# DEPARTMENT OF VERMONT HEALTH ACCESS
# BUDGET RECOMMENDATION
# STATE FISCAL YEAR 2019

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## Contents

# CHAPTER ONE: INTRODUCTION TO DVHA

## DVHA COMMISSIONER'S MESSAGE

I am honored once again to submit the Department of Vermont Health Access (DVHA) budget recommendation on behalf of Governor Scott, Secretary Gobeille; and our entire team. As a department within the Agency of Human Services, we hold common core values of integrity, transparency, and service that guide our work and decision making. DVHA's commitment is to serve all Vermonters by providing access to care for those utilizing our programs and acting as a careful steward of public dollars on behalf of Vermont taxpayers. Many people and organizations across the State and in our region, are working hard to make our health care system better. We here at DVHA recognize that we need to work with everyone to achieve the Governor's vision of a high-quality healthcare system that protects our most vulnerable while improving affordability for Vermonters. DVHA's budget recommendation is aligned with that vision.

The past year has been one of evaluation and prioritization at DVHA. In assessing the landscape of our responsibilities and execution, we are determined to focus on three key areas:

1. Adoption of Value Based Payments
2. Management of Information Technology Projects
3. Improve Operational Performance

Our department will approach these priorities and the complex issue of health care with simple and timeless Vermont values. We aim to work hard, be transparent, not overpromise, and above all, to be accountable to Vermonters. We strive to partner with Vermont's hospitals, doctors, and nurses rather than impose a government first solution. We seek to evaluate and manage ourselves with the rigorous scrutiny that we apply to our partners in the health care system. We seek to do better.

We continue to test a voluntary pilot program that prioritizes paying for the quality of care for each Vermonter rather than the quantity of services delivered. The value-based model is focused on prevention, empowering primary care providers, and coordinating care. The goal is to improve health while moderating health care costs, which are a barrier to affordability. Over 5,000 providers, including most of Vermont's hospitals, have decided to partner with us through the program in 2018. We look forward to evaluating the program on its merits to determine whether it meets our goals of better health, high quality care, and predictable and sustainable health care costs.

DVHA must execute information technology projects better in the future. We will marry our business processes with available technical options through a modular approach. This means we will not be pursuing a single end-all, be-all solution, but rather we will strive for incremental continuous

improvement in functionality. This deliberate approach will minimize risk, drive immediate and visible business value, and ensure Vermonters have an IT system that is sustainable over time.

While considering the future, we keep our eye focused on the challenges that present themselves today. The performance and management of Vermont Health Connect is looking up. The number of Vermonters on Medicaid is down. Proper management and stewardship of Medicaid, along with a focus on growing Vermont's economy, will help restore confidence in Vermont's public health care programs and result in savings for our budget and for taxpayers.

This budget book is designed to clearly depict the functional areas of responsibility within DVHA, to provide the public with the status of the initiatives which the teams are working to accomplish, and to ultimately portray our budgetary needs for the coming year. On behalf of the DVHA team, I thank you for your service to our state and look forward to working with you as we responsibly manage and improve the programs that touch the lives of Vermonters.

## ACCOMPLISHMENTS

While we recognize how much work we have yet to do, it is important to acknowledge the hard work of the past year. Below, is a partial list of DVHA accomplishments since the start of the Scott Administration. DVHA's team does important and impactful work every day and as such, no list could be comprehensive. These highlights are not meant to diminish the everyday successes of our team.

### Adoption of Value-Based Payments

**Vermont Medicaid Next Generation (VMNG) Accountable Care Organization (ACO) Program:** DVHA implemented the nation's first Medicaid Next Generation ACO program. VMNG is designed to empower the provider community by giving health care providers the opportunity and incentive to take leadership for cost containment and quality. The pilot is now in ten hospital service areas and includes over 5,000 providers and approximately 42,000 Medicaid members. In 2018, the program is testing whether program and payment alignment matters, as the ACO OneCare Vermont included Medicare and commercial payer programs on 1/1/18, as part of Vermont's All-Payer Model. This is a first step in potentially moderating Medicaid spending in the future by pushing risk down onto providers. This is DVHA's key effort to promote value-based payments, continuing DVHA's move away from a Fee for Service payment model and towards payment arrangements based on quality, risk, and accountability. Initial data appears promising.

**CMS Recognition of Seven Non-Fee for Service Payment Models:** Vermont's Global Commitment to Health Medicaid 1115 waiver requires Agency of Human Services (AHS) to submit non-fee-for-service payment models to the Centers for Medicare & Medicaid Services (CMS) for approval prior to implementation. AHS identified seven existing non-FFS payment models for future review and approval by CMS:

1. Vermont Medicaid Next Generation ACO
2. Blueprint for Health - Patient-Centered Medical Home

3. Blueprint for Health - Community Health Teams
4. Blueprint for Health - Women's Health Initiative
5. Dental Incentive Payment
6. Children's Integrated Services
7. Integrating Family Services

DVHA's Policy Unit played an integral role in ensuring that these seven payment models were approved by CMS, allowing Vermont to continue these programs, which are customized to meet the needs of Vermonters.

**Invested in Vermont's Health Centers:** DVHA concluded a multi-year project to evaluate the way it pays health centers, both Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC). The project achieved several key goals: (1) it brought DVHA into compliance with Federal law related to health center reimbursement, (2) it invested $2.4 million in health centers, (3) it aligned DVHA's payment methodology for health centers with DVHA's overall payment reform goals, including the All-Payer Model, and (4) it ended longstanding confusion and disagreement between DVHA and health centers regarding reimbursement policy.

**Delivery System Reform (DSR) Investments:** DVHA submitted and received Federal approval for the first ever DSR investments, which are a pathway to draw down Federal funds for activities in support of Medicaid's participation in the Vermont All-Payer ACO Model. Specifically, these investments support enhanced care coordination and information technology by an ACO to care for Vermont Medicaid members.

**Restored Primary Care Parity with Medicare:** Recognizing the importance of primary care, DVHA restored equity between Medicare and Medicaid for primary care payment rates, effective August 1, 2017. This increase was achieved by using a special conversion factor, which was formerly called an Enhanced Primary Care Payment (EPCP). For more information on this accomplishment, review DVHA's *Vermont Medicaid Payment Alignment Report, Act 85 of 2017*.

**New Women's Health Initiative Expanded Psychosocial Screening and Treatment, and Comprehensive Family Planning Services for Healthier Women and Families:** The Women's Health Initiative launched in January 2017 and already engages more than half of Vermont's women's health provider practices, in addition to 15 Patient Centered Medical Homes in:

- Expanding screenings for a range of psychosocial risk factors,
- Connecting patients who screen positive with brief intervention and referral to treatment,
- Offering same-day access to Long Acting Reversible Contraception (LARC) for patients who choose that highly-effective form of birth control, and
- Formally linking community organizations and practices with referral protocols that give patients the comprehensive family planning counseling they want, as soon as they want it.

**Piloting Payment for Multi-Disciplinary Team Based Care:** In 2017, the Blueprint team worked with OneCare Vermont to pilot new care management software and a complex-care management payment model in five Health Service Areas. The payment model rewards multi-disciplinary care for

people with especially complex needs. Under this model, a lead care manager is identified based on the best fit for the patient and is paid for their time whether they come from a traditional health care organization or a social, economic, or community-service provider. The lead care manager maintains the care plan and facilitates communication across participating organizations and agencies, making sure care is always directed towards the patient's goals and is safe, effective, and non-duplicative.

### Management of Information Technology Projects

**CMS Certification of the Pharmacy Benefit Management System:** The Pharmacy Unit completed the long and intensive process of pursuing CMS Certification of the Pharmacy Benefit Management Systems (PBMS). This was the culmination of three years of substantial effort by the Pharmacy Unit and others, including the Certification Team, the Design, Development, and Implementation (DDI) team, Vendor management, and Independent Verification, Validation (IV&V) resources. This collective effort required the successful implementation by the vendor of nearly all PBM programs, the completion of many contract deliverables, and completion of the Pharmacy Checklist and the five "common checklists" to satisfy CMS' requirements. As the final step in pursuing certification of the PBM system, the DVHA completed a site visit by CMS from 11/28/17 through 11/30/17. By achieving certification, DVHA can claim 75% Federal financial participation (FFP) for maintenance and operations (M&O) costs. Prior to certification, a state is only eligible for a lessor Federal medical assistance percentage (FMAP) matching funds for such costs. While the formal certification approval letter is still pending, CMS summarized the review as thorough, informative and successful. We anticipate an official notification from CMS by the end of January.

**Electronic Asset Verification System:** DVHA implemented an Electronic Asset Verification System (eAVS), which is used to verify resources for Vermonters applying for Medicaid for the Aged, Blind, and Disabled (MABD) and Long-Term Care Medicaid (LTC) Programs. eAVS electronically requests and receives financial institution data from US banks and credit unions. eAVS automation significantly reduces the verification documentation burden for clients and eligibility workers. eAVS provides a more complete and accurate financial picture on which to base a decision. The implementation of the eAVS solution was required under a mitigation plan between the State of Vermont and CMS.

**Presumptive Eligibility:** DVHA implemented Presumptive Eligibility (PE) processes, part of the CMS Mitigation Plan, allows participating hospitals to presume that someone is eligible for Medicaid based upon four simple questions (around U.S. citizenship, VT residency, size of household, and income level). This new streamlined eligibility process will ensure that eligible Vermonters can get quicker access to services and treatment. This will also benefit participating hospitals as they will get claims paid for delivered services.

### Improving Operational Performance

**Established Scorecards to Track Key Performance Indicators:** DVHA's Quality Unit worked with all units within DVHA to establish scorecards to measure performance on key functions. These

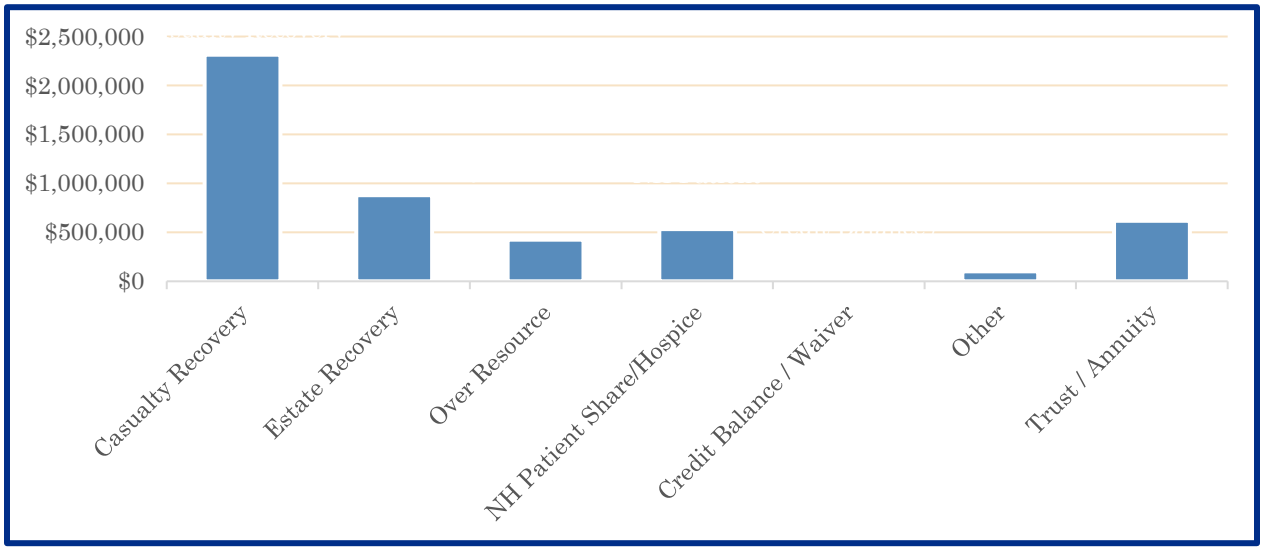
scorecards will be the primary way DVHA measures performance for each unit and demonstrates improvement over time. All units now have, and are able to use, these scorecards.

**Medicaid Audit & Compliance Unit:** The Medicaid Audit & Compliance Unit (MACU) is responsible for Medicaid Provider fraud, waste and abuse investigations, False Claims Act Compliance, and proactive support of policy and procedural compliance implementation. Calendar year 2017 accomplishments include recoveries valued at $4,088,508 and cost avoidance valued at $954,101 for a collective financial impact of $5,042,609.

**Oversight & Monitoring:** The Oversight & Monitoring (O&M) unit is responsible for external audit facilitation, Corrective Action Plan (CAP) submission and follow-through, CMS Reporting requirements submission and monitoring of internal business procedures. Calendar year 2017 accomplishments include audit facilitation of the Comprehensive Annual Financial Report (CAFR) and the Single State Audit and a reduction of five repeat findings to two.

**Beneficiary Healthcare Fraud Investigative Unit:** The Beneficiary Healthcare Fraud Investigative Unit is responsible for Beneficiary Healthcare Eligibility and Enrollment Fraud investigations. The Program Integrity Unit fully staffed this new unit in April 2017, established procedures, templates, and a temporary tracking tool, received 165 new referrals, and established working relationships with the Office of Inspector General (OIG) for Federal/State joint investigations, the Drug Enforcement Administration (DEA) for drug related offenses, and the Department of Children and Families (DCF) Beneficiary Fraud Unit.

**Coordination of Benefits Recovery Unit Saved Taxpayers Money:** The Coordination of Benefits (COB) Unit achieved $4,874,710 in recoveries in State Fiscal Year 2017:




**Resolved Dartmouth Hitchcock Medical Center Reimbursement Litigation:** The State of Vermont and Dartmouth Hitchcock Medical Center (DHMC) came to an agreement to end longstanding litigation regarding reimbursements. The State of Vermont committed to creating parity between rates paid to DHMC and Vermont's in-state academic medical center. These changes were

effective January 1, 2018. It is our hope that the resolution of this lawsuit can renew collaboration on health care reform.

**Focused on Financial Forecasting:** DVHA revamped its reporting of Medicaid caseload and utilization spending, commonly known as the 52 Points of Light. The changes were intended to help DVHA, the AHS Central Office, Department of Finance and Management, and the Legislative Joint Fiscal Office gain better insight into Medicaid spending.

**Created an Administrative Services Unit:** DVHA aligned and integrated its administrative functions to streamline and improve processes and procedures for the department.

**Adopted Delinquent Provider Tax Standard Operating Procedures:** DVHA collects nearly $200 million in health care related taxes. DVHA continues to improve this operation, this year developing and implementing standard operating procedures that make clear the process for providers that fall behind on their tax obligations.

**Healthcare Eligibility Policy and Operations (HEPO) Implementation:** In 2017, the DVHA policy director, health care director, and HAEEU worked together to institute a process to track the implementation status of policy related to eligibility and enrollment. Though still in its early stages, the HEPO process allows DVHA to quantify the level of effort for implementing rules and regulations and to assess related compliance issues.

**Completed 2018 QHP Design and Certification:** DVHA manages the annual certification process for qualified health plans (QHP). The process includes publishing the certification timeline and plan design guidance, convening a stakeholder advisory group, formally certifying plans, and entering plan year agreements with QHP issuers. In 2017, DVHA completed each of these milestones in a timely manner and, as a result, Vermonters had access to a strong selection of QHP for 2018 enrollment.

**Internal Process Improvements:** DVHA created a process and standard operating procedures around payroll, hiring, and department wide policies that brought DVHA into compliance with the Internal Control Audits.

**Brattleboro Retreat Pilot:** DVHA partnered with the Brattleboro Retreat to initiate a pilot project that allows five days initial authorization in an effort to streamline discharge planning.

**Implemented New Transportation Contract:** DVHA executed the new Non-Emergency Transportation Contract and worked in partnership to make sure it was implemented well for our members. DVHA conducted five "Road Show" presentations to the Vermont Public Transportation Agency (VPTA) subcontractors who are delivering transportation to our members. The Road Shows outlined expectations, rules of the program, and addressed good customer service. This ensures our members are getting the rides they need to medical appointment

**Implemented the CMS Covered Outpatient Drugs Final Rule:** The DVHA Pharmacy Unit successfully implemented the CMS Covered Outpatient Drugs Final Rule (CMS-2345FC) published

on February 2, 2016, on time, on April 1, 2017. This was a major rule impacting all Medicaid pharmacy programs nationally. We were directed by CMS to adopt pharmacy payment policies designed to pay pharmacies for the actual acquisition cost of drugs plus a reasonable professional dispensing fee. DVHA Pharmacy unit with the New England States Consortium Systems Organization (NESCSO), conducted a pharmacy cost of dispensing survey, to analyze the cost of dispensing prescription medications to Vermont Medicaid members. In addition, the Pharmacy unit and its PBM conducted extensive analysis to determine the ingredient cost benchmarks needed to more accurately reflect actual pharmacy acquisition cost for ingredient cost reimbursement. A "lower-of" methodology utilizing the benchmark of National Average Drug Acquisition Cost (NADAC) was created. Once we determined the methodology, we implemented that in the Point of Sale (POS) Pharmacy system and performed multiple outreach activities and education to pharmacies. Because of our considerable efforts, there was very little disruption or negative feedback from our pharmacy provider network and no member impact.

**Reimbursement Re-basing:** DVHA re-based its Outpatient Prospective Payment System (OPPS), Disproportionate Share Hospital (DSH) payment methodology, and fee schedule for Durable Medical Equipment Prosthetics, Orthotics, and Supplies. (DMEPOS).

**Engaging Almost all Primary Care Practices in Vermont:** In previous years, the Blueprint had reported it was approaching a saturation point, where the program had recruited most of the available primary care practices. The team was surprised by a new influx of practices in 2017, representing most of the remaining primary care practices with more than one provider that are known to the Blueprint. The net gain in recognized Patient-Centered Medical Homes in Vermont was seven practices in 2017.

**SASH Participants Experience Measurable Difference in End-of-Life Planning and Chronic Disease Management:** Regarding end-of-life planning, Support and Services at Home (SASH) staff worked with program participants to develop advance directives, increasing the percentage of participants with a documented end-of-life plan in place from 59% to 66% in 2017, well above the national average of 26% of adults with advance directives. Regarding chronic disease management, SASH staff helped increase the rate of participants with diagnosed hypertension and documented blood pressure readings classified as "in control" by the National Quality Forum (NQF) from 77% in 2016 to 87% in 2017.

**Helping Vermonters Help Themselves:** In 2017, 1,263 Vermonters completed a Blueprint sponsored Self-Management workshop, on one of the following topics: smoking cessation, diabetes management, diabetes prevention, chronic condition management, chronic pain, and emotional wellness. These workshops are offered in all parts of the state.

**Getting More Vermonters with Opioid Use Disorder into Lifesaving Treatment Sooner:** In 2017, the Hub and Spoke program was recognized by the White House's Director of National Drug Control Policy as "unique" and an "incredible, valuable national model." State leadership and the people who work in Hubs and Spokes have not stopped there – they are continuously working to expand access. The enrollment in Hubs and Spokes continued to increase throughout 2017 to just

over 6,000. At the same time, the number of providers actively offering Medication Assisted Treatment in Spoke settings increased from 187 to 213. Local Blueprint leaders and staff participated in triage teams, helping people who ask for help with opioid use disorder get to the right level of treatment as soon as possible, whether in the regional Hub or a local Spoke.

## OUR CORE VALUES

### Our Mission

DVHA is committed to;

**Improving health and well-being of Vermonters by providing access to quality healthcare, cost effectively.**

### Our Members

In State Fiscal Year 2017, DVHA offered health care assistance to 206,955 Vermonters. This included 57.69% of Vermont's children; a total of 68,468 kids under age 19. The Vermont Health Connect Marketplace put Qualified Health Insurance plans within reach for 28,009 people.

### Our Providers

Members of DVHA's direct coverage programs have access to a network of 18,133 enrolled providers as of this publication. In SFY 2017, over 7.1 million claims were processed.

### Collaboration

The Department's initiatives require strong working relationships with other state agencies, federal and local governments, and community partners.

### Focus on Vermonters

DVHA's priority is to its member and provider communities. Outreach and education teams work from locations throughout Vermont to ensure that those in need of coverage or access to care have the assistance they need. DVHA works diligently to promote an adequate network of providers to meet the health care needs of Vermonters. Our internal champions lead cultural change by identifying specific processes and policies that can become more person-centered. The Department's leadership team continues to model, drive and support the integration of person-centered principles into our organizational culture.

## Future Vision

In Vermont, we are focused on the future of health care in alignment with the triple aim of improving patient experience of care, improving population health, and reducing per capita cost growth. DVHA is committed to continuous improvement by focusing on 1) adoption of value-based payments, 2) effective management of information technology projects, and 3) improving operational performance.

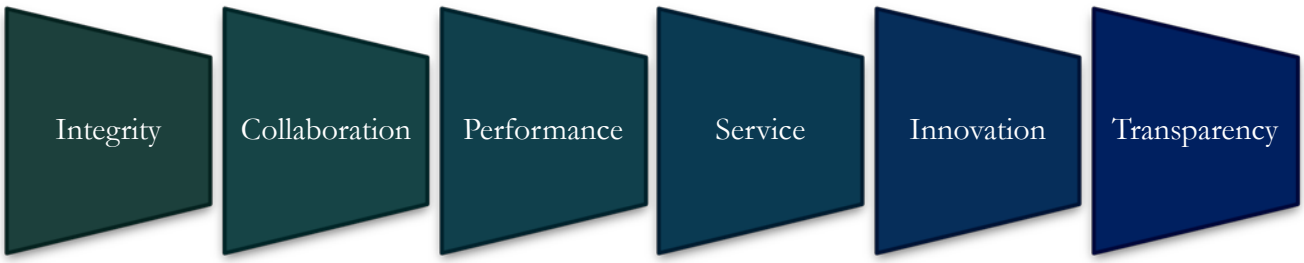
DVHA has made a policy choice to focus on paying for value, not volume. This is consistent with the trend nationally. For example, the Federal government continues to move away from fee-for-service (FFS) under the Medicare Access and CHIP Reauthorization Act of 2005 (MACRA) and via other innovation programs. Overall, DVHA continues to move away from FFS payment models and toward payment arrangements based on quality, risk and accountability. For example, the ACO model is an opportunity to move a larger portion of spending away from Medicaid FFS arrangements and towards more predictable payment models that focus on providing members with the care needed to support their mental and physical well-being, focusing on preventing high cost hospital visits and curbing substance use disorder.

Leadership at DVHA is committed to ensuring that supportive, cost-effective, health information technology systems are in place to provide tools and resources designed to improve the health of Medicaid members. We continue to pursue modern Medicaid and integrated eligibility systems changes in small, manageable modules to minimize risk and provide immediate business value. The SFY 2018 Information Technology (IT) procurements are focused on improving and streamlining the customer experience for the Medicaid member and the provider community. The procurements purposely start small to allow the State to execute an agile approach to procurement and delivery successfully before increasing project complexity. Development and implementation of these initiatives will continue over several years. The SFY 2019 procurement cycle will be focused on repairing and/or replacing legacy infrastructure. Moving into the SFY 2020 plan, we will focus on the operational and technical changes impacting the staff experience. The focus on 2021 and beyond will be on technological and operational optimization.

Throughout this transformation, DVHA recognizes that effective collaboration and coordination needs to exist across State stakeholders and the federal government and is critical to our success. DVHA has implemented formal steering committees that include representatives from the business, Economic Services Division (ESD) and DVHA, finance, legal, policy, and Agency of Digital Services (ADS). We have completed a three month "Plan the Business" effort to prioritize programs for inclusion in the development roadmap. We have also brought in specialized expertise to assist us in implementing a modular, agile procurement strategy. Evaluating performance constantly and consistently through results-based accountability and key performance indicators (KPIs), a core tenet of the agile development process, will empower DVHA to measure success and adapt as needed.

DVHA will continue to focus on operational improvements. DVHA now uses scorecards to determine what drives success in our business and measure performance in these functions over time.

The SFY 2019 budget request benefitted from increased collaboration and financial transparency in all areas of Medicaid. DVHA strives to continue to improve in order to provide and empower the State of Vermont with more predictable Medicaid budgeting and forecasting, and to constantly reach for better health outcomes for Vermonters.



# CHAPTER TWO: MEMBER EXPERIENCE


## OUTREACH AND EDUCATION

DVHA's Health Access Eligibility and Enrollment Unit (HAEEU) serves as the doorway for Vermonters to access the Department's programs and services. HAEEU's Outreach and Education team has two broad audiences:

- Vermonters who need health coverage,
- Members who are already enrolled in one of DVHA's health plans.

## Connecting with Vermonters who need health coverage

DVHA connects with community partners, including hospitals, clinics, agricultural organizations, libraries, pharmacies, and other stakeholders to participate in public events and conduct targeted outreach. Outreach seeks to help Vermonters understand health insurance terms and how to interact with the state's health insurance marketplace, Vermont Health Connect (VHC). Targeted outreach focuses on groups of Vermonters likely to lack access to health insurance, including farmers, justice-involved individuals, new Vermont residents, and those in the 26-34 age group.

- Vermont's uninsured rate fell to 2.7% in 2015.[1]
- Vermont cut its 18-64 uninsured rate by more than half from 2014 to 2015. [1]
- Vermont achieved the second lowest uninsured rate in the nation after Massachusetts. [1]
- Vermont had the lowest childhood rate in the nation. [2]
- Vermont had a less than 2% uninsured rate for children in all income brackets. [2]

[1] National Center for Health Statistics
[2] State Health Access Data Assistance Center

National studies point to Vermont's success in enrolling its citizens and improving health access. The most recent estimate of Vermont's uninsured rate fell to 2.7% in 2015. Vermont cut its 18-64-year-old uninsured rate by more than half from 2014 to 2015 and achieved the second lowest uninsured rate in the nation (after Massachusetts). Additionally, Vermont has the lowest childhood uninsured rate in the nation, and the state has made major gains, especially in terms of insuring low-income and middle-income children. A family's income no longer determines whether a child is covered in Vermont, as low, middle, and high-income children all have less than a two percent uninsured rate.

Vermont ranked first in the nation in terms of health access and affordability in SFY 2017.[3]

[3] Commonwealth Fund

Vermont continues to chip away at the remaining uninsured population. DVHA's public communication sought to ensure that young people and other Vermonters were aware of the increased federal fee for not having health insurance under the Affordable Care Act. Social media and other outreach focused on the fact that most uninsured Vermonters would qualify for enough financial help that it would be cheaper to buy a health insurance plan than to go uninsured and pay the federal fee. At the time of the last Vermont Household Health Insurance Survey in 2014, young people were more than twice as likely as any other age group to be uninsured. This group is now enrolling in health coverage at a much higher rate. In 2017, one in four (25%) new enrollees in a QHP through VHC were in the 26-34 age group, compared to just one in eight (12%) renewing QHP members.

### Helping members maintain the best coverage for their needs and budget

HAEEU's outreach with existing members focuses on helping them get the most out of their health plans, reminding them to respond to Medicaid renewal notices, and offering information.

- In 2014, people between the ages of 26-34 were more than twice as likely to be uninsured than any other age group. [4]
- In 2017, one in four (25%) new enrollees in a Qualified Health Plan (QHP) through VHC were in this age group, compared to the one in eight (12%) renewing members.
- Federal changes to individual mandates may increase the uninsured rate for this population.

[4]Vermont Household Health Insurance Survey

In SFY 2017, DVHA offered "Health Insurance 101" events and webinars. These events were promoted to existing members, and largely focused on VHC's online Plan Comparison Tool. The Tool is a resource for helping Vermonters better understand their subsidies and assess how various plan designs and out-of-pocket costs could impact their total health care costs. The Tool was created by the non-profit Consumers' Checkbook and was named the nation's best plan selection tool by the Robert Wood Johnson Foundation[5]. The tool was used nearly 60,000 times in SFY 2017 and was lauded as a key resource for QHP members, especially those transitioning out of Medicaid, or those new to healthcare plan comparison.

[5] https://www.rwjf.org/en/library/articles-and-news/2015/03/apps-to-use-when-shopping-for-health-insurance-win-national-comp.html

## ELIGIBILITY

Once Vermonters decide that they want to apply for health coverage, they can take one of three possible paths to enrollment: 1) they can apply online at VermontHealthConnect.gov, 2) they can call the Customer Support Center and apply by phone, or 3) they can meet with an Assister who will help them fill out the application in-person.

Regardless of the path the applicant takes, DVHA aims to promptly process the application and verify information so that they can be enrolled in appropriate programs. This section covers:

- Applying Online
- Applying by Phone
- Applying with an In-person Assister
- Application Processing and Verification

| How to Apply | |
|---|---|
| Online | http://info.healthconnect.vermont.gov/ |
| By Phone | 1-855-899-9600 (Toll Free) |
| Find an In-Person Assister | http://info.healthconnect.vermont.gov/ |

Vermonters on Medicare because of age (65 or older), blindness, or a disability must fill out a paper application, but can access help doing so through the Customer Support Center or through local help.

### Applying Online

The percentage of Vermonters applying for coverage online more than doubled in SFY 2017, increasing from 16% of VHC applications in June 2016 to 37% in June 2017. The online option has the potential for an improved customer experience as Vermonters can log in at their convenience. It can also save the State money through automation. The goal is for a continual increase in self-service adoption at a rate of at least 10% growth year-over-year.

Vermonters applying for coverage online jumped from 16% in June 2016 to 37% in June 2017.

The goal is for a continual increase in self-service adoption at a rate of at least 10% growth year-over-year.

### Applying by Phone

In SFY 2017, the experience for callers to VHC's Customer Support Center was initially difficult but finished strong. After difficulty handling call volume related to Medicaid renewals in the summer of 2016, the State worked with its contractor Maximus to ensure adequate staffing through an overflow call center. As a result, the Customer Support Center exceeded performance targets in eight of the last nine months of the fiscal year. DVHA aims to continue this performance.

### In-Person Assisters

The In-Person Assister (IPA) Program serves as a cornerstone of DVHA's five-year effort to help Vermonters understand and enroll in the health coverage that best meets their families' needs and budget. The program fosters collaboration between the State's health insurance marketplace and community organizations, helping Vermont dramatically reduce its uninsured rate. Paired with the Customer Support Center and online tools, the IPA Program provides an additional option of support to Vermonters who may have encountered barriers to enrollment in healthcare coverage.

Due to both financial constraints and growing recognition of the far-reaching value of in-person assistance, the IPA Program has changed significantly over the course of its existence. In SFY 2014

and SFY 2015, it consisted primarily of grant-funded Navigators who helped tens of thousands of Vermonters enroll in Vermont Health Connect for the first time. By SFY 2016, Federal funding ended, and the program consisted of a combination of State-funded Navigators and community partner-funded Certified Application Counselors (CAC), who serve the clients of their provider or organization. These organizations benefit from ensuring that their members have health coverage and can pay for services.

*50% increase in Assisters since SFY 2015.*

By the end of SFY 2017, the IPA program was stronger than ever, featuring more than 150 CAC and Navigators throughout Vermont. With an increase of over 50% more Assisters than two years earlier, the IPA Program is well-positioned to serve Vermonters who experience the greatest barriers to coverage. In addition, collaboration with other healthcare stakeholders will provide an array of options for those seeking assistance. DVHA-HAEEU worked with DCF-ESD to develop a back-up option for MABD applicants who wanted in-person assistance. In addition, the Area Agencies on Aging (AAA) and Senior Health Insurance Program (SHIP) offices continue to assist Vermonters who are submitting paper applications, or who may need assistance with Medicare.

### Assistant Operations Unit

The Assistant Operations unit (AOPS) is responsible for the creation and maintenance of Standard Operating Procedures for Health Care Eligibility and Enrollment and serves as the primary link between policy and operations. Staff are subject matter experts for health care project/development initiatives and ensure that technical design meets policy specifications. The unit also provides day to day support for operations by aiding in the resolution of escalated cases and providing subject matter expertise to the training department.

## ENROLLMENT INTEGRATION AND RECONCILIATION

DVHA's eligibility system is the system of record for QHP and dental plan enrollment, while the insurance carriers' systems (along with DVHA's MMIS on the Medicaid side) ensure that providers and pharmacies can see coverage and bill for services. In order to deliver a smooth customer experience, changes that are made to customers' accounts must promptly be integrated across all the applicable systems and errors that occur must be resolved in a timely manner.

DVHA has made significant progress improving performance, processing requests in an increasingly timely manner, and resolving errors for customers. By the end of SFY 2017 errors had fallen 80% from March 2016 levels. Integration errors were also cut 80%.

### Enrollment Integration

For calendar year 2017, DVHA-HAEEU set a primary goal of having less than one-tenth of one percent of cases sit in error status between the VHC and carrier systems for more than ten days. With more than 31,000 subscriber cases across all three carriers, that goal would leave 31 or fewer error statuses open beyond ten days. The idea behind this goal was that while error rate and total error inventories are important, the length of time that errors are open is a more accurate indicator of potential member impact.

DVHA-HAEEU 2017 GOAL

Have less than .10% of cases remain in error status for more than 10 days.

At the end of SFY 2017, there were no cases in error status over 10 days.

After just missing the target in February and March 2017, DVHA-HAEEU exceeded the primary goal in each of the last three months of SFY 2017. At the end of SFY 2016, 185 cases were in error status for over 10 days. At the end of SFY 2017, not a single case was in error status for over 10 days.

DVHA-HAEEU also set six secondary goals related to the error rates, the overall number of open errors, and the length of time it takes cases to be confirmed across systems. As of the end of SFY 2017, DVHA-HAEEU was meeting all six secondary targets.

### Enrollment Reconciliation

The ability to perform ongoing monthly reconciliation between DVHA's eligibility system and those of the three insurance carriers is essential to maintaining data integrity, ensuring a positive customer experience, and limiting financial liabilities. If discrepancies can be identified and the vast majority of those discrepancies addressed within the month, DVHA-HAEEU will be in a strong position to avoid the various issues caused by cases left in error status.

Effective January 2017, DVHA and the three insurance carriers established a new process for conducting monthly reconciliation and set a primary goal of addressing at least 90% of those discrepancies within the month. The reconciliation team met this goal in each of the following months in SFY 2017 and successfully completed work on 100% of the June 2017 discrepancies within 30 days.

DVHA also utilized control reports and an ongoing reconciliation process to resolve discrepancies between VHC's case management system and the legacy ACCESS system.

## MEMBER ACCOUNT MAINTENANCE

Once Vermonters are enrolled in benefit programs, DVHA-HAEEU aims to ensure both that they have the opportunity to get the maximum health benefits available to them and that they adhere to program rules. Members are required to promptly report changes to their household or income so that DVHA-HAEEU can determine whether they still qualify for the same benefits. Medicaid

members are required to report changes within ten days, while QHP members have 30 days to report. In addition to these ongoing changes, most benefit programs require members to go through an annual redetermination process. This process for QHP members takes place during VHC Open Enrollment, which in SFY 2017 ran from November 1, 2016 through January 31, 2017. Redetermination for Medicaid benefits is on a rolling basis throughout the year, twelve months after a household's prior renewal.

This section will provide greater detail on:

- Enrollment in PC Plus
- Ongoing Changes
- Medicaid Renewals
- QHP Renewals

## Enrollment in Primary Care

Having a health insurance card doesn't necessarily produce better health outcomes. Connecting with a primary care provider is a key step in the right direction. DVHA's Customer Support Center, managed by Maximus, provides enrollment functions for the State's primary care case management program for Medicaid members, Primary Care Plus (PC Plus). These functions include: outreach to eligible enrollees identified by the State, entering enrollments received via phone or mail, sending enrollment reminder and confirmation notices, and providing unbiased information to educate members of their enrollment options and program benefits. In addition, the Customer Support Center solicits the choice of a dental provider for PC Plus enrollees between age one and seventeen.

Enrollment forms that contain complete and accurate information are entered into the State's enrollment system within two business days of receipt. When the form received is incomplete, the Customer Support Center calls members to obtain the missing information. If they are unable to reach the consumer by telephone, the original enrollment form is mailed to the member along with a detailed description of the additional information required to complete the transaction. In SFY 2017, the Customer Support Center mailed more than 72,000 PC Plus enrollment notices and more than 43,000 handbooks.

## Ongoing Changes

In a typical month, DVHA-HAEEU receives more than 10,000 member requests, over half of which involve reported changes. Most of these requests are made by phone to the Customer Support Center.

DVHA-HAEEU receives more than 10,000 member requests per month.

All Vermonters who are served by DVHA-HAEEU should expect that their requests will be addressed promptly. However, during the first few years of VHC, many requests took several weeks or months to complete. In the first quarter of 2016, fewer than 60% of requests were completed within

ten business days. For SFY 2017, HAEEU set a goal of completing 75% of customer requests within ten business days by October 2016 and 85% by June 2017.

The improvements described in the Integration section above had a major impact on the ability of DVHA-HAEEU staff to promptly process changes. The results were clearly visible by early SFY 2017. In October 2016, HAEEU surpassed its June 2017 goal of completing 85% of member requests within ten days. Over the following months, performance continued to improve. With the 2017 QHP Open Enrollment and Renewal Period's successful completion, system integration improved over prior years and errors fell. As a result, customer requests were promptly completed on a more consistent basis.

DVHA-HAEEU SFY 2017 Goal:

Complete 75% of customer requests within 10 business days by October 2016 and 85% by June 2017.

The second week of March 2017 marked the first time that 95% of VHC requests were completed in ten days. Every subsequent week through the end of SFY 2017 surpassed that mark. Green Mountain Care (GMC) requests through the State's legacy ACCESS system didn't have the same level of consistently strong performance as VHC requests, yet the combined average for each of the last three months of SFY 2017 was at least 95%.

Early in SFY 2017, DVHA opened self-service functionality on the VHC system; allowing Vermonters to report changes online, as well as, pay bills, access tax documents, and other actions. Self-service can lead to an improved customer experience as Vermonters are able to log in at their convenience. It also has the potential to save the State money through automation. As of June 2017, three percent of change requests – far behind the number of initial applications (37%) – are submitted online. Stated in another way, making changes on the web lags behind the use of the web for submitting initial applications. DVHA-HAEEU has set a goal for a continual increase in self-service adoption at a rate of at least 10% growth year-over-year. DVHA-HAEEU promotes the self-service option using bill stuffers, call center staff and partner organizations, and social media.

In October 2016, HAEEU surpassed the June 2017 goal and continued to improve in the following months reaching 95% for the first time in March 2017.

Members who receive MABD and other non-MAGI benefit programs are served by the State's legacy ACCESS system and are unable to utilize self-service options at this time.

### Medicaid Renewals

Annual Medicaid redeterminations are an important piece of DVHA's work that were put on hold in 2014 due to the system and resource challenges associated with the implementation of the Affordable Care Act (ACA) and Vermont's Health Insurance Marketplace. Redeterminations for MABD beneficiaries re-started in late 2015, utilizing the State's legacy case management system, ACCESS.

Medicaid for Children & Adults (MCA) redeterminations re-started in January 2016 and initially focused on verifying and transitioning members who were still in ACCESS into the new system to be joined with members who had applied through VHC. DVHA then focused on renewing Medicaid members who were already in the VHC system.

In spring 2017, after all groups had completed their first annual redetermination cycle, DVHA deployed functionality that increased the number of MCA members who could be passively renewed – meaning the member's eligibility could be verified and their coverage renewed without any action on their part. More than two-thirds (68%) of MCA members in the last batch of SFY 2017 were able to be renewed in this manner, resulting in less burden on Vermonters, lower paper and mailing costs, and less processing work for DVHA-HAEEU staff. DVHA-HAEEU helped achieve the high success rate by prescreening relevant cases, identifying potential data issues, and working to clean the data in the weeks prior to the renewal.

DVHA-HAEEU promptly processed the remaining incoming applications, ending SFY 2017 with fewer than 150 open MCA applications (five that were older than 45 days) and fewer than 300 open MABD applications (none older than 45 days).

### QHP Renewals

DVHA kicks off a series of preparatory meetings at the beginning of every summer for the coming Open Enrollment with its insurance carrier partners and the Health Care Advocate to prepare for system testing, business, and transactional planning activities. QHP renewals have presented major challenges for VHC in past years, including the 2016 Open Enrollment which was the first year with automated renewal functionality and was complicated by a significant contractor going out of business at the start of Open Enrollment. In SFY 2017, the State of Vermont and its partners successfully completed three major steps on, or ahead of, schedule to ensure a successful 2017 renewal effort.

The first step in the renewal effort involves determining eligibility for the coming year's State and Federal subsidies and enrolling members in new comparable versions of their health and/or dental plans. In SFY 2017, this step was operated with a single, clean automated run that took care of 91.5% of eligible cases. The remaining cases were processed the same week using the staff renewal form; allowing all members to have updated accounts and 2017 information prior to the start of Open Enrollment. This meant that they could log onto their online accounts on the first day of Open Enrollment, see their benefits and net premiums for the coming year, and select a new plan if they wanted to do so. They could call the Customer Support Center or meet with an In-Person Assister and go through the same steps if they didn't want or were unable to use the online option.

In SFY 2017, 91.5% of eligible renewals were handled through a single, clean automated process.

The second step involves sending these files to the payment and premium processor, Wex Health, and the insurance carriers to ensure appropriate billing and effectuation. In SFY 2017, this initial

integration run was completed with 99% accuracy in mid-November. DVHA and its partners collaborated to clean up and re-send the remaining cases well in advance of the new year.

The third step consists of a year-end business process that allows changes to be made on cases, if the member reports changes in household or income information. In SFY 2017 this process ran with a 100% success rate, meaning all cases were ready to accept change requests starting on January 1st.

Altogether, performance on these three steps made the 2017 QHP renewal experience markedly different than the prior year -- when the renewal process was not complete until the end of March – and left DVHA staff both optimistic and well-positioned to tackle other challenges.

## COVERAGE, BENEFITS, AND PREMIUMS

Vermont Health Connect (VHC) is Vermont's health insurance marketplace, created because 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, 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 MCA or private health insurance with financial help, such as Federal Advanced Premium Tax Credits (APTC), 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.

### Vermont Medicaid Programs

Medicaid programs provide low-cost or free coverage for low-income parents, children, 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 health care services such as doctor's visits, hospital care, prescription medications, vision care, 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.

Vermont provides prescription assistance programs to help Vermonters pay for prescription medications 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.

Vermont Pharmacy Program (VPharm) assists Vermonters enrolled in Medicare Part D with paying for prescription medications. Those eligible include people age 65 and older, and Vermonters of all ages with disabilities with household incomes up to 225% Federal Poverty Level (FPL).

Healthy Vermonters provides a discount on prescription medications 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.

Individuals with household income over 138% of FPL can choose to 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 Vermont Health Access Plan (VHAP) and Catamount. The State of Vermont further subsidizes premiums and cost sharing for enrollees whose income is < 300% of FPL to address this affordability challenge.

Income calculation are based on Gross Monthly Income minus deductions. The following programs are determined using Modified Adjusted Gross Income (MAGI): QHP, APTC, CSR, MCA, VPA, and VCSR. The following table provides the January 2018 FPL information as an example of household income levels.

**2018 Federal Poverty Levels (FPLs)**

Monthly

| Household Size | 100% | 133% | 138% | 150% | 200% | 225% | 250% | 275% | 300% | 400% |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | $1,012 | $1,346 | $1,396 | $1,518 | $2,023 | $2,276 | $2,529 | $2,782 | $3,035 | $4,047 |
| 2 | $1,372 | $1,824 | $1,893 | $2,058 | $2,743 | $3,086 | $3,429 | $3,772 | $4,115 | $5,487 |
| 3 | $1,732 | $2,303 | $2,390 | $2,598 | $3,463 | $3,896 | $4,329 | $4,762 | $5,195 | $6,927 |
| 4 | $2,092 | $2,782 | $2,887 | $3,138 | $4,183 | $4,706 | $5,229 | $5,752 | $6,275 | $8,367 |
| 5 | $2,452 | $3,261 | $3,383 | $3,678 | $4,903 | $5,516 | $6,129 | $6,742 | $7,355 | $9,807 |
| 6 | $2,812 | $3,740 | $3,880 | $4,218 | $5,623 | $6,326 | $7,029 | $7,732 | $8,435 | $11,247 |
| 7 | $3,172 | $4,218 | $4,377 | $4,758 | $6,343 | $7,136 | $7,929 | $8,722 | $9,515 | $12,687 |
| 8 | $3,532 | $4,697 | $4,874 | $5,298 | $7,063 | $7,946 | $8,829 | $9,712 | $10,595 | $14,127 |

Annually

| Household Size | 100% | 133% | 138% | 150% | 200% | 225% | 250% | 275% | 300% | 400% |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | $12,140 | $16,146 | $16,753 | $18,210 | $24,280 | $27,315 | $30,350 | $33,385 | $36,420 | $48,560 |
| 2 | $16,460 | $21,892 | $22,715 | $24,690 | $32,920 | $37,035 | $41,150 | $45,265 | $49,380 | $65,840 |
| 3 | $20,780 | $27,637 | $28,676 | $31,170 | $41,560 | $46,755 | $51,950 | $57,145 | $62,340 | $83,120 |
| 4 | $25,100 | $33,383 | $34,638 | $37,650 | $50,200 | $56,475 | $62,750 | $69,025 | $75,300 | $100,400 |
| 5 | $29,420 | $39,129 | $40,600 | $44,130 | $58,840 | $66,195 | $73,550 | $80,905 | $88,260 | $117,680 |
| 6 | $33,740 | $44,874 | $46,561 | $50,610 | $67,480 | $75,915 | $84,350 | $92,785 | $101,220 | $134,960 |
| 7 | $38,060 | $50,620 | $52,523 | $57,090 | $76,120 | $85,635 | $95,150 | $104,665 | $114,180 | $152,240 |
| 8 | $42,380 | $56,365 | $58,484 | $63,570 | $84,760 | $95,355 | $105,950 | $116,545 | $127,140 | $169,520 |

https://www.gpo.gov/fdsys/pkg/FR-2018-01-18/pdf/2018-00814.pdf

## Medicaid Mandatory/Optional Services

States are required to cover mandatory specific services and may opt to cover additional optional services. In general, benefits must be equivalent in amount, duration, and scope for all members. The covered services must be uniform across the state and members must have freedom of choice among health care providers participating in Medicaid.

Children under age 21 are covered under the Early, Periodic, Screening, Diagnostic, and Treatment (EPSDT) benefit. This requires states to provide all services described in the Medicaid statute necessary for physical or mental conditions found by a screening, regardless of whether that treatment is part of the state's traditional Medicaid benefit package. This includes treatment for any vision and hearing problems, as well as eyeglasses and hearing aids. In addition, regular preventive dental care and treatment to relieve pain and infections, restore teeth, and maintain dental health, as well as some orthodontia, is covered.

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

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. The following table depicts the differences across states on providing optional services to their Medicaid populations.[6]

[6] http://kff.org/health-reform/issue-brief/medicaid-moving-forward/

| 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 N/A* | No |
| Tuberculosis (TB) Related Services | No | No | No | No | No | *Data N/A* | Yes |
| Health Homes for Enrollees with Chronic Conditions – Nursing services, Home health aides and medical supplies/equipment | Yes | No | No | Yes | No | Yes | Yes |

## Premiums and Co-Pays

States can impose copayments most Medicaid-covered benefits, both inpatient and outpatient services and States can assess premium requirements for eligibility.

Co-pays cannot be imposed for emergency services, family planning services, pregnancy-related services, or preventive services for children. Because Medicaid covers particularly low-income and often very sick patients, services cannot be withheld for failure to pay, but members may be held liable for unpaid copayments. The total cost sharing (out-of-pocket) cost may not be exceed 5 percent of the family's household income.

If a Vermonter is determined eligible for a program that has a monthly premium, they pay that premium to effectuate coverage and must continue to pay their bill on a timely basis to maintain their benefits. DVHA-HAEEU's enrollment team monitors the integrity, accuracy, and timeliness of transactions between the VHC case management system, our billing system with Wex Health, as well as the Medicaid ACCESS and private insurance carriers' systems. The team works closely with Wex, the systems integrator Optum, the DVHA Business Office, and each of the insurance carriers, to ensure sound performance in both system integration and reconciliation.

The table below illustrates the benefit programs and any cost sharing requirements that may exist.

| Program | Who is Eligible? | Benefits & Cost Sharing |
|---|---|---|
| **MABD Medicaid** | Age ≥ 65, blind, disabled<br>At or below the PIL<br>Resource limits:<br>Individual: $2000<br>Couple: $3000 | • Physical and mental health<br>• Chiropractic (limited)<br>• Transportation (limited)<br>• Dental ($510 cap/yr, no dentures)<br>• Prescriptions<br>• $1/$2/$3 prescription co-pay if no Medicare Part D coverage<br>• $3.35-$8.35 co-pays with Medicare Part D coverage<br>• $3 dental co-pay<br>• $3 outpatient hospital visit co-pay (over 21 yrs of age) |
| **Katie Beckett Medicaid** | Up to age 19<br>Only disabled child's income/resources used to meet MABD limits | No monthly premium<br>No co-pays<br>Same benefits as Dr. Dynasaur |
| **Medicaid Working Disabled** | ≤ 250% FPL<br>Meet working criteria<br>Resource Limits:<br>Individual: $10,000<br>Couple: $15,000 | • Physical and mental health<br>• Chiropractic (limited)<br>• Transportation (limited)<br>• Dental ($510 cap/yr, no dentures)<br>• Prescriptions<br>• $1/$2/$3 prescription co-pay if no Medicare Part D coverage<br>• $3.35-$8.35 co-pays with Medicare Part D coverage<br>• $3 dental co-pay<br>• $3 outpatient hospital visit co-pay (over 21 yrs of age) |
| **MCA (Expanded Medicaid – New Adults)** | ≤ 138% of FPL<br>Not eligible for Medicare<br>And either: Parent or caretaker relative of a dependent child;<br>or ≥ 21 years of age, ≤ 65 years of age | • Physical and mental health<br>• Chiropractic (limited)<br>• Transportation (limited)<br>• Dental ($510 cap/yr, no dentures)<br>• Prescriptions<br>• $1/$2/$3 prescription co-pay if no Medicare Part D coverage<br>• $3.35-$8.35 co-pays with Medicare Part D coverage<br>• $3 dental co-pay<br>• $3 outpatient hospital visit co-pay (over 21 yrs of age) |

| | | |
|---|---|---|
| **Dr. Dynasaur** | Children under age 19 at or below 317% FPL<br><br>Pregnant persons at or below 213% FPL | • Same as Medicaid plus:<br>o Eyeglasses<br>o Full Dental Benefits<br>• Up to 195% FPL: no premium<br>• Up to 237% FPL: $15/family/month<br>• Up to 317% FPL: $20/family/month, ($60/family/mo. w/out other insurance)<br>• No co-pays<br>• No co-pays for pregnant or post-partum persons, or persons in LTC facility |
| **VPharm1, 2, & 3** | Eligible and enrolled in Medicare PDP or MAPD<br>VPharm1:<br>≤ 150% FPL<br>Must apply for LIS<br>VPharm2:<br>150.01% - 175% FPL<br>VPharm3:<br>175.01% - 225% FPL | • VPharm1 (after primary LIS reductions):<br>o Medicare Part D cost-sharing<br>o Excluded classes of Part D meds<br>o Diabetic supplies<br>o Eye exams<br>• VPharm 2&3:<br>o Maintenance meds<br>o Diabetic supplies<br>• Monthly premium per person:<br>o VPharm1: $15<br>o VPharm2: $20<br>o VPharm3: $50<br>• $1/$2 prescription co-pays<br>• No retroactive payments |
| **Medicare Savings Programs** | ≥ age 65, blind, or disabled<br>Active Medicare beneficiaries<br>QMB: ≤ 100% FPL<br>SLMB 100.01 - 120% FPL<br>QI-1 120.01 - 135% FPL<br>QI-1 Not eligible for Medicaid | • QMB covers Medicare Part B (and A if not free) premiums; Medicare A & B cost-sharing<br>• SLMB and QI-1 cover Medicare Part B premiums only<br>• No monthly premium<br>• QMB may still have to pay Medicare co-pay, and not eligible for retroactive payments<br>• 3 months retroactive payments are possible for SLMB and QI-1 |
| **Healthy Vermonters Program** | 350% FPL if uninsured<br>400% FPL if ≥ age 65, blind, or disabled | • Medicaid prescription pricing<br>• If enrolled in Medicare Part D, excluded classes of prescriptions are priced at Medicaid rate<br>• No monthly premium<br>• No retroactive payments |
| **Qualified Health Plan (QHP)** | Vermont Residents who do not have Medicare | • Choice of Eligible QHPs on (VHC)<br>• Full QHP cost sharing unless reduced by tax credits, or employer share |
| **Federal Advance Premium Tax Credits (APTC)** | 100-400% FPL<br>No Medicaid<br>Enrolled in any level (Bronze, Silver, Gold) QHP | • Tax credit received yearly as a lump sum, or monthly toward QHP premium<br>• Full QHP cost sharing minus tax credit |

| | | |
|---|---|---|
| **Federal Cost-Sharing Reduction (CSR)** | ≤ 250% FPL<br>No affordable Minimum Essential Coverage (MEC)<br>Meets APTC<br>Enrolled in Silver Plan QHP | • Reduces co-pays, co-insurance, deductibles, etc.<br>• Full QHP cost sharing with reduction in co-pays, co-insurance, deductibles, etc. |
| **Vermont Premium Assistance (VPA)** | ≤ 300% FPL<br>No affordable MEC<br>Meets APTC | • Covers all or part of QHP premium<br>• Covers all or part of QHP premium |
| **Vermont Cost Sharing Reductions (VCSR)** | 200-300% FPL<br>Enrolled in Silver Plan QHP | • Reduces co-pays, co-insurance, deductibles, etc.<br>• Full QHP cost sharing with reduction in co-pays, co-insurance, deductibles, etc. |

## LONG TERM CARE

Vermont's Long-Term Care (LTC) Medicaid Program includes Choices for Care (CFC), Developmental Disability Services (DDS), Developmental Disability Home and Community Based Services (DD HCBS), Traumatic Brain Injury (TBI), and Enhanced Family Treatment (EFT); which is for children with mental illness. Vermont's LTC staff assist eligible Vermonters with accessing services in their chosen setting. This could be in the client's home, an approved residential care home, assisted living facility, or an approved nursing home. In calendar year 2017, there were 2,571 LTC applications processed by DVHA LTC staff.

There are two parts to determining Vermont LTC eligibility:

1) Most clinical eligibility is performed by the Department of Disabilities, Aging and Independent Living (DAIL); and
2) Financial eligibility is performed by the workers in the Department for Vermont Health Access (DVHA).

The LTC application is usually submitted to DVHA and a copy is forwarded to DAIL for the CFC clinical assessment. DD HCBS, TBI, and EFT have the clinical assessment completed prior to applying for LTC Medicaid. Upon receipt of the LTC application, DVHA workers begin the financial eligibility determination process. Many applicants have complex financial histories and have hired elder law attorneys to assist them with planning and sheltering their assets. The more complicated applications take a significant amount of staff time to analyze before making a final financial eligibility determination.

DVHA-LTC workers must evaluate income and resources, as well as review financial statements for a five year "Look Back" period. Transfers made within the 60 months prior to the month of application must be carefully reviewed to determine if a penalty period must be applied. There are complicated rules which address client assets and what types of transfers are allowed.

DVHA-LTC financial eligibility processing times improved in calendar year 2017. DVHA-LTC reduced application processing times from an average of 55 days for the first six months of 2017, down to an average of 51 days for the last six months of 2017. After adjusting the average processing

times for delays related to client extensions and clinical placements, DVHA-LTC processing times were reduced from an average of 47 days for the first six months of 2017, down to an average of 33 days for the last six months of 2017.

The DVHA-LTC staff work closely with clients, families, nursing facilities, case managers, and authorized representatives to ensure eligible Vermonters can access needed LTC services in a timely manner. One of the challenges for the LTC program is the client's ability to gather and submit verification documents in a timely manner. DVHA-LTC works collaboratively with applicants who are trying to provide needed documentation while also ensuring applications are processed within the 45-day Federal timeliness standard. Unlike many other states, Vermont does not deny applicants who are trying to provide verification documents but cannot do so within the initial verification period. Instead of denying those applications, Vermont LTC gives cooperating applicants additional verification deadlines and extensions of time for extenuating circumstances.

The LTC program monitors cases to help ensure that cases only age beyond the 45-day Federal timeliness standard because of delays beyond the control of the LTC worker (e.g., client needs additional time to provide verification documents). Federal audit rules allow exceptions to the timeliness standard in those cases.

In January 2018, Vermont Medicaid is launching the new CMS-mandated electronic asset verification system (eAVS). DVHA expects eAVS will provide electronic verification of many of the applicant's financial accounts. However, based on the experiences of other states who are using eAVS, Vermont recognizes that eAVS will not eliminate the need for some clients to provide paper verification documents. DVHA has made the time to process these applications a Key Performance Indicator (KPI).

## CASELOAD AND UTILIZATION

Green Mountain Care is the branded name of the state-sponsored low-cost and free health coverage programs available to uninsured Vermonters. The Green Mountain Care programs offer access to quality, comprehensive healthcare coverage with limited cost sharing.

This section will provide caseload, utilization, and expenditure trends as well as SFY 2019 projections for these different programs.


### Redetermination Impact to Caseload

The State was unable to re-determine eligibility beginning in April of 2014. In accordance with a CMS waiver and mitigation plan, DVHA is now on regular cycles of re-determinations.

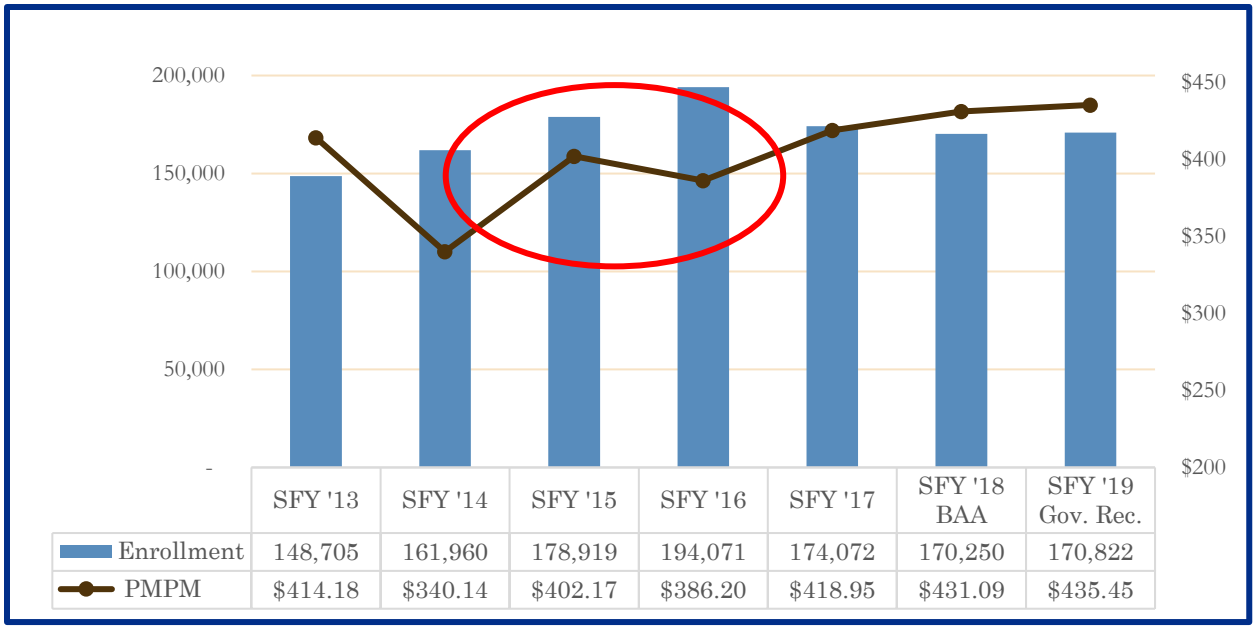
- Medicaid for the Aged, Blind, and Disabled (MABD) renewals restarted in October 2015 with the first annual cycle completed in October 2016 and the population has since been on a regular cycle of re-determinations.

