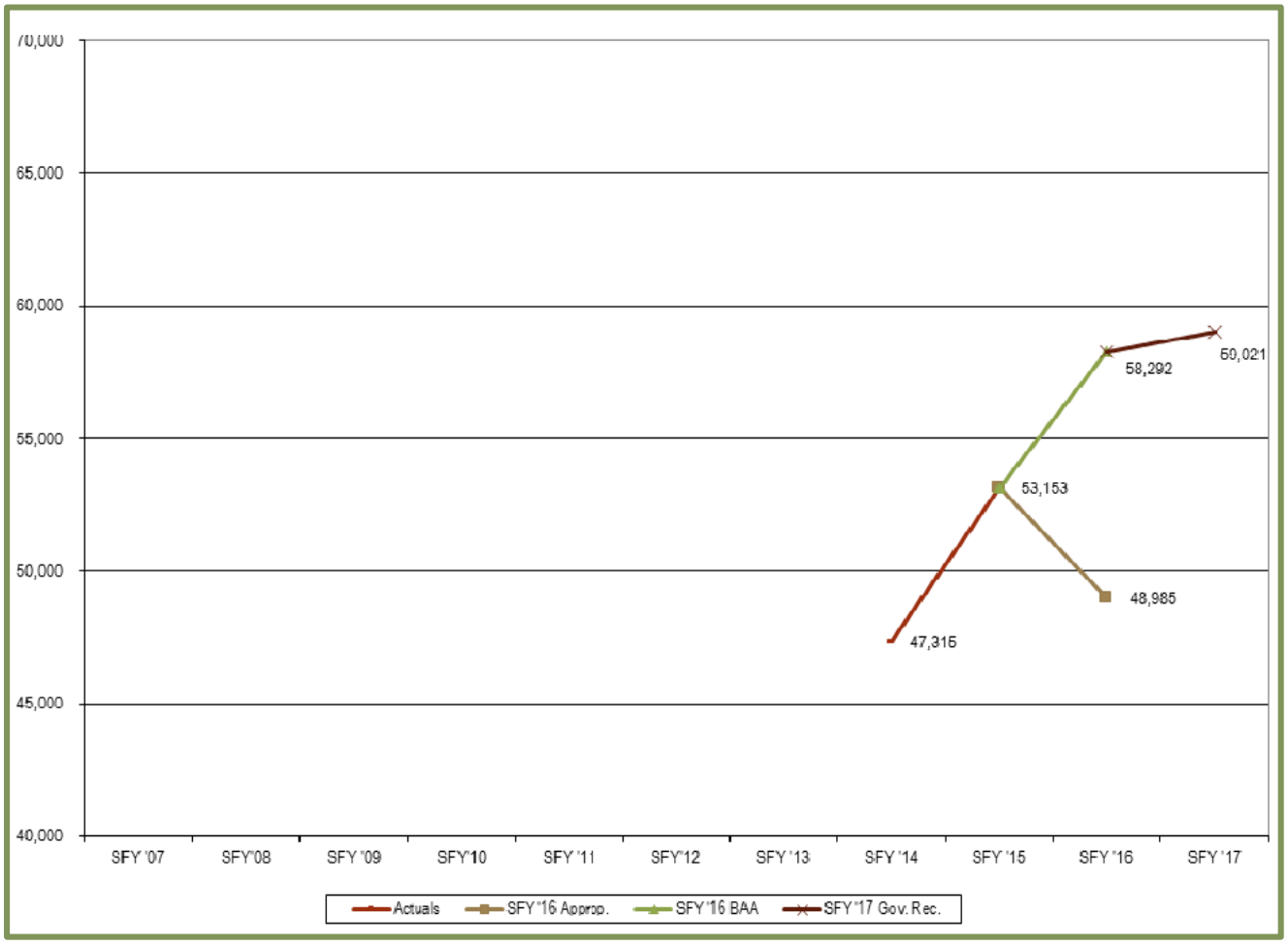
New Adult

Due to Affordable Care Act changes that expanded Medicaid eligibility, adults who are at or below 138% of the federal poverty level will now qualify for traditional Medicaid.

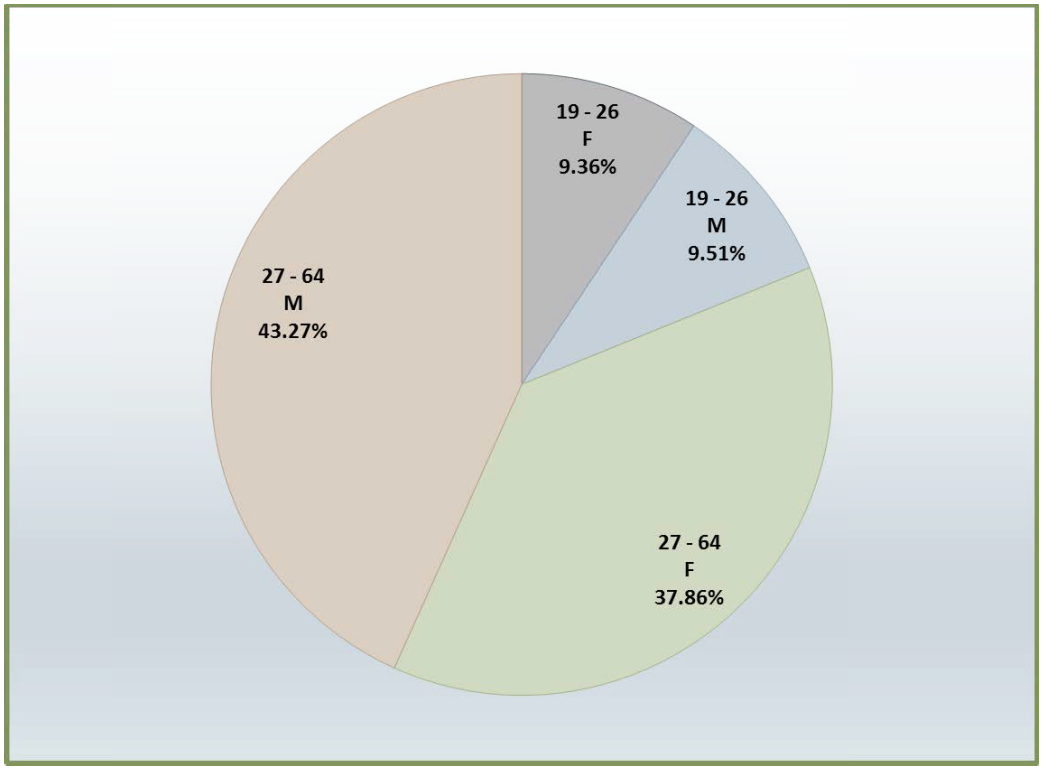
New Adult Caseload, Expenditure, and PMPM Comparison by State Fiscal Year

New Adult					
		DVHA Only		Total	
SFY	Caseload	Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '14 Actual	47,315	$ 72,982,243	$ 128.54	$ 80,536,031	$ 350.28
SFY '15 Actual	53,153	$224,311,542	$ 351.68	$ 246,954,265	$ 387.18
SFY '16 Appropriated	48,985	$193,377,396	$ 328.97	$ 213,533,274	$ 363.26
SFY '16 Budget Adjustment	58,292	$239,299,057	$ 342.10	$ 261,255,819	$ 373.49
SFY '17 Governor's Recommend	59,021	$235,785,764	$ 332.91	$ 261,145,862	$ 368.72

New Adults Caseload Comparison by State Budget Cycle



New Adults SFY 2015 Average Enrollment Breakout by Age and Gender



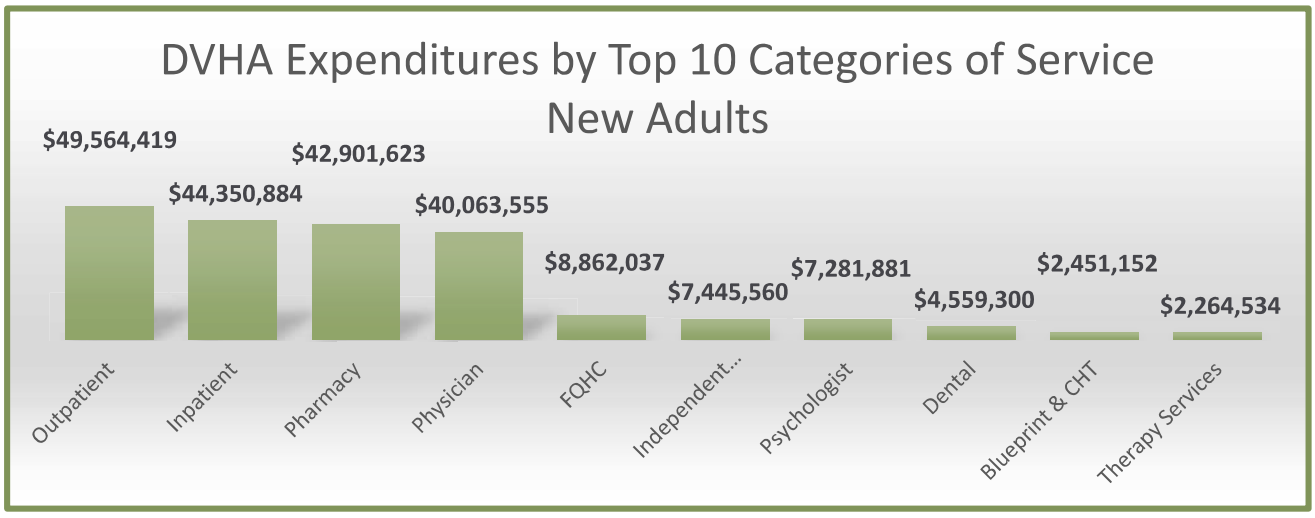
Many of the enrollees in the New Adults categories were previously covered through other Green Mountain Care Programs such as Employer Sponsored Insurance Assistance (ESIA), VHAP, or Catamount Premium Assistance. Some, however, are brand new to any program. The table below displays the breakdown of the new enrollees each quarter since the implementation of Medicaid Expansion.

		New Enrollees -New Adults Combined									
Category	Demographic	QE Mar 2014	QE Jun 2014	QE Sept 2014	QE Dec 2014	QE Mar 2015	QE June 2015	QE Sept 2015	QE Dec 2015	Medicaid Expansion New Enrollees	New Enrollees Trendline
New Adult - Combined	Female 19 - 26	613	215	197	296	354	228	195	200	2,298	
New Adult - Combined	Female 27 - 64	2,015	541	504	650	1,009	493	553	513	6,278	
New Adult - Combined	Female 65+	7	5	3	1	3	2	2	1	24	
New Adult - Combined	Male 19 - 26	687	210	211	273	434	228	221	185	2,449	
New Adult - Combined	Male 27 - 64	2,711	716	606	865	1,473	627	630	605	8,233	
New Adult - Combined	Male 65+	4	3	1	1	3	3	2	1	18	
New Adult - Combined		**6,037**	**1,690**	**1,522**	**2,086**	**3,276**	**1,581**	**1,603**	**1,505**	**19,300**	

Definition: Has not had Medicaid/VHAP/VPHARM/CAT/ESIA Coverage in 3 years prior to month of enrollment. May have had GA Voucher or Healthy Vermonters Discounted Pharmacy

New Adult Utilization

Outpatient, inpatient, pharmacy (net drug rebate), and professional services accounted for the majority of the $224,311,542. New Adult utilization for lab services is partially due to the opioid dependency prevalence within this population.



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.

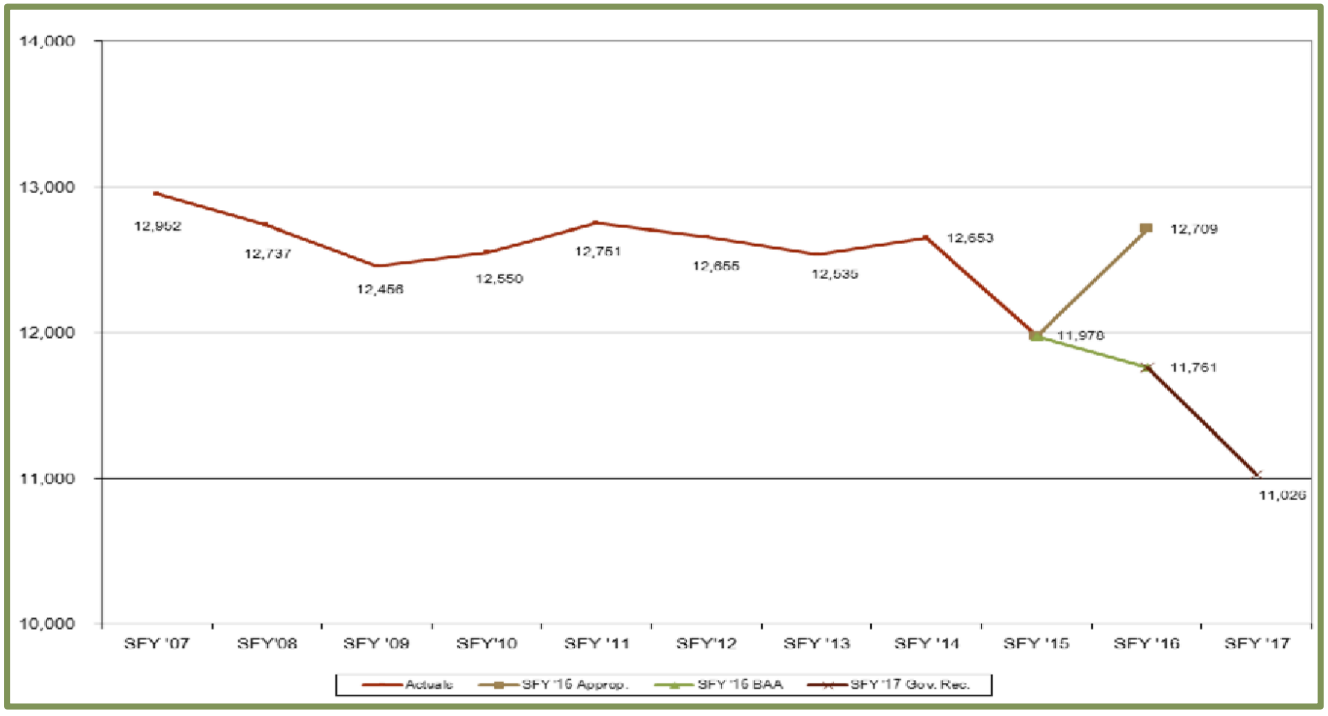
VPharm assists Vermonters enrolled in Medicare Part D with paying for prescription medicines. Those eligible include people age 65 and older, and Vermonters of all ages with disabilities with household incomes up to 225% FPL.

Please note that historical numbers include 3 pharmacy only programs that expired effective 1/1/14. Those programs were: VHAP-Pharmacy, VScript and VScript Expanded.

Pharmacy Only Caseload, Expenditure, and PMPM Comparison by State Fiscal Year

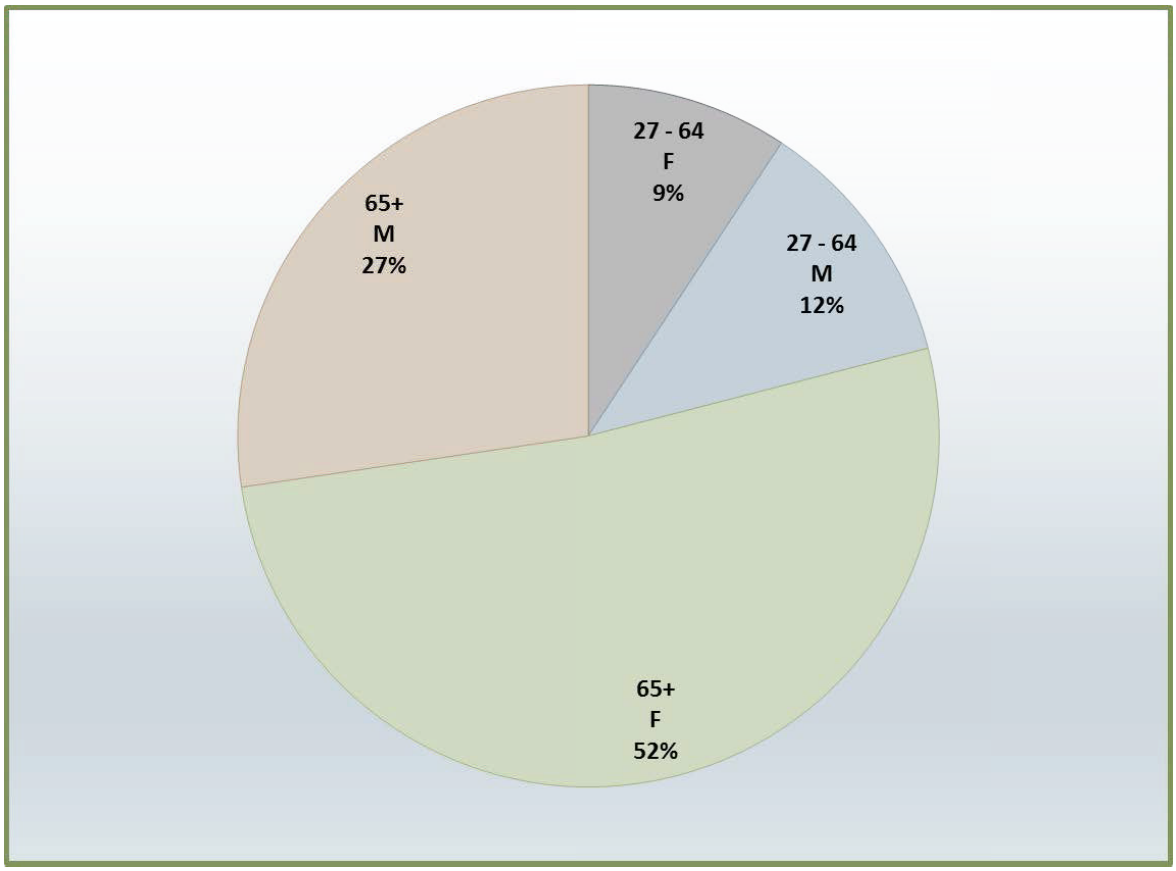
Pharmacy Only Programs					
		DVHA Only		Total	
SFY	Caseload	Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '14 Actual	12,653	$ 4,485,706	$ 29.54	$ 4,485,706	$ 29.54
SFY '15 Actual	11,978	$ 4,914,695	$ 34.19	$ 4,914,695	$ 34.19
SFY '16 Appropriated	12,709	$ 6,396,479	$ 41.94	$ 6,396,479	$ 41.94
SFY '16 Budget Adjustment	11,761	$ 5,203,272	$ 36.87	$ 5,203,272	$ 36.87
SFY '17 Governor's Recommend	11,026	$ 6,480,649	$ 48.98	$ 6,480,649	$ 48.98

Pharmacy Only Caseload Comparison by State Budget Cycle



Prescription Assistance Pharmacy Only Programs Continued

SFY 2015 Average Enrollment Breakout by Age and Gender



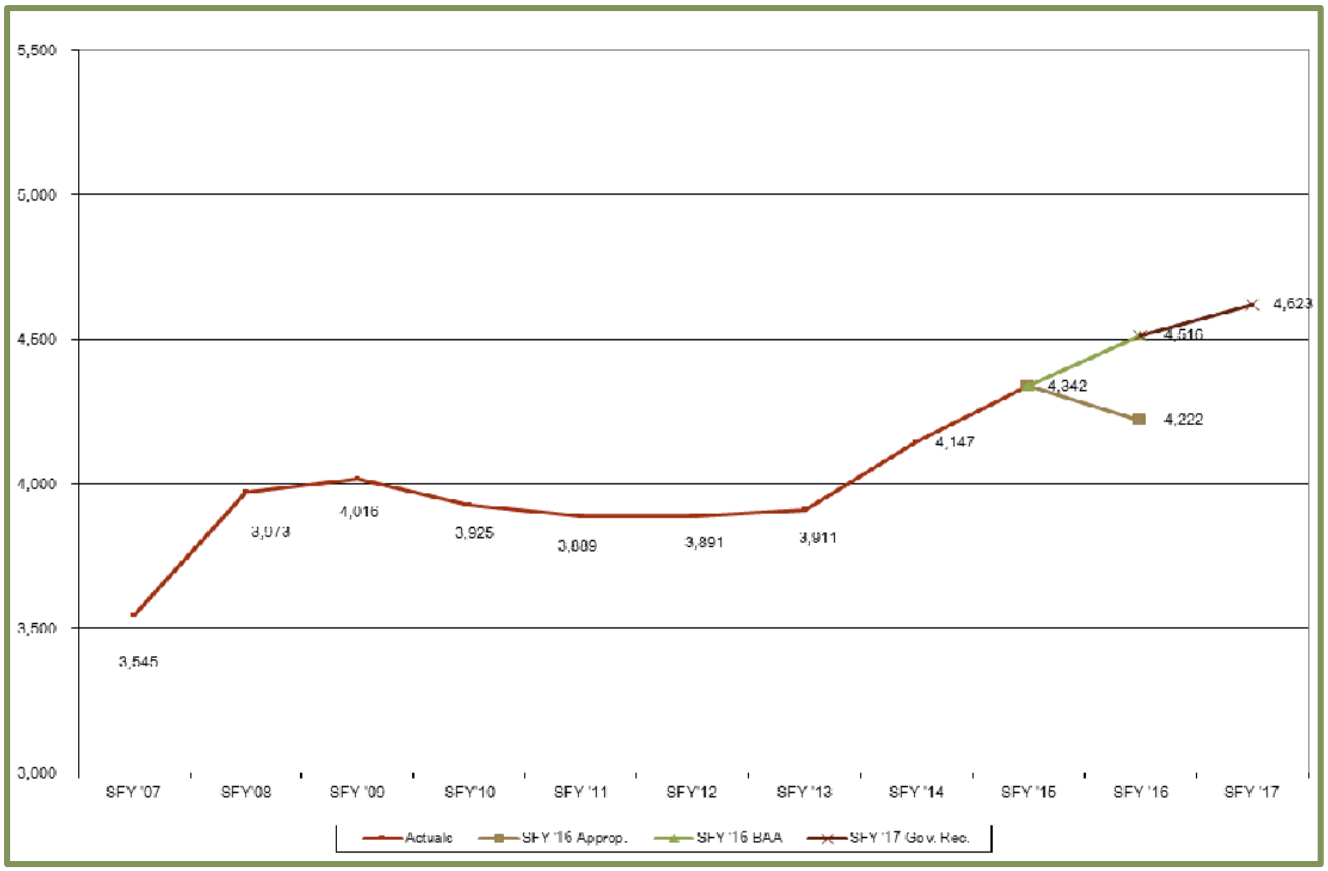
Choices for Care

The general eligibility requirements for this subset are: Vermonters in nursing homes, home-based settings under home and community based services (HCBS) waiver programs, and enhanced residential care (ERC).

Choices for Care Caseload, Expenditure, and PMPM Comparison by State Fiscal Year

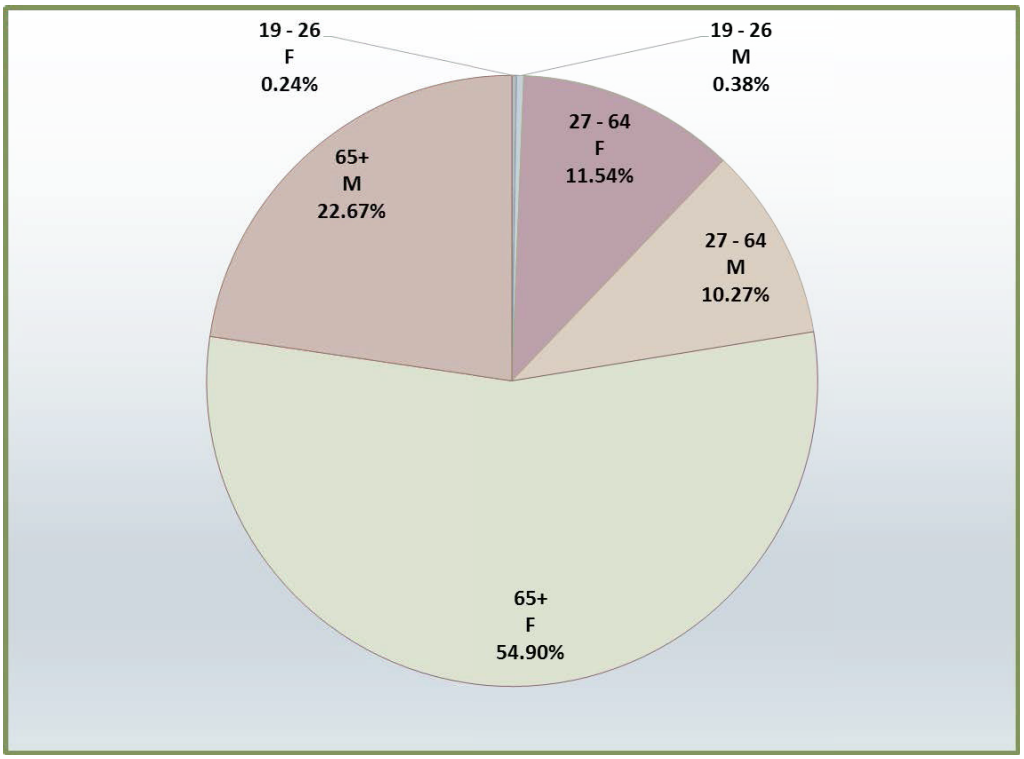
Choices for Care Waiver					
		DVHA Only		Total	
SFY	Caseload	Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '14 Actual	4,147	$202,593,610	$ 4,071.09	$ 202,593,610	$ 4,071.09
SFY '15 Actual	4,342	$208,149,276	$ 3,995.26	$ 208,149,276	$ 3,995.26
SFY '16 Appropriated	4,222	$207,145,319	$ 4,088.40	$ 210,254,106	$ 4,149.76
SFY '16 Budget Adjustment	4,516	$208,560,336	$ 3,848.68	$ 211,558,519	$ 3,904.01
SFY '17 Governor's Recommend	4,623	$207,069,585	$ 3,732.31	$ 209,336,163	$ 3,773.17

Choices for Care Caseload Comparison by State Budget Cycle

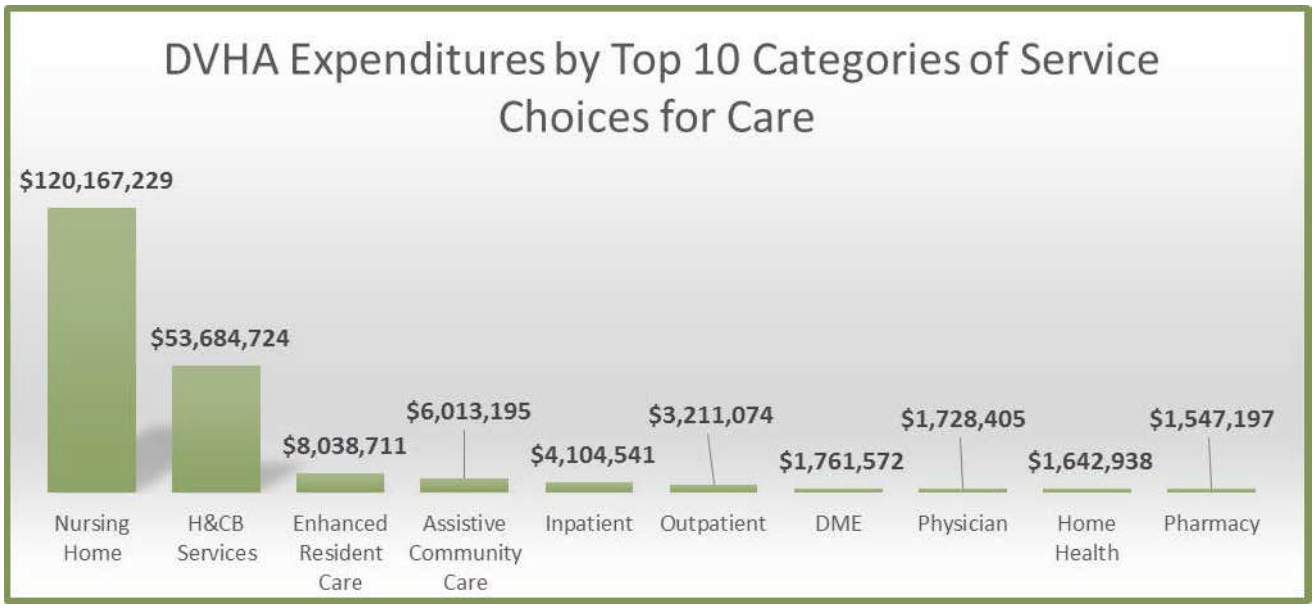


Choices for Care Continued

Choices for Care SFY 2015 Average Enrollment Breakout by Age and Gender



A high percentage of the Choices for Care costs relate to nursing home services. This highlights the need to promote Home and Community Based Services over the more costly option of nursing home services.



Healthy Vermonters

Healthy Vermonters provides a discount on 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.

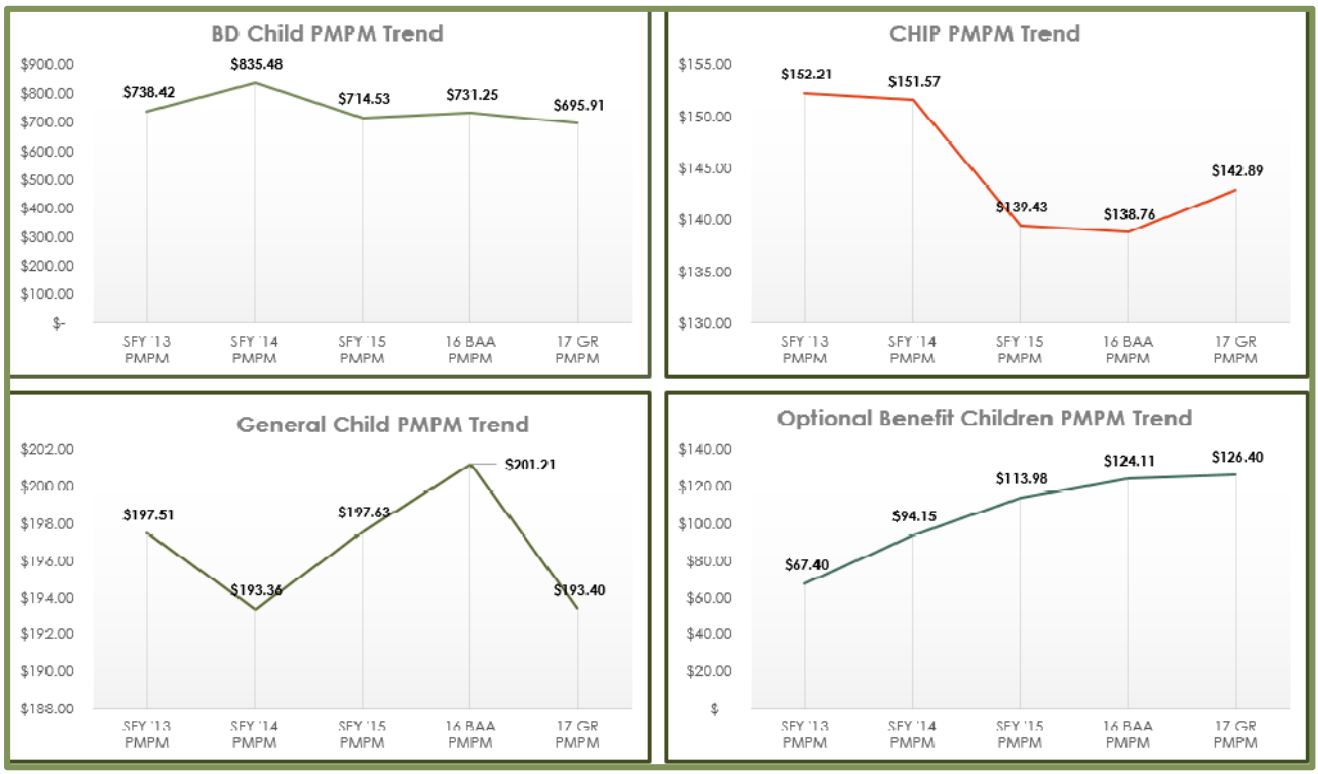
Healthy Vermonters Caseload, Expenditure, and PMPM Comparison by State Fiscal Year

Healthy Vermonters Program					
		DVHA Only		Total	
SFY	Caseload	Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '14 Actual	5,597	$ -	n/a	$ -	n/a
SFY '15 Actual	4,330	$ -	n/a	$ -	n/a
SFY '16 Appropriated	5,820	$ -	n/a	$ -	n/a
SFY '16 Budget Adjustment	5,820	$ -	n/a	$ -	n/a
SFY '17 Governor's Recommend	5,820	$ -	n/a	$ -	n/a

Healthy Vermonters Caseload Comparison by State Budget Cycle

Medicaid for Children

The below section isolates and compares each population group of children DVHA PMPMs.



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.

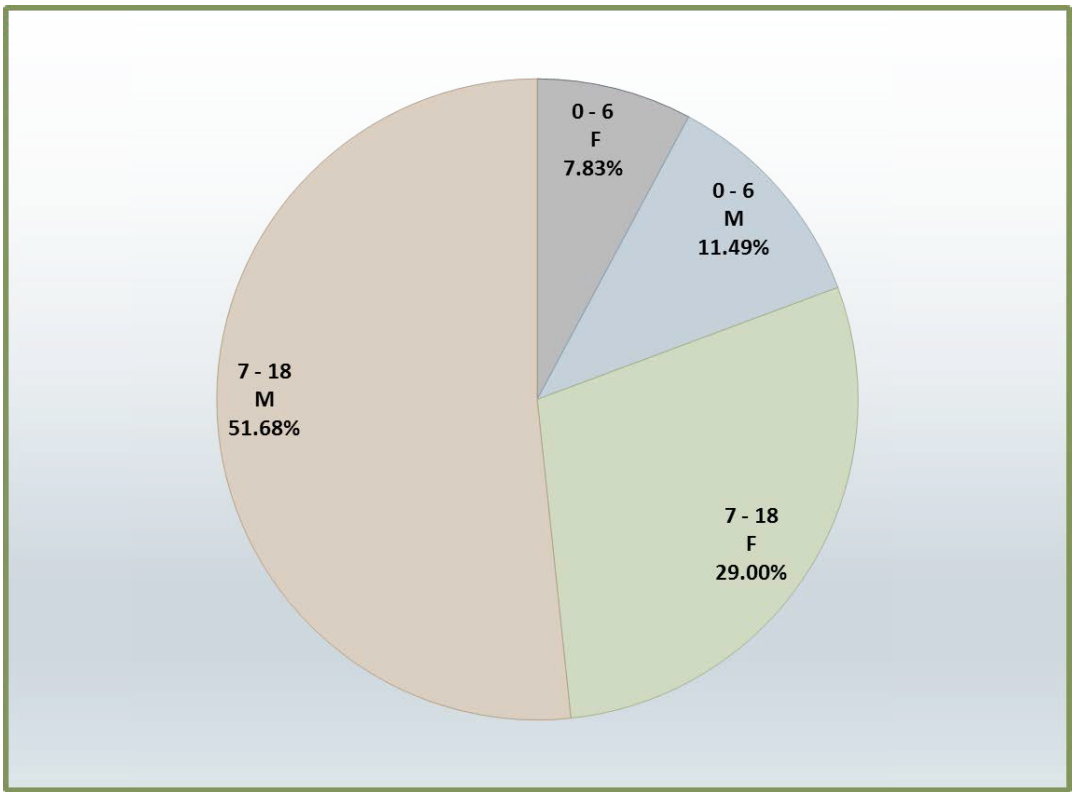
Blind or Disabled and/or Medically Needy Children Caseload, Expenditure, and PMPM Comparison by State Fiscal Year

Blind or Disabled and/or Medically Needy Children					
		DVHA Only		Total	
SFY	Caseload	Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '14 Actual	3,639	$ 36,486,052	$ 835.48	$ 91,503,344	$ 2,095.29
SFY '15 Actual	3,603	$ 30,889,676	$ 714.53	$ 87,051,488	$ 2,013.64
SFY '16 Appropriated	3,727	$ 38,392,328	$ 858.33	$ 91,730,054	$ 2,050.80
SFY '16 Budget Adjustment	3,503	$ 30,739,310	$ 731.25	$ 85,624,409	$ 2,036.90
SFY '17 Governor's Recommend	3,417	$ 28,535,845	$ 695.91	$ 85,540,745	$ 2,086.11

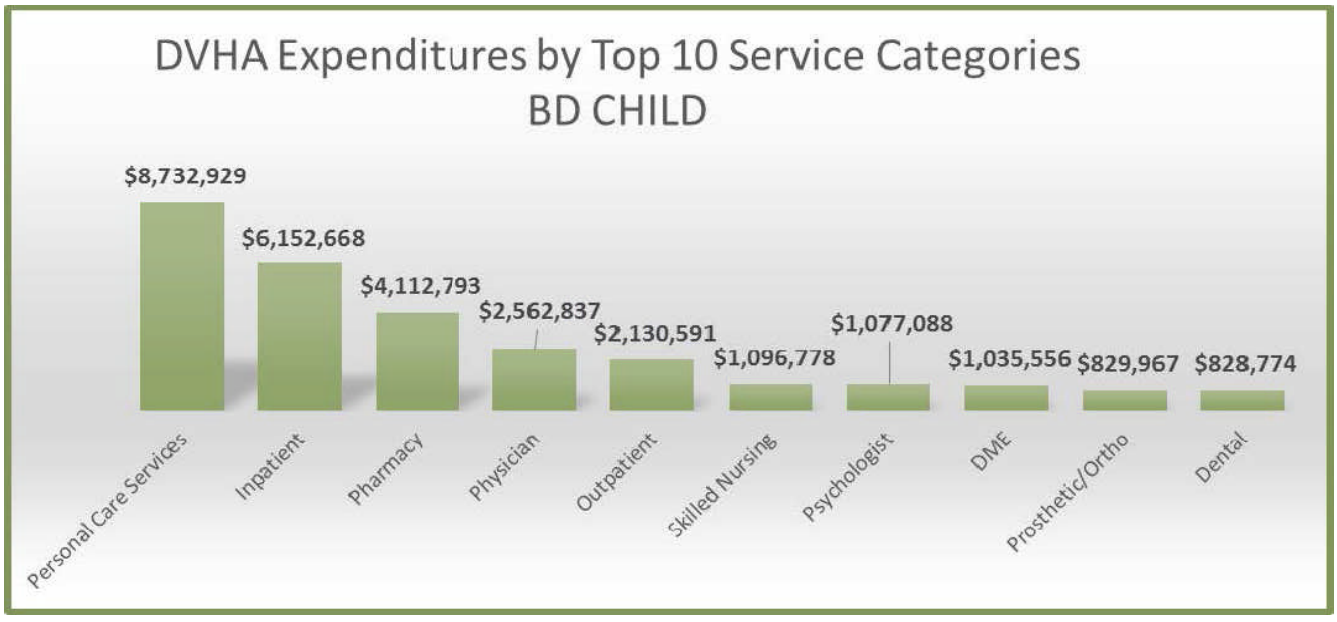
Blind or Disabled Children Caseload Comparison by State Budget Cycle

Blind or Disabled (BD) and/or Medically Needy Children Continued

BD Child SFY 2015 Average Enrollment Breakout by Age and Gender



Personal Care Services, inpatient, pharmacy (net drug rebate), and professional services accounted for the majority of the $30,889,676.



General Children

The general eligibility requirements for General Children are: under age 19 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).

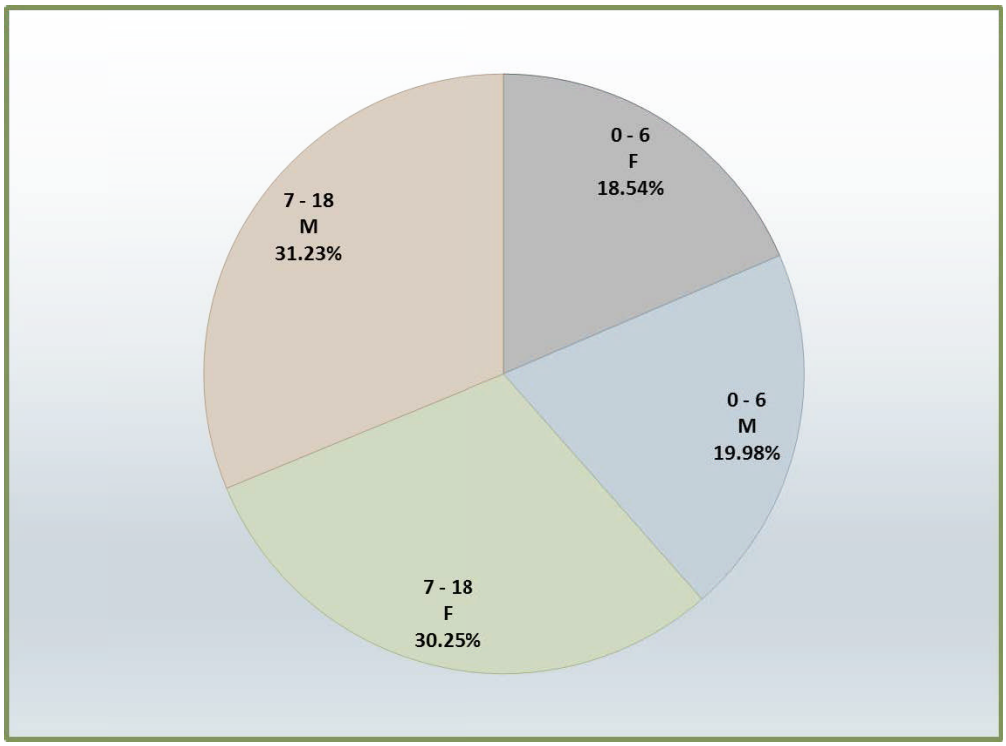
General Children Caseload, Expenditure, and PMPM Comparison by State Fiscal Year

General Children					
		DVHA Only		Total	
SFY	Caseload	Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '14 Actual	56,431	$130,940,851	$ 193.36	$ 236,587,894	$ 349.38
SFY '15 Actual	60,863	$144,338,098	$ 197.63	$ 267,623,445	$ 366.43
SFY '16 Appropriated	57,594	$132,798,298	$ 192.15	$ 249,488,277	$ 360.98
SFY '16 Budget Adjustment	62,462	$150,818,731	$ 201.21	$ 272,587,232	$ 363.67
SFY '17 Governor's Recommend	64,846	$150,491,497	$ 193.40	$ 277,411,859	$ 356.50

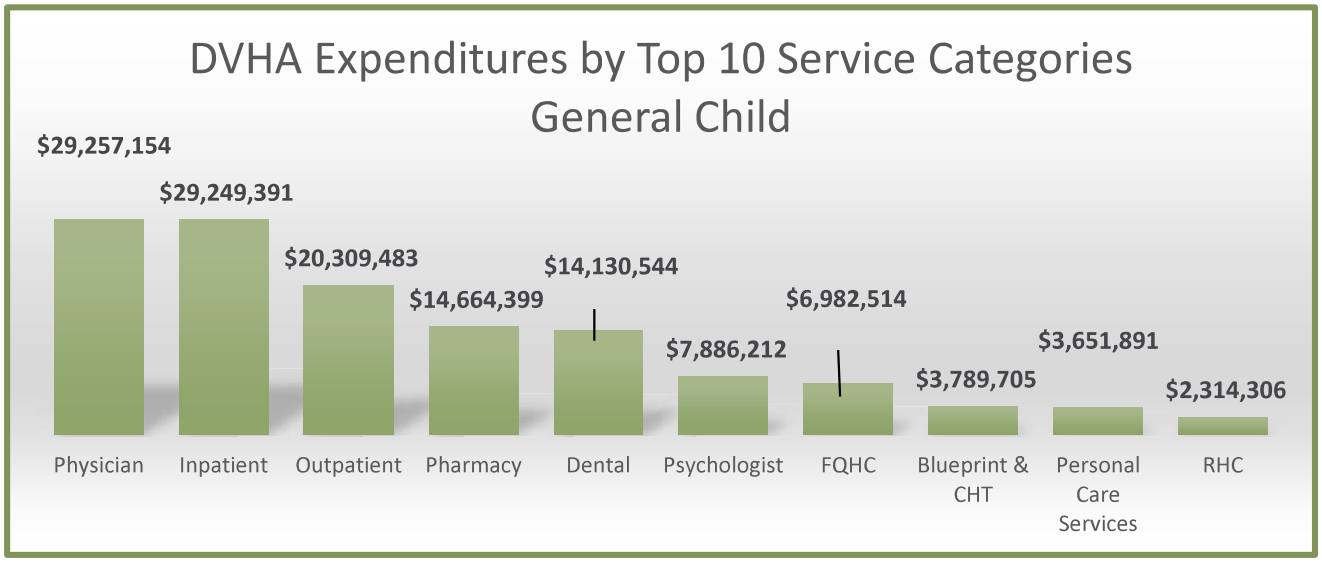
General Children Caseload Comparison by State Budget Cycle

General Child Enrollment

General Child SFY 2015 Average Enrollment Breakout by Age and Gender



Professional services, inpatient, outpatient, and pharmacy (net drug rebate) accounted for the majority of the $144,388,098.



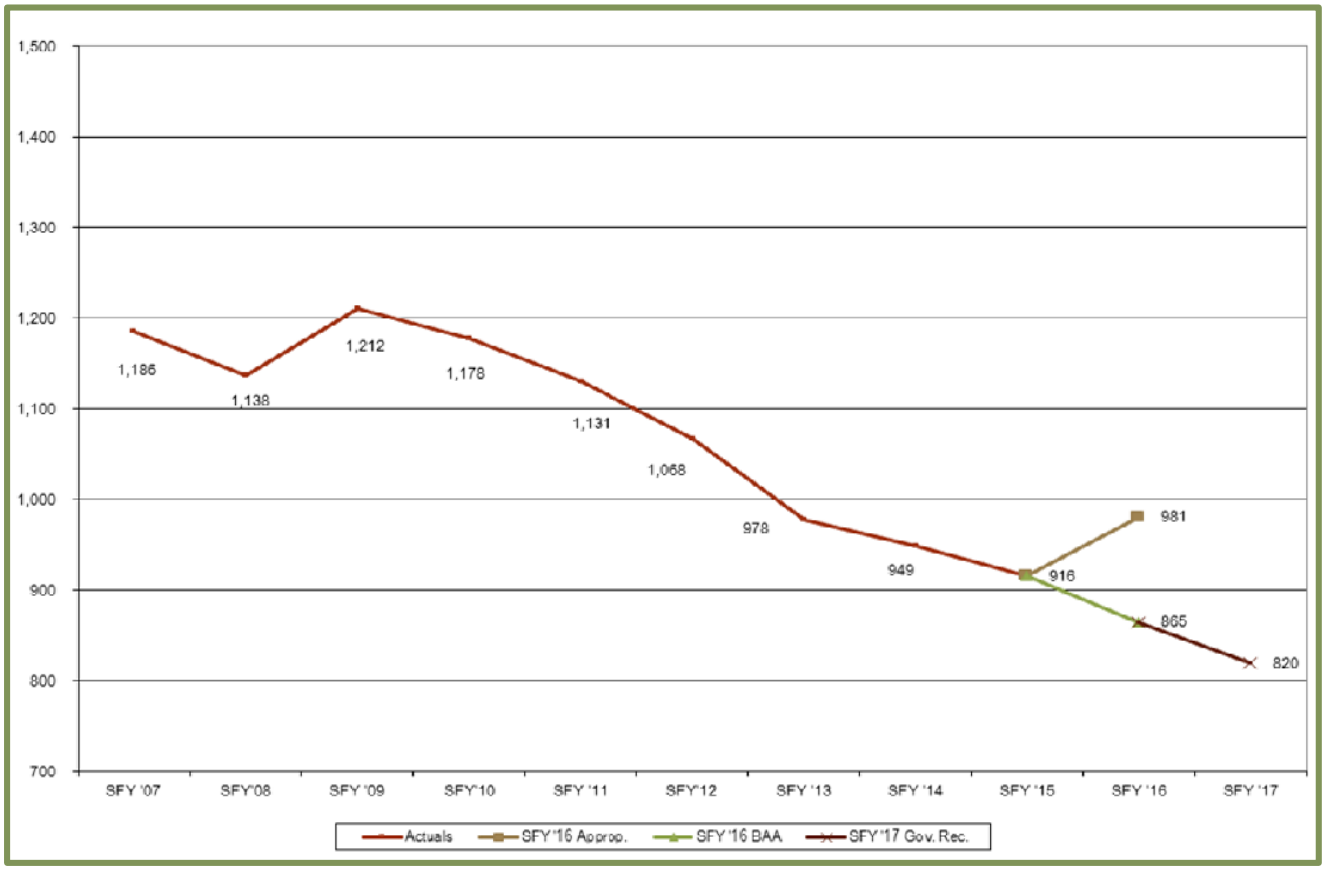
Optional Benefit Children

The general eligibility requirements for Underinsured Children are: up to age 19 and up to 312% FPL. This program was designed as part of the original 1115 Waiver to Title XIX of the Social Security Act to provide healthcare coverage for children who would otherwise be underinsured.

Optional Benefit Children Caseload, Expenditure, and PMPM Comparison by State Fiscal Year

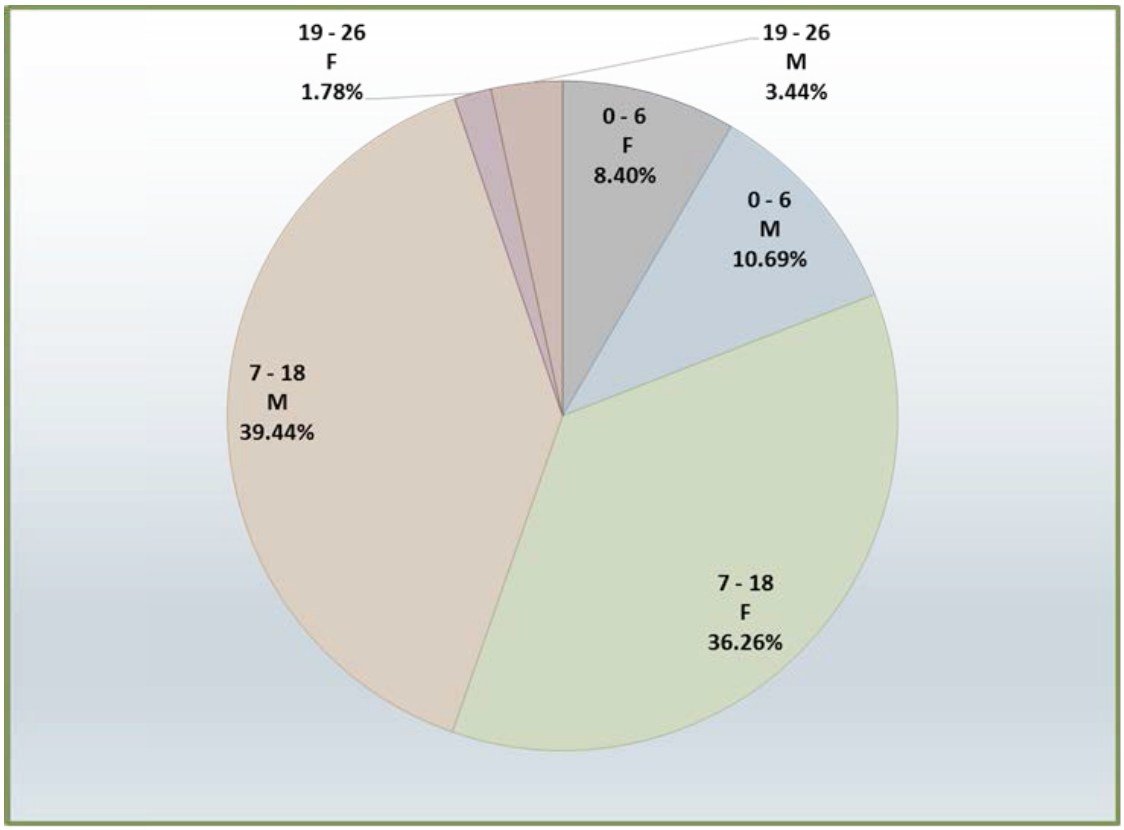
Optional Benefit Children					
		DVHA Only		Total	
SFY	Caseload	Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '14 Actual	949	$ 1,072,657	$ 94.15	$ 2,521,774	$ 221.34
SFY '15 Actual	916	$ 1,253,421	$ 113.98	$ 2,962,429	$ 269.39
SFY '16 Appropriated	981	$ 1,137,209	$ 96.59	$ 2,744,907	$ 233.13
SFY '16 Budget Adjustment	865	$ 1,288,846	$ 124.11	$ 2,786,997	$ 268.38
SFY '17 Governor's Recommend	820	$ 1,243,929	$ 126.40	$ 2,806,428	$ 285.16

Optional Benefit Children Caseload Comparison by State Budget Cycle

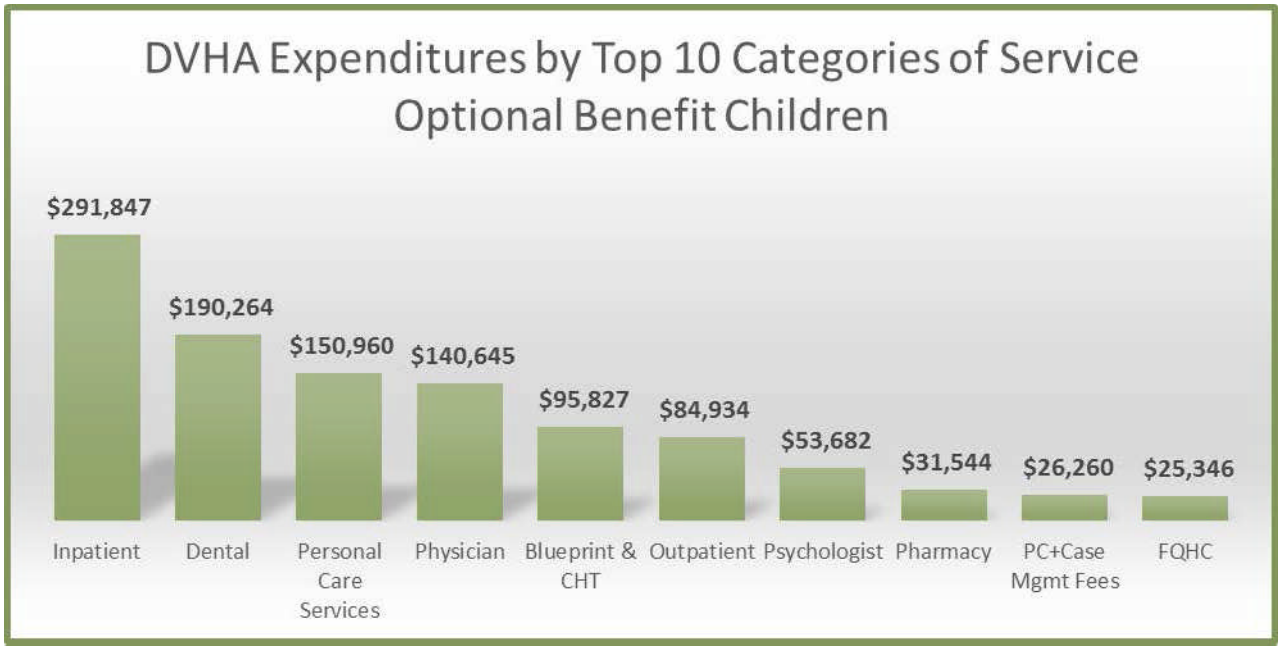


Optional Benefit Children Continued

Optional Benefit Children SFY 2015 Average Enrollment Breakout by Age and Gender



Inpatient, dental, personal care services, and professional services accounted for the majority of the $1,253,421.



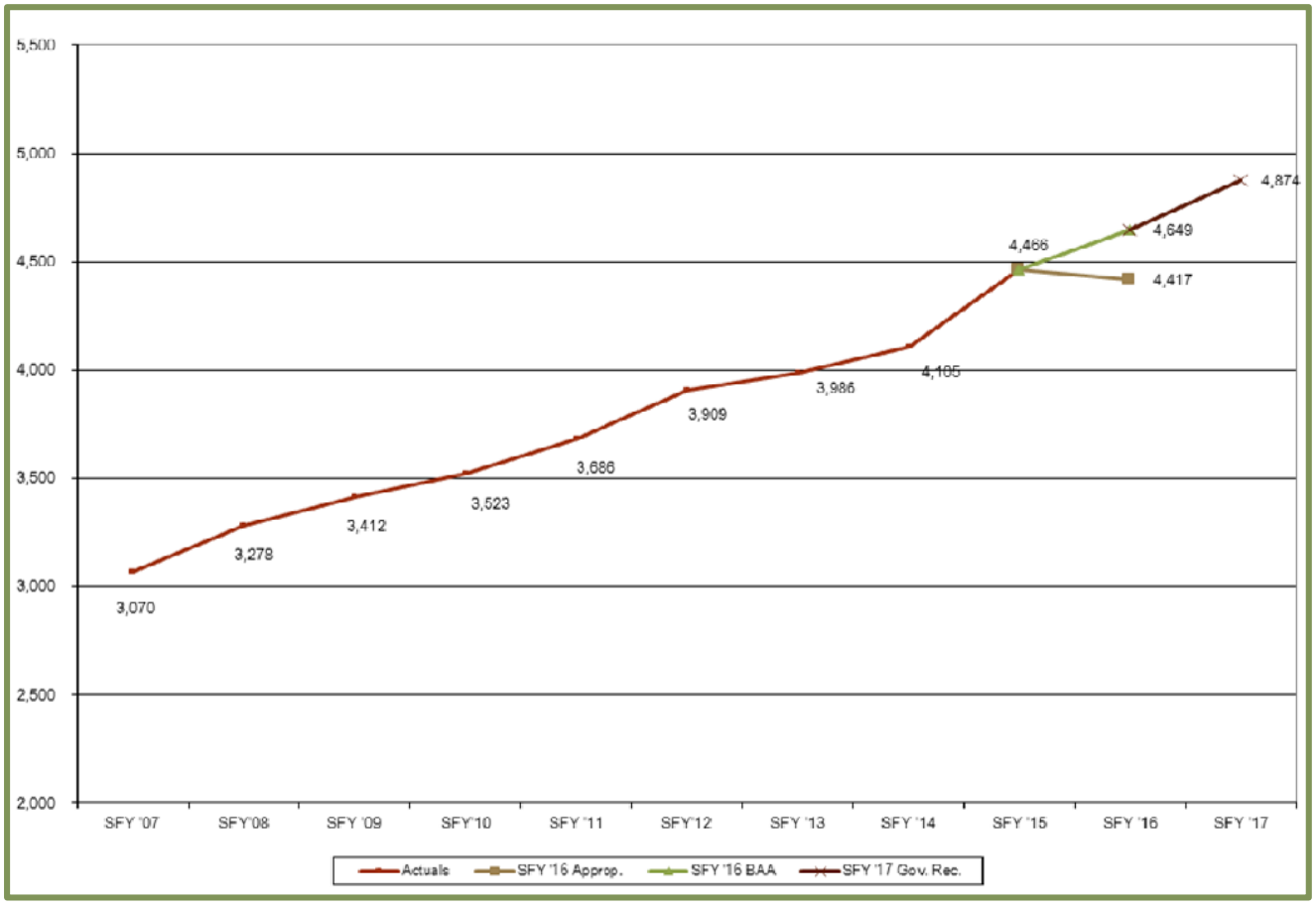
Children's Health Insurance Program (CHIP)

The general eligibility requirements for the Children's Health Insurance Program (CHIP) are: up to age 19, uninsured, and up to 312% Federal Poverty Limit (FPL). As of January 1, 2014 CHIP is operated as a Medicaid Expansion with enhanced federal funding from Title XXI of the Social Security Act.

CHIP Caseload, Expenditure, and PMPM Comparison by State Fiscal Year

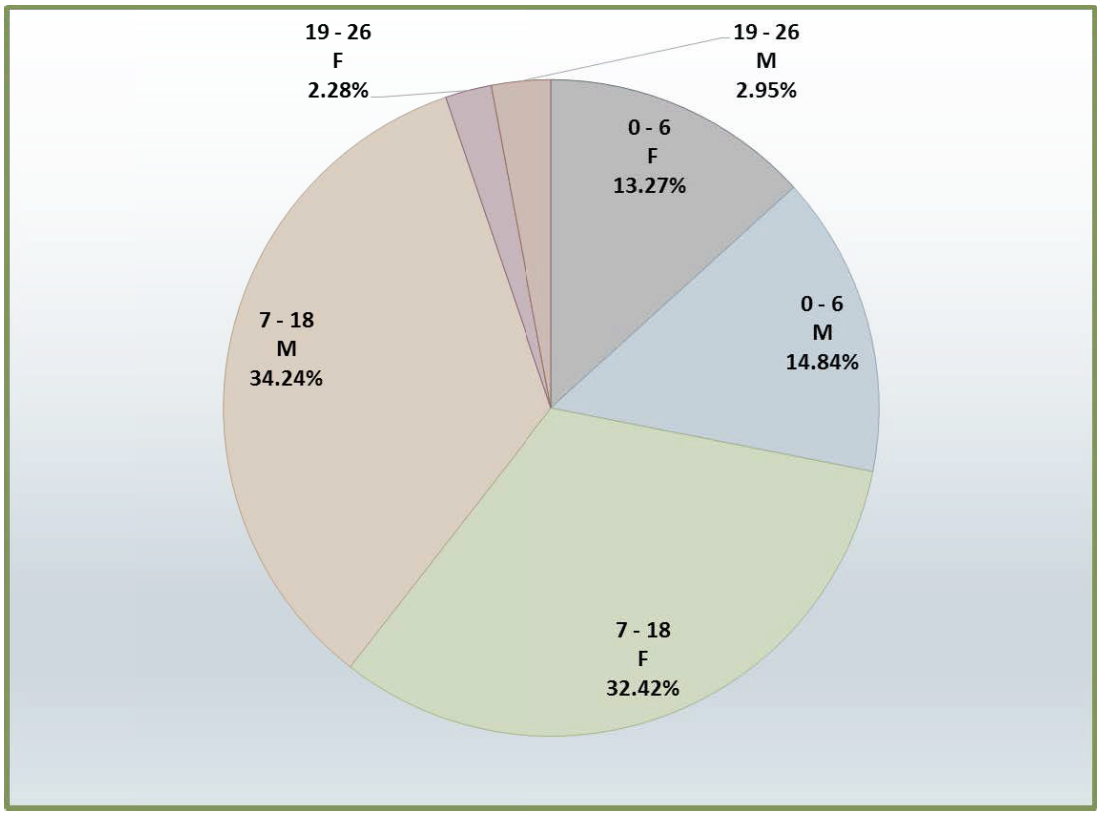
CHIP (Uninsured)					
		DVHA Only		Total	
SFY	Caseload	Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '14 Actual	4,105	$ 7,465,861	$ 151.57	$ 10,218,851	$ 207.46
SFY '15 Actual	4,466	$ 7,471,592	$ 139.43	$ 8,775,083	$ 163.75
SFY '16 Appropriated	4,417	$ 7,417,112	$ 139.93	$ 8,720,602	$ 164.52
SFY '16 Budget Adjustment	4,649	$ 7,741,066	$ 138.76	$ 9,049,328	$ 162.21
SFY '17 Governor's Recommend	4,874	$ 8,358,259	$ 142.89	$ 9,661,749	$ 165.18

CHIP Caseload Comparison by State Budget Cycle

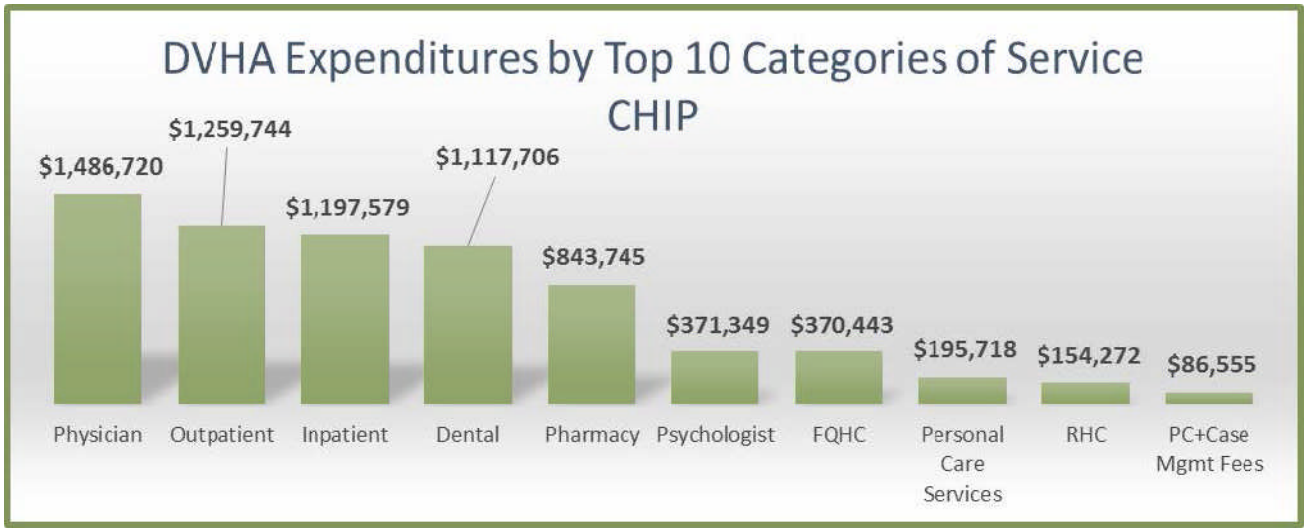


CHIP Continued

CHIP SFY 2015 Average Enrollment Breakout by Age and Gender



Professional services, outpatient, inpatient, and dental accounted for the majority of the $7,471,592.



Premium Assistance and Cost Sharing

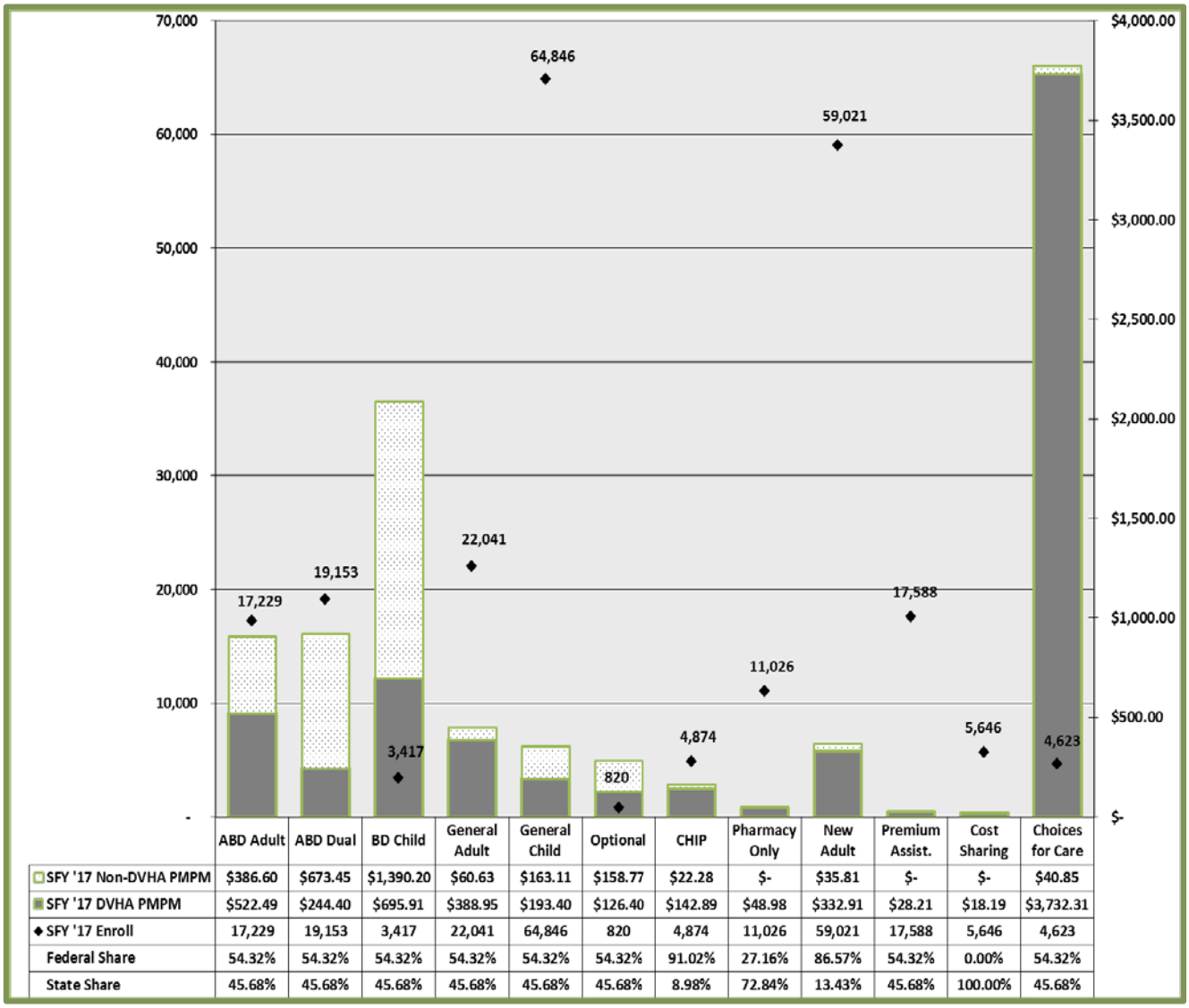
Individuals with household income over 138% of FPL can choose and enroll in qualified health plans purchased on Vermont Health Connect, Vermont's health benefit exchange. These plans have varying cost sharing and premium levels. There are federal tax credits to make premiums more affordable for people 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 had previously experienced under VHAP and Catamount. To address this affordability challenge, the State of Vermont further subsidizes premiums and cost sharing for enrollees whose income is < 300%. The following table depicts the caseload and expenditure information by SFY, including the Governor's Recommend for SFY2016 for additional Cost Sharing supports.

Premium Assistance For Exchange Enrollees < 300%					
		DVHA Only		Total	
SFY	Caseload	Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '14 Actual	14,013	$ 2,571,477	$ 36.91	$ 2,571,477	$ 36.91
SFY '15 Actual	16,906	$ 5,611,465	$ 27.66	$ 5,611,465	$ 27.66
SFY '16 Appropriated	18,368	$ 8,541,105	$ 38.75	$ 8,541,105	$ 38.75
SFY '16 Budget Adjustment	17,244	$ 5,838,169	$ 28.21	$ 5,838,169	$ 28.21
SFY '17 Governor's Recommend	17,588	$ 5,954,932	$ 28.21	$ 5,954,932	$ 28.21

Cost Sharing For Exchange Enrollees < 300%					
		DVHA Only		Total	
SFY	Caseload	Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '14 Actual	4,452	$ 332,623	$ 19.52	$ 332,623	$ 19.52
SFY '15 Actual	5,322	$ 1,138,775	$ 17.83	$ 1,138,775	$ 17.83
SFY '16 Appropriated	6,034	$ 1,522,615	$ 21.03	$ 1,522,615	$ 21.03
SFY '16 Budget Adjustment	5,481	$ 1,196,397	$ 18.19	$ 1,196,397	$ 18.19
SFY '17 Governor's Recommend	5,646	$ 1,232,289	$ 18.19	$ 1,232,289	$ 18.19

The summary below displays the efficiency of Vermont Medicaid programs by comparing population served with DVHA and non-DVHA PMPMs. This highlights the large number of children in the General Child category who cost a small amount; and the small number of enrollees into Choices for Care, who cost the most by far, and whose cost is carried entirely by DVHA. In addition, it also informs on the Federal Medicaid Assistance Percentage (FMAP) received for each Medicaid Eligibility Group.

DVHA Program Efficiency

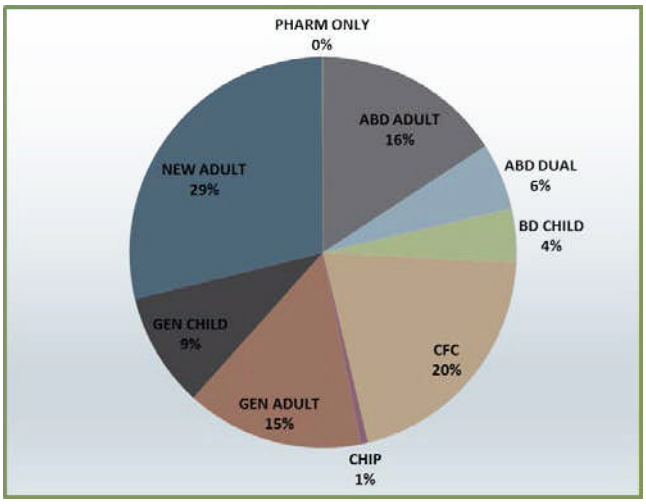


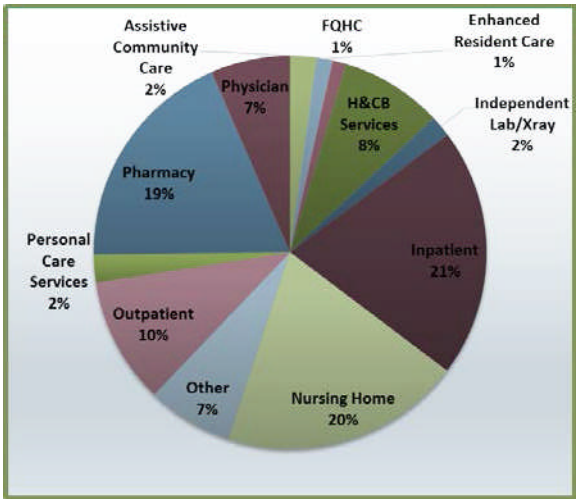
	ABD Adult	ABD Dual	BD Child	General Adult	General Child	Optional	CHIP	Pharmacy Only	New Adult	Premium Assist.	Cost Sharing	Choices for Care
SFY '17 Non-DVHA PMPM	$386.60	$673.45	$1,390.20	$60.63	$163.11	$158.77	$22.28	$-	$35.81	$-	$-	$40.85
SFY '17 DVHA PMPM	$522.49	$244.40	$695.91	$388.95	$193.40	$126.40	$142.89	$48.98	$332.91	$28.21	$18.19	$3,732.31
SFY '17 Enroll	17,229	19,153	3,417	22,041	64,846	820	4,874	11,026	59,021	17,588	5,646	4,623
Federal Share	54.32%	54.32%	54.32%	54.32%	54.32%	54.32%	91.02%	27.16%	86.57%	54.32%	0.00%	54.32%
State Share	45.68%	45.68%	45.68%	45.68%	45.68%	45.68%	8.98%	72.84%	13.43%	45.68%	100.00%	45.68%

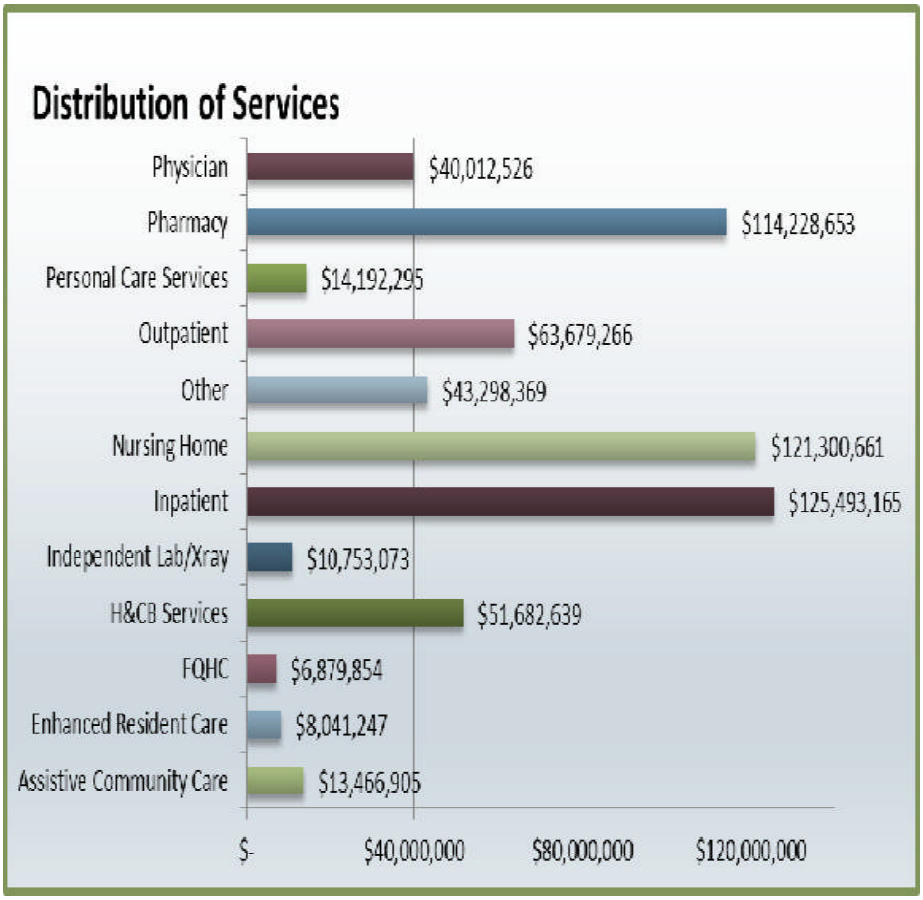
It should be noted that in the above graph, the Pharmacy Only FMAP used is a blend of the Global Commitment Waiver fund matching, and State Only funds, and the New Adult FMAP used is that of the New Adult childless population, while the population and spend are both New Adults with children, and childless.

High Cost Utilizers

DVHA Medicaid claim expenditures are highly concentrated; the top 10% of users account for 67.53% of claim expenditures. The median SFY 2015 PMPY claim cost for the top 10% of users was $28,882. The following graphs depict the profiles of the high cost users. The non-DVHA Medicaid claim spend – not depicted – for this population in SFY 2015 was $111,719,800.







The largest categories of claim expenditures for high cost utilizers are inpatient hospital, nursing home, and pharmacy. The "other" claim expenditures depicted in the graph above represent services for which make up less than 1% of the spend for this population such as dialysis facility, non-emergency transportation, and ambulance.

GMC & VHC INFORMATION

PROGRAM	WHO IS ELIGIBLE	COVERED SERVICES	COST-SHARING
MABD Medicaid **Katie Becket Medicaid** **Medicaid Working Disabled** **MCA (Expanded Medicaid – New Adults)**	• Age ≥ 65, blind, disabled • At or below the PIL • Katie Becket: o Only disabled child's income/resources used to meet MABD limits • Medicaid Working Disabled: o ≥ 250% FPL o Meet working criteria • MCA o ≥ 138% of FPL o Not eligible for Medicare And either: • Parent or caretaker relative of a dependent child; or • ≤ 21 years of age, ≥ 65 years of age	• Physical and mental health • Dental ($510 cap/yr, no dentures) • Prescriptions • Chiropractic (limited) • Transportation (limited) • Excluded classes of Medicare Part D drugs with Medicare eligibility • Katie Becket Medicaid covers 100% of recipient's costs • Additional benefits for youth ages 19-20, and Katie Becket recipients (see Dr. Dynasaur below)	• No monthly premium • $1/$2/$3 prescription co-pay if no Medicare Part D coverage • $1.20 -$6.60 co-pays with Medicare Part D coverage • $3 dental co-pay • $3 outpatient hospital visit co-pay (over 21 yrs of age) • No co-pay for pregnant or post-partum persons, or persons in LTC facility
Dr. Dynasaur	• Children under age 19 at or below 317% FPL • Pregnant persons at or below 213% FPL	• Same as Medicaid plus: o Eyeglasses o Dental o Additional benefits	• Up to 195% FPL: no premium • Up to 237% FPL: $15/family/month • Up to 317% FPL: $20/family/month ($60/family/mo. w/out other insurance) • No prescription co-pays
VPharm1, 2, & 3	• ≥ age 65, blind, or disabled • eligible and enrolled in Medicare PDP or MAPD •VPharm1: o ≤ 150% FPL o Must apply for LIS •VPharm2: o 150.01% - 175% FPL •VPharm3: o 175.01% - 225% FPL	• VPharm1 (after primary LIS reductions): o Medicare Part D cost-sharing o Excluded classes of Part D meds o Diabetic supplies o Eye exams • VPharm 2&3: o Maintenance meds o Diabetic supplies • No retroactive payments	• Monthly premium per person: o VPharm1: $15 o VPharm2: $20 o VPharm3: $50 • $1/$2 prescription co-pays
Medicare Savings Programs	• ≥ age 65, blind, or disabled • Active Medicare beneficiaries • QMB: ≤ 100% FPL • SLMB 100.01 - 120% FPL • QI-1 120.01 - 135% FPL • QI-1 Not eligible for Medicaid	• 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 monthly premium • QMB may still have to pay Medicare co-pay, and not eligible for retroactive payments • 3 months retroactive payments are possible for SLMB and QI-1
Healthy Vermonters Program	• 350% FPL if uninsured • 400% FPL if ≥ age 65, blind, or disabled	• Medicaid prescription pricing • If enrolled in Medicare Part D, excluded classes of prescriptions are priced at Medicaid rate • No retroactive payments	• No monthly premium
Qualified Health Plan (QHP)	• Vermont Residents who do not have Medicare/Medicaid	• Choice of Eligible QHPs on (VHC)	• Full QHP cost sharing unless reduced by tax credits, or employer share
Federal Advance Premium Tax Credits (APTC)	• 100-400% FPL • No Medicaid • Enrolled in Silver Plan QHP	• Tax credit received yearly as a lump sum, or monthly toward QHP premium	• Full QHP cost sharing minus tax credit
Federal Cost-Sharing Reduction (CSR)	• ≥ 250% FPL • No affordable Minimum Essential Coverage (MEC) • Meets APTC	• Reduces co-pays, co-insurance, deductibles, etc.	• Full QHP cost sharing with reduction in co-pays, co-insurance, deductibles, etc.
Vermont Premium Assistance (VPA)	• ≥ 300% FPL • No affordable MEC • Meets APTC	• Covers all or part of QHP premium	• Covers all or part of QHP premium
Vermont Cost Sharing Reductions (VCSR)	• ≥ 300% FPL • No affordable MEC • Meets APTC	• Reduces co-pays, co-insurance, deductibles, etc.	• Full QHP cost sharing with reduction in co-pays, co-insurance, deductibles, etc.

2016 FPL Chart

HH size	PIL outside Chitt. County	PIL inside Chitt. County	100% FPL	120% FPL	138% FPL	150% FPL	175% FPL	200% FPL	225% FPL	250% FPL	350% FPL	400% FPL
1	$1,008	$ 1,083	$ 990	$1,188	$1,366	$ 1,485	$ 1,733	$ 1,980	$ 2,228	$ 2,475	$ 3,465	$ 3,960
2	$1,008	$ 1,083	$ 1,335	$1,602	$1,842	$ 2,003	$ 2,337	$ 2,670	$ 3,004	$ 3,338	$ 4,673	$ 5,340
3	$1,208	$ 1,283	$ 1,680	$2,016	$2,318	$ 2,520	$ 2,940	$ 3,360	$ 3,780	$ 4,200	$ 5,880	$ 6,720
4	$1,366	$ 1,450	$ 2,025	$2,430	$2,795	$ 3,038	$ 3,544	$ 4,050	$ 4,557	$ 5,063	$ 7,088	$ 8,100
5	$1,541	$ 1,625	$ 2,370	$2,844	$3,271	$ 3,555	$ 4,148	$ 4,740	$ 5,333	$ 5,925	$ 8,295	$ 9,480
6	$1,650	$ 1,733	$ 2,715	$3,258	$3,747	$ 4,073	$ 4,752	$ 5,430	$ 6,109	$ 6,788	$ 9,503	$10,860
7	$1,850	$ 1,925	$ 3,060	$3,672	$4,223	$ 4,590	$ 5,355	$ 6,120	$ 6,885	$ 7,650	$10,710	$12,240
8	$2,008	$ 2,091	$ 3,405	$4,086	$4,699	$ 5,108	$ 5,959	$ 6,810	$ 7,662	$ 8,513	$11,918	$13,620
9	$2,166	$ 2,250	$ 3,750	$4,500	$5,175	$ 5,625	$ 6,563	$ 7,500	$ 8,438	$ 9,375	$13,125	$15,000
10	$2,325	$ 2,400	$ 4,095	$4,914	$5,651	$ 6,143	$ 7,167	$ 8,190	$ 9,214	$10,238	$14,333	$16,380
11	$2,483	$ 2,558	$ 4,440	$5,328	$6,127	$ 6,660	$ 7,770	$ 8,880	$ 9,990	$11,100	$15,540	$17,760
12	$2,633	$ 2,716	$ 4,785	$5,742	$6,603	$ 7,178	$ 8,374	$ 9,570	$10,767	$11,963	$16,748	$19,140
13	$2,791	$ 2,875	$ 5,130	$6,156	$7,079	$ 7,695	$ 8,978	$10,260	$11,543	$12,825	$17,955	$20,520
14	$2,950	$ 3,025	$ 5,475	$6,570	$7,556	$ 8,213	$ 9,582	$10,950	$12,319	$13,688	$19,163	$21,900
15	$3,100	$ 3,183	$ 5,820	$6,984	$8,032	$ 8,730	$10,185	$11,640	$13,095	$14,550	$20,370	$23,280

Income calculations are based on Gross Monthly Income minus some deductions. Taxes and FICA are not considered available deductions. QHP, APTC, CSR, VPA, and VCSR income is determined using MAGI (Modified Adjusted Gross Income).

Premiums

A subset of Green Mountain Care enrollees is required to pay monthly premiums. These premiums are income based, the chart below describes FPL guidelines, and population estimates as well as their impact on premium collection.