- Medicaid for Children and Adults (MCA) renewals re-started in January 2016 with the first annual cycle completed in January 2017, and the population has since been on a regular cycle of redeterminations.

Resuming redeterminations led to drops in each of our eligibility groups caseload counts. DVHA also found an increase in the number of retroactive eligibility segments as there is an opportunity for 90 days retroactive coverage which means those responding within three months can avoid a gap in coverage. Additional eligibility responses trickled in throughout the year, often when members needed to use coverage. This contributed to uncertainty in the caseload forecast process. In addition, the PMPMs were artificially held down when caseload was at its peak. The reason for this was that there were people eligible for Medicaid that no longer needed the benefit, and analysis of spending trends finds that new applicants tend to be more medically needy and, thus, costlier than people who have had coverage for more than four continuous months.

The following graph illustrates the enrollment trend for full benefit members and the corresponding PMPMs for the period before the implementation of the Affordable Care Act and after the completion of the redetermination. Full benefit members include ABD Adults, Dual Eligibles, General Adults, New Adults, Children's Medicaid and CHIP, Choices for Care (CFC), and the refugee population. In SFY 2013 and 2014 the VHAP population is also counted.

**Enrollment and PMPM Impacts for Full Benefit Enrollees including Dual Eligibles**




| | SFY '13 | SFY '14 | SFY '15 | SFY '16 | SFY '17 | SFY '18 BAA | SFY '19 Gov. Rec. |
|---|---|---|---|---|---|---|---|
| Enrollment | 148,705 | 161,960 | 178,919 | 194,071 | 174,072 | 170,250 | 170,822 |
| PMPM | $414.18 | $340.14 | $402.17 | $386.20 | $418.95 | $431.09 | $435.45 |

Certain eligibility groups were more impacted by the re-determinations such as the ABD Adult and the BD children groups. Changes made to eligibility standards (increased federal poverty level) allow Vermonters to qualify for Medicaid without the additional effort of qualifying under the Aged, Blind, Disabled rules.

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

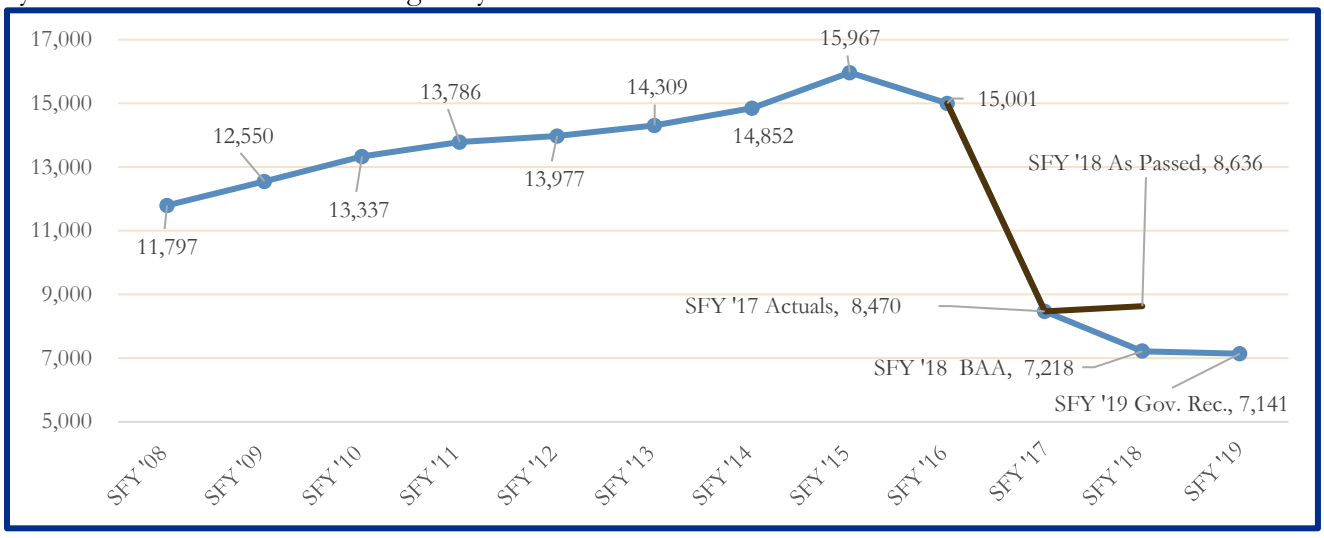
The eligibility requirements for the aged, blind, or disabled (ABD) and/or Medically Needy Adults are: age 19 and older; determined ABD but ineligible for Medicare; generally includes Supplemental Security Income (SSI) cash assistance recipients, working disabled, hospice patients, Breast and Cervical Cancer Treatment (BCCT) participants, or Medicaid/Qualified Medicare Beneficiaries (QMB); and medically needy (i.e., eligible because their income is greater than the cash assistance level but less than the protected income level (PIL). Medically needy adults may be ABD or the parents/caretaker relatives of minor children. The following table illustrates the caseload and expenditure actual and estimated information.

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

| Aged, Blind, & Disabled (ABD) and/or Medically Needy Adults | | | | | |
|---|---|---|---|---|---|
| | | DVHA Only | | All AHS and AOE | |
| SFY | Caseload | Expenditures | PMPM | Expenditures | PMPM |
| SFY 2015 Actual | 15,967 | $ 102,508,327 | $ 535.01 | $ 185,718,082 | $ 969.31 |
| SFY 2016 Actual | 15,001 | $ 99,308,972 | $ 551.69 | $ 182,970,086 | $ 1,016.46 |
| SFY 2017 Actual | 8,470 | $ 68,865,433 | $ 677.58 | $ 150,586,971 | $ 1,481.66 |
| SFY 2018 As Passed | 8,636 | $ 73,762,355 | $ 711.73 | $ 166,989,598 | $ 1,611.29 |
| SFY 2018 BAA | 7,218 | $ 65,698,848 | $ 758.46 | $ 154,861,622 | $ 1,787.81 |
| SFY 2019 Gov. Rec. | 7,141 | $ 65,601,177 | $ 765.55 | $ 157,939,052 | $ 1,843.10 |

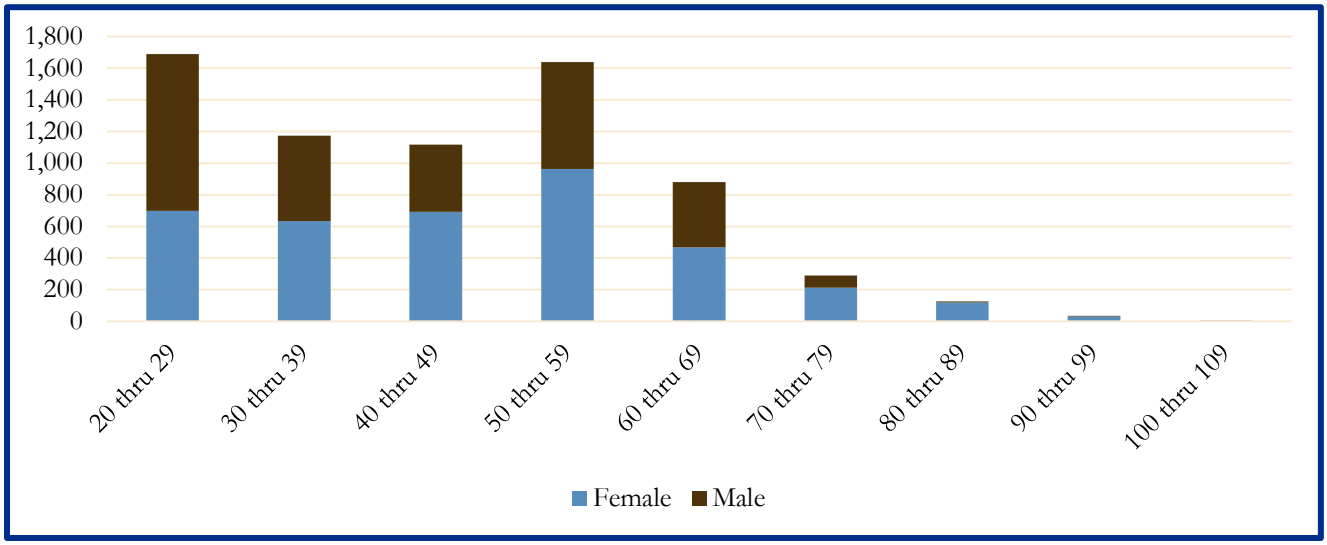
### ABD Caseload Comparison by State Fiscal Year

As stated above, redetermination for this population heavily impacted the enrollment trends beginning in SFY 2016. DVHA anticipates that the caseload is entering a more stable period as demonstrated by the most recent months of eligibility data.



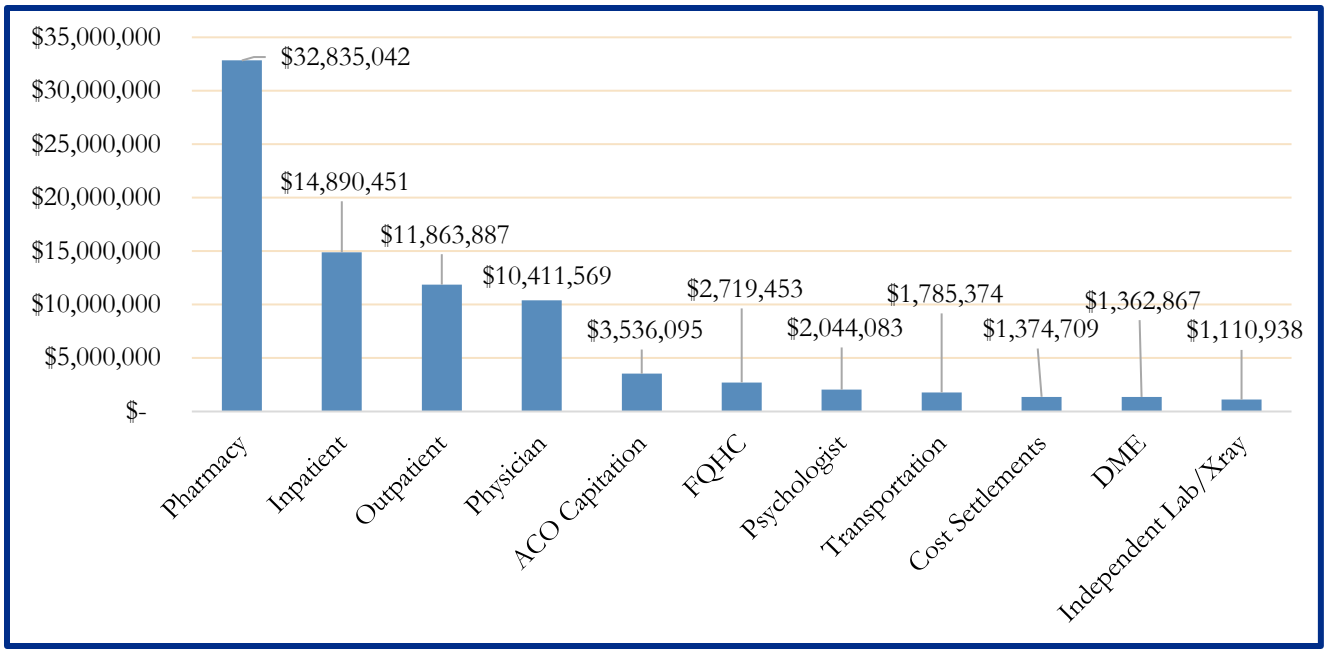

The eligibility and enrollment redetermination activities have resulted in higher PMPM expectations for SFY 2018 as the remaining population tends to have more health care needs.

### ABD Adult SFY 2017 Average Enrollment Breakout by Age and Gender




For adults with disabilities, pharmacy, outpatient, inpatient, and professional services accounted for the majority of the $68,865,433 DVHA expenditure for ABD Adults.

### ABD DVHA Expenditures by Top 10 Service Categories



## Dual Eligible

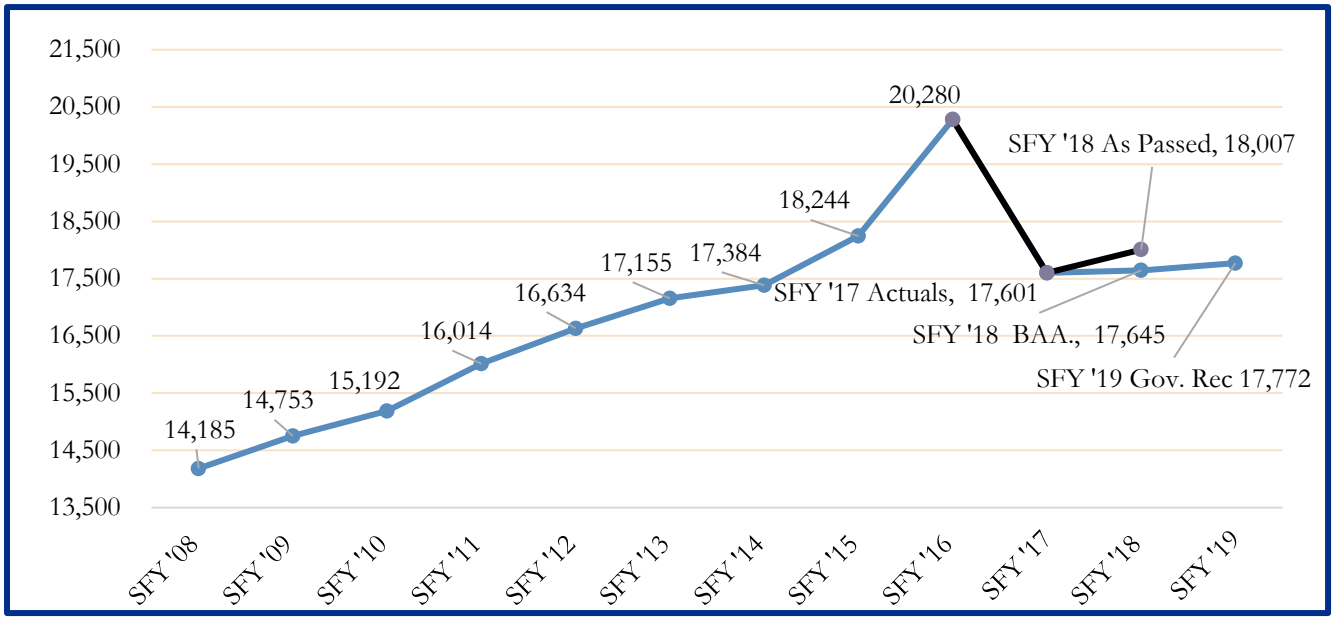
Dual Eligible members are enrolled in both Medicare and Medicaid. Medicare eligibility is based on being at least 65 years of age or determined blind or disabled. Medicaid is responsible for the co-payments, co-insurance and deductibles for this population. The benefit also makes non-Medicare covered services such as routine hearing, dental, and transportation available to dually eligible members. The following table illustrates the caseload and expenditure actual and estimated information.

### Dual Eligible Caseload, Expenditure, and PMPM Comparison by State Fiscal Year

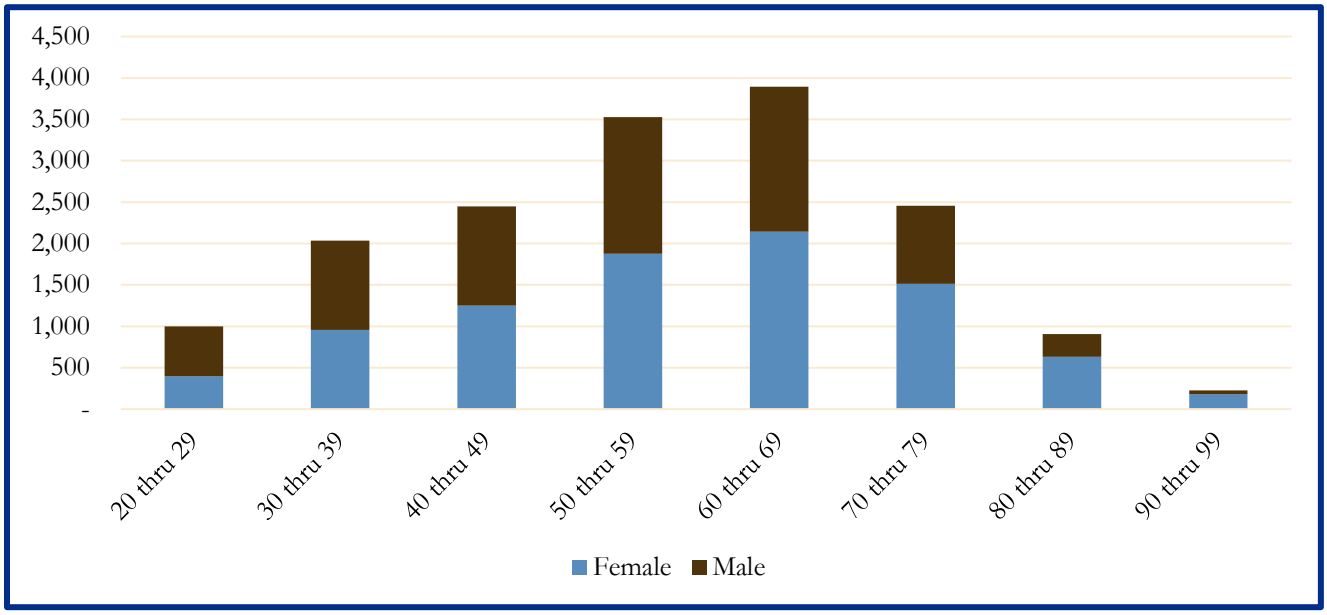
| Aged, Blind, & Disabled (ABD) Dual Eligibles | | | | | |
|---|---|---|---|---|---|
| | | DVHA Only | | All AHS and AOE | |
| SFY | Caseload | Expenditures | PMPM | Expenditures | PMPM |
| SFY 2015 Actual | 18,244 | $ 53,518,538 | $ 244.46 | $ 216,083,619 | $ 987.00 |
| SFY 2016 Actual | 20,280 | $ 55,523,042 | $ 228.15 | $ 243,884,642 | $ 1,002.14 |
| SFY 2017 Actual | 17,601 | $ 52,597,445 | $ 249.02 | $ 214,721,288 | $ 1,016.60 |
| SFY 2018 As Passed | 18,007 | $ 59,347,069 | $ 274.64 | $ 239,475,604 | $ 1,108.23 |
| SFY 2018 BAA | 17,645 | $ 54,637,311 | $ 258.04 | $ 226,912,702 | $ 1,071.65 |
| SFY 2019 Gov. Rec. | 17,772 | $ 53,560,746 | $ 251.15 | $ 231,970,892 | $ 1,087.72 |

### Dual Eligible Caseload Comparison by State Budget Cycle

The re-determination effort stabilized the trend line to a line more consistent with the period prior to the halt of redeterminations.

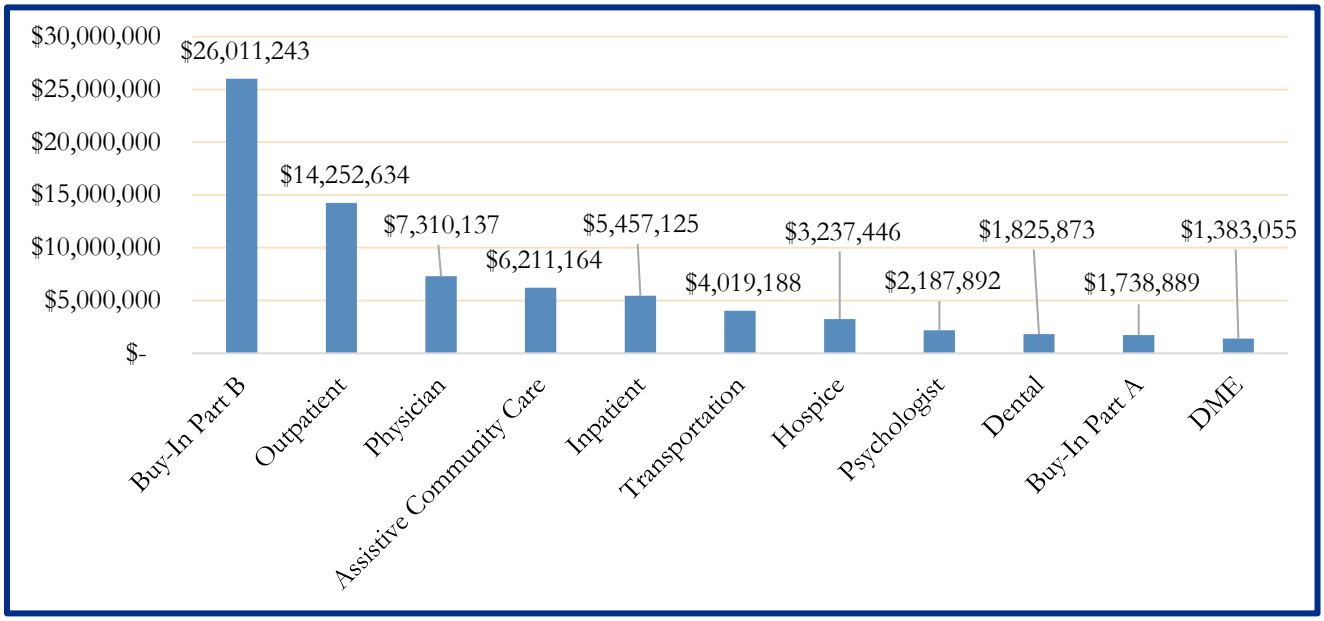


## Dual Eligible SFY 2017 Average Enrollment Breakout by Age and Gender




## Dual Eligible DVHA Expenditures by Top 10 Service Categories

For the Dual Eligible population, outpatient, assistive community supports, inpatient, and professional services accounted for the majority of the $52,597,445 DVHA spend in SFY 2017. This population is covered by Medicare as the primary insurer, and Medicaid pays for co-insurance and deductibles, as well as wrapping certain services not covered by Medicare.



## General Adults

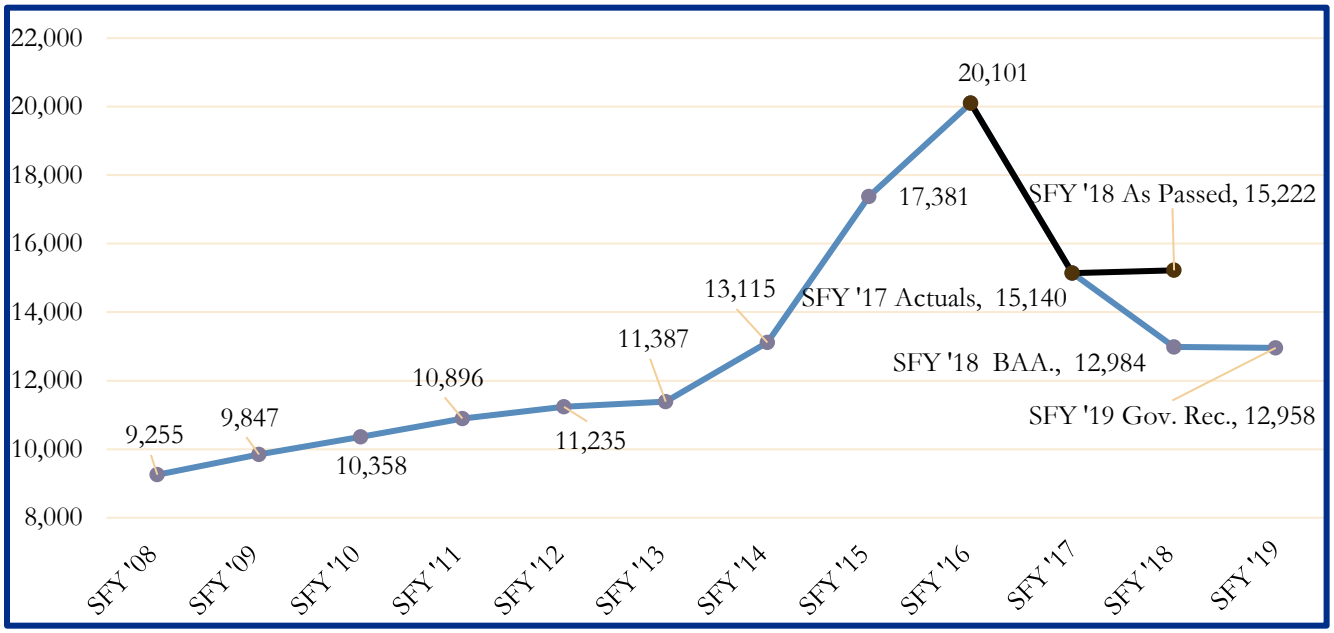
The general eligibility requirements for General Adults are: parent/caretaker, relatives of minor children (including cash assistance recipients), and those receiving transitional Medicaid after the receipt of cash assistance, whose income is below the PIL. The following table illustrates the caseload and expenditure actual and estimated information.

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

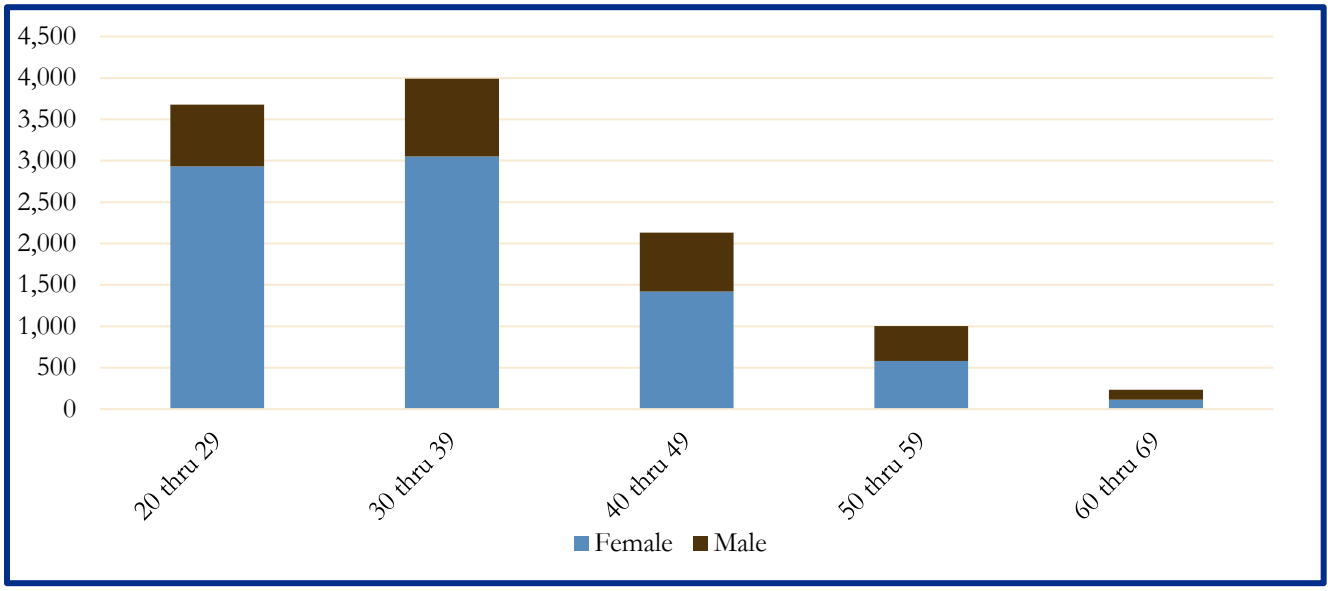
| General Adults | | | | | |
|---|---|---|---|---|---|
| | | DVHA Only | | All AHS and AOE | |
| SFY | Caseload | Expenditures | PMPM | Expenditures | PMPM |
| SFY 2015 Actual | 17,381 | $ 88,383,933 | $ 423.75 | $ 98,968,224 | $ 474.49 |
| SFY 2016 Actual | 20,101 | $ 92,641,465 | $ 384.07 | $ 105,326,128 | $ 436.66 |
| SFY 2017 Actual | 15,140 | $ 77,460,396 | $ 426.37 | $ 89,853,697 | $ 494.58 |
| SFY 2018 As Passed | 15,222 | $ 84,987,048 | $ 465.27 | $ 98,756,688 | $ 540.66 |
| SFY 2018 BAA | 12,984 | $ 76,353,007 | $ 490.03 | $ 89,522,326 | $ 574.55 |
| SFY 2019 Gov. Rec. | 12,958 | $ 71,955,447 | $ 462.75 | $ 85,593,729 | $ 550.46 |

### General Adults Caseload Comparison by State Budget Cycle

As with the Dual population, this eligibility group looks to have stabilized to the period before the halt of redeterminations.

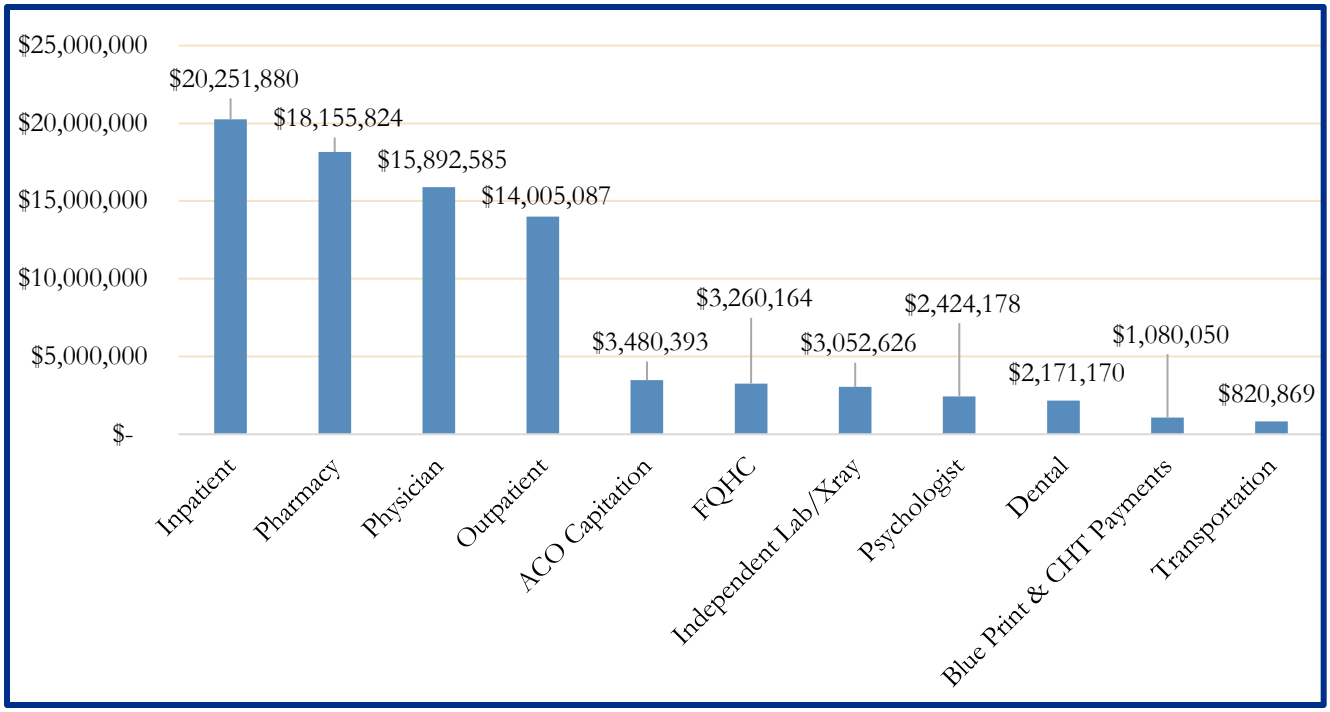


### General Adults SFY 2017 Average Enrollment Breakout by Age and Gender




### General Adults DVHA Expenditures by Top 10 Service Categories

Inpatient, physician, outpatient, and pharmacy accounted for the majority of the $77,460,396 SFY 2017 DVHA spend.



## New Adults

Adults who are at or below 138% of the FPL qualify for expanded Medicaid. This population includes members who both are childless and those who have children. The Federal government reimburses services for new adults without children in the household at a higher percentage rate.

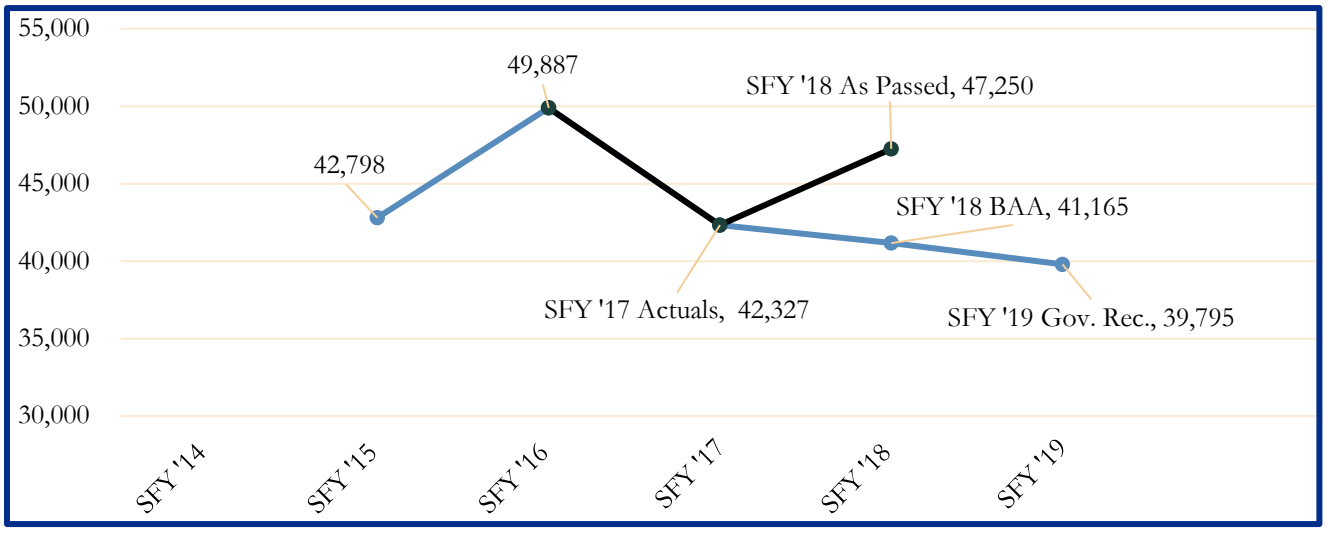
The following tables illustrates the caseload and expenditure actual and estimated information. Since the new adult population without children receives a higher federal participation rate, we have organized the information by adults without children and adults with children.

### New Adult – Without Children Caseload, Expenditure, and PMPM Comparison by State Fiscal Year

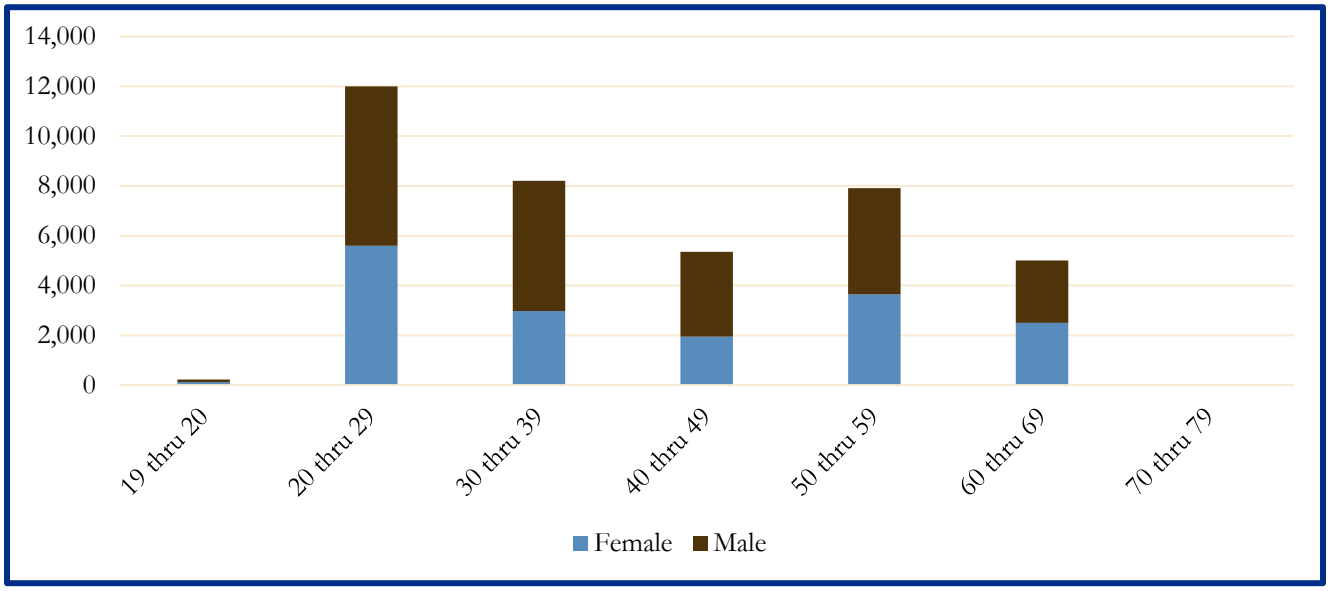
| New Adult Childless | | | | | |
|---|---|---|---|---|---|
| | | DVHA Only | | All AHS and AOE | |
| SFY | Caseload | Expenditures | PMPM | Expenditures | PMPM |
| SFY 2015 Actual | 42,798 | $ 192,120,214 | $ 374.08 | $ 211,513,441 | $ 411.84 |
| SFY 2016 Actual | 49,887 | $ 210,571,135 | $ 351.74 | $ 234,059,775 | $ 390.98 |
| SFY 2017 Actual | 42,327 | $ 194,062,032 | $ 382.07 | $ 215,734,379 | $ 424.74 |
| SFY 2018 As Passed | 47,250 | $ 219,128,094 | $ 386.47 | $ 245,344,195 | $ 432.71 |
| SFY 2018 BAA | 41,165 | $ 194,734,970 | $ 394.22 | $ 220,374,288 | $ 446.12 |
| SFY 2019 Gov. Rec. | 39,795 | $ 194,889,542 | $ 408.11 | $ 221,441,880 | $ 463.71 |

### New Adults – Without Children Caseload Comparison by State Budget Cycle

The New Adults without children group is projected to decline slightly between SFY 2018 and 2019.

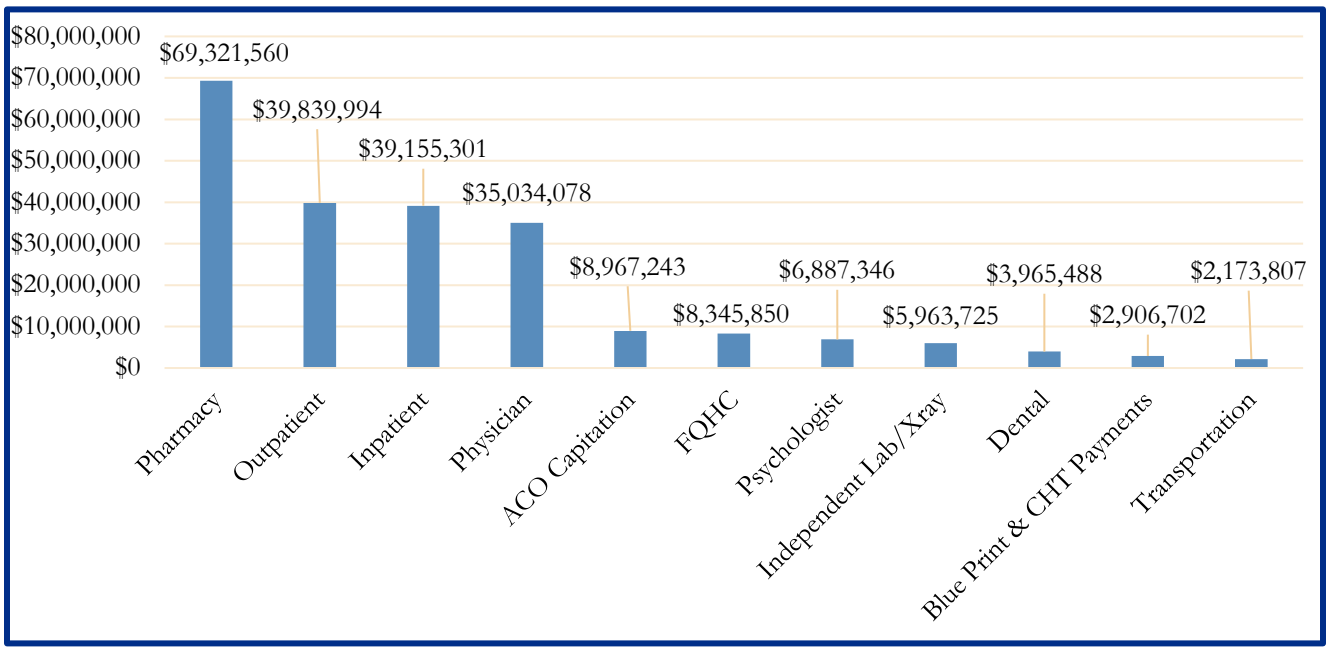


### New Adult – Without Children SFY 2017 Average Enrollment Breakout by Age and Gender




Outpatient, inpatient, pharmacy (net drug rebate), and professional services accounted for the majority of the $194,062,032 New Adult – Without Children DVHA spend. Utilization of lab services is higher in the New Adult populations in part because of the prevalence of opioid dependency within this population.

### New Adults – Without Children DVHA Expenditures by Top 10 Service Categories

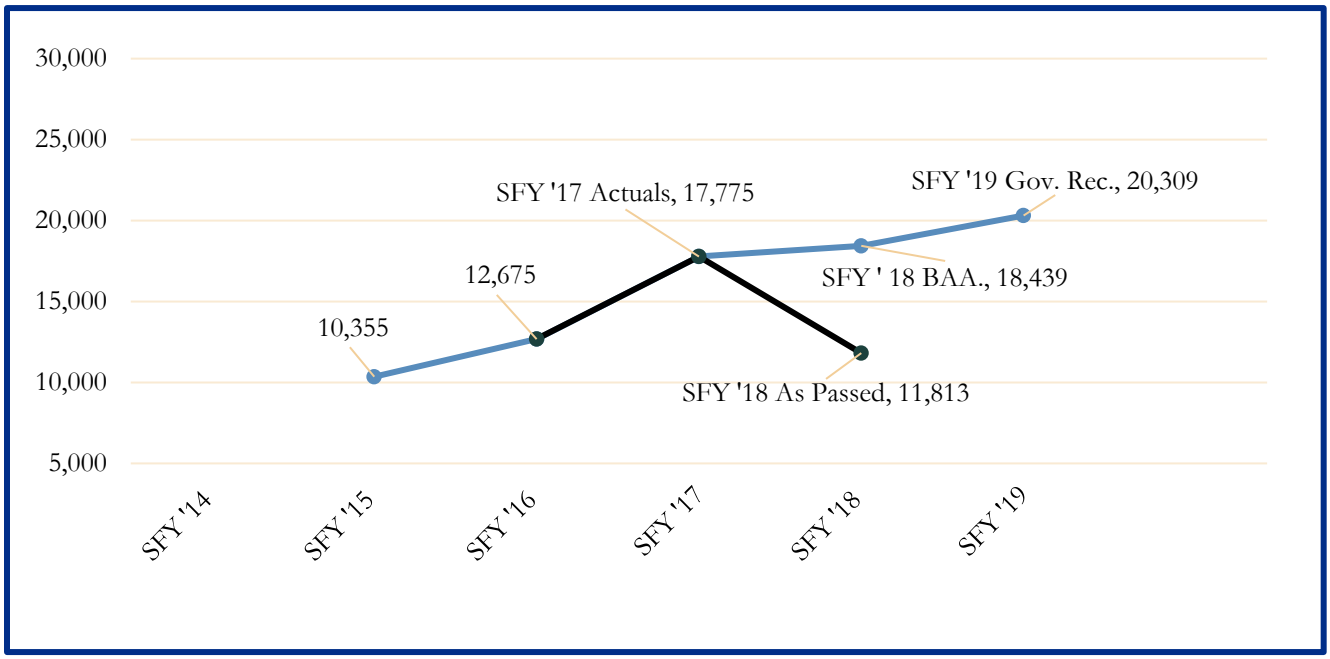


## New Adult – With Child Caseload, Expenditure, and PMPM Comparison by State Fiscal Year

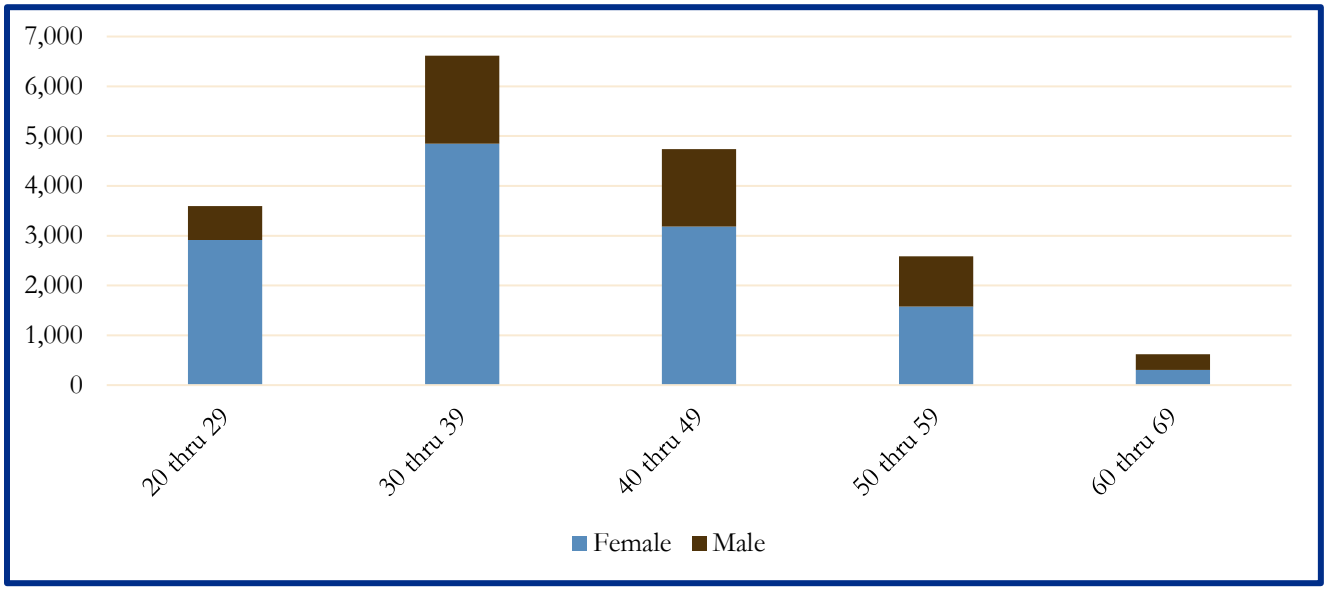
| New Adult with Child | | | | | |
|---|---|---|---|---|---|
| | | DVHA Only | | All AHS and AOE | |
| SFY | Caseload | Expenditures | PMPM | Expenditures | PMPM |
| SFY 2015 Actual | 10,355 | $ 32,191,328 | $ 259.07 | $ 35,440,824 | $ 285.22 |
| SFY 2016 Actual | 12,675 | $ 38,150,227 | $ 250.83 | $ 42,405,781 | $ 278.81 |
| SFY 2017 Actual | 17,775 | $ 70,043,265 | $ 328.38 | $ 77,865,517 | $ 365.05 |
| SFY 2018 As Passed | 11,813 | $ 54,782,023 | $ 386.47 | $ 61,336,049 | $ 432.71 |
| SFY 2018 BAA | 18,439 | $ 73,864,372 | $ 333.82 | $ 79,566,486 | $ 359.59 |
| SFY 2019 Gov. Rec. | 20,309 | $ 84,063,247 | $ 344.93 | $ 89,968,415 | $ 369.16 |

## New Adults – With Child Caseload Comparison by State Budget Cycle

The New Adult with Child(ren) is one of the few eligibility groups that is experiencing growth. We are seeing some shift from other eligibility groups such as ABD adult and General Adult into this aid category, presumably due to the changes the Affordable Care Act instituted.

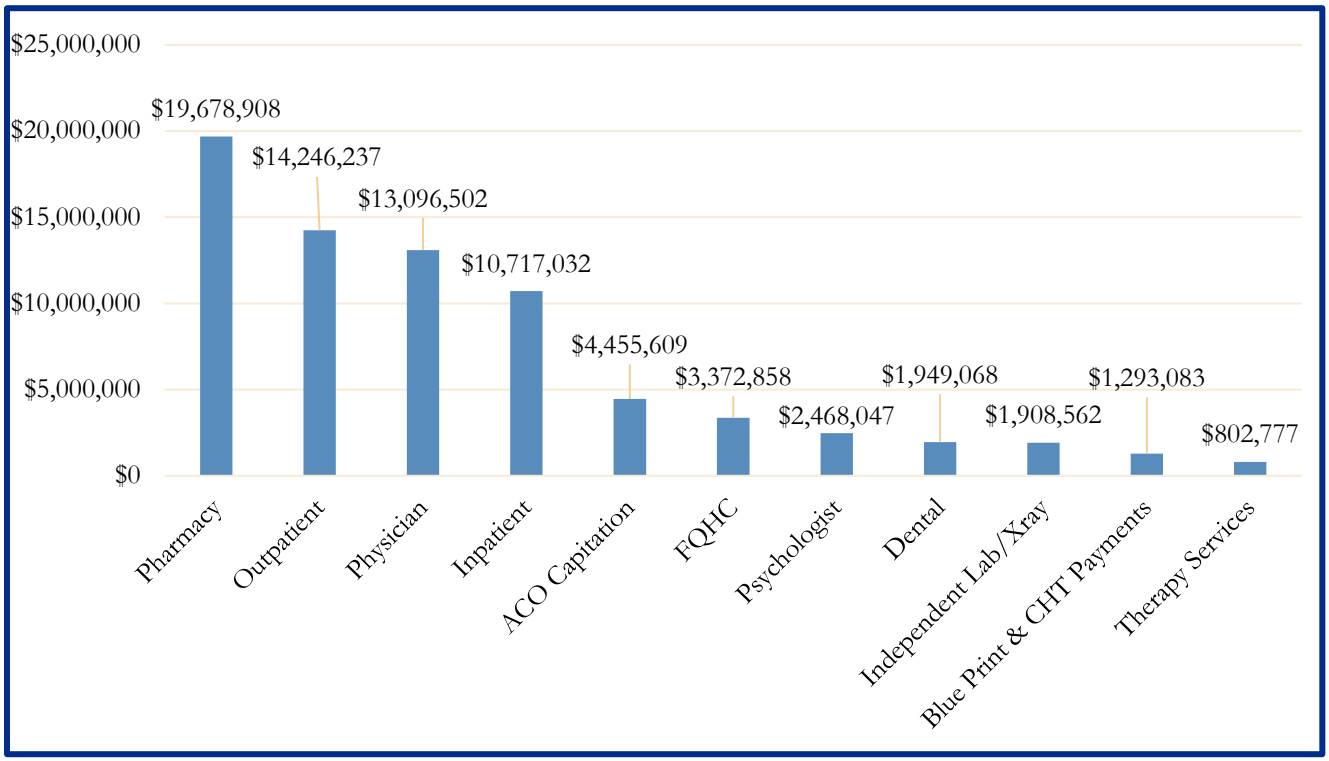


### New Adult – With Child SFY 2017 Average Enrollment Breakout by Age and Gender




### New Adults – With Child DVHA Expenditures by Top 10 Service Categories

Outpatient, inpatient, pharmacy (net drug rebate), and professional services accounted for the majority of the $70,043,265 New Adult – with Child DVHA spend. Utilization of lab services is higher in the New Adult populations in part because of the prevalence of opioid dependency within this population.



## Pharmacy Only Programs – Prescription Assistance

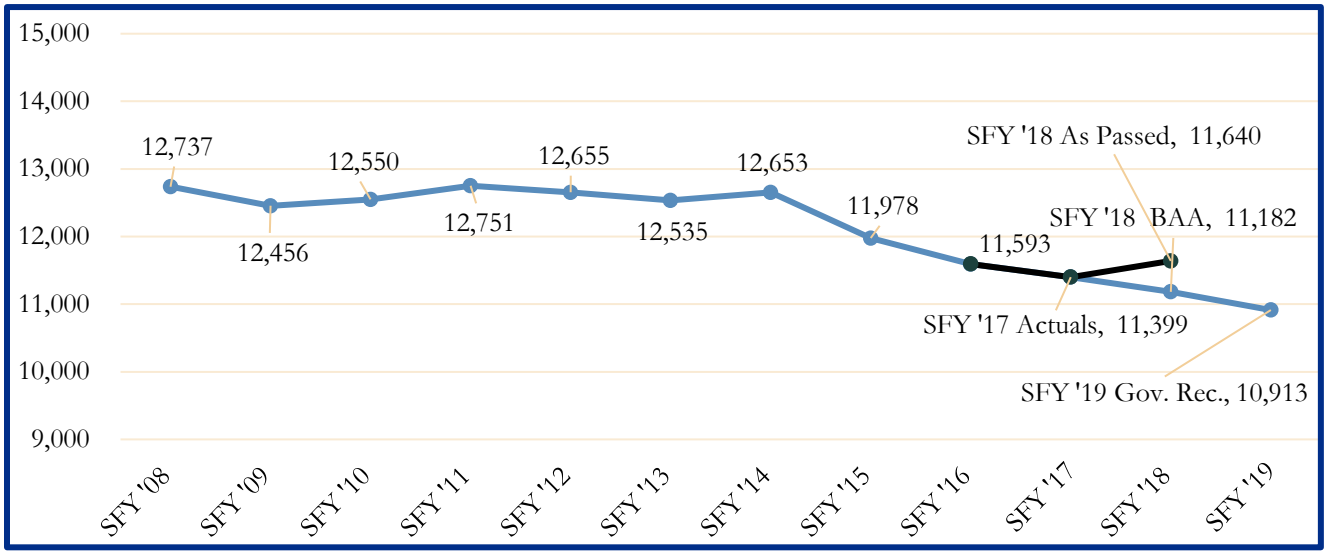
Vermont provides prescription assistance programs to help Vermonters pay for prescription medicines based on income, disability status, and age. There are monthly premiums based on income and co-pays based on the cost of the prescription.

VPharm assists Vermonters enrolled in Medicare Part D with paying for prescription medicines as well as their Medicare Part D premiums. Eligibility requirements include current Medicare Part D eligibility and household income up to 225% FPL. Medicare is available to those age 65 and older and of any age with a disability. The following table illustrates the caseload and expenditure actual and estimated information.

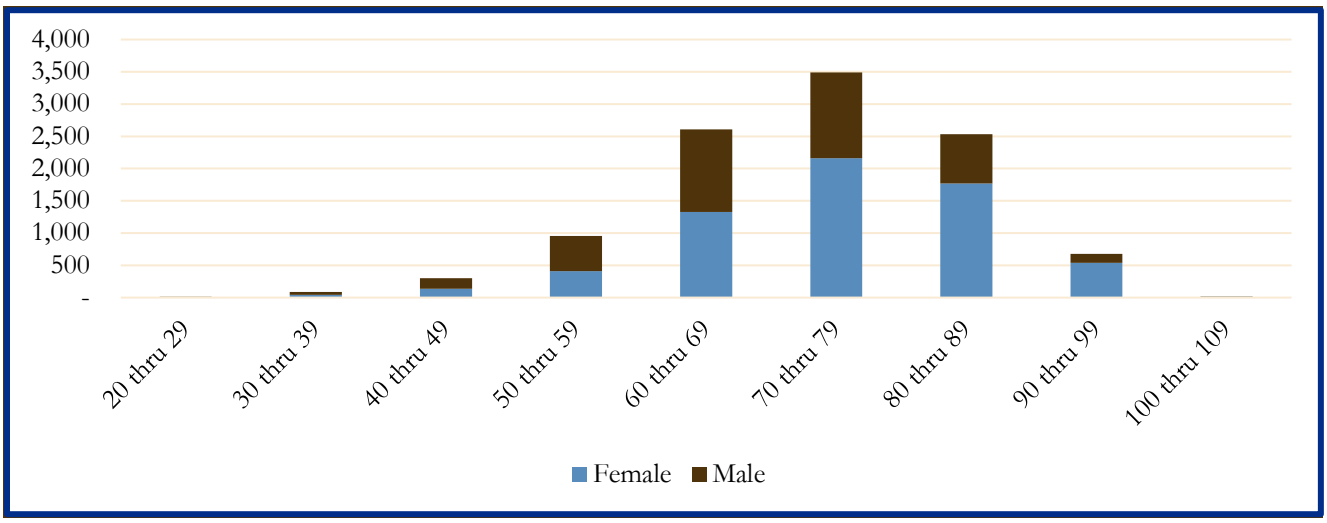
### VPharm Caseload, Expenditure, and PMPM Comparison by State Fiscal Year

| Pharmacy Only Programs | | | | | |
|---|---|---|---|---|---|
| | | DVHA Only | | All AHS and AOE | |
| SFY | Caseload | Expenditures | PMPM | Expenditures | PMPM |
| SFY 2015 Actual | 11,978 | $ 4,914,695 | $ 34.19 | $ 4,914,695 | $ 34.19 |
| SFY 2016 Actual | 11,593 | $ 2,302,437 | $ 16.55 | $ 2,302,437 | $ 16.55 |
| SFY 2017 Actual | 11,399 | $ 3,155,724 | $ 23.07 | $ 3,155,724 | $ 23.07 |
| SFY 2018 As Passed | 11,640 | $ 6,375,171 | $ 45.64 | $ 6,375,171 | $ 45.64 |
| SFY 2018 BAA | 11,182 | $ 4,678,042 | $ 34.86 | $ 4,678,042 | $ 34.86 |
| SFY 2019 Gov. Rec. | 10,913 | $ 6,134,624 | $ 46.84 | $ 6,134,624 | $ 46.84 |

### VPharm Caseload Comparison by State Fiscal Year



## SFY 2017 Average VPharm Enrollment Breakout by Age and Gender



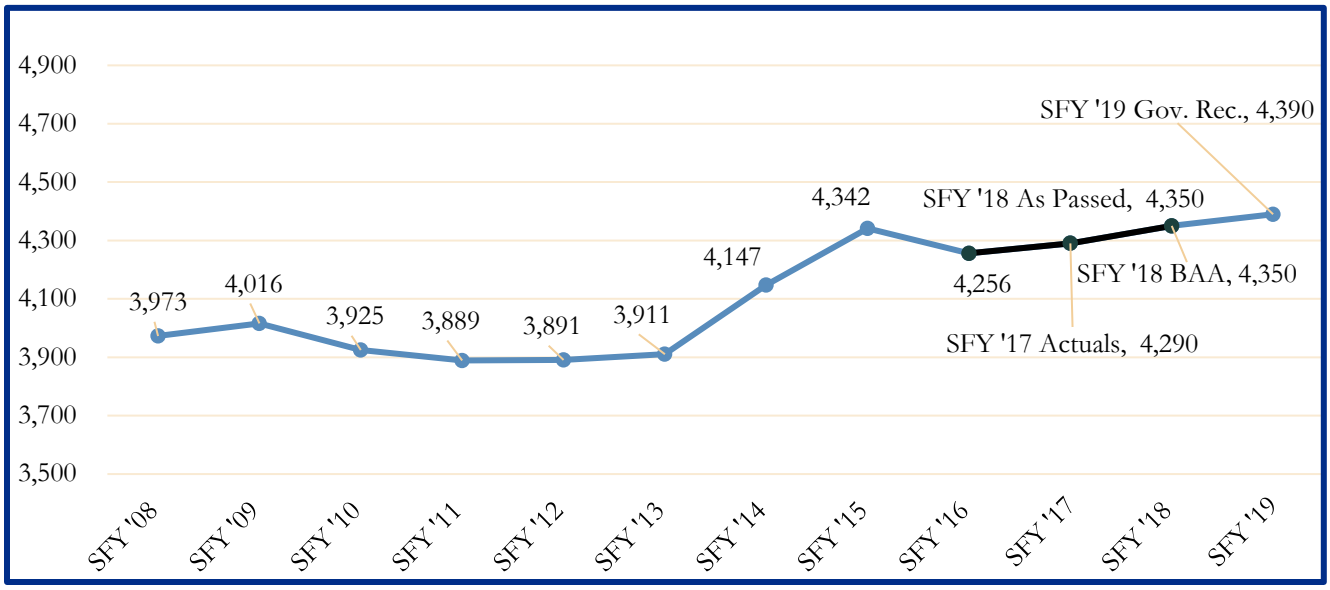
## Choices for Care Caseload, Expenditure, and PMPM Comparison by State Fiscal Year

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).