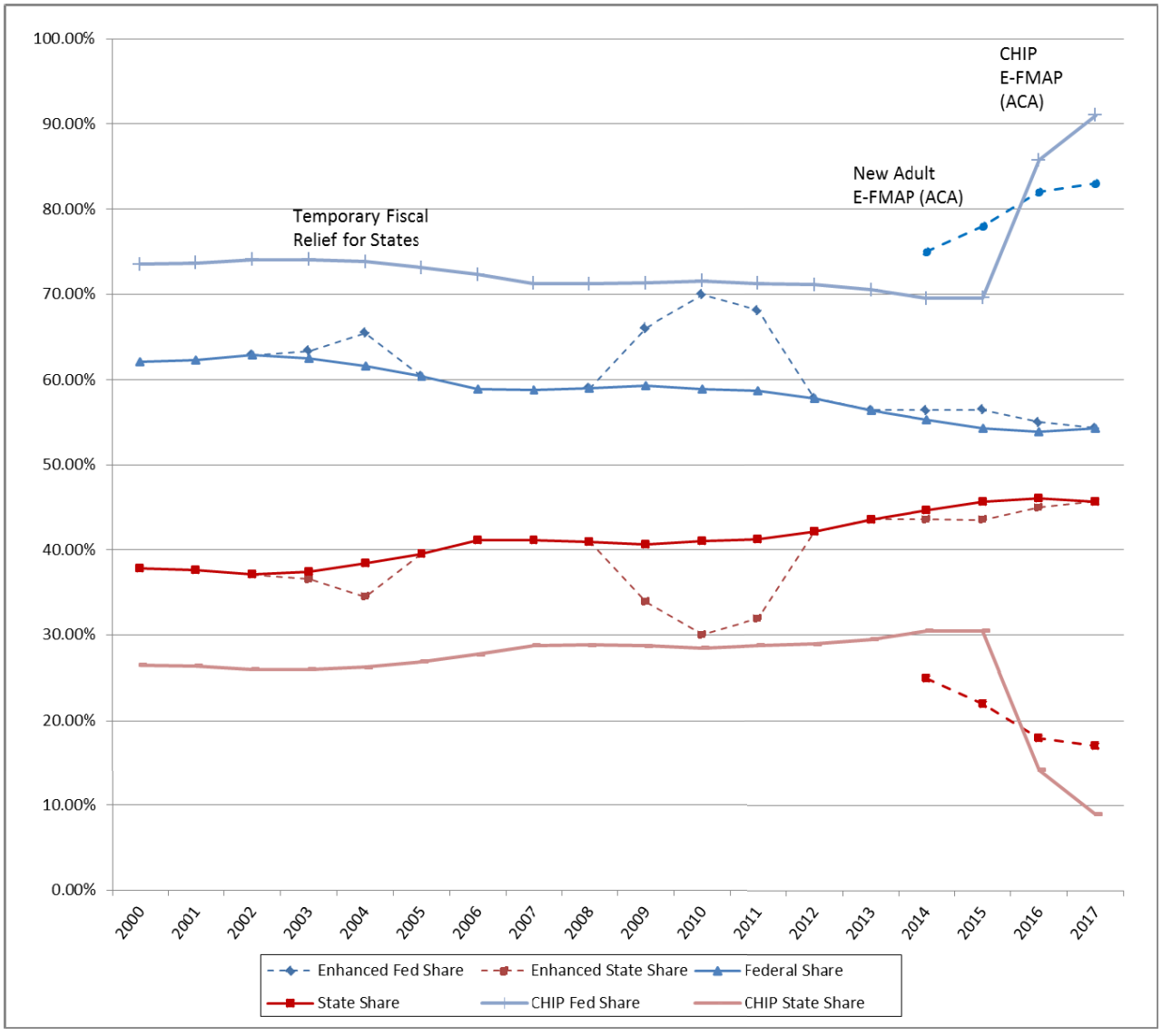
Program	% FPL	'16 Steady State Enroll	'16 Steady State Premium	'16 Steady State Premiums	'16 BAA Enroll	'16 BAA Premium	'16 BAA Premiums	'17 Gov. Rec. Enroll	'17 Gov. Rec. Premium	'17 Gov. Rec. Premiums
Dr. Dynasaur	0-195%	56,601	$ -	$ -	60,887	$ -	$ -	63,008	$ -	$ -
Dr. Dynasaur	195-237%	4,721	$ 15.00	$ 531,071	5,078	$ 15.00	$ 571,280	5,255	$ 15.00	$ 591,183
Dr. D *with ins.*	237-312%	981	$ 20.00	$ 147,177	865	$ 20.00	$ 129,808	820	$ 20.00	$ 123,018
Dr. D *without ins.*	237-312%	4,417	$ 60.00	$ 1,987,685	4,649	$ 60.00	$2,092,011	4,874	$ 60.00	$2,193,489
Dr. D Total		66,720		$ 2,665,933	71,479		$2,793,099	73,957		$2,907,690
VPharm 1	0-150%	8,018	$ 15.00	$ 1,443,244	7,420	$ 15.00	$1,335,586	6,956	$ 15.00	$1,252,093
VPharm 2	150-175%	2,469	$ 20.00	$ 592,548	2,285	$ 20.00	$ 548,347	2,142	$ 20.00	$ 514,068
VPharm 3	175-225%	2,222	$ 50.00	$ 1,333,475	2,057	$ 50.00	$1,234,005	1,928	$ 50.00	$1,156,863
Pharmacy Total		12,709		$ 3,369,267	11,761		$3,117,938	11,026		$2,923,023
TOTAL				$ 6,035,200			$5,911,037			$5,830,713
Federal				$ 2,210,593			$2,258,943			$2,307,829
GF				$ 3,824,607			$3,652,094			$3,522,885
Total				$ 6,035,200			$5,911,037			$5,830,713

Federal Medical Assistance Percentage (FMAP)

The FMAP is the share of state Medicaid benefit costs paid by the federal government. The Secretary of the U.S. Dept. of Health and Human Services calculates the FMAPs each year, based on a three-year average of state per capita personal income compared to the national average.

No state can receive less than 50% or more than 83%, with the exception of "enhanced FMAPs" for expansion populations under the ACA and for the Children's Health Insurance Program (CHIP).

Vermont Medicaid, SFY 2000 - 2017



FEDERAL MATCH RATES
Fiscal Years 2010 to 2017

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

Federal Fiscal Year

FFY	From	To	Federal Share w/o hold harmless	e-FMAP	Total Federal Share	State Share
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		**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	10/01/13	09/30/14	55.11%	n/a	55.11%	44.89%
	ACA Expansion State e-FMAP		**55.11%**	**1.65%**	**56.76%**	**43.24%**
2015	10/01/14	09/30/15	54.01%	n/a	54.01%	45.99%
	ACA Expansion State e-FMAP		**54.01%**	**2.20%**	**56.21%**	**43.79%**
2016	10/01/15	09/30/16	53.90%	n/a	53.90%	46.10%
	ACA Expansion State e-FMAP		**53.90%**	**0.55%**	**54.45%**	**45.55%**
2017 proj.	*10/01/16*	*09/30/17*	*54.46%*		*54.46%*	*45.54%*

State Fiscal Year

SFY	From	To	Federal Share w/o hold harmless	e-FMAP	Total Federal Share	State Share
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		**58.72%**	**9.35%**	**68.07%**	**31.93%**
2012	7/1/2011	6/30/2012				
	Non-ARRA		57.86%	n/a	57.86%	42.14%
2013	7/1/2012	6/30/2013	56.43%	n/a	56.43%	43.57%
2014	7/1/2013	6/30/2014	55.34%	n/a	55.34%	44.66%
	ACA Expansion State e-FMAP		**55.34%**	**1.10%**	**56.44%**	**43.56%**
2015	7/1/2014	6/30/2015	54.29%	n/a	54.29%	45.71%
	ACA Expansion State e-FMAP		**54.29%**	**2.20%**	**56.49%**	**43.51%**
2016	7/1/2015	6/30/2016	53.93%	n/a	53.93%	46.07%
	ACA Expansion State e-FMAP		**53.93%**	**1.10%**	**55.03%**	**44.97%**
2017 proj.	*7/1/2016*	*6/30/2017*	*54.32%*		*54.32%*	*45.68%*

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

Federal Fiscal Year

FFY	From	To	Federal Share	e-FMAP	Total Federal Share	State Share
2010	10/01/09	09/30/10	71.11%	n/a	71.11%	28.89%
2011	10/01/10	09/30/11	71.10%	n/a	71.10%	28.90%
2012	10/01/11	09/30/12	70.31%	n/a	70.31%	29.69%
2013	10/01/12	09/30/13	69.23%	n/a	69.23%	30.77%
2014	10/01/13	09/30/14	68.08%	n/a	68.08%	31.92%
	Expanded CHIP FMAP		**68.08%**	**1.65%**	**69.73%**	**30.27%**
2015	10/01/14	09/30/15	67.15%	n/a	67.15%	32.85%
	Expanded CHIP FMAP		**67.15%**	**2.20%**	**69.35%**	**30.65%**
2016 proj.	*10/01/15*	*09/30/16*	*67.57%*	*n/a*	*67.57%*	*32.43%*
	Expanded CHIP FMAP		***67.57%***	***23.55%***	***91.12%***	***8.88%***
2017 proj.	*10/01/16*	*09/30/17*	*68.12%*	*n/a*	*68.12%*	*31.88%*
	Expanded CHIP FMAP		***68.12%***	***23.00%***	***91.12%***	***8.88%***

State Fiscal Year

SFY	From	To	Federal Share	e-FMAP	Total Federal Share	Share
2010	7/1/2009	6/30/2010	71.24%	n/a	71.24%	28.76%
2011	7/1/2010	6/30/2011	71.10%	n/a	71.10%	28.90%
2012	7/1/2011	6/30/2012	70.51%	n/a	70.51%	29.49%
2013	7/1/2012	6/30/2013	69.50%	n/a	69.50%	30.50%
2014	7/1/2013	6/30/2014	68.41%	n/a	68.41%	31.59%
	Expanded CHIP FMAP		**68.41%**	**1.10%**	**69.51%**	**30.49%**
2015	7/1/2014	6/30/2015	67.34%	n/a	67.34%	32.66%
	Expanded CHIP FMAP		**67.34%**	**2.20%**	**69.54%**	**30.46%**
2016 proj.	*7/1/2015*	*6/30/2016*	*67.42%*	*n/a*	*67.42%*	*32.58%*
	Expanded CHIP FMAP		***67.42%***	***18.35%***	***85.77%***	***14.23%***
2017 proj.	*7/1/2016*	*6/30/2017*	*68.02%*	*n/a*	*68.02%*	*31.98%*
	Expanded CHIP FMAP		***68.02%***	***23.00%***	***91.02%***	***8.98%***

****Title IV-E FMAPs during the ARRA period (10/1/2008-6/30/2011) are calculated as follows:**

10/1/2008-12/31/2010: Base Federal share + 6.2% ARRA
1/1/2011-3/31/2011: Base Federal share + 3.2% ARRA
4/1/2011-6/30/2011: Base Federal share + 1.2% ARRA
Title IV-E does not receive ACA Expansion State Enhanced FMAP.

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BUDGET SUMMARY ADMINISTRATION

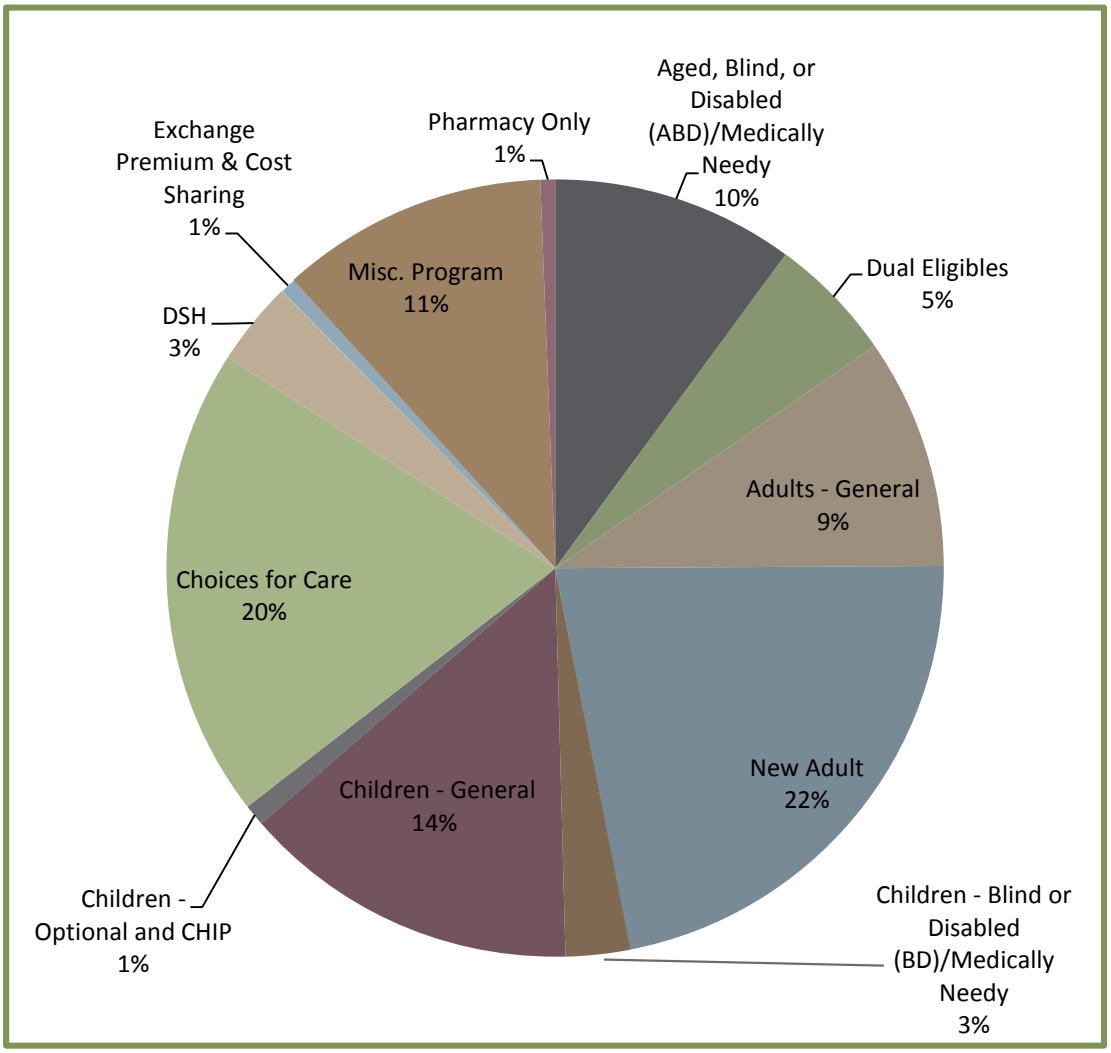
Administration	GF	SF	IdptT	FF	VT Health Connect (Portion Funded By SHCRF)	Medicaid GCF	Invmnt GCF	Total
DVHA Administration - As Passed FY16	**1,447,997**	**797,332**	**9,201,544**	**84,243,588**		**77,703,344**	**8,904,971**	**182,298,776**
Personal Services:								
2015 Act 58 Section B. 1104 (BAA Item)	(13,990)		(15,168)	(148,797)		(843,694)		**(1,021,649)**
Operating Expenses:								
2015 Act 58 Sections B. 1103 and B. 1104 (BAA Item)	(4,545)			(8,212)		(5,339)		**(18,096)**
FY16 after other changes	**(18,535)**	**0**	**(15,168)**	**(157,009)**	**0**	**(849,033)**	**0**	**(1,039,745)**
Total after FY16 other changes	**1,429,462**	**797,332**	**9,186,376**	**84,086,579**	**0**	**76,854,311**	**8,904,971**	**181,259,031**
FY16 after other changes								
Personal Services:								
Salary increase	5,227	1,086		69,187	8,913	234,802	6,753	**325,968**
Fringe increase	3,070	638		40,634	5,234	137,900	3,966	**191,442**
Workers' Compensation Insurance	(263)	(55)	(448)	(3,483)		(11,819)	(340)	**(16,408)**
Transfer DCF Health Access Eligibility Unit (HAEU) and Assisted Operations (AOPs) positions from DCF to DVHA (108 positions) [AHS net-neutral]	686,662			2,002,304	533,865	4,712,165		**7,934,996**
VT Health Connect (VHC) Personal Services budget realignment (BAA Item)					(171,126)	(182,064)		**(353,190)**
VHC Overhead budget realignment (BAA Item)					(187,914)	(824,207)		**(1,012,121)**
VHC Contracts budget realignment (BAA Item)					1,210,613	(168,075)		**1,042,538**
VHC OAPD Enhanced funding for contracted M&O services up (BAA Item)	4,550,585			13,651,754		(18,202,339)		**0**
Position transfer to AHS CO from DVHA (AHS net-neutral) [BAA Item]	(130,381)							**(130,381)**
Blueprint contract reduction						(182,700)	(117,300)	**(300,000)**
3.5 new FTE's needed						530,871		**530,871**
Swaps SHCRF for Exchange, replaced with IDT			1,304,892		(1,304,892)			**0**
Operating:								
Transfer HAEU and AOPs Operating expenses from DCF to DVHA (AHS net-neutral)					94,693	766,157		**860,850**
Internal Services Fund (ISF) DII	(252)	(48)	(683)	(3,359)		(12,271)	(336)	**(16,949)**
ISF DHR	(232)	(44)	(628)	(3,088)		(11,283)	(309)	**(15,585)**
ISF VISION	(160)	(30)	(434)	(2,133)		(7,794)	(213)	**(10,765)**
ISF General Liability Insurance	28	5	75	370		1,353	37	**1,869**
ISF Property Insurance	0	0	1	4		16	0	**22**
ISF Commercial Policies	2	0	6	30		109	3	**150**
ISF Fee For Space	4,507	854	12,211	60,009		219,236	6,001	**302,818**
ISF DII Demand	(186)	(35)	(504)	(2,478)		(9,055)	(248)	**(12,507)**
Leased Space - increase for new leases at Global Foundries	14,372			129,344				**143,715**
Lease savings	(12,023)		(89,726)	(273,243)		(221,758)		**(596,750)**
Property Management Surcharge	668	191	3,554	6,013		63,608	1,270	**75,305**
Grants:								
Reduce special projects grant to fund Licensed Alcohol and Drug Abuse Counselors (LADC) (DVHA net-neutral)						(160,000)		**(160,000)**
								0
FY17 Changes	**5,121,624**	**2,562**	**1,228,315**	**15,671,864**	**189,386**	**(13,327,147)**	**(100,715)**	**8,785,888**
FY17 Gov Recommended	**6,551,086**	**799,894**	**10,414,691**	**99,758,443**	**189,386**	**63,527,164**	**8,804,256**	**190,044,919**
FY17 Legislative Changes								
FY17 Subtotal of Legislative Changes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
FY17 As Passed - Dept ID 3410010000	**6,551,086**	**799,894**	**10,414,691**	**99,758,443**	**189,386**	**63,527,164**	**8,804,256**	**190,044,919**

BUDGET SUMMARY PROGRAM

FY17 Department Request - DVHA

Program	GF	SF	State Health Care Res	IdptT	FF	VT Health Connect (Portion Funded By SHCRF)	Medicaid GCF	Invmnt GCF	Total
DVHA Program - As Passed FY16	144,786,830				141,792,900		659,633,970	7,989,887	954,203,587
Grants:									
2015 Act 54 Increase payments to patient-centered medical homes and community health teams (BAA Item)							2,446,075		2,446,075
2015 Act 54 Increase reimbursement rates to primary care providers (BAA Item)							1,036,540		1,036,540
2015 Act 54 Increase to reimbursement rates for mental health and substance abuse treatment not through DAs (BAA Item)							111,185		111,185
2015 Act 54 Increase to reimbursement rates for HCBS (BAA Item)							139,945		139,945
2015 Act 54 Cost-sharing subsidies (BAA Item)	761,308								761,308
FY16 after other changes	761,308	0	0	0	0	0	3,733,745	0	4,495,053
Total after FY16 other changes	145,548,138	0	0	0	141,792,900	0	663,367,715	7,989,887	958,698,640
FY16 after other changes									
Other Changes:									
Appropriation adjustments due to GC and CFC waiver consolidation (AHS net-neutral) [BAA Item]	(93,750,824)				(114,723,364)		208,474,188		0
Grants:									
Caseload and Utilization	(1,617,851)				749,433		69,406,982	(113,740)	68,424,824
Buy-in								46,379	46,379
GC Buy-in (BAA Item)							526,379		526,379
Buy-in premium increase (BAA Item)					497,919		4,481,272		4,979,191
Applied Behavioral Analysis (ABA) - current rate structure plus increase plus funding for NCSS IFS program from DVHA to DMH (AHS net-neutral) (BAA Item)							4,870,901		4,870,901
Change in Federal Participation	(1,137,087)				1,137,087				0
Clawback (BAA Item)	5,967,321								5,967,321
Licensed Alcohol and Drug Abuse Counselors (LADC) [BAA Item] (DVHA net-neutral)							160,000		160,000
Implement best practice - Involuntary Medication policy							(5,000,000)		(5,000,000)
Long Acting Reversible Contraception (LARC) (BAA Item)							(4,750,000)		(4,750,000)
Technical rate adjustments to align with best practices							(7,820,882)		(7,820,882)
Pregnant persons between 138% and 213% FPL							(4,929,003)		(4,929,003)
Group psychotherapy reimbursement adjustment							(2,000,000)		(2,000,000)
Total (gross) rate increase for dentists							2,200,000		2,200,000
Total (gross) rate increase for doctors							8,400,000		8,400,000
Nursing Home changes and carryforward from SFY16 to SFY17							4,786,983		4,786,983
FY17 Changes	(90,538,441)	0	0	0	(112,338,925)	0	278,806,820	(67,361)	75,862,093
FY17 Gov Recommended	55,009,697	0	0	0	29,453,975	0	942,174,535	7,922,526	1,034,560,733
FY17 Legislative Changes									
FY17 Subtotal of Legislative Changes	0	0	0	0	0	0	0	0	0
FY17 As Passed - Dept ID 3410015000	55,009,697	0	0	0	29,453,975	0	942,174,535	7,922,526	1,034,560,733
TOTAL FY16 DVHA Big Bill As Passed	146,234,827	797,332	0	9,201,544	226,036,488	0	737,337,314	16,894,858	1,136,502,363
TOTAL FY16 DVHA Reductions & other changes	742,773	0	0	(15,168)	(157,009)	0	2,884,712	0	3,455,308
TOTAL FY17 DVHA Starting Point	146,977,600	797,332	0	9,186,376	225,879,479	0	740,222,026	16,894,858	1,139,957,671
TOTAL FY17 DVHA ups & downs	(85,416,817)	2,562	0	1,228,315	(96,667,060)	189,386	265,479,673	(168,077)	84,647,982
TOTAL FY17 DVHA Gov Recommended	61,560,783	799,894	0	10,414,691	129,212,419	189,386	1,005,701,699	16,726,781	1,224,605,653
TOTAL FY17 DVHA Legislative Changes	0	0	0	0	0	0	0	0	0
TOTAL FY17 DVHA As Passed	61,560,783	799,894	0	10,414,691	129,212,419	189,386	1,005,701,699	16,726,781	1,224,605,653

SFY 2017 Program Budget Breakout by Medicaid Eligibility Group



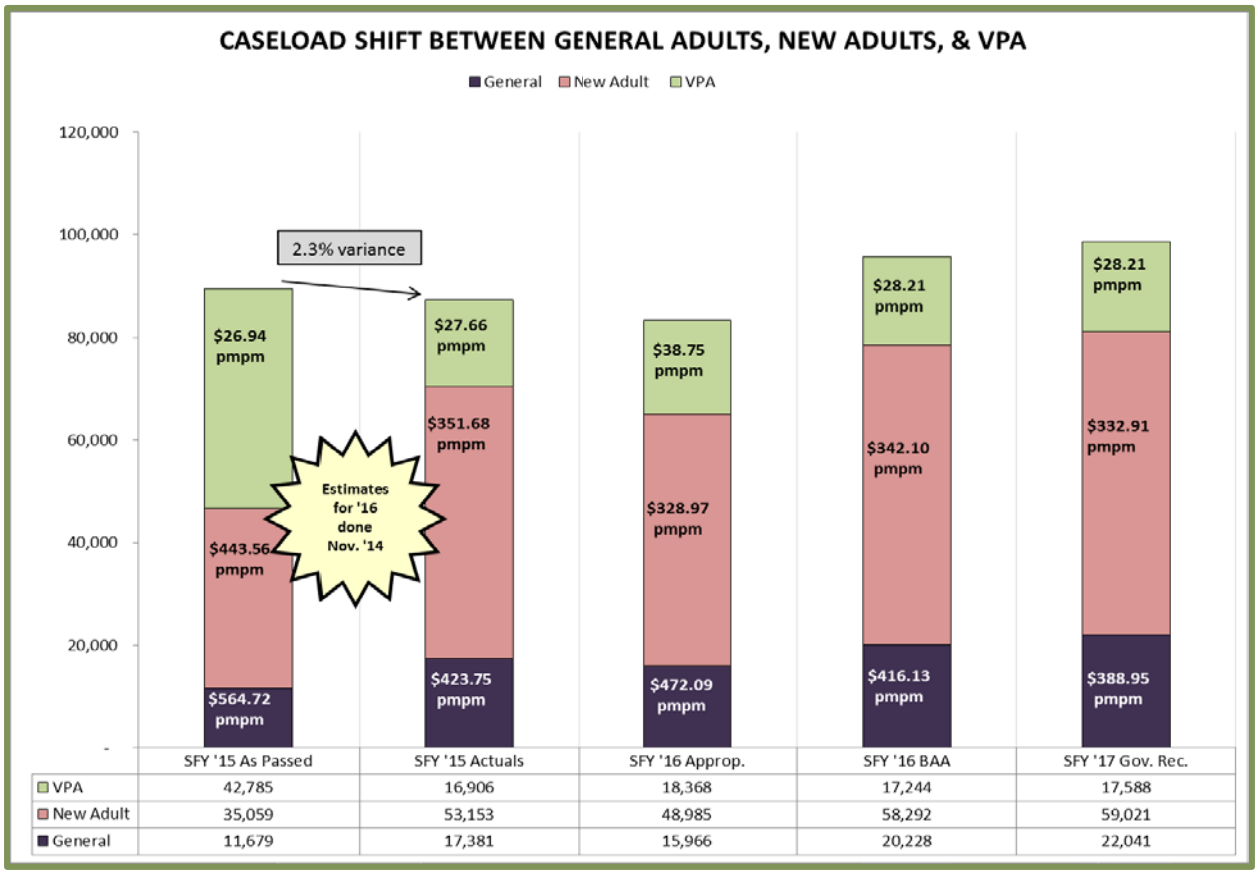
The Department of Vermont Health Access (DVHA) budget request includes an increase in administration of $8,785,888 and an increase in program of $75,862,093 for a total of $84,647,982 in new appropriations (a combination of new funds and new expenditure authority) as compared to our SFY16 appropriated spending authority.

The programmatic changes in DVHA's budget are spread across four different covered appropriations: 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. It is also worth noting that while Choices for Care is still handled independently of the Global Commitment appropriation, the expenditures are now allocated at the same rates and using the same funds.

Caseload and Utilization Changes $68,424,824

$26,415,651 state

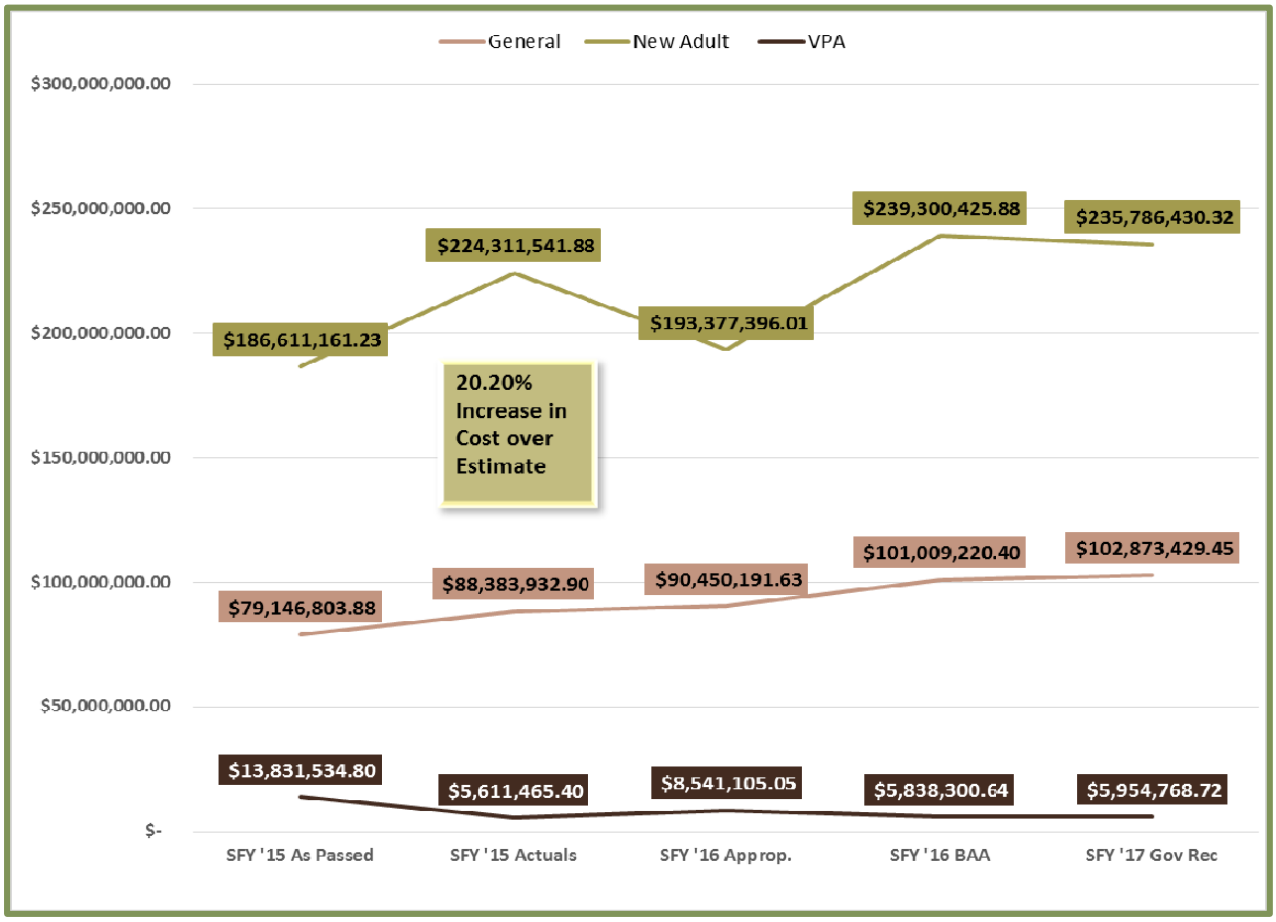
DVHA engages in a consensus caseload estimate process with the Joint Fiscal Office, the Department of Finance and Management, and the Agency of Human Services when projecting caseload and utilization growth. The success of Vermont's Medicaid expansion means a growth in the caseload seen primarily in the New Adults category. The original predictions, made after the VHAP and Catamount programs ended in 2014, estimated the majority of enrollees would move into one of the QHP cost assistance programs. After reviewing the SFY 2015 actuals, it was evident that while caseload numbers were projected well, the crosswalk analysis done by a third party proved incorrect. This can be seen in the chart below. The expanded eligibility guidelines allowed for a significant number of those previously enrolled in a Catamount program to transition to the more costly New Adults program and SFY 2017 estimates must accommodate this connection. The utilization changes included in this request are based not only on increases predicted by the same consensus process as the caseload estimates, but also changes to the prescription drug formulary that include new and expensive medications which offer much needed treatments where less effective options existed. For more information on the fiscal pressures associated with the increased medication costs, see the *Vermont Medicaid Trends – A National & Regional Comparison* section of this document.



	SFY '15 As Passed	SFY '15 Actuals	SFY '16 Approp.	SFY '16 BAA	SFY '17 Gov. Rec.
VPA	42,785	16,906	18,368	17,244	17,588
New Adult	35,059	53,153	48,985	58,292	59,021
General	11,679	17,381	15,966	20,228	22,041

Based on the case shift above, the total costs changed dramatically from SFY2015 As Passed to SFY 2015 Actuals.

SFY 2017 Projected Spend Based on Caseload for Non-ABD Adults



Additional Changes

GC and CFC Waiver consolidation appropriation adjustments . . . . . $(0)

$1,480,185 state

Buy-In Adjustment $572,758

$261,636 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.

Buy-in Medicare Part B premium increase $4,979,191

$2,047,045 state

As of January 1, 2016, CMS has increased Medicare Part B premiums by nearly 14% for those who have assistance in paying their premiums. The structure of this increase puts the burden of additional cost on the individual states. The above request is reflective of that cost increase.

Applied Behavioral Analysis (ABA) $4,870,901

$2,225,028 state

DVHA garnered state plan approval to offer applied behavior analysis services to individuals with autism in order to address a service delivery gap. This adds funding to support the new service costs ~ $2,800,000, increases rates due to feedback received through the public notice process that established rates were not sufficient ~ $2,500,000, and transfers funding to DMH to support ABA expansion in the NCSS IFS bundle ~ ($429,099).

Change in Federal Participation Match Rate $0

$(1,137,087) state

The federal receipts the State receives is dependent upon a funding formula used by the federal government (Federal Medical Assistance Percentage - FMAP) and which is based on economic need for each state across the country. This general fund impact is due to a reduction in the traditional match rate, a significant increase in the CHIP match rate, and the elimination of the 2.2% as of January 1, 2016.

Increase in Clawback $5,967,321

$5,967,321 state

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 those enrollees who are or would be eligible for Medicaid drug coverage. This is referred to as "Clawback" or "state phase down."

Licensed Alcohol and Drug Abuse Counselors $160,000

$73,088 state

In a DVHA net-neutral shift, DVHA has removed the cost of this specific group of providers from the Special Projects grant, and moved it into the standard Program budget.

Long Acting Reversible Contraceptives . . . . . $(4,750,000)

$(2,169,800) state

Long-acting reversible contraceptives (LARC) methods include the intrauterine device (IUD) and the birth control implant. Both methods are highly effective in preventing pregnancy, last for several years, are easy to use, and are reversible. Inpatient setting after delivery is a critical time to promote contraceptive use. Too often after hospital discharge, individuals do not follow up with outpatient providers for birth control, while they're at higher risk for future unintended pregnancies. 46% of Vermont pregnancies are unintended. The immediate postpartum period – prior to hospital discharge— can be an opportune time to offer contraception. Increasing the post-partum inpatient Diagnosis Related Grouping (DRG) with an add-on payment will promote post-partum contraceptive intervention. While a benefit to all individuals in the postpartum period, this is an especially important strategy for more vulnerable persons who face social and economic barriers. These individuals' life circumstances may be encumbered by substance

abuse, mental health issues, and/or poverty. As such they are at risk of not returning for a postpartum visit. Preliminary 2012 Vermont data show that of the 6,007 births, only 50.3% were intended pregnancies. 74% of unplanned births are publicly funded in Vermont and more than $30 million is spent each year on unintended pregnancies in the state.

Technical Rate Adjustments to Align with Best Practices . . . . . $(7,820,882)

$(3,572,579) state

DVHA has committed to making changes in the areas of payment methodologies to align with best practices. These changes include:

- **Align Inpatient Detox Reimbursement with Best Practice** ~ ($1,489,882) gross: Beginning July 1, 2015, admissions to an inpatient hospital for opioid detoxification must meet medical necessity criteria in order to be reimbursable through Vermont Medicaid. The Department of Vermont Heath Access (DVHA) utilizes the McKesson InterQual ® Level of Care Criteria. These nationally recognized, evidence-based criteria will be used to determine the medical necessity of any inpatient admission submitted to the DVHA for reimbursement.
- **Prior Authorize Outpatient Psychotherapy > 24 Visits per Calendar Year** ~ ($2,200,000) gross: The Clinical Utilization Review Board (CURB) reviewed utilization of the outpatient psychotherapy services for adults and children. The number of outpatient psychotherapy services per person has been increasing. After reviewing the utilization data, on July 15, 2015 the CURB voted unanimously in favor of requiring outpatient psychotherapy providers. Recommendation from CURB: Require Prior Authorization for outpatient psychotherapy visits one standard deviation beyond median. This equates to after 24 visits per calendar year, a prior authorization is needed for additional visits.
- **Adopt Medicare's Reimbursement Practice for Oxygen** ~ ($70,000) gross**:** Medicare limits the reimbursement for Oxygen to a 36 month rental cap. After the 36 months, the supplier is responsible for performing any repairs or maintenance and servicing of the equipment. Medicare will pay for maintenance and service no more often than every 6 months beginning 6 months after the 36 month rental cap.
- **Revise Psychiatric Inpatient Reimbursement Methodology to Only Apply When a Patient is Cared for on a Psychiatric Unit** ~ ($1,500,000) gross: Currently any inpatient claim grouped into a psych DRG is paid using the inpatient psychiatric reimbursement methodology, including inpatient stays on medical floors. This change proposes to adjust the current inpatient psych reimbursement methodology to only apply to inpatient stays on psychiatric floors and have any inpatient stay on a medical floor be paid as other inpatient stays on medical floors, according to the DRG, without the psychiatric per diem. This would ensure that only stays receiving the full complement of psychiatric services expected to be provided on a psychiatric unit are paid with the psychiatric reimbursement methodology.

Technical Rate Adjustments to Align with Best Practices Continued

- **Cardiology High-Tech Imaging Prior Authorization** ~ ($711,000) gross: Currently cardiology services are not prior authorized. Adopting this proposal will allow the current vendor performing prior authorizations for other hi-tech imaging services, will also perform prior authorizations and monitor inappropriate utilization for cardiac imaging.
- **Add-ons for Newborn DRGs** ~ ($1,000,000) gross: Currently, DRG pricing logic takes into account the mean length of stay (LoS), and add-on claims do not. This proposal would adjust the add-on payment by taking into consideration the mean length of stay.
- **Add-on Code Reimbursement** ~ ($175,000) gross: Medicare requires that an add-on code be reimbursed only in conjunction with a primary service (also known as a parent code). This adjustment brings Medicaid payment methodologies in line with Medicare rules.
- **Endoscopy Reimbursement Policy** ~ ($200,000) gross: Medicare has special payment rules for multiple endoscopies performed on the same day. When two endoscopies in the same family are performed, the endoscopy with the highest fee schedule amount is allowed at 100%. The additional related endoscopies are priced by subtracting the base endoscopy price. This adjustment brings Medicaid payment methodologies in line with Medicare rule.
- **Generic Drug Rebate Expansion** ~ ($475,000) gross: Currently, we are allowed to set a State Maximum Allowable Cost (SMAC) on all generic drugs. This has always been a pricing service contracted service through the PBM. Our new vendor GHS, who has a more robust SMAC program, is recommending new SMAC's on a number of generics which could save the state $475,000 SFY 2017. We have already implemented some new SMAC's totaling $1.5 million in savings for SFY'16, which we submitted for SFY'16 BAA.

Group Psychotherapy Reimbursement Adjustment . . . . . $(2,000,000)

$(913,600) state

As previously requested in the SFY 2016 BAA, DVHA is revising the reimbursement methodology for group psychotherapy billed under Current Procedural Terminology (CPT®) Code 90853, to the Resource Based Relative Value System (RBRVS) payment methodology DVHA uses for professional services. This is needed to comply with federal requirements. The Medicaid State Plan requires professional services to follow RBRVS, and this is the methodology used by DVHA for the payment of all other psychotherapy CPT® codes. This change went into effect January 1, 2016 and no additional changes to payment methodology are being requested at this time.

Nursing Home Changes and Carryforward $4,786,983

$2,186,694 state

Changes to Nursing home costs include: utilization, the statutory Nursing Home rate increase, a backfilling of one-time SFY2016 funds, caseload pressure from the Home and Community Based population, and the anticipated carryforward from SFY2016 into SFY2017.

All Payer Model (APM)

The Governor, his senior healthcare advisors, and Green Mountain Care seek to transform Vermont's healthcare system under the All Payer Model from one that rewards fee-for-service, quantity-driven care to one that rewards quality-based care; focusing on keeping Vermonters healthy. This work will enable Vermont to address rising healthcare costs that are squeezing the budgets of families, businesses, and state government.

The fee-for-service healthcare model is over 50 years old and was designed to treat acute medical conditions that required a single visit. Today, treating people with chronic diseases account for 86 percent of healthcare costs, according to the Centers for Disease Control. The disconnect means that doctors are governed by a payment system that does not address the needs of patients, a situation that results in Vermonters receiving care that is expensive, fragmented, and disorganized. The All Payer Model seeks to change that by enabling the three main payers of healthcare in Vermont - Medicaid, Medicare, and private insurance - to pay doctors and hospitals in a different way than they do today. Instead of paying for each test or procedure, doctors and hospitals will receive a set payment for each patient attributed to them, shifting the financial incentive from running tests and procedures to keeping patients healthy.

The heart of the proposal is to keep healthcare costs below the growth of the general economy. The terms outlined today propose a statewide healthcare spending target for all payers in the healthcare system of 3.5 percent with a maximum allowable spending growth of 4.3 percent for the next five years. The financial cap is set approximately 1 percent higher than Vermont's economic growth as measured by gross state product over the past 15 years.

Along with spending targets will be quality ones that ensure Vermonters not only spend less but see better health outcomes. The three goals included in this proposal are: increasing access to primary care, reducing the prevalence of and improving the management of chronic diseases, and addressing the substance abuse epidemic.

Under the All Payer Model, Vermonters will continue to see the doctor or heath care provider of their choice. Vermonters on Medicare and Medicaid will see no change to their benefits. In fact, Vermont proposes to expand Medicare benefits to seniors, including services at home for seniors in through the successful Services and Supports at Home (SASH) program by expanding the program statewide and addiction treatment services through the Hub and Spoke program.

Involuntary Inpatient Mental Health Treatment Best Practice . . . . . $(5,000,000)

$(2,284,000) state

Under current practices found only in Vermont, a patient deemed in need of involuntary inpatient mental health services waits for their due process for a median of 60 days in a facility before beginning treatment. This practice is no longer viewed by the medical and

psychiatric communities as an effective or *ethical* approach to helping these patients and results in several important unintended consequences. In all other states, when persons with serious mental illness are involuntarily hospitalized and refuse treatment, the due process underlying the decision to require involuntary treatment is carried out in approximately two weeks or less. Clinical, ethical, and economic issues that are unique to Vermont would be remedied by implementing the use of an administrative model of due process that is common in other states. By reducing the 60 day waiting period to the currently accepted best practice of two weeks, Vermont reduces the cost of the stay and brings its approach to mental healthcare up to current standards.

Eligibility for Special Enrollment Period for Pregnant Persons and their Families $0

$0 state

New policy will allow for pregnant persons above 138% of the FPL, along with their entire family, to enroll in any QHP, and be screened for all available premium and cost sharing assistance – APTCs, VPA, and/or CSR subsidies.

Eligibility for Pregnant Persons Between 138% and 213% of the FPL . . . . . $(4,929,003)

$(2,251,569) state

DVHA currently offers additional eligibility to pregnant persons above the FPL guideline used for the non-pregnant population. By removing this additional eligibility window, pregnant persons will be subject to the same income guidelines as their non-pregnant counterparts. It ensures that all pregnant individuals with household income at or below 133 percent of federal poverty level with a 5 percent disregard shall receive Medicaid coverage. All others in the individual or small group market will be able to enroll in a qualified health plan through Vermont Health Connect. This eligibility alignment will be accompanied by a change in the enrollment policy for QHPs.

Dental Rate Increase $2,200,000

$1,004,960 state

When VHAP was eliminated, 50,000 former private pay patients converted to adult Medicaid. A number of dental offices found that they could no longer survive financially and needed to significantly reduce the number of Medicaid patients they were able to accept in their practices. This created an access to care issue. The cost of delivery of care from every aspect: taxes, staffing, disposable materials, and capital investment for hard goods, has continued to rise without fee increases. In order to have the infrastructure to provide the care for the general welfare of enrollees, additional funding must be made available. An increase in reimbursement of 18% is recommended for preventive services including routine care such as restorations, fluoride treatment and cleanings.

Primary Care Rate Increase $8,400,000

$3,837,120 state

Primary Care is critical to Vermont's healthcare system. Medicaid expansion has led to more pressure on Primary Care physicians patients due to the increased patient volume. Current reimbursement for Primary Care is approximately 80% of Medicare. The provider community has expressed concerns that the current level of reimbursement is impacting access to care. This budget initiative proposes to fully restore the enhanced primary care payments as defined by the Affordable Care Act (ACA). These rates were in place from 1/1/13 to 12/31/14 and were fully funded by Federal dollars. It is DVHA's recommendation to fully restore the EPCP rates.

Improved Data Matching for Coordination of Benefits Activities . . . . . $(0)

$(0) state

DVHA needs private insurer data files in a Medicaid format that CMS now uses in order to perform mandated Coordination of Benefits activities. DVHA will use the results of the data files to determine whether members have private insurance that should pay for medical claims before DVHA, in compliance with Medicaid as the payer of last resort. Further, federal law requires that the state shall provide assurances to the Secretary that it has laws in effect requiring health insurers to provide data regarding who is enrolled in private coverage and dates of coverage and benefits.

Provider Assessment Expansion . . . . . $(0)

$(17,000,000) State Health Care Resources Fund

The Administration is proposing a 2.35% provider assessment on independent physician practices and practicing dentists. This will raise $17 million in state funds. Of the $17 million, $12 million in state funds will go towards general Medicaid support. This will offset the increased funding to primary care services and preventive dental care services by $5 million.

Provider Assessment Expansion by Provider

Subject to 2.35% tax:	Not included:
Independent entities made up of one or more:	• Chiropractors
• Dentists	• Radiologists
• Dental Hygienists	• Podiatrists
• Dental Assistants	• Optometrists
• Dental Therapists if S.20 passes	• Psychologists
• Primary care physicians	• Drug and Alcohol Counselors
• Physician assistants	• Physical Therapists
• Specialists	• Occupational Therapists
• Osteopaths	• Speech Therapists
• Psychiatrists	• Acupuncturists
• Ophthalmologists	• Dieticians
• Naturopaths	• Midwives
	• Nursing Homes
	• Hospitals
	• Home Health Agency
	• Ambulatory surgical center
	• Free-standing lab
	• Free-standing x-ray facility

Provider Assessment Expansion Continued

Monies from provider taxes are deposited into the State Health Care Resources Fund, and are subject to federal laws including:

- Must be broad based;
- Must be uniformly imposed;
- Cannot violate hold harmless provisions – tax paid is not returned to providers to make them whole. There is a presumption of meeting this requirement if the tax is less than or equal to 6% of net patient revenue.

Revenue from Current Provider Taxes

Class of Provider	FY16 (Gov Rec for e-board BAA Jan. 2016)	FY17 (Gov Rec for e-board January 2016)
Hospital 6% of net patient revenue	$ 129,647,755	$ 133,570,285
Nursing Home per bed assessment	$ 15,644,925	$ 15,245,623
Home Health Agencies 19.3% of net operating revenue	$ 4,487,950	$ 4,521,602
Intermediate Care Facilities 5.9% of total annual and indirect expenses	$ 73,308	$ 73,308
Pharmacy $0.10/script	$ 780,000	$ 780,000
TOTAL	**$ 150,633,938**	**$ 154,191,218**

ADMINISTRATIVE **$8,785,888 GROSS/$218,653 STATE**

Personal Services $8,483,298
$3,046,980 state

- Pay Act and Fringe. . . . . $501,002 *$178,847 state*

- Position and Management Change . . . . . $8,335,486 *$2,951,300 state*

  - DCF is transferring the Health Access Eligibility unit (HAEU), as well as its Assisted Operations (AOPs) positions to DVHA. This transfer is a total of 108 positions, and is an AHS net-neutral shift ~ $7,934,996 gross.

  - DVHA is also transitioning one Full Time Employee position to AHS Central Office ~ ($130,381) gross.

  - In order to oversee and maintain a proposed expansion of Vermont's provider tax to include doctors and dentists, DVHA is requesting 3 new full-time employees. Currently, those two provider populations are excluded from the standard provider tax and including them is expected to increase tax revenue significantly. This expansion requires oversight and management, additional Accounts Receivable staff, and auditing in order to be handled properly ~ $530,871 gross.

- VHC Personal Services budget realignment . . . . . $(353,190) *$(83,167) state*

Operating . . . . . $(279,948)
$(82,071) state

- General Operating . . . . . $(377,730) *$(154,627) state*

  In response to budget pressures, DVHA continues to evaluate the efficacy of current operating expenses, enacting changes where savings can be found. This amount includes lease negotiations and changes, and reflects costs associated with facility changes made in SFY 2016.

- Other Department Allocated Costs . . . . . $249,053 *$99,073 state*

  DVHA receives allocations from the Department of Buildings and General Services (BGS) to cover our share of the Vision system and fee-for-space, the Department of Information and Innovation (DII) costs, and the Department of Human Resources (DHR). Departments are notified every year of

Operating Continued

increases or decreases in their relative share in order to incorporate these changes into budget requests.

- HAEU and AOPs related operational costs . . . . . $860,850 *$349,981 state*

  This is an AHS net-neutral shift to accompany the transition of HAEU and AOPs staff from DCF to DVHA.

- VHC Overhead budget realignment . . . . . $(1,012,121) *$(376,498) state*

  At the end of the legislative session, there was a reduction to DVHA's VHC operating budget of $6.8 million. We were able to realign expenses in order to meet this reduction value.

Grants and Contracts $582,538
$(2,746,256) state

- Blueprint Contract . . . . . $(300,000) *$(137,040) state*

  The University of Vermont Child Health Improvement Program conducts a third party on-site review and submits materials to the National Commission on Quality Assurance (NCQA) on behalf of primary care practices in Vermont who are seeking Patient Centered Medical Home (PCMH) recognition and participation in the Blueprint for Health. PCMH recognition triggers multi-payer per patient medical home payments to the practices and community health team payments to the communities. In light of the current budget climate, Blueprint agreed to eliminate this arrangement.

- Licensed Alcohol and Drug Abuse Counselors **. . . . . .**$(160,000) $*(73,088) state*

  DVHA had special projects money in a UVM grant to support certain analytical and programmatic needs. Again, due to the known budget pressures and the need to increase services to individuals in need of alcohol or drug abuse treatment, a decision was made to eliminate these administrative supports.

- VHC Contracts budget realignment . . . . . .$1,042,538 *$(2,536,128) state*

  As mentioned above, DVHA was able to adjust budget changes made by the legislature in order to meet legislative expectations. Additionally, an Operations Advanced Planning Document (OAPD) was approved by CMS allowing us to draw down 75%/25% funding on systems and direct eligibility staff costs.

CATEGORY OF SERVICE (COS) SPEND

State of Vermont ~ Office of Vermont Health Access

Description of Service	BAA SFY '16	2015 Actual 2016 BAA % Change	Gov. Rec. SFY '17	2016 BAA - 2017 Rec. %	Change	5-Yr. Total Change	Growth %	10-Yr. Total Change
Inpatient	157,483,461	10.2%	147,005,812	-6.7%	3.5%	22,029,595	6.8%	89,337,405
Outpatient	136,498,230	6.0%	141,034,085	3.3%	8.1%	44,325,123	7.5%	79,028,463
Physician	117,019,702	0.0%	111,697,395	-4.5%	8.3%	28,583,670	6.5%	50,461,887
Pharmacy	195,559,489	5.4%	200,084,922	2.3%	7.4%	58,595,348	1.7%	91,018,929
Nursing Home	119,134,106	-2.5%	122,914,730	3.2%	1.2%	6,902,803	1.4%	13,678,118
Mental Health Facility	1,091,600	22.5%	1,305,513	19.6%	24.9%	842,395	50.7%	1,104,575
Dental	29,135,770	7.6%	33,132,134	13.7%	10.2%	12,510,443	6.7%	18,006,424
MH Clinic	5,067,215	3507.2%	5,128,453	1.2%	712.8%	5,003,396	459.8%	4,995,190
Independent Laboratory	15,917,954	10.5%	16,580,485	4.2%	35.7%	11,996,124	20.3%	13,645,979
Home Health	6,740,353	0.2%	6,638,279	-1.5%	0.3%	69,254	-1.4%	970,085
RHC & FQHC	34,972,604	11.2%	37,743,580	7.9%	10.4%	14,456,071	11.9%	25,679,212
Hospice	4,598,182	18.5%	5,383,625	17.1%	38.9%	4,229,899	30.6%	4,441,618
Chiropractor	1,365,154	11.3%	1,443,021	5.7%	12.7%	637,629	3.9%	1,394,236
Nurse Practitioners	1,047,461	9.0%	1,090,611	4.1%	4.8%	218,254	8.0%	524,413
Skilled Nursing	2,684,131	-4.6%	2,558,648	-4.7%	-5.4%	(874,505)	-6.1%	(1,576,456)
Podiatrist	335,945	5.2%	341,847	1.8%	-2.4%	(50,798)	5.1%	123,078
Psychologist	24,801,985	0.9%	21,010,157	-15.3%	3.0%	2,286,896	4.8%	8,230,096
Optometrist	2,336,826	13.3%	2,574,692	10.2%	16.3%	1,359,800	11.7%	1,760,664
Optician	197,956	2.8%	204,803	3.5%	-1.4%	(19,078)	-0.6%	(21,006)
Transportation	13,753,812	10.1%	14,889,803	8.3%	7.7%	4,476,718	4.0%	4,989,585
OT/PT/ST Services	5,711,710	15.1%	6,296,973	10.2%	18.3%	3,538,455	12.0%	4,780,706
Prosthestic/Orthro	3,331,523	6.2%	3,492,942	4.8%	4.9%	712,656	7.7%	1,970,166
Medical Supplies & DME (26-00)	10,698,897	3.6%	10,866,394	1.6%	4.9%	2,308,958	3.0%	4,041,097
H&CB Services	50,150,380	-10.3%	56,199,521	12.1%	5.1%	11,793,910	5.5%	20,120,814
H&CB Mental Health Services	683,028	2.1%	704,872	3.2%	1.8%	14,340	1.3%	170,817
H&CB Mental Retardation	-	-100.0%	-	0.0%	-143.8%	(11,019)	-64.9%	(34,556)
TBI Services		0.0%		0.0%	0.0%	-	0.0%	-
Enhanced Resident Care	8,522,753	4.8%	8,179,611	-4.0%	4.4%	1,557,188	12.3%	3,403,975
Personal Care Services	20,726,516	23.9%	21,012,230	1.4%	-1.3%	(2,351,781)	1.6%	4,179,843
Target Case Management	72,159	7.0%	73,827	2.3%	16.2%	29,805	267.3%	71,057
Assistive Community Care Services	14,629,764	3.5%	14,965,767	2.3%	3.1%	2,131,816	5.7%	5,140,370
Day Treatment (MHS)	-	0.0%	-	0.0%	-60.3%	(19,770)	-40.6%	(75,895)
ADAP Families in Recovery	3,024,393	12.6%	3,136,798	3.7%	136.8%	2,971,664	134.5%	3,102,978
Rehabilition/D&P Dept. of Health	763,747	-7.3%	664,744	-13.0%	-16.6%	(1,138,828)	-12.6%	(4,055,630)
PC+ Case Management Fees	3,761,763	6.3%	3,891,861	3.5%	-6.2%	(2,220,069)	-2.2%	(583,402)
Blueprint & CHT	12,011,179	38.3%	12,719,488		59.1%	10,656,295	251.2%	12,719,488
Other Premiums (CSR)	1,196,397	0.0%	1,232,289	3.0%	-42.7%	(4,171,731)	-23.9%	1,232,289
(VPA)	5,838,169	34.9%	6,124,211	4.9%	10.9%	2,369,410	7.4%	3,836,498
Ambulance	3,749,307	0.0%	4,926,000					
Dialysis	1,692,161	8.0%	1,807,763	6.8%	6.4%	368,318	0.1%	1,115,355
ASC	70,778	6.3%	72,197	2.0%	9.9%	26,646	58.2%	68,667
Outpatient Rehab	(1,329,882)	0.0%	160,000	-112.0%	-22.4%	160,000	-26.4%	(43,595)
PDP Premium Payments		0.0%		0.0%	0.0%	-	-21.6%	(2,421,626)
New Premium Payments		-100.0%		0.0%	-38.0%	(54,252,308)	-12.6%	-
Miscellaneous	706,295	-481.6%	(12,841,873)	-1918.2%	-9243.7%	(12,706,408)	-4742.7%	(14,015,084)
Provider Non Classified	(515,359)	0.0%		-100.0%				
Total	**1,015,237,615**	**4.9%**	**1,016,448,209**	**0.1%**	**4.3%**	**184,272,580**	**3.9%**	**457,442,826**
DSH	37,448,781	0.0%	37,448,781	0.0%	0.0%	(0)	5.6%	(21,928,948)
Clawback	29,404,521	13.6%	32,946,564	12.0%	6.9%	9,162,534	25.0%	13,804,414
Insurance Premium Payouts	1,936,281	4.5%	2,020,437	4.3%	-0.5%	(54,891)	107.6%	1,954,130
HIV Insurance Fund F	11,045	9.7%	12,143	9.9%	-13.9%	(25,310)	-7.7%	(37,326)
Lund Home Family Ctr Retro PNMI	-	0.0%	-	0.0%	0.0%	-	4.1%	(684,813)
Legal Aid	593,648	0.0%	593,648	0.0%	3.6%	91,331	0.9%	28,711
Rate Setting		0.0%		0.0%	0.0%	-	-10.0%	-
CMS Refugee Resettlement Adjustment		0.0%		0.0%	0.0%	-	0.0%	-
Interdept'l GF Transfer	-	-100.0%		0.0%	-20.0%	-	-20.0%	-
Misc.		0.0%		0.0%	0.0%	-	0.0%	-
Buy In	38,162,835	12.1%	42,585,842	11.6%	5.4%	9,564,365	8.7%	15,838,848
Total Other	**107,557,112**	**7.7%**	**115,607,414**	**7.5%**	**3.7%**	**18,738,028**	**8.7%**	**8,975,016**
Drug Rebates	(84,923,174)	4.4%	(85,457,608)	0.6%	4.3%	(13,729,832)	6.2%	(58,104,883)
ACA Rebates	(3,651,081)	-0.1%	(3,674,058)	0.6%	-4.4%	1,110,856	-2.0%	(3,674,058)
Drug Rebate Interest	(787)	0.0%	(787)	0.0%	-20.1%	4,313	-21.9%	(787)
Supplemental Drug Rebates	(9,817,753)	16.5%	(10,093,769)	2.8%	1.7%	(172,316)	2.0%	(5,351,379)
TPL	(3,160,541)	-7.3%	(3,252,033)	2.9%	-4.0%	824,663	1.2%	(370,414)
Costs Settlements	4,813,707	5.5%	4,983,365	3.5%	28.7%	3,071,998	-55.3%	4,733,720
Total Offsets	**(96,739,630)**	**4.8%**	**(97,494,890)**	**0.8%**	**2.5%**	**(8,890,317)**	**3.9%**	**(62,767,802)**
Total	**1,026,055,097**	**5.1%**	**1,034,560,733**	**0.8%**	**4.5%**	**194,120,291**	**4.6%**	**403,650,040**

DEPARTMENT OF VERMONT HEALTH ACCESS BUDGET BY MEDICAID ELIGIBILITY GROUP

PROGRAM EXPENDITURES

	SFY '12 Actuals			SFY '13 Actuals			SFY '14 Actuals			SFY '15 Actuals			SFY '16 As Passed			SFY '16 BAA			SFY '17 Gov Rec		
Adults	Enrollment	Expenses	PMPM	Enrollment	Expenses	PMPM	Enrollment	Expenses	PMPM	Enrollment	Expenses	PMPM	Enrollment	Expenses	PMPM	Enrollment	Expenses	PMPM	Enrollment	Expenses	PMPM
Aged, Blind, or Disabled (ABD)/Medically Needy	13,977	$ 95,212,717	$ 567.66	14,309	$ 104,236,243	$ 607.05	14,852	$ 108,329,783	$ 607.82	15,956	$ 102,508,327	$ 535.38	15,680	$ 113,165,353	$ 601.43	16,508	$ 106,347,928	$ 536.86	17,229	$ 108,022,293	$ 522.49
Dual Eligibles	16,634	$ 43,120,000	$ 216.03	17,155	$ 48,224,153	$ 234.25	17,384	$ 49,143,760	$ 235.58	18,244	$ 53,518,538	$ 244.46	17,978	$ 50,051,552	$ 232.01	18,772	$ 55,062,284	$ 244.43	19,153	$ 56,172,024	$ 244.40
General	11,235	$ 61,521,695	$ 456.33	11,397	$ 73,079,701	$ 534.83	13,115	$ 76,094,174	$ 483.51	17,381	$ 88,369,593	$ 423.75	15,966	$ 90,450,192	$ 472.09	20,228	$ 101,008,816	$ 416.13	22,041	$ 102,873,429	$ 388.95
VHAP	36,991	$ 144,423,060	$ 325.36	37,475	$ 165,952,625	$ 369.03	36,637	$ 97,932,892	$ 423.90		$ (292,634)										
VHAP ESI	825	$ 1,452,802	$ 146.81	793	$ 936,724	$ 98.48	720	$ 849,213	$ 158.08		$ (8,048)										
Catamount	10,713	$ 52,066,782	$ 405.01	11,484	$ 53,960,735	$ 391.56	13,329	$ 48,366,058	$ 387.41		$ (9,233)										
ESIA	726	$ 954,128	$ 109.54	742	$ 699,507	$ 78.54	689	$ 638,510	$ 117.75		$ (15,969)										
New Adult							47,315	$ 72,982,243	$ -	53,153	$ 224,311,542	$ 351.68	48,985	$ 193,377,396	$ 328.97	58,292	$ 239,299,057	$ 342.10	59,021	$ 235,785,764	$ 332.91
Premium Assistance For Exchange Enrollees < 300%							14,013	$ 2,571,477	$ 36.91	16,906	$ 5,611,465	$ 27.66	18,368	$ 8,541,105	$ 38.75	17,244	$ 5,838,169	$ 28.21	17,588	$ 5,954,932	$ 28.21
Cost Sharing For Exchange Enrollees < 300%							4,452	$ 332,623	$ 19.52	5,322	$ 1,138,775	$ 17.83	6,034	$ 1,522,615	$ 21.03	5,481	$ 1,196,397	$ 18.19	5,646	$ 1,232,289	$ 18.19
Subtotal Adults	91,101	$ 398,751,184	$ 364.75	93,345	$ 447,089,687	$ 399.14	96,726	$ 457,230,732	$ 393.92	121,640	$ 475,146,697	$ 325.51	116,977	$ 457,108,212	$ 325.64	131,043	$ 508,752,651	$ 323.53	135,033	$ 510,040,732	$ 314.76
Children																					
Blind or Disabled (BD)/Medically Needy	3,712	$ 33,805,689	$ 759.03	3,701	$ 32,794,574	$ 738.42	3,639	$ 36,486,052	$ 835.48	3,603	$ 30,899,676	$ 714.53	3,727	$ 38,392,328	$ 858.33	3,503	$ 30,739,310	$ 731.25	3,417	$ 28,535,845	$ 695.91
General	55,274	$ 117,361,607	$ 176.97	55,394	$ 131,289,464	$ 197.51	56,431	$ 130,940,851	$ 193.36	60,863	$ 144,338,098	$ 197.63	57,594	$ 132,798,298	$ 192.15	62,462	$ 150,818,731	$ 201.21	64,846	$ 150,491,497	$ 193.40
Underinsured	1,068	$ 766,013	$ 59.78	978	$ 791,009	$ 67.40	949	$ 1,072,657	$ 94.15	916	$ 1,253,421	$ 113.98	961	$ 1,137,209	$ 96.59	865	$ 1,288,846	$ 124.11	820	$ 1,243,929	$ 126.40
SCHIP (Uninsured)	3,909	$ 6,873,629	$ 146.52	3,986	$ 7,279,703	$ 152.21	4,105	$ 7,465,861	$ 151.57	4,466	$ 7,471,592	$ 139.43	4,417	$ 7,417,112	$ 139.93	4,649	$ 7,741,066	$ 138.76	4,874	$ 8,358,259	$ 142.89
Subtotal Children	63,963	$ 158,826,938	$ 206.93	64,058	$ 172,154,749	$ 223.96	65,124	$ 175,965,422	$ 225.17	69,848	$ 183,962,788	$ 219.47	66,720	$ 179,744,947	$ 224.50	71,479	$ 190,587,953	$ 222.20	73,957	$ 188,629,530	$ 212.54
Pharmacy Only Programs	12,655	$ (1,421,868)	$ (9.36)	12,535	$ 1,813,724	$ 12.06	12,653	$ 4,485,706	$ 29.54	11,978	$ 4,914,695	$ 34.19	12,709	$ 6,396,479	$ 41.94	11,761	$ 5,203,272	$ 36.87	11,026	$ 6,480,649	$ 48.96
Choices for Care																					
Nursing Home, Home & Community Based, ERC	3,891	$ 171,257,632	$ 3,667.97	3,911	$ 173,842,505	$ 3,704.61	4,147	$ 178,448,959	$ 3,585.90	4,342	$ 183,700,087	$ 3,525.98	4,222	$ 182,506,879	$ 3,602.12	4,516	$ 184,611,076	$ 3,406.74	4,623	$ 187,293,862	$ 3,375.87
Acute-Care Services ~ DVHA	3,891	$ 21,310,228	$ 456.42	3,911	$ 21,145,391	$ 450.61	4,147	$ 22,448,822	$ 451.11	4,342	$ 22,938,346	$ 440.28	4,222	$ 22,907,871	$ 515.29	4,516	$ 23,949,260	$ 441.95	4,623	$ 19,775,723	$ 356.45
Acute-Care Services ~ Other Depts.	3,891	$ 1,298,408	$ 27.81	3,911	$ 1,471,934	$ 31.37	4,147	$ 1,695,828	$ 34.08	4,342	$ 1,510,843	$ 29.00	4,222	$ 1,730,569	$ 34.16	4,516	$ -	$ -	4,623	$ -	$ -
Buy-In		$ 2,611,685			$ 2,573,180			$ 2,630,639			$ 2,639,101			$ 3,052,130			$ 2,930,312			$ 3,202,586	
Subtotal Choices for Care*	3,891	$ 196,477,952	$ 4,208.14	3,911	$ 199,033,009	$ 4,241.42	4,147	$ 205,224,249	$ 4,071.09	4,342	$ 210,788,377	$ 3,995.26	4,222	$ 210,197,449	$ 4,088.40	4,516	$ 211,490,649	$ 3,848.68	4,623	$ 210,272,171	$ 3,732.31
Subtotal Direct Services	171,610	$ 752,634,207	$ 365.48	173,849	$ 820,091,169	$ 393.11	178,650	$ 842,906,108	$ 393.18	207,808	$ 874,802,557	$ 350.81	200,629	$ 853,447,088	$ 354.49	218,799	$ 916,034,525	$ 348.89	224,640	$ 915,423,082	$ 339.59
Miscellaneous Program																					
GC to CFC Funding Reallocation		$ (1,298,408)			$ (1,471,934)			$ (1,696,912)			$ (1,509,760)		-	$ (1,730,569)	$ -		$ -			$ -	
Refugee	68	$ 283,439	$ 346.08	66	$ 308,395	$ 390.37	22	$ 96,121	$ 358.66	-	$ 15,884		1	$ 3,490	$ 290.87	1	$ 18,586	$ 1,548.81	-	$ (1,321)	
ACA Rebates		$ (4,784,914)			$ (4,453,259)			$ (3,363,203)			$ (3,654,840)		-	$ (3,500,000)	$ -		$ (3,651,081)			$ (3,674,058)	
HIV	91	$ 37,452	$ 34.31	96	$ 39,881	$ 34.62	103	$ 26,540	$ 21.51	118	$ 10,072	$ 7.12	133	$ 25,946	$ 16.32	129	$ 11,045	$ 7.12	142	$ 12,143	$ 7.12
Civil Unions	308	$ 1,438,940	$ 389.22	344	$ 1,288,895	$ 311.93		$ 1,099,414			$ 285,335		-	$ -	$ -		$ -			$ -	
Underinsured					$ 10,155,454			$ 10,671,650			$ 10,539,574		-	$ 11,612,228	$ -		$ 10,962,549			$ 11,512,292	
DSH		$ 37,448,781			$ 37,448,781			$ 37,448,781			$ 37,448,781		-	$ 37,448,781	$ -		$ 37,448,781			$ 37,448,781	
Clawback		$ 23,784,030			$ 25,971,679			$ 25,833,314			$ 25,888,658		-	$ 26,979,242	$ -		$ 29,404,521			$ 32,946,554	
Buy-In ~ GC		$ 26,993,495			$ 26,705,032			$ 27,471,919			$ 27,792,073		-	$ 30,282,256	$ -		$ 31,308,476			$ 35,122,032	
Buy-In ~ State Only (MCO Invest.)		$ 24,000			$ 17,878			$ 17,728			$ 27,169		-	$ 17,433	$ -		$ 41,638			$ 63,812	
Buy-In ~ Federal Only		$ 3,392,297			$ 3,499,264			$ 3,541,610			$ 3,593,474		-	$ 3,627,846	$ -		$ 3,882,409			$ 4,197,412	
Legal Aid		$ 502,318			$ 502,318			$ 593,648			$ 593,648		-	$ 502,318	$ -		$ 593,648			$ 593,648	
Misc. Pymts. (incl. family planning option)		$ (15,196)			$ (9,566)			$ (17,420)			$ (9,223)		-	$ (17,420)	$ -		$ -			$ 916,347	
Healthy Vermonters Program	6,115	$ -	n/a	5,911	$ -	n/a	5,597	$ -	n/a	4,330	$ -	n/a	5,820	$ -	n/a	5,820	$ -	n/a	5,820	$ -	n/a
Subtotal Miscellaneous Program	6,582	$ 87,806,235		6,417	$ 100,002,818		5,722	$ 101,723,191		4,448	$ 101,020,847		5,953	$ 105,251,552		5,950	$ 110,020,572		5,950	$ 119,137,651	
TOTAL PROGRAM EXPENDITURES	178,192	$ 840,440,442		180,265	$ 920,093,987		184,372	$ 944,629,299		212,255	$ 975,823,404		206,582	$ 958,698,640		224,750	$ 1,026,055,097		230,602	$ 1,034,560,733	

	SFY '12 Actuals		SFY '13 Actuals		SFY '14 Actuals		SFY '15 Actuals		SFY '16 As Passed		SFY '16 BAA		SFY '17 Gov Rec	
		Expenses		Expenses		Expenses		Expenses		Expenses		Expenses		Expenses
Contract														
Claims Processing		$ 11,134,619		$ 11,527,296		$ 11,956,861		$ 11,849,882		$ 11,659,273		$ 11,659,273		$ 11,659,273
Member Services		$ 3,049,591		$ 2,819,787		$ 8,538,622		$ 4,507,624		$ 7,438,600		$ 7,438,600		$ 8,520,840
Pharmacy Benefits Manager		$ 2,404,369		$ 2,603,080		$ 3,224,686		$ 2,262,544		$ 3,725,000		$ 3,725,000		$ 3,725,000
Care Coordination & Chronic Care Management		$ 2,759,477		$ 2,420,594		$ 2,860,702		$ 2,640,648		$ 2,484,366		$ 2,484,366		$ 2,484,366
Catamount Outreach		$ 500,000												
Miscellaneous		$ 15,995,585		$ 4,449,169		$ 5,053,983		$ 3,243,813		$ 5,296,036		$ 11,317,904		$ 5,201,073
Health Information Technology/Healthcare Reform		$ 6,336,833		$ 10,182,727		$ 8,602,532		$ 8,591,950		$ 16,704,387		$ 16,704,387		$ 16,704,387
MITA/MOVE		$ 2,298,430		$ 38,388,614		$ 88,722,853		$ 71,710,572		$ 105,842,152		$ 106,000,618		$ 105,802,452
Blueprint & Payment Reform		$ 2,870,383		$ 4,214,530		$ 4,756,092		$ 6,734,984		$ 4,153,599		$ 4,003,599		$ 3,853,599
Operating/Personnel Services		$ 12,097,553		$ 15,093,080		$ 19,416,839		$ 22,690,603		$ 24,995,363		$ 30,753,016		$ 32,093,929
Total Administrative Expenses		$ 59,446,840		$ 91,698,877		$ 153,133,170		$ 134,232,620		$ 182,298,776		$ 194,086,763		$ 190,044,919
TOTAL ALL EXPENDITURES	178,192	$ 932,337,790	180,265	$ 1,011,792,864	184,372	$ 1,097,762,469	212,255	$ 1,110,056,024	206,582	$ 1,140,997,416	224,750	$ 1,220,141,860	230,602	$ 1,224,605,652

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DEPARTMENT OF VERMONT HEALTH ACCESS BUDGET BY MEDICAID ELIGIBILITY GROUP WITH FUNDING DESCRIPTION

PROGRAM EXPENDITURES

	SFY '16 As Passed		SFY '16 BAA		SFY '17 Gov. Rec.		SFY '17 Funding Description
Adults	Gross Expenses	State Funds	Gross Expenses	State Funds	Gross Expenses	State Funds	
Aged, Blind, or Disabled (ABD)/Medically Needy	$ 113,165,353	$ 50,893,288	$ 106,347,926	$ 48,997,149	$ 108,022,293	$ 58,677,710	Global Commitment funded (GC) ~ g.f. @ 45.68%
Dual Eligibles	$ 50,051,552	$ 22,509,434	$ 55,062,284	$ 25,368,571	$ 56,172,024	$ 30,512,644	
General	$ 90,450,192	$ 40,677,712	$ 101,008,816	$ 46,537,287	$ 102,873,429	$ 55,880,847	
VHAP	$ -		$ -		$ -		
VHAP ESI	$ -		$ -		$ -		
Catamount	$ -		$ -		$ -		
ESIA	$ -		$ -		$ -		
New Adult	$ 193,377,396	$ (42,791,130)	$ 239,299,057	$ (50,320,524)	$ 235,785,764	$ 31,666,028	g.f. @ 86.57% (base rate of 45.68% plus enhancement)
Premium Assistance For Exchange Enrollees < 300%	$ 8,541,105	$ 4,541,148	$ 5,838,169	$ 3,389,790	$ 5,954,932	$ 3,234,719	GC funded as detailed above
Cost Sharing For Exchange Enrollees < 300%	$ 1,522,615	$ 1,522,615	$ 1,196,397	$ 1,196,397	$ 1,232,289	$ 1,232,289	100% general fund
Subtotal Adults	$ 457,108,212	$ 77,353,068	$ 508,752,651	$ 75,168,670	$ 510,040,732	$ 181,204,236	
Children							
Blind or Disabled (BD)/Medically Needy	$ 38,392,328	$ 17,265,990	$ 30,739,310	$ 14,162,369	$ 28,535,845	$ 15,500,671	Global Commitment funded (GC) ~ g.f. @ 45.68%
General	$ 132,798,298	$ 59,722,714	$ 150,818,731	$ 69,485,960	$ 150,491,497	$ 81,746,981	
Underinsured	$ 1,137,209	$ 511,431	$ 1,288,846	$ 593,804	$ 1,243,929	$ 675,702	
SCHIP (Uninsured)	$ 7,417,112	$ 1,055,511	$ 7,741,066	$ 1,101,612	$ 8,358,259	$ 750,572	Title XXI ~ g.f. @ 8.98% and expanded federal @ 91.02%
Subtotal Children	$ 179,744,947	$ 78,555,646	$ 190,587,953	$ 85,343,744	$ 188,629,530	$ 98,673,926	
Pharmacy Only Programs	$ 6,396,479	$ 4,544,556	$ 5,203,272	$ 4,031,835	$ 6,480,649	$ 4,907,346	Predominantly all GC as detailed above
Choices for Care							
Nursing Home, Home & Community Based, ERC	$ 182,506,879	$ 82,077,906	$ 184,611,076	$ 85,050,323	$ 187,293,862	$ 101,738,026	Global Commitment funded (GC) ~ g.f. @ 45.68%
Acute-Care Services ~ DVHA	$ 22,907,871	$ 10,302,242	$ 23,949,260	$ 11,033,424	$ 19,775,723	$ 10,742,173	
Acute-Care Services ~ Other Depts.	$ 1,730,569	$ 778,280	$ -	$ -	$ -	$ -	
Buy-In	$ 3,052,130	$ 1,372,619	$ 2,930,312	$ 1,349,995	$ 3,202,586	$ 1,739,645	
Subtotal Choices for Care	$ 210,197,449	$ 94,531,048	$ 211,490,649	$ 97,433,742	$ 210,272,171	$ 114,219,843	
Subtotal Direct Services	**$ 853,447,088**	**$ 254,984,317.82**	**$ 916,034,525**	**$ 261,977,991**	**$ 915,423,082**	**$ 399,005,351.07**	
Miscellaneous Program							
GC to CFC Funding Reallocation	$ (1,730,569)	$ (778,280)	$ -	$ -	$ -	$ -	GC funded as detailed above
Refugee	$ 3,490	$ -	$ 18,586	$ -	$ (1,321)	$ -	100% federally reimbursed
ACA Rebates	$ (3,500,000)	$ -	$ (3,651,081)	$ -	$ (3,674,058)	$ -	100% federally reimbursed
HIV	$ 25,946	$ 11,669	$ 11,045	$ 5,089	$ 12,143	$ 6,596	MCO Investments ~ matched like GC above
Civil Unions	$ -	$ -	$ -	$ -	$ -	$ -	MCO Investments ~ matched like GC above
Underinsured	$ 11,612,228	$ 5,222,309	$ 10,962,549	$ 5,050,720	$ 11,512,292	$ 6,253,477	MCO Investments ~ matched like GC above
DSH	$ 37,448,781	$ 16,841,653	$ 37,448,781	$ 17,253,590	$ 37,448,781	$ 16,440,015	43.90% g.f, 56.10% federal
Clawback	$ 26,979,242	$ 26,979,242	$ 29,404,521	$ 29,404,521	$ 32,946,564	$ 32,946,564	100% general fund
Buy-In ~ GC	$ 30,282,256	$ 13,618,688	$ 31,308,476	$ 14,424,598	$ 35,122,032	$ 19,078,288	GC funded as detailed above
Buy-In ~ State Only (MCO Invest.)	$ 17,433	$ 7,840	$ 41,638	$ 19,184	$ 63,812	$ 34,663	MCO Investments ~ matched like GC above
Buy-In ~ Federal Only	$ 3,627,845	$ -	$ 3,882,409	$ -	$ 4,197,412	$ -	100% federally reimbursed
Legal Aid	$ 502,318	$ 225,905	$ 593,648	$ 273,509	$ 593,648	$ 322,470	GC funded as detailed above
Misc. Pymts.	$ (17,420)	$ (5,084)	$ -	$ -	$ 916,347	$ 497,760	GC funded as detailed above
Healthy Vermonters Program	$ -	$ -	$ -	$ -	$ -	n/a	
Subtotal Miscellaneous Program	**$ 105,251,552**	**$ 62,123,942**	**$ 110,020,572**	**$ 66,431,210**	**$ 119,137,651**	**$ 75,579,831**	
TOTAL PROGRAM EXPENDITURES	**$ 958,698,640**	**$ 317,108,259**	**$ 1,026,055,097**	**$ 328,409,201**	**$ 1,034,560,733**	**$ 474,585,183**	

ADMINISTRATIVE EXPENDITURES

	SFY '16 As Passed		SFY '16 BAA		SFY '17 Gov. Rec.		SFY '17 Funding Description
Contract	Gross Expenses	State Funds	Gross Expenses	State Funds	Gross Expenses	State Funds	
Claims Processing	$ 11,659,273	$ 5,239,290	$ 11,659,273	$ 5,239,290	$ 11,659,273	$ 5,239,290	Most admin. expenses are funded with: Global Commitment funds as stated above and Title XXI funds (g.f. @ 8.98% and expanded federal @ 91.02%)
Member Services	$ 7,438,600	$ 3,397,952	$ 7,438,600	$ 3,397,952	$ 8,520,840	$ 3,892,320	
Pharmacy Benefits Manager	$ 3,725,000	$ 1,673,892	$ 3,725,000	$ 1,673,892	$ 3,725,000	$ 1,673,892	
Care Coordination & Chronic Care Management	$ 2,484,366	$ 1,116,391	$ 2,484,366	$ 1,116,391	$ 2,484,366	$ 1,116,391	
Miscellaneous	$ 5,296,036	$ 2,152,404	$ 11,317,904	$ 5,170,019	$ 6,201,073	$ 2,107,394	
Health Information Technology/Healthcare Reform	$ 16,704,387	$ 4,651,493	$ 16,704,387	$ 4,651,493	$ 16,704,387	$ 4,651,493	Blended based on enhanced federal opportunities (match = s.f.)
IT Enterprise Solution	$ 105,842,152	$ 15,573,758	$ 106,000,618	$ 42,262,906	$ 105,802,452	$ 9,086,503	Blended based on federal programs ~ match GF, SF, IDT
Blueprint & Payment Reform	$ 4,153,599	$ 1,897,364	$ 4,003,599	$ 1,828,844	$ 3,853,599	$ 1,760,324	
Operating/Personnel Services	$ 24,995,363	$ 8,676,487	$ 30,753,016	$ 14,119,840	$ 32,093,929	$ 11,472,754	GC funded as detailed above
Total Administrative Expenses	**$ 182,298,776**	**$ 44,379,031**	**$ 194,086,763**	**$ 79,460,627**	**$ 190,044,919**	**$ 41,000,361**	
TOTAL ALL EXPENDITURES	**$ 1,140,997,416**	**$ 361,487,290**	**$ 1,220,141,860**	**$ 407,869,828**	**$ 1,224,605,652**	**$ 515,585,544**	

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MANDATORY/OPTIONAL GROUPS/SERVICES

State Plan Groups			
Mandatory; Categorically Needy			
Population Description	**Green Mountain Care Group**	**Standards and Methodologies**	**Benefit Package**
Section 1931 low-income families with children (Parents and caretaker relatives)	Commonly referred to as Medicaid (for adults) and Dr. Dynasaur (for children)	AFDC standard and MAGI-based 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 • Services for individuals with persistent mental illness up to 150 FPL • Community and nursing home services for individuals eligible for long-term care supports • Community based services for individuals with moderate needs as identified through long-term care eligibility
Children receiving IV-E payments (IV-E foster care or adoption assistance)		No income or resource tests	
Individuals who lose eligibility under §1931 due to employment		AFDC standard and MAGI-based methodologies	
Individuals who lose eligibility under §1931 because of spousal support		AFDC standard and MAGI-based methodologies	
Individuals participating in a work supplementation program who would otherwise be eligible under §1931		AFDC standard and MAGI-based 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	
Pregnant women		≤ 208% of the FPL and MAGI-based methodologies	
Children under age 19		≤ 312% of the FPL and MAGI-based methodologies	
Individuals age 19 or older and under 65		≤ 133% FPL and MAGI-based methodologies	
Blind and disabled individuals eligible in December 1973		SSI standard and methodologies	
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 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	
Newborns deemed eligible for one year		Automatically eligible	
Pregnant women eligible on their last day of pregnancy receive 60 days coverage		Automatically eligible	
Poverty level infants and children receiving inpatient services who lose eligibility because of age must be covered through an inpatient stay		Automatically eligible	Inpatient hospital services
Qualified Medicare Beneficiaries	Commonly referred to as QMBs	Medicare beneficiaries with income at or below 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 at or below 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 QI-1s	Medicare beneficiaries with income between 120% and 135% of the FPL and not eligible for Medicaid	Payment of Medicare Part B premiums

MANDATORY/OPTIONAL GROUPS/SERVICES CONTINUED

Optional; Categorically Needy			
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 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			
Breast & Cervical Cancer Treatment			
BBA Working Disabled with income < 250%			
Individuals receiving only a State supplementary payment with agreement under 1634 of the Act			
Katie Beckett children			
Medically Needy Individuals under 21 who would be mandatorily categorically eligible except for income			
Medically Needy Specified relatives of dependent children who are ineligible as categorically needy			
Medically Needy Aged individuals who are ineligible as categorically needy			
Medically Needy Blind individuals who are ineligible as categorically needy but meet the categorically needy definition of blindness			
Medically Needy Disabled individuals who are ineligible as categorically needy that meet the categorically needy definition of disabled			
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)			
Medically Needy Pregnant women who would be categorically eligible except for income and resources			

Expansion Populations			
Population Description	**Medicaid Eligibility Group**	**Standards and Methodologies**	**Benefit Package**
Medicare beneficiaries 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% of the FPL	Medicaid Prescriptions, eyeglasses and related eye exams; MSP beneficiaries also receive benefits as described in the title XIX state plan.
Medicare beneficiaries 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 at or below 225% of the FPL	Maintenance Drugs; MSP beneficiaries also receive benefits as described in the title XIX state plan.