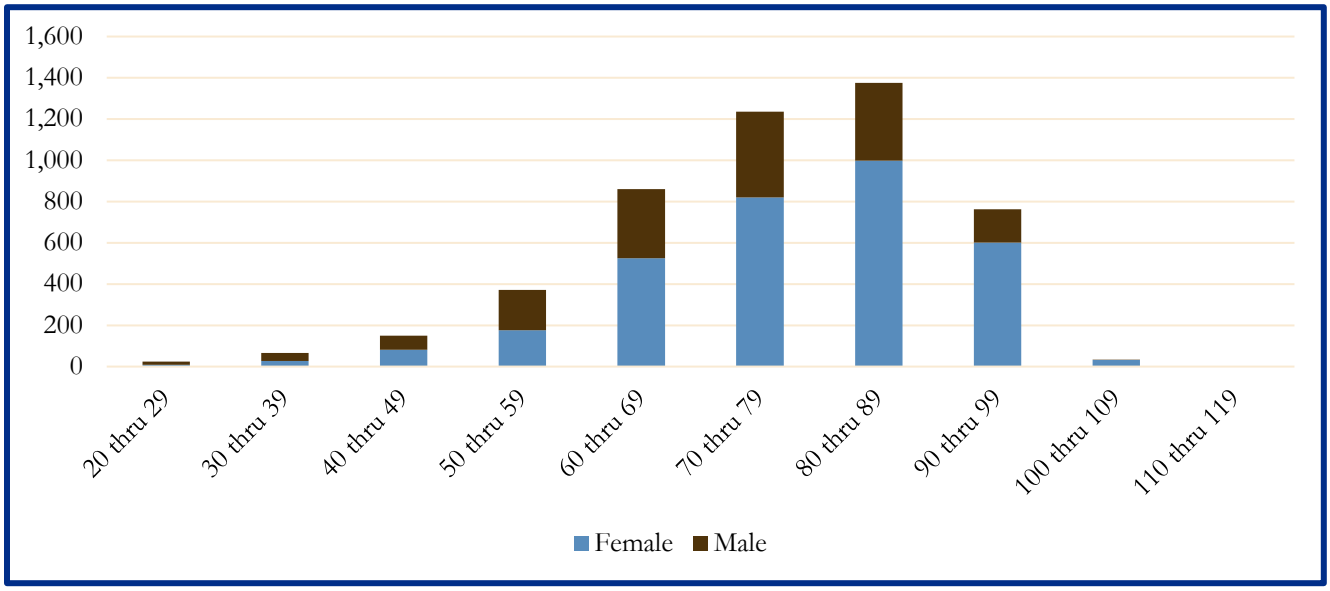
The following table illustrates the caseload and expenditure actual and estimated information.

| Choices for Care | | | | | |
|---|---|---|---|---|---|
| | | DVHA Only | | All AHS and AOE | |
| SFY | Caseload | Expenditures | PMPM | Expenditures | PMPM |
| SFY 2015 Actual | 4,342 | $ 208,149,276 | $ 3,995.26 | $ 208,149,276 | $ 3,995.26 |
| SFY 2016 Actual | 4,256 | $ 213,115,112 | $ 4,172.59 | $ 218,544,540 | $ 4,278.89 |
| SFY 2017 Actual | 4,290 | $ 222,772,830 | $ 4,327.20 | $ 225,042,484 | $ 4,371.28 |
| SFY 2018 As Passed | 4,350 | $ 225,842,140 | $ 4,326.35 | $ 225,842,140 | $ 4,326.35 |
| SFY 2018 BAA | 4,350 | $ 225,368,260 | $ 4,317.40 | $ 225,368,260 | $ 4,317.40 |
| SFY 2019 Gov. Rec. | 4,390 | $ 231,193,211 | $ 4,388.63 | $ 231,193,211 | $ 4,388.63 |

## Choices for Care Caseload Comparison by State Budget Cycle

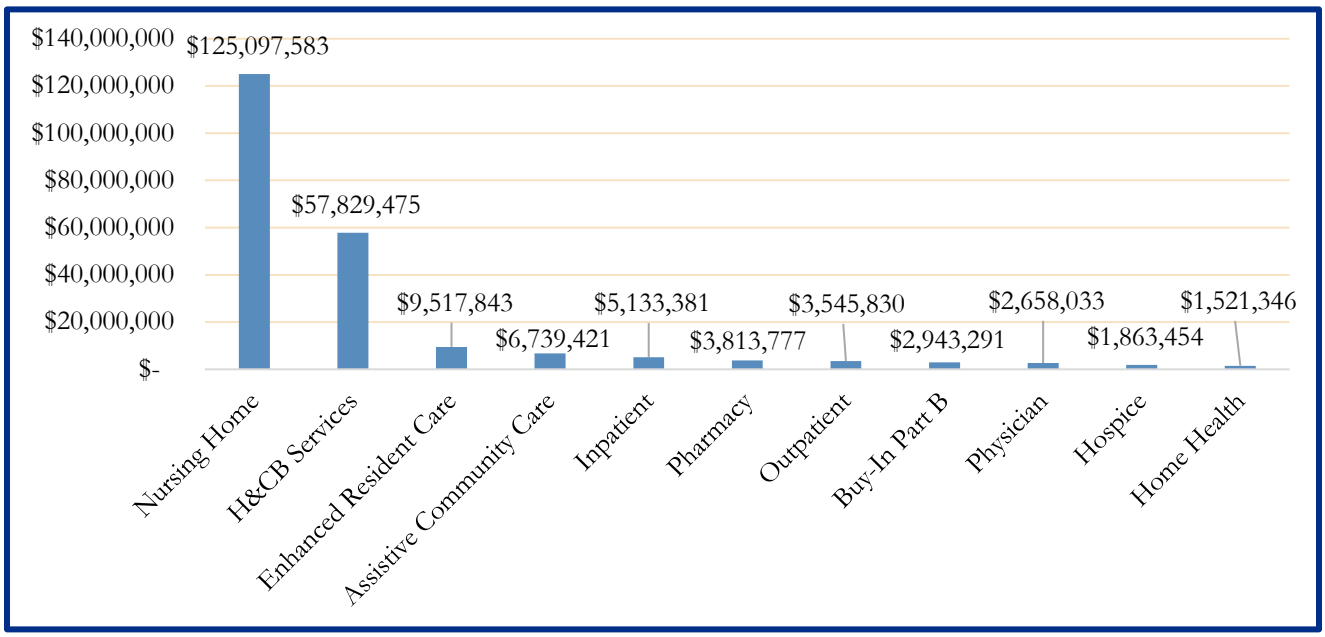


## Choices for Care SFY 2017 Average Enrollment Breakout by Age and Gender




## DVHA Expenditures by Top 10 Service Categories: Choices for Care

This population receives Choices for Care Services – Nursing Home, Enhanced Residential Care, and Home and Community Based Services - as well as acute services such as Inpatient, Pharmacy, and Outpatient Services. The Department of DAIL manages the Choices for Care (CFC) Program Benefit while DVHA manages the CFC appropriation and the acute services.



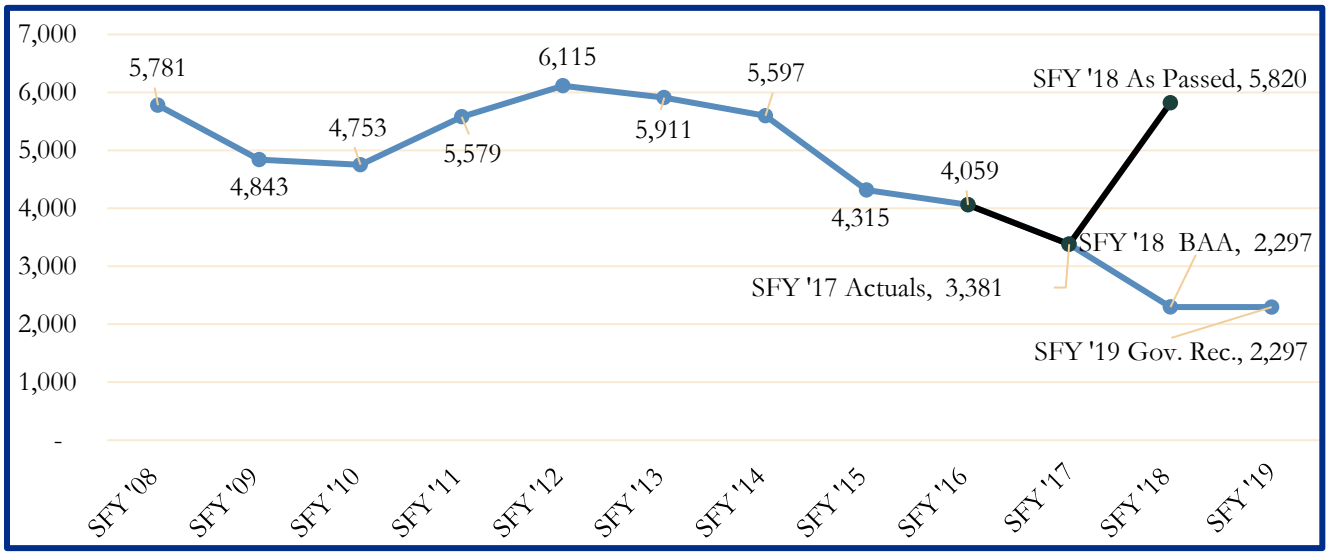
## Healthy Vermonters

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. The following table illustrates the caseload and expenditure actual and estimated information.

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

| Healthy Vermonters Program | | | | | |
|---|---|---|---|---|---|
| | | DVHA Only | | All AHS and AOE | |
| SFY | Caseload | Expenditures | PMPM | Expenditures | PMPM |
| SFY 2015 Actual | 4,315 | $ - | n/a | $ - | n/a |
| SFY 2016 Actual | 4,059 | $ - | n/a | $ - | n/a |
| SFY 2017 Actual | 3,381 | $ - | n/a | $ - | n/a |
| SFY 2018 As Passed | 5,820 | $ - | n/a | $ - | n/a |
| SFY 2018 BAA | 2,297 | $ - | n/a | $ - | n/a |
| SFY 2019 Gov. Rec. | 2,297 | $ - | n/a | $ - | n/a |

### Healthy Vermonters Caseload Comparison by State Budget Cycle



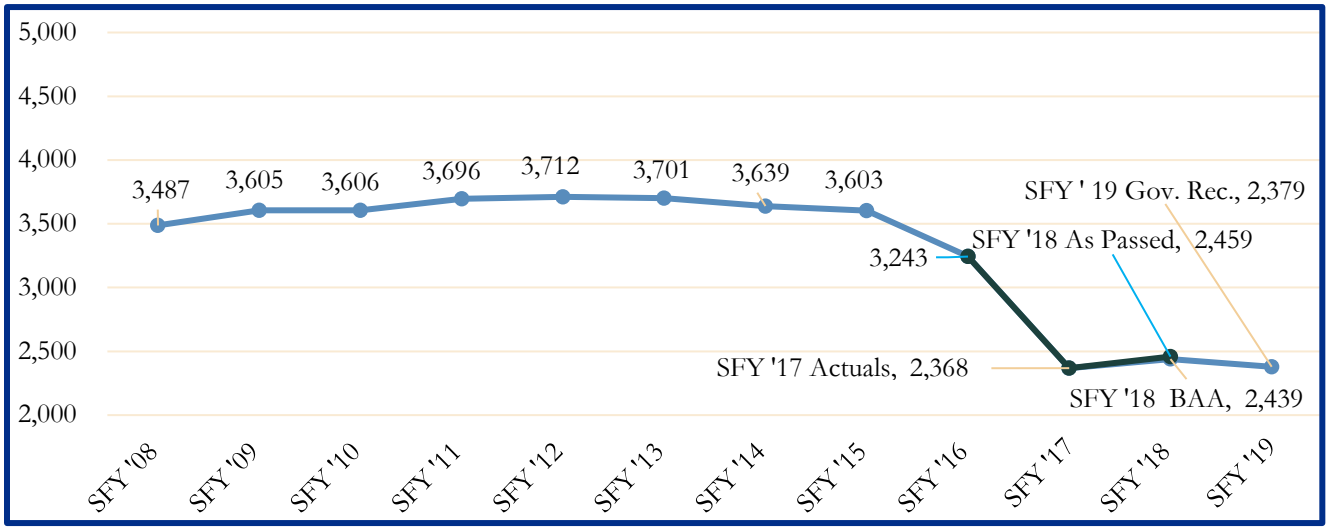
## Blind or Disabled (BD) and/or Medically Needy Children

Eligibility requirements for BD and/or Medically Needy Children include an age cap of 21 years, and blind or disabled status as determined by the federal Social Security Administration, or the State, and the population can also include Supplemental Security Income (SSI) cash assistance recipients, hospice patients, those eligible under "Katie Beckett" rules, and medically needy Vermonters – i.e., those children whose household income is greater than the cash assistance level but less than the PIL. Medically needy children may or may not be blind or disabled. The following table illustrates the caseload and expenditure actual and estimated information.

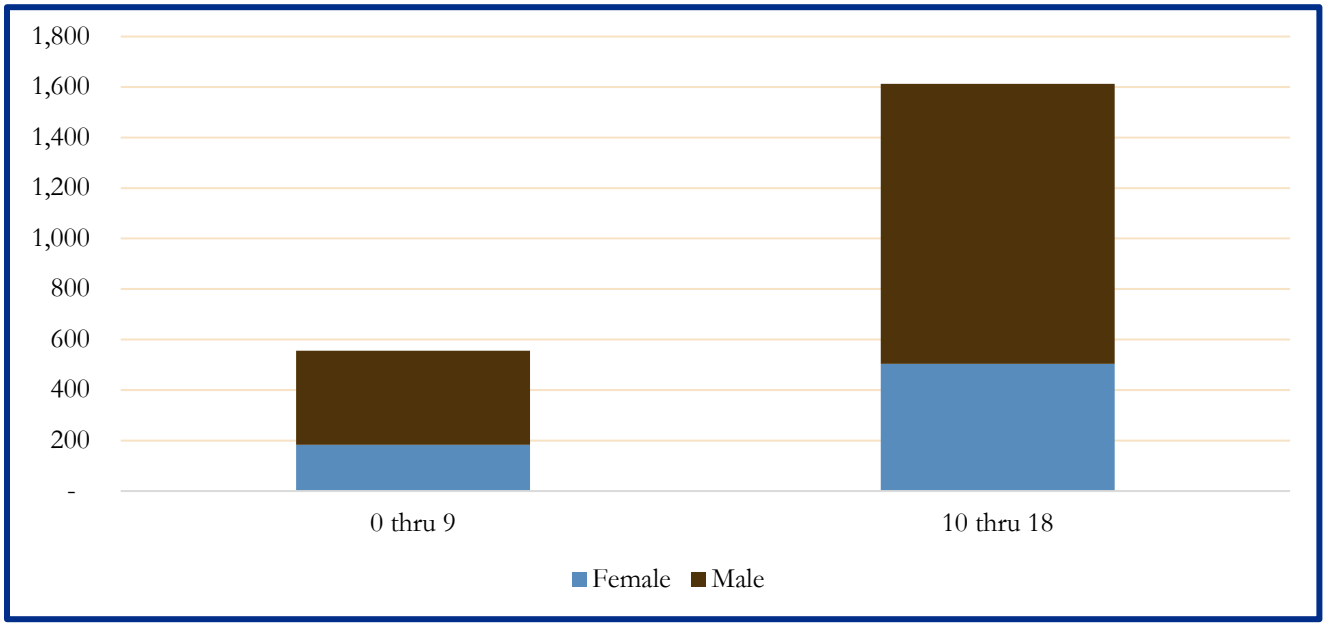
### Blind or Disabled and/or Medically Needy Children Caseload, Expenditure, and PMPM Comparison by State Fiscal Year

| Blind or Disabled (ABD) and/or Medically Needy Children | | | | | |
|---|---|---|---|---|---|
| | | DVHA Only | | All AHS and AOE | |
| SFY | Caseload | Expenditures | PMPM | Expenditures | PMPM |
| SFY 2015 Actual | 3,603 | $ 30,889,676 | $ 714.53 | $ 87,051,488 | $ 2,013.64 |
| SFY 2016 Actual | 3,243 | $ 27,174,573 | $ 698.22 | $ 82,411,072 | $ 2,117.45 |
| SFY 2017 Actual | 2,368 | $ 23,032,607 | $ 810.47 | $ 71,540,812 | $ 2,517.36 |
| SFY 2018 As Passed | 2,459 | $ 24,864,632 | $ 842.64 | $ 78,759,924 | $ 2,669.10 |
| SFY 2018 BAA | 2,439 | $ 24,090,018 | $ 822.99 | $ 75,635,614 | $ 2,583.94 |
| SFY 2019 Gov. Rec. | 2,379 | $ 24,357,410 | $ 853.21 | $ 77,738,553 | $ 2,723.08 |

### Blind or Disabled Children Caseload Comparison by State Budget Cycle

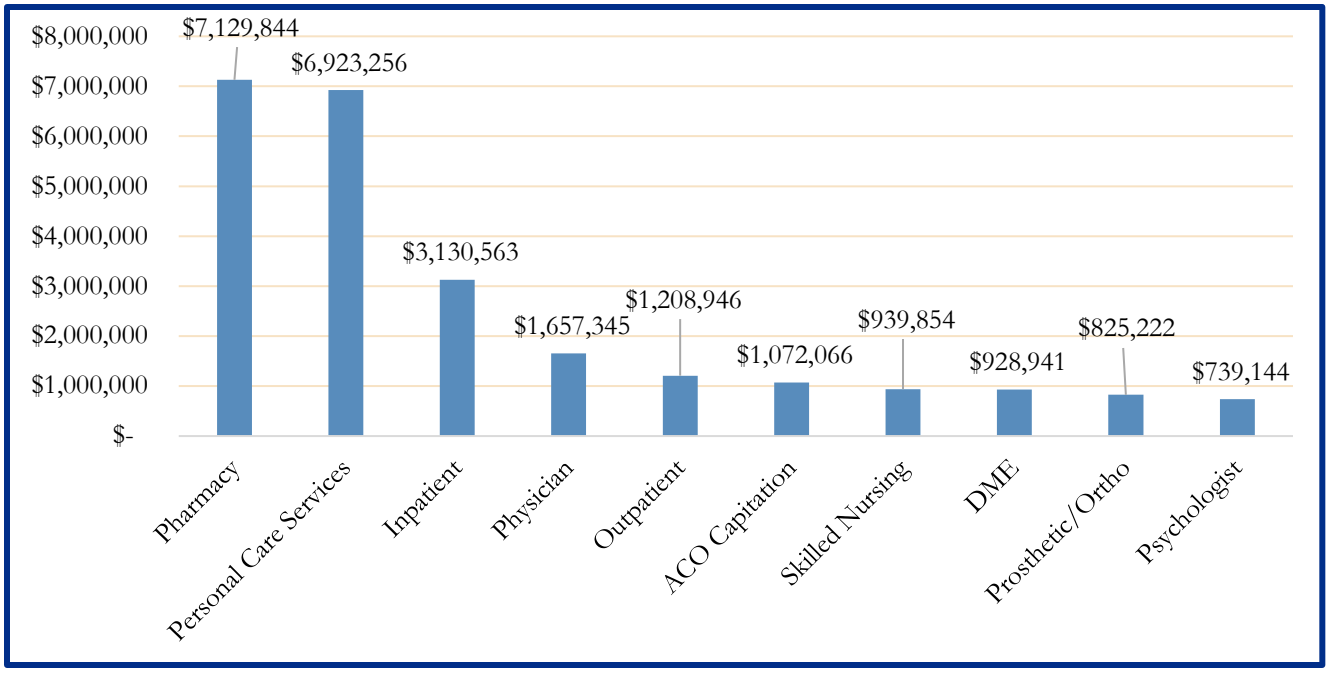


## BD Child SFY 2017 Average Enrollment Breakout by Age and Gender




## DVHA Expenditures by Top 10 Service Categories: BD Child

Personal Care Services, inpatient, pharmacy (net drug rebate), and professional services accounted for the majority of the $23,032,607 SFY 2017 DVHA spend.



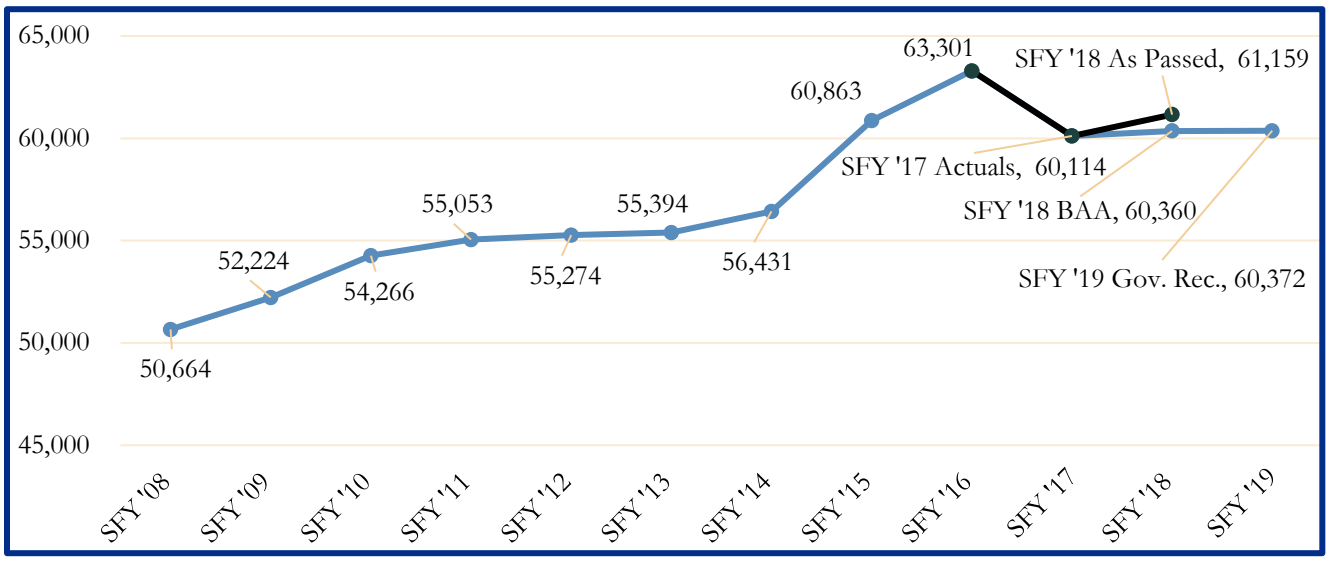
## General Children

The general eligibility requirements for General Children are: under age 19 and below the PIL, categorized as those eligible for cash assistance including Reach Up (Title V) and foster care payments (Title IV-E). The following table illustrates the caseload and expenditure actual and estimated information.

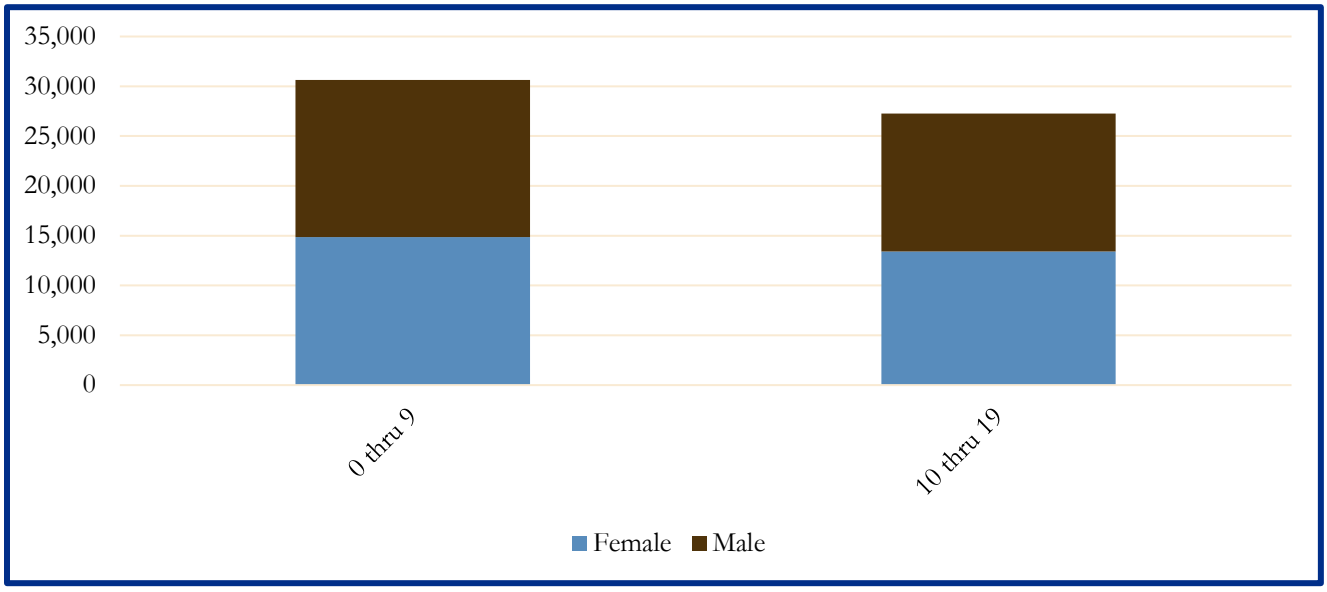
### General Children Caseload, Expenditure, and PMPM Comparison by State Fiscal Year

| General Children | | | | | |
|---|---|---|---|---|---|
| | | DVHA Only | | All AHS and AOE | |
| SFY | Caseload | Expenditures | PMPM | Expenditures | PMPM |
| SFY 2015 Actual | 60,863 | $ 144,338,098 | $ 197.63 | $ 267,623,445 | $ 366.43 |
| SFY 2016 Actual | 63,301 | $ 151,736,910 | $ 199.75 | $ 286,746,415 | $ 377.49 |
| SFY 2017 Actual | 60,114 | $ 153,917,906 | $ 213.37 | $ 295,676,075 | $ 409.88 |
| SFY 2018 As Passed | 61,159 | $ 155,903,794 | $ 212.43 | $ 313,404,942 | $ 427.04 |
| SFY 2018 BAA | 60,360 | $ 153,061,657 | $ 211.32 | $ 303,696,157 | $ 419.29 |
| SFY 2019 Gov. Rec. | 60,372 | $ 154,108,565 | $ 212.72 | $ 310,107,184 | $ 428.05 |

### General Children Caseload Comparison by State Fiscal Year

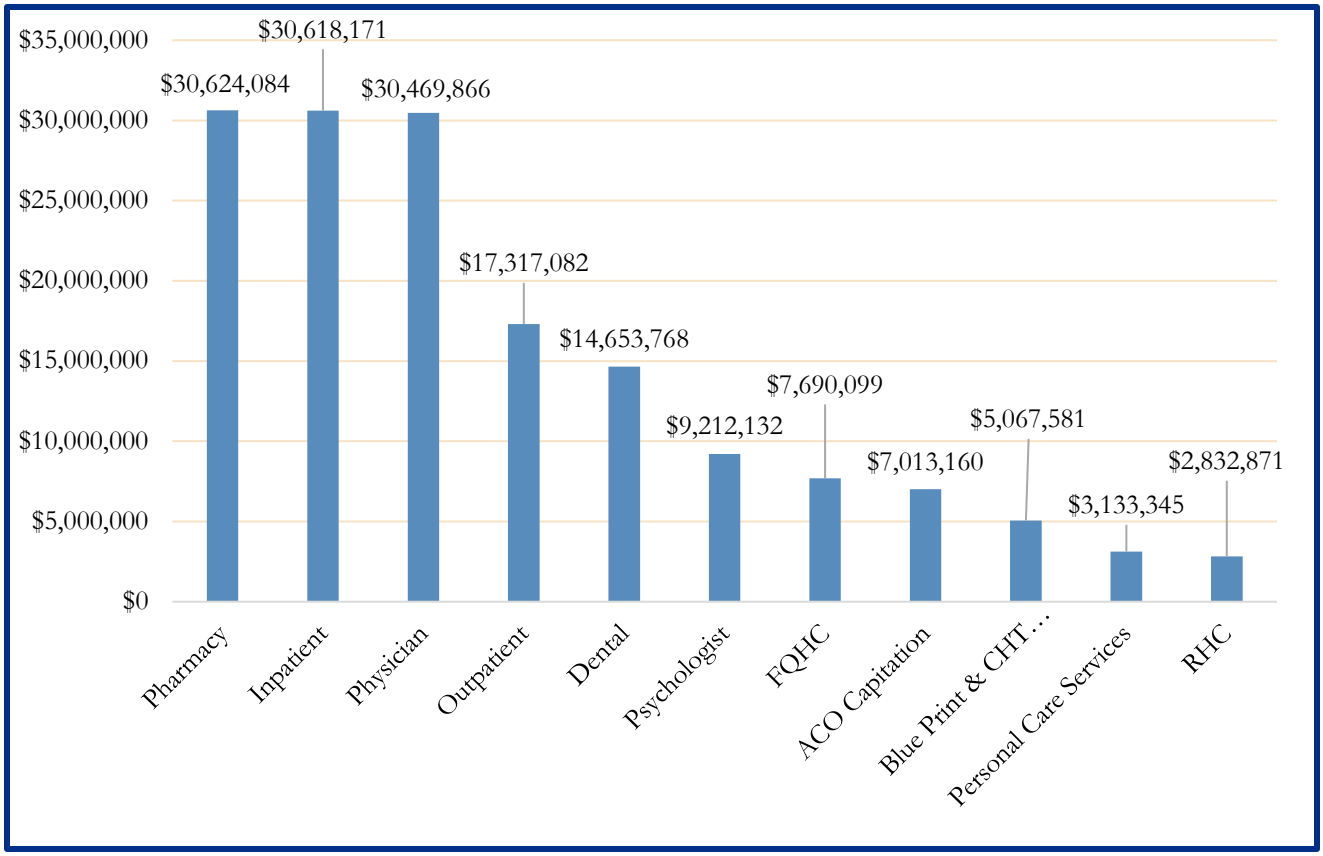


### General Child SFY 2017 Average Enrollment Breakout by Age and Gender




### DVHA Expenditures by Top 10 Service Categories: General Child

Professional services, inpatient, outpatient, and pharmacy (net drug rebate) accounted for the majority of the $153,917,906 SFY 2017 DVHA spend.



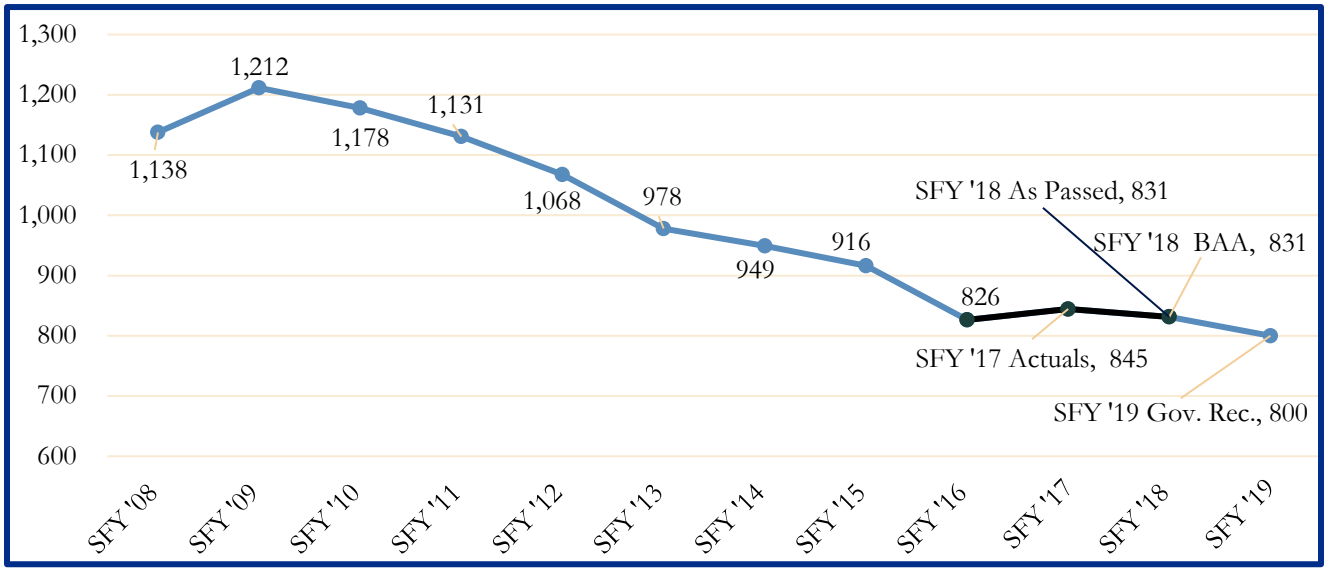
## Optional Benefit Children

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. The following table illustrates the caseload and expenditure actual and estimated information.

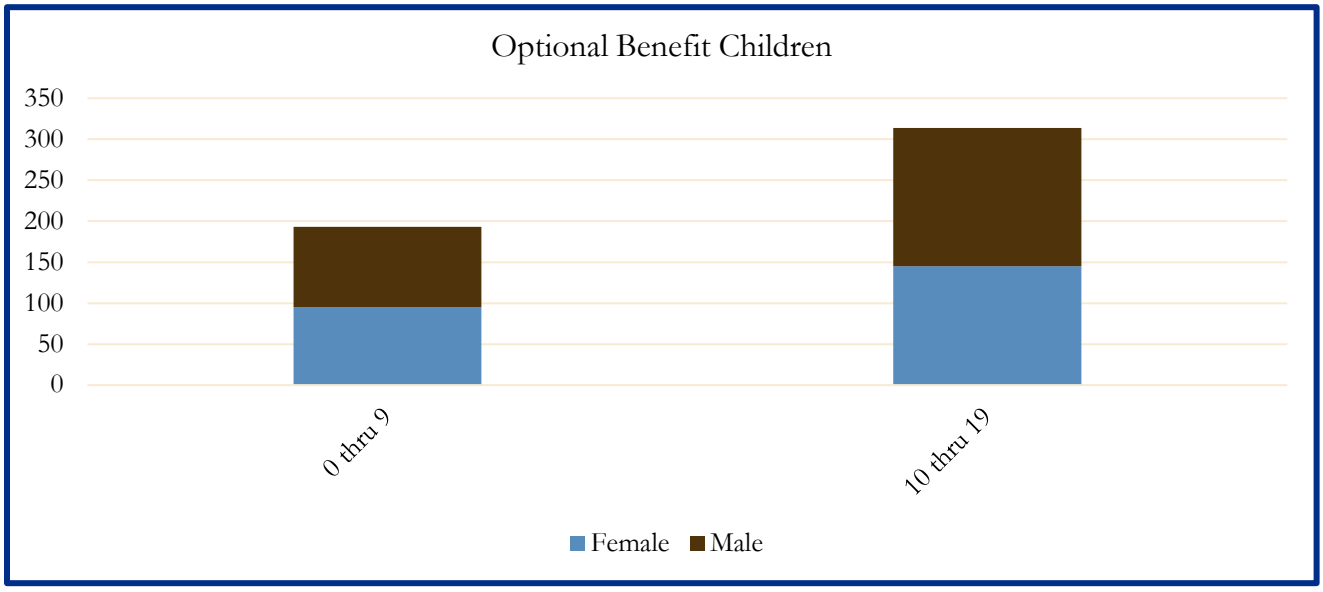
### Optional Benefit Children Caseload, Expenditure, and PMPM Comparison by State Fiscal Year

| Optional Benefit Children | | | | | |
|---|---|---|---|---|---|
| | | DVHA Only | | All AHS and AOE | |
| SFY | Caseload | Expenditures | PMPM | Expenditures | PMPM |
| SFY 2015 Actual | 916 | $ 1,253,421 | $ 113.98 | $ 2,962,429 | $ 269.39 |
| SFY 2016 Actual | 826 | $ 1,186,527 | $ 119.66 | $ 2,329,302 | $ 234.90 |
| SFY 2017 Actual | 845 | $ 1,095,901 | $ 108.14 | $ 2,440,929 | $ 240.87 |
| SFY 2018 As Passed | 831 | $ 1,224,168 | $ 122.72 | $ 2,718,568 | $ 272.52 |
| SFY 2018 BAA | 831 | $ 1,171,707 | $ 117.46 | $ 2,600,955 | $ 260.73 |
| SFY 2019 Gov. Rec. | 800 | $ 1,130,307 | $ 117.74 | $ 2,610,450 | $ 271.92 |

### Optional Benefit Children Caseload Comparison by State Fiscal Year

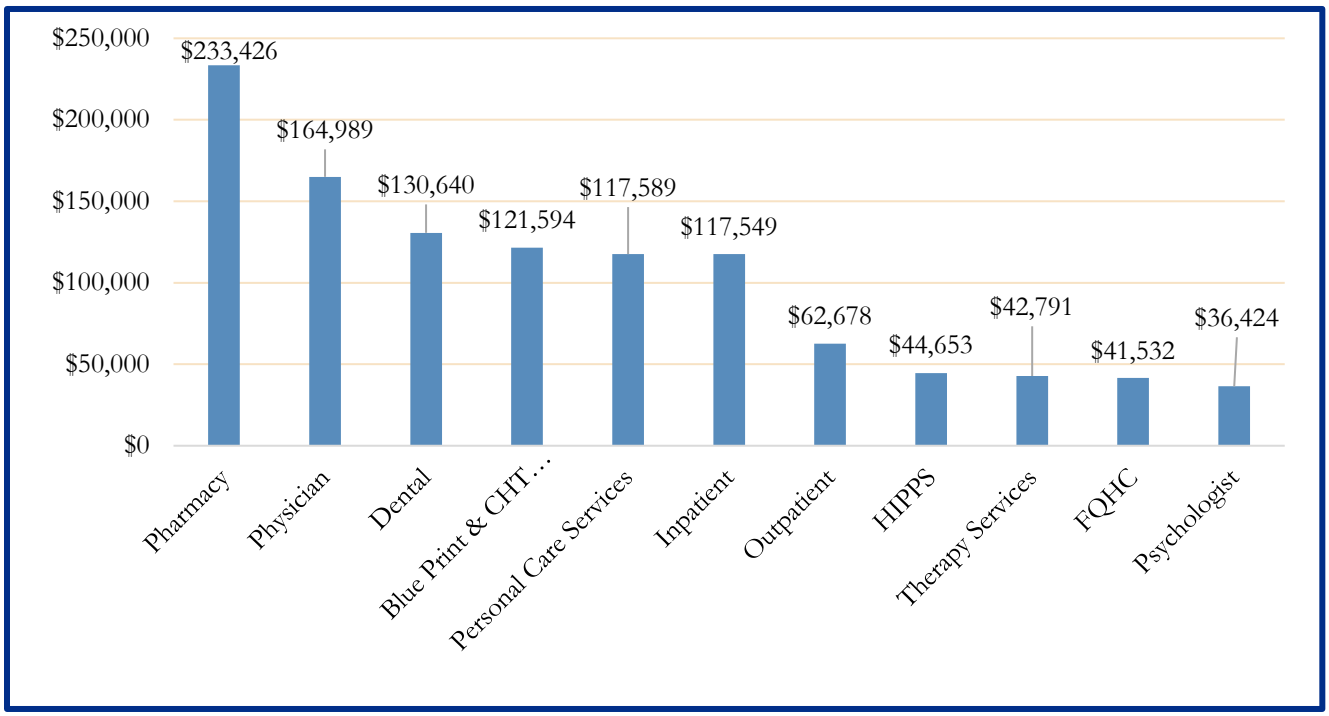


### Optional Benefit Children SFY 2017 Average Enrollment Breakout by Age and Gender




### DVHA Expenditures by Top 10 Service Categories: Optional Benefit Child

Inpatient, dental, personal care services, and professional services accounted for the majority of the $1,095,901 SFY 2017 DVHA spend.



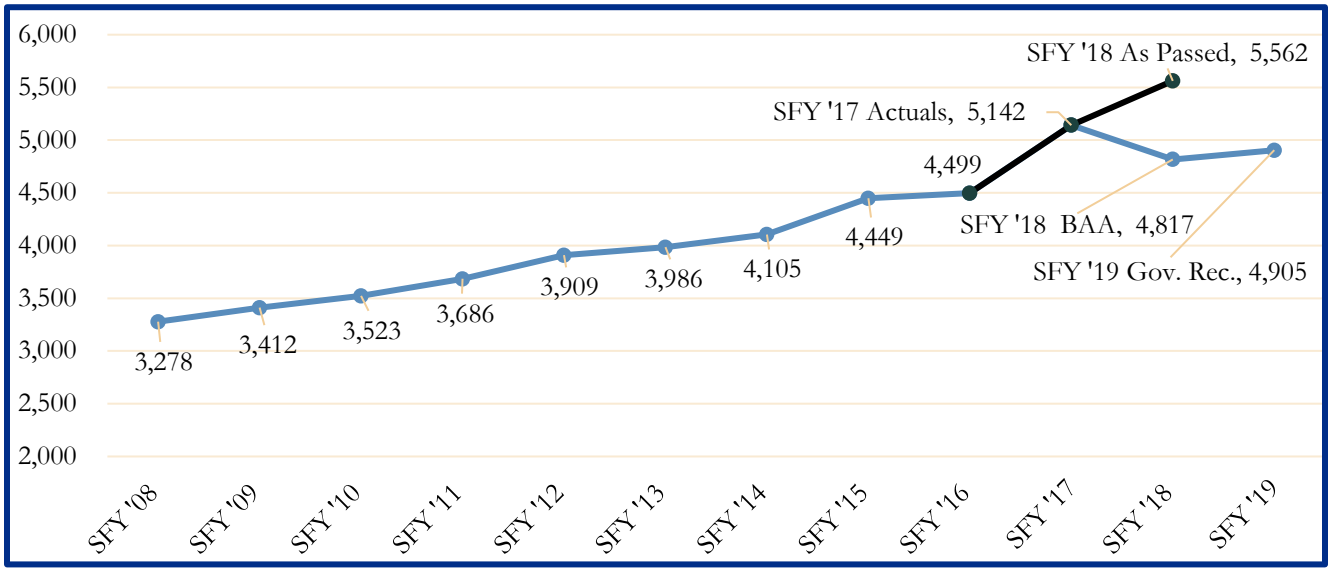
## Children's Health Insurance Program (CHIP)

The general eligibility requirements for the CHIP are: up to age 19, uninsured, and up to 312% 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. The following table illustrates the caseload and expenditure actual and estimated information.

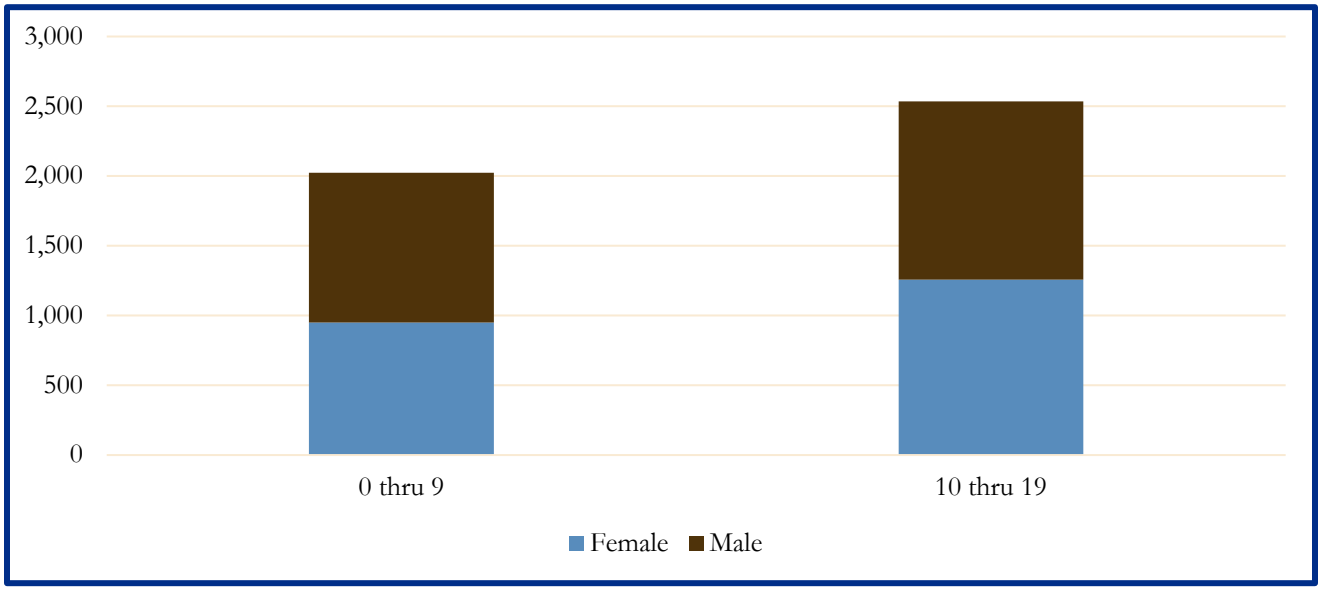
### CHIP Caseload, Expenditure, and PMPM Comparison by State Fiscal Year

| CHIP (Uninsured) | | | | | |
|---|---|---|---|---|---|
| | | DVHA Only | | All AHS and AOE | |
| SFY | Caseload | Expenditures | PMPM | Expenditures | PMPM |
| SFY 2015 Actual | 4,449 | $ 7,471,592 | $ 139.95 | $ 8,775,083 | $ 164.36 |
| SFY 2016 Actual | 4,499 | $ 7,025,792 | $ 130.15 | $ 9,755,883 | $ 180.72 |
| SFY 2017 Actual | 5,142 | $ 7,893,710 | $ 127.94 | $ 11,615,325 | $ 188.25 |
| SFY 2018 As Passed | 5,562 | $ 9,286,093 | $ 139.13 | $ 13,007,708 | $ 194.89 |
| SFY 2018 BAA | 4,817 | $ 8,314,607 | $ 143.84 | $ 12,036,223 | $ 208.23 |
| SFY 2019 Gov. Rec. | 4,905 | $ 8,295,782 | $ 140.94 | $ 12,017,397 | $ 204.17 |

### CHIP Caseload Comparison by State Budget Cycle

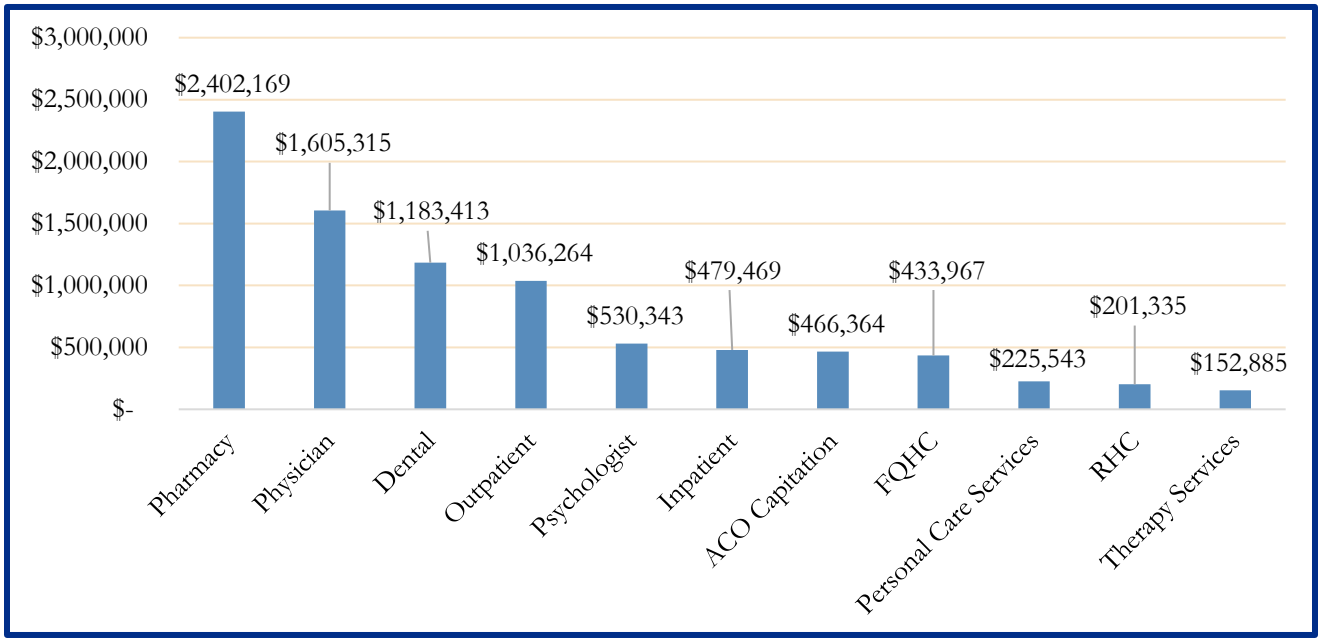


### CHIP SFY 2017 Average Enrollment Breakout by Age and Gender




### DVHA Expenditures by Top 10 Service Categories: CHIP

Professional services, outpatient, inpatient, and dental accounted for the majority of the $ 7,893,710 SFY 2017 DVHA spend.




## Premium Assistance and Cost Sharing

Individuals with household income over 138% of FPL can choose to 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

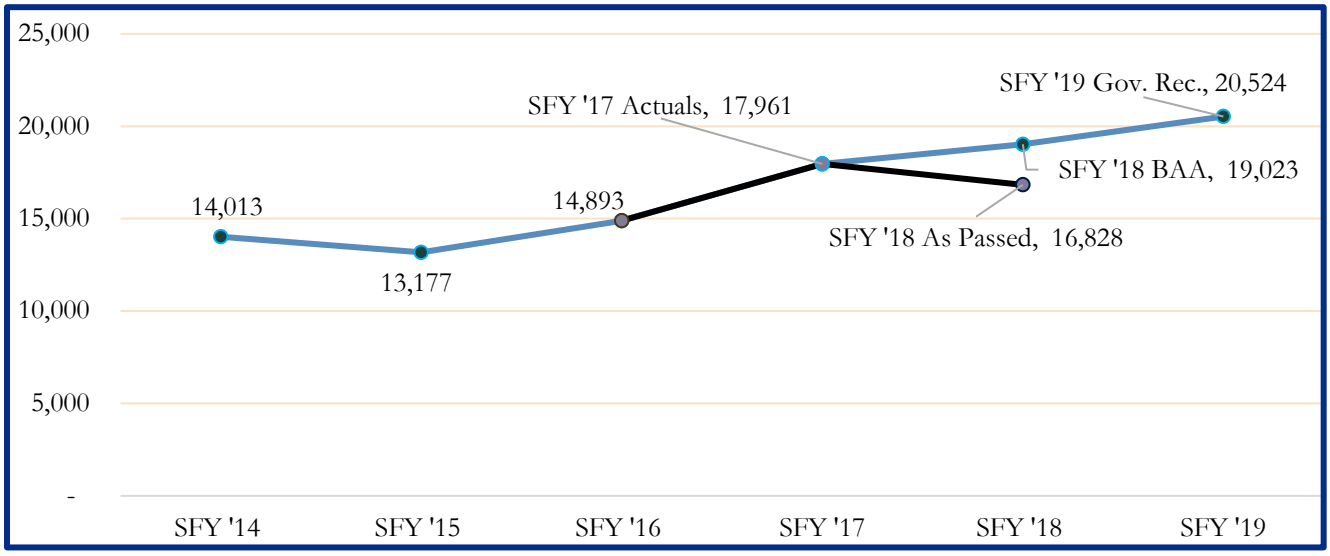
more affordable for people with incomes below 250% FPL. Despite these Federal tax credits and cost sharing subsidies provided by the Affordable Care Act, coverage through these QHP will be less affordable than Vermonters had previously experienced under VHAP and Catamount. The State of Vermont further subsidizes premiums and cost sharing for enrollees whose income is < 300% of FPL to address this affordability challenge. The following tables depict the caseload and expenditure information by SFY, including the Governor's Recommendation for SFY 2019 for the elimination of Vermont CSR effective January 1st 2019.

The following table illustrates the caseload and expenditure actual and estimated information.

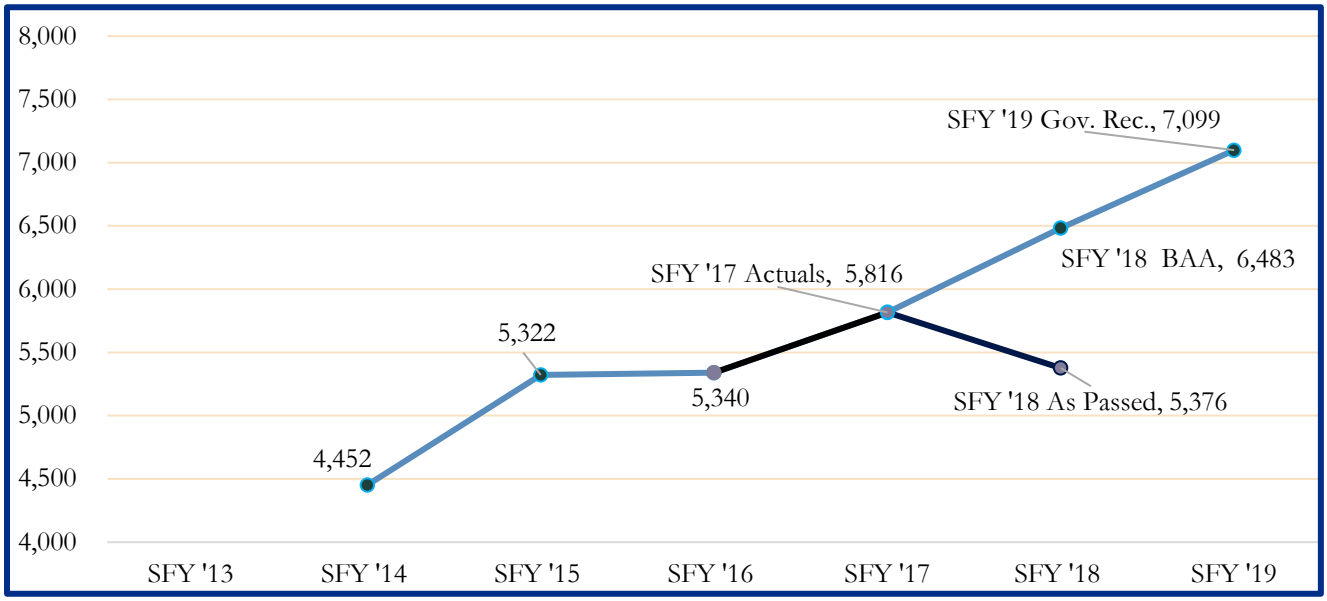
| **Premium Assistance for Exchange Enrollees < 300%** | | | | | |
|---|---|---|---|---|---|
| | | DVHA Only | | All AHS and AOE | |
| SFY | Caseload | Expenditures | PMPM | Expenditures | PMPM |
| SFY 2015 Actual | 13,177 | $ 5,611,465 | $ 35.49 | $ 5,611,465 | $ 35.49 |
| SFY 2016 Actual | 14,893 | $ 5,266,242 | $ 29.47 | $ 5,266,242 | $ 29.47 |
| SFY 2017 Actual | 17,961 | $ 6,100,378 | $ 28.30 | $ 6,100,378 | $ 28.30 |
| SFY 2018 As Passed | 16,828 | $ 5,706,135 | $ 28.26 | $ 5,706,135 | $ 28.26 |
| SFY 2018 BAA | 19,023 | $ 6,649,761 | $ 29.13 | $ 6,649,761 | $ 29.13 |
| SFY 2019 Gov. Rec. | 20,524 | $ 7,112,797 | $ 28.88 | $ 7,112,797 | $ 28.88 |

| **Cost Sharing for Exchange Enrollees < 300%** | | | | | |
|---|---|---|---|---|---|
| | | DVHA Only | | All AHS and AOE | |
| SFY | Caseload | Expenditures | PMPM | Expenditures | PMPM |
| SFY 2015 Actual | 5,322 | $ 1,138,775 | $ 17.83 | $ 1,138,775 | $ 17.83 |
| SFY 2016 Actual | 5,340 | $ 1,186,720 | $ 18.52 | $ 1,186,720 | $ 18.52 |
| SFY 2017 Actual | 5,816 | $ 1,355,318 | $ 19.42 | $ 1,355,318 | $ 19.42 |
| SFY 2018 As Passed | 5,376 | $ 1,232,289 | $ 19.10 | $ 1,232,289 | $ 19.10 |
| SFY 2018 BAA | 6,483 | $ 2,640,929 | $ 33.95 | $ 2,640,929 | $ 33.95 |
| SFY 2019 Gov. Rec. | 7,099 | $ 827,175 | $ 9.71 | $ 827,175 | $ 9.71 |

### Premium Assistance Caseload Comparison by State Budget Cycle




### Cost Sharing Reduction Caseload Comparison by State Budget Cycle




## Operations Support Team

The DVHA Operations Support team provides hands-on training, reporting, workflow, administrative support, and business process support for the Healthcare Eligibility and Enrollment Unit. This team ensures that the appropriate tools, training, and infrastructure are in place to ensure that staff can successfully assess Vermonters' eligibility for healthcare assistance programs and enroll them in the correct coverage. The Operations Support team provides support for enrollment functions, including invoicing, premium processing, and data integration which is the electronic transfer of benefit information to the qualified health plans. The team monitors these transactions, remediating errors and performing monthly enrollment reconciliation functions.

## GRIEVANCES AND FAIR HEARINGS

Vermonters have a right to file grievances and fair hearing requests – two forms of validation and contestation for eligibility determinations with which they disagree. That disagreement can come in the form of concern a mistake was made or a disagreement with the relevant policy as written. When dealing with multiple systems, complex State and Federal policies, over three hundred staff, and more than 200,000 members, it is inevitable that there will be mistakes, disagreements, and other problems. DVHA aims to both minimize the occurrence of these problems and to provide clear, formal, and informal paths for members to seek resolution

Staff at DVHA's Customer Support Center are permitted to work on member cases up until the point that a formal grievance or appeal is filed. If a mistake was made, they work to correct it or escalate it to DVHA-HAEEU's escalated case team. If, on the other hand, the system worked properly, and procedures were followed, then the customer support representatives and escalated case team may not be able to take further action. If a member disagrees with State or Federal laws or policies, then policymakers (not operational staff) are positioned to take action.

Health Care Appeals 2017 Goal:

Resolve half of appealed cases without going to the Human Services Board.

More than 7 out of 10 appealed cases were resolved without HSB involvement.

If a member files a formal grievance or appeal, only appeals staff from DVHA's Health Care Appeals Team are permitted to discuss the case with a member.

If the case is referred from the Health Care Appeals Team to the Human Services Board (HSB), only the Assistant Attorney General (AAG) will communicate directly with the member – although appeals staff will testify at the HSB hearing.

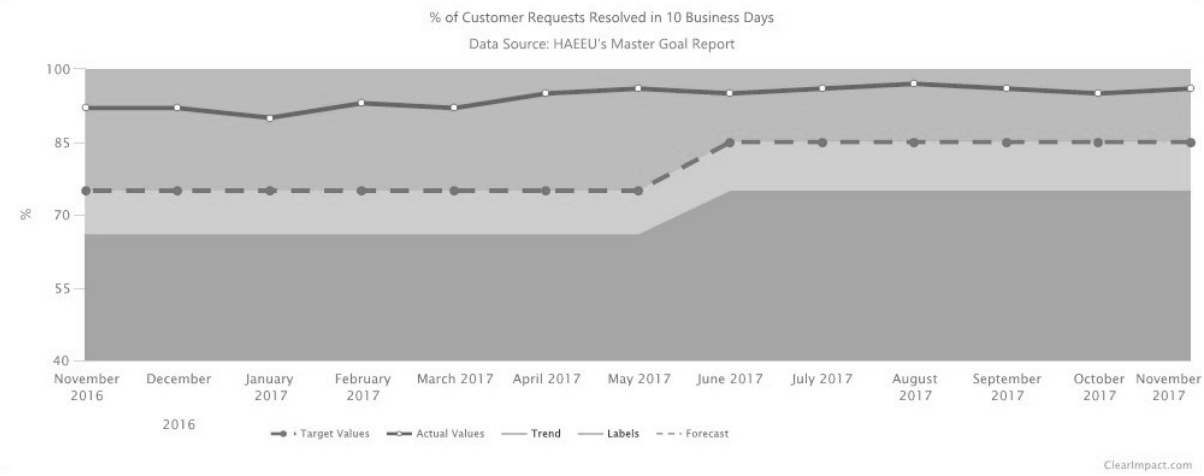
In order to provide strong customer service and to save the State's resources, the appeals staff work to identify cases that can be resolved in the customer's favor prior to referring cases to the HSB and engaging in the resource-intensive formal Fair Hearing process. This process benefits Vermonters by providing expeditious and favorable resolution to their eligibility appeals wherever possible.

In SFY 2017, the Health Care Appeals Team set a goal of resolving at least half of appealed cases in this manner per month. The unit exceeded this goal in all twelve months. For the year, more than seven out of ten appealed cases were resolved without having to go to the HSB.

Key Performance Indicators for DVHA-HAEEU are set forth on the next page.

# P Healthcare Access, Eligibility & Enrollment Unit (HAEEU) and 1 more...

## PM HAEEU % of Customer Requests Resolved in 10 Business Days




### Story Behind the Curve

This metric measures the speed at which customer requests are processed. It includes requests related to Qualified Health Plan (QHP) and MAGI-Medicaid members in the Vermont Health Connect (VHC) system as well as those related to Medicaid for the Aged, Blind and Disabled (MABD) members in Green Mountain Care (GMC) programs in the State's legacy ACCESS system.

All Vermonters who are served by DVHA-HAEEU should expect that their requests will be addressed promptly. And yet, for the first few years of VHC, many requests took several weeks or months to complete. In the first quarter of 2016, fewer than 60% of requests were completed within ten business days. That spring HAEEU set a goal of completing 75% of customer requests within ten business days by October 2016 and 85% by June 2017.

In March 2016, the State of Vermont and VHC Systems Integrator Optum deployed their final major release to enable the processing of Medicaid renewals. With the completion of major system development work, the teams no longer had to manage continual cycles of major code changes. Instead they could focus on identifying and remediating defects and making process improvements within a stable system. This effort came to be known as the Maintenance and Operations (M&O) Surge. The M&O Surge began in March 2016 and continued into the summer of 2016.

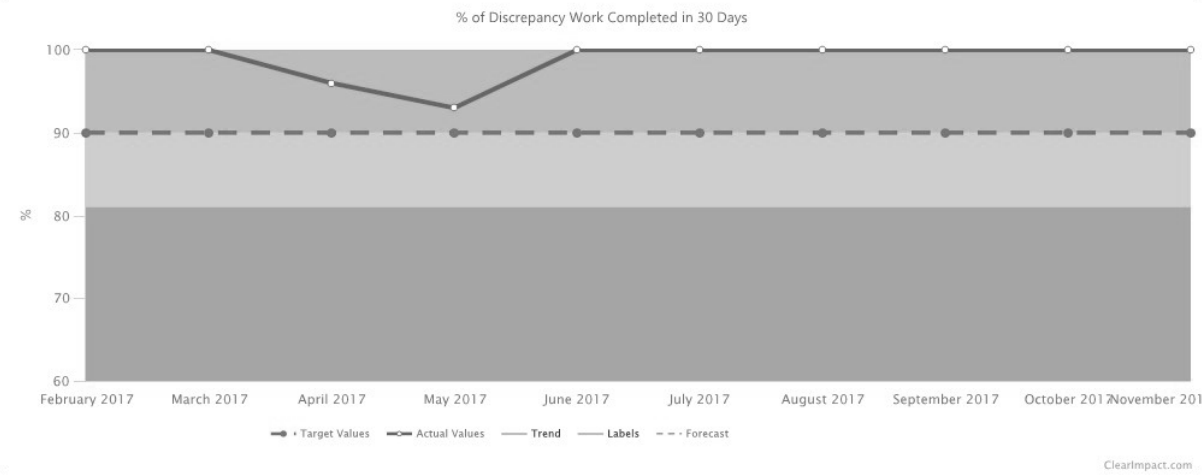
The results of the M&O Surge were clearly visible by late spring 2016. Escalated case inventories fell 80% from March levels. Integration errors were also cut 80%. Customer requests were processed in an increasingly timely manner.

In June 2016, HAEEU surpassed its October goal of completing 75% of requests in ten business days. In October 2016, they surpassed their June 2017 goal of 85%. Over the following months, performance continued to improve. With the 2017 QHP Open Enrollment and Renewal Period's successful completion, system integration improved over prior years and errors fell. As a result, customer requests were promptly completed on a more consistent basis.

The second week of March 2017 marked the first time that 95% of VHC requests were completed in ten days. Every subsequent week through the time of this writing (November 2017) then surpassed that mark. GMC requests have not had quite the same level of consistently strong performance as VHC requests over that time, yet the combined average for every month since April 2017 has been at least 95%.

# P Healthcare Access, Eligibility & Enrollment Unit (HAEEU)

## PM HAEEU % of Discrepancy Work Completed in 30 Days




### Partners

DVHA-HAEEU partners with its three carrier partners (BlueCross BlueShield of Vermont, MVP Healthcare, and Northeast Delta Dental) as well as its premium processing contractor (Wex Health).

### Story Behind the Curve

This metric looks at the number of discrepancies between the State's system and the systems of its carrier partners that are identified and should be worked within 30 days, then evaluates how many of those items actually are worked within the month.

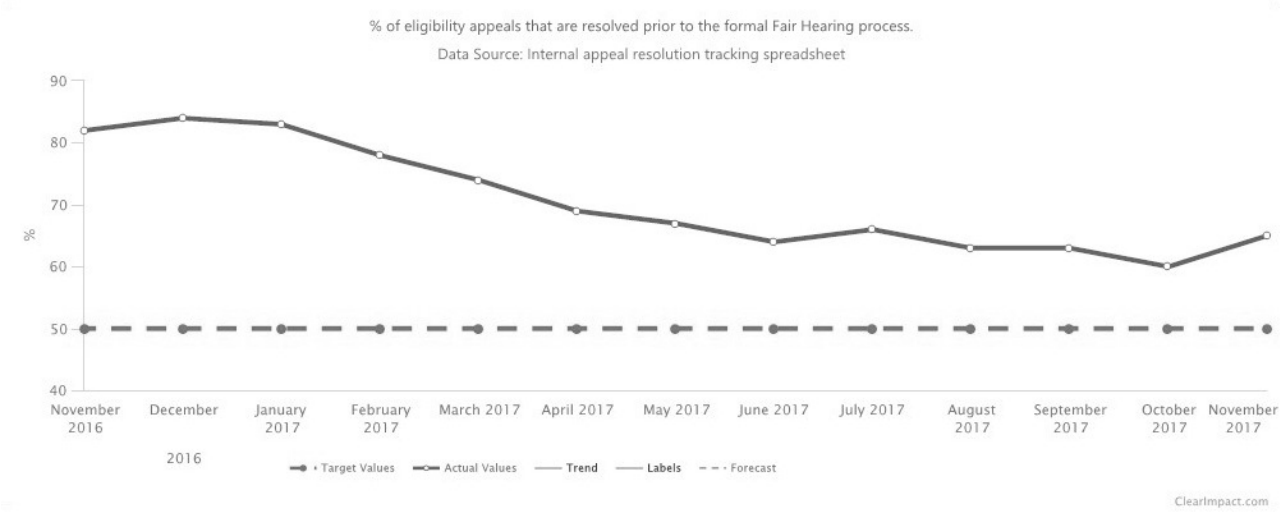
The ability to perform ongoing monthly reconciliation between the State's system and the systems of its carrier partners is essential to maintaining data integrity, ensuring a positive customer experience, and limiting financial liabilities. If the State and its partners can identify discrepancies that arise and address the vast majority (>90%) of those discrepancies within the month, they will be in a strong position to avoid lingering inventories and the accompanying risks.

False positives and items related to the timing of reports are screened out. MVP Health Care needs to improve the quality of its reports in order to enable reconciliation, which is a priority for 2018 now that MVP has a new integration vendor in place as of November 2017.

In November 2017, the reconciliation team reported that it had completed 100% of October discrepancy work -- all with the Blue Cross Blue Shield of Vermont and Northeast Delta Dental systems -- within 30 days, surpassing the 90% goal for the ninth straight month.

# P Appeals Unit

PM Appeals % of eligibility appeals that are resolved prior to the formal Fair Hearing process.




## Partners

- Office of the Attorney General
- DVHA Health Access Eligibility & Enrollment Unit

## Story Behind the Curve

This metric tracks the percentage of eligibility appeal requests received during a month that are resolved prior to a formal fair hearing. Because internal resolution may take longer than one month, the data points for previous months may be updated retrospectively.

This process benefits Vermonters by providing expeditious and favorable resolution to their eligibility appeals wherever possible. The appeals staff work to identify cases that can be resolved in the customer's favor prior to expending resources on the formal Fair Hearing process before the Human Services Board. The goal has been to resolve more than 50% in this manner. Given that the unit consistently surpassed this goal in SFY17, DVHA is increasing the goal to 65% for 2018.

*Author: Appeals Unit*

*Last updated: 12/15/17*

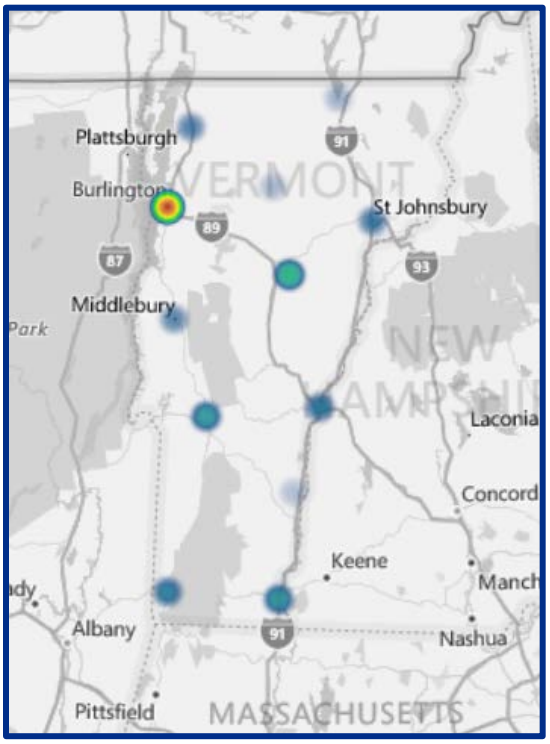
# CHAPTER THREE: PROVIDER NETWORK MANAGEMENT

## PROVIDER DEMOGRAPHICS

DVHA strives to ensure that the provider network is sufficient to deliver the right care; at the right time to prevent Vermonters from traveling too far and to maximize member choice of provider. This is true for members within the Accountable Care Organization and the remaining managed Medicaid population. Vermonters have a variety of health care needs and require an adequate network of providers that can address all of those needs and deliver all of the covered services.

Specifically, DVHA recognizes that regularly visiting a primary care provider (PCP) is beneficial for health and wellness, management of chronic disease and the reduction of overall health care costs.

The maps below demonstrate (1) the number of primary care practitioners within Vermont and across the border and (2) Medicaid members by county.




In addition to ensuring that its provider network meets State and Federal requirements, DVHA must act as a gate keeper to safeguard vulnerable Vermonter and mitigate financial risk of fraud and abuse. Additionally, DVHA conducts training and outreach to help providers understand how to bill properly so that they can get paid promptly. Training and outreach also helps members and providers stay up-to-date with changes to programs. The Provider and Member Relations (PMR) unit conducts these crucial functions and oversees a vendor responsible for provider enrollment, credentialing and phone support.

There are 18,133 providers enrolled in DVHA's network. The following table lists the number of providers by type.

## Enrolled Providers by Type of Provider

| | | | |
|---|---|---|---|
| PHYSICIAN | 10,043 | PERSONAL CARE AIDE/ASSISTANT | 23 |
| MASTERS LVL PSYCHOLOGIST/COUNSELOR | 1,508 | RURAL HEALTH CLINIC | 20 |
| NURSE PRACTITIONER | 1,493 | MR CLINIC | 16 |
| PHYSICIAN ASSISTANT | 692 | MR WAIVER | 16 |
| LIC THERAPIST OR ANES ASSISTANT | 680 | NONPROFIT TRANSPORTATION AGENCY | 16 |
| DENTIST | 505 | SRS | 16 |
| GENERAL HOSPITAL | 399 | LICENSED MIDWIVES (LAYPERSON) | 15 |
| PHARMACY | 332 | MH/NF WAIVER, NFI, BAIRD | 15 |
| PSYCHOLOGIST - DOCTORATE | 308 | ADULT DAY CARE | 13 |
| OTHER | 209 | COUNTY HEALTH DEPARTMENT | 13 |
| CHIROPRACTOR | 192 | DDMHS CASE RATE | 12 |
| DME SUPPLIER | 172 | DIALYSIS FACILITIES | 12 |
| NON-MEDICAL RESIDENTIAL FACILITY | 151 | HOSPICE | 12 |
| AGED/DISABLED WAIVER | 141 | LICENSED NURSE | 10 |
| LICENSED ALCOHOL DRUG COUNSELOR | 135 | MH/DS CLINIC - VHAP | 10 |
| OPTOMETRIST | 131 | FREESTANDING PSYCHIATRIC HOSPITAL | 8 |
| AMBULANCE | 123 | NURSING HOME - NON-MEDICARE PARTICI | 7 |
| INDEPENDENT LAB | 112 | CASE MANAGER/SOCIAL WORKER | 6 |
| NATUROPATHIC PHYSICIAN | 73 | PROSTHETICS/ORTHOTICS | 4 |
| DEPARTMENT OF EDUCATION | 65 | AMBULATORY SURGICAL CENTER | 3 |
| AUDIOLOGIST | 60 | CLINIC | 3 |
| NURSING HOME - MEDICARE PARTICIPATI | 56 | LICENSED THERAPY ASSISTANT | 3 |
| FEDERALLY QUALIFIED HEALTH CENTER | 53 | OPTICIAN | 3 |
| PODIATRIST | 47 | INDEPENDENT RADIOLOGY | 2 |
| MH CLINIC | 42 | PSYCHIATRIC RESIDENTIAL TREATMENT C | 2 |
| CHILDREN'S MEDICAL SERVICES | 32 | ACO | 1 |
| OADAP FACILITY | 31 | DEVELOPMENTAL DISABILITY AGENCY (VD | 1 |
| INDEPEND. BILLING HIGH TECH NURSES | 28 | ICF-MR PRIVATE FACILITY | 1 |
| HOME HEALTH AGENCY | 27 | SOLE SOURCE EYEGLASS LAB | 1 |
| VOCATIONAL REHAB AGENCY | 27 | TARGETED CASE MANAGEMENT | 1 |
| | | WAIVER CASE MANAGER-AGING AND ADULT | 1 |

## ENROLLMENT AND CREDENTIALING

As stated in the introduction to this section, the DVHA 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 PMR unit, beyond other responsibilities as set forth above, has responsibilities relating to providers including: provider enrollment, screening, revalidation screening and monitoring of the network to help prevent Medicaid fraud and abuse. Federal rules, specifically Title 42 Code of Federal Regulations (CFR) §§455.410 and §455.450 require all participating providers to be screened upon initial enrollment and revalidation of enrollment. Health care providers are categorized by screening levels established by the CMS and utilized by DVHA. The defined risk levels of limited, moderate and high are based on an assessment of potential fraud, waste and abuse for each provider/supplier type. DVHA then screens providers according to their risk level. DVHA may increase risk level assignments at any time and the new risk level will apply to all enrollment-related transactions.

Number of Active Providers Enrolled in Vermont Medicaid:

18,133

PMR works closely with its fiscal agent, DXC, to screen and enroll providers. There are 18,133 providers actively enrolled with Vermont Medicaid at this time. These providers are not solely practicing in Vermont as some members received care out of state. On average, DVHA enrolls about 300 new providers a month and terminates about 25 a month from participation with Vermont Medicaid. Providers terminate with Vermont Medicaid for various reasons including, but not limited to: not wanting to accept Medicaid rates, not submitting claims in the past 36 months, moving or retirement. Due to access issues with certain provider types, such as dental providers, the PMR team often contacts the provider when they indicate that they wish to no longer participate with Vermont Medicaid.

Vermont Medicaid's current enrollment process is paper-based, manual, and cumbersome for DVHA and its providers. First, providers must submit a 10 to 50-page paper application. Then DXC manually screens the provider, frequently taking up to 120 days to complete. The enrollment process is manual and time-intensive. DVHA is committed to improving this process and is working collaboratively with providers and DXC to develop short-term and long-term solutions. The PMR unit has worked closely with DVHA management to solicit an online tool to assist providers in enrolling with Vermont Medicaid. A new tool has been identified and the PMR unit along with DXC and a dedicated DVHA staff will work to implement a new Provider Management Module (PMM) in the next 12-18 months.

PMR conducts site visits for a subset of providers upon enrollment and every five years thereafter. Specifically, this subset of providers includes: ambulance service suppliers, community mental health centers (CMHC), comprehensive outpatient rehabilitation facilities (CORF), hospice organizations, independent clinical laboratories, independent diagnostic testing facilities (IDTF), physical therapists enrolling as individuals or group practices, portable x-ray suppliers (PXRS), revalidating home health agencies (HHA) and revalidating DMEPOS suppliers. In addition, newly-enrolling DMEPOS and newly-enrolling HHAs must have a site visit performed to be in compliance of 42 CFR §455.432.

Network Adequacy of the GMC Network evaluation is completed every six months. The PMR unit works with a variety of associations and societies to solicit providers to participate with Vermont Medicaid to meet the needs of its members.

## TRAINING

The PMR unit is responsible for outreach and communication to both members and providers. On an annual basis PMR oversees the publishing of a member newsletter. This newsletter is a collaborative effort with many units within DVHA. In addition, the PMR unit is responsible for the Green Mountain Care website as well as many other communications to the member community.

The PMR unit works closely with members to address their issues. The Green Mountain Care Member Support Center contractor is the point of initial contact for members' questions and concerns. If questions or concerns exist after taking with Member Support the call may come to PMR for additional research. The goal within the PMR unit is to address member issues in a timely manner and ensure the member is satisfied with the answers received. Member issues come from many different avenues, including but not limited to the Governor's office, Legislators, Vermont Legal Aid, and the provider community. The PMR unit always strives to ensure all parties are informed of the outcome of issues.

PMR has oversight of the DVHA website. In 2018, PMR will collaborate with the Vermont Agency of Digital Services to launch a new and improved DVHA website which will host information on budget, legislative rules, information on clinical resources, and more information for providers and members.

In addition to the DVHA website, PMR is responsible for the provider manual as well as the provider newsletter that goes out six times a year to enrolled providers.

For the provider community, the PMR ensures that the Vermont Medicaid provider portal, VTMedicaid.com, is kept up-to-date with fee schedules, provider billing manuals, and fee schedules.

This houses information on billing and allows providers to request assistance. The PMR unit reviews and approves DXC's provider training plan on a quarterly basis.

## SUPPORT SERVICES FOR PROVIDERS

### Provider and Member Relations

The PMR staff strives to resolve members' out-of-network emergency care billing issues while remaining mindful of enrollment and claims processing rules and regulations. The team works to ensure that members are not held responsible for emergency or post stabilization medical services when out-of-network.

There are times when members need medical services that are not available in Vermont. These services are provided by out-of-state providers after receiving authorization by DVHA's clinical staff. PMR staff, in conjunction with DXC's enrollment and claims processing staff, utilize a process that streamlines one-time enrollment requirements through timely and detailed outreach resulting in greater out-of-network provider participation and claims submission. Vermont Medicaid, through the work of dedicated PMR staff, has received praise from CMS staff for continuing to focus on such needs.

PMR oversees and monitors Non-Emergency Transportation (NEMT), issuing policies and procedures to coincide with changing circumstances and federal and state directives. PMR is also responsible for approving various trips and exceptions, including authorizing trips outside of a 60-mile radius from a member's home and out-of-state trips. As the contracted Vermont NEMT administrator, VPTA subcontracts with a network of public transportation providers to ensure statewide access to transportation services for eligible members. VPTA must ensure that these subcontractors screen for eligibility, schedule the least-costly mode of transportation to medical appointments/services, and submit claims to DXC for processing.

Challenge

VPTA will be losing the subcontractor for Windham and southern Windsor Counties effective January 2018.

Solution

VPTA created a centralized call center and a new diverse transportation network (Shared Transportation Services) that will continue to serve the area.

PMR has worked with VPTA and its subcontractors to conduct roadshows, ensure rules and expectations are followed, and respond to changes that arise. For example, in 2017, a subcontractor

in southeastern Vermont announced that it would no longer provide demand response transit service in their jurisdiction. VPTA responded by creating a centralized call center and a new diverse transportation network, called "Shared Transportation Services". This new program will continue to serve all eligible Medicaid Beneficiaries in Windham and southern Windsor Counties. In addition, "Shared Transportation Services" will strive to consistently meet or exceed the Medicaid Performance Standards around customer service, safety, timeliness, efficiency and associated reporting requirements.

### Reimbursement

The DVHA Medicaid Reimbursement Unit oversees rate setting, pricing, implementation of the National Correct Coding Initiative Program, quarterly code changes, provider payments, and reimbursement methodologies for a large array of services provided under Vermont Medicaid. The unit works with Medicaid providers and other stakeholders to support equitable, transparent, and predictable payment policy 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. This work is crucial because outpatient, inpatient and professional services combine to account for a majority of total payments overseen by Medicaid Reimbursement.

In addition, the Reimbursement Unit oversees a complementary set of specialty fee schedules including, but not limited to: durable medical equipment, ambulance and transportation, clinical laboratory, blood, physician administered drugs, dental, and home health. The unit also manages the FQHC and RHC payment process as well as supplemental payment administration such as the 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 DAIL, the Vermont Department of Health (VDH), the Vermont Department of Mental Health (DMH), DCF.

## Highlights from Calendar Year 2017 Prospective Payment Systems(PPS), Fee Schedule and Other Payment Updates

Reimbursement Calendar Year 2017 Goal:

Increase payments for E&M and VA services to be closer to Medicare payments and discounting policies.

Each year, the Reimbursement Unit updates prospective payment systems and fee schedules for inpatient, outpatient, and professional services. In calendar year 2017, in addition to continuing this update the unit worked with primary care stakeholders to increase payments for Evaluation and Management (E&M) and certain Vaccine Administration (VA) services. The program known as Enhanced Primary Care Payments (EPCP) was introduced as part of the Affordable Care Act and began paying higher rates for E&M and VA services provided on or after January 1, 2013.

The EPCP program promotes early diagnosis of serious medical conditions by primary care professionals, thereby keeping our Vermont residents healthy and helping to prevent more expensive medical treatments down the road. The goal for calendar year 2017 was to increase payments for these essential services to be closer to Medicare payments for similar services and to more closely align with Medicare discounting policies. To accomplish this the unit made program changes that aligned with Federal law to the EPCP program that included a site of service policy and revised the list of eligible services to exclude observation and emergency room visits from receiving increased payments. In consultation with primary care stakeholders, savings of $1.6 million from these policy changes were reinvested in increased payments for E&M and VA services along with an additional $1.6 million of legislatively directed funds.

On August 1, 2017, Vermont Medicaid began reimbursing at 100% of the Medicare rate for Primary Care Services.

DVHA Medicaid Reimbursement has also been working with stakeholders for FQHC and RHC to introduce a new Vermont Medicaid prospective payment system to align more fully with the Federal Benefits Improvement and Protection Act (BIPA) initially introduced in 2000. BIPA requires reimbursement of covered services to FQHC and RHC to be reimbursed based on a prospective payment system, while allowing for an alternative payment model (APM) during the time that the details of the new PPS were being developed. The new Vermont PPS will invest an additional $2.4 million for covered FQHC/RHC services and is slated for a January 1, 2018 implementation, with providers having a choice of the new PPS rates or APM rates for calendar year 2018.

As required by BIPA, DVHA will use the applicable Medicare Economic Index factor (MEI) for calendar year 2019 to update calendar year 2018 PPS rates. The update will also incorporate any changes to the base rate due to eligible changes in scopes and reasonable cost adjustment. In Calendar Year 2019, DVHA will eliminate the APM option while allowing FQHC and RHC providers to

voluntarily participate in the Vermont Medicaid Next Generation Accountable Care Organization program, where payment would be made by the ACO based on ACO rates for the attributed populations.

DVHA Reimbursement also worked with multiple stakeholders, including hospital representatives and the hospital association, to update the outpatient PPS for an October 1, 2017 implementation. Changes included a new peer group for in-state and border academic teaching hospitals and finalizing policy changes for billing services provided at off site hospital owned clinics.

DVHA Reimbursement Unit is developing a new payment methodology for DME services, that will align with the new Medicare Cures act.

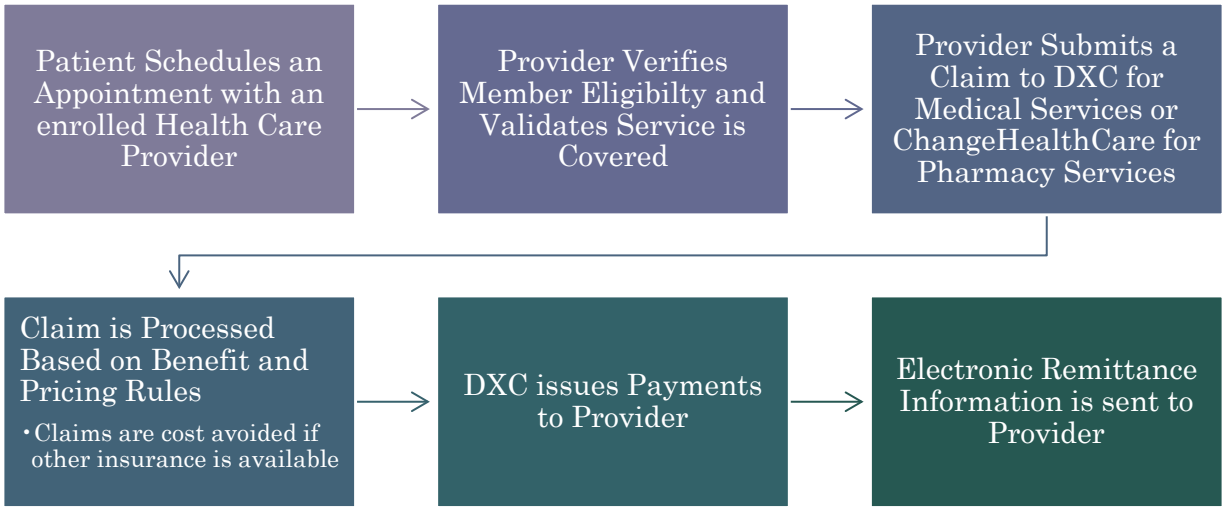
The unit and its stakeholders are developing a new payment methodology for the reimbursement of durable medical equipment (DME) to align with the new Medicare Cures act. The DME fee schedule will be updated on an annual basis following initial implementation in early 2018.

During the most recent legislative session the unit was tasked with the following projects:

- Adjusting rates upwards by 2% for home health services provided by home health agencies, hospice and high-tech services provided on or after July 1, 2017.
- Reduce DSH payments for uncompensated costs in providing services by $10 million for SFY 2018.
- Adjust the methodology used in calculating provider tax assessments due from home health agencies for SFY 2018.

The unit also updated and implemented new electronic processes for timely filing and reconsideration requests that will better serve the needs of providers with better tracking capabilities resulting in decisions being made in a timelier manner.

# CHAPTER FOUR: CLAIMS SERVICES




Claim processing and payment are functions of the Medicaid Fiscal Agent, the Clinical Unit, the Accountable Care Organization, Pharmacy Benefit Manager, and Pharmacy Unit.

## CLINICAL REVIEW AND OPERATIONS

The Clinical Operations Unit (COU) is a vital link between providers, DVHA, and the Agency of Human Services (AHS). The clinical perspective ensures that the decisions made by the department and the agency are based on solid, evidence-based medical information. Providers are supported by the COU to provide collaborative, outcome driven, comprehensive member-focused care.

The COU provides guidance via real-time telephonic support, meetings with provider groups, on-site in-services, and listening sessions. Clinical guidelines and information related to prior authorization (PA) is posted on the DVHA website for providers to access.

### Timely Reviews

The COU performs timely, thorough, and consistent reviews of medical necessity. The COU staff determines the medical necessity of a service or product provided to its members using the prior authorization (PA) process. Medical necessity determinations are made using evidence-based clinical guidelines. PA decisions must be made within time frames specified in the Medicaid Rules and in Federal regulations. The COU has a three-day goal for decisions to be rendered based

DVHA Goal:

Finalize prior authorization decisions within three days based on Medicaid regulations.

on these regulations. Reaching this goal is heavily dependent on having adequate staffing, made challenging by vacancies.

The COU can also provide post-provision oversight of services, to ensure that fair, efficacious, outcomes-driven services have been provided. This can include outcomes comparisons between payment methodologies.

### Access to Codes

As per National Correct Coding, providers must use the appropriate and correct codes for services that are provided to members. The use of correct codes allows for appropriate reimbursement for services provided to members. All CPT, HCPCS, and ICD-10 codes released each year are implemented in the Medicaid Management Information System (MMIS) by specific deadlines so that providers may submit timely claims for reimbursement. The bulk of the codes are released at the end of each year, with some new codes released quarterly. Intensive review is performed on each code before implementation in the MMIS to determine:

- Coverage, if service is permissible under state plan/rule;
- Effectiveness of service;
- FDA approval;
- Number of units allowed; and
- Edits and audits.

### Other COU Functions

- Review utilization claims reports from the Accountable Care Organization (ACO),
- Works with the Chief Medical Officer and DVHA senior management regarding specific highly complex unique cases; and
- Develops service requests log for advanced planning documents for fiscal agent services within the areas of clinical expertise.

### Successes

The COU had three significant achievements in SFY 2017, including:

1. Providing Clinical Expertise to the Policy Unit

The COU has worked closely with the Policy Unit to ensure that all policy updates are grounded in the most current medical research and perspectives. This process improvement initiative will ensure that policy changes do not have unexpected consequences for our members, our providers, and for our stakeholders.

2. Near-completion of the Rent to Purchase project

Medicare and many regional State Medicaid programs utilize a Rent to Purchase or a capped rental payment system for specific durable medical equipment (DME). Medicare's capped rental program is designed to pay for a piece of DME for 13 months. After 13 months of rental the beneficiary owns the DME item. Medicare pays for reasonable and necessary maintenance and servicing of the item, i.e., parts and labor not covered by a supplier's or manufacturer's warranty.

DVHA has implemented a Rent to Purchase payment system for Vermont Medicaid.

The COU partnered with the Reimbursement and Program Integrity Units to implement a Rent to Purchase payment system for Vermont Medicaid. The Vermont Rent to Purchase program will pay for specific DME for ten months and the item will then be considered fully purchased. This payment method will save VT Medicaid money because the rental payments will be included in the purchase price, which is not the current practice. The rental reimbursement for the item is based on the maximum allowed for the DME. Charges beyond the ten-month rental will be denied. The multi-unit team is working with DXC to implement necessary systems enhancements before the start of program. DME vendors were informed of the Rent to Purchase payment policy at a meeting held at DVHA in November 2017. The start date for this program is January 1, 2018. Unlike Medicare's program, DVHA remains the owner of all purchased DME. This allows DVHA to recycle equipment, resulting in additional savings.

3. Healthcare Advancements

The COU constantly seeks out research regarding the ongoing changes in medical technology and procedures that are changing the landscape of the healthcare industry. The COU ensures that decisions made by DVHA are based on the most current, well supported, peer reviewed medical literature at least annually. COU also uses data analysis to create initiatives and to track progress. The unit utilizes targeted data pulls to ensure that Medicaid funds are spent wisely and fairly.

## Future State

The Clinical Operations Unit has identified four increasingly important areas of future work, including:

1. Clinical Criteria Development for Genetic Tests and Procedures

Genetic testing is a relatively new science and can be performed to confirm a suspected diagnosis, predict future illness, detect when an individual might pass a genetic mutation to his or her children, screen newborns, and predict response to therapy. Many of the laboratories developing new genetic tests, and many of the existing tests, are not regulated by the Food and Drug Administration or any other entity. The scientists developing this new field of medicine are focused on its expansion and not necessarily the costs. The cost of a single test can range into hundreds of dollars.

To make clinically sound, medically appropriate, and cost-effective decisions, we need evidence-based guidelines. Due to limited staff resources and the time it takes to develop credible guidelines, the COU has only developed about a dozen guidelines. Commercial genetic test guidelines do not clearly demonstrate the clinical utility for most genetic tests in order to support our decisions.

2. Incontinence Supplies

After a competitive bidding process, our goal is to establish a single source contract with a company that can provide high quality incontinence products and related supplies to Vermont Medicaid members in a cost-effective and customer-friendly manner, utilizing economies of scale. The goal is to:

- Increase member access to special size and types of incontinence supplies.
- Increase product quality.
- Reduce the cost of Medicaid incontinence supplies.

3. Adult Outpatient Therapy Services:

COU would like to focus on ensuring that adult outpatient therapy services are being provided in a way that is most efficient and most demonstrates best practice, while also adhering to Medicaid Rule. With no increase in staff, this can be done with post-provision review for selected practices that appear to demonstrate over- or under-utilization of services. With additional support, a higher level of oversight and guidance could be provided, including pre-provision review. Providers prefer pre-provision review because it is focused on provider education, rather than the far more painful post-provision recoupment.

4. Post Payment Reviews of Inpatient Admissions:

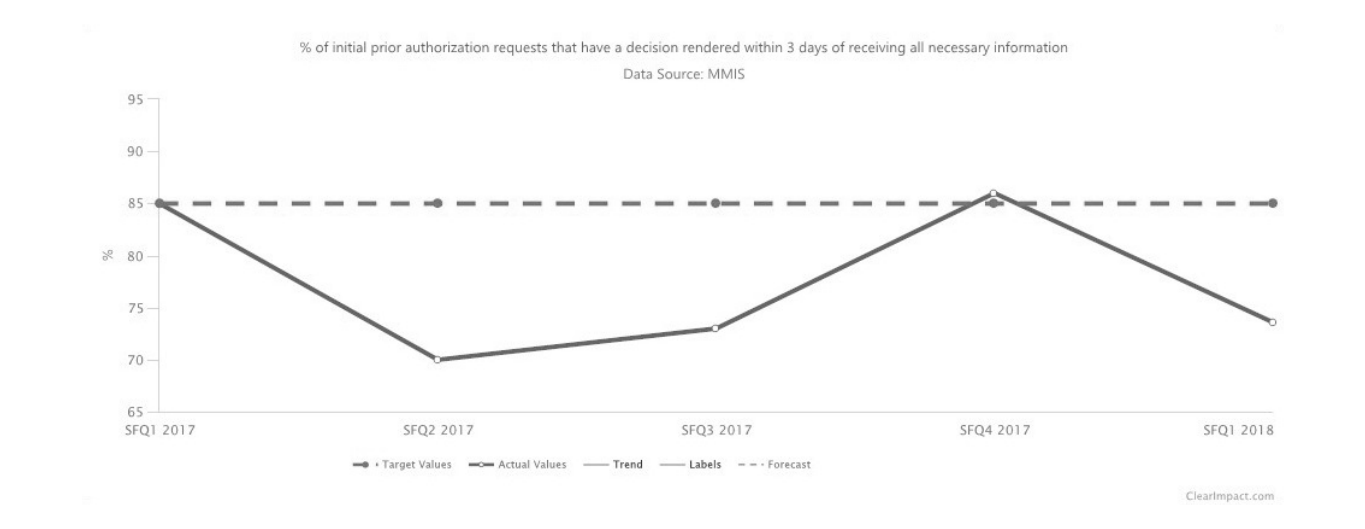
The COU plans to implement the following studies to obtain a thorough understanding of providing the most efficacious care for Medicaid members:

- Review a percentage of cases from each facility to verify the medical necessity of admission, intensity of services, appropriate level of care, length of stay, and effective discharge planning.
- Review rehospitalization rates, including the issues that have led to rehospitalization. This study includes the rehospitalization diagnosis, the length of time post discharge for admission by a home health agency, and the length of time before medically necessary equipment is received, for individuals who are re-hospitalized.

The Key Performance Indicators for the Clinical Review and Operations Unit are set forth on the next page.

# P Clinical Operations Unit

## PM COU % of initial prior authorization requests that have a decision rendered within 3 days of receiving all necessary information




### Partners

- DXC contract staff
- Part time physician support
- Chief Medical Officer (CMO)

### Story Behind the Curve

The Clinical Operations Unit (COU) staff determine the medical necessity of a service or product provided to its members using the prior authorization (PA) process. Medical necessity determinations are made using evidence-based clinical guidelines. PA decisions must be made within time frames specified in the Medicaid Rules and in Federal regulations.

The 3 day goal for a decision to be rendered is based on CMS rule. Reaching this goal is heavily dependent on having adequate staffing. Th e COU has had extended review time due to vacancies:

- Nurse out for 6 weeks due to injuries
- Chief Medical Officer position being vacant with only part time coverage
- Administrative vacancy

**This performance measure is important because it shows:**

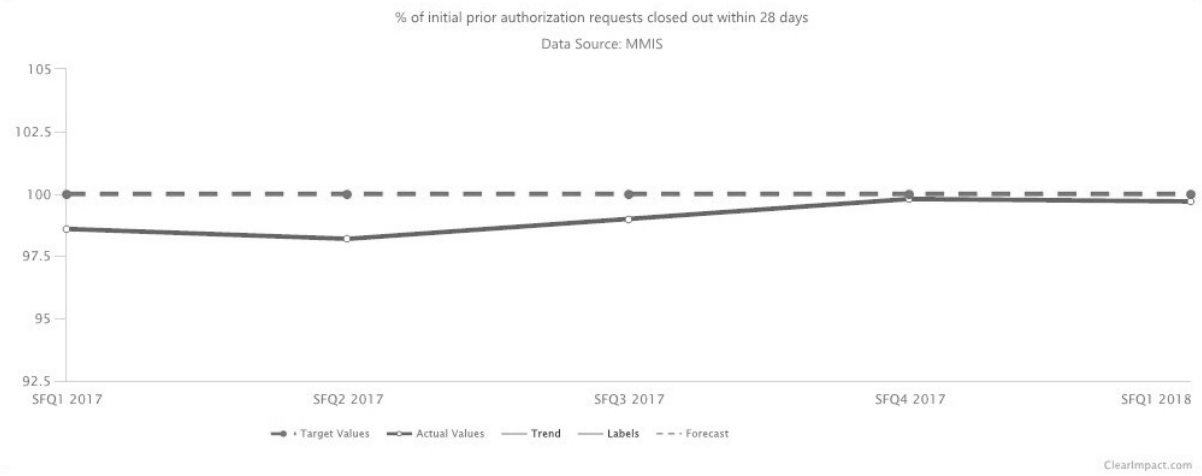
- Timely access to treatment/services for members.
- Compliance with State and Federal Regulations.
- The PA turnaround times are reported to the External Quality Review Board (EQRO) and to KPMG, an auditing service that monitors the COU's regulatory compliance.

*Last updated: 10/31/17*

*Author: Clinical Operations Unit*

# P Clinical Operations Unit

## PM COU % of initial prior authorization requests closed out within 28 days




### Partners

- Part time physician support
- Chief Medical Officer (CMO)
- DXC contract staff
- DXC Provider Relations
- DVHA Provider Member Relations Unit
- DVHA Data Unit
- DVHA enrolled providers and vendors

### Story Behind the Curve

The Clinical Operations Unit (COU) staff determine the medical necessity of a service or product provided to its members using the prior authorization (PA) process. Medical necessity determinations are made using evidence-based clinical guidelines. PA decisions must be made within time frames specified in the Medicaid Rules and in Federal regulations.

There is variation in this data that is out of the control of the COU. This data heavily relies on Medicaid providers sending sufficient clinical information so a complete clinical review and decision can be rendered.

The COU has had extended review time due to vacancies:

- Nurse out for 6 weeks due to injuries
- Chief Medical Officer position being vacant with only part time coverage.

This performance measure is important because it shows:

- Timely access to treatment/services for members
- Compliance with State and Federal Regulations
- The PA turnaround times are reported to the External Quality Review Board (EQRO) and to KPMG, an auditing service that monitors the COU's regulatory compliance

*Last updated: 11/14/17*

*Author: Clinical Operations Unit*

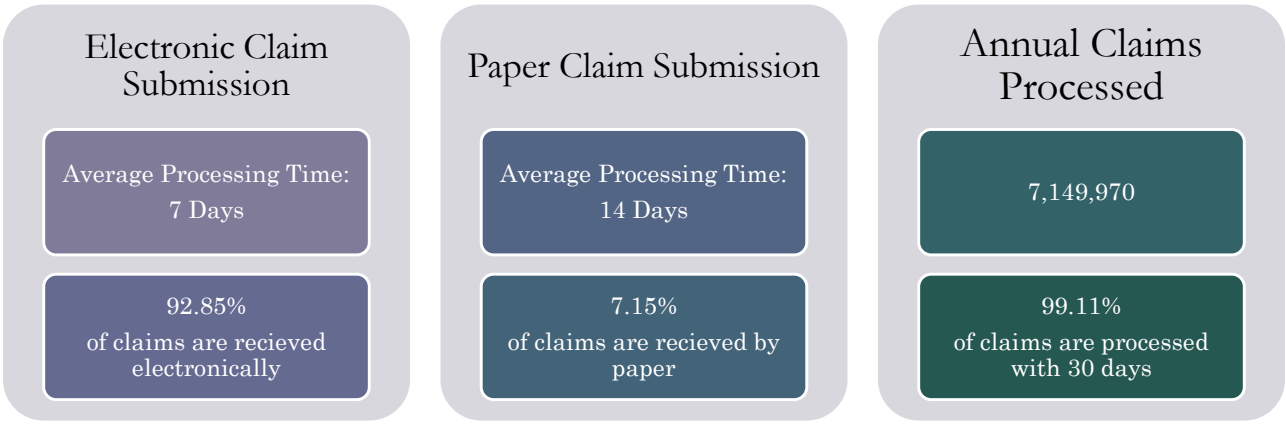
## CLAIMS UTILIZATION AND PAYMENT

DXC Technologies, formerly known as Hewlett Packard Enterprise (HPE), provides DVHA with Medicaid fiscal agent services that include claims processing and payment, financial services, provider enrollment, and system maintenance and operation. This system is referred to as the fiscal agent/claims processing component of the MMIS.

DXC processes over seven million claims a year for the State through the MMIS. DXC has provided Medicaid fiscal agent services to DVHA since 1981. The fiscal agent accepts claims and mail in the mailroom, scans the mail into micro media data, enters the claims (paper and electronic), processes the claims, mails checks or EFT payments to the providers, enrolls providers, answers help desk calls from providers, performs coordination of benefit services, and supports data analytics activities. MMIS activities include:

| | |
|---|---|
| **Member Identification Card Production and Distribution** | **Financial Services** |
| **Claims Processing and Payment** | **Coordination of Benefits** |
| **Management Reporting, Data Analytics** | **Security** |
| **Provider Education and Relations** | **System Maintenance and Operation** |
| **Provider Enrollment** | **System Modification and Enhancement** |

The system is certified by CMS and CMS provides for 75% of the cost of operating the DXC MMIS. The graphic below depicts the SFY 2017 claims processing statistics and highlights the advantage to providers if they submit claims electronically.



## PHARMACY UNIT

The Pharmacy Benefit Management programs ensure that our members receive medically necessary medications in the most efficient and cost-effective manner possible. The DVHA Pharmacy Unit is responsible for managing all aspects of Vermont's publicly funded pharmacy benefits program. Responsibilities include but are not limited to: processing pharmacy claims; making drug coverage determinations; assisting with drug appeals and exception requests; overseeing federal, state, and supplemental drug rebate programs and the manufacturer fee program; resolving drug-related pharmacy and medical provider issues; overseeing and managing the Drug Utilization Review (DUR) Board; managing of the Preferred Drug List (PDL); and assuring compliance with state and federal pharmacy and pharmacy benefits regulations. The Pharmacy Unit is responsible for seeing that members receive high-quality, clinically appropriate, evidence-based medications in the most efficient and cost-effective manner possible. In addition, the unit focused on improving health information exchange and reducing provider burden through e-prescribing, automating prior authorizations, and other efforts related to administrative simplification for DVHA and its providers.

### Pharmacy Benefit Programs Summary

| Benefit Plans | Pharmacy Coverage | Co-Pays |
|---|---|---|
| **Medicaid**<br>**Dr. Dynasaur**<br>**GA** | Coverage of all CMS covered outpatient drug, rebate participating manufacturers. Also, limited list of OTC, Rx, Vitamins, cough and cold preparations | $1<br>$2<br>$3 |
| **Healthy Vermonters** | Passes through to the patient the Medicaid Pharmacy Reimbursement rate. DVHA does not reimburse for services. | 100% Co-Pay |
| **VPharm** | SPAP "wrap-around" Medicare drug benefit, pays Part C/D cost-share | $1<br>$2 |
| **VMAP (managed at VDH)** | HIV/AIDS and related medications | $1, $2, $3 |
| **Dual Eligible (including CFC)** | Non-Part C/D covered drugs only | $1, $2, $3 |

## Successes

The Pharmacy Unit realized four areas of achievement:

1. Strong Clinical and Cost Management

The Pharmacy Unit processed over 2.1 million claims through the contracted Pharmacy Benefit Manager, Change Healthcare, and managed nearly $191 million in gross drug spending in SFY 2017, a decrease of $17 million from SFY 2016. Over half of this reduction is attributed to decreases in Medicaid enrollment, while approximately $4 million is attributed to improved pharmacy management and cost control programs such as optimizing our preferred drug list, rebates, and maximum allowable cost programs. Gross drug spending reflects what DVHA paid to both in-state and out-of-state pharmacies enrolled in our network.

### SFY 2017 Pharmacy Spend

| SFY 2017 | No. of Claims | Amount Paid | Cost Per Claim |
|---|---|---|---|
| Medicaid and Duals | 1,755,455 | $185,419,175 | $105.62 |
| VPharm | 355,249 | $5,892,685 | $16.59 |
| **All Programs** | **2,110,704** | **$191,311,860** | **$90.64** |

Change Healthcare (CHC) has employed physicians who provide additional support to DVHA and the drug benefit program by attending and presenting clinical drug information at our Drug Utilization Review Board Meeting, acting as a clinical resource to the pharmacy team, providing peer to peer consults and supporting DVHA's medical director as needed, and supporting DVHA's drug appeals and fair hearings. This has provided a higher level of clinical support and credibility to our programs.

2. Improved Customer Service

Beginning in January 2015, pharmacies and prescribers now have a Vermont-based Help Desk in South Burlington servicing DVHA providers and staffed by Vermont pharmacists and pharmacy technicians. This call center assists pharmacies with drug coverage questions, claims processing issues, and processes all the prior authorization requests from prescribers for Medicaid members. The Help Desk is the first point of contact for pharmacy and medical providers with questions, concerns, and complaints. The Help Desk software tracks contacts and problem resolution through a technical call management application, to facilitate logging, tracking, and resolution of all calls and issues in addition to performance monitoring.

3. Improved Automation and Administrative Simplification for Providers

The Pharmacy Unit continues to make strides toward reducing the burden of manual prior authorizations. One notable achievement in SFY 2017 was the launch of an automated prior authorization (PA) program. This program has allowed the automation of many edits in the system that alleviate the need for a prescriber to fax a paper form to DVHA. As a result, less than 5% of claims require a manual PA.

**Monthly Prior Authorization Summary**

| | Automated PA's/Overrides | | | | | Manual PA's | |
|---|---|---|---|---|---|---|---|
| **PA Statistics** | **Paid without PA** | **Paid with Auto-PA** | **Paid with online override** | **Paid with Emergency PA (Auto)** | **Paid due to grandfathered GPI** | **Paid with Clinical PA (Manual)** | **Total Claim Count** |
| **Claim Counts** | 141,479 | 22,697 | 190 | 106 | 3,291 | 8,168 | 175,931 |
| **% of Total Claims** | 80.42% | 12.90% | .11% | 0.06% | 1.87% | 4.64% | 100.00% |

A new provider portal called eWEBS will launch in February 2018. The portal is being developed by our Pharmacy Benefits Manager Change Healthcare®, and is designed for use by prescribers, pharmacies, and program administrators. It provides a secure way for registered users to look up member eligibility, member drug history, and PDL information. In addition, providers can electronically submit PA requests, and track the progress of PA requests online. Prescribers are guided through preferred or non-preferred selections, as well as potential step therapy, dose limits or other PDL criteria giving them the ability to make informed drug choices.

In addition, in February 2018, DVHA will implement e-prescribing interface which will enable Medicaid-enrolled prescribers with EHR systems to utilize the Surescripts® network and system platform to view Vermont Medicaid members' drug history and the State's preferred drug list to make informed prescribing decisions.

4. CMS Certification of the Pharmacy Benefit Management System (PBMS)

As the final step in pursuing certification of the PBM system, DVHA completed a site visit by CMS in November 2017. Presentations were given to CMS and MITRE by both state staff and Change Healthcare staff on PBM system access, basic navigation, and all components and functionality within

the PBMS. Presentations also included demonstrations of how the PBMS meets the criteria with in the following CMS certification checklists: Pharmacy Module, Information Architecture, Standards and Conditions for Medicaid IT, Technical Architecture (TA) Access & Delivery, TA Intermediary & Interface, and TA Integration & Utility which constitute the five "Common Checklists."

This certification effort evaluated the solution and associated documentation to ensure adherence to federal regulations and industry standards. By achieving certification, DVHA can claim 75% federal financial participation (FFP) for maintenance and operations (M&O) costs; until a solution is certified, a state is only eligible for 50%. While the formal certification approval letter is still pending, CMS summarized the review as thorough, informative, and successful.

## Challenges and the Future

The Pharmacy Unit has identified two significant future challenges:

1. Increasing Expenditures on Specialty Drugs

   Although there is no standard industry definition, a specialty drug is generally defined as:
   - The cost of the medication exceeds $5,000 per month.
   - The medication is used in the treatment of a complex, chronic condition. This may include, but is not limited to drugs which require administration, infusion, or injection by a health care professional.
   - The manufacturer or FDA requires exclusive, restricted, or limited distribution. This includes medications which have Risk Evaluation and Mitigation Strategies (REMS) requirements requiring training, certifications, or ongoing monitoring for the drug to be distributed.
   - The medication requires specialized handling, storage, or inventory reporting requirements.

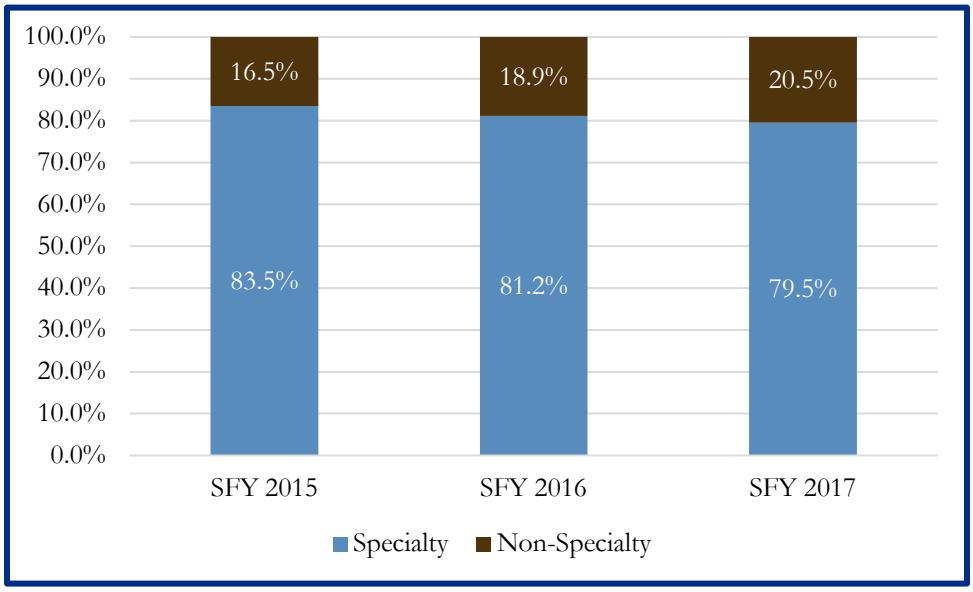
In SFY 2017, the average cost of prescription drugs was about $106, and the average cost of a specialty prescription drug was over $7,000.

Specialty medications include, but are not limited to, drugs used in the treatment of the following conditions: Cancer, Cystic Fibrosis, Endocrine Disorders, Enzyme Deficiencies, Hemophilia, Hepatitis C, Hereditary Angioedema, Immune Deficiency, Inflammatory Conditions such as Crohn's Disease, Ulcerative Colitis, Rheumatoid Arthritis, Psoriatic Arthritis, Ankylosing Spondylitis, and Psoriasis, Multiple Sclerosis, Pulmonary Arterial Hypertension, and Respiratory Syncytial Virus (RSV).

In SFY 2017, specialty drugs represented 20.5% of DVHA's overall drug spend. This was a 1.6% increase over SFY 2016, when specialty drugs represented 18.9% of DVHA's drug spend. While the average cost per prescription of drugs dispensed by DVHA was about $106 dollars, the average cost of a specialty drug prescription was over $7,000 dollars. Specialty drugs will continue to put financial strain on the Medicaid program, especially some of the newer targeted and gene therapies; which can cost more than $500,000 per patient per year. DVHA will be laser-focused on monitoring the pipeline of new drugs, the prevalence of the diseases they treat in Vermont, and analyzing their potential overall impact to DVHA's budget.

In SFY 2017, specialty drugs were 20.5% of DVHA's drug spend, which was a 1.6% increase when compared to SFY 2016.

### Clinical and Fiscal Challenges: Specialty Drugs as a Percent of Total Drug Cost




**Value-Based Contracting as it Impacts Specialty Drugs:** During the past decade, payment models for the delivery of health care have undergone a dramatic shift from focusing on volume to focusing on value. This shift began with the Affordable Care Act and was reinforced by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which increased the emphasis on payment for delivery of quality care. Today, value-based care is a primary strategy for improving patient care while managing costs.

Pharmaceutical value-based contracts (VBC) have emerged as a mechanism that payers may use to better align their contracting structures with broader changes in the healthcare system. Pharmaceuticals are one of the fastest-growing segments of the healthcare marketplace and increasing drug costs necessitate the flexibility to contract in new ways based on the value of these products.

Increasingly, reimbursement decisions for drugs will be based on their demonstrated impact on patient outcomes.

Although not all drugs are appropriate for these types of contracts, VBC could be a part of the solution to address increasing drug prices and overall drug spending. Under value-based pricing agreements, payers and pharmaceutical companies agree to link payment for a medicine to value achieved, rather than volume. DVHA is carefully monitoring opportunities to participate in VBC's through its membership in the Sovereign States Drug Consortium (SSDC), which is now the largest and only independent state-owned rebate pool in the country. Vermont was one of the three founding members of the SSDC, which now boasts twelve member-states.

2. Pharmacist-Based Medication Management Services


As we move toward a healthcare system focused less on "fee-for-service" payments and more focused on payments for improved health outcomes, DVHA's Pharmacy Unit is exploring pharmacist payments for improved medication management. Medication management services performed by pharmacists are distinct from medication dispensing and focus on a patient-centered, rather than an individual product-centered process of care. The key goals of a medication management program include providing quality services to patients, enhancing therapeutic outcomes, and maximizing cost-effectiveness. Medication management services encompass the assessment and evaluation of the patient's complete medication therapy regimen, rather than focusing on an individual medication product. The type of care provided through medication management may include the pharmacist checking in regularly with the patient to ensure he or she is taking medications as prescribed, verify the patient is following health and wellness guidelines, and checking into any related problems such as adverse reactions to medications. Various medication management programs are demonstrating positive clinical, economic, and health outcomes.

## DATA MANAGEMENT AND ANALYSIS UNIT

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.

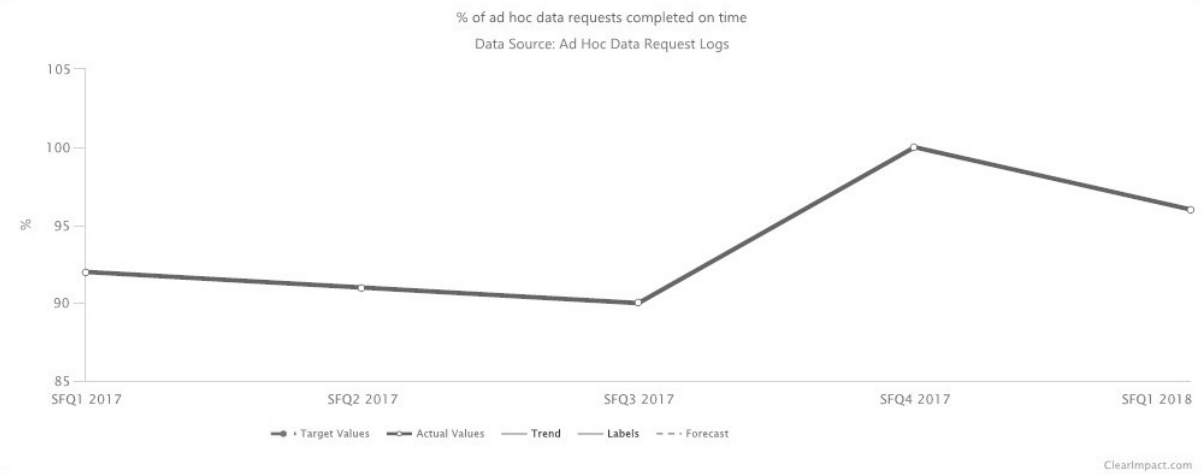
AHS and DVHA initiatives around performance measures, performance improvement projects, and pay-for-performance initiatives are supported by the unit. DVHA has successfully implemented hybrid measures for the three last HEDIS seasons. The unit continues to support the AHS Central Office monitoring of the 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.

Key Performance Indicators for the Data Team are set forth on the next page.