APPENDIX A: MCO INVESTMENTS

MCO INVESTMENT EXPENDITURES

Department	Investment Description	SFY09 Actuals	SFY10 Actuals	SFY11 Actuals	SFY12 Actuals	SFY13 Actuals	SFY14 Actuals	SFY15 Preliminary
AHSCO	Designated Agency Underinsured Services	$ -	$ -	$2,510,099	$5,401,947	$6,232,517	$7,184,084	$6,894,205
AHSCO	2-1-1 Grant	$415,000	$415,000	$415,000	$415,000	$415,000	$499,792	$499,667
AOA	Blueprint Director	$ 68,879	$179,284	$ -	$ -	$ -	$ -	
AOA		$ -	$ -	$ -	$ -	$ -	$ -	$639,239
DCF	Family Infant Toddler Program	$335,235	$81,086	$624	$ -	$ -	$ -	
DCF	Medical Services	$65,278	$45,216	$64,496	$47,720	$37,164	$33,514	$32,299
DCF	Residential Care for Youth/Substitute Care	$9,392,213	$8,033,068	$7,853,100	$9,629,269	$10,131,790	$11,137,225	$10,405,184
DCF	AABD Admin	$ -	$ -	$ -	$ -	$ -	$ -	
DCF	AABD	$ -	$ -	$ -	$ -	$ -	$ -	
DCF	Aid to the Aged, Blind and Disabled CCL Level III	$2,591,613	$2,827,617	$2,661,246	$2,563,226	$2,621,786	$2,611,499	$2,864,727
DCF	Aid to the Aged, Blind and Disabled Res Care Level III	$172,173	$137,356	$136,466	$137,833	$124,731	$89,159	$77,196
DCF	Aid to the Aged, Blind and Disabled Res Care Level IV	$366,161	$299,488	$265,812	$273,662	$269,121	$183,025	$160,963
DCF	Essential Person Program	$620,052	$485,536	$736,479	$775,278	$783,860	$801,658	$707,316
DCF	GA Medical Expenses	$380,000	$583,080	$492,079	$352,451	$275,187	$253,939	$211,973
DCF	CUPS/Early Childhood Mental Health	$499,143	$166,429	$112,619	$165,016	$45,491	$ -	
DCF	VCRHYP/Vermont Coalition for Runaway and Homeless Youth Program	$ -	$ -	$ -	$ -	$ -	$ -	
DCF	HBKF/Healthy Babies, Kids & Families	$63,921	$ -	$ -	$ -	$ -	$ -	
DCF	Catamount Administrative Services	$339,894	$ -	$ -	$ -	$ -	$ -	
DCF	Children's Integrated Services Early Intervention						$200,484	
DCF	Therapeutic Child Care	$978,886	$577,259	$570,493	$596,406	$557,599	$543,196	$605,419
DCF	Lund Home	$325,516	$175,378	$196,159	$354,528	$181,243	$237,387	$405,034
DCF	GA Community Action	$ -	$ -	$199,762	$338,275	$420,359	$25,181	
DCF	Prevent Child Abuse Vermont: Shaken Baby	$ -	$ -	$44,119	$74,250	$86,969	$111,094	$54,125
DCF	Prevent Child Abuse Vermont: Nurturing Parent	$ -	$ -	$ -	$107,184	$186,916	$54,231	$195,124
DCF	Challenges for Change: DCF	$ -	$ -	$50,622	$196,378	$197,426	$207,286	$189,378
DCF	Strengthening Families	$ -	$ -	$ -	$465,343	$429,154	$399,841	$370,003
DCF	Lamoille Valley Community Justice Project	$ -	$ -	$ -	$162,000	$216,000	$402,685	$83,315
DCF	Building Bright Futures	$ -	$ -	$ -	$ -	$398,201	$594,070	$514,225
DDAIL	Elder Coping with MMA	$ -	$ -	$ -	$ -	$ -	$ -	
DDAIL	Mobility Training/Other Svcs.- Elderly Visually Impaired	$250,000	$245,000	$245,000	$245,000	$245,000	$245,000	$245,000
DDAIL	DS Special Payments for Medical Services	$522,058	$469,770	$757,070	$1,498,083	$1,299,613	$1,277,148	$385,896
DDAIL	Flexible Family/Respite Funding	$1,364,896	$1,114,898	$1,103,748	$1,103,749	$ 1,088,889	$2,868,218	$1,400,997
DDAIL	Quality Review of Home Health Agencies	$126,306	$90,227	$103,598	$128,399	$84,139	$51,697	$44,682
DDAIL	Support and Services at Home (SASH)	$ -	$ -	$ -	$773,192	$773,192	$1,013,671	$1,026,155
DDAIL	Home Sharing	$ -	$ -	$ -	$ -	$310,000	$ 317,312	$327,163

This table extends to the next two pages and is totaled there.

MCO Investment Expenditures Continued								
Department	**Investment Description**	**SFY09 Actuals**	**SFY10 Actuals**	**SFY11 Actuals**	**SFY12 Actuals**	**SFY13 Actuals**	**SFY14 Actuals**	**SFY15 Preliminary**
DDAIL	Self-Neglect Initiative	$ -	$ -	$ -	$ -	$150,000	$200,000	$265,000
DDAIL	Seriously Functionally Impaired: DAIL	$ -	$ -	$ -	$ -	$1,270,247	$ 859,371	$ 333,331
DFR	Healthcare Administration	$ 1,871,651	$1,713,959	$1,898,342	$1,897,997	$659,544	$165,946	
DII	Vermont Information Technology Leaders	$339,500	$-	$-	$-	$-	$-	
DMH	Special Payments for Treatment Plan Services	$164,356	$ 149,068	$134,791	$132,021	$180,773	$168,492	$152,047
DMH	MH Outpatient Services for Adults	$1,320,521	$864,815	$522,595	$974,854	$1,454,379	$2,661,510	$3,074,989
DMH	Mental Health Elder Care	$ -	$ -	$ -	$ -	$ -	$ -	
DMH	Mental Health Consumer Support Programs	$707,976	$802,579	$582,397	$67,285	$1,649,340	$2,178,825	$1,132,931
DMH	Mental Health CRT Community Support Services	$1,124,728	$ -	$1,935,344	$1,886,140	$6,047,450	$11,331,235	$282,071
DMH	Mental Health Children's Community Services	$3,597,662	$2,569,759	$1,775,120	$2,785,090	$3,088,773	$3,377,546	$3,706,864
DMH	Emergency Mental Health for Children and Adults	$2,165,648	$1,797,605	$2,309,810	$4,395,885	$8,719,824	$6,662,850	$4,148,197
DMH	Respite Services for Youth with SED and their Families	$412,920	$516,677	$543,635	$541,707	$823,819	$749,943	$931,962
DMH	CRT Staff Secure Transportation	$ -	$ -	$ -	$ -	$ -	$ -	
DMH	Recovery Housing	$ -	$332,635	$512,307	$562,921	$874,194	$985,098	$463,708
DMH	Transportation - Children in Involuntary Care	$ -	$ -	$ -	$ -	$ -	$ -	
DMH	Vermont State Hospital Records	$ -	$19,590	$ -	$ -	$ -	$ -	
DMH	Challenges for Change: DMH	$ -	$ -	$229,512	$945,051	$819,069	$ -	
DMH	Seriously Functionally Impaired: DMH	$ -	$ -	$68,713	$160,560	$1,151,615	$721,727	$392,593
DMH	Acute Psychiatric Inpatient Services	$ -	$ -	$ -	$12,603,067	$5,268,556	$3,011,307	$2,423,577
DMH	Institution for Mental Disease Services: DMH	$ -	$ -	$ -	$ -	$10,443,654	$7,194,964	$25,371,245
DOC	Intensive Substance Abuse Program (ISAP)	$200,000	$591,004	$591,000	$458,485	$400,910	$547,550	$58,280
DOC	Intensive Sexual Abuse Program	$88,523	$68,350	$70,002	$60,585	$69,311	$19,322	$15,532
DOC	Intensive Domestic Violence Program	$229,166	$173,938	$174,000	$164,218	$86,814	$64,970	$169,043
DOC	Women's Health Program (Tapestry)	$527,956	$ -	$ -	$ -	$ -	$ -	$ -
DOC	Community Rehabilitative Care	$1,997,499	$2,190,924	$2,221,448	$2,242,871	$2,500,085	$2,388,327	$2,539,161
DOC	Return House	$51,000	$ -	$ -	$ -	$ 399,999	$ 399,999	$ 343,592
DOC	Northern Lights	$ -	$40,000	$40,000	$ -	$393,750	$335,587	$354,909
DOC	Challenges for Change: DOC	$ -	$ -	$ -	$687,166	$524,594	$433,910	$539,727
DOC	Northeast Kingdom Community Action	$ -	$ -	$ -	$ -	$548,825	$287,662	$267,025
DOC	Pathways to Housing	$ -	$ -	$ -	$ -	$802,488	$830,936	$830,336
DOE	School Health Services	$8,956,247	$8,956,247	$4,478,124	$11,027,579	$9,741,252	$10,454,116	$10,029,809
DVHA	Vermont Information Technology Leaders/HIT/HIE/HCR	$ -	$339,500	$646,220	$1,425,017	$1,517,044	$1,549,214	$2,915,149
DVHA	Vermont Blueprint for Health	$ -	$ -	$2,616,211	$1,841,690	$2,002,798	$2,490,206	$1,987,056
DVHA	Buy-In	$248,537	$200,868	$50,605	$24,000	$17,878	$17,728	$27,169
DVHA	VScript Expanded	$ -	$ -	$ -	$ -	$ -	$ -	$ -
DVHA	HIV Drug Coverage	$48,711	$38,904	$39,176	$37,452	$39,881	$26,540	$10,072

This table extends to the next page and is totaled there.

MCO Investment Expenditures Continued								
Department	**Investment Description**	**SFY09 Actuals**	**SFY10 Actuals**	**SFY11 Actuals**	**SFY12 Actuals**	**SFY13 Actuals**	**SFY14 Actuals**	**SFY15 Preliminary**
DVHA	Civil Union	$556,811	$627,976	$999,084	$1,215,109	$1,112,119	$760,819	$ (50,085)
DVHA	VPharm	$278,934	$210,796	$ -	$ -	$ -	$ -	$ -
DVHA	Hospital Safety Net Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -
DVHA	Patient Safety Net Services	$ -	$ -	$36,112	$73,487	$2,394	$363,489	$335,420
DVHA	Institution for Mental Disease Services: DVHA	$ -	$ -	$ -	$ -	$6,214,805	$6,948,129	$7,792,709
DVHA	Family Supports	$ -	$ -	$ -	$ -	$4,015,491	$3,723,521	$2,982,388
GMCB	Green Mountain Care Board	$ -	$ -	$ -	$789,437	$1,450,717	$2,360,462	$2,517,516
UVM	Vermont Physician Training	$4,006,156	$4,006,152	$4,006,156	$4,006,156	$4,006,156	$4,006,156	$4,046,217
VAAFM	Agriculture Public Health Initiatives	$ -	$ -	$ -	$90,278	$90,278	$90,278	$90,278
VDH	Emergency Medical Services	$427,056	$425,870	$333,488	$274,417	$378,168	$498,338	$480,027
VDH	AIDS Services/HIV Case Management	$ -	$ -	$ -	$ -	$ -		$ -
VDH	TB Medical Services	$28,359	$41,313	$36,284	$39,173	$34,046	$59,872	$28,571
VDH	Epidemiology	$204,646	$241,932	$315,135	$329,380	$766,053	$623,363	$872,449
VDH	Health Research and Statistics	$217,178	$254,828	$289,420	$439,742	$497,700	$576,920	$715,513
VDH	Health Laboratory	$1,522,578	$1,875,487	$1,912,034	$1,293,671	$2,885,451	$2,494,516	$3,405,659
VDH	Tobacco Cessation: Community Coalitions	$1,016,685	$535,573	$94,089	$371,646	$498,275	$632,848	$702,544
VDH	Statewide Tobacco Cessation	$230,985	$484,998	$507,543	$450,804	$487,214	$1,073,244	$1,148,535
VDH	Family Planning	$300,876	$300,876	$275,803	$420,823	$1,574,550	$1,556,025	$1,390,410
VDH	Physician/Dentist Loan Repayment Program	$1,516,361	$970,000	$900,000	$970,000	$970,105	$1,040,000	$900,000
VDH	Renal Disease	$15,095	$2,053	$13,689	$1,752	$28,500	$3,375	$10,125
VDH	Newborn Screening	$ -	$ -	$ -	$ -	$ -	$ -	$ -
VDH	WIC Coverage	$86,882	$ -	$36,959	$ -	$77,743	$317,775	$1,824,848
VDH	Vermont Blueprint for Health	$1,395,135	$1,417,770	$752,375	$454,813	$875,851	$713,216	$703,123
VDH	Area Health Education Centers (AHEC)	$565,000	$725,000	$500,000	$540,094	$496,176	$547,500	$543,995
VDH	Community Clinics	$640,000	$468,154	$640,000	$600,000	$640,000	$688,000	$ -
VDH	FQHC Lookalike	$105,650	$81,500	$87,900	$102,545	$382,800	$160,200	$97,000
VDH	Patient Safety - Adverse Events	$100,509	$44,573	$16,829	$25,081	$42,169	$38,731	$34,988
VDH	Coalition of Health Activity Movement Prevention Program (CHAMPPS)	$486,466	$412,043	$290,661	$318,806	$345,930	$326,184	$395,229
VDH	Substance Abuse Treatment	$2,997,668	$3,000,335	$1,693,198	$2,928,773	$2,435,796	$2,363,671	$2,913,591
VDH	Recovery Centers	$713,576	$ 716,000	$648,350	$771,100	$864,526	$1,009,176	$1,299,604
VDH	Immunization	$ 726,264	$ -	$ -	$ 23,903	$ 457,757	$ 165,770	$ 253,245
VDH	DMH Investment Cost in CAP	$64,843	$ -	$752	$140	$ -	$ -	$ -
VDH	Poison Control	$ -	$176,340	$ 115,710	$213,150	$ 152,250	$152,433	$105,586
VDH	Challenges for Change: VDH	$ -	$ -	$ -	$309,645	$ 353,625	$288,691	$426,000
VDH	Fluoride Treatment	$ -	$ -	$ -	$43,483	$75,081	$59,362	$55,209
VDH	CHIP Vaccines	$ -	$ -	$ -	$196,868	$482,454	$707,788	$557,784
VDH	Healthy Homes and Lead Poisoning Prevention Program	$ -	$ -	$ -	$ -	$ 101,127	$479,936	$421,302
VSC	Health Professional Training	$405,407	$405,407	$405,407	$405,407	$405,407	$405,407	$409,461
VVH	Vermont Veterans Home	$881,043	$837,225	$1,410,956	$1,410,956	$1,410,956	$410,986	$410,986
TOTALS		$62,419,988	$55,554,314	$56,275,877	$89,836,470	$123,669,882	$127,103,459	$128,924,888

APPENDIX B: SCORECARDS

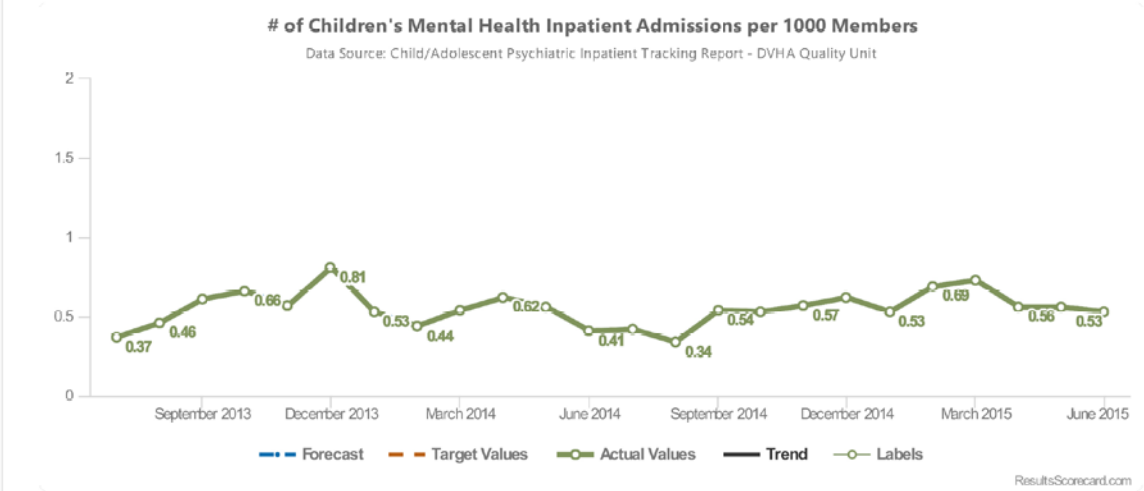
DVHA Programmatic Performance Budget (FY17)

		Time Period	Actual Value	Forecast Value	Current Trend
O DVHA	Vermonters Receive Appropriate Care				
P DVHA	Medicaid Inpatient Psychiatric and Detoxification Utilization				
Budget Information	**Total Program Budget FY 2017: $960,728.86**				
PM DVHA	# of Children's Mental Health Inpatient Admissions per 1000 Members	Jun 2015	0.53	–	↘ 1
PM DVHA	# of Adult Mental Health Inpatient Admissions per 1000 Members	Jun 2015	0.57	–	↘ 2
PM DVHA	# of Detoxification Admissions per 1000 Members	Jun 2015	0.84	–	↗ 1
PM DVHA	Average Length of Stay - Children's Mental Health Inpatient Admissions	Jun 2015	16.30	–	↗ 1
PM DVHA	Average Length of Stay - Adult Mental Health Inpatient Admissions	Jun 2015	5.90	–	↘ 2
PM DVHA	Average Length of Stay - Detox. Admissions	Jun 2015	4.80	–	↗ 1
PM DVHA	Paid Claims - Children's Mental Health Inpatient Admissions	Jun 2015	698,247	–	↘ 4
PM DVHA	Paid Claims - Adult Mental Health Inpatient Admissions	Jun 2015	602,255	–	↘ 2
PM DVHA	Paid Claims - Detox. Admissions	Jun 2015	521,263	–	↗ 1
P DVHA	Medicaid's Vermont Chronic Care Initiative (VCCI)				
Budget Information	**Total Program Budget FY 2017: $2,608,703.46**				
PM VCCI	# of Medicaid Beneficiaries Enrolled in the Vermont Chronic Care Initiative	SFY 2015	1,657	–	↘ 2
PM VCCI	% of Eligible High Cost/High Risk Medicaid Beneficiaries Enrolled in the Vermont Chronic Care Initiative	SFY 2015	21%	–	↘ 2
PM VCCI	30 Day Hospital Readmission Rate Among VCCI-eligible Medicaid Beneficiaries (#/1000)	SFY 2014	49	–	↘ 3
PM VCCI	# of ER visits by Medicaid beneficiaries Eligible for VCCI	SFY 2014	1,299	–	↘ 1
PM VCCI	# of Inpatient Admissions by Medicaid beneficiaries Eligible for VCCI	SFY 2014	429	–	↘ 1
PM VCCI	Net Savings over Anticipated Expense (in millions of dollars) for VCCI Eligible Members	SFY 2014	$30.5	–	↗ 2

INPATIENT PSYCHIATRIC

P Medicaid Children - Inpatient Psychiatric Utilization and 1 more...

PM DVHA # of Children's Mental Health Inpatient Admissions per 1000 Members



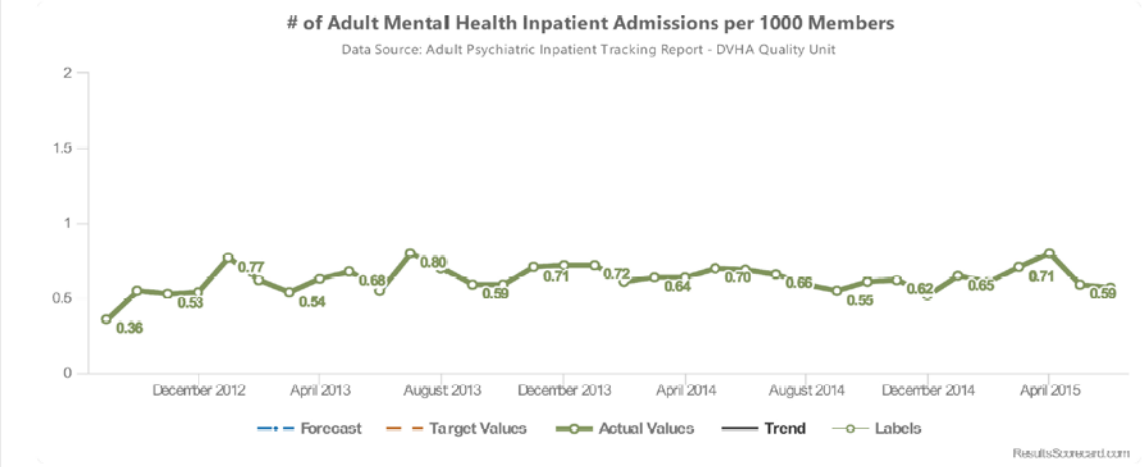
Story Behind the Curve

Since beginning the utilization management program in 2010, the State has experienced a number of challenges, including the flooding of the Vermont State Psychiatric Hospital and subsequent move to a de-centralized mental health inpatient system, an increase in opiate addiction and resulting need for services which has led to inpatient level of care being used in place of medically necessary lower levels of care, and a slow economic recovery which strained both resources and already vulnerable beneficiaries.

These issues have contributed to a significant challenge for the utilization management program to successfully bend the cost curve for inpatient mental health and substance abuse costs. However, without the utilization management program, history has indicated that costs and average lengths of stay would have grown even more exponentially.

P Medicaid Adults - Inpatient Psychiatric Utilization and 1 more...

PM DVHA # of Adult Mental Health Inpatient Admissions per 1000 Members



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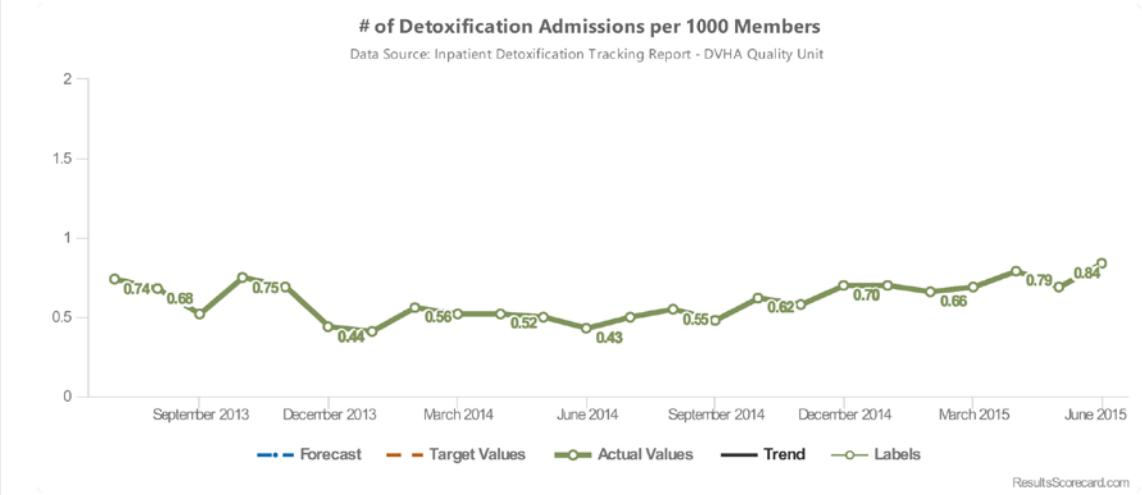
Data Note: This data excludes admissions for the populations that the Department of Mental Health manages (CRT, involuntary, Level 1 and adults who are being served by an adult outpatient program at a Designated Agency).

P Medicaid Inpatient Detoxification Utilization and 1 more...

PM DVHA # of Detoxification Admissions per 1000 Members



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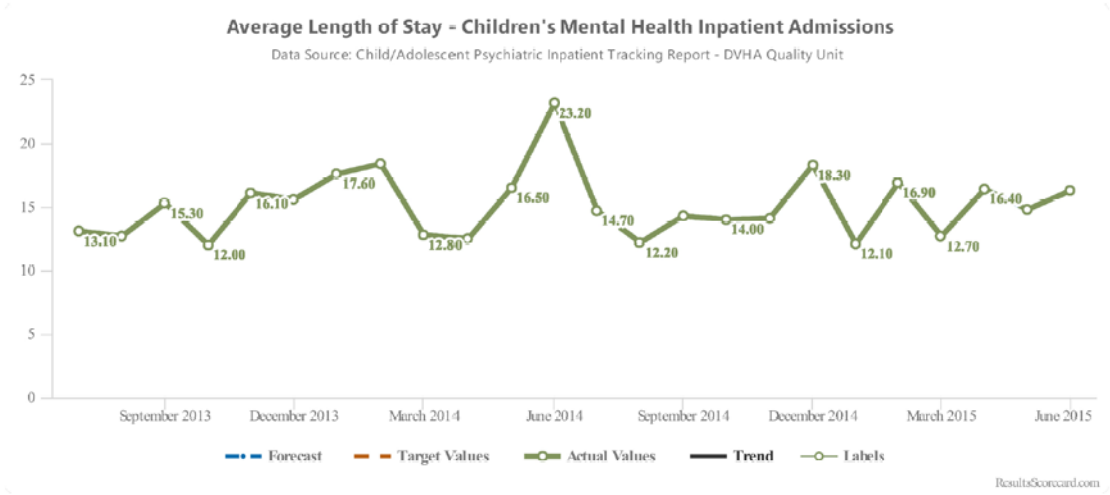
PM DVHA Average Length of Stay - Children's Mental Health Inpatient Admissions



Story Behind the Curve

The DVHA strives towards the Institute for Healthcare Improvement's "Triple AIM":

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations
- Reducing the per capita cost of healthcare

As a part of DVHAs pursuit of the "Triple Aim", the goals for the utilization management system are as follows:

- Clinical care is provided only as long as necessary for safety and/or other acute needs.
- There are standardized criteria for admission, continued stay and discharge throughout the system of care.
- Care is continuous between the ongoing community treatment teams and episodes of inpatient or residential care. Ideally the hospital or residential facility and community teams develop and share a common treatment plan developed in partnership with the individual and their family, beginning within 24 hours of admission.
- Resources of the public system are effectively and efficiently used.
- The system of care will ensure access to effective, appropriate, recovery-based services that promote an individual's health, wellness and resiliency and will support successful integration into the community.

Historically, as a part of an acute care management program that was developed in response to the 1115b Waiver, children's inpatient admissions at the Brattleboro Retreat were managed through a concurrent review process, however this oversight ended in late 2006 and during this "unmanaged" period the average length of stay and inpatient costs grew substantially.

As a part of DVHA's utilization management program, the Quality Unit tracks the average length of stay for Vermont Medicaid members and changes to this average over time in our population. In addition, the Quality Unit also looks at the Vermont averages in comparison to the national average length of stay as reported by the CDC.

In a report from the CDC, average lengths of stay (LOS) for all ages from short-stay hospitals (hospitals with average LOS of less than 30 days) for first-listed diagnostic categories (ICD-10) in 2010 were as follows:

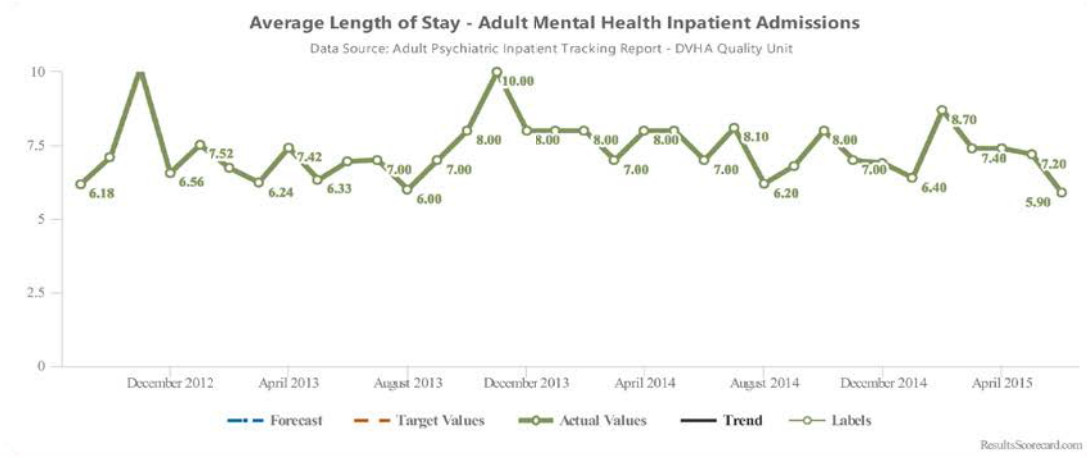
- Psychoses - 7.2 days
- Schizophrenic - 10.6 days
- Major depressive disorder - 6.5 days

In a similar report from 2007:

- All mental disorders - 6.9 days, Psychoses - 7.6 days, Schizophrenic - 10.6 days, Major depressive disorder - 6.9 days

P Medicaid Adults - Inpatient Psychiatric Utilization and 1 more...

PM DVHA Average Length of Stay - Adult Mental Health Inpatient Admissions



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P Medicaid Inpatient Detoxification Utilization and 1 more...

PM DVHA Average Length of Stay - Detox. Admissions

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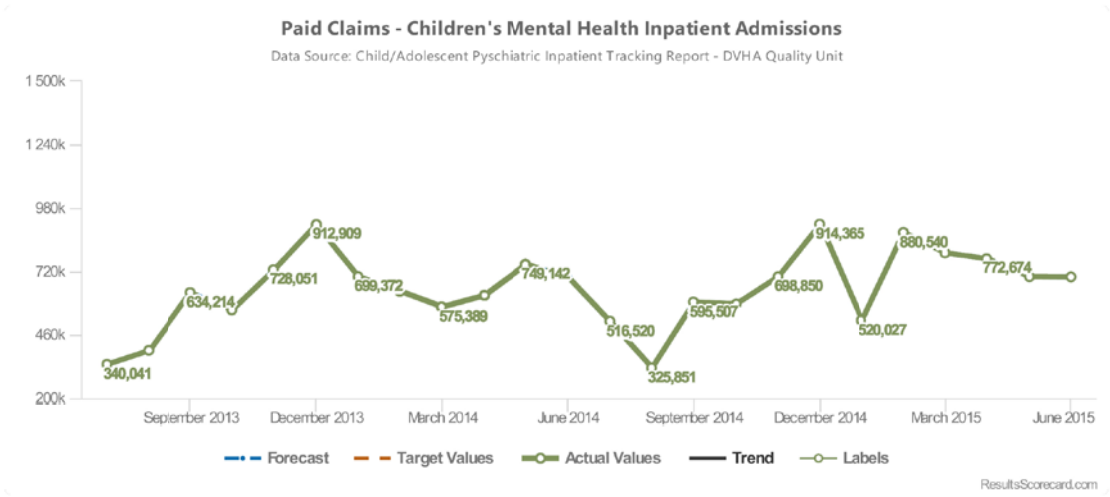
PM DVHA Paid Claims - Children's Mental Health Inpatient Admissions



Story Behind the Curve

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· Improving the patient experience of care (including quality and satisfaction)

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One of the strategies the DVHA has adopted to move towards the "Triple AIM" is utilization management of our most intensive and high-cost services, which include inpatient psychiatric hospitalization. Inpatient psychiatric services, which include detoxification, are paid on a per day basis, unlike hospitalization on traditional medical inpatient units. This per day payment methodology has the potential to create a dis-incentive for providers to make efficient use of this high cost, most restrictive level of care. While CRT members' hospital costs are included in their case rate payment to the Designated Agencies (DAs), which creates an incentive for the DAs to work efficiently with the inpatient units to transition their members back to their existing community services and supports, no such incentives exists for children or non-CRT enrolled adults.

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The DVHA Quality Unit reviews paid claims and tracks the costs of inpatient hospitalization for specific populations.

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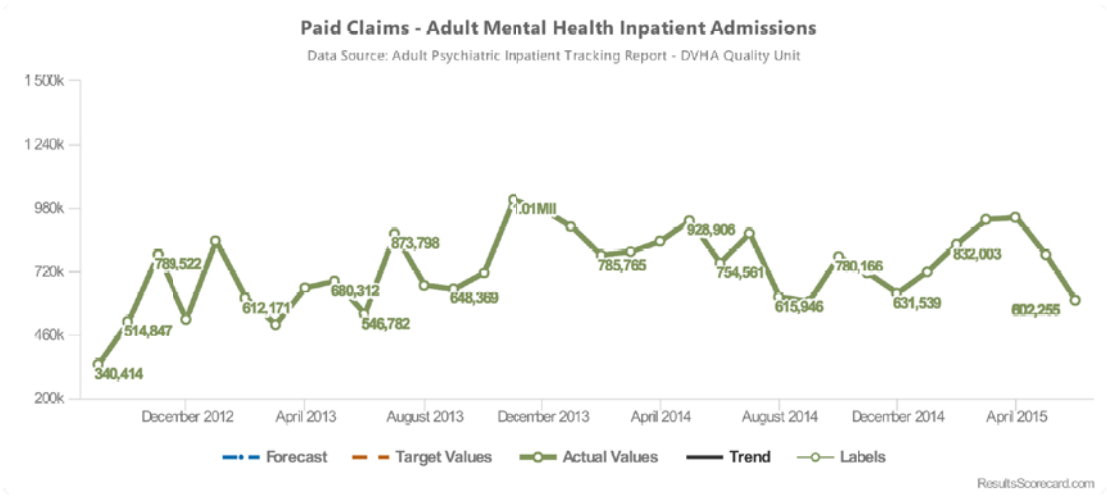

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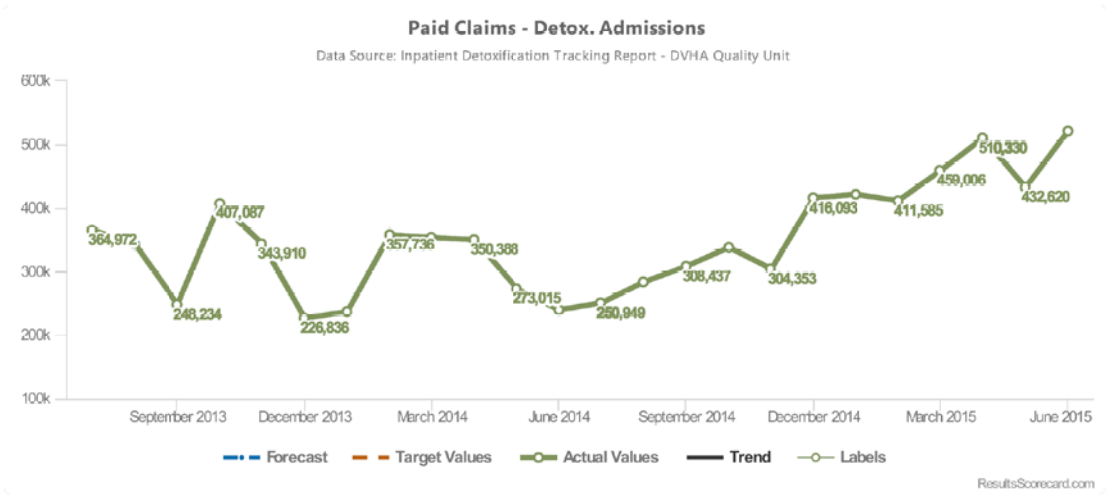

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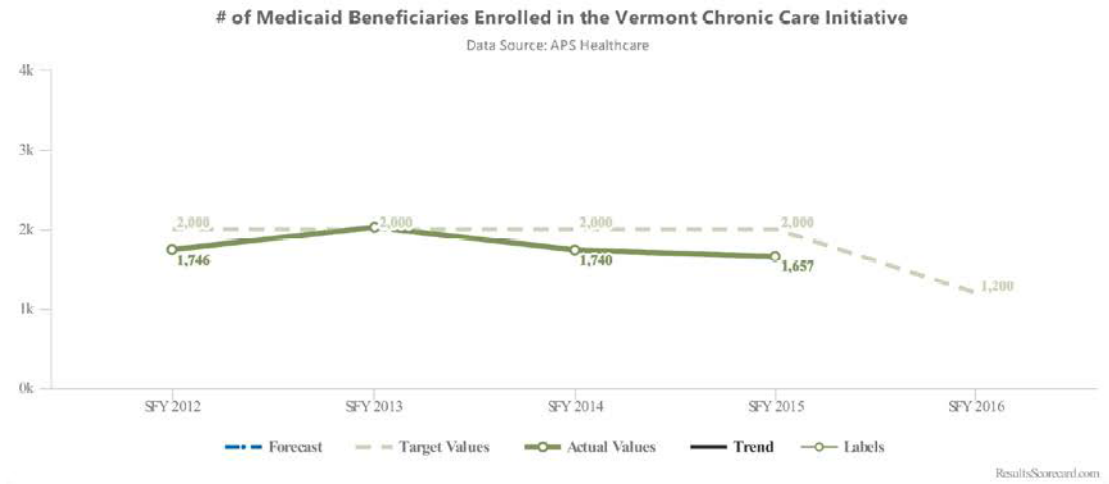
P Vermont Chronic Care Initiative and 1 more...

PM VCCI # of Medicaid Beneficiaries Enrolled in the Vermont Chronic Care Initiative



Partners

The VCCI currently utilizes a holistic and multidisciplinary approach to the intensive case management services provided to Medicaid's high risk/high cost members (top 5% VCCI eligible members account for roughly 39% of the Medicaid spend). Local partners include:

- AHS Field Directors,
- AHS district colleagues within sister departments (VDH, DAIL, DMH, DOC, DCF);
- housing authorities, facilities, shelters and advocacy groups;
- community service providers including food shelves, transportation service providers;
- and various health care provider partners such as hospitals, primary care medical homes, mental health and substance use/abuse service providers (designated mental health agencies, hub/spokes), hospital inpatient/outpatient and ED case managers as well as Community Health Teams (CHTs) funded by Medicaid, to assure coordination among service providers and improved adherence to evidence based care and financial improvement to the system.

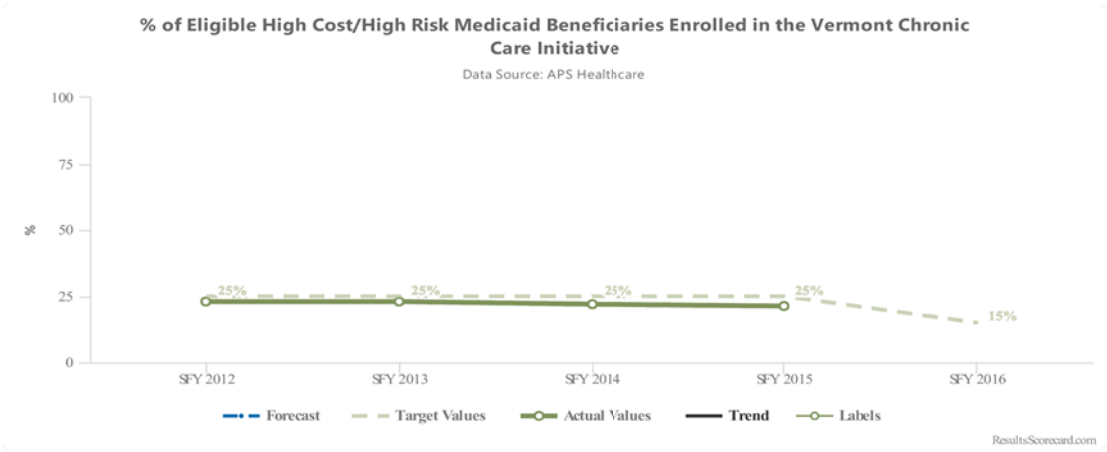
Story Behind the Curve

The DVHA/VCCI enrollment for top 5% high cost/high risk members will continue to decrease because:

- The DVHA/VCCI contract with APS healthcare is due to expire 12/2015 after multiple extension. We have suffered a slow loss of nursing staff prior to our renegotiated 2015 one year extension and the newest 6 month extension for SFY 2016 such that all nursing staff is now provided remotely and telephonically vs. locally. Thus the VCCI experienced –and anticipates further –clinical staff attrition through the contract end date of 12/2016. The nursing attrition at both APS and DVHA will continue to adversely impact our ability to actively outreach, engage and case manage 25% of the total eligible cohort (8500-9500).
- With the sun setting of the APS contract in 12/2016, the VCCI staff will help develop, learn and ultimately migrate to the new enterprise Care Management system provided by eQHealth. These transitions will require a drop in the VCCI case load as the APS Healthcare vendor provided 6 FTE nursing and 2 FTE social worker positions (8 clinical FTEs), program support functions and data analytical and reporting staff (4 FTE's). The loss of these 12 FTE's will result in a decline in our overall case load and related cost savings generated by intensive individual and population based approaches to care management. The VCCI is also loosing a part time medical director and full time pharmacist with this work being absorbed by current DVHA staff.
- The VCCI also lost one FTE nurse case manager position in the 2016 legislative budget cuts, further reducing our capacity to cover key hospital service areas (1 RN position now will serve 4 counties and 3 HSA's in the rural northeast kingdom), and the related clinical and financial benefits.
- The VCCI leadership and central support staff will be preparing for relocation to Waterbury concurrent with the Enterprise CM system deployment.

P Vermont Chronic Care Initiative (VCCI) and 2 more...

PM VCCI % of Eligible High Cost/High Risk Medicaid Beneficiaries Enrolled in the Vermont Chronic Care Initiative



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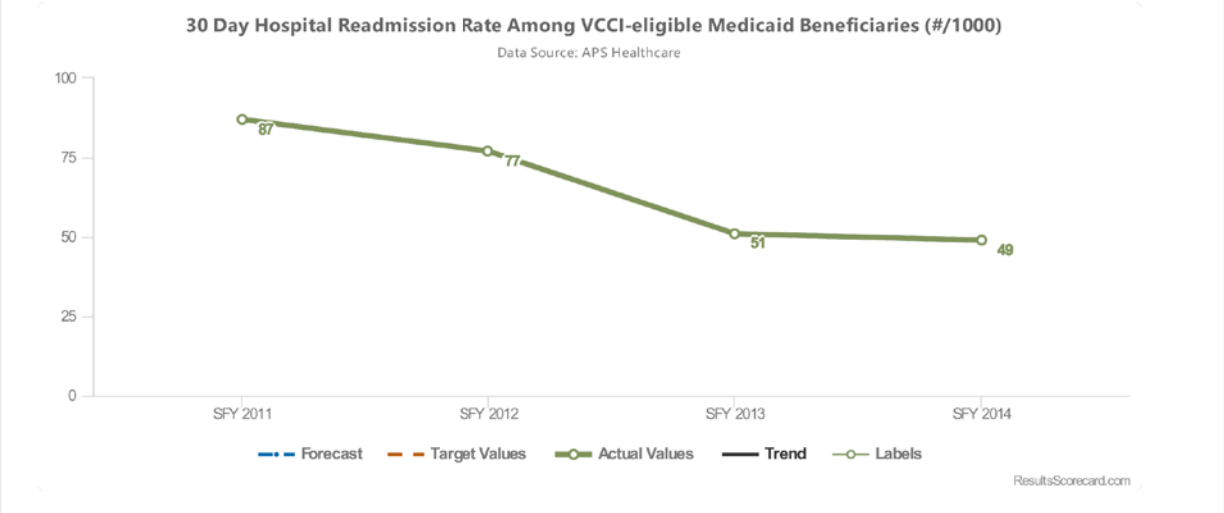


What Works

- State employed, locally deployed VCCI staff (nurses and licensed mental health, substance abuse counselors and/or clinical social workers) who are embedded in AHS offices, high volume hospitals and/or primary care locations where Medicaid members receive services, in order to outreach/engage and deliver case management support services within the local community where members reside. The VCCI team are skilled in working with high cost members with complex medical, psychosocial and socio-economic need, utilize motivational interviewing and try to develop and maintain trusting relationships to facilitate achievement of common goals.
- Staff co-located within AHS district offices facilitates access to and networking with internal colleagues on behalf of members; and helps facilitate communication, relationship development and offers the opportunity to link members to core programs and services for which they are eligible; and which support sustainable results (3 squares/WIC– toward food security; fuel assistance, VR services, eligibility staff, etc.)

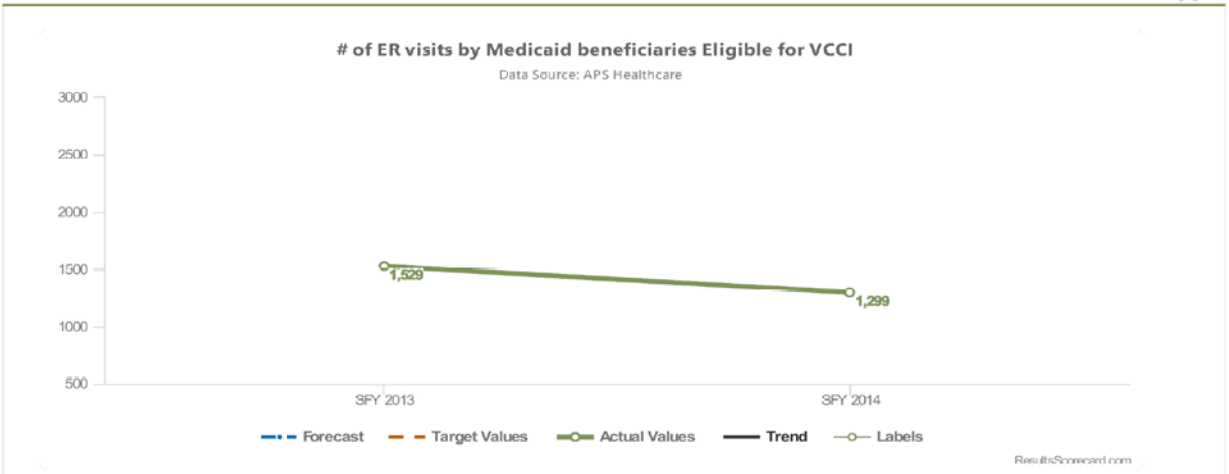
The VCCI saved a net $30.5 million over anticipated costs in SFY 2014.