# P Data Management & Integrity Unit

## PM DATA % of ad hoc data requests completed on time




### Partners

- Agency of Human Services Central Office
- Vermont Department of Health Alcohol & Drug Abuse Program
- Vermont Department of Health Oral Health Program
- Green Mountain Care Board
- OneCare Vermont
- Joint Fiscal Office
- Clinical Utilization Review Board
- DVHA Business Office
- DVHA Clinical Operations Unit
- DVHA Coordination of Benefits Unit
- DVHA Policy Unit
- DVHA Provider & Member Relations Unit
- DVHA Payments Reform Unit
- DVHA Quality Unit
- Vermont Health Connect

### Story Behind the Curve

Percent of ad hoc data requests completed on time by the Data Unit.

As a support entity within the department responsible for the development of information resources required for effective policy making, planning, regulation and evaluation for the state's Medicaid program it is important to know how often the Data Unit is asked and relied on to provide data analysis to support ongoing policy development and implementation of Medicaid programs.

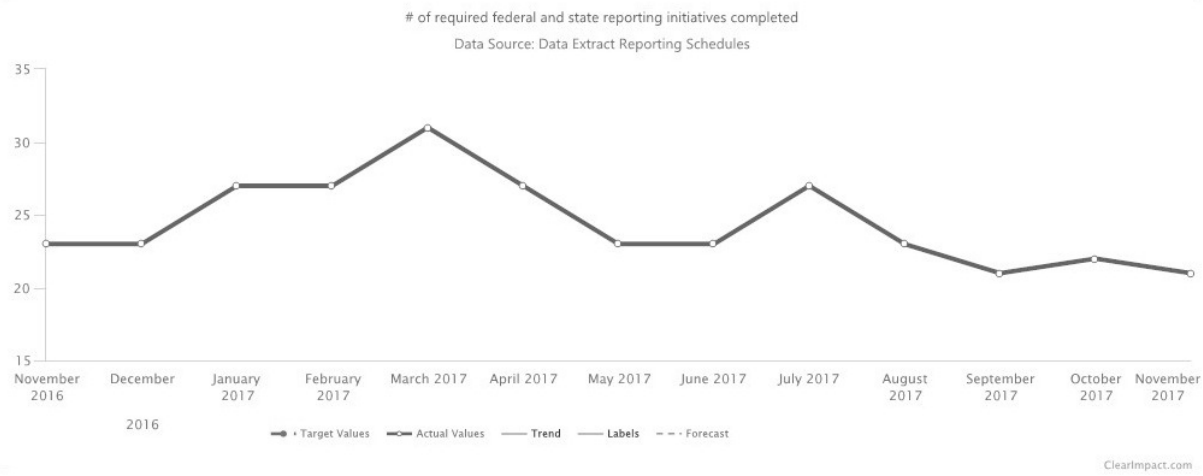
Requests come into the Data Unit from various program staff in DVHA and sister departments in the Agency on any given day. ASAP requests are assigned a 2 business day turn around time. As an example, if an ASAP request comes in on Monday, it is assigned a due date of Wednesday. Other requests that are not ASAP are assigned a 10 business day turn around time.

*Last updated: 10/31/17*

*Author: Data Management & Integrity Unit*

# P Data Management & Integrity Unit

## PM DATA # of required federal and state reporting initiatives completed




### Partners

- Agency of Human Services Central Office
- Burns & Associates
- Centers for Medicare & Medicaid Services
- DVHA Business Office
- eQ Health Systems
- Onpoint Health
- OneCare Vermont

### Story Behind the Curve

Number of data extracts/required reporting deliverables completed by the Data Unit.

As a support entity within the department responsible for the development of information resources required for effective policy making, planning, regulation and evaluation for the state's Medicaid program it is important to know how often the Data Unit is asked and relied on to provide data analysis to support ongoing policy development and implementation of Medicaid programs.

The Data Unit routinely completes ad hoc data requests, receives and provides data extracts (files) to and from contracted business partners to support department initiatives and complementary data systems, and regularly provides mandated reporting to state and federal entities.

*Last updated: 12/15/17*

*Author: Data Management & Integrity Unit*

## HEALTH INFORMATION TECHNOLOGY

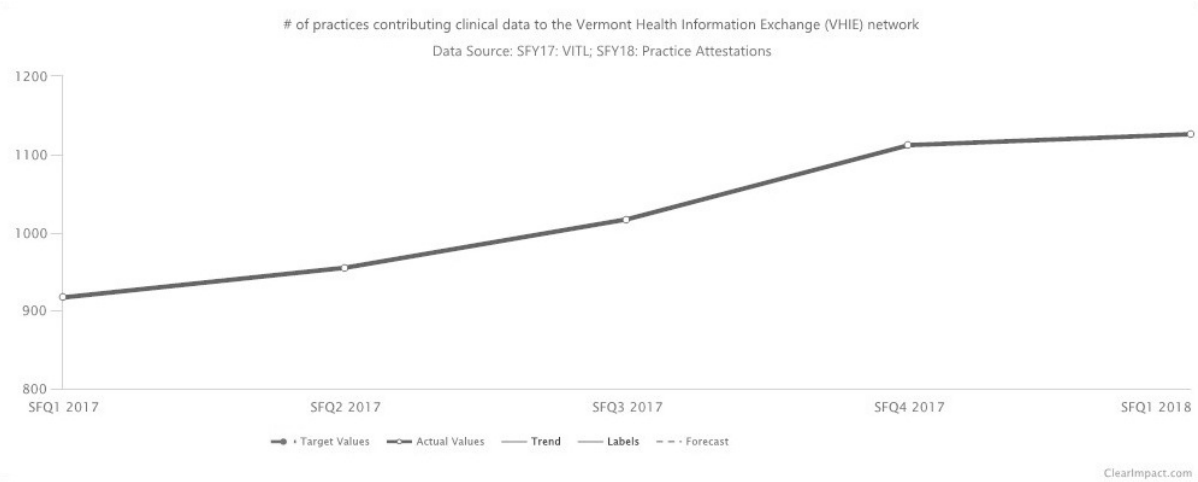
DVHA's Health Information Technology (HIT) program exists to put high quality health data in the hands of those who need it, whether their focus is caring for individual patients or working to improve the health of Vermont's population through health analytics. Health information informs our decisions and allows us to see opportunities and progress made with regards to controlling healthcare costs and improving Vermonters' health and well-being. The HIT program initiatives are federally, and state funded to support a variety of dependent HIT efforts such as Vermont's Health Information Exchange (VHIE), the Blueprint for Health's Clinical Registry, and the Department of Health's Immunization Registry. The HIT program continues to mature as state policy evolves as a tool to understand, coordinate and support the healthcare landscape.

Beginning in SFY 2018, DVHA's HIT plan includes support for development of a care coordination platform as part of the State's all-payer accountable care model and improved connectivity with the Vermont Care Network's behavioral health repository.

Key Performance Indicators for the HIT unit are set forth on the next page.

# P Health Information Technology (HIT) & Health Information Exchange (HIE) Unit

## HIE/HIT # of practices contributing clinical data to the Vermont Health Information Exchange (VHIE) network




### Notes on Methodology

- VITL's goal for SFY18 is to establish 120 new interfaces. The state has contracted with VITL to remediate or create up to 85 interfaces.

### Partners

- Vermont Information Technology Leaders (VITL)
- Medical Practices

### Story Behind the Curve

The Vermont Health Information Exchange (VHIE) exists to aggregate clinical data to support providers at the point of care and those measuring the population's health and the cost of health care. The mechanism for obtaining the clinical data is an interface (technical connection) between an electronic health record system and the VHIE. Since 2009, the state has funded VITL to develop these interfaces and the VHIE to aggregate the clinical data documented in medical records.

The sharing of clinical data is essential to improving health care quality, making care more efficient, reducing administrative burden, engaging patients in their care, and supporting the health and well-being of the Vermont community. As more practices contribute to exchange data, the better able providers are to care for patients.

*Last updated: 10/31/17*

*Author: HIE-HIT Unit*

# P Health Information Technology (HIT) & Health Information Exchange (HIE) Unit

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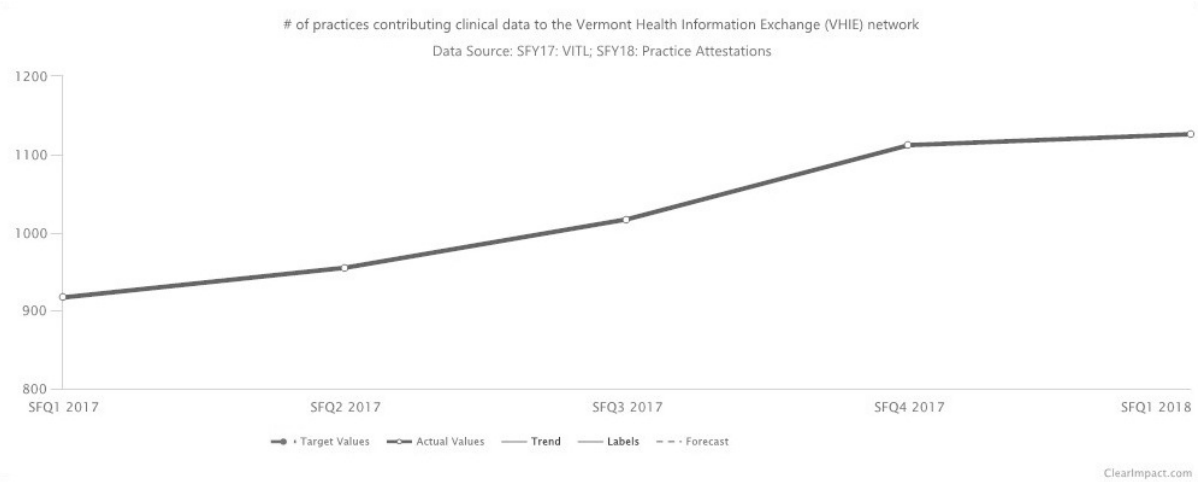


### Notes on Methodology

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*Last updated: 10/31/17*

*Author: HIE-HIT Unit*

## PAYMENT REFORM

The Payment Reform Unit seeks to transition Vermont Medicaid's healthcare revenue model from Fee-for-Service payments to Value-Based payments. In support of this goal, the Payment Reform Unit partners with internal and external stakeholders in taking incremental steps toward the integrated healthcare system envisioned by the Vermont All-Payer Accountable Care Organization Model agreement with the Centers for Medicare and Medicaid Services. The Payment Reform Unit also works with providers and provider organizations in testing models, and ensures the models encourage higher quality of care and are supported by robust monitoring and evaluation plans.

The Payment Reform Unit is available as a resource to DVHA and to other departments within the Agency of Human Services in the consideration of potential payment reform options. The unit is also responsible for the implementation and oversight of the VMNG Accountable Care Organization (ACO) program, a financial model designed to support and empower the clinical and operational capabilities of the ACO provider network in support of the Triple Aim of better care, better health and lower costs.

During the next year, the Medicaid Payment Reform team will continue to oversee the implementation, evaluation and evolution of the VMNG program, and will provide support to Departmental and Agency leadership in the consideration of and planning for any additional value-based payment reform models to support continued advancement toward an integrated healthcare system in Vermont.

### Accountable Care

In 2017, DVHA began to test a voluntary pilot program, the VMNG Accountable Care Organization (ACO) program, which prioritizes paying for the quality of care for each Vermonter rather than the quantity of services delivered. The model is focused on prevention, empowering primary care providers and coordinating care. It does so through ACOs, which are provider-led and -governed organizations, with a substantial regional clinical leadership role, that have agreed to assume accountability for the quality, cost, and experience of care. The goal of the pilot is to improve health while moderating healthcare costs which are a barrier to affordability. The VMNG ACO program pursues this goal by taking the next step in transitioning the healthcare revenue model from Fee-for-Service payments to Value-Based payments. One ACO, OneCare Vermont, is currently working with the State to participate in this model. In its first year (2017), OneCare's Medicaid pilot included four hospital communities made up of approximately 2,000 providers and around 29,000 attributed Medicaid members. In calendar year 2018, ten communities

In OneCare Vermont's 2017 Medicaid pilot there were four hospital communities with approximately 2,000 providers and 29,000 Medicaid members.

will participate, including more than 5,000 unique providers and approximately 42,000 attributed Medicaid members.

Through the VMNG, DVHA (through DXC Technologies) pays OneCare a monthly fixed prospective payment (FPP) for services provided by hospitals (and hospital-owned practices) participating with the ACO. This is a monthly, per member payment made in advance of the services being performed. Medicaid fee-for-service payments continue for all other non-hospital providers in the ACO, for all providers who are not a part of the ACO, and for all services that are not included in the fixed prospective payment. As OneCare providers are still required to submit claims for all services, zero-paid "shadow claims" are used to calculate the cost of services delivered (according to the Medicaid fee-for-service fee schedule) that were covered by the prospective payment from DVHA to OneCare. In addition, OneCare has agreed to a risk-based spending target for the full attributed population during the performance year. If the ACO exceeds its spending target for the performance year, it is liable for expenses up to 103% of the target; if the ACO spends less than its target, it may retain savings to 97% of the target. This arrangement provides an incentive to use resources efficiently. Because the ACO is responsible for both the cost and quality of care for each attributed member, OneCare will also withhold some of the payment to providers up front—0.5% in 2017—to support a quality incentive program. The providers in the ACO can earn this money back through high quality performance on targeted quality measures. This type of payment incentive is provided to encourage high quality care and is expected to grow over time.

Though the fixed prospective payment gives providers and DVHA certainty and predictability regarding revenue for a pre-identified population of Vermonters, claims lag makes it difficult to gauge actual financial performance of the program with certainty until a period of claims run-out has been allowed. The program is designed to consider 180 days as a sufficient period of time for claims to have been completed, after which time DVHA will conduct a year-end financial reconciliation exercise for the 2017 performance year. Caution must be exercised before drawing conclusions based on financial reporting during the performance year.

The 2017 pilot year has served as a baseline year and valuable learning experience both internally at DVHA, and externally in its partnership with OneCare. Though the Payment Reform Unit is the designated contract monitor for the ACO program, coordination across the department in a number of functional areas is crucial to the program's success. Subject matter experts throughout DVHA review required reports from the ACO which

monitor its quality improvement, clinical, financial, provider/member communications, and care management data, to ensure alignment with the department's goals of high-quality care for its members. Externally, DVHA and OneCare have developed a collaborative partnership in support of program implementation and oversight. Regular meetings between DVHA and OneCare operational teams have ensured that a continuous feedback mechanism is in place, giving staff the ability to make operational adjustments as needed. As a result, VMNG program operations have become further streamlined over the course of the year. Ongoing coordination between DVHA and OneCare will be required to maintain and optimize operations in a second performance year.

As the program continues into a second performance year, more data will be available to support meaningful evaluation of both quality and financial performance. DVHA will continue to analyze the financial, clinical, and quality performance of the program to determine its efficacy and to determine whether the ACO program generally, and the fixed prospective payments to hospitals specifically, are contributing to an overall moderation in DVHA healthcare spending.

Table A shows monthly changes in attribution of Medicaid members in the 2017 VMNG Program.

**Table A. Medicaid Members Attributed to OneCare for the 2017 VMNG Program**

| ***Attributed Medicaid Members**** | **Jan** | **Feb** | **Mar** | **Apr** | **May** | **Jun** | **Jul** | **Aug** | **Sep** | **Oct** | **Nov** | **Dec** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % of 29,102 | **100.00%** | **99.72%** | **98.54%** | **97.04%** | **93.17%** | **92.11%** | **91.07%** | **89.29%** | **86.58%** | **84.67%** | **83.61%** | **82.60%** |
| Total | 29,102 | 29,021 | 28,676 | 28,240 | 27,115 | 26,806 | 26,503 | 25,985 | 25,197 | 24,642 | 24,332 | 24,038 |
| Aged, Blind, Disabled | 1,910 | 1,907 | 1,906 | 1,878 | 1,819 | 1,808 | 1,790 | 1,791 | 1,773 | 1,764 | 1,755 | 1,742 |
| General Adult | 12,987 | 12,933 | 12,754 | 12,525 | 11,980 | 11,845 | 11,646 | 11,331 | 10,764 | 10,512 | 10,326 | 10,164 |
| General Child | 14,205 | 14,181 | 14,016 | 13,837 | 13,316 | 13,153 | 13,067 | 12,863 | 12,660 | 12,366 | 12,251 | 12,132 |

*Defined after February 1, 2017 as number of individuals for whom a monthly prospective payment was made.

Attribution of Medicaid members to the ACO occurs prospectively, at the start of the program year. In this way, the ACO is aware of the full population for which it is accountable at the program's outset and can use that information to identify and engage members most effectively. Although no members can be added during the course of a program year, some of the prospectively attributed members may become ineligible for attribution during the course of the program year. Members may become ineligible for attribution due to:

- Becoming ineligible for Medicaid coverage[7]
- Switching to a limited Medicaid benefits package (e.g. pharmacy-only benefits)
- Gaining additional sources of insurance coverage (e.g. commercial or Medicare)
- Death

A member may also become ineligible for attribution if the primary care practice through which they were attributed terminates its contract with the ACO in the middle of the year. Effective May 1, 2017, a practice of four primary care providers seeing approximately 500 of the prospectively attributed Medicaid members terminated its contract with OneCare Vermont for the 2017 performance year because it was acquired by an organization that is not a part of OneCare's 2017 VMNG network. As

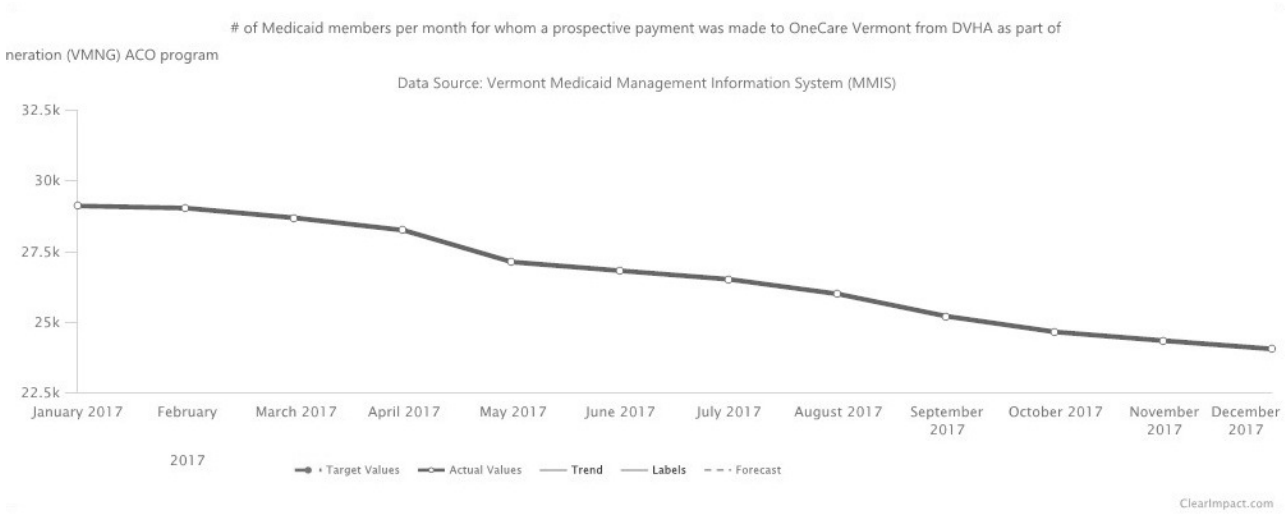
a result, the table below shows a more pronounced drop in attribution from April to May than any of the preceding or following months.

[7]If a member has lost Medicaid coverage but later becomes eligible for Medicaid again during the performance year, they may also become eligible for attribution again at the time.

Key Performance Indicators for the Payment reform unit are set forth on the next page.

# P Payment Reform Unit

PM Payment Reform # of Medicaid members per month for whom a prospective payment was made to OneCare Vermont from DVHA as part of the Vermont Medicaid Next Generation (VMNG) ACO program




## Notes on Methodology

| PMPM Payment Information by Medicaid Eligibility Group (MEG) by Month | | | | | | |
|---|---|---|---|---|---|---|
| Report Period | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 |
| % of 29,102 | 91.1% | 89.3% | 86.6% | 84.5% | 83.6% | 82.6% |
| Total # | 26,503 | 25,985 | 25,197 | 24,642 | 24,332 | 24,038 |
| ABD # | 1,790 | 1,791 | 1,773 | 1,764 | 1,755 | 1,742 |
| ABD % | 6.8% | 6.9% | 7.0% | 7.2% | 7.2% | 7.2% |
| Gen Adult # | 11,646 | 11,331 | 10,764 | 10,512 | 10,326 | 10,164 |
| Gen Adult % | 43.9% | 43.6% | 42.7% | 42.7% | 42.4% | 42.3% |
| Gen Child # | 13,067 | 12,863 | 12,660 | 12,366 | 12,251 | 12,132 |
| Gen Child % | 49.3% | 49.5% | 50.2% | 50.2% | 50.4% | 50.5% |

## Story Behind the Curve

This measure shows ACO Attribution. It is broken down by Medicaid Eligibility Group (MEG) and shows what percentage of each MEG makes up the reported total.

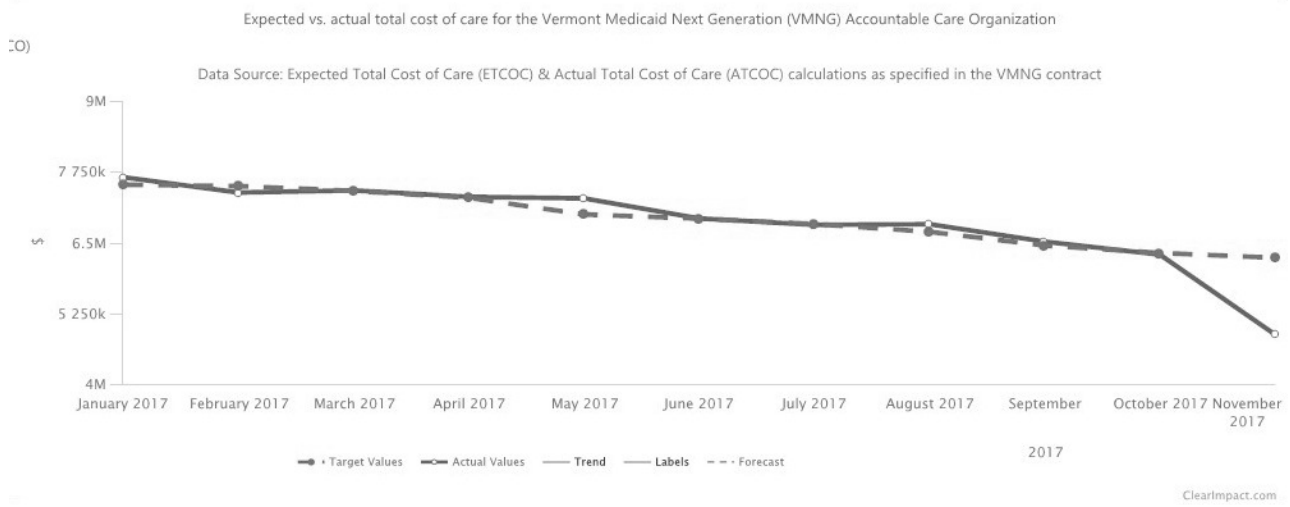
**This measure is a useful indicator of:**

- How many actively attributed members the ACO has in a given month (which helps quantify the program's scale)
- Any fluctuation in attribution on a month-to-month basis, overall and by MEG (which helps quantify population dynamism and the effects of changing Medicaid eligibility on prospective ACO attribution).

Member attribution to the VMNG ACO program is set prospectively (at the beginning of a performance year), and no new members are added to the population during a performance year. However, prospectively attributed members may be considered ineligible for attribution in a given month due to a number of factors, including eligibility changes (e.g. loss of Medicaid coverage); evidence of an additional source of insurance coverage or ageing into Medicare eligibility; death; or termination of a contractual relationship between an attributing provider practice and the ACO (at which time all members that had been attributed through that practice are no longer considered attributed to the ACO). Some members may subsequently become eligible for attribution again after losing eligibility in an earlier point in the year, but a 1-1.5% decrease in the number of PMPM payments made is expected month-to-month in a given program year. The more significant decrease (4%) in the number of members for whom payments were made between April and May highlights an instance in which an entire practice's membership was removed from the ACO-attributed population due to termination of a contractual relationship between that practice and the ACO (OneCare Vermont).

# P Payment Reform Unit

PM Payment Reform Expected vs. actual total cost of care for the Vermont Medicaid Next Generation (VMNG) Accountable Care Organization (ACO)




## Notes on Methodology

****Please note in the chart above that the solid trend line shows the actual total cost of care (ATCOC) and the dotted trend line shows the expected total cost of care (ETCOC)**

| ETCOC & ATCOC for the Vermont Medicaid Next Generation Accountable Care Organization | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Report Period** | **Jan-17** | **Feb-17** | **Mar-17** | **Apr-17** | **May-17** | **Jun-17** | **Jul-17** | **Aug-17** | **Sep-17** | **Oct-17** | **Nov-17** |
| ETCOC | $7,522,630 | $7,498,277 | $7,413,414 | $7,292,219 | $6,997,783 | $6,923,243 | $6,829,556 | $6,691,562 | $6,449,538 | $6,318,547 | $6,231,854 |
| ATCOC* | $7,655,673 | $7,385,142 | $7,422,600 | $7,308,814 | $7,282,379 | $6,927,519 | $6,814,790 | $6,825,712 | $6,517,342 | $6,288,614 | $4,877,553 |
| Over/(Under)* | $133,043 | ($113,135) | $9,186 | $16,595 | $284,596 | $4,276 | ($14,766) | $134,150 | $67,804 | ($29,933) | ($1,354,301) |
| *Please note that data for ATCOC and the over/(under) will be updated for all historical months on a monthly basis as additional claims are processed. Expected values will remain constant. | | | | | | | | | | | |

## Story Behind the Curve

The Accountable Care Organization's (ACO's) expected total cost of care (ETCOC) is derived based on actuarial projections of the cost of care in 2017 for the population of prospectively attributed Medicaid members, using 2015 claims for the attributed members as a baseline and trending it forward to 2017.

The ACO's actual total cost of care (ATCOC) is the sum of the Fixed Prospective Payment (FPP) paid to the ACO and the total actual Fee-For-Service expenditures paid by DVHA on behalf of the ACO to its providers for services not covered by the FPP.

The ACO has agreed to a risk-based spending target for the full attributed population during the performance year. If the ACO exceeds its spending target for the Performance Year, it is liable for expenses up to 103% of the target; if the ACO spends less than its target, it may retain savings to 97% of the target. This arrangement provides an incentive to use resources efficiently. If the ETCOC and ATCOC are equal, then the ACO's actual spending is on consistent with its projected spending for the performance year, and a minimal amount of financial reconciliation will occur between the ACO and DVHA during the final financial reconciliation. If the ETCOC is greater than the ATCOC, the ACO's spending has been less than the financial target, and the ACO would be eligible to retain a portion of the dollars saved relative to the target. Conversely, if the ATCOC is higher than the ETCOC, the ACO's spending has exceeded its financial target, and the ACO would be liable for a portion of the dollars spent in excess of the target.

Caution should be exercised when using this information to evaluate financial performance during the performance year, as claims lag has a significant impact on financial data, and the data does not factor in claims or payments that will need to be reconciled after the program year. At this time, the ACO's overall expenditure for January through June of 2017 is higher than the expected total cost of care for the corresponding months.

# CHAPTER FIVE: DVHA'S COMMITMENT TO QUALITY AND IMPROVEMENT

## VERMONT CHRONIC CARE INITIATIVE

The Vermont Chronic Care Initiative (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 behavioral health conditions including depression and substance use continue to be focus areas for the VCCI population, as there is high prevalence of these conditions along with other chronic diseases among members who account for the highest cost of care; and supporting members in depression management is indicated prior to addressing other chronic healthcare conditions.

VCCI also offers case management for at-risk pregnant persons (Medicaid Obstetrical and Maternal Supports (MOMS)), including people with substance use and mental health disorders; and those with a prior history of premature delivery. Studies have suggested that these conditions in pregnancy put the pregnant person and infant at greater risk and generate higher associated cost of delivery and Neonatal Intensive Care Unit costs (NICU). These risks and costs may be positively impacted by proactive care management by VCCI field-based staff during pregnancy.

VCCI has had success caring for Vermonters; however, DVHA is seeking to align its healthcare reform vision, goals, and resources. Accordingly, DVHA will re-evaluate VCCI's work to determine the best use of these resources, including how VCCI coordinates with partners like the Blueprint for Health. The rest of this section will discuss current practice.

The VCCI works with the most vulnerable Medicaid members – those with highest risk, cost and utilization of services - to support timely and appropriate access to health care services; health education and coaching on their chronic health conditions to improve health literacy; and the advocacy and tools required to support effective and ongoing self-management of their chronic health conditions.

A core component of VCCI case management and care coordination of complex Medicaid members is concurrently addressing the medical, behavioral, and psychosocial needs of these high risk/high cost members to help them make sustainable change that improves not only their health but reduces health care costs. National research indicates that individuals with complex health needs account for 5% of the overall population and these individuals account for 50% of medical expenses. A significant percent of the complex need population has high frequency of emergency department (ED) visits (47%) and stress related to insecurity in food, housing, transportation (62%), as compared to those without complex health needs. The attributes of the VCCI target population are similar.

Individuals with complex health care needs account for 5% of the population, but 50% of medical expenses.

### Member Identification and Outreach

A typical VCCI member has multiple chronic medical and/or behavioral health conditions, complex pharmacy needs, and patterns of high use of hospital emergency and inpatient resources; indicating poor management of their health condition. Members enrolled by the VCCI are often overweight, obese, or morbidly obese, and thus at increased risk for multiple chronic conditions and their sequela, including diabetes, heart disease, hypertension and hyperlipidemia. Targeted members may have gaps in or poor adherence to evidence-based treatment including pharmacy, either due to limited health literacy or other socio-economic barriers to care such as insecurity in finances, housing, food, and/or transportation for preventive or urgent health care needs.

For member identification, the VCCI utilizes the component MMIS Care Management system, eQHealth, to trend the high risk and the 'rising risk' members who will benefit most from case management. The vendor applies the Johns Hopkins predictive analytical tool to member claims history for identification of eligible members in the top 10% who are anticipated to remain high cost in the future. In addition, the VCCI receives direct referrals from medical and behavioral health providers, hospital case managers, community health team colleagues, AHS field directors and sister departments, and internal DVHA units performing concurrent hospital review for substance use and mental health care. These referrals support the real time need of members at a point when they may be most ready to engage in supportive services.

The VCCI staff outreach and engage members using the predictive modeling outputs for the target population and direct collaboration with their primary care provider. Staff are embedded in several high-risk practices to meet with members at the time of the primary care appointment, or more ideally, in advance of their needed/scheduled visit to prepare for the visit and maximize the provider-patient interaction. Staff also function as liaisons to hospitals, work with case management staff for identification of VCCI currently enrolled members or those eligible for services, support the post

hospitalization transition in care, including medication reconciliation, health education and coaching, and the post discharge primary care or behavioral health provider follow-up.

The member's readiness to change is a significant factor in the VCCI case manager-Medicaid member relationship and the staff employ motivational interviewing skills to engage members, starting with the member identified need, while concurrently providing supportive education and coaching on linkages between assessed behavior and health, and future health and life goals. Using a holistic and strength-based approach, the VCCI case manager, member, and provider jointly develop the Plan of Care goals for short term, intensive case management, and care coordination support.

VCCI CORE PROGAM GOAL

Secure access to a medical home and formation of a trusting relationship between the member and their primary care provider for improved health management and decreased acute care service utilization.

### Intervention Services

The statewide, licensed VCCI staff perform outreach and case management services for members in the target population. They carry a case load of roughly 20-25 members at a time, performing short term, intensive case management services of high risk members with complex medical and psycho-social needs. Staff are co-located within AHS district offices, hospitals and/or provider locations to meet and support members where they may already engage with local service providers for assistance. The team works directly with members to perform general and disease specific health assessments which include: socio-economic gaps and barriers to care, knowledge of their medical condition(s), evidence-based care goals, and pharmaceutical treatment; which informs the holistic and member centric care plan.

Face-to-face interactions with members occur in state offices or provider practices and at the member's home to best assess health risks or barriers, assess medication knowledge, perform medication reconciliation and coach on treatment adherence. Members set goals, and in partnership with the case manager and provider, generate a self-management plan and a disease specific action plan. The action plan informs proactive primary care engagement versus emergency department utilization. A core goal of the program is to secure access to a medical home and formation of a trusting relationship between the member and their primary care provider, as a requisite for improved health management and decreased acute care service utilization.

Research (Commonwealth Fund) indicates that individuals with complex health care needs, multiple providers, hospital admissions and polypharmacy have less confidence in their providers, and more errors in care management, including medication prescribing that may be complicated, duplicative and/or contraindicated. Subsequently, the VCCI team focuses on the members medication knowledge, reconciliation, adherence, and communication among service providers and prescribers, to promote medication management in an environment of specialists. The VCCI clinical team works

with members to assure coordination of care among their service providers and recommends and refers to specialty services as appropriate, in collaboration with the PCP as indicated. The team prepares members for appointments and difficult discussions with the medical team; and accompany them to medical appointments to help create an environment of safety and personal empowerment for the individual member and their treatment team.

Cases are typically open for 3-6 months for 'intensive' case management, based on progressive improvement toward plan of care goals, followed by a transition back to the medical home care team, in support of sustainable change over time.

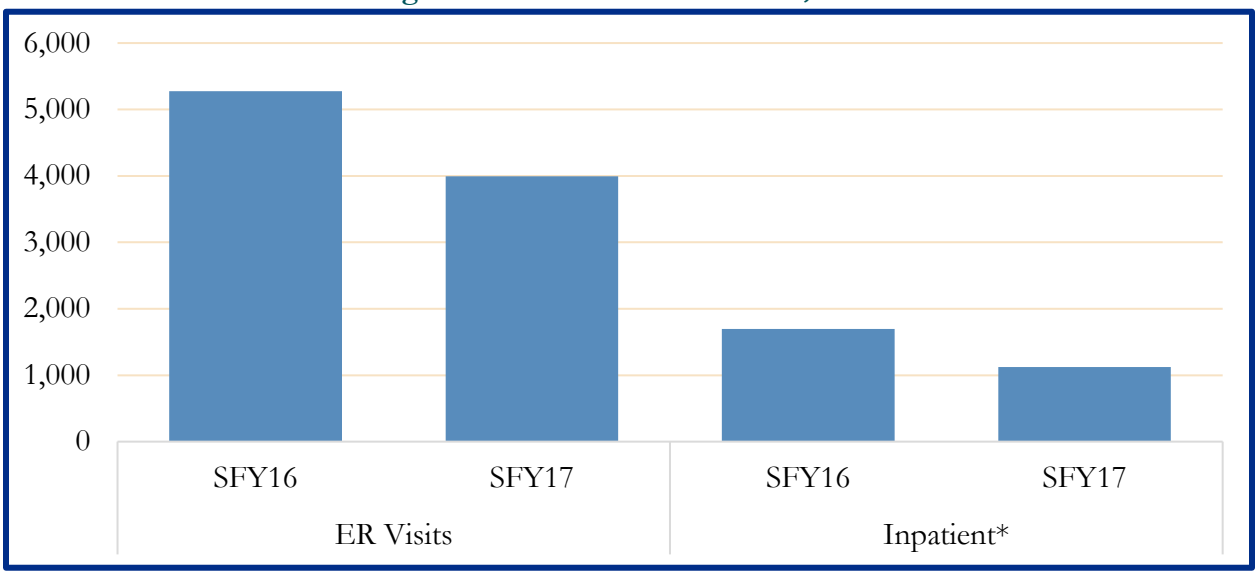
### Successes

The VCCI works at both the individual and population level to implement change and monitor improvement.

**Impact to Emergency Department (ED) utilization:** An analysis of VCCI target population usage of the ED for SFY 2016 and 2017 demonstrates a decline in usage; a more detailed analysis of an intervened population before, during, and 6 months post VCCI case management demonstrates a similar drop in ED usage among intervened members.

| Time Frame | ED Visits | ED Visits/1000 |
|---|---|---|
| Before Jan - Jun 2016 | 1,153 | 1,579 |
| During July - Dec 2016 | 1,157 | 1,585 |
| After Jan - Jun 2017 | 902 | 1,236 |

**VCCI Target Utilization Measures: n=1,896 Members**



## Impacts to Vermonters: Case Studies

Case highlight: A member with substance use issues, known to the Department of Corrections. Lost employment due to injury and impending loss of residence; and risk of reincarceration due to terms of probation and unemployment. Member referred to VCCI, agreed to connect with substance use treatment (vivitrol). VCCI facilitated securing a loan (Help Fund) working with AHS field director. Member gained employment with two jobs and re-paid Help Fund loan within one week. **Member *averted return to jail, remains sober, secure residence, paying taxes, still engaged with VCCI*.**

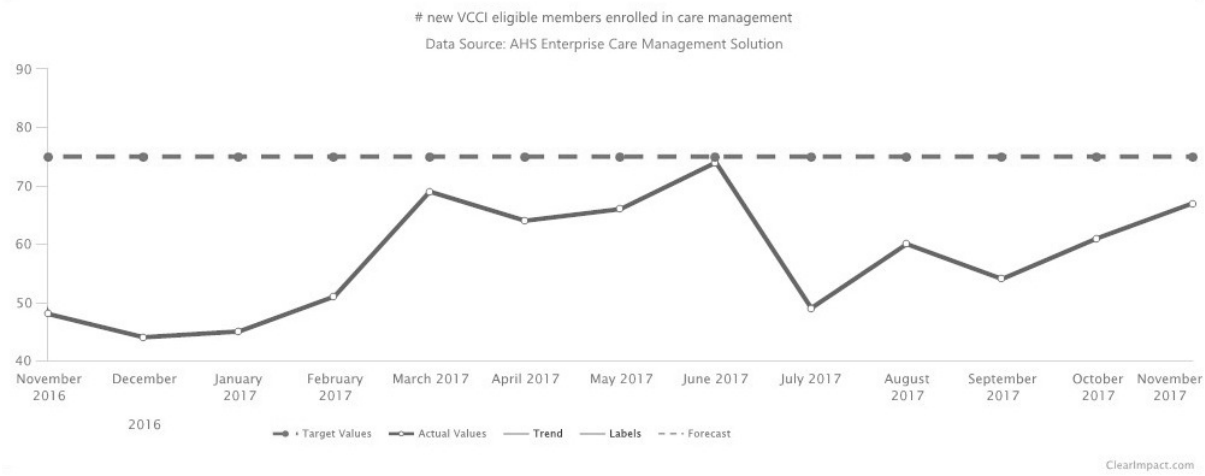
Case highlight: A member with mental health disorder, chronic back pain and history of substance use, and social anxiety, referred to VCCI by local partner. Member was referred for medical and mental health issues, housing instability (evicted and living in a tent) and food insecurity. VCCI facilitated access to medical provider and related medication for stabilization on mental health and anxiety disorder; referred to economic services for 3-Squares, Homeless Prevention resource, and Social Security for disability. **Learned during the process that the member was a veteran who had been court marshaled and felt he was not eligible for benefits, however, VCCI was able to refer to Supportive Services for Veterans and member qualified for assistance. He has subsequently also secured housing.**

These are just two examples of how our efforts directly impact vulnerable Vermonters.

Key Performance Indicators for the Vermont Chronic Care Initiative unit are set forth on the next page.

# P Medicaid's Vermont Chronic Care Initiative (VCCI) and 1 more...

## VCCI # new VCCI eligible members enrolled in care management




### Partners

- Medicaid Medical Director
- Medicaid Providers
- Community Health Teams
- MMIS & Care Management vendors

### Story Behind the Curve

The Vermont Chronic Care Initiative (VCCI) eligible cohort is established based on criteria including high risk/cost members that are Medicaid primary and receive no other waiver services (CRT, Choices for Care). This measure represents the total number of **new enrollments** during the reporting month and directly impacts the VCCI ability to meet clinical and financial outcome measures among the target population. This measure captures new cases only, not the total case load. Staff case loads average 20- 25 members per month for "short term, intensive case management, prior to transition to a lower level of case management within the medical home''.

The VCCI implemented a new Care Management system for member identification and case management documentation during SFYs 2016 & 2017; in 2018 there are continued deployments of new functionality and related user acceptance testing by and training requirements for end users. In January 2017, the VCCI lost the ability to enroll members assigned to the ACO. This prompted a related transfer of active members and a drop in both the eligible population and provider referrals in these communities.

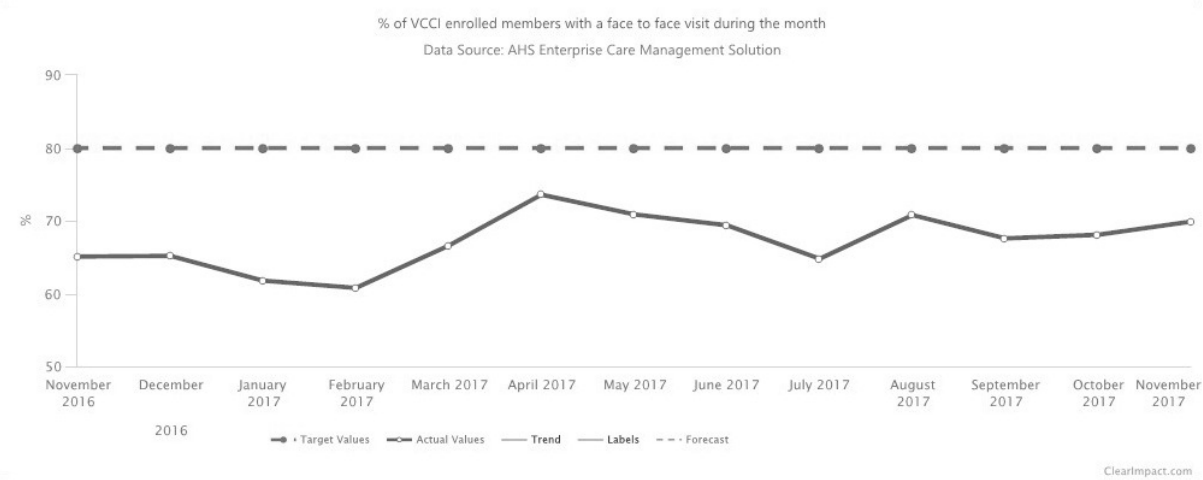
The VCCI turn over in SFY 2017 (6 FTE's) and SFY to date 2018 (3 FTE's) due to career advancement, retirement and out-of-state relocation has adversely impacted VCCI enrollment. The required recruitment, orientation, training and case load development for new staff hired in the past 6 months, pushes down our team's case load capacity. Concurrently, the VCCI new target population identification methodology and testing, necessitated by the next generation ACO pilot efforts, were manually being implemented by field staff, pending the deployment of new logic into production; and, the new ACO population exclusion rules, which are currently in development, also generates a manual workaround by professional staff performing outreach to our target population. Summer vacations and staff out on FMLA further confound performance in the last 2 measurement months. A continued drop in VCCI enrollment over desired levels may continue to be a risk in the near term, as the final deployment of the care management system (originally targeted for 12/31/17) will require significant end user testing and pre-deployment training, prior to the final scheduled deployment. As the MMIS/Care Management project slows in 2018 and the business stabilizes the operating system, VCCI will continue PDSAs toward increasing member engagement.

*Last updated: 12/15/17*

*Author: Vermont Chronic Care Initiative*

# P Medicaid's Vermont Chronic Care Initiative (VCCI) and 1 more...

## PM VCCI % of VCCI enrolled members with a face to face visit during the month




## Partners

- Medicaid Beneficiaries
- Medicaid Providers
- Community Health Teams
- Housing Coalitions
- AHS Field Directors
- Probation & Parole
- Others who support intensive case management of high risk/cost members and opportunities for face to face visiting in the safest environment

## Story Behind the Curve

One of the important and differentiating elements of the Vermont Chronic Care Initiative (VCCI) model is member face to face meetings as a measure of member engagement and trust, to support effective self-management and sustainable change. This measure is calculated as the percent of all members enrolled during the reporting month that received at least one face to face visit.

Face to face visits are a component of short term, intensive case management and a factor in overall assessment of need and relationship building. Both are required to generate effective self-management and sustainable change.

The VCCI continues to work on staffing goals and standardized documentation and reporting in the new MMIS/Care Management system. While measurement is based on the month activity, there may be new enrollments for a partial month, members lost to contact (phone/home address change), member 'no shows' and/or case closures during the enrollment month, thus impacting face to face visit calculation in the measurement period. Staff goals are set toward improvement using PDSA cycles and to better evaluate baseline and 'stretch' goals.

While face to face visits have increased over prior months, the overall percentage of VCCI enrolled members with visits is under goal. This may be related to general issues of member no show rates, being lost to follow up or incarcerated or inpatient; as well as the method for calculation. For example, staff close a case after 3 unsuccessful attempts to reach a member, which could result in a member on their monthly case load with no face to face visits or successful interventions, as they are 'lost to follow-up' during the reporting period, although still on the active case load. Staff re-education related to timing of cases is in process to facilitate the case closure timeline (i.e. on 10/30 vs. on 11/6, thus showing no activity for the month of November)

*Last updated: 12/15/17*

*Author: Vermont Chronic Care Initiative*

## BLUEPRINT

The Vermont Blueprint for Health (the Blueprint) is a state-led, nationally-recognized health reform program located in the Department of Vermont Health Access. The state supports a network of Practice Facilitators and Project Managers, who work with Patient-Centered Medical Homes (PCMHs), Community Health Teams (CHTs), and local health and human services leaders. This network allows for rapid response to Vermont's health priorities through statewide implementation of new initiatives.

Blueprint performs comprehensive evaluations of health care quality and outcomes at the practice, community, and state levels. As the care delivery system and payment model evolve, the Blueprint's aim is constant: connecting Vermonters with whole-person health care that is evidence-based, patient- and family-centered, and cost-effective.

### Supporting Primary Care Practices and Providers

The Blueprint uses national standards as a benchmark to drive improvements in primary care delivery and payment. The program helps primary care providers transform their practices into National Committee for Quality Assurance (NCQA)-certified Patient Centered Medical Homes. Most of Vermont's primary care practices participate in the Blueprint. The Blueprint supports each participating practice with a quality-improvement coach, called a Practice Facilitator. Practice Facilitators bring Blueprint generated all-payer data about practice performance (Blueprint Practice Profiles, Blueprint Community Health Profiles) and their own training and expertise in process improvement methodologies (like clinical microsystems, the Plan-Do-Study-Act (PDSA) cycle, and Lean process improvement). They initially help launch patient-centered practices and secure NCQA-Patient Centered Medical Home recognition, then return regularly to help with quality improvement and workflow efficiency. Providers and practice teams value Practice Facilitators' knowledge, expertise, and habit of making meaningful change accessible to busy primary care offices.

At the end of the 3rd Quarter of 2017, 139 Vermont practices were operating at Patient Centered Medical Homes, thanks to the commitment of providers and staff and the technical assistance of Practice Facilitators. The Blueprint currently estimates that there are about 151 total primary care practices that employ more than one provider operating in the state.

### Supporting Primary Care Patients

What difference does being a Patient Centered Medical Home make to patients? When a practice first achieves recognition as a Patient Centered Medical Home, its patients may notice certain improvements in accessibility, outreach, and information sharing.

- Patients may notice that their provider's office is open outside of the traditional 9-5 Monday-Friday hours, making it easier to balance work and wellbeing, or they may be surprised to get

a sick-appointment right away when they or their loved one needs care, or get connected to a nurse on-call when an urgent concern arises in the middle of the night.

- Patients with a chronic illness, like Diabetes or Hypertension, may receive a check-in call if they haven't been in to the office recently, encouraging them to make an appointment to have critical health indicators (like HbA1c for Diabetes, or blood pressure for Hypertension) tested and their ongoing management plan updated as needed according to the findings.
- Providers can offer patients resources for improving their wellbeing, like referrals to the Community Health Team for condition education, health coaching, care management, brief counseling and connections with longer-term treatment options.
- Patients may also receive referrals from their primary care provider to a Blueprint self-management workshop, such as Tobacco Cessation, Diabetes Prevention, Diabetes Prevention, Chronic Pain Management, Wellness Recovery Action Plan (WRAP) or general Chronic Condition Management.

Patient Centered Medical Homes build in evidence-based care, age and gender appropriate prevention services, and chronic condition management and patient- and family-friendly access and communication, then work over time to maintain and improve quality.

### Community Health Teams Connect Providers, Patients, and Community Services

The Blueprint Community Health Teams are groups of multi-disciplinary health and human services providers that supplement the services available in Patient Centered Medical Homes and link patients with the social and economic services that make healthy living possible for all Vermonters. These teams are funded by all Vermont insurers, public and commercial, and operate in all areas of the state. Having a Community Health Team, including members embedded in the practices or linked through mutually agreed-upon workflows, gives primary care providers the confidence to dig deep with patients to uncover the basis of health problems that have a psychosocial component, problems managing chronic conditions, or simply opportunities for improved wellness. Providers are more confident doing full screenings because they have a team of professionals ready to jump in and help the patient move from screening to brief interventions and then connect them with treatment, either through the Community Health Team itself or with community partners.

Community Health Teams provide patients with referrals and warm hand-offs to a wide range of services, including long-term mental health counseling, substance use disorder treatment services, financial support to afford prescriptions and healthy food, or any other support the patient might need to stay well. For patients, this is the difference between their physician not asking about depression (for example) or asking and then providing the patient a list of names and phone numbers of counselors to call (many of whom may not be accepting new patients). Instead, with a Community Health Team in place, the patient gets a warm hand-off to a trained staff member (possibly even located in the same office and available the same day) who can help the patient further explore their

risk factors, needs, and personal goals and then make a referral to counselor with availability for longer term treatment.

In addition to these brief intervention and referral services, Community Health Team providers can provide some complete interventions in-house. These interventions include condition education, for instance helping a patient newly-diagnosed with Diabetes understand their condition and how to manage it day-to-day, or health coaching for a patient who is looking for support eating better, or exercising more, or managing a recurring condition.

### Community Health Teams Partner for Complex Care

The Community Health Teams support patients at all levels of acuity, whether they need a little information and coaching to maximize their wellness, or wraparound health and social services to maintain safety and basic functioning. Regardless of the level of need, the Community Health Team helps put patient motivations first. The Blueprint Community Health Teams have partnered with the Vermont Department of Health, OneCare Vermont, and numerous community organizations to train multi-disciplinary community teams in patient-centered community care management. This model was initially introduced through a Learning Collaborative. In 2017, Blueprint staff, including local leadership, worked with OneCare Vermont to pilot new care management software and payment models in five health service areas. The payment model requires the team and patient to identify a lead care manager, based on the best fit for the patient, and funds their time. The lead care manager maintains the care plan and communications across participating organizations and agencies, to make sure care is always directed towards the patient's goals, and is safe, effective, and non-duplicative.

### Self-Management Workshops Help People with Chronic Conditions Thrive

For people living with one or more of the most common chronic health conditions, and for Vermonters who appreciate learning alongside their peers, the Blueprint offers a series of Self-Management Workshops. In 2017, 1,263 Vermonters completed one of these workshops, which focus on the topics of Smoking Cessation, Diabetes Management, Diabetes Prevention, Chronic Condition Management generally, Chronic Pain, and Emotional Wellness and are offered in all parts of the state. Some participants say the experience is life-changing even small improvements in habits can make a big health difference over the long term (a national study showed the Diabetes Prevention workshop model that is also used in Vermont helped participants exercise more, track their food intake, and lose weight, with a resulting $2,650 estimated reduction in Medicare spending per participant over a 15-month period).

### Designing New Initiatives to Meet Vermonters' Health Needs

The Blueprint is also a design resource, which leaders in the Department of Vermont Health Access, Agency of Human Services, Governor's Office and Legislature call on to research national and international best practices for addressing priority population health needs. With direction from

Agency of Human Services and DVHA Leadership, the Blueprint has led multi-stakeholder processes to inform, conceive, prototype, and implement interventions that benefit the health of Vermonters while slowing the growth of health care costs. Hub & Spoke and the Women's Health Initiative are two recent examples of this process and its benefits for Vermonters.

### Hub & Spoke Helps Providers Treat Opioid Use Disorder

The Blueprint administers the Spoke part of the Hub & Spoke program providing Medication Assisted Treatment for people in recovery from opioid use disorder. It links regional opioid treatment programs for complex addictions, called "Hubs," with lower-intensity treatment options closer to home, in places like primary care offices, women's health clinics, pain clinics, and other office-based opioid treatment services, called "Spokes." The program pays for Spoke care teams, including one nurse and one licensed mental health or addictions counselor per 100 patients. The Blueprint also offers Learning Collaboratives with expert-led and peer-supported training in providing effective Medication Assisted Treatment. For many physicians, nurse practitioners, and physicians' assistants, this specialized staffing and ongoing training opportunities provide the support and confidence they need to accept the challenge of treating opioid use disorder. For patients, these staff members become a critical part of their team, working together week-by-week and month-by-month towards long-term recovery. Capacity for Spoke-based Medication Assisted Treatment has grown, and more than 2,500 people with Medicaid insurance are currently in 80 different Spoke settings.

### Women's Health Initiative offers Enhanced Preventative Care

Like Hub & Spoke, the Women's Health Initiative began as a challenge from state leadership, then became a design project for the Blueprint, in partnership with the Vermont Department of Health and other key policy-makers, providers, and experts, then a statewide intervention that helps the people of Vermont access the latest evidence-based care. The Women's Health Initiative puts special emphasis on connecting community organizations and Women's Health Providers. The initiative requires participating practices to make plans with community organizations to accept referrals within a week. When a woman working with a participating community organization, for instance a Parent Child Center, indicates that she is interested in family planning or contraceptive services, that community organization helps her get an appointment right away. When she visits the participating Women's Health provider, she (and all other new patients) will receive a screening for a range of psychosocial risk factors, including substance use disorder, depression, partner violence, and more. If she screens positive, she will have the option to work with a Women's Health Initiative – specific Community Health Team member who can help her access the services she needs for total wellness. At her Women's Health provider visit, she will also have access to comprehensive, evidence-based family planning counseling. If she chooses the most effective form of birth control, LARC, she will be able to begin using this method that same day. This is made possible by a Medicaid payment to practices, which helps them launch all aspects of the Women's Health Initiative including stocking enough LARC to provide same-day access for all patients who choose that method. This is a service

Women's Health providers had wanted to provide before, but many were limited by the reimbursement structure and had to ask patients to return a week or more later. Technical support from Blueprint Practice Facilitators and training through Learning Collaboratives help these practices develop the skills and workflows to make full psychosocial screening and follow-up part of daily practice, and comprehensive family planning counseling and same-day access to LARC a routine.

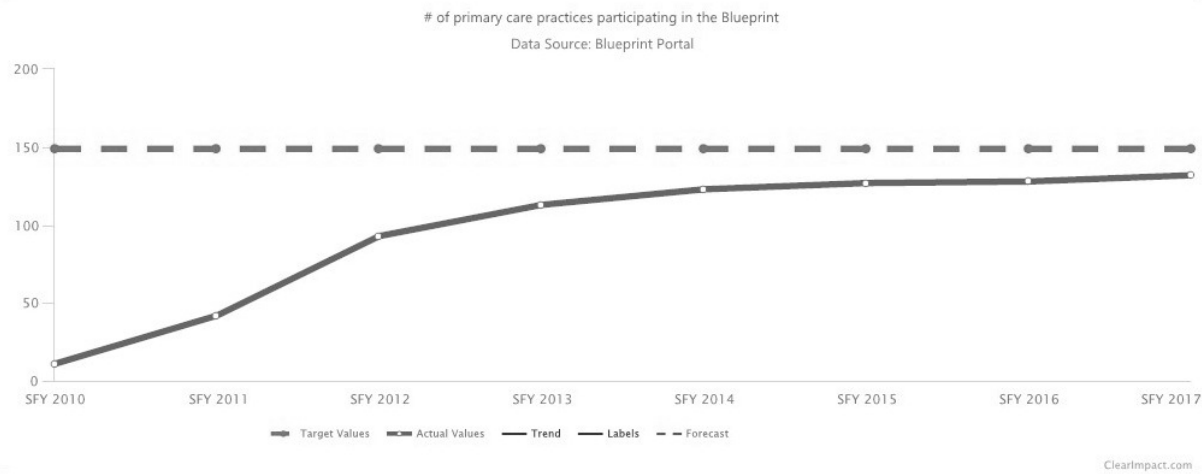
### Challenges

The Blueprint's Patient Centered Medical Homes and Community Health Teams each support providers and patients through the funding of all Vermont insurers: Medicare, Medicaid, and the major commercial insurers. This all-payer participation is part of what makes these programs effective and sustainable. The newer Blueprint service models of Hub and Spoke and the Women's Health Initiative do not currently have all-payer support. Hub and Spoke staffing and the Women's Health Initiative are all funded by Medicaid only. In both cases, the reality of service provision is that providers do not to limit their offerings to only those patients with the appropriate insurance, but rather spread the resources they are provided by any insurer over all patients. This may result in fewer resources (usually in the form of staff time) being devoted to any given patient within the target population of the intervention. Additionally, while underfunding an initiative may not prevent a provider from extending services to everybody, it may limit the services they are able to offer. For instance, a Women's Health Initiative – funded Community Health Team member may be able to offer health coaching and brief counseling, but not complex care management (or vice versa) because resources meant to provide all those services for a select population are being stretched to cover the full practice population regardless of insurer. In the year ahead, the Blueprint team plans to continue investigating opportunities to engage Medicare and major commercial insurers in paying for Hub & Spoke, an evidence-based, cost-effective approach to care for people with opioid use disorder. Likewise, the Blueprint will continue working closely with Vermont's major commercial insurers to demonstrate the value of the Women's Health Initiative through the wellbeing of Vermonters and their families, improved care quality, and immediate or modeled impacts on health care expenditures, to encourage their participation in fully funding the Women's Health Initiative.

Key Performance Indicators for the Blueprint unit are set forth on the next page.

# P Blueprint for Health

## PM BP # of primary care practices participating in the Blueprint




### Notes on Methodology

- The number of participating practices per quarter is generated from data stored in the Blueprint portal (https://blueprintforhealthport...). The Blueprint Data Analyst manages information stored in the Blueprint portal.
- The goal figure for this measure was obtained by identifying all primary care practices in the AHEC survey database and immunization registry database, validating these primary care practices with our Blueprint project managers, and eliminating from the count practices with 1 FTE or less of a provider.

### Story Behind the Curve

These are practices who meet the NCQA standard of a patient-centered medical home (PCMH) and participate in Blueprint initiatives. This measure is fundamental in assessing the reach of the Blueprint program. As larger numbers of practices are qualified as PCMHs and supported by Blueprint payments, increasing numbers of Vermonters should have access to high quality primary care.

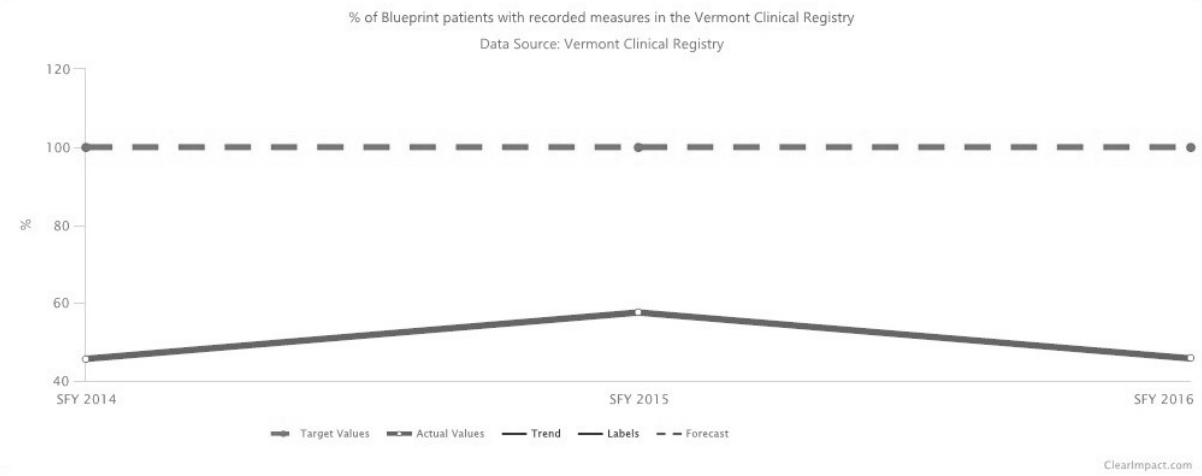
The trend line above clearly highlights the rapid increase in practice participation in the Blueprint as NCQA-recognized Patient-Centered Medical Homes (PCMHs) in 2011. This rapid increase is the result of a coordinated effort by the Blueprint team to comply with the enactment of Act 128 in May 2010 by the Vermont General Assembly. The Act mandated the statewide expansion of the Blueprint, including practice recognition as PCMHs. Evidence of this expansion required a minimum of two primary care practices in each health service area (HSA) becoming PCMHs by July 2011. The Act additionally required the involvement of all willing primary care providers in Vermont by October 2013 (full statewide spread). A significant achievement in 2010 that paved the way towards compliance with Act 128 was the Blueprint's successful application for the Centers for Medicare & Medicaid Services' Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration Project. In mid-July, Medicare joined all other major insurers in Vermont in contributing to the financial payments to PCMHs.

Since the mandate that all willing primary care providers in Vermont be involved as a PCMH in the Blueprint by October 2013, Blueprint practice facilitators have continued to engage providers across the State to encourage and inspire participation. Practice facilitators, highly skilled and intensively trained clinical and process coaches, work with primary care practices throughout the state and guide them as they make quality improvement changes on the path towards becoming PCMHs. When practices achieve NCQA certification as a PCMH with the assistance of the Blueprint practice facilitators, they demonstrate adherence with important characteristics of high quality healthcare and well-coordinated health services. The practices find the NCQA PCMH standards and Blueprint program as value-adds to their practice, as since the inception of the Blueprint program, only one PCMH has dropped out of the Blueprint (pending an upcoming move out of state).

The Blueprint has approached a saturation point where the program has recruited most of the available primary care practices in the state, and the rate of onboarding of new practices has generally plateaued. Program expansion is continuing due to the outreach efforts of the Blueprint practice facilitators, who are making a coordinated effort to reach primary care practices in their communities that have not participated in the Blueprint as a patient-centered medical home in the past. Generally, the practices that are continuing to join the Blueprint are independent and naturopathic practices.

# P Blueprint for Health

## PM BP % of Blueprint patients with recorded measures in the Vermont Clinical Registry




### Notes on Methodology

- The denominator is the number of Blueprint patients in the Vermont Clinical Registry who could be linked to claims data in VHCURES.
- The statewide average percentage of linked Blueprint patients with recorded measures in the Clinical Registry is generated by Onpoint Health Analytics, the statewide administrator of the All-Payer Claims Dataset (APCD). Onpoint links claims in the APCD to clinical records stored by Capitol Health Associates in the Clinical Registry. Onpoint updates this percentage every six months, accounting for the next 6 month time period.
- The goal figure for this measure is 100%, as the Blueprint is aiming to have all Blueprint patients in the Vermont Clinical Registry who could be linked to claims data in VHCURES to also have at least one recorded measure within the Vermont Clinical Registry.

### Story Behind the Curve

This is a measure of the percentage of Blueprint patients that have been identified in claims and linked to the Clinical Registry, who also have key clinical measures recorded in the Clinical Registry.

This measure is an indicator of the effectiveness of the HIE to aggregate data and the effectiveness of the Clinical Registry to populate clinical measures. This measure also reflects the ability of EHR systems to send structured data in Clinical Continuity Documents (CCDs). These data can be used to enhance patient care and inform improvements throughout the system.

The trend line above suggests an opportunity for improvement given that the data is not moving in the right direction. Blueprint practices across the state have been populating the Clinical Registry for over 7 years. The Registry, previously referred to as DocSite, was purchased from Covisit under a perpetual software license and is now managed by Capitol Health Associates, LLC. After analysis of the data in the Clinical Registry for quality and completeness, the data are de-identified and linked at the person level with the corresponding individual's claims records in VHCURES. This linkage is conducted by the Blueprint's analytics vendor, Onpoint Health Analytics, who determines the portion of the population in VHCURES for which clinical data can be associated with claims, and of that population, the percentage that have recorded clinical measures.

In July 2015, a number of practices experienced interruptions in, or terminations to, their clinical data feeds to the VHIE as a result of upgrades made to their EHRs, including: switching to a cloud-based system, EHR vendors releasing updated software, and practices switching EHR vendors.

*Last updated: 08/31/17*

*Author: Blueprint for Health*

## COORDINATION OF BENEFITS

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. States are mandated to have a system to identify medical services that are the legal obligation of third parties, such as private health or accident insurers. Third-party resources should be exhausted prior to paying claims with program funds. If a liable third-party is established after a claim is paid, reimbursement from that third party should be sought. Individuals eligible for Medicaid assign their rights to third party payments to the State Medicaid Agency.

Medicaid Recoveries Collected in SFY 2017:

$7,971,665

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 (TPL) 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. Medicaid Recovery totaled nearly $8 Million dollars in SFY 2017, the result of various recovery and recoupment practices.

The State has various types of TPL sources, with the most common being other insurance, casualty, and estate. Examples of third parties which may be liable to pay for services:

- Self-insured plans
- Managed care organizations
- Pharmacy benefit managers
- Medicare
- Group Health Plans
- Court-ordered health coverage
- Settlements from a liability insurer
- Workers' compensation
- Long-Term Care insurance
- Other State or Federal coverage programs (unless specifically excluded by law)

### Coordination of Benefits (COB)

- Dedicated team specializing in the coordination of Medicare/Medicaid pharmacy issues
- Accesses Federal systems to verify Medicare, Medicare Hospice, Buy-in, Low Income Subsidy. and other important programs.
- Specializes in billing issues between Medicaid and all other insurers

- Responsible for ensuring that Medicaid is the "Payer of Last Resort". The unit is responsible for recovering payments made by Medicaid as the primary payer, when Medicaid should have been the secondary payer.

- Responsible for systems and process changes that will increase efficiencies and decrease incorrect Medicaid payments.

### Medicare and the Medicare Prescription Drug Program (PDP)

The PDP team responds to daily inquiries from member services, the Health Care Advocates office, pharmacists, providers, and other state agencies regarding benefit issues and resolve the case issues. These beneficiaries are covered by both Medicare part C or D and a Vermont secondary program.

The team also works to resolve issues with the Medicare Part A and/or Part B enrollment as enrollment in these programs is a requirement for enrollment in a Medicare Part C or Part D prescription drug plan. The PDP Team will take in an average of 350 referrals a month to assist with enrollment (Medicare/Medicaid), premium cost, and pharmacy/medical cost share.

Aids beneficiary enrollees with their premiums, deductibles and co-insurance, under a Medicare Part D Plan.

### Casualty Recovery Process

As a condition of eligibility, applicants are required to assign their rights to medical support and payments for medical care from any third-party payer. Applicants/members are also required to cooperate with the State in the pursuit of any third-party payer, including the establishment of paternity for dependent children. Failure to cooperate may lead to termination of their benefits, unless good cause can be established.

Casualty Recoveries Collected in SFY 2017:

$2,313,460

Medicaid providers are required (except as noted below under cost avoidance methods) to apply third party payment resources prior to billing Medicaid. Third party resources include Medicare, private health insurance, accident insurance, or worker's compensation. If Medicaid providers fail to apply third party payment resources prior to billing Medicaid, this could result in a recoupment of amounts paid to the provider (a reduction of the next payment for services rendered).

The Medicaid State Plan (section 4.22-B), requires the State to investigate all casualty cases with a medical expense of $200 or more that have trauma related diagnosis codes within the MMIS system. If these specified codes are related to an injury, a monthly Accident/Trauma Report is generated by DXC. Letters and insurance/accident questionnaires are sent to members requesting additional information. All cases with no response remain on the Accident/ Trauma report until the proper documentation is received or cases are closed. All returned questionnaires are reviewed to determine

the possibility of third-party liability; whether it is an insurer or a potential legal recovery. If a settlement was obtained by the member, the State would be entitled to recover the amount Medicaid paid for services.

If an injury was motor vehicle related, the COB Unit may access the crash file, as well as obtain the accident report through the Department of Motor Vehicles. Workers Compensation information may be obtained from the employer, if it is a work-related injury claim. The COB Unit also has the authority to review homeowner's insurance policies for potential medical coverage.

State statutes mandate that attorneys and insurance companies must inquire whether their injured clients are Medicaid beneficiaries and whether claims were paid. If claims are potentially recoverable, DVHA places a lien against any possible settlement.

### Estate Recovery

The State has the authority to recover all amounts paid under the Medicaid program from a member's estate at the time of death. The State has an agreement with Probate Courts/State Tax Department whereby the State is notified of all estate cases filed.

Estate Recoveries Collected in SFY 2017:

$879,247

Each case is researched to determine if the deceased was a Medicaid member 55 or older and had received Long Term Care (LTC) services. If the deceased is found to be a recipient, a claim for LTC service is sent to the Executor/Administrator of the estate, and a copy is sent to the Probate Court petitioning a claim to be paid from the estate. Once the estate case comes to settlement and payment is received, the case is closed by the staff. Estate recovery staff annually review outstanding estate cases and request up-dates from the executors/executrix, administrators, or attorneys.

### Over Resource

When a member/beneficiary has been found LTC eligible and exceeds the income and resource limits set by the program, the excesses are payable to Medicaid and processed by COB staff.

Over Resource Recoveries Collected in SFY 2017:

$425,903

## Patient Share/ Credit Balance

A long-term care patient's share is determined by Economic Services Division and is payable directly to a LTC provider/facility monthly by the beneficiary, family or administrator.

- When LTC claims are received at DVHA, the patient share amount for the month is deducted prior to Medicaid's payment to the LTC provider.
- A Medicaid Credit Balance exists with the LTC provider when the monthly patient share has not been deducted from a claim.

Patient Share Recoveries Collected in SFY 2017:

$636,026

A report is generated monthly showing balance due from a LTC provider and provides the basis for DVHA/Coordination of Benefits to seek recovery.

## Trust & Annuity Accounts

A trust is a legal method in which a person can transfer their assets to be held, managed and administered by an appointed trustee for the benefit of the individual. Certain trusts are allowed by Medicaid such as a Special Needs Trust. A Special Needs Trust can be an excluded resource for the Medicaid beneficiary.

Any money remaining in the trust, after the death of the beneficiary must be sent to DVHA as Medicaid recovery.

Trust & Annuity Recoveries Collected in SFY 2017:

$618,451

## TPL & Medicare Cost Avoidance

Cost avoidance is the Coordination of Benefits team's main goal. Once other insurance or Medicare information is known to the MMIS or the PBM, the system will begin cost avoiding claims. If the provider sends in a claim without the other insurers payment or an explanation of why there is no payment, the system denies and sends the claim back to the provider with a message that the beneficiary had other insurance or Medicare on the date of service and that claims should be filed with the other insurance first.

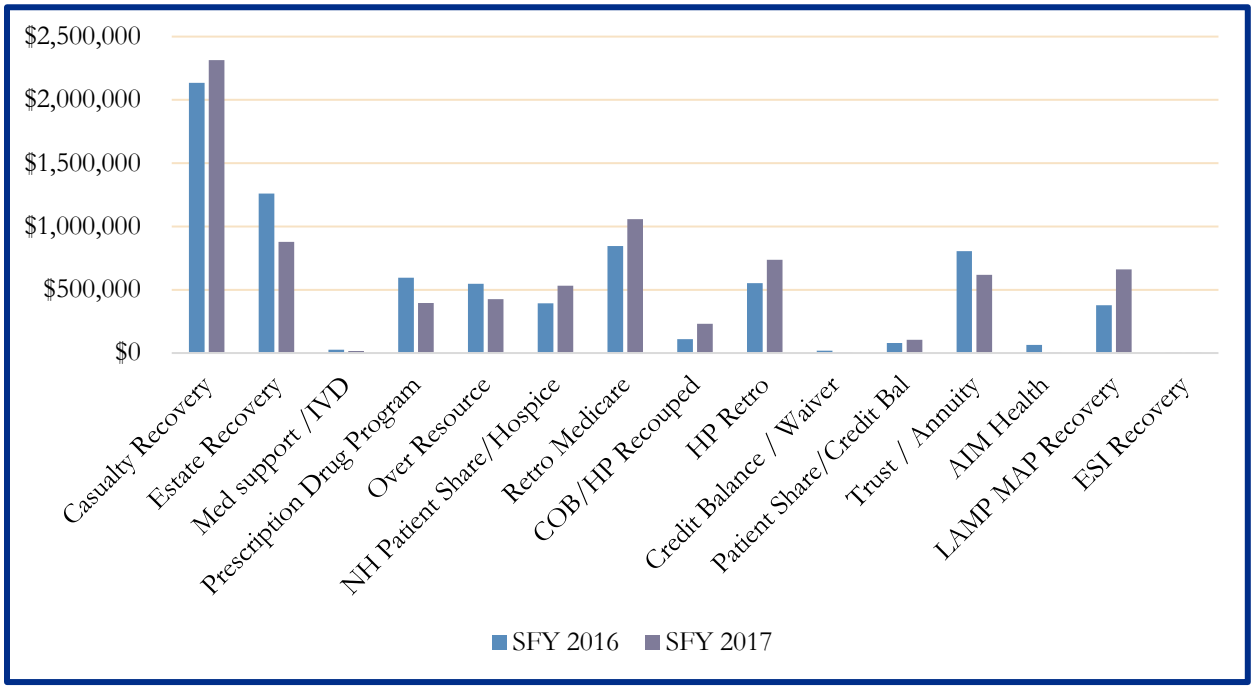
TPL Cost Avoided in SFY 2017:

$130,385,510

Medicare Cost Avoided in SFY 2017

$514,438,610

**COB Medicaid Recoveries SFY 2016 & SFY 2017 by Category**




## Health Insurance Premium Program (HIPP)

When a member is eligible for both Medicaid and a private health insurance, the case is referred to Coordination of Benefits.

The case is reviewed, and a cost-effective determination is performed.

If cost-effective for Medicaid, DVHA will reimburse the household for part of or the entirety of the private health insurance premium. The private insurance makes Medicaid the second payer of services for the Medicaid-Eligible beneficiary, which is a cost savings for Medicaid.

## COB Successes

- Strengthened State Statutes to enforce Data Matching with Insurance providers.
- Working towards a successful data match process with BC/BS of Vermont.
- Submitted a legislative statute amendment to enforce and assist in Estate recoveries.

## COB Challenges

Coordination of Benefits Casualty and Estate recovery teams are burdened with extensive paper case files and a limited Third-Party Liability data system that provides limited accountability/reconciliation of all transactions. A better system that would allow electronic storage of scanned documents, produce necessary letters, lien notices, and monthly reports would increase worker efficiencies.

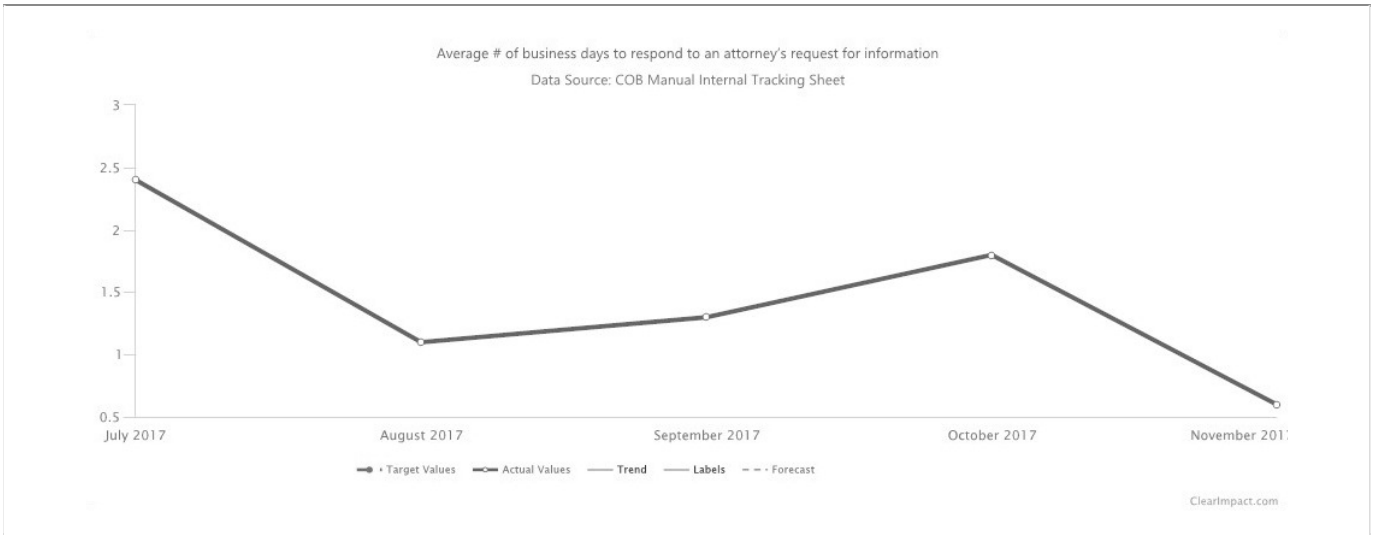
## Future State

After completion of BC/BS data matching, COB will work towards implementing a similar process with MVP and CIGNA. Increased data matching will increase DVHA's ability to cost avoid – the Coordination of Benefits goal.

Key Performance Indicators for the Coordination of Benefits unit are set forth on the next page.

# P Coordination of Benefits Unit

## PM COB Average # of business days to respond to an attorney's request for information




### Partners

- Medicaid Beneficiaries
- Attorneys

### Story Behind the Curve

State of Vermont Legislation passed Title 33 VSA 1910 (amended) which enhances the ability to collect from third party payers by establishing procedures which third party payers must adhere to in the State of Vermont. Attorneys representing clients that are Vermont Medicaid members must follow Vermont Statute 33 V.S.A. § 1910: Liability of third parties; liens: "*(c) A recipient who has applied for or has received medical assistance under this subchapter and the recipient's attorney, if any, shall cooperate with the agency by informing the agency in writing within a reasonable period of time after learning that the agency has paid medical expenses for the recipient. The recipient's attorney shall take reasonable steps to discover the existence of the agency's medical assistance.*"

Attorneys outreach our Coordination of Benefits (COB) Casualty Recovery Team via phone, fax, email and snail mail to verify Medicaid coverage of their client and vice versa. This can begin with the client informing their attorney that they are covered by Medicaid, or by a returned Accident/Questionnaire, which states that the member has retained an attorney after a trauma related injury. Once the COB Unit receives an attorney's request for information, it has 45 days to respond. However, the goal has always been a timely and accurate response to all requests.

July 2017 results were a bit higher due to a couple of cases that had increased turn-around times. Sometime there are difficulties connecting with attorneys. Also, COB will not release information until a copy of an Authorization to Release Information form is received. This can increase the time to case closure.

*Last updated: 12/15/17*

*Author: Coordination of Benefits Unit*

## PROGRAM INTEGRITY

The Program Integrity Unit is responsible for DVHA programmatic compliance with Federal and State Medicaid regulations and has the responsibility to monitor, detect, prevent and investigate inappropriate use of resources, fraud, waste and abuse.

The team works with providers, beneficiaries, fiscal agents, contractors, the Centers for Medicare & Medicaid (CMS), AHS, DVHA and many other various partners to ensure that federal and state regulatory requirements are met, and that compliance and integrity are fundamental in all aspects of the Vermont Medicaid Program.

The Program Integrity Unit has undergone significant changes in the past year to streamline processes and to create an optimal compliance structure for DVHA. Seven distinct business areas make up this unit and collectively, are responsible for the overall integrity of the Medicaid program.

By ensuring compliance, reducing fraud, waste & abuse and supporting the appropriate spend of Federal and State tax dollars, Vermonters will continue to have access to excellent healthcare by our enrolled Providers.

The following seven distinct business areas within the Program Integrity unit work to meet Federal and State obligations to ensure compliance and to reduce risk to the Medicaid program.

| | |
|---|---|
| Medicaid Audit & Compliance Unit (MACU) | • Prevent, detect and investigate Provider fraud, waste and abuse.<br>• Investigate allegations of provider fraud.<br>• Identify aberrant billing patterns amongst Medicaid providers. |

The Medicaid Audit & Compliance Unit works to establish and maintain the integrity of the Medicaid Program by engaging

in activities to prevent, detect and investigate Medicaid provider fraud, waste and abuse. MACU receives referral(s) from all sources and uses data mining and analytics to investigate allegations of fraud, waste and abuse. MACU works with our Vermont Medicaid providers and the various AHS departments to identify payment integrity issues. MACU works with medical professionals to develop appropriate resolutions to the many issues confronting Medicaid. MACU assists other Medicaid program units to facilitate changes in policies, procedures and program logic to ensure the integrity of the programs. In addition, MACU provides education to 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's General's Medicaid Fraud and Residential Abuse Unit (MFRAU).

| | |
|---|---|
| Beneficiary Healthcare Fraud Investigative Unit (BFIU) | • Prevent, detect and investigate Beneficiary healthcare eligibility and enrollment fraud.<br>• Manage the Public Assistance Reporting Information System (PARIS) matches for dual enrollment amongst other states.<br>• Propose program recommendations for the prevention of Mediaid enrollment fraud. |

In July 2015, DVHA became responsible for the Medicaid Health Access Eligibility & Enrollment Unit (HAEEU). As a result of this, beneficiary healthcare eligibility and enrollment fraud also became the responsibility of DVHA. In April 2017, new staff were hired, and the Beneficiary Healthcare Fraud Investigative Unit (BFIU) was formed. The responsibility of this team is to investigate, detect and prevent Vermont Medicaid beneficiary healthcare eligibility and enrollment fraud in the Vermont Medicaid Program. All other programs such as TANIF, 3SQUARESVT, Fuel Assistance, and Reach Up investigations remain the responsibility of the Department for Children and Families (DCF). Collectively, the BFIU team works with DCF to evaluate and investigate allegations received. BFIU works regularly and in collaboration with the DEA, the Office of the Inspector General (OIG) and other State and Federal Agencies.

| | |
|---|---|
| Oversight & Monitoring (O&M) | • Faciliatate audit discussions and work product between DVHA and external regulators and auditors.<br>• Monitor audit findings and follow up on any corrective action plans.<br>• Collaborate with DVHA staff for standardized policies and procedures. |

The Oversight & Monitoring (O&M) Unit is responsible for ensuring the effectiveness and efficiency of departmental control environments, operational processes, regulatory compliance, and financial and performance reporting in line with applicable laws and regulations. O&M facilitates communication and collaboration between state staff, leadership, federal and state auditors and independent auditors including but not limited to CMS, OIG, Government Accounting Office (GAO), Internal Revenue Service (IRS), etc. This facilitation helps ensure accurate, consistent, and appropriate communication is made in a succinct, informative, and professional manner. The goal is standardization of efforts across all DVHA resulting in satisfactory audit results and proactive determination of audit issues and their timely resolution through collaboration of the appropriate course of action with program management. O&M oversees the tracking, reporting and escalation of DVHA Medicaid Program findings to DVHA Senior Leadership until properly resolved therefore reducing regulatory exam findings potentially resulting in costly monetary penalties.

| | |
|---|---|
| DVHA Compliance Officer | • Support DVHA adherance to all State and Federal Requirements.<br>• Manage DVHA Inter-Governmental Agreements (IGA's) with other AHS Departments.<br>• Identify and resolve DVHA compliance related issues. |

The DVHA Compliance officer (CO) is responsible for ensuring DVHA's adherence to all state and federal Medicaid requirements. The CO manages DVHA's Inter-Governmental Agreements (IGA) with other AHS departments and coordinates audits aimed at evaluating the compliance and quality of Medicaid activities and programs. If a compliance issue is identified, the Compliance Officer, alone, or in collaboration with the AHS Compliance Committee, will create, manage and monitor any corrective action plan.

Each year, the Compliance Officer coordinates a compliance audit, which is conducted by an External Quality Review Organization (EQRO), designated by CMS. As the 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 Officer works closely with the various unit within DVHA to maintain continuity between compliance, education and quality improvement activities.

| | |
|---|---|
| Medicaid Management Information Systems (MMIS) Compliance (MC) | • Monitor MMIS Fiscal Agent Service Level Agreements (SLRs) and Service Level Credits (SLCs).<br>• Identify and resolve discrepancies between MMIS and Medicaid policies<br>• Facilitate and manage System requests for edit and audit changes. |

Medicaid Management Information System Compliance is new to the Program Integrity Unit. The primary responsibility of MMIS Compliance is to provide oversight of the DXC contract service level requirements (SLRs), service level credits (SLCs), and incentives. In addition, MMIS Compliance collaborates with DVHA's Fiscal Agent to address process improvements for state requested MMIS changes. The primary goals of this unit are to ensure that Vermont Medicaid is getting quality customer service from our MMIS Fiscal Agent and to prevent unnecessary spending on system changes or solutions that may be accomplished in another, less costly, manner.

| | |
|---|---|
| HealthCare Quality Control (HCQC) | • Reduce errors in beneficiary enrollment and eligibility determinations through a systemmatic approach.<br>• Conduct and assist with the Payment Error Rate Measurement (PERM) audit .<br>• Facilitate Medicaid Eligibility Quality Control (MEQC) examinations. |

The HealthCare Quality Control Unit (HCQC) joined Program Integrity in September 2017, in line with the Vermont State Plan, which stipulates the implementation of a quality control system designed to reduce erroneous expenditures by monitoring eligibility determinations, third-party liability activities, and claims processing. HCQC focuses on identifying quality issues, based on adherence to approved processes and policies. HCQC manages the DVHA Quality Control Program which includes internal and external quality control audit efforts. Additional responsibilities include the Payment Error Rate Measurement (PERM) and Medicaid Eligibility Quality Control (MEQC) exams to ensure appropriate decision making and determinations were made regarding Medicaid Beneficiary eligibility and enrollment determinations.

HCQC staff maintain strong, professional relationships with regulators, examiners, auditors and leadership in support of creating an environment of compliance with state and federal regulations and laws governing Health Care assistance programs. The HCQC unit oversees the tracking and reporting of eligibility and enrollment findings to DVHA leadership until properly resolved therefore reducing regulatory exam findings.

| | |
|---|---|
| DVHA Fiscal Compliance Unit | • Monitor subrecipient compliance with contractual requirements.<br>• Minimize risks to financial assesst by to subrecipients.<br>• Work to resolve, reduce and prevent weaknesses with subrecipient contracts/agreements. |

The DVHA Fiscal Compliance Unit (DFCU) is a solutions-focused, results-oriented, learning organization established upon the tenets of the COSO (Committee of Sponsoring Organizations) Internal Control Integrated Framework. The DFCU seeks to ensure the fiscal integrity of DVHA and its subrecipients/grantees through proactive, preventative strategies. The primary objective of the unit is to minimize the risk to DVHA's current financial assets by ensuring its compliance, and that of its subrecipients and grantees, to all applicable fiscal/financial regulations. To this end, the DFCU examines the financial records of the Department and its subrecipients noting any compliance exceptions, regulation at risk, cause of the exception, party accountable and the financial exposure to DVHA. DFCU acts as a resource to DHVA programs by providing training and engaging with

managers early on in the process to prevent non-compliance. The Unit provides DVHA leadership with reports showing the results of each review.

## SUCCESSES

The Program Integrity Unit has achieved many successes this year. Through an internal reorganization at DVHA, we have successfully aligned and joined together, all business areas that are responsible for the integrity and compliance in the Medicaid program. Placing these functional units together have a further reach to the other departments with Medicaid responsibilities.

The Vermont Program Integrity Unit is regularly regarded, by CMS, as well as other Federal and State partners, as a leading and strong unit. The Program Integrity unit takes pride in ensuring the appropriate use and spending of Medicaid federal and state dollars, which further allows for more flexibility in the budget to consider increased coverage options, increased budgetary appropriations, and potential increased rates.

The Medicaid Audit & Compliance Unit (MACU), in SFY 2017, worked more than 300 provider fraud, waste and abuse allegation cases. Of these cases, MACU successfully recovered and cost-avoided a collective $6,153,140.

MACU recovered and cost-avoided:

$6,153,140

The MMIS Compliance Unit, the Beneficiary Healthcare Fraud Investigative Unit, and the Healthcare Quality Control unit are three completely new units within DVHA. Each of these units required a ground-up approach to structure, organization and planning for successful outcomes. These three functional units are making a solid difference within the Medicaid program and will continue to strengthen and grow in SFY 2018.

The Oversight & Monitoring Unit has a goal to reduce repeat findings from DVHA audits and has dramatically reduced findings and repeat audit findings across the board in each of the audits that have been conducted thus far. This is the result of direct communication and collaboration between the DVHA units, as well as Federal and State regulators. Adherence to, and completion of corrective actions has further strengthened the program.

## CHALLENGES

Each year, new legislation for programmatic and policy changes come with tight timeframes for compliance, systematic changes, and defined coverage and funding requirements. These new requirements can sometimes create challenges where conflicts between other existing policies and regulations exist.

It is increasingly difficult to proactively ensure system changes can accurately enroll and re-determine beneficiary and provider eligibility, process claims and make correct payments when the Medicaid

enrollment, eligibility, and claims engine systems are outdated. It is becoming apparent and concerning that providers and members are expected to bill and submit appropriate documentation in order to support accurate results since the system is less able to utilize edits and audits and business intelligence software to guide our work.

Federal and State regulations continue to be introduced and evolve. Existing staff are used to evaluate, implement, monitor and enforce these new and changing policies, all while also ensuring that daily work continues.

## FUTURE STATE

DVHA just introduced a new asset verification tool that will support the work in the Medicaid Audit & Compliance Unit, the Beneficiary Fraud Investigative Unit and the Healthcare Quality Control Unit.

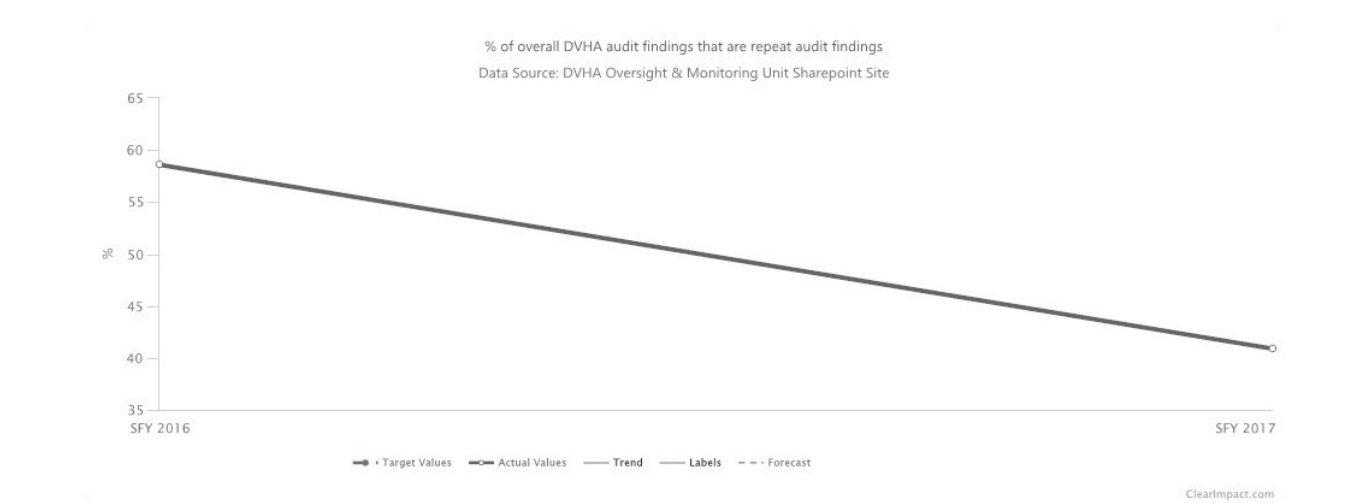
The Beneficiary Fraud Investigative Unit and the Medicaid Audit & Compliance Unit are looking into new tools for enhanced fraud investigations, to support better case tracking and to provide stronger business intelligence.

Early in SFY 2018, DVHA's Compliance Officer will begin a multi-department risk assessment focusing on Prepaid Inpatient Hospital Plan (PIHP) operations, fiscal controls, sub-contractual monitoring and policy/procedure development. The results of the risk assessment will drive a compliance work plan which will be used by the Compliance Committee to organize its work.

Key Performance Indicators for the Program Integrity unit are set forth on the next page.

# P Program Integrity Unit

## PM PIU % of overall DVHA audit findings that are repeat audit findings




### Notes on Methodology

| Audit Name | SFY16 | | | SFY17 | | |
|---|---|---|---|---|---|---|
| | Total # | Repeat # | Repeat % | Total # | Repeat # | Repeat % |
| 45 CFR VHC | 10 | 0 | 0.0% | 4 | 1 | 25.0% |
| CAFR | 5 | 5 | 100.0% | 4 | 4 | 100.0% |
| A133 | 14 | 12 | 85.7% | 6 | 3 | 50.0% |
| CMS PI | N/A | N/A | | 8 | 1 | 12.5% |
| Total | 29 | 17 | 58.6% | 22 | 9 | 40.9% |

**45 CFR** is an annual audit of the Vermont State Exchange "VHC" by an independent qualified auditing entity which, follows generally accepted governmental auditing standards (GAGAS) to perform an annual independent external financial and programmatic audit and must make such information available to HHS for review by CMS/CCIIO/HHS. The Centers for Medicare & Medicaid Services (CMS) is part of the Department of Health and Human Services (HHS). CMS administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace. The Center for Consumer Information and Insurance Oversight (CCIIO) has direct enforcement authority over non-Federal governmental health plans and is charged with ensuring adequate implementation of the provisions of the Affordable Care Act.

**The Comprehensive Annual Financial Report (CAFR)** is a thorough and detailed annual presentation of the state's financial condition. It reports on the state's activities and balances for each fiscal year. The State's external accounting firm works with the State of Vermont to review prepared modified accrual financial statements for compliance with GAAS and GAAP guidelines.

**The A133 Single Audit** is an annual review by the State's external audit firm to ensure a recipient of federal funds is in compliance with the federal program's requirements for how the money can be used. Each federal agency that gives out grants outlines specific items it feels are important for recipients to meet to ensure the successful management of the program and alignment with the legislative intent of the program. These items are laid out in the A-133 Compliance Supplement.

**CMS PI Review** - Every 3 or 4 years, the Centers for Medicare & Medicaid Services (CMS) conduct a focused review to determine the extent of program integrity oversight of the managed care program at the state level.

### Story Behind the Curve

This measure is shows the total number of audit findings in audits that closed during a state fiscal year (SFY) and the % that are repeat findings from previous audits.

DVHA is required to be compliant with all Federal and State policies regarding the administration of the Medicaid Program and the Qualified Health Plans. When DVHA is audited by an external auditor or regulator, and findings are identified, DVHA will correct the issue, in the approved time frames to ensure there are no repeat findings when that auditor or regulator returns.

Federal and State policies define the regulations for which DVHA must follow to be compliant with the administration of the Medicaid

Federal and State policies define the regulations for which DVHA must follow to be compliant with the administration of the Medicaid Program, including the Qualified Health Plans. When repeat findings exist, it brings to light that deficiencies and/or material weaknesses remain and that the programs are not compliant with the requirements. A compliant program will help to strengthen the economy, make Vermont more affordable and protect the most vulnerable.

Tracking of this data is limited, historically, as the Oversight & Monitoring unit has only been in existence for a few years. Historical data is captured, as current audits present, where repeat findings may be brought forward. At present, approximately 2 years of data has been captured so for any audit that happens more than every 2 years (CMS IAG Review is every 3-4 years), the data may need to be captured for the first time, as the beginning of the next review time frame.

The 45 CFR VHC audit that closed in SFY 2016 was the first audit of VHC and resulted in an Adverse Opinion due to the lack of documented Standard Operating Procedures (SOPs). A tremendous undertaking was made by DVHA HAEEU with assistance from Oversight & Monitoring to complete numerous SOPs before the next year's review. As noted in the above table, there was only one repeat finding and an Unqualified Opinion was issued.

In 2016, the Oversight & Monitoring unit was established within Program Integrity to formalize an Oversight & Monitoring Program for the Medicaid Program, including the Vermont Health Connect, in line with the strategic direction of DVHA and Agency Leadership to ensure the effectiveness and efficiency of departmental control environments and operational processes in alignment with applicable laws and regulations. Working closely with DVHA departments, corrective action plans were put in place and actively pursued to ensure a reduction in repeat findings. The result was a reduction from 12 to 3 repeat findings reduction for SFY 2017 Single audit.

**Adverse Opinion** – the State did not comply in all material respects with the federal compliance requirements that could have a direct and material effect on major federal programs.

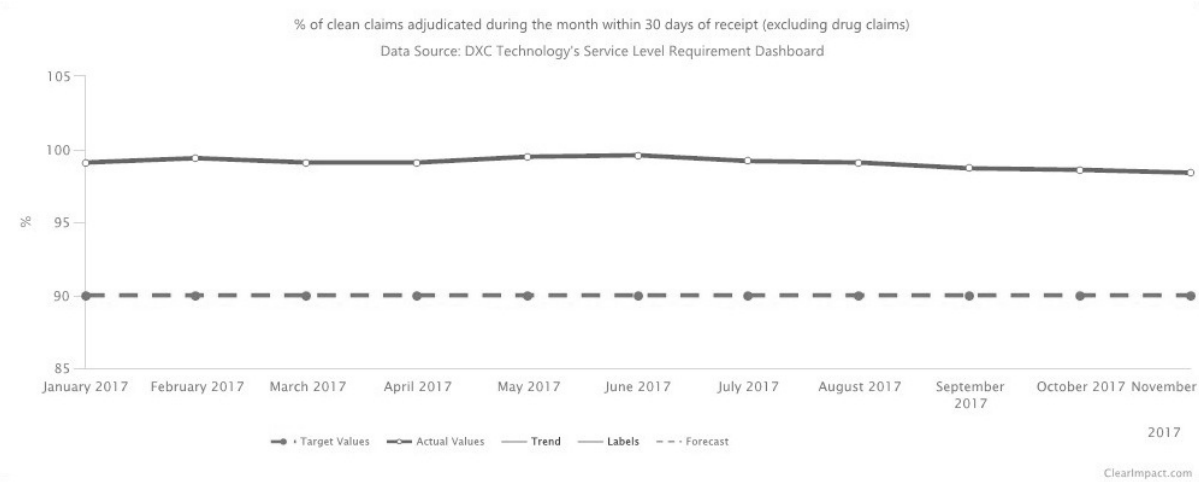
**Unqualified Opinion** – The State compiled in all material respects with federal requirements that could have a direct and material effect on major federal programs.

*Last updated: 12/04/17*

*Author: Program Integrity Oversight & Monitoring Unit*

# P Program Integrity Unit

## PM PIU % of clean claims adjudicated during the month within 30 days of receipt (excluding drug claims)




### Partners

- DXC Technology Claims Processing Unit

### Story Behind the Curve

In accordance with federal rules for prompt payments (31 U.S Code Chapter 39 – Prompt Payment), any bills or invoices submitted to government must be paid within 30 days. DXC SLR 3.1.8 requires that at least 90% of clean claims (those without missing or invalid information) are adjudicated within 30 calendar days of receipt.

The Vermont Medicaid Provider network relies on timely Medicaid payments to maintain their operations and facilities so that they can continue to serve Vermont Medicaid members.

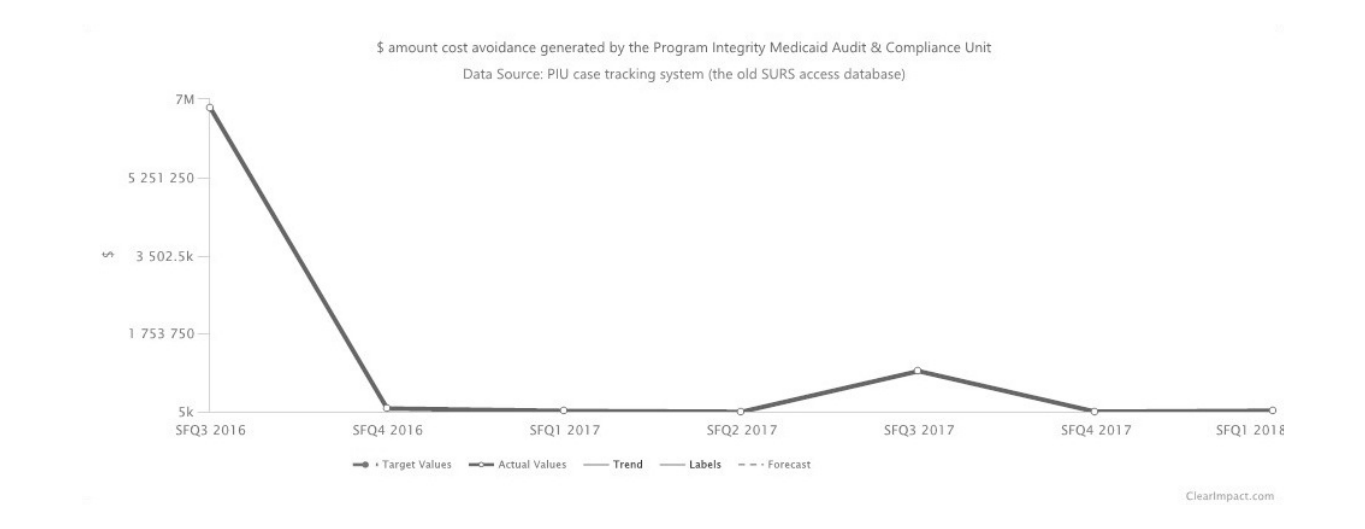
This requirement has been consistently met and exceeded for many years. The current claims processing system is able to auto-adjudicate a high percentage of claims.

*Last updated: 12/15/17*

*Author: Program Integrity Unit*

# P Program Integrity Unit

## PM PIU $ amount cost avoidance generated by the Program Integrity Medicaid Audit & Compliance Unit




### Partners

- Other DVHA Units (such as Clinical or Policy) who assist in policy or systems change in support of future "cost avoidance"

### Story Behind the Curve

The Program Integrity / Medicaid Audit & Compliance Unit (MACU) measures cost avoidance or cost saving, when it refers to the projected reduction in future Medicaid expenditures for services/claims being reimbursed improperly. The actual avoidance occurs when edits and/or policy changes occur which support the case closure plan. This measure is time based and projects the potential reduction of expense within the category (claim type). These dollars are used in the system to provide additional services to qualified beneficiaries. Program Integrity cost saving based on the anticipated decrease or avoidance of future Medicaid expenditures related to the issue. Cost saving is projected and counted for a 1year period.

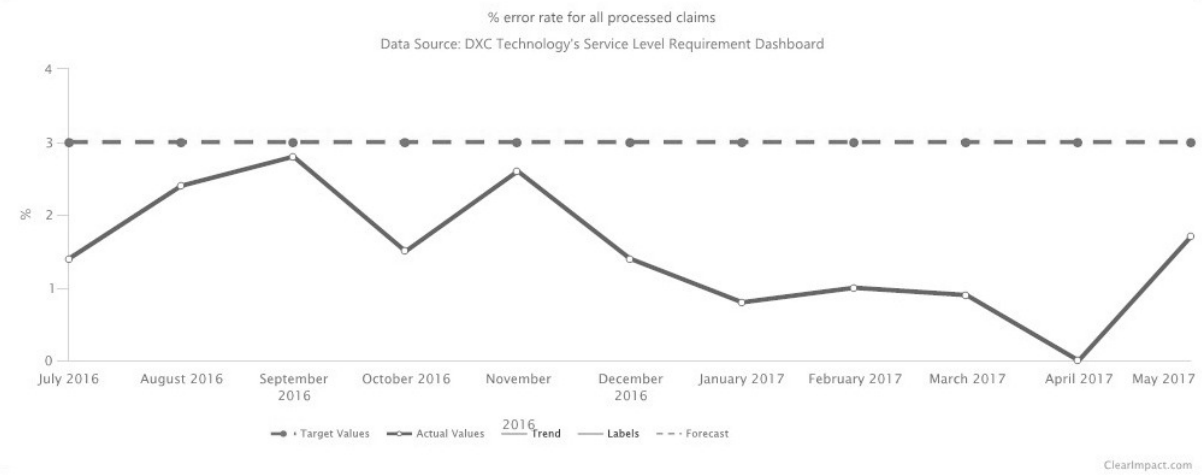
The MACU works to ensure Medicaid federal and state dollars are spent on authorized expenditures and to recover dollars expended on unauthorized expenditures. The goal of the Program Integrity Unit to increase payment integrity by recommending changes to DVHA policies or edits and audits within the MMIS. When these conditions are met, the projected cost avoidance represents future dollars remain available to be further reallocated to other services. This situation of cost avoidance doesn't exist with each case opened with PI.

*Last Updated: 11/14/17*

*Author: Program Integrity / Medicaid Audit & Compliance Unit (MACU)*

# P Program Integrity Unit

## PM PIU % error rate for all processed claims




### Notes on Methodology

- The goal is to have a **less than 3%** error rate for all claims processed.

### Partners

- DXC Technology Claims Processing Unit

### Story Behind the Curve

In accordance with the DXC contract, a quality assurance review is performed on a sample of claims that were adjudicated by the DXC Claims Unit staff. DXC SLR 3.1.12 requires that the error rate for the sample is less than 3%. This is important because Vermont Medicaid and the Vermont Medicaid Provider network rely on DXC to process claims correctly in order to have proper reimbursement.

The claim error rate methodology changed, effective January 2017, with increased criteria for the quality review. Prior to 2017, the quality review comprised of a much smaller sample that was derived for each of the claims processing clerks. The data for this performance measure is supplied by the contractor/fiscal agent, DXC. The 01/01/17 contract re-write for DXC and DVHA was finalized, but the service level requirement (SLR) requirement documents were not fully agreed upon until later. The SLR for this performance measure was finalized on 05/19/17, and DXC began their work to analyze the claims error rate based on the new requirements. The statistical sample size was much larger than the previously used sample size, thus increasing the work involved in determining the error rate. In addition, the new requirements added several new areas of review for each claim. DXC has been working on establishing their internal processes and is gaining momentum in overcoming their backlog. As of 12/20/17, DXC's projected timeline is that they will have the error rate calculated through 2017 in April 2018 & will have 2018 rates up-to-date in June 2018.

*Last updated: 12/29/17*

*Author: Program Integrity Unit*

## QUALITY IMPROVEMENT & CLINICAL INTEGRITY UNIT

The Quality Improvement & Clinical Integrity Unit monitors, evaluates, and improves the quality of care for Vermont Medicaid beneficiaries by improving internal processes, identifying performance improvement projects, and performing utilization management. Efforts are aligned across the Agency of Human Services and community providers. The unit is responsible for instilling the principles of quality throughout DVHA and helping everyone in the organization to achieve excellence. The unit's goal is to develop a culture of continuous quality improvement throughout DVHA.

One step in developing that culture is being able to communicate with each other about our performance on the areas of work that are important to running a high-quality health plan. A tool that we use to communicate our Department's goals and the work that goes into achieving those goals is our Results Based Accountability (RBA) Scorecard. Quality Unit staff have taken the lead on developing DVHA's scorecards – some of which are posted on the DVHA website; others are used for internal performance management.

The Quality Unit also annually reports out on Vermont Medicaid's performance on national standard measure sets. These measure sets include both clinical indicators, as well as experience of care, or customer satisfaction, measures. Quality Unit staff lead committees within DVHA that analyze performance on these measures each year. Knowing how Vermont performs compared to other state Medicaid programs (and against ourselves from year to year) helps identify opportunities for improvement.

The Clinical Utilization Review (UR) team is responsible for the utilization management of mental health and substance use disorder services. These services include both promoting the integration of, and coordination of services for, Vermont Medicaid members with substance use disorder and mental health needs. The team works to ensure that members get the right level of care for the appropriate length of time. All reviewers are licensed clinicians dedicated to increased access and positive outcomes for our members. The team performs utilization management activities including concurrent review and authorization of mental health and substance use disorder services.

In SFY 2017, the UR team authorized and performed concurrent reviews for 349 child/adolescent psychiatric inpatient admissions, 468 withdrawal management inpatient admissions, 1,163 adult psychiatric inpatient admissions and 1,838 residential treatment admissions. Single case agreements were authorized to support members in receiving services not available in state. In addition, the Autism Specialist assisted providers in submitting prior authorization requests and receiving payment for applied behavior analysis (ABA) services for 73 members. Outreach to providers to address underutilization of ABA services resulted in ongoing payment reform exploration.

The unit has initiated pilot projects aimed at addressing systemic issues and ensuring continuity of care for members. Specifically, DVHA partnered with the only instate psychiatric facility for children on a pilot project aimed at decreasing extended stays in emergency rooms and supporting thoughtful

discharge planning. Authorizations at the acute rate continue when discharge barriers are attributable to other departments within the state, or forces beyond the control of the provider. Weekly case consultations allow for transparency, a greater understanding of barriers, and exploration of available services. The team has strengthened relationships with external partners through participation in site visits, training, case consultations, and frequent inter- rater reliability checks.

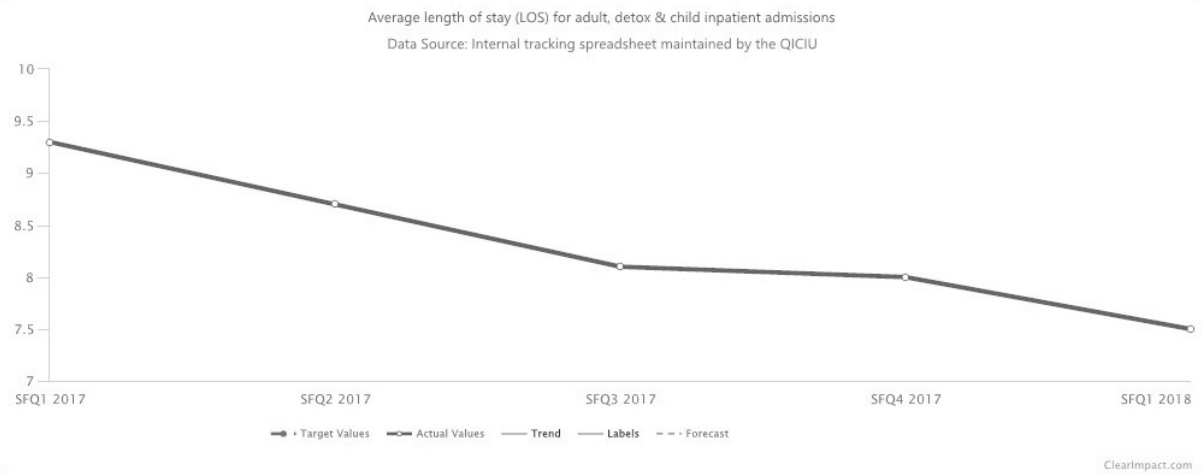
The team has also partnered with the Department of Mental Health, the Department for Children and Families, the Department of Corrections and the Vermont Department of Health's Division of Alcohol and Drug Abuse Program to participate in case consultations and management to support members in receiving needed care while being fiscally responsible. Additionally, the team has developed a system to refer members to the Vermont Chronic Care Initiative (VCCI).

The UR team also administers the Team Care program. This program exists to support members who have a history of drug-seeking behavior or other problematic uses of prescription drugs in accessing appropriate care. Once enrolled the member is "locked in" to a single provider and pharmacy which allows for closer monitoring. The unit has recently reviewed the protocol and is considering modifications to the program. Specifically, the team 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.

Key Performance Indicators for the Quality Improvement & Clinical Integrity Unit are set forth on the next page.

# P Quality Improvement & Clinical Integrity Unit

## PM QICIU Average length of stay (LOS) for adult, detox & child inpatient admissions




### Notes on Methodology

| Average LOS by Type | SFY17 Q1 | SFY17 Q2 | SFY17 Q3 | SFY17 Q4 | SFY18 Q1 |
|---|---|---|---|---|---|
| **Adult** | 8.3 | 7.4 | 6.7 | 7.0 | 7.2 |
| **Detox** | 5.5 | 4.9 | 5.5 | 5.1 | 4.8 |
| **Children** | 19.8 | 18.0 | 15.4 | 14.6 | 10.8 |
| **Total** | **9.3** | **8.7** | **8.1** | **8.0** | **7.5** |

### Partners

- Vermont Medicaid Inpatient Providers
- Department of Children & Families
- Department of Mental Health

### Story Behind the Curve

As a part of DVHA's utilization management program, the Quality Unit impacts and tracks the average length of inpatient psychiatric and detox stays for Vermont Medicaid members over time.

The Utilization Review (UR) Clinicians conduct numerous utilization management and review activities to ensure that quality services, those which increase the likelihood of desired health outcomes and are consistent with prevailing professionally-recognized standards of medical practice, are provided to members and that providers are using the program appropriately, effectively and efficiently. The UR Clinicians utilize clinical criteria for making utilization review decisions that are objective and based on sound medical evidence.

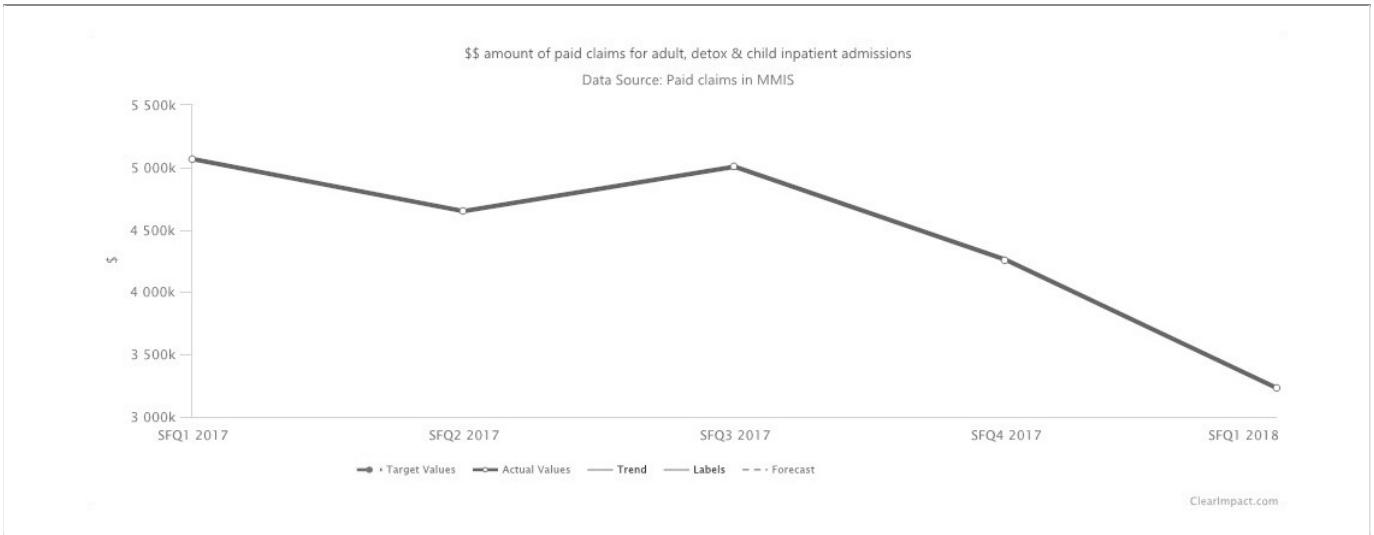
The data in the above trend lines show relatively consistent average lengths of stay for the psychiatric adult and detox populations. In January of 2017, UR Clinicians began participation in weekly status calls for all children placed in the Brattleboro Retreat. In doing so, some disposition issues were addressed. This may have contributed to the decrease in the average length of stay for children.

*Last updated: 10/19/17*

*Author: Quality Improvement & Clinical Integrity Unit*

# P Quality Improvement & Clinical Integrity Unit

## PM QICIU $$ amount of paid claims for adult, detox & child inpatient admissions




### Notes on Methodology

| Paid Claims by Type | SFY17 Q1 | SFY17 Q2 | SFY17 Q3 | SFY17 Q4 | SFY18 Q1 |
|---|---|---|---|---|---|
| **Adult** | $2,454,107 | $2,418,881 | $2,571,705 | $2,073,740 | $2,203,703 |
| **Detox** | $845,469 | $437,773 | $545,029 | $496,944 | $232,521 |
| **Children** | $1,769,510 | $1,793,968 | $1,890,571 | $1,690,421 | $796,255 |
| **Total** | **$5,069,086** | **$4,650,622** | **$5,007,305** | **$4,261,105** | **$3,232,479** |

### Partners

- Vermont Medicaid Inpatient Providers
- DVHA Business Office
- DXC Technology

### Story Behind the Curve

The Quality Unit reviews paid claims and tracks the costs of inpatient hospitalization for specific populations. The $ amounts above include all paid claims for the Medicaid members who had an inpatient stay prior authorized by a Quality Unit Utilization Review Clinician. Please note that the SFY18 Q1 data points are low because not all claims for admissions during the quarter for have been billed yet.

The Quality Unit is currently working with the Business Office to review the claims reconciliation process with the goals of ensuring that the appropriate paid claims are being captured in the most efficient way and that DVHA is paying for the approved level of care at the appropriate rate. It is anticipated that process will be complete by the end of SFY18 Q3.

*Last updated: 10/19/17*

*Author: Quality Improvement & Clinical Integrity Unit*

As compared to the SFY 2018 Budget Post-Rescission, the DVHA SFY 2019 request reflects a decrease of $22,546,077. The SFY 2019 administration appropriation is $24,498,260 less, while the program appropriation is $1,952,183 greater.

The DVHA program budget relates to direct health care services and this change represents less than 0.2% growth year-over-year. The programmatic growth relates to overall decreases to DVHA managed expenditures and an increase in the Choices for Care (CFC) appropriation. The CFC appropriation is housed at DVHA and managed at DAIL.

Programmatic adjustments in DVHA's budget reflect updated Medicaid consensus forecasts, and the resolution of longstanding litigation with Dartmouth Hitchcock Medical Center, and other program changes. Program spending is spread across four different appropriations: Global Commitment, Choices for Care, State Only, and Medicaid-Matched Non-Waiver; however, the descriptions of the changes are similar across these appropriations. Accordingly, this budget narrative consolidates these items.