Action Plan

- VCCI staff align with health care reform goals within DVHA and coordinate with local partners toward joint goals, shared utilization of tools and integrated care management, to facilitate transition between levels of service providers (i.e. Primary Care/Blueprint CHTs refer to VCCI to support high risk/cost population for intensive case management including care coordination, health education/coaching needs via home visiting of co-visits with PCPs and other service providers. Tools are available for standardization and sharing across the system of care (i.e. Action Plans/Self-Management plans).
- DVHA/VCCI leadership are engaged with the Medicaid ACO contracting process and ACO requirements for collaboration with VCCI to prevent/eliminate redundancy in efforts among populations receiving case management; and to assure staff integration and referral systems
- Regular bi-weekly meetings between DVHA Commissioner's office, VCCI and the Blueprint for Health to assure alignment, integration and collaboration centrally and locally.

P Medicaid's Vermont Chronic Care Initiative (VCCI)

PM VCCI # of ER visits by Medicaid beneficiaries Eligible for VCCI



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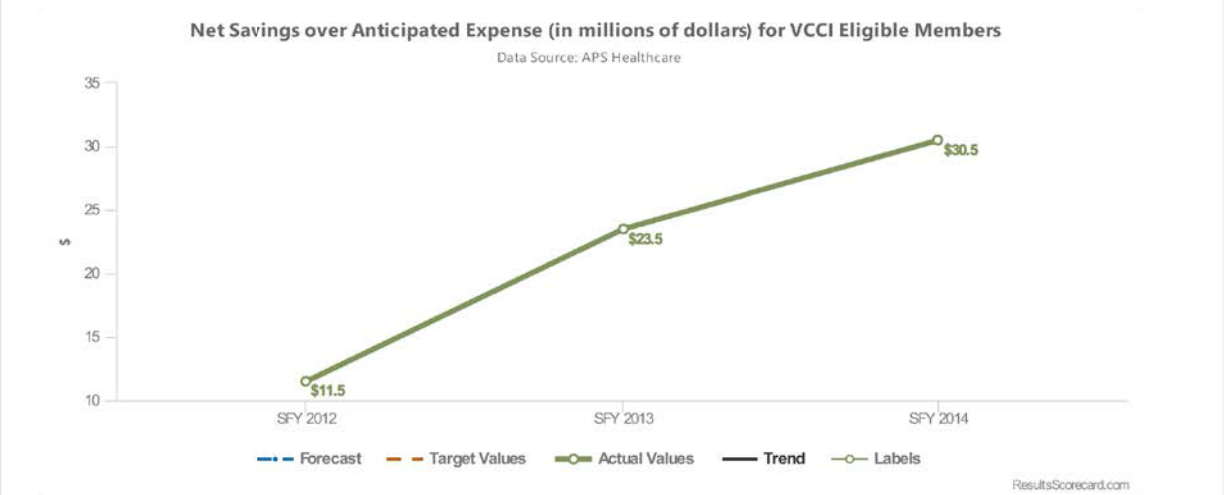

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State of Vermont

Agency of Human Services

Departments of Mental Health and Vermont Health Access:

Unified Service and Financial Allocation for Publically Funded Mental Health Services as part of

An Integrated Healthcare

System

Submitted to:

THE VERMONT GENERAL ASSEMBLY

In Response to ACT 58 of 2015

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SECTION ONE: INTRODUCTION

Act 58 of the 2015 Legislative session directs the Agency of Human Services (AHS), through the Departments of Vermont Health Access (DVHA) and Mental Health (DMH), to create an implementation plan for a unified service and financial allocation for publicly funded mental health services as part of an integrated health care system. As written in Act 58, the goal of the plan is to integrate public funding for direct mental health care services within the Department of Vermont Health Access while maintaining oversight functions and the data necessary to perform those functions within the department of appropriate jurisdiction. As part of the planning contemplated by Act 58, DMH and DVHA must ensure alignment with:

- The Global Commitment (GC) to Health Section 1115 Demonstration;
- AHS-wide policy and operations that support services to vulnerable populations;
- Current State Innovation Model (SIM) work; and
- The emerging All Payer Model Design and its related Medicare waivers.

This report provides an update on activities as AHS continues its approaches for the essential integration of mental and physical health. Activities must be considered in the context of the State's overall health reform framework and in the context of efforts to integrate Medicaid programs across the AHS enterprise.

Section One of this report provides an overview of the Agency's ultimate vision for publically funded mental health services in Vermont. It also provides an overview of the goals and principles used to guide the DMH/DVHA joint planning and program development.

Section Two of this report provides an overview of the current mental health delivery system and the State's efforts to integrated care in the context of statewide Health Care Reform.

Section Three of this report provides an overview of near term and long term activities and action steps that the Agency will undertake to support meaningful integration of mental and physical health across all of its publically funded mental and physical health services.

Vision

Using the 2013 DMH Strategic Plan as its foundation, the AHS has adopted the following vision for its publically funded mental health programs:

> *Mental Health will be a cornerstone of health of Vermont. People will live in caring communities with compassion for and a determination to respond effectively and respectfully to the mental health needs of all citizens. Vermonters will have access in all health care settings to effective prevention, early intervention and mental health treatment and supports as needed to live, work, learn and participate fully in their communities.*

Priorities for the public mental health system include:

- Promotion: Promotion of mental health and wellness for all Vermonters
- Prevention: Protect all Vermonters from the risk for mental disorders
- Treatment: Intervene early to treat mental health problems
- Re-Claiming: Provide support and treatment to achieve recovery and resiliency

Implementation Plan Goals and Principles

As a foundation for collaborative planning, the following goals and principles were adopted to guide the design and on-going refinement of AHS mental and physical health care integration efforts. As each action step is undertaken, a review of these goals and their associated principles will ensure that implementation activities, now and in the future, align with underlying AHS commitments to Access, Quality and Cost Containment.

- Ensure Access to Care for Consumers with Special Health Needs
  - "Access to Care" includes availability of high quality service types as well as the sustainability of specialized providers (i.e., network adequacy and capacity).
  - Service delivery models should ensure the State's most vulnerable populations have access to comprehensive person and family centered care.
- Promote Person and/or Family Centered Care
  - "Person and/or Family Centered" includes supporting a full continuum of traditional (e.g., skilled therapy and inpatient treatment) as well as non-traditional Medicaid services (e.g., community wraparounds, peer run alternatives, mobile crisis and diversion and step down programs) based on an individual and/or family's treatment needs and choices.
  - Service delivery should be coordinated across all systems of care (physical, behavioral and mental health and long term services and supports).
- Ensure Quality and Promote Positive Health Outcomes

- "Quality Indicators" should utilize a broad measure set that include structure, process and experience of care measures.

- "Positive Health Outcomes" should include measures of independence (e.g., employment and living situation) as well as traditional health scores (e.g., assessment of functioning and condition specific indicators).

❖ Ensure the Appropriate Allocation of Resources and Manage Costs

- Financial responsibility, provider oversight and policy need to be aligned to mitigate the potential for unintended consequences of decisions in one area made in isolation of other factors.

❖ Create a Structural Framework to Support the Integration of Mental and Physical Health Services at the provider level

- Any proposed change should be goal directed and promote meaningful improvement.
- Departmental structures must support accountability and efficiency of operations at both the State and provider level.
- Short and long term goals should align with current Health Care Reform efforts.

SECTION TWO: CURRENT DELIVERY SYSTEM AND REFORM EFFORTS

This Section provides an overview of DMH and DVHA, the mental health delivery system and the State's efforts to integrated care in the context of statewide Health Care Reform. An overview of funds supporting mental health services across AHS is also provided.

Department of Mental Health

The mission of the Vermont Department of Mental Health (DMH) is to promote and improve the mental health of Vermonters and to provide Vermonters with access to effective prevention, early intervention, and mental health treatment and supports as needed to live, work, learn, and participate fully in their communities.

The Department was created under Title 18 of the Vermont Statutes. The following excerpts provide background for the action steps outlined in Section Three of this Report.

> *§ 7201 [DMH] shall centralize and more efficiently establish the general policy and execute the programs and services of the state concerning mental health, and integrate and coordinate those programs and services with the programs and services of other departments of the state, its political subdivisions, and private agencies, so as to provide a flexible comprehensive service to all citizens of the state in mental health and related problems.*
>
> *§ 7202 [DMH] shall be responsible for coordinating efforts of all agencies and services, government and private, on a statewide basis in order to promote and improve the mental health of individuals through outreach, education, and other activities.*
>
> *§ 7205 [DMH] shall operate the Vermont State Hospital or its successor in interest and shall be responsible for patients receiving involuntary treatment.*
>
> *§ 7251 (4) The mental health system shall be integrated into the overall health care system.*
>
> *§ 7251 (8) Vermont's mental health system shall be adequately funded and financially sustainable to the same degree as other health services.*

DMH has primary responsibility for overseeing the quality of psychiatric and mental health care provided through:

- Six Designated Hospitals;
- Ten Designated Agencies;
- Two Specialized Service Agencies; and
- A network of specialized residential and peer-run/supported treatment options for persons experiencing a severe and persistent mental illness.

The Adult Mental Health Services Division funds the following three major programs that offer or assure access to mental health services through Designated Agencies (DAs) in communities throughout the state:

- **Community Rehabilitation and Treatment (CRT) Program,** which provides comprehensive mental health and emergency services for adults with diagnoses of severe and persistent mental illness (e.g., schizophrenia, bipolar disorder, major depression, and others).

- **Adult Outpatient services,** which are services for adults who do not have a diagnoses of major mental illnesses but who are nevertheless experiencing serious emotional or behavioral problems that disrupt their lives.

- **Emergency Services,** which are for anyone of any age experiencing a mental health crisis. Emergency services are available statewide from Designated Agencies (DAs) to anyone in a mental health crisis, 24 hours a day, and 365 days a year.

The Adult Mental Health Services Division also oversees an array of inpatient and residential programs and services for adults with mental illnesses and persons receiving CRT Program services, including:

- **Hospitals** for individuals who require acute psychiatric inpatient care. These services are managed jointly with DVHA. DMH takes a lead role for persons who are CRT eligible and/or requiring Emergency Evaluations (EE) and DVHA takes a lead role for persons who are admitted without CRT or EE status.

- **Intensive Residential Programs and Recovery Housing** for individuals who no longer require acute inpatient care but remain in need of treatment in a supportive, recovery-oriented setting for an extended period of time.

- **Secure Residential Programs** for individuals who no longer require acute inpatient care but remain in need of treatment in a secure, recovery-oriented setting for an extended period of time.

- **Crisis Beds** for individuals who are experiencing acute symptoms but do not require inpatient care.

In addition, the **DMH Legal Unit** supports adults in need of intensive services and supports through administration of such services as Orders of Non-Hospitalization, Guardianship and Forensic Evaluations, legal aspects of Involuntary Treatment, and other litigation or appeals.

Services provided through the Adult Mental Health Division include an array of Medicaid State Plan services, as well as a unique set of specialized managed care services authorized under the

Special Terms and Conditions (STCs) of the State's Global Commitment (GC) to Health Section 1115 Demonstration.

Under the CRT Specialized Program in the GC Demonstration, expenses associated with providing the full continuum of care to CRT clients are considered part of a sub-capitated payment from DVHA to DMH in the Medicaid program. Services reimbursed with this payment are authorized and overseen by DMH under legislative authority and direction. The Global Commitment to Health Demonstration Waiver approved in January 2015 (STC #18c) provides the State with the authority to define Program services, coverage and any service limitation in Vermont rule and policy. All CRT community support services and inpatient psychiatric hospital services (excluding services provided in an Institution for Mental Deficiency (IMD) for persons 21-64) are considered part of the sub-capitated payment arrangement.

Additionally, CRT participants who are not Medicaid eligible and who have incomes at or below 185% of the Federal Poverty Level (FPL) are allowable as part of the STCs. CMS refers to this group as a Designated State Health Program (DSHP). All covered services for CRT participants who are eligible for Medicaid or have incomes at or below 185% of FPL can be included in the sub-capitation rate paid by DVHA to DMH.

Child, Adolescent, and Family Mental Health Services

The Child, Adolescent, and Family Mental Health treatment system is organized around the following five core capacity services that are available separately or in combination to a youth and their family, depending on their desires and needs:

- **Immediate Response Services** for children and adolescents who are experiencing a mental health crisis and their families.

- **Clinic-Based Treatment Services** that are provided within a clinic and are available during daytime and evening hours for school-age children and/or when families can easily access them.

- **Outreach Treatment Services** are available in the home, school, and general community settings.

- **Family Support Services** for parents and caregivers to help with guidance, support, and skill to cope with a difficult-to-care-for child, including respite services; these services are offered in partnership with parents and consumer advocates.

- **Prevention, Screening, Referral, and Community Consultation** that focuses on promoting healthy lifestyles and healthy communities for all youth and families.

DMH also supports a child/youth in an out-of-home placement when the current treatment plan is unable to meet the child/youth/family's treatment needs in the home through the following services and programs:

- **Enhanced Family Treatment** (formally known as Children's Mental Health Waiver), which is a funding mechanism that allows a Designated Agency or Special Service Agency to provide a package of home and community-based services in an intensive manner.

- **Residential Care**, which provides 24-hour awake night staffing, 24-hour medical and psychiatric back-up, in-house crisis back-up, and an array of psychological assessment and treatment services.

- **Emergency/Hospital Diversion Beds**, which are community-based programs that provide a very high level of care and have the ability to divert youth from in-patient hospitalization.

- **Hospital Inpatient Services** that are provided in a psychiatric hospital that offers around-the-clock medical monitoring.

DMH is participating in the AHS-wide effort, Integrating Family Services. Specifically, DMH Children's Mental Health Medicaid allocation in two pilot regions, (Addison and Franklin/Grand Isle Counties), are pooled with other Medicaid funds to support a full continuum of child and family mental health and wellness services. These DMH services and funds comprise approximately 70% of the total IFS Initiative.

Department of Vermont Health Access

The Department of Vermont Health Access was established as the operational unit of State Government, designated by AHS, to administer the Medicaid program. DVHA is also responsible for: Vermont Health Connect (Medicaid and Qualified Health Plan enrollment); Health Information Technology Planning and Oversight; participation in statewide Health Care Reform efforts through the Blueprint for Health Patient Centered Medical Home Initiative, Specialized Health Home and other Medicaid, Medicare and multi-payer State initiatives.

AHS and DVHA are charged with managing public resources while preserving and enhancing access to health care services in the State. The Department of Vermont Health Access is authorized in statute to serve as a publically operated managed care organization and comply with federal rules governing managed care organizations in 42 CFR Part 438. The following excerpts from Title 33 of the Vermont Statutes provide background for the action steps outlined in Section Three of this Report as it relates to DVHA's role and responsibilities.

> *§ 1901 (a) (1) The Secretary of Human Services or designee shall take appropriate action, including making of rules, required to administer a medical assistance program under Title XIX (Medicaid) and Title XXI (SCHIP) of the Social Security Act.*
>
> *§ 1901(d)(1-2) To enable the State to manage public resources effectively while preserving and enhancing access to health care services in the State, the Department of Vermont Health Access is authorized to serve as a publicly operated managed care*

organization (MCO)... The MCO shall comply with the federal rules governing managed care organizations in 42 C.F.R. Part 438.

§ 1901 (3) The Agency of Human Services and Department of Vermont Health Access shall report to the Health Care Oversight Committee about implementation of Global Commitment……Reporting shall, at a minimum, enable the tracking of expenditures by eligibility category, the type of care received, and to the extent possible allow historical comparison with expenditures under the previous Medicaid appropriation model (by department and program) and, if appropriate, with the amounts transferred by another department to the Department of Vermont Health Access.

§ 1901a. The annual Medicaid budget shall include an annual financial plan, and a five-year financial plan accounting for expenditures and revenues relating to Medicaid and any other health care assistance program administered by the Agency of Human Service.

DVHA's current role in mental health services includes responsibilities for the enrollment of all providers and general oversight of independently practicing mental health providers in the Medicaid program. DVHA is responsible for funding a number of mental health related services including hospital services, psychiatrists, psychologists and pharmacy services. DVHA also provides utilization review and management of inpatient psychiatric hospital admissions for non-CRT clients and adults who are not affiliated with a Designated or Specialized Agency and/or who are not court ordered and for all children's admissions. DVHA's utilization management team manages episodes of inpatient psychiatric hospital admissions, prior authorizations and payment decisions.

Current coverage and payment policy is defined by both DMH and DVHA based on provider types and departmental budget allocations. DMH Statutory role includes oversight and general policy obligations for all programs and services of the state concerning mental health. Title 18 intends for DMH to integrate and coordinate programs across departments to provide a flexible comprehensive service to all citizens of the state in mental health and related problems on a statewide basis.

Currently, DMH is staffed to address to the specialized programs offered through the Designated and Specialized Agency provider network. Inpatient Psychiatric Hospital Services are currently managed by both DMH and DVHA. In addition, post Tropical Storm Irene a "Level I" designation was created to identify individuals that, because of their behavioral presentation, required extraordinary staffing during their inpatient admission. DMH prior authorizes these stays and reconciles payments to hospitals through a cost settlement process.

Currently, DMH manages: all admissions for persons affiliated with DA/SSA programs; Level I clinical designations; Emergency Evaluations and Level I hospital cost settlements. Annually unallocated inpatient hospital funding in the DMH budget is used to support and enhance CRT community services. DMH monitors overall capacity within Mental Health System of Care and supports continuity of care planning between multiple levels and providers of care (e.g. outpatient, inpatient, hospital diversion, step down and other community beds).

DVHA manages episodes of care for all non-DA/SSA and non-court involved adult admissions and all children's admissions. DVHA ensures discharge planning is timely and coordinated. DVHA also provides general provider oversight through traditional fee for service Medicaid provider enrollment and program integrity process. An overview of provider programs and oversight responsibilities is provided in Table 1 below.

Table 1: Summary of Provider Types and DMH/DVHA Oversight Responsibilities

DMH/DVHA Mental Health Providers			
Provider/Program	**Oversight Responsibility**		
	Policy	**Funding**	**Provider**
DA/SSA Specialized Programs	DMH	DMH	DMH
Designated Agency Outpatient Mental Health	DMH, DVHA	DMH, DVHA	DMH
Hospital Inpatient Psychiatric	DMH, DVHA	DMH, DVHA	DMH, DVHA
Independent Practice Outpatient Mental Health	DVHA	DMH, DVHA	DVHA
FQHC and Other Clinic Outpatient Mental Health	DVHA	DVHA	DVHA

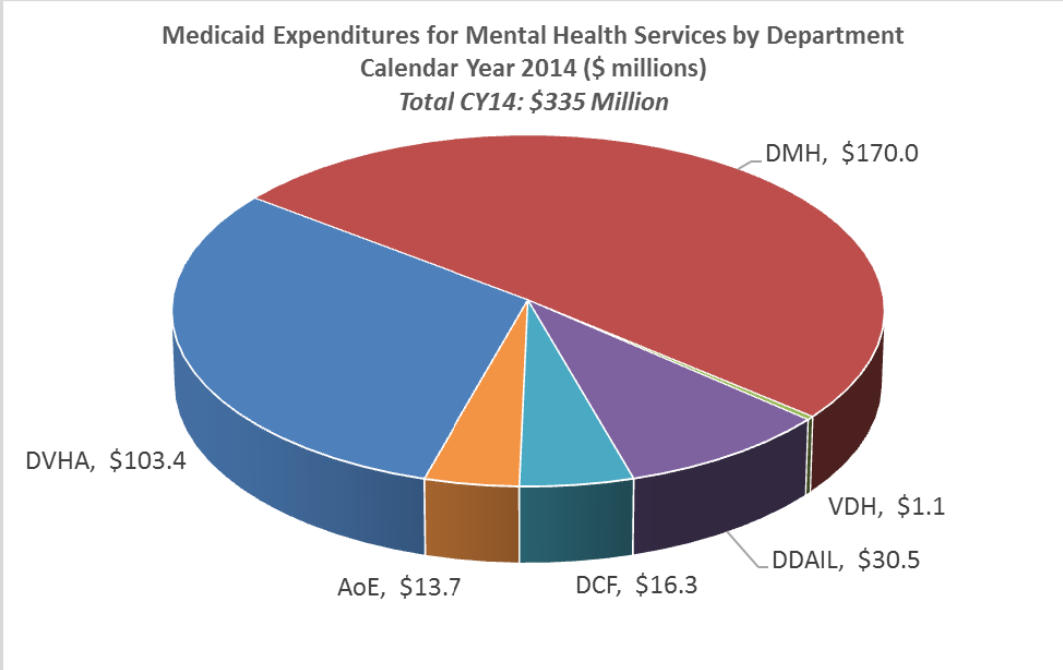
Publically funded mental health services are also supported across a variety of other AHS Departments. In many cases, but not exclusively, these programs are delivered through contracts with Designated or Specialized Service Agencies. Table 2 below provides an overview of mental health supports provided to targeted populations across the AHS.

Table 2: Publically funded programs providing behavioral and mental health support

Publically Funded Mental Health Services Across AHS & AOE	
Behavioral and Mental Health Program	Brief Description
Integrating Family Services	This initiative reimburses services using a global budget agreement and Medicaid bundled rate. Provider expectations are unified across multiple Medicaid funding streams to support early intervention and treatment for children and families. Approximately 70% of IFS funds are supported through the DMH Children's Mental Health Appropriation.
Children's Integrated Services	This project reimburses multiple early childhood service types using a global budget agreement and single Medicaid bundled rate. The program includes early childhood developmental and mental health services.
DCF/FSD Contracted Treatment Services	Service contracts in the Family Service Division are targeted to at risk families and those who have a child involved with DCF. Mental health related programs include Intensive Family Based Services, Runaway and Homeless Youth Programs, Sex Offender and Victim Treatment services, family and parental skill building and other supports.
Alcohol & Addiction Treatment	Programs offered through the Division of Drug and Alcohol employ best practices in addiction treatment and co-occurring mental health treatment.
Developmental Services Clinical Supports	Clinical supports include psychiatric, crisis and behavioral support by providers who specialized in assisting individuals with cognitive and intellectual disabilities.
Psychological Supports for Traumatic Brain Injury	Psychological supports include psychiatric, crisis and behavioral support by providers who specialized in assisting individuals with traumatic brain injuries.
Autism Services	Supports include psychiatric, crisis and behavioral support by providers who specialized in assisting individuals with Autism Spectrum Disorders.
Correctional Mental Health	Programs include prison mental health services as well as community based treatment and support by providers who specialized in working with offenders.
Agency of Education	IEP related services that include mental health support to children in the school setting are supported through the AoE Medicaid program.

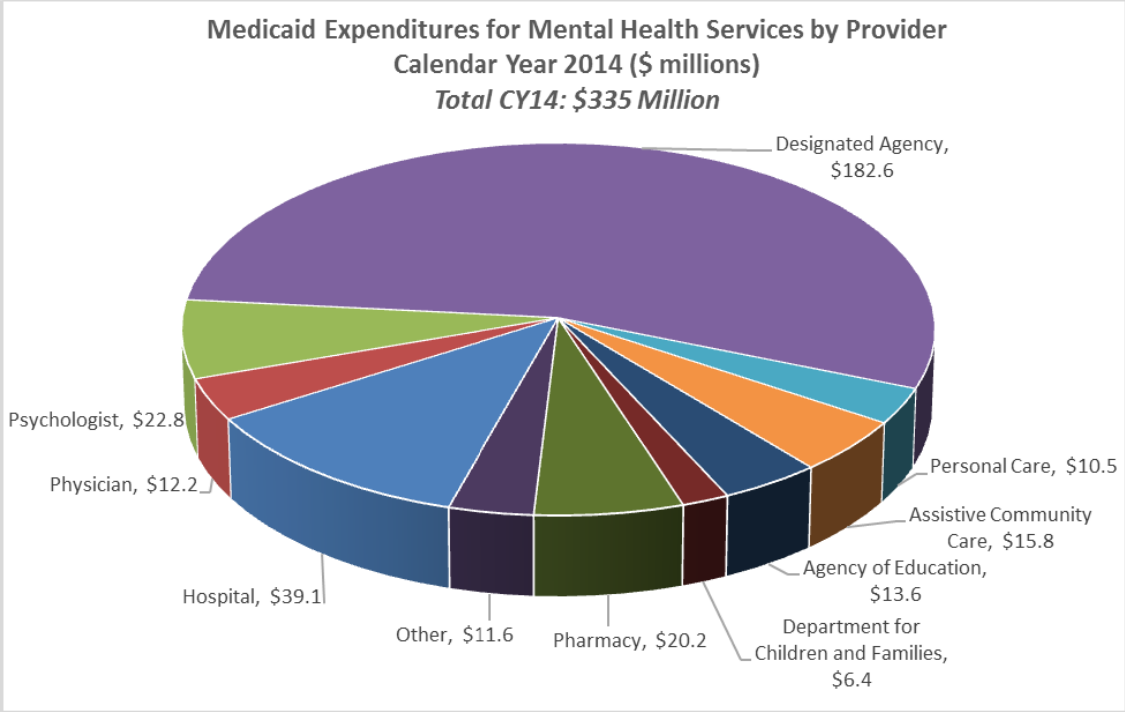
A recent DVHA analysis examined the total claims paid for mental health related services, excluding those related to a substance use disorder, and including pharmacy and lab claims. Overall approximately $335 million of Medicaid expenditures can be attributed to mental health related services in calendar year 2014 (CY14). Approximately $170 million in support was provided through DMH primarily through the DA/SSA network, of that total approx. In CY14 approximately $103 million was paid by DVHA. An additional $48 million in mental health service was provided through other AHS programs in DCF, DAIL and VDH. IEP related mental health claims supported through the Agency of Education represented approximately $13 million of the total expenditures in this analysis. This data does not include payments made for services outside of the Medicaid claims system and thus does not represent total State spending. Exhibit 1 below provides an overview of CY14 claims expenditures for each department.

Exhibit 1: Medicaid Expenditures for Mental Health Services by Department for CY14



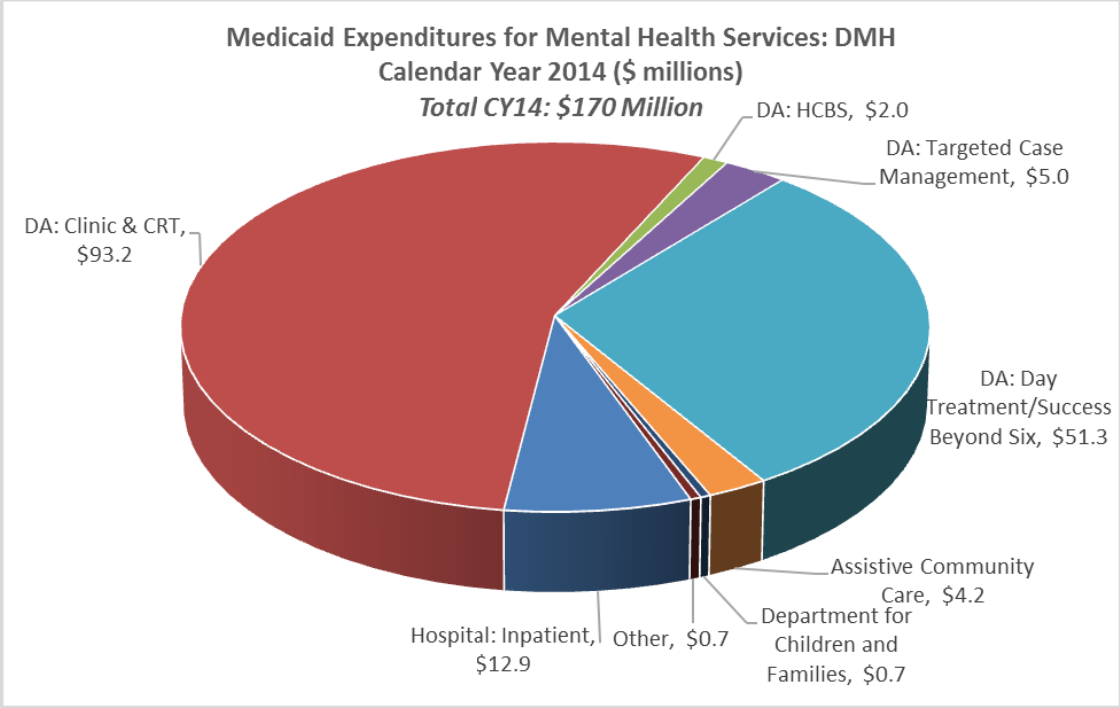
Total expenditures for mental health services in CY14 included $182 million in payments to Designated and Specialized Service Agencies, $39 million to hospitals, $20 million in pharmacy claims and approximately $35 million to independent practitioners and physicians. An additional $58 million supported DCF case managers, DCF contracted treatment services, Personal Care providers, Assitive Community Care providers and providers of IEP services in the schools. Exhibit 2 below provides an overview of mental health related services by provider type.

Exhibit 2: Medicaid Expenditures for Mental Health Services by Provider Type for CY14



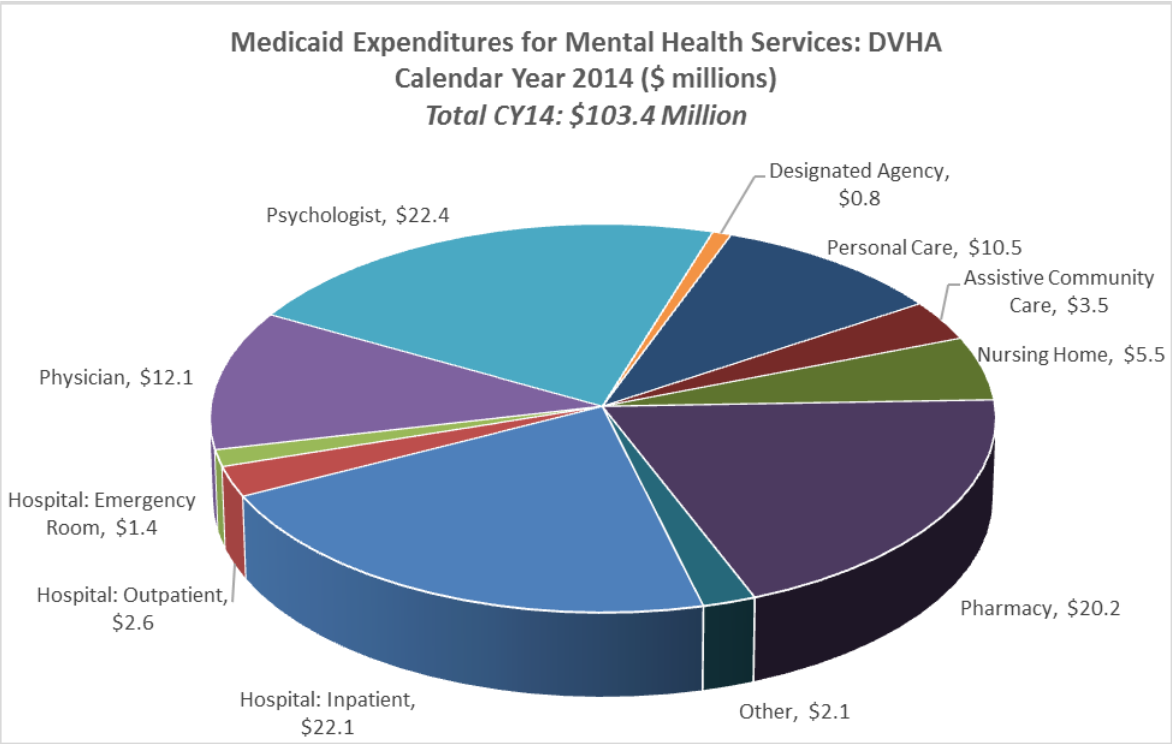
Using the same Mediciad claims data, an analysis was conducted to examine expenditures in the DMH and DVHA fund sources. Of the $170 million in DMH paid claims, approximately $151 million supported services through the Designated and Specialized Agencies, $13 million supported inpatient psychiatric hospital services and $5 million supported payments to other community providers. Exhibit 3 below provides an breakout of DMH claims payments.

Exhibit 3: DMH Mediciad Claims Expenditures for Mental Health Services for CY14



A review of $103 million in DVHA paid claims shows that less than $1 million supported Designated and Specialized Service Agencies, while $38 million supported mental health claims through hospitals and physician services, $22 million supported independent psychologists, $20 million supported pharmacy related mental health services and $21 million supported Personal Care, Nursing Home, Assitive Community Care and other mental health services. Exhibit 4 on the following page provides an breakout of DVHA claims payments for mental health related services.

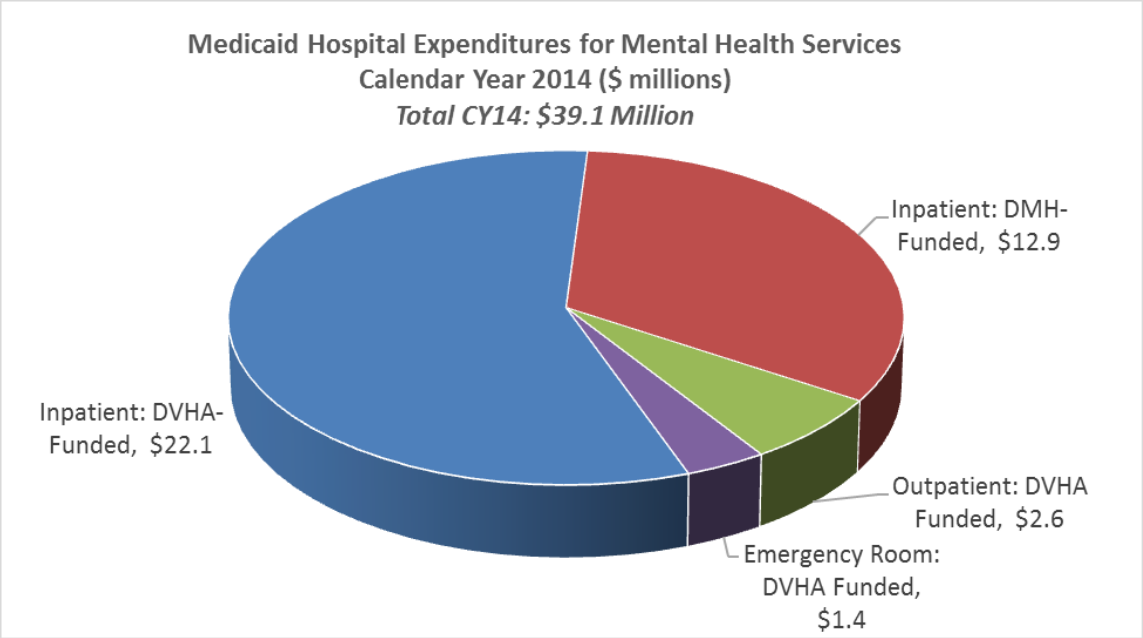
Exhibit 4: DVHA Mediciad Claims Expenditures for Mental Health Services for CY14



Funding of Inpatient Hospital Services by DMH and DVHA

Hospital services are managed jointly by DVHA and DMH. DMH takes a lead role for persons who are CRT eligible and/or requiring Emergency Evaluations (EE) and DVHA takes a lead role for persons who are admitted without CRT or EE status. DVHA also is responsible for Emergency Room and Outpatient Hospital Services. A breakdown of Medicaid claims between DVHA and DMH shows that of the $39 million spent on hospital services; approximately $13 million is supported by DMH with the remainder supported by DVHA. Exhibit 5 on the following page provides an overview of inpatient psychiatric claims data.

Exhibit 5: Mental Health Related Hospital Claims by Department for CY14

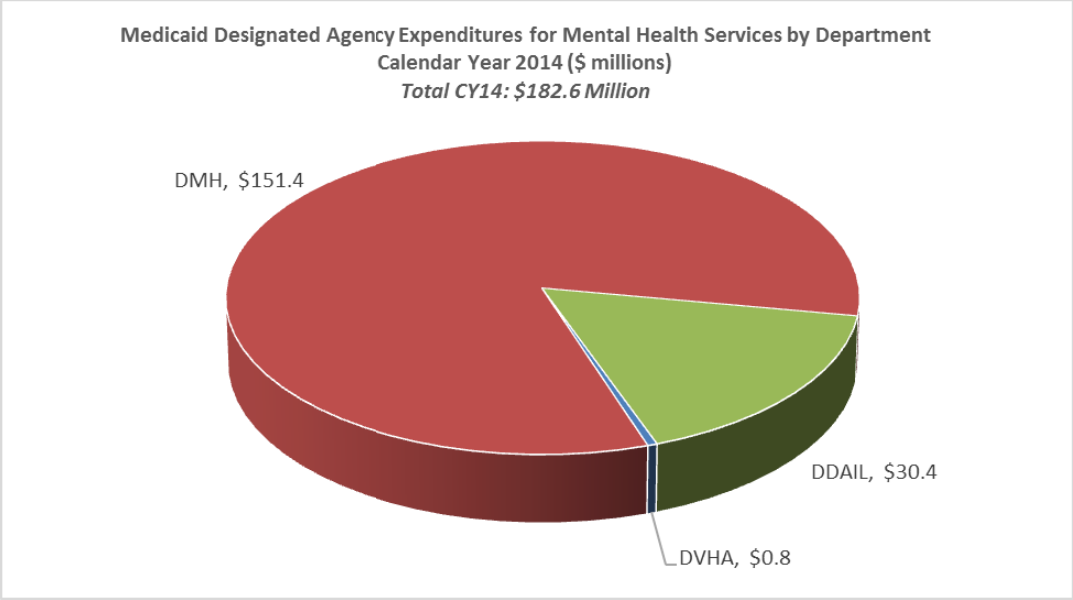


Funding of Designated Agency Services by DMH and DVHA

Direct mental health services are delivered by ten private, non-profit Designated Agencies (DAs) and by two Specialized Service Agencies (SSA) throughout the state. DAs are designated by DMH in each geographic region of the state to be responsible for ensuring needed services are available by providing services directly or contracting with other providers or individuals. They also are responsible for local planning, service coordination, and monitoring outcomes within their regions. In the case of a SSA, providers are responsible for specific specialized services across a region or statewide as designated by DMH. These agencies cannot refuse services to clients who meet DMH's eligibility criteria for specialized programs.

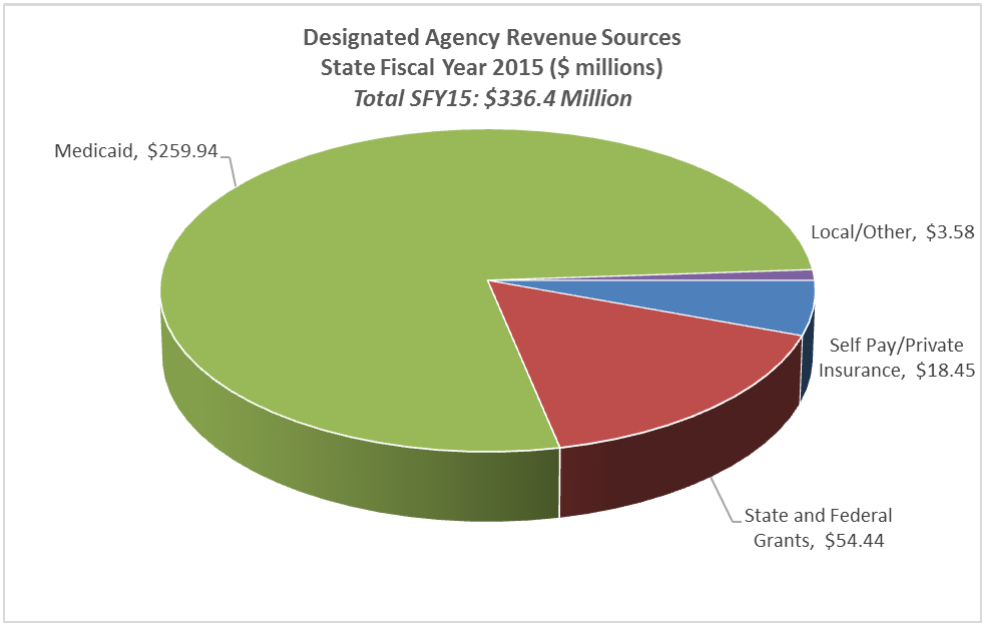
Mental health claims submitted by the DA/SSA's totaled approximately $183 million in CY14. The vast majority of mental health services provided by the DA/SSA network are reimbursed through the DMH fund source. A review of paid claims shows $151 million reimbursed through DMH, $30 million of mental health related services reimbursed by DAIL for eldercare and disability specific behavioral and mental health services and less than $1 million of paid DA/SSA claims reimbursed through DVHA. Exhibit 6 on the following page provides an overview of mental health claims in the DA/SSA network.

Exhibit 6: DA/SSA Medicaid Mental Health Expenditures by Department for CY14



DA/SSA providers also provide support to multiple AHS programs (e.g. Integrating Family Services, Traumatic Brain Injury, Developmental Services, Choices for Care, DCF Child Development Division, Family Services Division, VDH Alcohol and Drug Abuse Programs, Vocational Rehabilitation Services and DVHA. Because these providers support programs across AHS, changes in one area may have unintended consequences in other programs. For the Designated and Specialized Service Agencies, Medicaid represents the largest revenue source at 77% of total revenue, other State and Federal grants represents 16% and all other third party payments represent 7% of the DA system revenue. Exhibit 7 below provides an overview of overall DA revenue for all programs and services across the AHS for State Fiscal Year 2015.

Exhibit 7: Total Designated Agency Revenue from All Sources State Fiscal Year 2015



Vermont has been a leader in Statewide Health Care Reform. In the coming year within an All-Payer Model, and through the GC Waiver, Vermont's goals are to move away from volume-based payments toward a payment system that reinforces efforts to improve the health of Vermonters, improve quality of care, and contain the rate of growth in health care costs. Additionally, overarching goals of reform efforts are to strengthen primary care and better integrate mental health and substance abuse treatment into the health care system as a whole.

The AHS planning outlined in this report in response to Act 58 must take into account and align with efforts across the Health Care System and payers. Vermont's Health Care Innovation Project supports the research, feasibility analysis, design, and implementation of numerous payment models to support delivery system transformation. These include:

- Shared Savings Program (Medicaid and commercial that align with Medicare program)
- Patient-Centered Medical Home (Medicaid, commercial, and Medicare)
- Specialized Health Home: Medication Assisted Opiate Treatment (Medicaid and commercial)

In addition, other payment models are being designed and enhanced. These include:

- Episodes of Care for Perinatal and Neonatal Care: Expected to launch 7/1/16 for Medicaid.
- Prospective Payment System for Home Health Agencies: Expected to launch 7/1/16.
- Medicaid Value Based Purchasing for Integrating Family Services: under review and refinement
- Accountable Communities for Health: In research and feasibility review stages
- Choices for Care New Provider Payment Model: In design and development phase

In addition to these efforts, the State of Vermont has committed to move forward with development of Designated Agency and Substance Abuse provider payment and delivery system reforms during the third year of the Vermont Health Care Improvement Project (i.e., calendar year 2016).