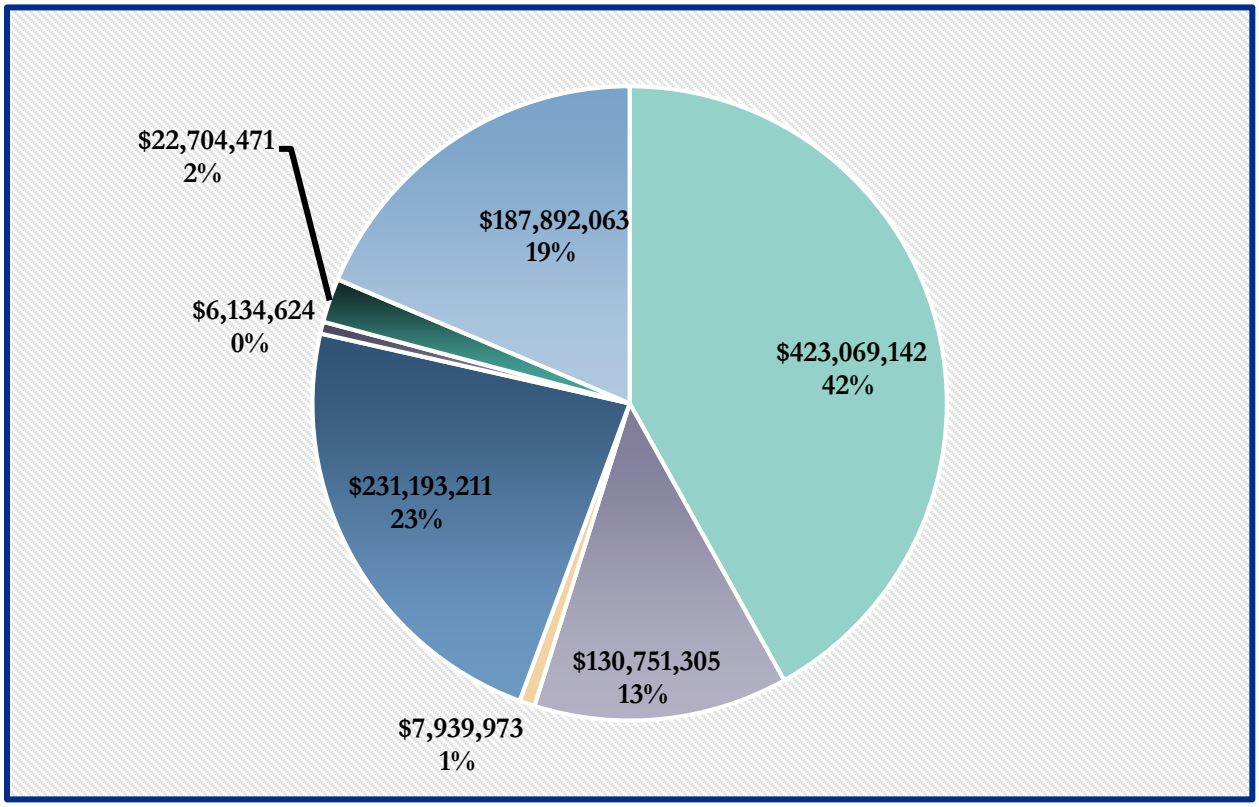
The decrease in DVHA's administrative appropriation is largely due to DVHA's coordinated effort to make IT project budgeting more realistic and align the SFY 19 budget with actual project scope and timeline. DVHA conducted a careful review of projects in planning and development and re-evaluated the State funds needed to complete each phase in the current and next fiscal year.

| Changes | Program | Administration | Total DVHA | G.F. Estimate* |
|---|---|---|---|---|
| **SFY 2018 As Passed** | **$1,036,331,851** | **$190,047,259** | **$1,226,379,108** | **$543,273,814** |
| 2018 Rescission & Management Savings | ↓ ($28,599,243) | ↓ ($2,354,980) | ↓ ($30,954,223) | ↓ ($14,707,406) |
| **SFY 2018 Post Rescission** | **$1,007,732,607** | **$187,692,279** | **$1,195,424,886** | **$528,566,408** |
| 2019 Changes | ↑ $1,952,183 | ↓ ($24,498,260) | ↓ ($22,546,077) | ↓ ($3,796,402) |
| **SFY 2019 Governor's Recommendation** | **$1,009,684,790** | **$163,194,019** | **$1,172,878,808** | **$524,770,006** |

* This estimate converts Global Commitment which is handled at AHS Central Office using a blended Federal Medical Assistance Percentage (FMAP) which may not fully reflect the actual mix of caseload for the New Adults.

## SFY 2019 Program Budget Breakout by Medicaid Eligibility Group

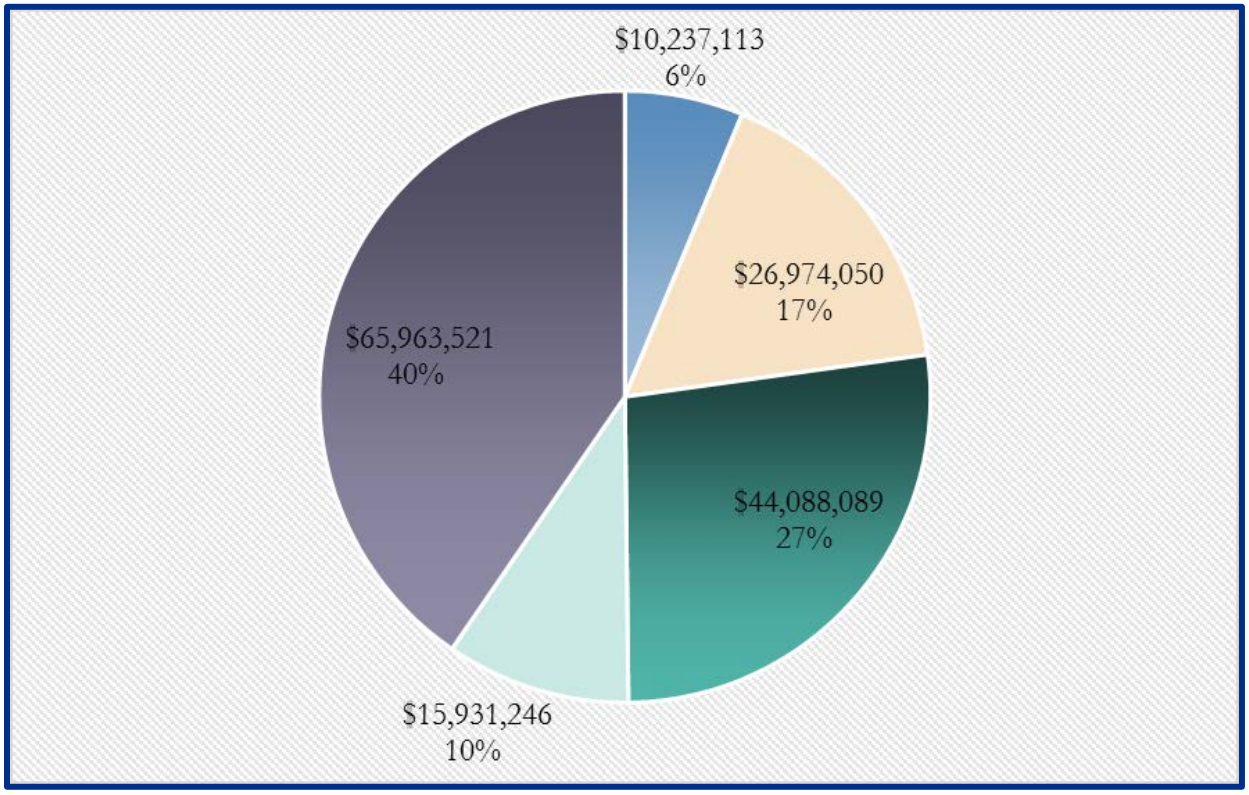
## $1,009,684,789




| | |
|---|---|
| Adults Full Benefit | $423,069,142 |
| Adults Dual Eligible, Buy In, & Clawback | $130,751,305 |
| Exchange Premium & Cost Sharing | $7,939,973 |
| Choices for Care, LTC and Acute Services | $231,193,211 |
| Pharmacy Only | $6,134,624 |
| DSH | $22,704,471 |
| Children's Medicaid & CHIP | $187,892,063 |

## SFY 2019 Administration Budget Breakout by Area of Spend

## $163,194,019




| | |
|---|---|
| General Administration | $10,237,113 |
| Claims Services & Provider Management Systems and Staff | $26,974,050 |
| Member Enrollment & Eligibility Systems and Staff | $44,088,089 |
| Quality & Improvement Systems and Staff | $15,931,246 |
| Design, Development and Implementation Projects | $65,963,521 |

# BUDGET SUMMARY PROGRAM

| | GF | SF | IdptT | FF | VT Health Connect (Portion Funded By SHCRF) | Medicaid GCF | Invmnt GCF | Total |
|---|---|---|---|---|---|---|---|---|
| **DVHA Global Commitment - As Passed FY18** | | | | | | **752,459,668** | | **752,459,668** |
| **other changes:** | | | | | | | | |
| **Grants:** | | | | | | | | |
| **FY18 after other changes** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| **Total after FY18 other changes** | **0** | **0** | **0** | **0** | **0** | **752,459,668** | **0** | **752,459,668** |
| **FY18 after other changes** | | | | | | | | |
| **Grants:** | | | | | | | | |
| BAA FY18 rescission (Caseload and Utilization) | | | | | | (22,152,087) | | **(22,152,087)** |
| BAA FY18 rescission (OPP rebase) | | | | | | (3,525,000) | | **(3,525,000)** |
| Caseload and Utilization | | | | | | 2,649,001 | | **2,649,001** |
| Primary Care Case Management (PCCM) Fee Elimination | | | | | | (3,200,634) | | **(3,200,634)** |
| Transfer to DMH Applied Behavior Analysis (ABA) (AHS net-neutral, BAA item) | | | | | | (965,101) | | **(965,101)** |
| Dartmouth Hitchcock Medical Center (DHMC) Rate Increase | | | | | | 6,576,707 | | **6,576,707** |
| Transfer to DAIL due to High Tech reductions (Unified Service Plans) (AHS net-neutral) | | | | | | (450,000) | | **(450,000)** |
| DME Rate adjustment to be in compliance with Federal regulations | | | | | | (1,500,000) | | **(1,500,000)** |
| Cost avoidance due to increased COB and PI activities | | | | | | (1,959,716) | | **(1,959,716)** |
| **FY19 Changes** | **0** | **0** | **0** | **0** | **0** | **(24,526,830)** | **0** | **(24,526,830)** |
| **FY19 Gov Recommended** | **0** | **0** | **0** | **0** | **0** | **727,932,838** | **0** | **727,932,838** |
| | | | | | | | | |
| **DVHA - Med Prog - LTC Waiver-As Passed FY18** | **753,720** | | | **896,280** | | **194,833,201** | | **196,483,201** |
| **other changes:** | | | | | | | | |
| **Grants:** | | | | | | | | |
| **FY18 after other changes** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| **Total after FY18 other changes** | **753,720** | **0** | **0** | **896,280** | **0** | **194,833,201** | **0** | **196,483,201** |
| **FY18 after other changes** | | | | | | | | |
| **Traditional:** | | | | | | | | **0** |
| Statutory Nursing Home inflationary rate increase (from Ratesetting) | | | | | | 3,272,108 | | **3,272,108** |
| Nursing Home Medicaid Bed Day decrease in utilization 1.% - 6,221 days @ $195 per day | | | | | | (1,213,095) | | **(1,213,095)** |
| Vermont Veterans Home - Increase Medicaid Rates - Remove Upper Payment Limit (statewide net GF savings of $1,098,847) | | | | | | 2,806,903 | | **2,806,903** |
| Home and Community Based caseload pressure 49 x $30,100 | | | | | | 1,470,000 | | **1,470,000** |
| CFC consumers funding changing from Money Follows the Person Grant to Global Commitment as demonstration grant has ended. - net neutral | (753,720) | | | (896,280) | | 1,631,076 | | **(18,924)** |
| Sick Leave Legislation Implementation - Choices for Care | | | | | | 250,570 | | **250,570** |
| **FY19 Changes** | **(753,720)** | **0** | **0** | **(896,280)** | **0** | **8,217,562** | **0** | **6,567,562** |
| **FY19 Gov Recommended** | **0** | **0** | **0** | **0** | **0** | **203,050,763** | **0** | **203,050,763** |
| | | | | | | | | |
| **DVHA - Medicaid Program - State Only - As Passed FY18** | **40,507,054** | | | | | | **9,668,028** | **50,175,082** |
| **other changes:** | | | | | | | | |
| **Grants:** | | | | | | | | |
| **FY18 after other changes** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| **Total after FY18 other changes** | **40,507,054** | **0** | **0** | **0** | **0** | **0** | **9,668,028** | **50,175,082** |
| **FY18 after other changes** | | | | | | | | |
| **Grants:** | | | | | | | | |
| FY18 rescission (Caseload and Utilization) | (1,712,958) | | | | | | (409,694) | **(2,122,652)** |
| Caseload and Utilization | (704,390) | | | | | | 461,695 | **(242,695)** |
| Clawback Rate Increase | 1,211,632 | | | | | | | **1,211,632** |
| Cost Share Reduction (CSR) Elimination (1/1/2019) | (827,175) | | | | | | | **(827,175)** |
| Technical adjustment to Investment | | | | | | | (838,252) | **(838,252)** |
| **FY19 Changes** | **(2,032,891)** | **0** | **0** | **0** | **0** | **0** | **(786,251)** | **(2,819,142)** |
| **FY19 Gov Recommended** | **38,474,163** | **0** | **0** | **0** | **0** | **0** | **8,881,777** | **47,355,940** |
| | | | | | | | | |
| **DVHA - Medicaid Matched NON Waiver Expenses - As Passed FY18** | **13,685,694** | | | **23,528,204** | | | | **37,213,898** |
| **other changes:** | | | | | | | | |
| **Grants:** | | | | | | | | |
| **FY18 after other changes** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| **Total after FY18 other changes** | **13,685,694** | **0** | **0** | **23,528,204** | **0** | **0** | **0** | **37,213,898** |
| **FY18 after other changes** | | | | | | | | |
| **Grants:** | | | | | | | | |
| FY18 rescission (Caseload and Utilization) | (62,555) | | | (736,949) | | | | **(799,504)** |
| Caseload and Utilization SCHIP | (18,512) | | | (179,479) | | | | **(197,991)** |
| DSH rate reduction | (2,192,364) | | | (2,551,946) | | | | **(4,744,310)** |
| Primary Care Case Management (PCCM) Fee Elimination | (11,857) | | | (114,988) | | | | **(126,845)** |
| | | | | | | | | **0** |
| **FY19 Changes** | **(2,285,288)** | **0** | **0** | **(3,583,362)** | **0** | **0** | **0** | **(5,868,650)** |
| **FY19 Gov Recommended** | **11,400,406** | **0** | **0** | **19,944,842** | **0** | **0** | **0** | **31,345,248** |
| | | | | | | | | |
| **FY19 Gov Recommended Program** | **49,874,569** | **0** | **0** | **19,944,842** | **0** | **930,983,601** | **8,881,777** | **1,009,684,789** |

# BUDGET SUMMARY ADMINISTRATION

| | GF | SF | IdptT | FF | VT Health Connect (Portion Funded By SHCRF) | Medicaid GCF | Invmnt GCF | Total |
|---|---|---|---|---|---|---|---|---|
| **DVHA Administration - As Passed FY18** | **31,518,780** | **3,577,938** | **7,482,609** | **139,552,196** | | | **7,915,736** | **190,047,259** |
| **other changes:** | | | | | | | | |
| **Grants:** | | | | | | | | |
| **FY18 after other changes** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| **Total after FY18 other changes** | **31,518,780** | **3,577,938** | **7,482,609** | **139,552,196** | **0** | **0** | **7,915,736** | **190,047,259** |
| **FY18 after other changes** | | | | | | | | |
| **Personal Services:** | | | | | | | | |
| Management savings reduction COB and PI funding (no new positions) (BAA item) | (303,574) | | | | | | | **(303,574)** |
| Management savings reduction ADS contract values (BAA item) | (570,623) | | | (1,356,315) | (121,474) | | | **(2,048,412)** |
| Payact Salary and Fringe | 962 | | | 962 | | | | **1,924** |
| Workers Compensation Allocation (BAA Management savings reduction) | (144) | | | | | | | **(144)** |
| Workers Compensation Allocation FY 19 Change | 1,924 | | | 1,924 | | | | **3,848** |
| Decrease Salary and Benefits for IT Positions (1) to ADS | (56,117) | | | (56,117) | | | | **(112,234)** |
| Position Transfer AHS to DVHA: Policy Unit; 8 FTE (AHS net-neutral) | 402,227 | | | 402,227 | | | | **804,454** |
| Position Transfer AHS to DVHA: General Counsel; 1 FTE (AHS net-neutral) | 74,661 | | | 74,661 | | | | **149,322** |
| Delay Hiring Actons for 30 Days - Increase Vacancy Savings | (358,047) | | | (358,047) | | | | **(716,094)** |
| Realignment of Care Coordination Activities | (650,000) | | | (1,176,928) | | | | **(1,826,928)** |
| Increase in M&O Contracts, MMIS, PBM, Misc | 1,649,096 | | | 2,468,465 | | | | **4,117,561** |
| Swap in Match based on OAPD Contracts | (1,794,906) | | | 1,794,906 | | | | **0** |
| End Premium Processing Contract | (979,923) | | | (1,029,699) | (126,683) | | | **(2,136,305)** |
| Changes on Contracts Based on DDI Efforts | (2,422,856) | (160,312) | 12,537 | (23,216,785) | | | | **(25,787,416)** |
| Delivery System Reform GC Investment Funded | | | | | | | 1,875,000 | **1,875,000** |
| Delivery System Reform IAPD Funded | | 75,000 | | 675,000 | | | | **750,000** |
| HIT Investment Phasedown, Reduction in HIT Contracts, and Partial Swap to HIT Fund | | 29,959 | | 1,005,060 | | | (2,995,647) | **(1,960,628)** |
| Technical correction between IE and VHC Operation | | | (2,558,849) | | 2,558,849 | | | **0** |
| Swaps SHCRF for IdptT Fund | | | 2,310,692 | | (2,310,692) | | | **0** |
| **Operating Expenses:** | | | | | | | | **0** |
| DHR Allocation FY 19 change | 10,088 | | | 10,088 | | | | **20,176** |
| General Liability Allocation FY 19 Change | 11,752 | | | 11,752 | | | | **23,504** |
| AoA Commercial Policy Allocation FY 19 Change | 550 | | | 550 | | | | **1,100** |
| Fee For Space Allocation FY 19 Change | 29,179 | | | 29,179 | | | | **58,358** |
| VISION Development Allocation FY 19 Change | 5,208 | | | 5,208 | | | | **10,416** |
| VISION Allocation (BAA Management savings reduction) | (134) | | | | | | | **(134)** |
| VISION Allocation FY 19 Change | 52,557 | | | 60,891 | | | | **113,448** |
| Management savings reduction Travel (BAA item) | (2,716) | | | | | | | **(2,716)** |
| Decrease Operating Expenses for IT Positions to ADS | (1,000) | | | (1,000) | | | | **(2,000)** |
| Decrease Internal Service Funds for IT Positions to ADS | (745) | | | (746) | | | | **(1,491)** |
| Increase for ADS Billed Services | 57,862 | | | 57,863 | | | | **115,725** |
| **FY19 Changes** | **(4,844,719)** | **(55,353)** | **(235,620)** | **(20,596,901)** | **0** | **0** | **(1,120,647)** | **(26,853,240)** |
| **FY19 Gov Recommended Admin** | **26,674,061** | **3,522,585** | **7,246,989** | **118,955,295** | **0** | **0** | **6,795,089** | **163,194,019** |
| **FY19 Gov Recommended Program** | **49,874,569** | **0** | **0** | **19,944,842** | **0** | **930,983,601** | **8,881,777** | **1,009,684,789** |
| **FY19 Gov Recommended DVHA** | **76,548,630** | **3,522,585** | **7,246,989** | **138,900,137** | **0** | **930,983,601** | **15,676,866** | **1,172,878,808** |

## BUDGET CONSIDERATIONS PROGRAM

### Rescission Items ($28,599,243) gross / ($13,830,215) state

**Caseload and Utilization Revisions** **($25,074,243) gross** *($12,201,312) state*

DVHA, in partnership with the Agency of Human Services Central Office, the Department of Finance and Management, and the Joint Fiscal Office forecasts Medicaid enrollment and expenditures. Program spending is based on projected enrollment, utilization of services, and price. DVHA's budget features several reductions in program spending with the first. Two factors affected previous enrollment estimates and led to the August rescission forecast.

First, the State was unable to re-determine eligibility beginning in April of 2014. In accordance with a CMS waiver and mitigation plan, DVHA is now on regular cycles of re-determinations.

- Medicaid for the Aged, Blind, and Disabled (MABD) renewals re-started in October 2015
  - Monthly batches of 600-2,000 households
  - First annual cycle completed in October 2016
  - Now proceeding with normal, ongoing renewal schedule
  - Most members respond promptly, though some net migration to MCA
- Medicaid for Children and Adults (MCA) renewals re-started in January 2016.
  - Monthly batches of 3,000-9,000 households
  - First annual cycle completed in January 2017
  - Now proceeding with normal, ongoing renewal schedule
  - Nearly nine out of ten (88.4%) responding households still eligible for Medicaid, but fewer than half of renewing members respond before receiving closure notice
    - Opportunity for 90 days retroactive coverage means those responding within three months can avoid gap in coverage
    - Additional responses trickle in throughout the year, often when member need to use coverage
    - New applicants tend to be more medically needy than non-responding members.

| | |
|---|---|
| *Global Commitment Appropriation* | **($22,152,087) gross** *($10,236,479) state* |
| *State Only Appropriation* | **($2,122,652) gross** *($1,902,278) state* |
| *Non-Waiver Appropriation* | **($799,504) gross** *($62,555) state* |

**Hospital Outpatient Prospective Payment System** **($3,525,000) gross** *($1,628,903) state*

DVHA made changes to its outpatient payment methodology (OPPS) to hospitals to re-set the payment baseline so that it fully eliminated provider-based billing.

*Global Commitment Appropriation Only*

## SFY 2019 Program Changes — $1,952,183 gross / $858,476 state

### Caseload and Utilization Revisions — $2,208,315 gross *$714,551 state*

Due to system functionality issues at the Vermont Health Connect (VHC), CMS approved a waiver of re-determinations for Medicaid enrollees until January 2016. DVHA is now current with re-determinations and is presenting an adjustment of caseload that is aligned to November 2017 enrollment data which demonstrates a stabilization of member enrollment overall. The consensus process predicts modest caseload growth within the Global Commitment Medicaid eligibility groups and near level growth within the remainder of the groups.

| | |
|---|---|
| *Global Commitment Appropriation* | **$2,649,001 gross** *$1,224,104 state* |
| *State Only Appropriation* | **($242,695) gross** *($491,041) state* |
| *Non-Waiver Appropriation* | **($197,991) gross** *($18,512) state* |

### Primary Care Case Management (PCCM) Fee Elimination — ($3,327,479) gross *($1,490,870) state*

PCCM was intended as a payment incentive for providers to coordinate services and compensate them for any extra support needed for complex cases. Vermont put it in place under the original VHAP program; however, the payment is not aligned with DVHA's focus on value-based payments. Specifically, the payment is not tied to a specific program or activity. Its impact cannot be assessed. It's designed poorly, being commingled with a provider's regular Medicaid remittance. Given scarce resources, DVHA proposes the elimination of PCCM to hold base primary care payment rates, which are equal to 100% of Medicare rates, constant.

| | |
|---|---|
| *Global Commitment Appropriation* | **($3,200,634) gross** *($1,479,013) state* |
| *Non-Waiver Appropriation* | **($126,845) gross** *($11,857) state* |

### Transfer to DMH: ABA Services — ($965,101) gross *(445,973) state*

DVHA has State Plan approval to offer applied behavior analysis (ABA) services to individuals with autism in order to address a service delivery gap. This is a revenue neutral transfer to DMH to support ABA expansion in the NCSS IFS bundle.

*Global Commitment Appropriation Only*

### Dartmouth Hitchcock Medical Center Rate Increase — $6,576,707 gross *$3,039,096 state*

AHS reached a settlement agreement with Dartmouth Hitchcock Medical Center (DHMC) regarding DVHA's rate setting policies. DVHA will reimburse DHMC on par with the in-state academic medical center. This rate increase is prospective and began January 1st, 2018.

*Global Commitment Appropriation Only*

**Transfer to DAIL: High Tech Nursing** **($450,000) gross** *($207,945) state*

Clinical evaluations for high tech service has resulted in fewer services/hours deemed medically necessary. The population may still have the need for other supports. This has led to an increased pressure now on Developmental Services (DS) within DAIL in particular for people with Unified Service Plans and having to fill the gap left by terminations or reductions to High Tech. This item is AHS Net Neutral.

*Global Commitment Appropriation Only*

**Rate adjustment: Compliance to Federal Regulations** **($1,500,000) gross** *($693,150) state*

New federal regulations limit the State's ability to draw down match for some goods and services based on price. Stated another way, the State will not draw down federal financial participation if it sets a price beyond the Medicare limit. Medicaid expenditures for Durable Medical Equipment to Medicare rates. To meet this these requirements, DVHA is changing the methodology and rates paid to suppliers of Durable Medical Equipment, Prosthetics/Orthotics, and Supplies and Clinical Lab services. These changes will ensure compliance with the 21st Century Cures Act and are part of the DVHA's ongoing strategy to modernize the way it pays for healthcare services.

*Global Commitment Appropriation Only*

**Cost avoidance due to increased COB and PI activities** **($1,959,716) gross** *($905,585) state*

The General Assembly proposed increased Coordination of Benefit (COB) and Program Integrity (PI) activities in the State Fiscal year 2018 budget; however, DVHA was not given any positions for these activities. DVHA has now reviewed its vacancies and resources and believes it can create an effective plan for SFY 2019 that honors the original budget directive.

*Global Commitment Appropriation Only*

**"Clawback" Rate Increase** **$1,211,632 gross** *$1,211,632 state*

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA), which established the Medicare Part D prescription drug program, eliminated Medicaid prescription drug coverage for people dually eligible for Medicare and Medicaid (duals), and required all duals to receive their drug coverage through a Medicare Part D plan. This would reduce state costs; however, MMA also required states to reimburse the federal government for costs associated with the transfer of prescription drug coverage for this population from state Medicaid programs to Medicare. The reimbursement to the federal government is known as the "Clawback" payment and is paid out of State funds. The "Clawback" rate will increase on 1/1/2018 from $138.97 per eligible member to $143.72.

*State Only Appropriation Only*

**Cost Share Reduction (CSR) Elimination** **($827,175) gross** *($827,175) state*

DVHA is committed to maintaining health care services for the most vulnerable Vermonters. This state funded only program is being eliminated to preserve those dollars to draw down federal financial participation for other Medicaid services.

*State Only Appropriation Only*

**Technical Adjustment to Investments** **($838,252) gross** *($387,356) state*

This is a technical correction to DVHA's Global Commitment Investment amount for inpatient psychiatric services delivered at Institutions of Mental Disease (IMD). This change aligns the budgeted amount with expected cost based on caseload and utilization.

*State Only Appropriation Only*

**Disproportionate Share Hospital (DSH) Rate Reduction** **($4,744,310) gross** *($2,192,364) state*

The federal government is reducing state DSH allotments over time. This continued step-down of DSH payments is intended to align with the overall federal policy direction. Additionally, in a time of limited resources, DVHA proposes leaving overall hospital rates intact and instead reducing DSH payments. Vermont aims to be a predictable payer in its rates and value-based programs. Vermont's low uninsured rate and the anticipated phaseout of most DSH spending per federal law make gradual DSH reductions the most sensible choice for spending reductions.

*Non-Waiver Appropriation Only*

**Choices for Care Changes Decision Items** **$6,567,562 gross** *$3,043,615 state*

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

- Statutory Nursing Home Inflationary Rate Increase;
- Nursing Home Bed Day Decrease in Utilization;
- Vermont Veteran's Home Rate Increase;
- Changes to the T&C of the GC waiver, the UPL for VVH has been lifted;
- Home and Community Cased Caseload Pressures;
- CFC Consumers funding changes from Money Follows the Person Grant to Global Commitment as demonstration grant ended (net neutral); and
- Choices for Care sick leave legislation implementation.

## Summary of Program Adjustments by Appropriation

| Program Changes | Global Commitment | Choices for Care | State | Non-Waiver | Total |
|---|---|---|---|---|---|
| **SFY 2018 As Passed** | **$752,459,668** | **$196,483,201** | **$50,175,082** | **$37,213,898** | **$1,036,331,849** |
| 2018 Rescission | ↓($25,677,087) | ↔ No Change | ↓($2,122,652) | ↓ ($799,504) | ↓ **($28,599,243)** |
| **SFY 2018 Post Rescission** | **$726,782,581** | **$196,483,201** | **$48,052,430** | **$36,414,394** | **$1,007,732,606** |
| Caseload & Utilization | ↑ $2,649,001 | ↔ No Change | ↓ ($242,695) | ↓ ($197,991) | ↑$2,208,315 |
| PCCM Elimination | ↓ ($3,200,634) | ↔ N/A | ↔ N/A | ↓ ($126,845) | ↓$3,327,479) |
| Transfer DMH: ABA Services | ↓ ($965,101) | ↔ N/A | ↔ N/A | ↔ N/A | ↓($965,101) |
| Dartmouth Hitchcock Medical Center Rate Increase | ↑ $6,576,707 | ↔ N/A | ↔ N/A | ↔ N/A | ↑$6,576,707 |
| Transfer to DAIL: High Tech | ↓ ($450,000) | ↔ N/A | ↔ N/A | ↔ N/A | ↓($450,000) |
| Rate adjustment: Compliance to Federal Regulations | ↓ ($1,500,000) | ↔ N/A | ↔ N/A | ↔ N/A | ↓($1,500,000) |
| Cost avoidance due to increased COB and PI activities | ↓ ($1,959,716) | ↔ N/A | ↔ N/A | ↔ N/A | ↓($1,959,716) |
| Clawback Rate Increase | ↔ N/A | ↔ N/A | ↑ $1,211,632 | ↔ N/A | ↑$1,211,632 |
| Cost Share Reduction (CSR) Elimination | ↔ N/A | ↔ N/A | ↓ ($827,175) | ↔ N/A | ↓($827,175) |
| Technical Adjustments to Investments | ↔ N/A | ↔ N/A | ↓ ($838,252) | ↔ N/A | ↓($838,252) |
| DSH Rate Reduction | ↔ N/A | ↔ N/A | ↔ N/A | ↓$4,744,310) | ↓($4,744,310) |
| Combined Choices for Care Adjustments | ↔ N/A | ↑ $6,567,562 | ↔ N/A | ↔ N/A | ↑$6,567,562 |
| **SFY 2019 Governor's Recommend** | **$727,932,839** | **$203,050,763** | **$47,355,940** | **$31,345,248** | **$1,009,684,779** |

## BUDGET CONSIDERATIONS ADMINISTRATION

**Personal Services Management Savings** **($2,352,130) gross / ($874,341) state**

**Workers Compensation** **($**144) gross *($144) state*

This represents DVHA's share of savings related a statewide project to re-evaluate workers comp costs.

**COB and PI Funding** ($303,574) gross *($303,574) state*

The SFY 2018 budget included an appropriation to enhance Coordination of Benefits and Program Integrity divisions to improve efficiency. The appropriation was not accompanied by positions. Accordingly, DVHA is returning the appropriation as management savings.

**Contract Reductions (ADS)** ($2,048,412) gross *($570,623) state*

To meet Management Savings target, DVHA did a preliminary review of operations contracts and found that the anticipated annual spending for the Agency of Digital Services budgeted amounts were overstated. This activity helped lead to further scrutinizing of contracts to ensure that IT budget matches projects plans and anticipated annual spending. Further reductions supporting this effort are below in the Design, Development and Implementation (DDI) Contract Reductions

**SFY 2019 Personal Services Changes** **($24,837,496) gross / ($4,820,329) state**

**Pay Act and Related Fringe** $1,924 gross *$962 state*

**Worker's Comp Allocation Change** $3,848 gross *$1,924 state*

**IT Position Transfer to ADS** ($112,234) gross *($56,117) state*

On January 17th, 2017, Governor Scott issued executive order 06-17 calling for the creation of the Agency of Digital Services. At the core of ADS, the Divisions of Shared Services, Data, Security, Enterprise Architecture, and Project Management help ensure information technology services are standardized, coordinated, secure, and cost-effective across Vermont State government.

This item moves one (1) FTE to better align business functions and information technology (IT). This item is budget neutral within DVHA. There is a corresponding increase to our Operating budget.

**Policy Unit Positions Transfer from AHS** $804,454 gross *$402,227 state*

DVHA received eight positions transferred from AHS to better align the accountability of Medicaid policy to the department of responsibility. The Medicaid Policy Unit (MPU) consists of eight positions – Director of Healthcare Policy and Planning, Health Policy and Planning Chief, 3 Health Program Administrators, 1 Program Consultant, and 2 Staff Attorneys. The Medicaid Policy Unit works to ensure that DVHA and other AHS departments administer the Medicaid program in compliance with

federal and state regulations. Additionally, the Policy Unit works with AHS staff and other public and private partners to develop and implement effective Medicaid policy aimed at advancing the agency's goals of improving access and quality while reducing overall costs. Primary Functions of the MPU include: 1) Policy Development and Implementation, 2) Medicaid Legislative Coordination, 3) Medicaid Administrative Rulemaking, 4) Policy Research and Analysis, and 5) Administration of the Medicaid State Plan and Global Commitment Waiver. Given DVHA's substantial role in the administration of Medicaid as compared to other departments within the Agency of Human Services (AHS), the MPU was transferred from the AHS Central Office to DVHA to better align authority and accountability. No new positions were added to the MPU with the transfer and the transfer did not result in any new spending for DVHA or AHS.

**General Counsel Position Transfer from AHS** $149,322 gross *$74,661 state*

DVHA gave up its General Counsel position during the transition to the new Administration, relying more on legal support from throughout the Agency and the Attorney General's Office. After further consideration, a General Counsel is essential to the operations of the department, both its administration of a public health plan and as the overseer of complex technology projects. A new General Counsel was hired with specific expertise in contracting.

**Increase Vacancy Savings** ($716,094) gross *($358,047) state*

DVHA proposes to delay all hiring actions for thirty days to maximize vacancy savings. The delay comports with DVHA's management strategy of reviewing the purpose, efficacy, and organizational alignment of each newly vacant position to determine (a) whether it is needed and (b) its best use in the department.

**Realignment of Care Coordination Activities** ($1,826,928) gross *($650,000) state*

DVHA proposes to restructure its care coordination operations to develop new goals and aligned programs. DVHA would evaluate programs, staff, current technology, and future IT projects to identify redundancies and efficiencies. Specifically, DVHA leadership believes that VCCI, the Blueprint for Health, and its Clinical Operations Unit could be aligned and restructured to focus on Vermont's healthcare reform goals, driving better performance and greater efficiency. DVHA will set a target of $650,000 in General Fund savings due to expected contract and staff efficiencies.

**Maintenance and Operation Contracts** $4,117,561 gross *$1,649,096 state*

DVHA contracts with its claims processor DXC (formerly Hewlett Packard Enterprise) to operate our Medicaid Management Information System and provide fiscal agent services for approximately $1 billion in program spending. This contract needed to be extended, and the extension required an increase in the contract value. Additionally, various contracts for both infrastructure and application maintenance and operations are experiencing modest cost increases including the hosting and the pharmacy benefit management contracts.

**Swap in Federal Participation** $0 gross *($1,794,906) state*

Anticipated CMS certification of the MMIS pharmacy benefit management system means that the maintenance and operation of this system will be eligible for increased federal participation from 50% federally funded to 75% federally funded.

**Design, Development, and Implementation** ($25,787,416) gross *($2,570,631) state*

DVHA has scrutinized its contracts to ensure that its budget matches project plans and anticipated annual spending. This direction supports DVHA's focus on an attainable modular procurement strategy for Integrated Eligibility and MMIS implementations. A memo detailing the procurement and development strategy will be provided at testimony.

**Carrier Managed Premium Processing** ($2,136,305) gross *($1,106,606) state*

DVHA processes premium payments as part of Vermont Health Connect. DVHA proposes turning the premium payment processing directly over to the insurance carriers, which would allow DVHA to eliminate the payment processing-related contract. This would generate savings of $4.5M ($2.4M state dollars) on an annualized basis. The SFY 2019 savings target is for a half year. Specifically, these savings assume a development start date of 07/01/2018 with a go-live of 01/01/2019 for Carrier Managed Premium Collection and Vermont Premium Assistance. The schedule is aggressive and depends on the carrier's ability to collect the premiums from all members and apply the VPA appropriately. DVHA would retain Dr. Dynasaur premium collections using the legacy Access system and through the reassignment of vacant positions.

Additionally, state cost sharing reductions would be eliminated effective 01/01/2019 as part of this proposal. This is discussed in the program spending section.

**Delivery System Reform Investments** $2,625,000 gross *$941,438 state*

DVHA runs the Vermont Medicaid Next Generation (VMNG) Program, a risk-based program connected to the Vermont All-Payer Accountable Care Organization (ACO) Model Agreement between the State of Vermont and CMS. The All-Payer Model agreement was negotiated together with a renewal of Vermont Global Commitment to Health 1115 Medicaid Waiver. The Medicaid Waiver granted Vermont the authority to make Delivery System Reform (DSR) investments, which allow the State to draw down federal match for certain approved investments in the care delivery system. AHS applied for, and was granted, permission to fund several investments in calendar year 2018.

These investments pertain to the creation and distribution of new tools and the development of existing tools to enhance OneCare's existing population health management analytics and care coordination platform by adding new analytic applications and system functionality, along with providing technical assistance and deployment support to ACO providers throughout the OneCare network. OneCare will undertake the following activities in 2018 to achieve goals related to this project:

- Integrate new data sources into OneCare's Health Information Technology systems to meet the State of Vermont's All Payer Accountable Care Organization Model requirements to support and improve the healthcare delivery system and promote transformation to value-based and integrated models of care;
- Provide suite of new or enhanced quality and health improvement information dissemination tools and reports to network participants to help manage risk, monitor performance, assist in care delivery, and help achieve the quadruple aim across payer programs; and
- Provide technical assistance and training on information dissemination tools to help support adoption within communities.

Overall, these investments are designed to enhance healthcare quality and care coordination.

**HIT Investment Phasedown** **(**$1,960,628) gross *($1,354,330) state*

Since 2005, DVHA has been able to make expenditures previously referred to as Managed Care Organization (MCO) Investments. As part of the 2017 Global Commitment to Health Waiver extension these expenditures are to be referred to as "Investments". The use of these Investment expenditure authority must be limited to the following areas:

- Reduce the rate of uninsured and/or underinsured in Vermont;
- Increase the access to quality healthcare by uninsured, underinsured, and Medicaid beneficiaries;
- Provide public health approaches and other innovative programs to improve health outcomes, health status and quality of life for uninsured, underinsured and Medicaid-eligible individuals in Vermont; and
- Encourage the formation and maintenance of public-private partnerships in healthcare including initiatives to support and improve the healthcare delivery system and promote transformation to value-based and integrated models of care.

As we move from the initial investment CMS has provided the state will a phase-down schedule of the HIT Investments. Beginning January 1, 2018, the DVHA is expected to replace 50% of the HIT Investment budget with HIT funds. Beginning calendar year 2019, the HIT fund will replace 100% of the HIT Investment funding.

In order to manage the HIT initiatives within the expected HIT revenue, DVHA has reduced HIT funded projects by $1,960,628.

**Operating Management Savings** **($2,850) gross / *($2,850) state***

**Travel Reduction** ($2,716) gross *($2,716) state*

**VISION Allocation Reduction** ($134) gross *($134) gross*

## SFY 2019 Operating Changes **$339,236 gross / *$165,451 state***

**Decrease in Operating Expenses and ISF** ($3,491) gross *($1,745) state*

This item moves the operating expenses for one (1) FTE to ADS to better align business functions and information technology (IT). This item is budget neutral within DVHA. There is a corresponding increase to our Operating budget.

**Increase in ADS Billed Service** $115,724 gross *$57,862 state*

This item moves one (1) FTE to ADS to better align business functions and information technology (IT). This item is budget neutral within DVHA. There is a corresponding decrease for the related operating costs and the salary plus fringe benefits.

**Allocation Changes** $227,002 gross *$109,334 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, Agency of Digital Services (ADS) costs, and Department of Human Resources (DHR) costs. Departments are notified annually of increases or decreases and the relative share in order to incorporate these changes into the budget request.

- DHR SFY 2019 Change
- Worker's Compensation SFY 2019 Change
- General Liability SFY 2019 Change
- AoA Commercial Policy SFY Change
- Fee for Space SFY 2019 Change
- VISION Development SFY 2019 Change

## Summary of Administration Adjustments by Group

| Changes | Personal Services | Operations | Grants | Total Admin |
|---|---|---|---|---|
| **SFY 2018 As Passed** | **$177,190,484** | **$5,542,033** | **$7,314,742** | **$190,047,259** |
| 2018 Management Savings | ↓ ($2,352,130) | ↓ ($2,850) | ↔ No Change | ↓ ($2,354,980 |
| **SFY 2018 Post Rescission** | **$174,838,354** | **$5,539,183** | **$7,314,742** | **$187,692,279** |
| Payact Salary & Fringe | ↓ ($1,924) | ↔ N/A | ↔ N/A | ↓ ($1,924 |
| Allocation Changes | ↑ $3,848 | ↑ $227,002 | ↔ N/A | ↑ $230,850 |
| Position Transfers In | ↑ $953,776 | ↔ N/A | ↔ N/A | ↑ $953,776 |
| Position Transfer Out To ADS | ↓ ($112,234) | ↔ N/A | ↔ N/A | ↓ ($112,234) |
| Increase Vacancy Savings | ↓ ($716,094) | ↔ N/A | ↔ N/A | ↓ ($716,094) |
| Realignment of Care Coordination | ↓ ($1,826,928) | ↔ N/A | ↔ N/A | ↓ ($1,826,928) |
| Increases to M&O Contracts | ↑ $4,117,561 | ↔ N/A | ↔ N/A | ↑ $4,117,561 |
| End Premium Processing Contract | ↓ ($2,136,305) | ↔ N/A | ↔ N/A | ↓ ($2,136,305) |
| Decrease related to Updated Plan for DDI Efforts | ↓ ($25,787,416) | ↔ N/A | ↔ N/A | ↓ ($25,787,416) |
| Delivery System Reform | ↑ $2,625,000 | ↔ N/A | ↔ N/A | ↑ $2,625,000 |
| HIT Investment Phasedown and Reduction to HIT Contracts | ↓ ($1,960,628) | ↔ N/A | ↔ N/A | ↓ ($1,960,628) |
| Increase Operating Related to ADS Transfer | ↔ N/A | ↑ $112,334 | ↔ N/A | ↑ $112,334 |
| Operating Allocation Changes | ↔ N/A | ↑ $227,002 | ↔ N/A | ↑ $227,002 |
| **SFY 2019 Governor's Recommend** | **$150,000,858** | **$5,878,419** | **$7,314,742** | **$163,194,019** |

# CATEGORIES OF SERVICE

| Category of Service | Actual SFY '17 | BAA SFY '18 | Gov. Rec. SFY '19 | 2018 BAA-2019 GR % Change | 5-Yr. Avg. Growth % Chg. | 5-Yr. Total Change | 10-Yr. Avg. Growth % Chg. | 10-Yr. Total Change |
|---|---|---|---|---|---|---|---|---|
| Inpatient | 138,544,384 | 141,031,367 | 144,394,884 | 2.38% | 2.26% | 13,568,166 | 9.76% | 80,875,976 |
| Outpatient | 118,139,830 | 120,609,048 | 125,182,012 | 3.79% | 4.97% | 21,430,869 | 7.21% | 56,134,208 |
| Physician | 119,045,147 | 120,858,961 | 121,984,008 | 0.93% | 9.54% | 35,931,423 | 8.00% | 57,809,639 |
| Pharmacy | 191,311,860 | 197,318,132 | 201,655,612 | 2.20% | 6.65% | 49,822,285 | 6.05% | 82,245,867 |
| Nursing Home | 125,765,820 | 127,889,488 | 129,004,283 | 0.87% | 1.65% | 9,753,894 | 1.46% | 16,529,208 |
| Mental Health Facility | 350,934 | 358,614 | 350,455 | -2.28% | 1.88% | (112,184) | 14.48% | 149,996 |
| Dental | 27,664,428 | 28,169,958 | 28,416,308 | 0.87% | 6.47% | 7,042,737 | 6.61% | 12,538,718 |
| MH Clinic | 215,437 | 221,576 | 225,118 | 1.60% | 20.93% | 90,380 | 86.47% | 82,173 |
| Independent Lab/Xray | 12,371,572 | 12,584,209 | 12,647,994 | 0.51% | 30.19% | 7,787,211 | 21.76% | 9,437,067 |
| Home Health | 6,610,943 | 6,636,042 | 6,654,959 | 0.29% | 0.19% | 41,918 | 1.70% | 942,749 |
| RHC | 7,264,016 | 7,396,603 | 7,494,326 | 1.32% | 7.19% | 1,975,984 | 5.53% | 2,692,238 |
| Hospice | 5,719,227 | 5,786,002 | 5,724,180 | -1.07% | 40.88% | 4,565,500 | 24.48% | 4,777,219 |
| FQHC | 27,996,351 | 28,486,818 | 28,820,131 | 1.17% | 9.61% | 9,996,875 | 14.54% | 20,503,761 |
| Chiropractor | 1,220,268 | 1,257,173 | 1,288,701 | 2.51% | 9.46% | 414,876 | 184.83% | 1,171,484 |
| Nurse Practitioner | 805,429 | 820,645 | 828,023 | 0.90% | -0.68% | (66,928) | 4.87% | 239,231 |
| Skilled Nursing | 2,695,313 | 2,742,819 | 2,308,229 | -15.84% | -4.39% | (737,840) | -3.40% | (1,439,791) |
| Podiatrist | 221,835 | 226,361 | 228,353 | 0.88% | -10.17% | (170,809) | 1.24% | 3,067 |
| Psychologist | 26,887,786 | 26,415,361 | 26,660,462 | 0.93% | 7.81% | 8,164,525 | 7.90% | 14,107,725 |
| Optometrist | 2,236,525 | 2,294,766 | 2,335,720 | 1.78% | 13.39% | 1,021,634 | 11.01% | 1,422,498 |
| Optician | 190,188 | 193,114 | 194,514 | 0.73% | -2.78% | (33,693) | -1.37% | (35,621) |
| Transportation | 12,517,142 | 12,728,117 | 12,695,321 | -0.26% | 4.02% | 2,104,057 | 2.63% | 2,616,924 |
| Therapy Services | 6,282,319 | 6,450,634 | 6,560,655 | 1.71% | 18.27% | 3,523,802 | 15.97% | 4,766,053 |
| Prosthetic/Ortho | 3,620,818 | 3,697,489 | 3,736,413 | 1.05% | 5.69% | 840,532 | 9.41% | 2,098,042 |
| Medical Supplies | 1,730,344 | 1,759,654 | 1,775,315 | 0.89% | 16.12% | 897,697 | 9.84% | 1,011,444 |
| DME | 8,532,385 | 8,648,026 | 7,214,747 | -16.57% | 2.47% | 807,595 | 3.83% | 2,425,988 |
| H&CB Services | 60,086,859 | 60,641,924 | 65,151,272 | 7.44% | 6.27% | 15,680,231 | 5.44% | 24,003,542 |
| H&CB Services Mental Service | 735,548 | 746,874 | 754,278 | 0.99% | 2.73% | 45,015 | 4.79% | 201,493 |
| H&CB Services Mental Retardation | - | - | - | 0.00% | -179.12% | (11,019) | -103.53% | (34,556) |
| Enhanced Resident Care | 9,519,611 | 9,607,403 | 9,607,357 | 0.00% | 7.55% | 2,897,188 | 8.02% | 4,743,974 |
| HCBS Other | - | - | - | 0.00% | -20.00% | 1,016 | -35.64% | 21,818 |
| Personal Care Services | 11,585,183 | 12,043,040 | 12,218,303 | 1.46% | -12.99% | (11,778,828) | -3.04% | (5,247,204) |
| Targeted Case Management (Drug) | 77,996 | 77,432 | 76,653 | -1.01% | 22.13% | 33,974 | 477.50% | 75,226 |
| Assistive Community Care | 13,772,830 | 13,772,459 | 13,681,669 | -0.66% | 1.45% | 938,879 | 3.50% | 3,947,433 |
| Day Treatment MHS | - | - | - | 0.00% | -80.26% | (19,770) | -47.20% | (75,895) |
| ADAP Families in Recovery | 3,194,014 | 3,366,189 | 3,481,464 | 3.42% | 141.47% | 3,028,880 | 111.74% | 3,160,194 |
| Rehabilitation | 535,325 | 541,915 | 538,313 | -0.66% | 2022.88% | 517,483 | 1033.18% | 523,518 |
| D & P Dept of Health | 264,610 | 268,680 | 269,466 | 0.29% | -24.32% | (1,521,120) | -20.20% | (4,443,957) |
| PC+Case Mgmt Fees | 3,231,590 | 3,291,674 | 8,477 | -99.74% | 2.43% | (2,880,340) | 4.49% | (1,243,673) |
| Blueprint & CHT | 16,464,698 | 18,241,973 | 13,357,305 | -26.78% | 55.89% | 14,401,504 | 155.03% | 16,464,698 |
| ACO Capitation | 29,164,439 | 21,361,621 | 21,393,513 | 0.15% | -43.32% | 23,760,419 | 527.78% | 29,147,230 |
| Other Premiums (CSR) | 1,355,318 | 2,640,929 | 827,176 | -68.68% | 52.16% | 1,355,318 | 16.08% | 1,355,318 |
| Cat, ESI, &VHAP ESI Premiums (VPA) | 6,100,103 | 6,649,761 | 7,112,797 | 6.96% | -17.04% | (48,152,205) | 25.36% | 6,100,103 |
| Ambulance | 6,424,310 | 6,489,960 | 6,519,628 | 0.46% | 12.37% | 2,669,508 | 11.51% | 4,136,597 |
| Dialysis | 1,410,716 | 1,430,938 | 1,434,956 | 0.28% | 1.35% | (28,729) | 36.83% | 718,308 |
| ASC | 58,653 | 61,168 | 62,498 | 2.17% | 5.83% | 13,102 | 63.22% | 55,123 |
| Outpatient Rehab | - | - | - | 0.00% | 0.00% | - | -21.84% | (203,595) |
| Miscellaneous | 4,172,257 | 686,696 | 684,044 | -0.39% | 140.13% | 4,011,712 | 63.60% | 2,896,493 |
| Provider Non Classified | (909,609) | (923,614) | (914,821) | -0.95% | 4.41% | (613,598) | 119.27% | (807,055) |
| Manual Payout | - | - | - | 0.00% | -20.00% | - | -23.50% | - |
| Clawback | 31,738,186 | 35,048,981 | 36,660,158 | 4.60% | 6.07% | 7,954,156 | 7.01% | 12,596,036 |
| DSH | 37,448,780 | 27,448,781 | 22,704,471 | -17.28% | 0.00% | (2) | -3.97% | (21,928,949) |
| HIV Insurance Fund F | 7,001 | 8,199 | 8,421 | 2.71% | -24.45% | (30,452) | -14.83% | (42,468) |
| Legal Aid | 547,983 | 547,983 | 547,983 | 0.00% | 2.10% | 45,665 | 0.15% | (16,954) |
| Buy-In | 41,490,820 | 40,524,729 | 40,530,402 | 0.01% | 4.78% | 8,469,343 | 4.65% | 14,743,826 |
| Lund Family Ctr Retro PNMI | - | - | - | 0.00% | 0.00% | - | 1.82% | (684,813) |
| Group Health Plan (Premiums) | - | - | - | 0.00% | 0.00% | - | 1822.25% | 2,270 |
| PDP Premium | 1,492,070 | 2,215,234 | 2,891,513 | 30.53% | -3.14% | (267,935) | -3.76% | (929,556) |
| HIPPS | 390,460 | 397,532 | 396,590 | -0.24% | 5.58% | 75,137 | -51.72% | 321,883 |
| Drug Rebates | (110,846,537) | (115,301,921) | (118,452,755) | 2.73% | 10.57% | (39,118,761) | 16.21% | (83,493,812) |
| ACA Rebate | (3,758,894) | (2,819,171) | (2,819,171) | 0.00% | -3.97% | 1,026,020 | -1.80% | (3,758,894) |
| Drug Rebate Interest | (12,236) | (13,178) | (13,310) | 1.00% | 127.57% | (7,135) | 58.51% | (12,236) |
| Supplemental Drug Rebates | (10,062,076) | (10,210,330) | (10,248,157) | 0.37% | 1.63% | (140,623) | 9.60% | (5,319,686) |
| Cost Settlements | 5,961,998 | 6,014,374 | 6,003,169 | -0.19% | 34.02% | 4,050,631 | -17.07% | 5,712,353 |
| TPL - All | (4,230,455) | (3,161,185) | (3,169,601) | 0.27% | 2.22% | (153,760) | 8.74% | (1,348,837) |
| | | | | | | | | |
| **Grand Total of All Expenditures** | **1,005,351,851** | **1,006,278,030** | **1,009,684,790** | **0.34%** | **3.70%** | **164,911,409** | **4.83%** | **374,441,158** |