The AHS DA/SSA planning includes a steering committee comprised of public and private sector members. Planning will examine alternatives to fee for service payment models and include discussion of sub-capitated payment arrangements as well as other prospective payment approaches. The new payment arrangement, which will include quality measures, will align with effort underway to design the State's All Payer Model regulatory structure. The project aims to reduce silos, streamline payment and reporting, and improve payment flexibility to support access, quality and cost containment. The DMH/DVHA implementation plan in Section Three includes critical alignment with these Health Care Reform efforts.

SECTION THREE: IMPLEMENTATION PLAN MILESTONES AND TIMELINE

The interdependencies of the AHS health and human services programs require planning efforts to be integrated and collaborative to mitigate potential unintended consequences of decisions in one department negatively effectively programs and services in another department. Similarly, financial responsibility, provider oversight and policy decisions that impact a given subject or policy area also need to be aligned to mitigate the potential for unintended consequences of decisions in one area (e.g. policy) made in isolation of other factors (e.g. fiscal and staffing impact).

The DMH/DVHA implementation plan will be implemented within the context of on-going AHS cross-departmental planning and statewide health care reform efforts. The specific focus for DMH and DVHA will be in the following three key areas of reform, each of these areas is described in more detail in this section.

- **Inpatient Psychiatric Services**: AHS will work to establish a shared Mental Health financial allocation in the DVHA appropriation for Inpatient Psychiatric Services. The intent of this work is to streamline and unify processes and continue to support departmental efforts to reduce both the frequency and length of admissions. Recommendations from this work with need to be aligned with findings of Task Two and Three below.

- **DMH Designated Agency/Specialized Service Agency Financing and All Payer Model Alignment**: AHS and Vermont Health Care Improvement Project have established a joint work group with providers to explore payment reform options for the DA/SSA system to support excellence in mental health and promote the integration of mental and physical health care in Vermont. The intent of this work is to decrease administrative burden and streamline finance models to support the integration of physical and mental health care and positive health outcomes for consumers and ready the system for alignment with the All Payer Model in 2017.

- **Alignment of Coverage and Payment Policies across AHS Programs**: AHS has established an internal operations committee with membership from all departments to review coverage and payment policies to mitigate any unintended consequences of proposed changes across departments. AHS-wide review will also include All Payer Model alignment as necessary.

Task One: Inpatient Psychiatric Services

Several activities are already under way to support the integration of inpatient psychiatric services contemplated by DMH/DVHA. These projects will continue January 1, 2016 – June 30, 2016. Milestones include:

1. Continue monthly DMH/DVHA inpatient utilization review team meetings to:

- Review and refine joint policy and clinical criteria including, but not limited to: voluntary versus involuntary stays; screening procedures; continued stay criteria; rates and payment guidelines.

- Determine best practices for involuntary admissions that balance: the State's obligation for payment; the client's clinical needs; and court orders.

- Assess data and clinical trends to identify options for community alternatives (e.g., community assisted treatment) to inpatient admission.

- Identify options for a joint DMH/DVHA hospital review process.

- Review recommendations for alignment with All Payer Model.

2. Establish joint DMH/DVHA policy and operation team to determine:

   - Whether the Level 1 hospital cost settlement process needs to be revised and determine if transfer of the settlement process to DVHA is appropriate.

   - How to track savings in the CRT hospital allocation and divert unused funding to CRT community services.

3. Supported integrated inpatient policies and recommended timing of unified service and financial allocation in the DVHA appropriation.

4. Determine optimal staffing and staff assignments for SFY2017 and beyond based on outcomes of steps 1-3 above.

Task Two: DMH DA/SSA Financing and All Payer Model Alignment

During this Phase of planning, DMH and DVHA will work with AHS to explore the options for new finance structures in the DA/SSA system; revise performance measures for the DA/SSA network; and work with Agency of Administration to create plans to integrate mental health and substance abuse services into the overall design of statewide Health Care Reform efforts. This Phase has begun and will continue through December 31, 2016. Milestones include:

1. Establish a joint AHS/VHCIP/DA/SSA Work Group to:

   - Assess provider readiness and risk tolerance;
   - Analyze current financial methodology and program requirements;
   - Identify targeted services and beneficiaries;
   - Review options for new finance models;
   - Identify quality measures and reporting requirements; and

- Produce an implementation plan including subsequent phases of the project that would expand to additional services and providers.

2. Implement revised DA/SSA performance measures in July 1, 2016 provider master grant agreements.

3. Determine if additional legislative or policy changes are needed to implement desired changes.

4. Determine if new finance models have stakeholder consensus and if so, finalize timelines for implementation in 2017.

Task Three: Alignment of AHS Coverage and Payment Policies for Mental Health Services

Several activities are already under way to support the meaningful integration of policy and practices across AHS programs. This work is expected to become standard operating practice for AHS and includes, as a first step, focus on DMH/DVHA alignments. The Global Commitment Policy Committee will include a DMH/DVHA sub group that will focus on operation alignments and Medicaid policy between the departments and with the All Payer Model. Milestones include:

1. Review of Medicaid coverage and payment policies for similar services provided across multiple AHS programs prioritizing work with a joint DMH/DVHA policy and operations sub- group.

2. Determine if additional policy or funding alignments are appropriate given the findings of the review and establish any necessary sub- groups.

3. Determine is recommended policy changes align with All Payer Model

4. Determine if Value Based Purchasing Opportunities exist and prioritize those opportunities for design and development.

5. Engage Stakeholders in review and discussion of options.

6. Determine if policy or legislative changes are needed to implement desired changes.

7. Prioritize coverage and payment policies for change in calendar year 2016 and 2017.

All Vermont Health Connect plans cover the same set of Essential Health Benefits. The difference lies in the plan designs, which determine how you pay for those benefits. Standard plans have the same designs across insurance carriers, while Blue Rewards and Vitality Plus plans were uniquely designed by the carriers, with a focus on wellness.

Vermont Health Connect
2016 Plan Designs & Monthly Premiums (before subsidy)

Interested in the cost *after* subsidy?
Most Vermonters who use Vermont Health Connect qualify for financial help to reduce their costs. To see if you qualify, visit the Subsidy Estimator at http://info.healthconnect.vermont.gov/subsidy_estimator or call 1-855-899-9600.

		Standard Plans				Standard High Deductible Health Plans (HDHP)				Blue Rewards				VT Vitality Plus			
		BCBSVT & MVP				Can Pair with Health Savings Account (HSA)				BCBSVT only				MVP only			
						Silver HDHP		Bronze HDHP									
		Platinum	Gold	Silver	Bronze	BCBSVT	MVP	BCBSVT	MVP	Gold	Silver	Gold CDHP Can pair with HSA	Bronze CDHP Can pair with HSA	Gold	Silver	Bronze	Gold HDHP Can pair with HSA
		Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family
Deductible (Ded.)	Integrated Ded.?	N	N	N	N	$1,425/$2,850[7]	$1,550/$3,100[7]	Y - $4,100/$8,200	Y - $4,400/$8,800	Y - $1,250/$2,500	$2,000/$4,000[7]	Y - $2,500/$5,000	Y - $6,550/$13,100	N	N	N	Y
	Medical Ded.	$150/$300	$750/$1,500	$2,000/$4,000[7]	$4,000/$8,000	See above	See above	See above	See above	See above	See above	See above	See above	$650/$1,300	$2,000/$4,000[7]	$5,000/$10,000	$2,400/$4,800
	Waived[1] for: (see Services below)	Prev, OV, UC, Amb, ER, Den1	Prev, OV, UC, Amb, ER, Den1	Prev, OV, UC, Amb, ER, Den1	Prev, Den1	Prev	Prev	Prev	Prev	Prev, 3 PCP/MH OV, Den1	Prev, 3 PCP/MH OV, Den1	Prev	Prev	Prev, OV, UC, Den1	Prev, PCP/MH, Den1	Prev, Den1	Prev
	Prescription (Rx) Ded.	$0	$50[8]	$150[7,8]	$500[8]	See above	See above	See above	See above	See above	See above	See above	See above	$200/$400	$250/$500[7]	$300/$600	See above
	Waived for:	N/A ($0 Ded)	Rx Generic	Rx Generic	Not Waived	Rx Wellness	Rx Wellness	Rx Wellness	Rx Wellness	Not Waived	Not Waived	Rx Wellness	Rx Wellness	VBID, Rx Generic	VBID	VBID	Rx Wellness
Max. Out-of-Pocket (MOOP)	Integrated?	N	N	N	Y-$6,850/$13,700	Y-$5,750/$11,500	Y-$5,750/$11,500	Y-$6,500/$13,000	Y-$6,500/$13,000	Y-$4,250/$8,500	Y-$6,850/$13,700[7]	Y - $2,500/$5,000	Y - $6,550/$13,100	N	N	Y-$6,850/$13,700	Y-$2,400/$4,800
	Medical	$1,250/$2,500	$4,250/$8,500	$5,600/$11,200[7]	See above	See above	See above	See above	See above	See above	See above	See above	See above	$5,550/$11,100	$5,550/$11,100[7]	See above	See above
	Prescription (Rx)	$1,250/$2,500	$1,250/$2,500	$1,250/$2,500[7]	$1,250/$2,500	$1,300/$2,600[7]	$1,300/$2,600[7]	$1,300/$2,600	$1,300/$2,600	$1,250/$2,500	$1,250/$2,500[7]	$1,300/$2,600	$1,300/$2,600	$1,300/$2,600	$1,300/$2,600[7]	$1,300/$2,600	$1,300/$2,600
Stacked or Aggregate?[6]		Stacked[6]	Stacked[6]	Stacked[6]	Stacked[6]	Aggregate Embedded[9,10]	Agg Ded/ Stack MOOP[6]	Aggregate Embedded[9,10]	Agg Ded/ Stack MOOP[6]	Aggregate Embedded[9,10]	Aggregate Embedded[9,10]	Aggregate[6]	Aggregate Embedded[9,10]	Stacked[6]	Stacked[6]	Stacked[6]	Aggregate[6]
Service Category (Examples)		Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)
Preventive (Prev)		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Office Visit (OV)	PCP or Mental Health (PCP/MH)	$10	$15	$25	Ded., then $35	Ded., then 10%	Ded., then 10%	Ded., then 50%	Ded., then 50%	3 visits per person (up to 9 per family) with no cost-share; then deductible applies with co-pay of $20 (Gold) or $30 (Silver)		Ded., then $0	Ded., then $0	$10	$20	Ded., then $40	Ded., then $0
	Specialist[2]	$20	$25	$50	Ded., then $85	Ded., then 25%	Ded., then 25%	Ded., then 50%	Ded., then 50%	Ded., then $30	Ded., then $50	Ded., then $0	Ded., then $0	$30	Ded., then $60	Ded., then $100	Ded., then $0
Urgent Care (UC)		$40	$45	$60	Ded., then $100	Ded., then 25%	Ded., then 25%	Ded., then 50%	Ded., then 50%	Ded., then $30	Ded., then $50	Ded., then $0	Ded., then $0	$45	Ded., then $60	Ded., then $100	Ded., then $0
Ambulance (Amb)		$50	$50	$100	Ded., then $100	Ded., then 25%	Ded., then 25%	Ded., then 50%	Ded., then 50%	Ded., then $30	Ded., then $50	Ded., then $0	Ded., then $0	Ded., then $50	Ded., then $100	Ded., then $100	Ded., then $0
Emergency Room (ER)[3]		$100	$150	Ded., then $250	Ded., then 50%	Ded., then 25%	Ded., then 25%	Ded., then 50%	Ded., then 50%	Ded., then $250	Ded., then $250	Ded., then $0	Ded., then $0	Ded., then $200	Ded., then $250	Ded., then 50%	Ded., then $0
Hospital Services[4]	Inpatient	Ded., then 10%	Ded., then 20%	Ded., then 40%	Ded., then 50%	Ded., then 25%	Ded., then 25%	Ded., then 50%	Ded., then 50%	Ded., then $500	Ded., then $1,750	Ded., then $0	Ded., then $0	Ded., then 20%	Ded., then 50%	Ded., then 50%	Ded., then $0
	Outpatient	Ded., then 10%	Ded., then 20%	Ded., then 40%	Ded., then 50%	Ded., then 25%	Ded., then 25%	Ded., then 50%	Ded., then 50%	Ded., then $500	Ded., then $1,750	Ded., then $0	Ded., then $0	Varies by service	Varies by service	Ded., then 50%	Ded., then $0
Prescription (Rx) Drug Coverage		30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply
Rx Generic[5]		$5	$5	$15	Ded., then $20	Ded.[9], then $10	Ded.[9], then $10	Ded.[9], then $12	Ded.[9], then $12	Ded., then $5	Ded., then $5	Ded.[9], then $5	Ded.[9], then $25	$5	Ded., then $15	Ded., then $20	Ded.[9], then $0
Rx Preferred Brand[5]		$40	Ded., then $40	Ded., then $60	Ded., then $80	Ded.[9], then $40	Ded.[9], then $40	Ded.[9], then 40%	Ded.[9], then 40%	Ded., then 40%	Ded., then 40%	Ded.[9], then 40%	Ded.[9], then 40%	Ded., then $40	Ded., then $50	Ded., then $90	Ded.[9], then $0
Rx Non-Preferred Brand[5]		50%	Ded., then 50%	Ded., then 50%	Ded., then 60%	Ded., then 50%	Ded., then 50%	Ded., then 60%	Ded., then 60%	Ded., then 60%	Ded., then 60%	Ded., then 60%	Ded., then 60%	Ded., then 50%	Ded., then 50%	Ded., then 60%	Ded., then $0
Additional Benefits																	
Wellness Benefits		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		Up to $300 in wellness rewards per adult			VBID Rx co-pay of $1/$3, up to $50 in wellness rewards			N/A
Premiums by Tier[9]		Cost before subsidy	Cost before subsidy	Cost before subsidy	Cost before subsidy	Cost before subsidy	Cost before subsidy	Cost before subsidy	Cost before subsidy	Cost before subsidy	Cost before subsidy	Cost before subsidy	Cost before subsidy	Cost before subsidy	Cost before subsidy	Cost before subsidy	Cost before subsidy
Single	BCBSVT	$656.63	$573.36	$484.49	$409.17	$468.90		$406.84		$531.33	$465.16	$506.32	$401.92				
	MVP	$660.42	$588.71	$493.38	$392.45		$468.05		$380.71					$574.85	$476.39	$391.36	$510.53
Couple	BCBSVT	$1,313.26	$1,146.72	$968.98	$818.34	$937.80		$813.68		$1,062.66	$930.32	$1,012.64	$803.84				
	MVP	$1,320.84	$1,177.42	$986.76	$784.90		$936.10		$761.42					$1,149.70	$952.78	$782.72	$1,021.06
Parent and Child(ren)	BCBSVT	$1,267.30	$1,106.58	$935.07	$789.70	$904.98		$785.20		$1,025.47	$897.76	$977.20	$775.71				
	MVP	$1,274.61	$1,136.21	$952.22	$757.43		$903.34		$734.77					$1,109.46	$919.43	$755.32	$985.32
Family	BCBSVT	$1,845.13	$1,611.14	$1,361.42	$1,149.77	$1,317.61		$1,143.22		$1,493.04	$1,307.10	$1,422.76	$1,129.40				
	MVP	$1,855.78	$1,654.28	$1,386.40	$1,102.78		$1,315.22		$1,069.80					$1,615.33	$1,338.66	$1,099.72	$1,434.59

Footnotes
1 Medical Deductible waived for: Preventive, Office Visit, Urgent Care, Ambulance, Emergency Room, Pediatric Dental Class 1 Series (as indicated by plan).
2 Specialist co-pay also applies to PT/ST/OT, vision, and any alternative medicine benefits, as appropriate.
3 ER co-pay is waived if admitted.
4 Hospital Services are Inpatient (including surgery, ICU/NICU, maternity, SNF and MH/SA); Outpatient (including ambulatory surgery centers); and Radiology (MRI, CT, PET). This cost-sharing will also include physician and anesthesia costs, as appropriate.
5 Each insurance carrier classifies drugs according to its own formulary. To see if a specific drug qualifies for the Generic or Preferred co-pay, view the formularies at http://info.healthconnect.vermont.gov/healthplans or contact BCBSVT (800-247-2583) or MVP (800-TALK-MVP). http://info.healthconnect.vermont.gov/glossary.
6 With an aggregate family deductible, your family must meet the family deductible before the plan pays benefits. With a stacked deductible, the plan pays benefits once you meet either your individual deductible or your family deductible.
7 If you purchase a silver plan and your income qualifies for cost-sharing reductions (for example, up to $72,750 for a family of four), your deductible and max. out-of-pocket could be lower than the figures stated above. To learn more, go to www.VermontHealthConnect.gov and click on "Health Plans."
8 BCBSVT Standard Gold/Silver/Bronze plans have a $50/$150/$500 Rx Deductible per person, while MVP Standard Gold/Silver/Bronze plans have an Rx Deductible of $50/$150/$500 for a Single plan or $100/$300/$1,000 for all other tiers.
9 With High Deductible Health Plans (HDHP), you do not have to pay the deductible for Wellness prescriptions. See the BCBSVT and MVP lists of Wellness drugs at http://info.healthconnect.vermont.gov/healthplans.
10 Some HDHP aggregate family deductibles have an embedded individual maximum out-of-pocket of $6,850 to prevent one individual from paying the full family maximum out-of-pocket when it exceeds the federal maximum out-of-pocket of $6,850 for an individual.

Abbreviations-- Ded: Deductible, Rx: Prescription Drugs, OV: Office Visits, UC: Urgent Care, Amb: Ambulance, VBID: Value-Based Insurance Design, Den1: Pediatric Dental Class 1 Series, ER: Emergency Room
Glossary-- Find definitions for VBID, Stacked, Aggregated, Integrated, and other terms at http://info.healthconnect.vermont.gov/glossary.
Plan details -- Different plans cover specific drugs and services in different ways. For specifics, contact BCBSVT (800-247-2583) or MVP (800-TALK-MVP).

Updated 11/9/15

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Proposal for the Adoption of best practices for Court-Ordered Involuntary Medication & Treatment

Under current practices, hearings for involuntary treatment are not conducted timely. Approximately 68% of court ordered applications for involuntary medication (AIM) are resolved in 90 days. The average time from hospital admission to an AIM decision in 2014 – 2015 was 128 days for a standard AIM application and 47 days for an expedited application. Of note, 76% of AIM applications were eventually granted.

This practice is not viewed by the medical and psychiatric communities as an effective approach to helping these patients. Nationally, Vermont stands alone; in all other states when persons with serious mental illness are involuntarily hospitalized and refuse treatment, the due process underlying the decision to require involuntary treatment is generally carried out in two weeks or less. Vermont's uniquely long process results in a number of unintended consequences:

- Unacceptable deprivation of personal liberties: pending the application for due process on the question of treatment, the person who is involuntarily hospitalized is deprived of their freedom for much longer lengths of time;
- While awaiting the application of due process, the involuntarily hospitalized person is generally moved away from a community hospital near their social supports which makes it more difficult to maintain needed connections;
- Increased likelihood of seclusion, restraint, or sedation when behaviors are escalate to an emergency intervention level with other patients or staff in a hospital setting;
- As a result of the longer length of time it takes to receive the standard of care for acute psychosis the involuntarily hospitalized person often has a more difficult time re-integrating into society post-hospitalization;
- A number of Vermont hospitals with psychiatric units are unwilling to hospitalize persons who meet the standard of care but are unwilling to receive treatment. This results in a decrease in the absolute number of beds available;
- The capacity of the remaining psychiatric hospital beds is decreased because of the uniquely long lengths of stay.

Beyond these compelling clinical and ethical reasons to conduct due process in a way that is more timely and commensurate with the rest of the country, Vermont's current practice is costly and results in an access problem for psychiatric beds.

Savings Calculation

In order to calculate a conservative estimate of the potential cost savings, DVHA considered the 40 – 50 petitions which go to hearing each year as well as other patients who will also exceed the recommended length of stay but who initially refuse treatment in the months awaiting hearing before ultimately making the decision to accept treatment.

Cost Savings when the decision to require involuntary treatment is carried out in two weeks or less: $1,300 (avg per diem) x 40 days x 90 persons = $4,680,000

The inpatient pricing methodology includes an additional payment for admissions that are more costly to the hospital - usually longer durations of stay - and thus are considered outliers. Moving forward with this initiative would reduce those costs by $540,000.

Total estimate of Inpatient Hospital cost savings: $5,220,000

Studies on Delayed Treatment

The longer the period of untreated psychosis, the smaller the level improvement that can be expected. (Norman & Lewis, 2005)

Not only are clinical outcomes better when the duration of untreated psychosis (DUP) is short but that reducing the duration of untreated psychosis early in the course of psychosis yields better outcomes than later on in course of an illness. (Norman & Lewis, 2005)

Treatment response is better with a shorter DUP across multiple clinical domains including; positive symptoms, negative symptoms, global pathology as well as functional outcomes. (Perkins & Gu, 2005)

DUP is an independent predictor of the likelihood of recovery from schizophrenia. (Perkins & Gu, 2005)

At least after the first episode of psychosis, there is significant body of evidence that clinical and functional outcomes are poorer with a longer DUP and that the potential for full recovery reduces with longer DUP. (Anderson & Rodrigues, 2014)

Through the lack of access of, or delay to treatment, there is increased need for more acute, complex, and costly outpatient and emergency department services. This puts pressure on the overall healthcare delivery system, specifically;

- ED staff
- Private clinicians
- DAs
- Hospital staff
- Pressure on criminal justice system, increasing Department of Corrections cost
- Families

GLOSSARY

Mandatory Benefits	Definition	Optional Benefits	Definition
Inpatient hospital services	Inpatient services furnished in an institution that is maintained primarily for the care and treatment of patients with disorders other than mental diseases and is licensed as a hospital. 42 CFR 440.10	**Prescription drugs**	Simple or compound substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance. *42 CFR 440.120*
Outpatient hospital services	Outpatient services (preventive, diagnostic, therapeutic, rehabilitative, or palliative) furnished by an institution that is licensed as a hospital. 42 CFR 440.20	**Clinic services**	Health services furnished by a facility that is not part of a hospital but is operated to provide medical care to outpatients. *42 CFR 440.90*
EPSDT: Early and Periodic Screening, Diagnostic, and Treatment Services	Screening and diagnostic services to determin physical or mental defects in beneficiaries under age 21, and healthcare to ameliorate any defects and chronic conditions discovered. 42 CFR 440.40, 441.50	**Physical therapy**	Services prescribed by a physician or other licensed practitioner and provided to a beneficiary by a qualified physicial therapist. *42 CFR 440.110*
Nursing Facility Services	Services that are needed on a daily basis and required to be provided on an inpatient basis by a nursing facility. 42 CFR 440.40; also 42 CFR 440.155	**Occupational therapy**	Services prescribed by a physician or other licensed practitioner and provided to a beneficiary by a qualified occupational therapist. *42 CFR 440.110*
Home health services	Services provided to a beneficiary at his/her place of residence which include nursing service, home health aide, medical supplies/equipment, and PT/OT/ST. *42 CFR 440.70*	**Speech, hearing and language disorder services**	Services prescribed by a physician or other licensed practitioner and provided to a beneficiary by a speech pathologist or audiologist. *42 CFR 440.110*
Physician services	Services furnished by a licensed physician within the scope of practice of medicine or osteopathy. *42 CFR 440.50*	**Respiratory care services**	Respiratory care for ventilator-dependent individuals that is not otherwise available under the State's plan, provided by a professional trained in respiratory therapy. *42 CFR 440.185*
Rural health clinic services	Services furnished by a physician or other licensed practitioner in a clinic which is located in a designated area. 42 CFR 440.20	**Other diagnostic, screening, preventive and rehabilitative services**	Other services within the scope of practice under State law of a licensed practitioner. *42 CFR 440.130*
Federally qualified health center (FQHC) services	Services furnished to a patient of a FQHC. *SSA Title 19 Section 1905(l)(2)(A)*	**Podiatry services**	Services performed by a licensed practitioner limited to non-routine foot care. *VT Medicaid Covered Services Rule 7308*
Laboratory and X-ray services	Professional and technical laboratory and radiological services ordered by a licensed practitioner. 42 CFR 440.30	**Optometry services**	Services related to vision and vision disorders for the purpose of diagnosis and treatment, including lenses, frames, other aids to vision, and therapeutic drugs. *42 CFR 440.60(a), 440.120(d), 441.30*

Mandatory Benefits	Definition	Optional Benefits	Definition
Family planning services	Family planning services and supplies for individuals of child-bearing age. Plan must provide that each beneficiary is freen from coercion or mental pressure and free to choose the method of family planning to be used. *42 CFR 440.40, 441.20*	**Dental services**	Diagnostic, preventive, or corrective procedures provided by or under supervision of a dentist. *42 CFR 440.100*
Nurse Midwife services	Services furnished by a registered professional nurse-midwife. 42 CFR 440.165	**Dentures**	Artificial structures made by a dentist to replace a full or partial set of teeth. *42 CFR 440.120*
Certified Pediatric and Family Nurse Practitioner services	Services furnished by a registered professional nurse who meets educational and clinical practice requirements beyond the 2 to 4 years of basic nursing education required of all registered nurses. *42 CFR 440.166*	**Prosthetics**	Replacement, corrective, or supportive devices prescribed to replace a missing portion of the body, prevent or correct physical deformity or malfunction, or support a weak portion of the body. *42 CFR 440.120*
Freestanding Birth Center services (when licensed or otherwise recognized by the state)	Services furnished to an individual at a licensed health facility that is not a hospital and where childbirth is planned to occur away from the pregnant woman's residence. *SSA Title 19 subsection (l)(3)(A)*	**Eyeglasses**	Lenses, including frames, and other aids to vision prescribed by an opthalmologist or optometrist. *42 CFR 440.120*
Transportation to medical care	Includes expenses for transportation and other related travel expenses determined to be necessary by the agency to secure medical examinations and treatment for a beneficiary. *42 CFR 440.170*	**Chiropractic services**	Services provided by a licensed chiropractor that consist of treatment by means of manual manipulation of the spine. *42 CFR 440.60*
Tobacco cessation counseling for pregnant women	Includes coverage of counseling and pharmacotherapy benefits for cessation of tobacco use by pregnant women.	**Other practitioner services**	Any medical or remedial care, other than physician services, provided by licensed practitioners within the scope of practice defined under State law. *42 CFR 440.60*
		Private duty nursing services	Nursing services for beneficiaries who require more care than is available from a visiting nurse or routinely provided by nursing staff of a hospital or skilled nursing facility. *42 CFR 440.80*
		Personal Care	Services furnished to an individual who is not in a hospital, nursing or other care facility, that are provided by a qualified person who is not a member of the individual's family. *42 CFR 440.167*
		Hospice	Services to terminally ill beneficiaries rendered by a Medicare certified hospice and provided in accordance with Medicare regulations. *Section 1905(o) of the Social Security Act*

Mandatory Benefits	Definition	Optional Benefits	Definition
		Case management	Services furnished to assist individuals who reside in a community setting in gaining access to needed medical, social, educational, and other services. *42 CFR 440.169*
		Services for Individuals Age 65 or Older in an Institution for Mental Disease (IMD)	Inpatient hospital services, nursing facility services, and intermediate care facility services. *42 CFR 440.140, 441.101*
		Services in an intermediate care facility for Individuals with Intellectual Disability	ICF/IID services are furnished in a licensed facility with a primary purpose of furnishing health or rehabilitative services to persons with Intellectual Disability or related conditions. *42 CFR 440.150*
		State Plan Home and Community Based Services- 1915(i)	Benefit that can include many services, including case management, homemaker, respite care, and homemaker services. *42 CFR 440.182*
		Self-Directed Personal Assistance Services- 1915(j)	Services designed to allow individuals, or their representatives, to exercise decision-making authority in identifying, accessing, managing, and purchasing their Personal Assistance Services. *42 CFR 441.450*
		Community First Choice Option- 1915(k)	Designed to make available home and community-based attendant services and support to individuals, as needed, to assist in accomplishing activities of daily living and health-related tasks through hands-on assistance and supervision. *42 CFR 441.500*
		TB Related Services	Option to extend Medicaid eligibility to low-income individuals infected with tuberculosis and receive federal support to reduce the likelihood of transmission. Includes certain outpatient services related to the TB infection and prescribed drugs.
		Inpatient psychiatric services for individuals under age 21	Services that are provided under the direction of the physician and are provided by a psychiatric hospital or psychiatric facility. *42 CFR 440.160, 441.151*

Mandatory Benefits	Definition	Optional Benefits	Definition
		Health Homes for Enrollees with Chronic Conditions- Sec. 1945	Health Homes are for people with Medicaid who have 2 or more chronic conditions, or have one chronic condition and are at risk for a second, or have one serious and persistent mental health condition. Services include care coordination, management, patient support, and referral to community and social support services.
		Other services approved by the Secretary	Any other medical care recognized under State law and specified by the Secretary, such as services furnished in a religious nonmedical healthcare institution. *42 CFR 440.170*

ACRONYMS

A

A/I/U .....Adoption/ Implementation/ Upgrade
A/R.....Accounts Receivable
A2A .....Application to Application
AA .....Alcoholics Anonymous
AAA.....Area Agency on Aging
AABD .....Aid to the Aged, Blind or Disabled
AAC.....Average Acquisition Cost
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.....Legacy Eligibility System
ACD.....Automatic Call Distributor
ACF.....Administration for Children and Families
ACH.....Automated Clearing House
ACL.....Access Control List
ACO.....Accountable Care Organization
ACT 248.....Supervision of people with developmental disabilities
AD .....Active Directory
ADA.....American Dental Association
ADABAS .....Adaptable Data Base System
ADAP.....Alcohol and Drug Abuse Programs
ADD.....Attention deficit disorder
ADL .....Activities of Daily Living
ADO .....St. Albans District Office
ADPC.....Application and Document Processing Center
ADRC.....Aging & Disability Resource Center
ADS .....Adult Day Services
ADTM.....Adjusted Downtime Minutes
ADUR .....Annual Drug Utilization Review
ADURS .....American Drug Utilization Review Society
AdvaMed .....Advances Medical Technology Association
AEP .....Annual Enrollment Period
AG .....Attorney General
AGA.....Adult General Assessment
AGO .....Office of the Attorney general
AHCA.....American Healthcare Association
AHCPR.....Agency for Healthcare & Policy Research
AHEC.....Are Health Education Center
AHFS .....American Hospital Formulary Service
AHHS.....(Vermont) Association of Hospitals & health Systems (see VAHHS)
AHIMA .....American Health Information Management Association
AHIP.....American's Health insurance Plans
AHRF .....Area Heath Recourse File
AHRQ .....Agency for Healthcare Research and Quality
AHS .....Agency of Human Services
AIDS .....Acquired Immune Deficiency Syndrome
AIM .....Agency Improvement Model
AIM .....Advanced Information Management System (see MMIS)
AIRS .....Automated Information and Referral System
ALS .....Advanced Life Support
AMA.....American Medical Association

AMAP.....Aids Medication Assistance Program
AMP.....Average Manufacturer Price
ANFC.....Aid to Needy Families with Children
ANHA.....American Nursing Home Association
ANSI.....American National Standards Institute
AOA.....Agency of Administration
AOE.....Agency of Education
AOPS.....Assistant Operations
APA.....Administrative Procedures Act
APC.....Ambulatory Payment Classification
APCP.....Advanced Primary Care Practice
APD.....Advanced Planning Document
AP-DRG.....All Patient Diagnosis Related groups
APDU.....Advance Planning Document Update
APG.....Ambulatory Patient Group
APhA.....American Pharmaceutical Association
APHA.....American Public Health Associations
APHSA.....American Public Human Services Association
API.....Application Program Interface
APM.....All Payer Model
APMH.....Advanced Practice Medical Homes
APS.....Adult Protective Services
APS.....APS Healthcare
APSE.....Association for Persons in Supported Employment
APT.....Admissions per thousand
APTC.....Advanced Premium Tax Credit
AR.....ACCESS Remediation
ARC.....Advocacy organization for people with developmental disabilities
ARIS.....Area Resources for Individualized Services
ARRA.....American Recovery & Reinvestment Act of 2009
AS1.....Applicability Statement 1
AS2.....Applicability Statement 2
ASD.....Adult Services Division
ASD.....Administrative Services Division
ASFA.....Adoption and Safe Families Act
ASHHRA.....American Society of Healthcare Human Resources Administration
ASHP.....American Society of Heal-System Pharmacists
ASHRM.....American Society for Hospital Risk Management
ASP.....Attendant Services Program
ASPA.....American Society for Personnel Administration
ASTHO.....Association of State and Territorial Health Officials
AT.....Access Transformation
AT.....Assistive Technology
ATD.....ACCESS Transformation and Decommissioning
ATNA.....Audit Trails and Node Authentication
AUR.....Ambulatory Utilization Review
AVR.....Automated Voice Response
AWP.....Average Wholesale Price

B

B2B.....Business To business
BA.....Business Analyst
BAFO.....Best And Final Offer
BASU.....Business Applications Support Unit

BBF.....Building Bright Futures
BC/BS.....Blue Cross/Blue Shield
BCBSVT.....Blue Cross/Blue Shield of Vermont
BCCH.....Bipartisan Commission on Comprehensive Healthcare
BCCT Breast & Cervical Cancer Treatment
BD.....Blind & Disabled
BDO.....Burlington District office
BENDEX.....Beneficiary Benefits Eligibility Screening Tool
BEST.....Social Security Benefits Eligibility Screening Tool
BGS.....Building and General Services
BHIE.....Bi-directional Health Information Exchange
BHP.....Basic Health Plan
BI.....Business Intelligence
BIAVT.....Brain injury Association of Vermont
BIN.....Bank Identification Number
BISCHA.....Banking and Insurance, Securities & healthcare Administration
BISHCA.....Banking, Insurance, Securities, & Healthcare Administration (Department of)
BizObj.....Business Objects
BJS.....Bureau of Justice Statistics
BLA.....Bureau of Labor Statistics
BMI.....Body Mass Index
BO.....Business Office
BOBI.....Business Objects Business Intelligence
BOD.....Business Office Division
BP.....Blueprint
BPA.....Business Process Analysis
BPEL..... Business Process Execution Language
BPFH.....Blueprint for Health
BPHC.....Bureau of Primary Healthcare
BPM.....Business Process Management
BPM.....Business Process Model/Modeling
BPMN.....Business Process modeling Notation
BPMS.....Business Process Management Software
BPS.....Benefits Programs Specialist
BPT.....Business Process template
BR.....Business Rule
BRE.....Business Rule Engine
BRFSS.....Behavioral Risk Factor Surveillance System
BRMS.....Business Rile Management System
BROC.....Bennington-Rutland Opportunity Council
BSV.....Biosurveillance

C

CA.....Community Associates
CAC.....Child Advocacy Center
CACFP.....Child and Adult Care Food Program
CAD.....Coronary Artery Disease
CAFU.....Child, Adolescent & Family Unit
CAH.....Critical Access Hospital
CAHPS.....Consumer Assessment of Health Plans Survey
CALT.....Collaborative Application Lifecycle Tool
CAN.....Child Abuse and Neglect
CAP.....Community Action Program
CAP.....Corrective Action Plan
CAP.....Center Accreditation Project
CAPTA.....Child Abuse Protection and Treatment Act
CARF.....Commission on Accreditation of Rehabilitation Facilities
CARU.....Child Abuse Registry Unit
CASSP.....Child Adolescent Services System Program
CBA.....Cost Benefit Analysis
CBO.....Congressional Budget Office
CBU.....Child Benefits Unit
CC.....Committed Child
CC.....Chronic Care
CC.....Contact Center
CCB.....Change Control Board
CCCSA.....Community Child Care Support Agencies
CCD.....Child Development Division of DCF
CCD.....Continuity of Care Documents
CCDBG.....Child Care Development Block Grant
CCFS.....Child Care Subsidy Program
CCHIT.....Certification Commission for Healthcare Information Technology

CCIO/CCIIO .....Center for Consumer Information & Insurance Oversight (CMS)
CCIS.....Chronic Care Information System
CCM .....Clinical Criteria Manual
CCMP .....Chronic Care Management Program
CCO .....Community Corrections Officer
CCP.....Care Coordination Program
CCPA .....Consumer Credit Protection Act
CCR.....Continuity of Care Record
CCRRP .....Child Care Resource and Referral Programs
CCSC.....Community Correctional Services Center
CCTA .....Chittenden County Transportation Authority
CCU .....Coronary Care Unit
CCV .....Community College of Vermont
CCWC .....Caledonia Community Work Camp
CD .....Compact Disk
CD/SD .....Consumer Directed/Surrogate Directed
CDC .....Center for Disease Control and Prevention
CDD.....Child Development Division of DCF
CDISC .....Clinical Data Interchange Standards Consortium
CDR .....Continuing Disability Review
CDS .....Clinical Decisions Support
CDS .....Community Developmental Services
CDT .....Current Dental Terminology
CEJ.....Continuing Exclusive Jurisdiction
CERT.....Corrections Emergency Response Team
CET .....Cost Effective Test
CF .....Crisis Fuel
CFC.....Choices for Care
CFCCP.....Children and Family Council for Prevention Programs
CFIS .....Clinical Financial Information Systems
CFR.....Code of Federal Regulations
CFSR.....Child and Family State Review
CFSS .....Correctional Facility Shift Supervisor
CGMP.....Current Good Manufacturing Price/Practice
CHAMPUS.....Civilian Health and Medical Program of the Uniformed Services
CHAMPVA.....Civilian Health and Medical Program of the Department of Veterans Affairs
CHAP.....Catamount Health Assistance Premium
CHC .....Community Health Centers
CHC .....Comprehensive Health Centers
CHI .....Consolidated Health Informatics
CHIP .....Children's Health Insurance Program
CHIPRA.....Children's Health Insurance Program Re-authorization Act
CHF.....Congestive Heart Failure
CHO.....Comprehensive Health Centers
CHP .....Certified Health Plan
CHPA.....Community Health Purchasing Alliance
CHPR.....Center for Health Policy and Research
CHS .....Community High School of Vermont
CHSO.....Comprehensive Health Services Organization
CHSVT .....Community High School of Vermont
CHT .....Community Health Team
CI.....Configuration Item
CIA .....Confidentiality, Integrity, and Availability
CIO .....Chief Information Officer
CIS.....Children's Integrated Services
CLD.....Claim Level Detail
CLIA.....Clinical Laboratory Improvement Amendments
CM .....Case Management
CM .....Change Management
CM .....Configuration Management
CMC .....Case Manager Conference
CMCM.....Care Management and Care Models
CMHC.....Community Mental health Center
CMHS.....Center for Mental Health Services
CMIA.....Cash Management Improvement Act
CMMI.....Center for Medicare and Medicaid Innovation

CMN.....Certification of Medical Necessity
CMS.....Centers for Medicare & Medicaid Services
CMSO.....Center for Medicaid & State Operations
CNM.....Certified Nurse Midwife
CO I.....Correctional Officer One
CO II.....Correctional Officer Two
COA.....Council On Aging
COB.....Coordination Of Benefits
COB.....certificate of Benefit
COB.....Close of Business
COB-MAT.....Coordination of Office Based Medication Assisted Therapy
COBRA.....Consolidated Omnibus Reconciliation Act of 1986 (health coverage)
COC.....Change of Circumstance
COC.....Certificate of coverage
CODTP.....Co-Occurring Disorders Treatment Program
COLA.....Cost Of Living Adjustment
COLST.....Clinician Orders for Life-Sustaining Treatment
CON.....Certificate Of Need
ConOps.....Concept of Operations
COPC.....Community Oriented Primary Care
COPD.....Chronic Obstructive Pulmonary Disease
COPS.....Computer Operations & Problem Solving
CORF.....Comprehensive Outpatient Rehabilitation Facility
COS.....Category of Service
COS.....Cost of Service
COTS.....Commercial/Common Off-The-Shelf
COU.....Clinical Operations Unit
COVE.....Community of Vermont Elders
CP.....Custodial Parent – recipient of the support
CP (2).....Certified Provider (or Cerebral Palsy)
CPC.....Certified Professional Coder
CPH.....Community Public Health (of the VDH)
CPI.....Center for Program Integrity
CPI.....Consumer Price Index
CPR.....Comparative Performance Reports
CPRC.....Customary, Prevailing and Reasonable Charge
CPRS.....Computerized Patient Record System
CPS.....Child Protective Services
CPT.....Common Procedural Terminology
CPTOD.....Capitated Program for the Treatment of Opiate Dependency
CQI.....Continuous Quality Improvement
CR.....Conditional Reentry
CRC.....Community Rating by Class
CRCF.....Chittenden Regional Correctional Facility
CRM.....Customer Relationship Management
CRT.....Community Rehabilitation & Treatment
CSAC..... Counseling Services of Addison County
CSAP.....Center for Substance Abuse Prevention
CSAT.....Center for Substance Abuse Treatment
CSBG.....Community Services Block Grant
CSC.....Customer Support Center
CSD.....Computer Services Division (OCS)
CSE.....Child Support Enforcement
CSFP.....Commodity Supplemental Food Program
CSHN.....Children with Special Health Needs
CSME.....Coverage & Services Management Enhancement
CSME.....Central Source for Measurements and Evaluation
CSP.....Child Support Problems
CSP.....Community Support Program
CSR.....Cost Sharing Reductions
CSR.....Customer Service Request
CSR.....Change System Request
CSR.....Customer Support/Service Representative
CSS.....Child Support Specialist
CSS.....Corrections Service Specialist
CSTL.....Community Services Team Leader
CUPS.....Children's Upstream Services Grant
CURB.....Clinical Utilization Review Board
CVCA.....Central Vermont Council on Aging

CVCAC.....Central Vermont Community Action Council
CVH.....Central Vermont Hospital
CVOEO.....Champlain Valley Office of Economic Opportunity
CVP.....Controlled Vendor Payment
CVSAS.....Central Vermont Substance Abuse Service
CW&YJ.....Child Welfare and Youth Justice
CY.....Calendar Year

D

DA.....Designated Agency
DAD.....Deliverable Acceptance Document
DAIL.....Department of Disabilities, Aging & Independent Living
DAW.....Dispense As Written
DAWN.....Drug Abuse Warning Network
DBA.....Database Administration
DBMS.....Database Management System/ Services
DBVI.....Division for the Blind and Visually Impaired
DC.....Delinquent in Custody
DCA.....Department of Cost Allocation (federal)
DCF.....Department for Children & Families
DCF BO.....Department for Children and Families Business Office
DCG.....Diagnostic Cost Group
DD.....Developmental Disabilities
DDC.....Developmental Disabilities Council
DDI.....Design, Development & Implementation
DDR.....Drug Data Reporting for Medicaid
DDS.....Disability Determination Services (part of DCF)
DDS.....Division of Developmental Services
DDS.....Developmental Disability Services
DDSD.....Developmental Disabilities Services Division
DEA.....Drug Enforcement Administration
DED.....Deliverable Expectations Document
DEL.....Deliverable
DESI.....Drug Efficacy Study Implementation
DHHS.....Department of Health & Human Services (federal)
DHHS/HHS.....United States Department of Health and Human Services
DHMC.....Dartmouth Hitchcock Medical Center
DHRS.....Day Health Rehabilitation Services
DII.....Department of Information & Innovation
DIS.....Detailed Implementation Schedule
DLP.....Division of Licensing and Protection
DLP.....Disability Law Project
DMC.....Disease Management Coordinators
DME.....Durable Medical Equipment
DMH.....Department of Mental Health
DO.....District Office
DOA.....Date Of Application
DOB.....Date Of Birth
DOC.....Department Of Corrections
DOE.....Department of Education (United States or state.)
DOE.....United States Department of Energy
DOH.....Department Of Health (now VDH)
DOJ.....Department of Justice
DOL.....Department Of Labor
DOS.....Date Of Service
DOT.....Dictionary of Occupational Titles
DP.....Delinquent on Probation
DR.....Disciplinary Report
DR.....Desk Review
DR.....Disaster Recovery
DR. D.....Dr. Dynasaur Program
DR.D.....Doctor Dynasaur
DRA.....Deficit Reduction Act
DRAMS.....Drug Rebate Analysis and Management System
DRG.....Diagnosis Related Grouping
DS.....Developmental Services
DS.....Day Supply
DSA.....Digital Signature Algorithm
DSCF.....Dale State Correctional Facility
DSH.....Disproportionate Share Hospital
DSHP.....Designated State Health Plan
DSM IV.....Diagnostic and Statistical Manual of Mental Disorders (4th Edition Revised)

DSM V or DSM 5.Diagnostic and Statistical Manual of Mental Disorders Version V
DSS.....Decision Support System
DUR.....Drug Utilization Review (Board)
DURSA .....Data Use and Reciprocal Support Agreement
DVHA .....Department of Vermont Health Access
DVR.....Vermont Division of Vocational Rehabilitation
DW.....Data Warehouse

E

E&E .....Eligibility & Enrollment (Funding for more than IE)
EA.....Emergency Assistance
EA.....Enterprise Architecture
EA.....Economic Assistance
EAC.....Estimated Acquisition Cost
EAC.....Estimate at Completion (estimate to complete)
EAI.....Enterprise Application Integration
EAP .....Employee Assistance Program
EBC.....Enterprise Business Capabilities
E-bed.....Emergency Bed
EBPM .....Enterprise Business Process Management
EBPO .....Enterprise Business Process Owner
EBT.....Electronic Benefit Transfer
ECM .....Enterprise Content Management
ECR.....Engineer Change Request
ECS .....Electronic Claims Submission
ECT .....Electro-convulsive Therapy
ED.....Emotionally disturbed
ED.....Emergency Department
EDA .....Event Driven Architecture
EDI .....Electronic Data Interchange
EDMS .....Electronic Documentation Management System
EDS.....Electronic Data Systems Corporation
EEG.....Electroencephalogram
EFT .....Electronic Funds Transfer
EGA .....Estimated Gestational Age
EHB .....Essential Health Benefits
EHR .....Electronic Health Record
EHRIP .....Electronic Health Record Incentive Program
EIA.....Enterprise Information Architecture
EITC.....Earned Income Tax Credit
ELC .....Enterprise Life Cycle
EMPI .....Enterprise Master Patient Index
EMR .....Electronic Medical Record
EMS.....Emergency Medical Services
EOB .....Explanation of Benefits
EOMB.....Explanation of Medicare (or Medicaid) Benefits
EP .....Essential Person
EP .....Emergency Preparedness
EPMO.....Enterprise Project Management Office
EPO .....Exclusive Provider Organization
EPSDT.....Early & Periodic Screening, Diagnosis & Treatment
EQR .....External Quality Review
EQRO .....External Quality Review Organization
ER.....Emergency Room
ERA .....Electronic Remittance Advice
ERC.....Enhanced Residential Care
ESB .....Enterprise Service Bus
ESD.....Economic Services Division (part of DCF)
ESDT or EPSDT ....Early Periodic Screening, Diagnosis and Treatment
ESGP .....Emergency Shelter Grants Program
ESI .....Employer Sponsored Insurance
ESIA.....Employer Sponsored Insurance Assistance
ESRD .....End Stage Renal Disease
EST .....Eastern Standard Time
ETL .....Extract, Transform, Load
EVAH.....Enhanced VT Ad Hoc (query & reporting system)
EVS.....Eligibility Verification System

F

FA.....Fiscal Agent
FAC.....Freestanding Ambulatory Center
FACA .....Federal Advisory Committee Act
FADS .....Fraud, Abuse & Detection System
FAQ.....Frequently Asked Questions
FAST.....Federal Adoption of Standards for Health IT
FAT.....Formal Acceptance Test (after UAT)

FBR.....Fiscal Budget Report
FC.....Foster Care
FCR.....Federal Case Registry
FDA.....Food & Drug Administration
FDP.....Family Development Plan
FDSH.....Federal Data Services Hub
FEA.....Federal Enterprise Architecture
FED.....Front End Deductible
FEIN.....Federal Employer's Identification Number
FEMA.....Federal Emergency Management Administration
FF.....Families First
FFF.....Flexible Family Funding
FFP.....Federal Financial Participation
FFS.....Fee For Service
FFY.....Federal Fiscal Year
FH.....Fair Hearing
FHA.....Federal Health Architecture
FHIPR.....Federal Health Information Planning and Reporting
FI.....Fiscal Intermediary
FICA.....Federal Insurance Contribution Act
FIDM.....Financial Institution Data Match
FIPS.....Federal Information Processing Standards
FISMA.....Federal Information Security Management Act
FITP.....Family, Infant and Toddler Program
FMAP.....Federal Medical Assistance Percentage
FMB.....Financial Measurement Baseline
FMP.....Financial Management Plan
FNS.....Food and Nutrition Service
FOA.....Funding Opportunity Announcement
FP.....Foster Parent
FP.....For Profit
FPL.....Federal Poverty Level
FPLS.....Federal Parent Locator Service
FPO.....Family Planning Option
FQHC.....Federally Qualified Health Center
FSA.....Flexible Spending Account
FSD.....Family Services Division
FSP.....Food Stamp Program
FSS.....Federal Security Strategy
FTE.....Full Time Equivalent
FTI.....Federal Tax Information
FTP.....File Transfer Protocol
FUL.....Federal Upper Limit (for pricing & payment of drug claims)
FVI.....Family Violence Indicator
FYE.....Fiscal Year End

G

G/L.....General Ledger
G2B.....Government To Business
G2C.....Government To Consumer
G2E.....Government To Employee
G2G.....Government To Government
GA.....General Assistance
GA/EA.....General Assistance/Emergency Assistance
GAAP.....Generally Accepted Accounting Principles
GAO.....General Accounting Office
GAO.....Government Accounting Office
GC.....Global Commitment
GCR.....Global Clinical Record (application of the MMIS)
GDEA.....Generic Drug Enforcement Act
GEP.....General Enrollment Period
GF.....General Fund
GH.....Group Home
GHRI.....General Health Rating Index
GHS.....Goold Health Systems
GMC.....Green Mountain Care
GMCB.....Green Mountain Care Board
GME.....Graduate Medical Education
GMP.....Good Manufacturing Practice
GMSA.....Green Mountain Self-Advocates
GOVNET.....State of Vermont Government Wide Area Network (WAN)
GPCI.....Geographic Practice Cost Index
GPI.....Generic Product Identifier
GS.....Guardianship services
GSD.....General Systems Design
GSS.....Guardian Services Specialist
GUI.....Graphical User Interface

H

HAEU.....Health Access Eligibility Unit
HAS.....Health Savings Account
HAS.....Health Services Area
HAS.....Health Systems Agency
HASS.....Housing and Supportive Services
HATF.....Health Access Trust Fund

HB .....Home-based
HBE .....Health Benefit Exchange
HBE or VHC .....Health Benefits Exchange
HBKF .....Healthy Babies, Kids and Families
HCBS .....Home & Community Based Services
HCERA.....Healthcare & Education Reconciliation Act of 2010
HCFA .....Healthcare Finance Administration (now CMS)
HCPCS .....Healthcare Common Procedure Coding System
HCQIA .....Healthcare Quality Improvement Act
HCR .....Healthcare Reform
HDO .....Hartford District Office
HEASB .....Health Standard Board
HEDIS .....Health Plan Employer Data and Information Set
HEDIS .....Healthcare Effectiveness Data & Information Set
HFMA.....Healthcare Financial Management Association
HHA.....Home Health Agency
HHS .....Health & Human Services (U.S. Department of)
HI .....Home Intervention
HIAA.....Health Insurance Association of America
HIB .....Health Insurance Benefits
HIB .....Hospital Insurance Benefit
HICN.....Health Insurance Claim Number
HIE .....Health Information Exchange
HIE/HIX.....Health Information Exchange
HIFA .....Health Insurance Flexibility & Accountability
HIM.....Health Insurance Marketplace
HIMSS .....Healthcare Information Management Systems Society
HIN.....Health Information Network
HIPAA .....Health Insurance Portability & Accountability Act
HIPP .....Health Insurance Premium Program
HIR .....Hire Into Range
HISP .....Health Information Service Provider
HISPC .....Health Information Security and Privacy Collaboration
HIT .....Health Information Technology
HITECH.....HIT for Economic & Clinical Health
HITPC .....Health Information Technology Policy Committee
HITSP .....Health Information Technology Standards Panel
HIV .....Human Immunodeficiency Virus
HIX .....Health Insurance Exchange
HJR.....House Joint Resolution
HMO .....Health Maintenance Organization
HMSA.....Health Manpower Shortage Area
HN Team.....Hostage Negotiations Team
HOS.....Health Outcomes Survey
HP .....Hewlett Packard
HPA.....Health Policy Agenda
HPID.....Health Plan Identifier
HPO.....Hospital Physician Organization
HPES.....Hewlett-Packard Enterprise Services
HPIU.....Health Programs Integration Unit
HR .....Health Reform
HRA.....Health Reimbursement Account
HRA.....Health Risk Assessment
HRAP.....Health Resource Allocation Plan
HRD.....Human Resource Development
HRP .....High Risk Pregnancy Program
HRQoL.....Health Related Quality of Life Scale
HRSA .....Health Resources & Services Administration
HSA .....Health Savings Account
HSA .....Health Services Area
HSB .....Human Services Board
HSE.....Health & Human Services Enterprise
HSE.....Health Services Enterprise
HSE ESC.....Health Services Enterprise Executive Steering Committee
HSE OSC .....Health Services Enterprise Operational Steering Committee
HSEP.....Health Services Enterprise Platform - “the Platform”; the shared services and infrastructure that will be shared across solutions.
HTHC.....Adult High Technology Home Care
HTML .....Hypertext Markup Language
HTTP .....Hypertext Transfer Protocol

HUD .....United States Department of Housing & Urban
HVP .....Healthy Vermonters Program

I

I&R .....Information and Referral
IA .....Information Architecture
IAM .....Identity and Access Management
IAPD .....Implementation Advance Planning Document
IAPDU .....Implementation Advanced Planning Document Update
IBM .....Intensive Benefits Management
IBNE .....Incurred but Not Enough
IBNR .....Incurred But Not Reported
IC .....Individual Consideration
ICD .....International Classification of Diseases (diagnosis codes & surgical codes)
ICD-9 .....ICD 9th Edition (prior version)-clinical modification
ICD-10 .....ICD 10th Edition (current version)-clinical modification
ICEHR .....Integrated Care Electronic Health Record
ICF .....Intermediate Care Facility
ICF/DD .....Intermediate Care Facility for people with Developmental Disabilities
ICF/MR .....Intermediate Care Facilities for Mentally Retarded
ICM .....Integrated Care Management
ICN .....Internal Control Number
ICN .....Incident Command Structure
ICS .....Information and Computer Services
ICS .....Incident Command Structure
ICU .....Intensive Care Unit
ICU/ICS .....Intensive Care Unit
ID .....Identification
IDA .....Individual Development Account
IDAP .....Intensive Domestic Abuse Program
IDN .....Integrated Delivery Network
IDS .....Integrated Delivery System
IDS .....Intrusion Detection System
IE .....Integrated Eligibility (DCF)
IEP .....Individual Education Plan
IEP .....Initial Enrollment Period
IEVS .....Income Eligibility Verification System
IFBS .....Intensive Family Based Services
IFC/DD .....Intermediate Care Facility for People with Developmental Disabilities
IFS .....Integrating Family Services
IFSP .....Individual Family Services Plan
IG .....Inspector General
IGA .....Inter Governmental Agreements
IHI .....Institute for Healthcare Improvement
IIOP .....Internet Inter-ORB Protocol
IOPT .....Integrated Operations and Policy Team
IL .....Independent Living
ILA .....Independent Living Assessment
INS .....Immigration and Naturalization Service
INS .....Initial Needs Survey
IP .....Internet Protocol
IPPS .....Inpatient Prospective Payment System
IPR .....Independent Review
IPS .....Integrated Practice System
IPS .....Individual Placement and Support
IPSec .....Internet Protocol Security
IR .....Independent Review
IRB .....Institutional Review Board
IRS .....Internal Revenue Service
ISA .....Individual Support Agreement
ISAP .....Intensive Substance Abuse Program
ISB .....Individualized Services Budget
ISC .....Integrated Systems of Care
ISD .....Information Services Division
ISN .....Integrated Services Network
ISO .....Intermediary Service Organization
ISR .....Intermediate Sanction Report
ISRA .....Information Security Risk Assessment
IT .....Information Technology
ITF .....Integrated Test Facility
ITIL v3 .....Information Technology Infrastructure Library Version 3
IV A .....Title of the Social Security Act governing TANF programs

(Temporary Assistance to Needy Families)

IV D .....Title of the Social Security Act governing child support programs

IV E.....Title of the Social Security Act governing foster care

IV&V .....Internal Validation & Verification

IV&V .....Independent Verification and Validation

IV-A.....Title IV-A of the Social Security Act governing TANF programs (Temporary Assistance to Needy Families)

IV-B sub-part II ..Safe and Stable Family Act

IV-D.....Title IV-D of the Social Security Act governing child support program

IVR .....Interactive Voice Response

IVRS .....Interactive Voice Response System

IVS.....Intervention Services

J

JAD.....Joint Application Development

JAD.....Joint Application Design

JAIBG .....Juvenile Accountability Incentive Block Grant

JAMA .....Journal of the American Medical Association

JCA .....Java Connector Architecture

JCAH.....Joint Commission on Accreditation of Hospitals

JCAHO.....Joint Commission on Accreditation of Healthcare Organizations

JCL.....Job Control Language

JDBC.....Java Database Connectivity

JDO .....St. Johnsbury District Office

JFO .....Joint Fiscal Office

JJDPA .....Juvenile Justice and Delinquency Prevention Act

JL.....Consent Decree Governing Involuntary Medication

JR .....Judicial Review

JVM.....Java Vitual Machine

L

LAMP .....Legal Aid Medicaid Project

LAN .....Local Area Network

LC .....Legislative Council

LDAP .....Lightweight Directory Access Protocol

LDO .....Brattleboro District Office

LEA.....Local Education Agency

LECC .....Legally Exempt Child Care

LECP .....Licensed Early Childhood Programs

LEIE .....Excluded Individuals/Entities

LERT .....Local Emergency Response Team

LIHEAP .....Low-Income Home Energy Assistance Program

LIS .....Low-Income Subsidy

LIT .....Local Interagency Team

LOC .....Level of Care

LOE.....Level of Effort

LOS.....Length of Stay

LSI .....Level of Services Inventory

LTC .....Long-Term Care

LUPA .....Low Utilization Payment Adjustment

M

M&O .....Maintenance and Operations

MA.....Medicare Advantage (Medicare Part C in Vermont)

MA .....Medical Assistance

MAA.....Medical Assistance for the Aged

MAB.....Medicaid Advisory Board

MAC.....Maximum Acquisition Cost

MAC.....Maximum Allowable Cost (refers to drug pricing)

MAF .....Medical Assistance Facility

MAGI .....Modified Adjusted Gross Income (expanded Medicaid)

MAP.....Medical Audit Program

MAPIR.....Medicaid Assistance Provider Incentive Repository

MARS.....Management & Administrative Reporting System

MARx.....Medicare Advantage & Part D Inquiry System

MAT.....Medication Assisted Therapy

MBES .....Medicaid Budget and Expenditure System

MCA.....Medicaid for Children and Adults

MCE .....Managed Care Entity

MCH.....Maternal & Child Health

MCI .....Master Client Index

MCIS .....Managed Care Information System

MCMC.....Managed Care Medical Committee

MCO.....Managed Care Organization

MCP .....Managed Care Plan

MCPI .....Medical Care Price Index
MCR .....Modified Community Rating
MDB.....Medicare DataBase
MDC.....Major Diagnostic Category
MDM.....Master Data Management - Includes Master Person Index, and Master Provider Index to ensure a common view and single version of the "truth" across AHS programs
MDO .....Barre District Office
MDS .....Minimum Data Set
MEAB .....Medicaid & Exchange Advisory Board
MEC .....Minimum Essential Coverage
MECT .....Medicaid Enterprise Certification Toolkit
MED .....Mental or emotional disturbance (or disorder.)
MEG .....Medicaid Eligibility Group
MEQC.....Medicaid Eligibility Quality Control
MES.....Medicaid Enterprise Solution
MFCN .....Military Family Community Network
MFCU .....Medicaid Fraud & Control Unit
MFP.....Money Follows the Person (DAIL)
MFRAU .....Medicaid Fraud & Residential Abuse Unit
MFP.....Money Follows the Person
MFRAU .....Medicaid Fraud & Residential Abuse Unit
MFS.....Medical Fee Schedule
MFT.....Managed File Transfer
MH .....Mental Health
MHSA.....Mental Health and Substance Abuse
MI .....Mental Illness
MIC .....Medicaid Integrity Contractor
MID .....Medicaid Identification Number (for member, see UID)
MIG.....Medicaid Integrity Group
MIG.....Medicare Insured Groups
MIP .....Medicaid Integrity Program
MIS.....Management Information System
MITA .....Medicaid Information Technology Architecture
MMA.....Medicare Modernization Act
MMIS .....Medicaid Management Information System
MMM.....Medicaid Information Technology Architecture Maturity Model
MMP .....Mixed Model Plan
MNF .....Medical Necessity Form
MOE .....Maintenance Of Effort
MOE .....Maintenance Of Eligibility
MOM .....Message-Oriented Middleware
MOS .....Medicaid Operations Services
MOU .....Memorandum Of Understanding
MOW .....Meals on Wheels
MOVE.....Modernization Of VT's Enterprise
MPI .....Master Provider Index
MPR .....Medication Possession Ratio
MPU.....Medicaid Policy Unit
MR .....Mental Retardation
MRP .....Management Reporting System
MSA .....Medical Savings Account
MSA .....Metropolitan Statistical Areas
MSIS.....Medicaid Statistical Information System
MSP .....Medicare Savings Programs
MSR .....Monthly Service Report
MSW .....Master's degree in Social Work
MTM .....Medication Therapy Management
MTMP.....Medication Therapy Management Program
MU.....Meaningful Use
MUA .....Medically Underserved Areas
MVP .....Mohawk Valley Physicians
MVRCF.....Marble Valley Regional Correctional Facility

N

NAEYC.....National Association for the Education of Young Children
NAMI .....National Association for Mental Illness
NAPPI.....Non-Abusive Physical & Psychological Intervention
NAPPI Non.....Abusive Physical and Psychological Intervention
NASW .....National Association of Social Workers
NCBD.....National CAHPS Benchmarking Database
NCCI .....National Correct Coding Initiative
NCIC .....National Criminal Information
NCP .....Non-Custodial Parent – obligated for the support

NCSEA .....National Child Support Enforcement Association
NCQA .....National Committee for Quality Assurance
NDC.....National Drug Code
NDO .....Newport District Office
NEKCA.....North East Kingdom Community Action
NEMT .....Non-Emergency Medical Transportation
NERCF .....Northeast Regional Correctional Facility
NEW.....National Eligibility Worker
NF.....Nursing Facility
NFR .....Non-Functional Requirements
NGA .....National Governors Association
NHR.....New Hire Reporting
NIMH .....National Institute of Mental Health
NLP.....Natural
NLP.....Neuro-Linguistic Programming
NLUOF.....Non-Lethal Use of Force
NNH .....Number Needed to Harm
NNT.....Number Needed to Treat
NOD .....Notice of Decision
NP .....Naturopathic Physician
NP .....Nurse Practitioner
NPA.....Non-Public Assistance
NPF .....National Provider File
NPI .....National Provider Identifier
NPRM.....Notice of Proposed Rulemaking
NSF.....Non-Sufficient Funds
NWSCF .....Northwest State Correctional Facility

O

OAA .....Older Americans Act
OAAM .....Oracle Adaptive Access Manager
OADAP.....Office of Alcohol & Drug Abuse Programs
OAM .....Oracle Access Manager
OASDHI.....Old Age Survivors, Disability and Health Insurance Program
OASDI .....Old Age, Survivors, Disability Insurance
OASIS .....Outcomes Assessment and Information Set
OBIEE .....Oracle Business Intelligence Suite Enterprise Edition
OBRA '90 .....Omnibus Reconciliation Act of 1990
OC .....Oleoresin Capsicum
OCIIO .....Office of Consumer Information & Insurance Oversight (CMS)
OCM.....Organizational Change Management
OCRB.....Operational Change Review Board
OCS .....Office of Child Support
OCSE .....Office of Child Support Enforcement (Federal agency)
ODBC .....Open Database Connectivity
ODS.....Operational Data Store
ODS.....Organized Delivery System
OEM.....Oracle Enterprise Manager
OEO.....Office of Economic Opportunity
OH.....Order of Hospitalization
OHA .....Office of Hearings and Appeals
OHITA .....Office of Health Information Technology Adoption
OHM .....Oracle HTTP Server
OHRA .....Oral Health Risk Assessment
OIG.....Office of the Inspector General
OIM.....Oracle Identity Manager
OIS .....Office of Interoperability & Standards
OJJDP .....Office of Juvenile Justice and Delinquency Prevention
OJP.....Office of Justice Programs
OLAP .....Online Analytical Processing
OLTP.....OnLine Transaction Processing
OMS.....Offender Management System
ONC.....Office of National Coordinator for Health Information Technology
ONH .....Order of Non-Hospitalization
OPG.....Office of Public Guardian
OPM.....Oversight Project Management
OPPS .....Outpatient Prospective Payment System
OPS .....Operations
ORP.....Offender Responsibility Plan
OSA.....Other State Agency
OSHA .....Occupational Safety & Health Administration
OTC .....Over The Counter
OTC .....Over the Counter
OUD .....Oracle Unified Directory
OVD .....Oracle Virtual Directory

OVHA .....Office of Vermont Health Access (now DVHA)

P

P & T .....Pharmacy and Therapeutics Committee
P&A.....Protection & Advocacy
P&P.....Probation and Parole or Policies and Procedures
PA .....Payment Authorization
PA .....Physician Assistant
PA .....Prior Authorization
PA .....Public Assistance
PACE .....Program for All-Inclusive Care for the Elderly
PADSS .....Prior Authorization Decision Support System
PAF.....Pre-Approved Furlough
PAL.....Parents' Assistance Line
PAPD.....Planning Advanced Planning Document (CMS)
PAR .....Personnel Action Request
PARIS .....Public Assistance Reporting Information System
PASARR.....Pre-admission, screening and annual resident review
PASRR .....Preadmission, Screening and Annual Resident Review
PATH .....Program to Assist in the Transition from Homelessness (federal)
PATH.....Prevention, Assistance, Transition and Health Access
PBA .....Pharmacy Benefit Administrator
PBA/PBM.....Pharmacy Benefits Administrator/Pharmacy Benefits Manager
PBM .....Pharmacy Benefit Management
PBMS .....Pharmacy Benefits Management System
PBSA .....Pharmacy Benefits Services Administration
PC.....Personal Computer
PC Plus .....Primary Care Plus (VT program)
PCA .....Personal Care Attendant
PCA .....Primary Care Association
PCC.....Parent Child Centers
PCCM .....Primary Care Case Management
PCIP.....Pre-existing Condition Insurance Plan
PCMH.....Patient-Centered Medical Home
PCMH.....Program in Community Mental Health
PCN .....Primary Care Network
PCN .....Processor Control Number
PCO .....Primary Care Office
PCP.....Primary Care Provider
PCPlus.....Primary Care Plus
PCS.....Procedure Coding System
PDC .....Primary Data Center
PDD.....Pervasive developmental disorder
PDF.....Portable Document File
PDL.....Preferred Drug List
PDL.....Project Document Library
PDP .....Prescription Drug Plan
PDP .....Pharmacy Drug Plan
PDP .....Medicare Part D Prescription Drug Plan
PDP .....Pharmacy Discount Program
PDSA .....Plan, Do, Study, Act
PEAKS .....Performance Enhancement and Knowledge System
PEP.....Principal Earner Parent
PEP.....Proposal Evaluation Plan
PERM .....Payment Error Rate Measurement
PERS.....Personal Emergency Response System
PES .....Provider Electronic Solutions
PHC .....Personalized Healthcare
PHI .....Protected Health Information
PHO.....Physician Hospital Organization
PHR .....Personal Health Record
PI.....Program Integrity
PIA .....Privacy Impact Assessment
PIC.....Parent Information Center
PIDL.....Physician Injectable Drug List
PII.....Personally Identifiable Information
PIL .....Protected Income Level (Poverty Income Guidelines)
PIL .....Project Information Library (also known as Project Document Library)
PIP.....Performance Indicator Project
PIP.....Performance Improvement Project
PIP.....Periodic Interim Payment
PIRL.....Plan Information Request Letter
PKI.....Public Key Infrastructure
PM .....Project Manager

PMBOK ..... Project Management Body of Knowledge
PMI ..... Project Management Institute
PMIS ..... Provider Management Information System
PMNI ..... Private Non-Medical Institution (treatment group home)
PMO ..... Project Management Office
PMP ..... Project Management Plan
PMP ..... Project Management Professional
PMPM ..... Per Member Per Month
PMPY ..... Per Member Per Year
PNA ..... Personal Needs Allowance
PNI ..... Personal Needs Issuance
PNMI ..... Private Non-Medical Institution
POC ..... Plan Of Care
POC ..... Public Oversight Committee
POLST ..... Physician Orders for Life-Sustaining Treatment
POS ..... Place Of Service
POS ..... Point Of Sale
POS ..... Point Of Service
POX ..... Plain Old XML
PP&D ..... Policy & Procedure Directive
PP&D ..... Policy, Procedures & Development (Interpretive Rule Memo)
PPA ..... Project Process Agreement
PPA ..... Prior Period Adjustment
PPACA ..... Patient Protection & Affordable Care Act
PPC ..... Program Participation Credit
PPCP ..... Pediatric Palliative Care Program
PPO ..... Preferred Provider Organization
PPPM ..... Per Patient Per Month
PPR ..... Planning, Policy & Regulation
PPS ..... Prospective Payment System
PPS ..... Production Problem Solving
PQA ..... Prior Quarter Adjustment
PQAS ..... Prior Quarter Adjustment Statement
PQRS ..... Physician Quality Reporting System
PREA ..... Prison Rape Elimination Act
PRO ..... Peer Review Organization
ProDUR ..... Prospective Drug Utilization Review
PROS ..... Pediatric Research in Office Settings
PRT ..... Proposal Review Team
PRWORA ..... Personal Responsibility & Work Opportunity Reconciliation Act
PSE ..... Post-Secondary Education
PSI ..... Pre-sentence Investigation
PSTG ..... Private Sector Technology Group
PSU ..... Payment Services Unit
PVRP ..... Physician Voluntary Reporting Program

Q

QA ..... Quality Assurance
QAAC ..... Quality Assurance and Assessment Committee
QAP ..... Quality Assurance Program
QARI ..... Quality Assurance Reform Initiative
QC ..... Quality Control
QDDP ..... Qualified Developmental Disabilities Professional
QDWI ..... Qualified Disabled Working Individuals
QHP ..... Qualified Health Plan
QI ..... Qualified Individual
QI ..... Quality Improvement
QIAC ..... Quality Improvement Advisory Committee
QMB ..... Qualified Medicare Beneficiary
QMHP ..... Qualified Mental Health Professional
QoS ..... Quality of Service
QWDI ..... Qualified Working Disabled Individual

R

R&C ..... Reasonable and Customary
R&R ..... Resource & Referral
R&T ..... Research and Training Centers
RA ..... Remittance Advice
RAC ..... Recovery Audit Contractor
RACI ..... Responsible, Accountable, Consulted, Informed
RAI ..... Residential Assessment Instrument
RAID ..... Risks Actions Issues Decisions
RAM ..... Responsibility Assignment Matrix
RAM/RACI ..... Responsibility Assignment Matrix
RAN ..... Rural Area Computer Network
RBA ..... Results Based Accountability
RBAC ..... Role Based Access Control
RBC ..... Risk Based Capital

RBRVS .....Resource-Based Relative Value Scale
RBUC.....Reported But Unpaid Claims
RC.....Restraint Chair
RCH .....Residential Care Home
RDBMS.....Relational Database Management System
RDO.....Rutland District Office
REMS .....Risk Evaluation and Mitigation Strategies
REOMB .....Recipient Explanation of Medicaid Benefits
REST.....Representational State Transfer
RetroDUR .....Retrospective Drug Utilization Review
REV/ONH.....Revocation of an Order of Non-Hospitalization
REVS.....Recipient Eligibility Verification System
RFB.....Request for Bid
RFCCH .....Registered Family Child Care Homes
RFI.....Request For Information
RFP.....Request For Proposals
RFQ.....Request for Quote
RFR.....Request For Classification Review
RFR.....Request for Reclassification
RHC.....Rural Health Clinic
RHFP .....Rural Hospital Flexibility Program
RHIO .....Regional Health Information Organization
RIA .....Rich Internet Application
RICW.....Risk, Issue, Contingency, Workaround
RLU .....Residential Licensing Unit
RMP .....Requirements Management Plan
RMP .....Risk Management Plan
RN .....Registered Nurse
RO .....Regional Office
ROA.....Return on Assets
ROB.....Rules Of Behavior
ROE .....Return on Equity
ROI.....Return On Investment
ROSI.....Reconciliation of State Invoice
ROX.....Report Object Executable
RPMS .....Resource and Patient Management System
RPO.....Recovery Point Objective
RPU.....Rebate Price per Unit
RR .....Railroad Retirement
ROSI.....Reconciliation of State Invoice
ROX.....Report Object Executable
RPMS .....Resource and Patient Management System
RPO.....Recovery Point Objective
RPU.....Rebate Price per Unit
RTM .....Requirements Traceability Matrix
RTO .....Recovery Time Objective
RU .....Reach Up program
RUCM .....Reach Up Case Manager
RVU.....Relative Value Units
RWJ.....Robert Wood Johnson Foundation

S

S/MMIE .....Secure/Multipurpose Internet Mail Extensions
SA.....Solution Architecture
SaaS .....Software as a Service
SAD .....Screening, Application and Determination
SAI.....Shared Analytics Infrastructure
SAMHSA .....Substance Abuse & Mental Health Services Administration
SAML.....Security Assertion Market Language
SAMS .....Social Assistance Management System
SAS.....Statement on Auditing Standards
SASH .....Support And Services at Home
SBC.....Summary of Benefits & Coverage
SBE.....State Health Benefit Exchange
SBM .....State-Based Marketplace
SBS.....Success Beyond Six
SCBA .....Self Contained Breathing Apparatus
SCC.....Specialized Community Care
SCHIP .....States Children's Health Insurance Program (Plan)
SCORE .....Service Corps of Retired Executives
SCP.....Senior Companion Program
SCS.....Supervised Community Sentence
SCSEP .....Senior Community Service Employment Program
SD.....Self-Determination
SDFSC.....Safe and Drug Free Schools and Communities
SDK .....Software Development Kit

SDLC.....Software Development Lifecycle
SDLC.....Systems Development Life Cycle
SDMP.....System Development Management Plan
SDO.....Standards Development Organization
SDO.....Springfield District Office
SDP.....Self-Determination Project
SDU.....State Disbursement Unit
SDX.....State Data Exchange System
SE.....Systems Engineer
SECCA.....State Employee Combined Charitable Appeal
SED.....Severe Emotional Disturbance
SEI.....Software Engineering Institute
SEI.....Systems Engineer
SEP.....Special Enrollment Periods
SESCF.....Southeast State Correctional Facility
SEVCA.....Southeastern Vermont Community Action
SF.....Supplemental Fuel
SFTP.....Secure File Transfer Protocol
SFY.....State Fiscal Year
SGF.....State General Fund
SGO.....Surgeon General's Office
SHCRF.....State Healthcare Resource Fund
SHIP.....State Health Insurance (and Assistance) Program
SHIP(s).....State Health Insurance Assistance Program(s)
SHMO.....Social Health Maintenance Organization
SHOP.....Small business Health Options Program
SHP.....Supportive Housing Program
SHRF.....State Healthcare Resources Fund
SI.....Systems Integration
SI.....Systems Integrator
SIDS.....Sudden Infant Death Syndrome
SILC.....Statewide Independent Living Council
SIM.....State Innovation Model
SIT.....State Interagency Team
SIT.....System Integration Test
SIU.....Special Investigation Unit
SLA.....Service Level Agreement
SLHIE.....State Level HIE Consensus Project
SLMB.....Specified Low-income Medicare Beneficiary
SLP (2).....Shared living provider (or speech language pathologist)
SLR.....System/Service Level Requirement
SMA.....State Medicaid Agency
SMA.....System Modification Authorization
SMAC.....State Maximum Acceptable Cost
SMDL.....State Medicaid Directors Letter
SME.....Subject Matter Expert
SMHA.....State Mental Health Agencies
SMHP.....State Medicaid HIT Plan
SMHRCY.....State Mental Health Representatives for Children and Youth
SMI.....Supplementary Medical Insurance
SMM.....State Medicaid Manual
SMOKE TEST.....Preliminary testing to reveal simple failures severe enough to reject a release
SNAP.....State Nutritional Assistance Program
SNF.....Skilled Nursing Facility
SNOMED.....Systematized Nomenclature of Medicine
SNTP.....Simple Network Time Protocol
SO.....State Office
SOA.....Service Oriented Architecture
SOAP.....Simple Object Access Protocol
SOP.....Standard Operating Procedure
SOR.....System Of Records
SORN.....System Of Record Notice
SOS.....Security and Operations Supervisor
SOV.....State Of Vermont
SOW.....Statement Of Work
SP.....Service Plan
SPA.....State Plan Amendment
SPAP.....State Pharmacy Assistance Program
SPAP.....State Pharmaceutical Assistance Program
SPAP.....State Prescription Drug Assistance Program
SPLS.....State Parent Locator Service
SPM.....Service Portfolio Management
SPP.....Specialized Programs Project (under the MMIS program)
SPR.....Safeguard Procedures Report

SQL.....Structured Query Language
SR.....Supplemental Rebate
SRA.....Supplemental Rebate Agreement
SRF.....Siebel Repository File
SRS.....Social & Rehabilitative Services (Department of)
SS.....Social Services
SSA.....Social Security Administration
SSA.....State Self-Assessment
SSA.....Specialized Service Agency
SSAE.....Statement on Standards for Attestation Engagements
SSA-ODX.....Social Security Data Exchange
SSBG.....Social Services Block Grant
SSCF.....Southern State Correctional Facility
SSDC.....Sovereign States Drug Consortium
SSDI.....Social Security Disability Insurance
SSH.....Secure Shell
SSI.....Supplemental Security Income
SSI/AABD.....Supplemental Security Income/Aid to Aged, Blind or Disabled
SSL.....Secure Sockets Layer
SSMIS.....Social Services Management Information System
SSN.....Social Security Number
SSO.....Single Sign On
SSO.....Standards Setting Organization
SSP.....Systems Security Plan
SSP.....Shared Savings Program
SSR.....Self Support Reserve
SSR.....Safeguard Security Report
SSRS.....SQL Server Reporting Services
SSU.....Support Services Unit
STARS.....Step Ahead Recognition System
STD.....Sexually Transmitted Disease
SUL.....State Upper Limit
SUR.....Surveillance & Utilization Review
SURS.....Surveillance and Utilization Review Subsystem
SR.....Service Request
SSU.....Service Support Unit
SWP.....Suggested Wholesale Price
SX6.....Success By Six

T

T4T.....Training for Trainers
TA.....Technology Architecture
TAD.....Turn Around Documents
TANF.....Temporary Assistance for Needy Families (see Reach Up)
TARB.....Technical Architecture Review Board
TB.....Tuberculosis
TBD.....To Be Determined
TBI.....Traumatic Brain Injury
TCN.....Transaction Control Number
TCO.....Total Cost of Ownership
TCP/IP.....Transmission Control Protocol/Internet Protocol
TCR.....Therapeutic Class Review
TCS.....Therapeutic Classification
TDD.....Technical Design Document
TDO.....Bennington District Office
TDOC.....Total Days of Care
TEFRA '82.....Tax Equity & Fiscal Responsibility Act of 1982
TH.....Oracle Thuderhead Product
TIN.....Taxpayer Identification Number
TLS.....Transport Layer Security
TM.....Transitional Medicaid
TMSIS.....Transformed Medicaid Statistical Information System
ToT.....Training of Trainers
TPA.....Third Party Administrator
TPCM.....Third Party Claim Management
TPL.....Third Party Liability
TPR.....Termination of Parental Rights
TQM.....Total Quality Management
TRS.....Treatment and Recovery Services
TSO.....Town Service Officer
TTY.....Text Telephony
Tx.....Treatment
TXIX.....Title XIX

U

UAP.....University Affiliated Program for Developmental Disabilities
UAT.....User Acceptance Test
UB.....Uniform Billing/Uniform Bill
UBP.....Uniform Benefit Package
UC.....Unemployment Compensation
UC.....Unmanageable in Custody
UCF.....Universal Claim Format
UCM.....Universal Customer Master
UCR.....Usual & Customary Rate
UCS.....United Counseling Services
UCUM.....Unified Code for Units of Measure

UDDI ..... Universal Description, Discovery and Integration
UI ..... Unemployment Insurance
UI ..... User Interface
UIB ..... Unemployment Insurance Benefits
UID ..... Unique Identification Number
UIFSA ..... Uniform Interstate Family Support Act - governs interstate child support cases
UIR ..... Unusual Incident Report
UM ..... Utilization Management
UML ..... Unified Modeling Language
UMLS ..... Unified Medical Language System
UR ..... Utilization Review
URA ..... Unreimbursed Public Assistance
URA ..... Unit Rebate Amount
URAC ..... Utilization Review Accreditation Commission
URC ..... Utilization Review Committee
URESA ..... Uniform Reciprocal Enforcement of Support Act
URO ..... Utilization Review Organization
USC ..... United States Code
USDA ..... United States Department of Agriculture
USPHS ..... U.S. Public Health Service
UT ..... Unit Test
UVM ..... University of Vermont

V

VA ..... Veterans Administration
VAB ..... VT Association for the Blind
VABIR ..... Vermont Association of Business, Industry & Rehabilitation
VABVI ..... Vermont Association for the Blind and Visually Impaired
VAC ..... Vermont Achievement Center
VAHHA ..... Vermont Assembly of Home Health Agencies
VAHHS ..... VT Association of Hospital & Health Systems
VAMH ..... Vermont Association for Mental Health
VAR ..... Value Added Reseller
VARC ..... Resources & Community Opportunities for Vermonters w/ Developmental Disabilities
VC ..... Voluntary Care
VCA ..... Vermont Correctional Academy
VCCI ..... Vermont Chronic Care Initiative
VCDMHS ..... Vermont Council of Developmental & Mental Health Services
VCDR ..... Vermont Coalition for Disability Rights
VCF ..... Vermont Children's Forum
VCHIP ..... Vermont Child Health Improvement Program
VCHIP ..... Vermont Healthcare Innovation Project
VCI ..... Vermont Correctional Industries
VCIL ..... Vermont Center for Independent Living
VCORP ..... Vermont Coalition of Residential Providers
VCRP ..... Vermont Coalition of Runaway Programs
VCTF ..... Vermont Children's Trust Fund
VDH ..... VT Department of Health
VDO ..... Morrisville District Office
VEAF ..... Vermont Enterprise Architecture Framework
VET ..... Vetting is a process of examination and evaluation
VFAFA ..... Vermont Foster and Adoptive Family Association
VHAP ..... Vermont Health Access Plan
VHAP-Rx ..... Vermont Health Access Plan Pharmacy Program
VHAT ..... VT Health Access Team
VHC ..... Vermont Health Connect
VHCA ..... Vermont Healthcare Association
VHCURES ..... Vermont Healthcare Claims Uniform Reporting and Evaluation System
VHITP ..... Vermont Health Information Technology Plan
VHPSI ..... Vermont Hospital Preventative Services Initiative
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

VISTA .....Volunteers in Service to America

VIT.....VT Interactive Television

VIT.....Vermont Interactive Technologies

VITL.....VT Information Technology Leaders

VITN.....Vermont Interactive Television Network

VLA.....Vermont Legal Aid

VMAP.....Vermont Medication Assistance Program

VMS .....VT Medical Society

VNA.....Visiting Nurses Association

VOIP.....Voice Over Internet Protocol

VP&A .....Vermont Protection and Advocacy

VPCCN.....Vermont Parent Child Center Network

VPHARM.....VT Pharmacy Program

VPIC .....Vermont Parent Information Center

VPN.....Virtual Private Network

VPQHC .....Vermont Program for Quality in Healthcare

VPS .....Vermont Psychiatric Survivors

VPTA .....Vermont Public Transportation Agency

VR .....Vocational Rehabilitation

VRS .....Voice Response System

VRU.....Voice Response Unit

VSA .....Vermont Statutes Annotated

Vscript .....VT Pharmacy Assistance Program

VSDS .....VT State Dental Society

VSEA .....Vermont State Employees Association

VSECU .....Vermont State Employees Credit Union

VSH .....Vermont State Hospital

VSHA.....Vermont State Housing Authority

VTCECH.....Vermont Campaign to End Childhood Hunger

VTDDC.....Vermont Developmental Disabilities Council

VTHR.....Vermont Human Resources

VTL.....Vermont Technology Leaders

VTPSA .....Vermont Treatment Program for Sexual Aggressives

W

WAC.....Wholesale Acquisition Cost

WAM .....Welfare Administration Manual

WAN .....Wide-Area Network

WAP/WX .....Weatherization Assistance Program

WBS .....Work Breakdown Structure

WC .....Worker's Compensation

WC .....Web Center

WIA.....Workforce Investment Act

WIC .....Supplemental Food Program for Women, Infants & Children

WJRC.....Woodside Juvenile Rehabilitation Center

WRAT.....Wide Range Achievement Test

WRP .....Welfare Restructuring Project

WS .....Web Services

WSDL .....Web Services Description Language

WSFL.....Web Services Flow Language

WS-I .....Web Services Interoperability

WTF.....Weatherization Trust Fund

X

XCA .....Cross-Community Access

XDEA.....X-DEA Number

XDS .....Cross-Enterprise Document Sharing

XHTML .....Extensible Hyper Text Markup Language

XML.....Extensible Markup Language

XPDL .....XML Process Definition Language

XSLT .....Extensible Style Sheet Language Transformations

Y

YDO.....Middlebury District Office

YRBS.....Youth Risk Behavior Survey

Z

ZDO.....State Office/Central Office