# BUDGET BY ELIGIBILITY GROUP PULLOUT

PROGRAM EXPENDITURES

| Adults | SFY '15 Actuals | | | SFY '16 Actuals | | | SFY '17 Actuals | | | SFY '18 As Passed | | | SFY '18 Rescission | | | SFY '18 BAA | | | SFY '19 Gov Rec | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Enrollment | Expenses | PMPM | Enrollment | Expenses | PMPM | Enrollment | Expenses | PMPM | Enrollment | Expenses | PMPM | Enrollment | Expenses | PMPM | Enrollment | Expenses | PMPM | Enrollment | Expenses | PMPM |
| Aged, Blind, or Disab | 15,967 | $ 102,508,327 | $ 535.01 | 15,001 | $ 99,308,972 | $ 551.69 | 8,470 | $ 68,865,433 | $ 677.58 | 8,636 | $ 73,762,355 | $ 711.73 | 7,243 | $ 66,250,625 | $ 762.26 | 7,218 | $ 65,698,848 | $ 758.46 | 7,141 | $ 65,601,177 | $ 765.55 |
| Dual Eligibles | 18,244 | $ 53,518,538 | $ 244.46 | 20,280 | $ 55,523,042 | $ 228.15 | 17,601 | $ 52,597,445 | $ 249.02 | 18,007 | $ 59,347,069 | $ 274.64 | 17,645 | $ 54,938,819 | $ 259.46 | 17,645 | $ 54,637,311 | $ 258.04 | 17,772 | $ 53,560,746 | $ 251.15 |
| General | 17,381 | $ 88,383,933 | $ 423.75 | 20,101 | $ 92,641,465 | $ 384.07 | 15,140 | $ 77,460,396 | $ 426.37 | 15,222 | $ 84,987,048 | $ 465.27 | 14,343 | $ 80,106,967 | $ 465.42 | 12,984 | $ 76,353,007 | $ 490.03 | 12,958 | $ 71,955,447 | $ 462.75 |
| VHAP | | $ (292,634) | | | $ 208,896 | | | $ 187,968 | | | | | | | | | | | | | |
| VHAP ESI | | $ (8,048) | | | $ (425) | | | $ - | | | | | | | | | | | | | |
| Catamount | | $ (9,233) | | | $ (2,525) | | | $ - | | | | | | | | | | | | | |
| ESIA | | $ (15,969) | | | $ 78 | | | $ (983) | | | | | | | | | | | | | |
| New Adult Childless | 42,798 | $ 192,120,214 | $ 374.08 | 49,888 | $ 210,571,136 | $ 351.74 | 42,327 | $ 194,062,032 | $ 382.07 | 47,250 | $ 219,128,094 | $ 386.47 | 41,583 | $ 195,714,512 | $ 392.22 | 41,165 | $ 194,734,970 | $ 394.22 | 39,795 | $ 194,889,542 | $ 408.11 |
| New Adult W/Child | 10,355 | $ 32,191,328 | $ 259.07 | 12,675 | $ 38,150,227 | $ 250.83 | 17,775 | $ 70,043,265 | $ 328.38 | 11,813 | $ 54,782,023 | $ 386.47 | 18,022 | $ 74,209,397 | $ 343.15 | 18,439 | $ 73,864,372 | $ 333.82 | 20,309 | $ 84,063,247 | $ 344.93 |
| New Adult Historical | | | | | | | | | | 59,063 | $ 273,910,117 | $ 386.47 | | | | | | | | | |
| Premium Assistance | 13,177 | $ 5,611,465 | $ 35.49 | 14,893 | $ 5,266,242 | $ 29.47 | 17,961 | $ 6,100,378 | $ 28.30 | 16,828 | $ 5,706,135 | $ 28.26 | 19,381 | $ 6,649,761 | $ 28.59 | 19,023 | $ 6,649,761 | $ 29.13 | 20,524 | $ 7,112,797 | $ 28.88 |
| Cost Sharing | 5,322 | $ 1,138,775 | $ 17.83 | 5,340 | $ 1,186,720 | $ 18.52 | 5,816 | $ 1,355,318 | $ 19.42 | 5,376 | $ 1,232,289 | $ 19.10 | 6,483 | $ 2,640,929 | $ 33.95 | 6,483 | $ 2,640,929 | $ 33.95 | 7,099 | $ 827,176 | $ 9.71 |
| Subtotal Adults | 117,922 | $ 475,146,697 | $ 335.78 | 132,837 | $ 502,853,828 | $ 315.46 | 119,273 | $ 470,671,253 | $ 328.85 | 117,756 | $ 498,945,012 | $ 353.09 | 118,216 | $ 480,511,010 | $ 338.72 | 116,475 | $ 474,579,198 | $ 339.54 | 118,499 | $ 478,010,133 | $ 336.16 |
| Children | | | | | | | | | | | | | | | | | | | | | |
| Blind or Disabled (BD | 3,603 | $ 30,889,676 | $ 714.53 | 3,243 | $ 27,174,573 | $ 698.22 | 2,368 | $ 23,032,607 | $ 810.47 | 2,459 | $ 24,864,632 | $ 842.64 | 2,221 | $ 24,204,894 | $ 908.35 | 2,439 | $ 24,090,018 | $ 822.99 | 2,379 | $ 24,357,410 | $ 853.21 |
| General | 60,863 | $ 144,338,098 | $ 197.63 | 63,301 | $ 151,736,910 | $ 199.75 | 60,114 | $ 153,917,906 | $ 213.37 | 61,159 | $ 155,903,794 | $ 212.43 | 60,360 | $ 154,012,569 | $ 212.63 | 60,360 | $ 153,061,657 | $ 211.32 | 60,372 | $ 154,108,565 | $ 212.72 |
| Underinsured | 916 | $ 1,253,421 | $ 113.98 | 826 | $ 1,186,527 | $ 119.66 | 845 | $ 1,095,901 | $ 108.14 | 831 | $ 1,224,168 | $ 122.72 | 831 | $ 1,177,236 | $ 118.01 | 831 | $ 1,171,707 | $ 117.46 | 800 | $ 1,130,307 | $ 117.74 |
| SCHIP (Uninsured) | 4,449 | $ 7,471,592 | $ 139.95 | 4,499 | $ 7,025,792 | $ 130.15 | 5,142 | $ 7,893,710 | $ 127.94 | 5,562 | $ 9,286,093 | $ 139.13 | 5,020 | $ 8,620,617 | $ 143.10 | 4,817 | $ 8,314,607 | $ 143.84 | 4,905 | $ 8,295,782 | $ 140.94 |
| Subtotal Children | 69,831 | $ 183,952,788 | $ 219.52 | 71,870 | $ 187,123,801 | $ 216.97 | 68,468 | $ 185,940,124 | $ 226.31 | 70,011 | $ 191,278,687 | $ 227.68 | 68,432 | $ 188,015,317 | $ 228.96 | 68,447 | $ 186,637,990 | $ 227.23 | 68,456 | $ 187,892,063 | $ 228.73 |
| Pharmacy Only Programs | 11,978 | $ 4,914,695 | $ 34.19 | 11,593 | $ 2,302,437 | $ 16.55 | 11,399 | $ 3,155,724 | $ 23.07 | 11,640 | $ 6,375,171 | $ 45.64 | 11,333 | $ 4,686,531 | $ 34.46 | 11,182 | $ 4,678,042 | $ 34.86 | 10,913 | $ 6,134,624 | $ 46.84 |
| Choices for Care | | | | | | | | | | | | | | | | | | | | | |
| Nursing Home, Hom | 4,342 | $ 183,700,087 | $ 3,525.98 | 4,256 | $ 186,796,298 | $ 3,657.29 | 4,290 | $ 194,689,010 | $ 3,781.69 | 4,350 | $ 196,483,201 | $ 3,763.93 | 4,350 | $ 196,483,201 | $ 3,763.93 | 4,350 | $ 197,420,739 | $ 3,782.01 | 4,390 | $ 203,050,763 | $ 3,854.42 |
| Acute-Care Services | 4,342 | $ 22,938,346 | $ 440.28 | 4,256 | $ 26,318,814 | $ 515.30 | 4,290 | $ 28,083,820 | $ 545.51 | 4,350 | $ 29,358,939 | $ 562.41 | 4,350 | $ 28,077,426 | $ 537.87 | 4,350 | $ 27,947,521 | $ 535.39 | 4,390 | $ 28,142,448 | $ 534.22 |
| Acute-Care Services | 4,342 | $ 1,510,843 | $ 29.00 | 4,256 | $ - | $ - | 4,290 | $ - | $ - | 4,350 | $ - | $ - | 4,350 | $ - | $ - | 4,350 | $ - | $ - | 4,390 | $ - | $ - |
| Buy-In | | $ 2,639,101 | | | $ 2,869,715 | | | $ 3,379,492 | | | $ 3,092,248 | | | $ 3,426,728 | | | $ 3,426,728 | | | $ 3,457,915 | |
| Subtotal Choices for Care* | 4,342 | $ 210,788,377 | $ 4,045.92 | 4,256 | $ 215,984,826 | $ 4,228.78 | 4,290 | $ 226,152,323 | $ 4,392.84 | 4,350 | $ 228,934,388 | $ 4,385.58 | 4,350 | $ 227,987,355 | $ 4,367.44 | 4,350 | $ 228,794,988 | $ 4,383.05 | 4,390 | $ 234,651,126 | $ 4,454.27 |
| Subtotal Direct Services | 204,074 | $ 874,802,557 | $ 4,286.70 | 220,556 | $ 908,264,892 | $ 4,118.07 | 203,430 | $ 885,919,423 | $ 4,354.90 | 203,757 | $ 925,533,258 | $ 378.53 | 202,331 | $ 901,200,213 | $ 371.17 | 200,454 | $ 894,690,218 | $ 371.94 | 202,258 | $ 906,687,946 | $ 373.57 |
| Miscellaneous Program | | | | | | | | | | | | | | | | | | | | | |
| Medicare ACO | | $ (1,509,760) | | | $ - | | | $ 3,148,191 | | | $ - | | | $ - | | | $ 5,055,417 | | | | |
| Refugee | 1 | $ 15,884 | $ 1,588.36 | 1 | $ 111,042 | $ 9,253.54 | 1 | $ 8,380 | $ 523.74 | 1 | $ 14,009 | $ 1,167.42 | 1 | $ 6,285 | $ 523.74 | 1 | $ 6,285 | $ 523.74 | 1 | $ 6,285 | $ 523.73 |
| ACA Rebates | | $ (3,654,840) | | | $ (3,793,338) | | | $ (3,758,894) | | | $ (3,937,084) | | | $ (2,819,171) | | | $ (2,819,171) | | | $ (2,819,171) | |
| HIV | 118 | $ 10,072 | $ 7.12 | 120 | $ 8,484 | $ 5.90 | 143 | $ 7,001 | $ 4.08 | 141 | $ 9,657 | $ 5.71 | 167 | $ 8,199 | $ 4.08 | 156 | $ 8,199 | $ 4.38 | 172 | $ 8,421 | $ 4.08 |
| Civil Unions | | $ 285,335 | | | $ 601,912 | | | $ - | | | $ - | | | $ - | | | $ - | | | $ - | |
| Underinsured | | $ 10,539,574 | | | $ 8,112,696 | | | $ 8,682,104 | | | $ 9,597,071 | | | $ 9,194,726 | | | $ 9,194,726 | | | $ 8,816,210 | |
| DSH | | $ 37,448,781 | | | $ 37,448,781 | | | $ 37,448,780 | | | $ 27,448,781 | | | $ 27,448,781 | | | $ 27,448,781 | | | $ 22,704,471 | |
| Clawback | | $ 25,888,658 | | | $ 29,011,845 | | | $ 31,738,186 | | | $ 36,207,593 | | | $ 35,048,981 | | | $ 35,048,981 | | | $ 36,660,158 | |
| Buy-In ~ GC | | $ 27,792,073 | | | $ 30,475,367 | | | $ 33,855,164 | | | $ 36,447,184 | | | $ 33,883,321 | | | $ 33,883,321 | | | $ 33,856,070 | |
| Buy-In ~ Investments/State Only | | $ 27,169 | | | $ (64,963) | | | $ 53,552 | | | $ 68,613 | | | $ 62,722 | | | $ 62,722 | | | $ 64,458 | |
| Buy-In ~ Federal Only | | $ 3,593,474 | | | $ 3,961,756 | | | $ 4,202,611 | | | $ 4,396,176 | | | $ 3,151,959 | | | $ 3,151,959 | | | $ 3,151,959 | |
| Legal Aid | | $ 593,648 | | | $ 547,983 | | | $ 547,983 | | | $ 547,983 | | | $ 547,983 | | | $ 547,983 | | | $ 547,983 | |
| Misc. Pymts. | | $ (9,223) | | | $ (1,641) | | | $ 3,499,372 | | | $ (1,390) | | | $ (1,390) | | | $ (1,390) | | | | |
| Healthy Vermonters | 4,315 | $ - | n/a | 4,059 | $ - | n/a | 3,381 | $ - | n/a | 5,820 | $ - | n/a | 4,040 | $ - | n/a | 2,297 | $ - | $ - | 2,297 | | n/a |
| otal Miscellaneous Program | 4,434 | $ 101,020,847 | | 4,180 | $ 106,419,926 | | 3,525 | $ 119,432,429 | | 5,962 | $ 110,798,593 | | 4,208 | $ 106,532,395 | | 2,454 | $ 111,587,812 | | 2,470 | $ 102,996,843 | |
| TOTAL PROGRAM EX | 208,507 | $ 975,823,404 | | 224,736 | $ 1,014,684,817 | | 206,955 | $ 1,005,351,851 | | 209,719 | $ 1,036,331,851 | | 206,539 | $ 1,007,732,607 | | 202,908 | $ 1,006,278,030 | | 204,728 | $ 1,009,684,789 | |

| ADMINISTRATIVE EXPENDI | SFY '15 Actuals | SFY '16 Actuals | SFY '17 Actuals | SFY '18 As Passed | SFY '18 Rescission | SFY '18 BAA | SFY '19 Gov Rec |
|---|---|---|---|---|---|---|---|
| | Expenses | Expenses | Expenses | Expenses | Expenses | Expenses | Expenses |
| General | $ 6,997,923 | $ 6,851,198 | $ 10,039,437 | $ 9,960,991 | $ 9,654,423 | $ 9,984,277 | $ 10,237,113 |
| Claims Services | $ 19,353,155 | $ 18,605,496 | $ 22,145,467 | $ 22,856,489 | $ 22,856,489 | $ 22,856,489 | $ 26,974,050 |
| Eligibility | $ 4,507,624 | $ 4,297,794 | $ 45,247,377 | $ 48,272,806 | $ 47,702,183 | $ 46,224,394 | $ 44,088,089 |
| Quality | $ 11,855,526 | $ 11,606,951 | $ 15,765,384 | $ 17,758,174 | $ 17,758,174 | $ 17,758,174 | $ 15,931,246 |
| Project | $ 91,518,391 | $ 108,633,897 | $ 96,516,383 | $ 91,198,799 | $ 91,198,799 | $ 67,405,963 | $ 65,963,521 |
| otal Administrative Expenses | $ 134,232,620 | $ 149,995,336 | $ 189,714,049 | $ 190,047,259 | $ 189,170,068 | $ 164,229,297 | $ 163,194,019 |
| TOTAL ALL EXPEND | 208,507 $ 1,110,056,024 | 224,736 $ 1,164,680,153 | 206,955 $ 1,195,065,900 | 209,719 $ 1,226,379,110 | 206,539 $ 1,196,902,675 | 202,908 $ 1,170,507,326 | 204,728 $ 1,172,878,808 |

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# BUDGET BY ELIGIBILITY GROUP FUNDING PULLOUT

PROGRAM EXPENDITURES

| | SFY '18 As Passed | | SFY '18 As Passed Rescission | | SFY '18 BAA | | SFY '19 GR | | Funding Description |
|---|---|---|---|---|---|---|---|---|---|
| Adults | Expenses | General Funds | Expenses | General Funds | Expenses | General Funds | Expenses | General Funds | |
| Aged, Blind, or Disabled (ABD) | $ 73,762,355 | $ 34,137,218 | $ 66,250,625 | $ 30,660,789 | $ 65,698,848 | $ 30,405,427 | $ 65,601,177 | $ 30,314,304 | Global Commitment Funded (GC) |
| Dual Eligibles | $ 59,347,069 | $ 27,465,823 | $ 54,938,819 | $ 25,425,686 | $ 54,637,311 | $ 25,286,147 | $ 53,560,746 | $ 24,750,421 | Global Commitment Funded (GC) |
| General | $ 84,987,048 | $ 39,332,006 | $ 80,106,967 | $ 37,073,504 | $ 76,353,007 | $ 35,336,171 | $ 71,955,447 | $ 33,250,612 | Global Commitment Funded (GC) |
| VHAP | | | | | | | | | |
| VHAP ESI | | | | | | | | | |
| Catamount | | | | | | | | | |
| ESIA | | | | | | | | | |
| New Adult Childless | $ 219,128,094 | $ 25,484,597 | $ 195,714,512 | $ 22,761,598 | $ 194,734,970 | $ 22,647,677 | $ 194,889,542 | $ 16,596,793 | Enhanced for Childless New Adults ~ General Funds |
| New Adult W/Child | $ 54,782,023 | $ 25,353,120 | $ 74,209,397 | $ 34,344,109 | $ 73,864,372 | $ 34,184,431 | $ 84,063,247 | $ 38,845,626 | Global Commitment Funded (GC) ~ General Funds |
| New Adult Historical | $ 273,910,117 | | | | | | | | |
| Premium Assistance | $ 5,706,135 | $ 2,640,799 | $ 6,649,761 | $ 3,077,509 | $ 6,649,761 | $ 3,077,509 | $ 7,112,797 | $ 3,286,824 | Global Commitment Funded (GC) |
| Cost Sharing | $ 1,232,289 | $ 1,232,289 | $ 2,640,929 | $ 2,640,929 | $ 2,640,929 | $ 2,640,929 | $ 827,176 | $ 827,176 | General Funds @ 100% |
| Subtotal Adults | $ 498,945,012 | $ 155,645,853 | $ 480,511,010 | $ 155,984,124 | $ 474,579,198 | $ 153,578,293 | $ 478,010,133 | $ 147,871,756 | |
| Children | | | | | | | | | |
| Blind or Disabled (BD) | $ 24,864,632 | $ 11,507,352 | $ 24,204,894 | $ 11,202,025 | $ 24,090,018 | $ 11,148,860 | $ 24,357,410 | $ 11,255,559 | Global Commitment Funded (GC) |
| General | $ 155,903,794 | $ 72,152,276 | $ 154,012,569 | $ 71,277,017 | $ 153,061,657 | $ 70,836,935 | $ 154,108,565 | $ 71,213,568 | Global Commitment Funded (GC) |
| Underinsured | $ 1,224,168 | $ 566,545 | $ 1,177,236 | $ 544,825 | $ 1,171,707 | $ 542,266 | $ 1,130,307 | $ 522,315 | Global Commitment Funded (GC) |
| SCHIP (Uninsured) | $ 9,286,093 | $ 872,893 | $ 8,620,617 | $ 810,338 | $ 8,314,607 | $ 781,573 | $ 8,295,782 | $ 775,863 | Title XXI Enhanced |
| Subtotal Children | $ 191,278,687 | $ 85,099,065 | $ 188,015,317 | $ 83,834,205 | $ 186,637,990 | $ 83,309,634 | $ 187,892,063 | $ 83,767,305 | |
| Pharmacy Only Programs | $ 6,375,171 | $ 4,597,367 | $ 4,686,531 | $ 1,962,562 | $ 4,678,042 | $ 1,954,073 | $ 6,134,624 | $ 2,573,849 | Mixture of Global Commitment Funding (GC) and General Funds |
| Choices for Care | | | | | | | | | |
| Nursing Home, Home & Community | $ 196,483,201 | $ 90,932,425 | $ 196,483,201 | $ 90,932,425 | $ 197,420,739 | $ 91,366,318 | $ 203,050,763 | $ 93,829,758 | Global Commitment Funded (GC) |
| Acute-Care Services ~ DVHA | $ 29,358,939 | $ 13,587,317 | $ 28,077,426 | $ 12,994,233 | $ 27,947,521 | $ 12,934,113 | $ 28,142,448 | $ 13,004,625 | Global Commitment Funded (GC) |
| Acute-Care Services ~ Other Depts. | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | Global Commitment Funded (GC) |
| Buy-In | $ 3,092,248 | $ 1,431,092 | $ 3,426,728 | $ 1,585,890 | $ 3,426,728 | $ 1,585,890 | $ 3,457,915 | $ 1,597,903 | Global Commitment Funded (GC) |
| Subtotal Choices for Care* | $ 228,934,388 | $ 105,950,835 | $ 227,987,355 | $ 105,512,548 | $ 228,794,988 | $ 105,886,321 | $ 234,651,126 | $ 108,432,286 | |
| Subtotal Direct Services | $ 925,533,258 | $ 351,293,120 | $ 901,200,213 | $ 347,293,438 | $ 894,690,218 | $ 344,728,320 | $ 906,687,946 | $ 342,645,195 | |
| Miscellaneous Program | | | | | | | | | |
| Medicare ACO | $ - | $ - | $ - | $ - | $ 5,055,417 | $ - | $ - | $ - | Federally Funded @ 100% |
| Refugee | $ 14,009 | $ - | $ 6,285 | $ - | $ 6,285 | $ - | $ 6,285 | $ - | Federally Funded @ 100% |
| ACA Rebates | $ (3,937,084) | $ - | $ (2,819,171) | $ - | $ (2,819,171) | $ - | $ (2,819,171) | $ - | Federally Funded @ 100% |
| HIV | $ 9,657 | $ 4,469 | $ 8,199 | $ 3,795 | $ 8,199 | $ 3,795 | $ 8,421 | $ 3,891 | Investments: Global Commitment Funded (GC) |
| Civil Unions | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | N/A |
| Underinsured | $ 9,597,071 | $ 4,441,524 | $ 9,194,726 | $ 4,255,319 | $ 9,194,726 | $ 4,255,319 | $ 8,816,210 | $ 4,073,971 | Investments: Global Commitment Funded (GC) |
| DSH | $ 27,448,781 | $ 12,703,296 | $ 27,448,781 | $ 12,703,296 | $ 27,448,781 | $ 12,703,296 | $ 22,704,471 | $ 10,491,736 | Global Commitment Funded (GC) |
| Clawback | $ 36,207,593 | $ 36,207,593 | $ 35,048,981 | $ 35,048,981 | $ 35,048,981 | $ 35,048,981 | $ 36,660,158 | $ 36,660,158 | General Funds @ 100% |
| Buy-In ~ GC | $ 36,447,184 | $ 16,867,757 | $ 33,883,321 | $ 15,681,201 | $ 33,883,321 | $ 15,681,201 | $ 33,856,070 | $ 15,644,890 | Global Commitment Funded (GC) |
| Buy-In ~ Investments/State Only | $ 68,613 | $ 31,754 | $ 62,722 | $ 29,028 | $ 62,722 | $ 29,028 | $ 64,458 | $ 29,786 | Investments: Global Commitment Funded (GC) |
| Buy-In ~ Federal Only | $ 4,396,176 | $ - | $ 3,151,959 | $ - | $ 3,151,959 | $ - | $ 3,151,959 | $ - | Federally Funded @ 100% |
| Legal Aid | $ 547,983 | $ 253,607 | $ 547,983 | $ 253,607 | $ 547,983 | $ 253,607 | $ 547,983 | $ 253,223 | Global Commitment Funded (GC) |
| Misc. Pymts. | $ (1,390) | $ (643) | $ (1,390) | $ (643) | $ (1,390) | $ (643) | $ - | $ - | Global Commitment Funded (GC) |
| Healthy Vermonters Program | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | |
| Subtotal Miscellaneous Program | $ 110,798,593 | $ 70,509,357 | $ 106,532,395 | $ 67,974,582 | $ 111,587,812 | $ 67,974,582 | $ 102,996,843 | $ 67,157,654 | |
| TOTAL PROGRAM EXPENDITUR | $ 1,036,331,851 | $ 421,802,477 | $ 1,007,732,607 | $ 415,268,020 | $ 1,006,278,030 | $ 412,702,902 | $ 1,009,684,789 | $ 409,802,850 | |

ADMINISTRATIVE EXPENDITURES

| | SFY '18 As Passed | | SFY '18 As Passed Rescission | | SFY '18 BAA | | SFY '19 GR | | Funding Description |
|---|---|---|---|---|---|---|---|---|---|
| | Expenses | General Funds | Expenses | General Funds | Expenses | General Funds | Expenses | General Funds | |
| General | $ 9,960,991 | $ 4,560,371 | $ 9,654,423 | $ 4,420,017 | $ 9,984,277 | $ 4,571,800 | $ 10,237,113 | $ 5,210,690 | Blended based on federal programs ~ match GF, SF, IDT |
| Claims Services | $ 22,856,489 | $ 6,518,881 | $ 22,856,489 | $ 6,518,881 | $ 22,856,489 | $ 6,518,671 | $ 26,974,050 | $ 8,065,241 | Blended based on federal programs ~ match GF, SF, IDT |
| Eligibility | $ 48,272,806 | $ 16,095,332 | $ 47,702,183 | $ 15,905,072 | $ 46,224,394 | $ 15,411,213 | $ 44,088,089 | $ 14,966,023 | Eligible for both traditional and enhanced match |
| Quality | $ 17,758,174 | $ 6,686,219 | $ 17,758,174 | $ 6,686,219 | $ 17,758,174 | $ 6,685,952 | $ 15,931,246 | $ 6,643,330 | Blended based on federal programs ~ match GF, SF, IDT |
| Project | $ 91,198,799 | $ 11,873,774 | $ 91,198,799 | $ 11,873,785 | $ 67,405,963 | $ 8,776,256 | $ 65,963,521 | $ 5,698,362 | Blended based on federal programs ~ match GF, SF, IDT, Enhanced |
| Total Administrative Expenses | $ 190,047,259 | $ 45,734,577 | $ 189,170,068 | $ 45,403,975 | $ 164,229,297 | $ 41,963,893 | $ 163,194,019 | $ 40,583,646 | |
| TOTAL ALL EXPENDITURES | $ 1,226,379,110 | $ 467,537,054 | $ 1,196,902,675 | $ 460,671,995 | $ 1,170,507,326 | $ 454,666,795 | $ 1,172,878,808 | $ 450,386,496 | |

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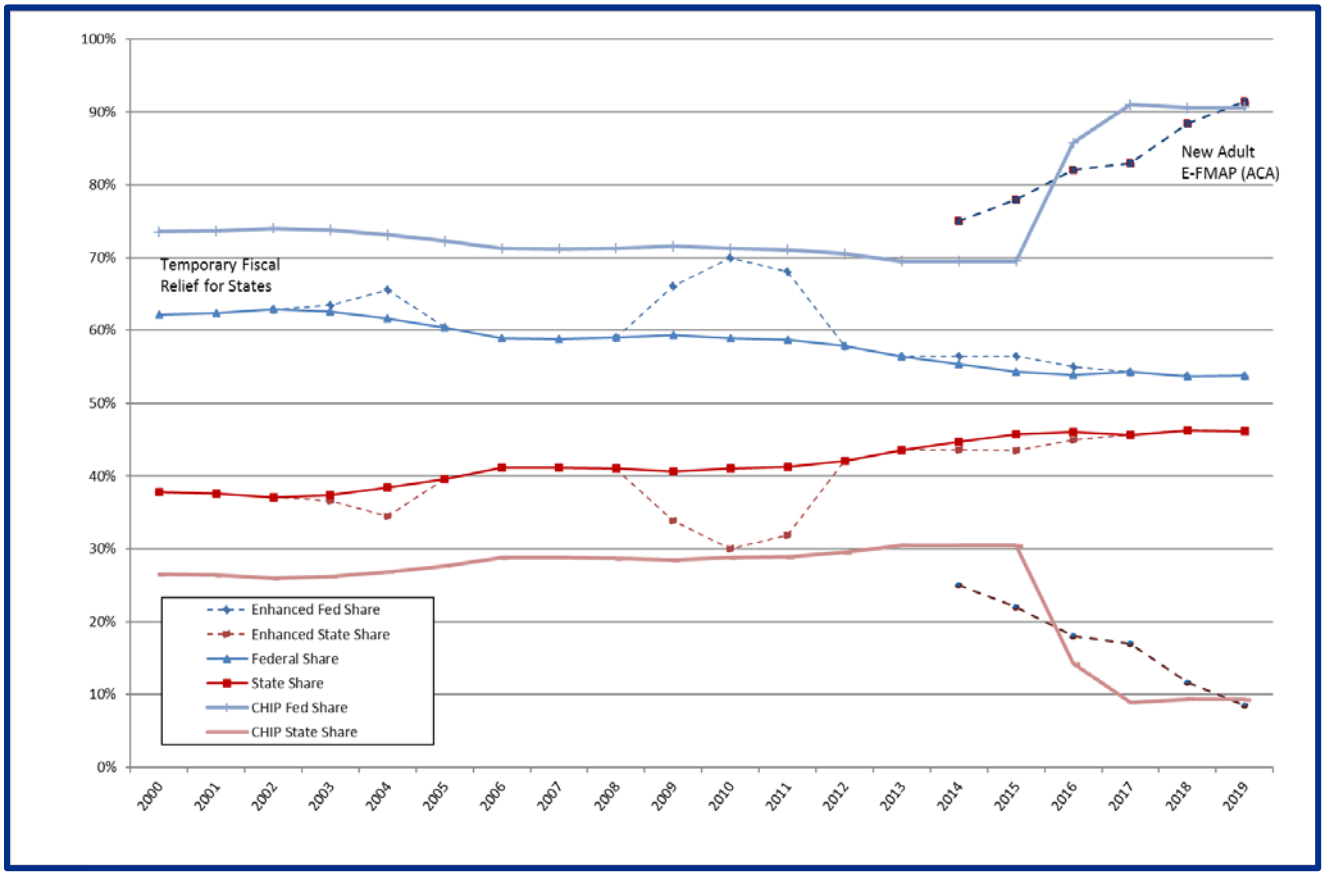
## FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP)

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% federal match, with the exception of "enhanced FMAPs" for expansion populations under the ACA and for the Children's Health Insurance Program (CHIP).

### Vermont Medicaid & CHIP, SFY 2000 - 2019



# Vermont Medicaid & CHIP Detail, SFY 2017 – 2019

## FEDERAL MATCH RATES
## Fiscal Years 2017 to 2019

### 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 |
|---|---|---|---|---|---|---|
| 2017 | 10/01/16 | 09/30/17 | 54.46% | | 54.46% | 45.54% |
| 2018 | 10/01/17 | 09/30/18 | 53.47% | | 53.47% | 46.53% |
| 2019 | 10/01/18 | 09/30/19 | 53.89% | | 53.89% | 46.11% |

**State Fiscal Year**

| SFY | From | To | Federal Share w/o hold harmless | e-FMAP | Total Federal Share | State Share |
|---|---|---|---|---|---|---|
| 2017 | 7/1/2016 | 6/30/2017 | 54.32% | | 54.32% | 45.68% |
| 2018 | 7/1/2017 | 6/30/2018 | 53.72% | | 53.72% | 46.28% |
| 2019 | 7/1/2018 | 6/30/2019 | 53.79% | | 53.79% | 46.21% |

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

**Federal Fiscal Year**

| FFY | From | To | Federal Share | e-FMAP | Total Federal Share | State Share |
|---|---|---|---|---|---|---|
| 2017 | 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%** |
| 2018 | 10/1/2017 | 09/30/18 | 67.43% | n/a | 67.43% | 32.57% |
| **Expanded CHIP FMAP** | | | **67.43%** | **23.00%** | **90.43%** | **9.57%** |
| 2019 | 10/1/2018 | 09/30/19 | 67.72% | n/a | 67.72% | 32.28% |
| **Expanded CHIP FMAP** | | | **67.72%** | **23.00%** | **90.72%** | **9.28%** |

**State Fiscal Year**

| SFY | From | To | Federal Share | e-FMAP | Total Federal Share | State Share |
|---|---|---|---|---|---|---|
| 2017 | 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%** |
| 2018 | 7/1/2017 | 6/30/2018 | 67.60% | n/a | 67.60% | 32.40% |
| **Expanded CHIP FMAP** | | | **67.60%** | **23.00%** | **90.60%** | **9.40%** |
| 2019 | 7/1/2018 | 6/30/2019 | 67.65% | n/a | 67.65% | 32.35% |
| **Expanded CHIP FMAP** | | | **67.65%** | **23.00%** | **90.65%** | **9.35%** |

# CHAPTER SEVEN: ADMINISTRATIVE

## COMMISSIONER'S OFFICE

The Commissioner's Office provides strategic management for the Department as it pursues its mission of improving access, quality, and cost effectiveness in Vermont's publicly funded health insurance programs. The DVHA Commissioner is responsible for all DVHA's operations and serves on the Governor's healthcare leadership team. The office consists of the Commissioner, two Deputy Commissioners, and support staff. The Commissioner's office promotes a team-based approach across the department, valuing communication and coordination. The office convenes senior management, management, and all-DVHA meetings on a regular basis to ensure the department is focused on outcomes and putting the needs of Vermonters first.

## BUSINESS OFFICE

The Business Office unit supports, monitors, manages, and reports on all aspects of fiscal planning and responsibility. The Business Office includes the Accounts Payable/Accounts Receivable (AP/AR), Grants and Contracts, and Fiscal Analytics units.

### Accounts Payable/Accounts Receivable (AP/AR)

The AP/AR unit is responsible for provider and drug manufacturer assessment billing and receipts, vendor payments, drug rebate receipts, internal expense approvals, and administration appropriation financial monitoring. As of SFY 2017, this unit also administers the ambulance assessments.

### Grants and Contracts

The Grants and Contracts unit is charged with the procurement and management of DVHA's grants, contracts, Memorandums of Understanding (MOU), and any additional contractual agreements. Staff serve as liaisons throughout the entire life of an agreement, from initiating the Request for Proposal (RFP) through agreement closeout. This work requires close collaboration with Agency and State staff and a high degree of responsibility complying with processes, State statutes and bulletins, policies, and Federal/State regulations. Currently, the unit manages over 150 agreements, and typically processes approximately 200 agreements and/or amendments per year. In addition to the outgoing agreements, the unit supports Federal grant submissions and the administration of incoming grants. Working side by side with various program managers, the unit ensures comprehensive management over all agreements and vendors. The unit oversees the financial monitoring and management of invoices and payments to ensure adherence with State and Federal financial reporting requirements, responds to audit requests, and manages agreement closeout.

The Grants and Contracts unit is engaged in a process improvement project to introduce Lean-agile procurement techniques. This approach to procurements stresses collaboration between people as a key success factor. The goals are to:

1. Reduce preparation efforts and rework as much as possible (reduce waste)

2. Eliminate variation so that creation and comparison of multiple proposals/contracts becomes as easy as possible

3. Reduce time to execution which will allow for quicker implementations

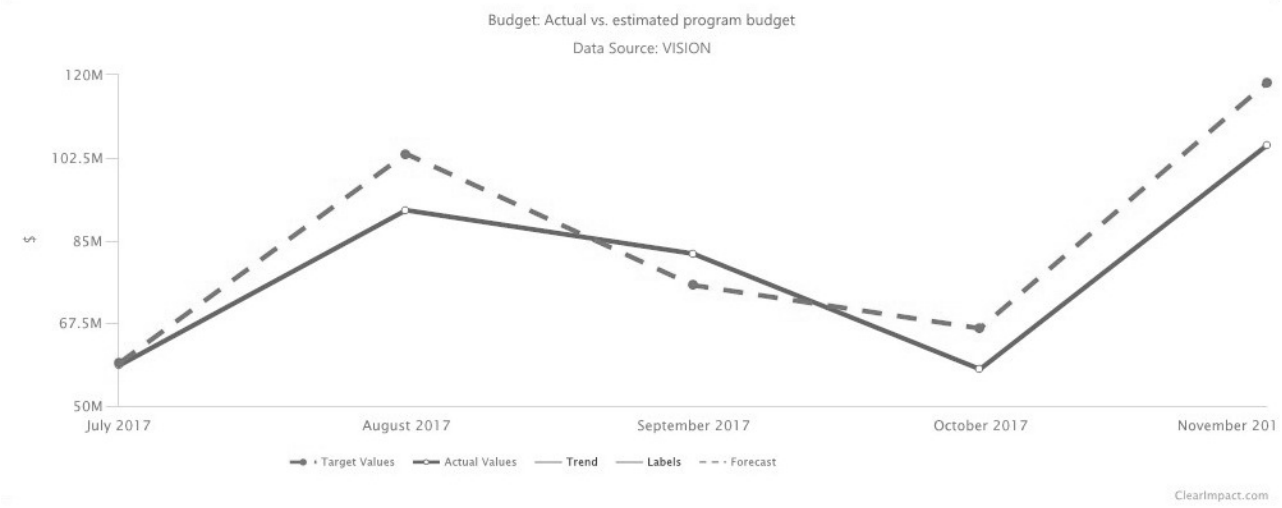
### Fiscal Analytics

The Fiscal Analytics unit formulates and performs analysis of the budget, periodic financial reporting, and ad-hoc research requests providing analytic support for DVHA leadership. This team monitors changes in Medicaid spending and Medicaid Policy, Budget, and Reimbursement (PBR) forms to determine financial impact, assists with programmatic budget preparation, and ensures financial reporting alignment with federal and state regulations.

The Key Performance Indicators for the Business Office Unit are set forth on the next page.

# P Business Office

## PM BO Budget: Actual vs. estimated program budget




### Notes on Methodology

- **Please note that the dotted target trend line represents the estimated budget in the above chart**.

| *Program Budget* | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 |
|---|---|---|---|---|---|
| Estimated | $59,074,858 | $103,349,282 | $75,572,703 | $66,444,826 | $118,383,240 |
| Actual | $58,589,271 | $91,422,871 | $82,239,485 | $57,815,936 | $105,151,563 |
| Over/(Under) | $485,587 | $11,926,411 | ($6,666,782) | $8,628,890 | $13,231,677 |

### Partners

- ADS

### Story Behind the Curve

The Business Office (BO) utilizes KPIs to locate barriers to successful operations and to design strategies that will lead to better performance.

*Last updated: 12/15/17*

*Author: Business Office*

## POLICY UNIT

The Medicaid Policy Unit (MPU) was transferred from AHS to DVHA in SFY 2018. The MPU consists of 8 positions – Director of Healthcare Policy and Planning, Health Policy and Planning Chief, 3 Health Program Administrators, 1 Program Consultant, and 2 Staff Attorneys.

The MPU works to ensure that DVHA and other AHS departments administer the Medicaid program in compliance with Federal and State regulations. Additionally, the MPU works with AHS staff and other public and private partners to develop and implement effective Medicaid policy initiatives aimed at advancing the agency's goals of improving access and quality while reducing overall costs. Primary functions of the MPU include: 1) Policy Development and Implementation, 2) Medicaid Legislative Coordination, 3) Medicaid Administrative Rulemaking, 4) Policy Research and Analysis, and 5) Administration of the Medicaid State Plan and Global Commitment Waiver. Given DVHA's substantial role in the administration of Medicaid as compared to other departments within the AHS, the MPU was transferred from the AHS Central Office to DVHA to better align authority and accountability.

## CONTACT LIST

Cory Gustafson, Commissioner
Cory.Gustafson@Vermont.gov

Lori Collins, Deputy Commissioner
Lori.Collins@Vermont.gov

Michael Costa, Deputy Commissioner
Michael.Costa@Vermont.gov

Beth Tanzman, Director
Blueprint for Health
Beth.Tanzman@Vermont.gov

Amerin Aborjaily, Legislative Liaison
Amerin.Aborjaily@Vermont.gov

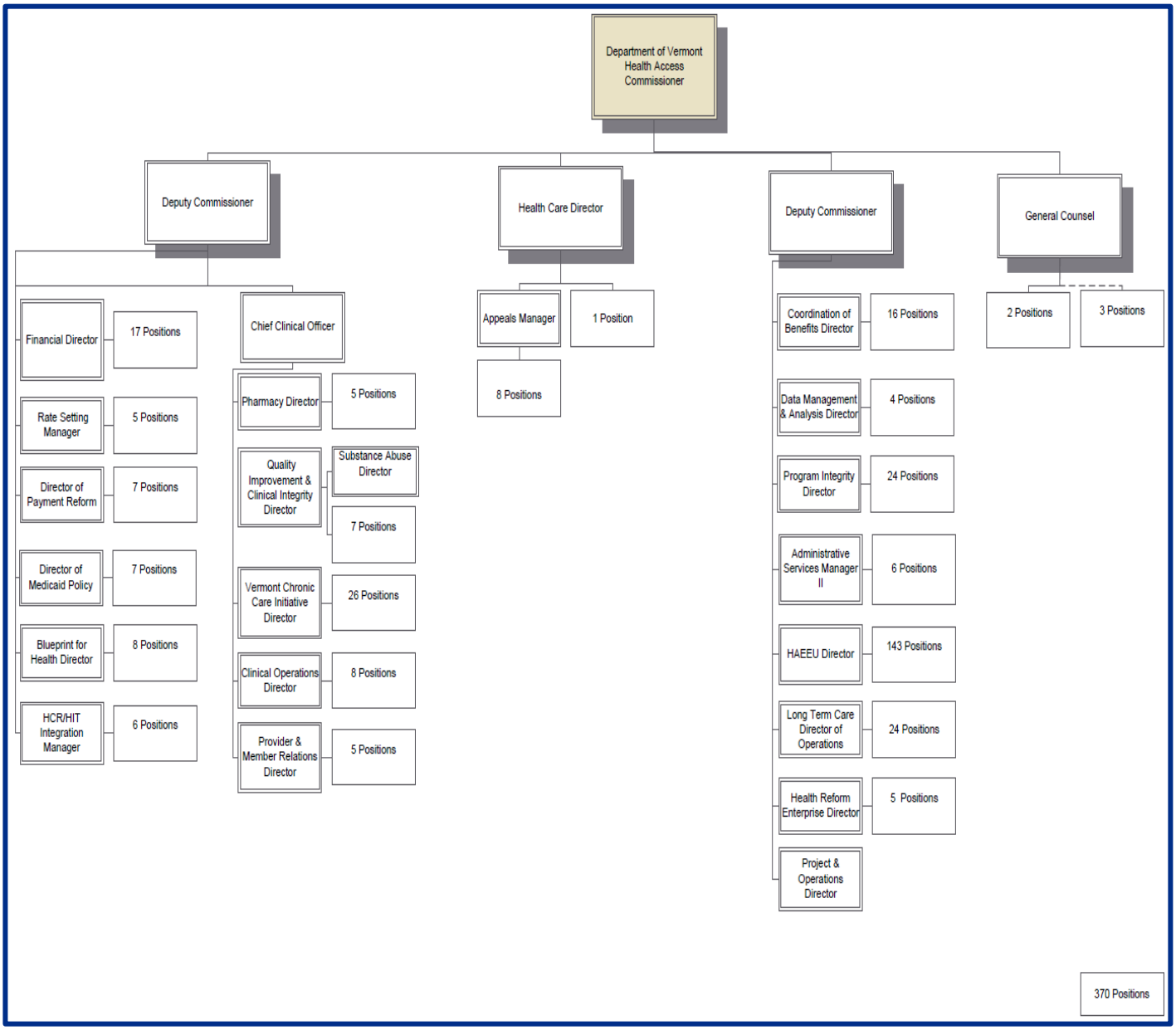
Lisa Schilling, Financial Director
Lisa.Schilling@Vermont.gov

**Phone:**
(802) 879-5900

**Address:**
280 State Drive
Building NOB 1 South
Waterbury, VT 05671-1010

**Web Sites:**
DVHA.Vermont.gov
VermontHealthConnect.gov
GreenMountainCare.org
HCR.Vermont.gov

# DVHA ORGANIZATIONAL CHART



# APPENDIX A: GLOBAL COMMITMENT INVESTMENTS

| Global Commitment Investment Expenditures | | | | | | |
|---|---|---|---|---|---|---|
| **Department** | Investment Description | SFY13 | SFY14 | SFY15 | SFY16 | SFY17 |
| **AHSCO** | Investments (STC-79) - 2-1-1 Grant (41) | $415,000 | $499,792 | $499,667 | $453,000 | $453,000 |
| **AHSCO** | Investments (STC-79) - Designated Agency Underinsured Services (54) | $6,232,517 | $7,184,084 | $6,894,205 | $5,632,253 | $7,652,462 |
| **AOA** | Green Mountain Care | $0 | $0 | $639,239 | $0 | $0 |
| **AOE** | Non-state plan Related Education Fund Investments (School Health Services) | $9,741,252 | $10,454,116 | $10,029,809 | $10,472,205 | $0 |
| **DCF** | Investments (STC-79) - Residential Care for Youth/Substitute Care (1) | $10,131,790 | $11,137,225 | $10,405,184 | $10,238,115 | $11,329,080 |
| **DCF** | Investments (STC-79) - Lund Home (2) | $181,243 | $237,387 | $405,034 | $261,081 | $1,769,128 |
| **DCF** | Investments (STC-79) - Challenges for Change: DCF (9) | $197,426 | $207,286 | $189,378 | $202,488 | $210,624 |
| **DCF** | Investments (STC-79) - Strengthening Families (26) | $429,154 | $399,841 | $370,003 | $426,417 | $439,420 |
| **DCF** | Investments (STC-79) - Prevent Child Abuse Vermont: Shaken Baby (33) | $86,969 | $111,094 | $54,125 | $54,125 | $38,795 |
| **DCF** | Investments (STC-79) - Prevent Child Abuse Vermont: Nurturing Parent (34) | $186,916 | $54,231 | $195,124 | $126,365 | $113,832 |
| **DCF** | Investments (STC-79) - Building Bright Futures (35) | $398,201 | $594,070 | $514,225 | $531,283 | $625,562 |
| **DCF** | Investments (STC-79) - Medical Services (55) | $37,164 | $33,514 | $32,299 | $55,400 | $85,151 |
| **DCF** | Investments (STC-79) - Aid to the Aged, Blind and Disabled CCL Level III (56) | $2,621,786 | $2,611,499 | $2,864,727 | $2,753,853 | $2,710,931 |

| | | | | | | |
|---|---|---|---|---|---|---|
| **DCF** | Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level III (57) | $124,731 | $89,159 | $77,196 | $80,830 | $61,678 |
| **DCF** | Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level IV (58) | $269,121 | $183,025 | $160,963 | $190,066 | $172,218 |
| **DCF** | Investments (STC-79) - Essential Person Program (59) | $783,860 | $801,658 | $707,316 | $802,619 | $1,022,339 |
| **DCF** | Investments (STC-79) - GA Medical Expenses (60) | $275,187 | $253,939 | $211,973 | $181,835 | $221,199 |
| **DCF** | Investments (STC-79) - Therapeutic Child Care (61) | $557,599 | $543,196 | $605,419 | $712,884 | $612,052 |
| **DCF** | Investments (STC-79) - Lamoille Valley Community Justice Project (62) | $216,000 | $402,685 | $83,315 | $216,000 | $216,000 |
| **DCF** | Investments (STC-79) - Children's Integrated Services Early Intervention | $0 | $200,484 | $0 | $371,836 | $371,870 |
| **DCF** | CUPS/Early Childhood Mental Health | $45,491 | $0 | $0 | $0 | $0 |
| **DCF** | GA Community Action | $420,359 | $25,181 | $0 | $0 | $0 |
| **DDAIL** | Investments (STC-79) - Flexible Family/Respite Funding (27) | $1,088,889 | $2,868,218 | $1,400,997 | $1,919,377 | $1,877,363 |
| **DDAIL** | Investments (STC-79) - Quality Review of Home Health Agencies (42) | $84,139 | $51,697 | $44,682 | $35,203 | $21,928 |
| **DDAIL** | Investments (STC-79) - Support and Services at Home (SASH) (43) | $773,192 | $1,013,671 | $1,026,155 | $1,013,283 | $1,022,170 |
| **DDAIL** | Investments (STC-79) - Mobility Training/Other Svcs.- Elderly Visually Impaired (63) | $245,000 | $245,000 | $245,000 | $270,170 | $295,403 |
| **DCF** | AABD Admin | $0 | $0 | $0 | $0 | $0 |

| | | | | | | |
|---|---|---|---|---|---|---|
| **DDAIL** | Investments (STC-79) - DS Special Payments for Medical Services (64) | $1,299,613 | $1,277,148 | $385,896 | $1,904,880 | $2,736,796 |
| **DDAIL** | Investments (STC-79) - Seriously Functionally Impaired: DAIL (65) | $1,270,247 | $859,371 | $333,331 | $120,997 | $74,041 |
| **DDAIL** | Investments (STC-79) - HomeSharing (77) | $310,000 | $317,312 | $327,163 | $339,966 | $340,882 |
| **DDAIL** | Investments (STC-79) - Self-Neglect Initiative (78) | $150,000 | $200,000 | $265,000 | $276,830 | $277,257 |
| **DFR** | Health Care Administration | $659,544 | $165,946 | $0 | $0 | $0 |
| **DMH** | Investments (STC-79) - Institution for Mental Disease Servcies: DMH (3) - VPCH | | $0 | $0 | $0 | $21,804,310 |
| **DMH** | Investments (STC-79) - Institution for Mental Disease Services: DMH (3) - BR | $10,443,654 | $7,194,964 | $25,371,245 | $22,335,938 | $4,786,816 |
| **DMH** | Investments (STC-79) - Mental Health Children's Community Services (12) | $3,088,773 | $3,377,546 | $3,706,864 | $4,379,820 | $4,511,388 |
| **DMH** | Investments (STC-79) - Acute Psychiatric Inpatient Services (13) | $5,268,556 | $3,011,307 | $2,423,577 | $3,145,476 | $4,287,792 |
| **DMH** | Investments (STC-79) - Mental Health CRT Community Support Services (16) | $6,047,450 | $11,331,235 | $282,071 | $5,866,297 | $7,446,247 |
| **DMH** | Investments (STC-79) - Emergency Support Fund (22) | $874,194 | $985,098 | $463,708 | $914,858 | $995,193 |
| **DMH** | Investments (STC-79) - Special Payments for Treatment Plan Services (28) | $180,773 | $168,492 | $152,047 | $158,316 | $155,800 |
| **DMH** | Investments (STC-79) - Emergency Mental Health for Children and Adults (29) | $8,719,824 | $6,662,850 | $4,148,197 | $2,528,751 | $7,989,001 |
| **DMH** | Investments (STC-79) - MH Outpatient Services for Adults (66) | $1,454,379 | $2,661,510 | $3,074,989 | $4,446,379 | $2,702,991 |

| | | | | | | |
|---|---|---|---|---|---|---|
| **DMH** | Investments (STC-79) - Respite Services for Youth with SED and their Families (67) | $823,819 | $749,943 | $931,962 | $1,286,154 | $1,209,076 |
| **DMH** | Investments (STC-79) - Seriously Functionally Impaired: DMH (68) | $1,151,615 | $721,727 | $392,593 | $246,049 | $114,942 |
| **DMH** | Investments (STC-79) - Mental Health Consumer Support Programs (79) | $1,649,340 | $2,178,825 | $1,132,931 | $470,222 | $464,525 |
| **DMH** | Challenges for Change: DMH | $819,069 | $0 | $0 | $0 | $0 |
| **DOC** | Return House | $399,999 | $399,999 | $343,592 | $342,084 | $437,023 |
| **DOC** | Northern Lights | $393,750 | $335,587 | $354,909 | $768,289 | $370,155 |
| **DOC** | Pathways to Housing - Transitional Housing | $802,488 | $830,936 | $830,336 | $1,018,229 | $910,936 |
| **DOC** | St. Albans and United Counseling Service Transitional Housing (Challenges for Change) | $524,594 | $433,910 | $539,727 | $0 | $667,967 |
| **DOC** | Northeast Kingdom Community Action | $548,825 | $287,662 | $267,025 | $220,436 | $201,744 |
| **DOC** | Intensive Substance Abuse Program (ISAP) | $400,910 | $547,550 | $58,280 | $0 | $0 |
| **DOC** | Intensive Domestic Violence Program | $86,814 | $64,970 | $169,043 | $88,152 | $0 |
| **DOC** | Community Rehabilitative Care | $2,500,085 | $2,388,327 | $2,539,161 | $2,639,580 | $2,690,514 |
| **DOC** | Intensive Sexual Abuse Program | $69,311 | $19,322 | $15,532 | $6,375 | $9,530 |
| **DVHA** | Investments (STC-79) - Institution for Mental Disease Services: DVHA (7) | $6,214,805 | $6,948,129 | $7,792,709 | $7,839,519 | $8,034,408 |
| **DVHA** | Investments (STC-79) - Vermont Information Technology Leaders/HIT/HIE/HCR (8) | $1,517,044 | $1,549,214 | $2,915,149 | $1,887,543 | $3,694,675 |
| **DVHA** | Investments (STC-79) - Patient Safety Net Services (18) | $2,394 | $363,489 | $335,420 | $573,050 | $647,696 |
| **DVHA** | Investments (STC-79) - Vermont Blueprint for Health (51) | $2,002,798 | $2,490,206 | $1,987,056 | $2,594,329 | $2,474,551 |

| | | | | | | |
|---|---|---|---|---|---|---|
| **DVHA** | Investments (STC-79) - Buy-In (52) | $17,878 | $17,728 | $27,169 | $29,447 | $53,552 |
| **DVHA** | Investments (STC-79) - HIV Drug Coverage (53) | $39,881 | $26,540 | $10,072 | $8,484 | $7,000 |
| **DVHA** | Investments (STC-79) - Family Supports (72) | $4,015,491 | $3,723,521 | $2,982,388 | $273,177 | $0 |
| **DVHA** | Civil Union | $1,112,119 | $760,819 | -$50,085 | -$585 | $0 |
| **GMCB** | Green Mountain Care Board | $1,450,717 | $2,360,462 | $2,517,516 | $2,188,901 | $2,795,198 |
| **UVM** | Vermont Physician Training | $4,006,156 | $4,006,156 | $4,046,217 | $4,046,217 | $4,046,217 |
| **VAAFM** | Agriculture Public Health Initiatives | $90,278 | $90,278 | $90,278 | $90,278 | $90,278 |
| **VDH** | Investments (STC-79) - Recovery Centers (17) | $864,526 | $1,009,176 | $1,299,604 | $1,354,104 | $1,505,120 |
| **VDH** | Investments (STC-79) - Emergency Medical Services (19) | $378,168 | $498,338 | $480,027 | $442,538 | $547,703 |
| **VDH** | Investments (STC-79) - Area Health Education Centers (AHEC) (21) | $496,176 | $547,500 | $543,995 | $562,000 | $463,000 |
| **VDH** | Investments (STC-79) - Public Inebriate Services, C for C (23) | $353,625 | $288,691 | $426,000 | $784,155 | $1,229,572 |
| **VDH** | Investments (STC-79) - Medicaid Vaccines (24) | $482,454 | $707,788 | $557,784 | $578,183 | $0 |
| **VDH** | Investments (STC-79) - Physician/Dentist Loan Repayment Program (25) | $970,105 | $1,040,000 | $900,000 | $770,000 | $834,222 |
| **VDH** | Investments (STC-79) - Substance Use Disorder Treatment (30) | $2,435,796 | $2,363,671 | $2,913,591 | $2,169,074 | $4,483,334 |
| **VDH** | Investments (STC-79) - Health Laboratory (31) | $2,885,451 | $2,494,516 | $3,405,659 | $3,294,240 | $3,227,611 |
| **VDH** | Investments (STC-79) - WIC Coverage (37) | $77,743 | $317,775 | $1,824,848 | $1,201,498 | $1,592,077 |
| **VDH** | Investments (STC-79) - Fluoride Treatment (38) | $75,081 | $59,362 | $55,209 | $75,916 | $62,341 |
| **VDH** | Investments (STC-79) - Health Research and Statistics (39) | $497,700 | $576,920 | $715,513 | $1,195,231 | $1,304,587 |
| **VDH** | Investments (STC-79) - Epidemiology (40) | $766,053 | $623,363 | $872,449 | $750,539 | $876,737 |

| | | | | | | |
|---|---|---|---|---|---|---|
| **VDH** | Investments (STC-79) - VT Blueprint for Health (44) | $875,851 | $713,216 | $703,123 | $757,576 | $874,534 |
| **VDH** | Investments (STC-79) - Enhanced Immunization (46) | $457,757 | $165,770 | $253,245 | $109,373 | $251,577 |
| **VDH** | Investments (STC-79) - Patient Safety - Adverse Events (47) | $42,169 | $38,731 | $34,988 | $35,033 | $39,465 |
| **VDH** | Investments (STC-79) - Poison Control (48) | $152,250 | $152,433 | $105,586 | $85,586 | $136,390 |
| **VDH** | Investments (STC-79) - Healthy Homes and Lead Poisoning Prevention Program (49) | $101,127 | $479,936 | $421,302 | $187,784 | $258,563 |
| **VDH** | Investments (STC-79) - Tobacco Cessation: Community Coalitions (50) | $498,275 | $632,848 | $702,544 | $0 | $0 |
| **VDH** | Investments (STC-79) - Renal Disease (73) | $28,500 | $3,375 | $10,125 | $13,500 | $11,625 |
| **VDH** | Investments (STC-79) - TB Medical Services (74) | $34,046 | $59,872 | $28,571 | $9,738 | $139,946 |
| **VDH** | Investments (STC-79) - Family Planning (75) | $1,574,550 | $1,556,025 | $1,390,410 | $1,193,215 | $1,473,280 |
| **VDH** | Investments (STC-79) - Statewide Tobacco Cessation (76) | $487,214 | $1,073,244 | $1,148,535 | $257,507 | $257,507 |
| **VDH** | Coalition of Health Activity Movement Prevention Program (CHAMPPS) | $345,930 | $326,184 | $395,229 | -$26,262 | $0 |
| **VDH** | Community Clinics | $640,000 | $688,000 | $0 | $0 | $0 |
| **VDH** | FQHC Lookalike | $382,800 | $160,200 | $97,000 | $6,000 | $0 |
| **VSC** | Health Professional Training | $405,407 | $405,407 | $409,461 | $629,462 | $409,461 |
| **VVH** | Vermont Veterans Home | $1,410,956 | $410,986 | $410,986 | $410,986 | $410,986 |
| Total | | **$123,669,882** | **$127,103,459** | **$128,924,888** | **$126,882,102** | **$138,740,345** |

**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 VT Plus plans were uniquely designed by the carriers, with a focus on wellness.

# Vermont Health Connect
## 2018 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 Plan Comparison Tool at https://vt.checkbookhealth.org or call 1-855-899-9600.

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

| | | Standard Plans | | | | | Standard High Deductible Health Plans (HDHP) | | | | Blue Rewards | | | | | MVP VT Plus Non-Standard | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | BCBSVT & MVP | | | | | Can Pair with Health Savings Account (HSA) | | | | BCBSVT only | | | | | MVP only | | | | |
| | | | | | | | Silver HDHP | | Bronze HDHP | | | | | | | | | | | |
| | | Platinum | Gold | Silver | Bronze | Bronze without Rx MOOP (New in 2018) | BCBSVT | MVP | BCBSVT | MVP | Gold | Silver | Bronze without Rx MOOP (New in 2018) | Gold CDHP (HDHP) Can pair with HSA | Bronze CDHP (HDHP) without Rx MOOP (Can pair with HSA) | Gold | Silver | Bronze | Gold HDHP Can pair with HSA | Bronze without Rx MOOP (New in 2018) |
| | | 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 | Individual / Family | Individual / Family | Individual / Family |
| **Deductible (Ded.)** | Integrated Ded.? | N | N | N | N | Y - $7,350/$14,700 | Y - $1,550/$3,100[7] | Y - $1,550/$3,100[7] | Y - $5,250/$10,500 | Y - $5,250/$10,500 | Y - $1,500/$3,000 | Y - $2,750/$5,500[7] | Y - $7,350/$14,700 | Y - $2,750/$5,500 | Y - $6,650/$13,300 | N | N | N | Y - $2,400/$4,800 | Y - $7,350/$14,700 |
| | Medical Ded. | $300/$600 | $850/$1,700 | $2,600/$5,200[7] | $5,000/$10,000 | See above | See above | See above | See above | See above | See above | See above | See above | See above | See above | $950/$1,900 | $2,000/$4,000[7] | $6,000/$12,000 | See above | See above |
| | Waived[1] for: (see Services below) | Prev, OV, UC, Amb, Den1[11] | Prev, OV, UC, Amb, Den1[11] | Prev, OV, UC, Amb, Den1[11] | Prev, Den1 | Prev, OV, Den 1 | Prev | Prev | Prev | Prev | Prev, 3 PCP/MH OV, Den1 | Prev, 3 PCP/MH OV, Den1 | Prev, 3 PCP/MH OV, Den1 | Prev | Prev | Prev, UC, OV, Den1[11] | Prev, 3 PCP/MH, Den1 | Prev | Prev | Prev, 3 PCP/MH OV, Den1 |
| | Prescription (Rx) Ded. | $0 | $100[8] | $300[7B] | $900[8] | See above | See above | See above | See above | See above | See above | See above | See above | See above | See above | $250/$500 | $600/$1,200[7] | $350/$700 | See above | See above |
| | Waived for: | N/A ($0 Ded) | Rx Generic | Rx Generic | Not Waived | Rx Generic | Rx Wellness | Not Waived | Rx Wellness | Not Waived | Not Waived | Not Waived | Not Waived | Rx Wellness | Rx Wellness | Rx Generic | Not Waived | Not Waived | Not Waived | Rx Generic |
| **Max. Out-of-Pocket (MOOP)** | Integrated? | N | N | Y-$6,800/$13,600[7] | Y-$7,350/$14,700 | Y - $7,350/$14,700 | Y-$6,400/$12,800 | Y-$6,400/$12,800 | Y-$6,550/$13,100 | Y - $6,550/$13,100 | Y-$4,500/$9,000 | Y-$7,350/$14,700[7] | Y - $7,350/$14,700 | Y - $2,750/$5,500 | Y - $6,650/$13,300 | N | N | Y-$7,350/$14,700 | Y - $2,400/$4,800 | Y - $7,350/$14,700 |
| | Medical | $1,300/$2,600 | $4,500/$9,000 | See above | See above | See above | See above | See above | See above | See above | See above | See above | See above | See above | See above | $6,050/$12,100 | $6,050/$12,100[7] | See above | See above | See above |
| | Prescription (Rx) | $1,300/$2,600 | $1,300/$2,600 | $1,300/$2,600[7] | $1,300/$2,600 | See above | $1,350/$2,700[7] | $1,350/$2,700[7] | $1,350/$2,700 | $1,350/$2,700 | $1,350/$2,700 | $1,350/$2,700[7] | See above | $1,350/$2,700 | See above | $1,300/$2,600 | $1,300/$2,600[7] | $1,300/$2,600 | $1,350/$2,700 | See above |
| Stacked, Embedded or Aggregate?[6] | | Stacked[6] | Stacked[6] | Stacked[6] | Stacked[6] | Stacked[6] | Aggregate Embedded[610] | Aggregate Embedded[610] | Aggregate Embedded[610] | Aggregate Embedded[610] | Aggregate Embedded[610] | Aggregate Embedded[610] | Aggregate Embedded[610] | Aggregate[6] | Aggregate Embedded[610] | Stacked[6] | Stacked[6] | Stacked[6] | Aggregate[6] | Stacked[6] |
| **Service Category (Examples)** | | Co-insurance (%) / Co-pay ($) | 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 ($) | Co-insurance (%) / Co-pay ($) | 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 | $0 | $0 | $0 |
| Office Visit (OV) | PCP or Mental Health (PCP/MH) | $10 | $15 | $25 | Ded., then $35 | $40 | Ded., then 10% | Ded., then 10% | Ded., then 50% | Ded., then 50% | 3 visits/person (9/family) with no cost-share; then deductible applies + co-pay: $20 (Gold), $30 (Silver), $0 (Bronze) | | | Ded., then $0 | Ded., then $0 | $15 | $30 x 3, then Ded. | Ded., then $40 | Ded., then 0% | $0 x3 then deductible |
| | Specialist[2] | $30 | $30 | $75 | Ded., then $90 | $100 | Ded., then 30% | Ded., then 30% | Ded., then 50% | Ded., then 50% | Ded., then $30 | Ded., then $50 | Ded., then $0 | Ded., then $0 | Ded., then $0 | $30 | Ded., then $60 | Ded., then $100 | Ded., then 0% | Ded., then $0 |
| Urgent Care (UC) | | $40 | $40 | $85 | Ded., then $100 | Ded., then $0 | Ded., then 30% | Ded., then 30% | Ded., then 50% | Ded., then 50% | Ded., then $30 | Ded., then $50 | Ded., then $0 | Ded., then $0 | Ded., then $0 | $30 | Ded., then $60 | Ded., then $100 | Ded., then 0% | Ded., then $0 |
| Ambulance (Amb) | | $50 | $50 | $100 | Ded., then $100 | Ded., then $0 | Ded., then 30% | Ded., then 30% | Ded., then 50% | Ded., then 50% | Ded., then $30 | Ded., then $50 | Ded., then $0 | Ded., then $0 | Ded., then $0 | Ded., then $50 | Ded., then $100 | Ded., then $100 | Ded., then 0% | Ded., then $0 |
| Emergency Room (ER)[3] | | Ded, then $100 | Ded, then $150 | Ded., then $250 | Ded., then 50% | Ded., then $0 | Ded., then 30% | Ded., then 30% | Ded., then 50% | Ded., then 50% | Ded., then $250 | Ded., then $400 | Ded., then $0 | Ded., then $0 | Ded., then $0 | Ded., then $250 | Ded., then $400 | Ded., then 50% | Ded., then 0% | Ded., then $0 |
| Hospital Services[4] | Inpatient | Ded., then 10% | Ded., then 30% | Ded., then 40% | Ded., then 50% | Ded., then $0 | Ded., then 30% | Ded., then 30% | Ded., then 50% | Ded., then 50% | Ded., then $500 | Ded., then $1,500 | Ded., then $0 | Ded., then $0 | Ded., then $0 | Ded., then 20% | Ded., then 50% | Ded., then 50% | Ded., then 0% | Ded., then $0 |
| | Outpatient | Ded., then 10% | Ded., then 30% | Ded., then 40% | Ded., then 50% | Ded., then $0 | Ded., then 30% | Ded., then 30% | Ded., then 50% | Ded., then 50% | Ded., then $500 | Ded., then $1,500 | Ded., then $0 | Ded., then $0 | Ded., then $0 | Ded., then 20% | Ded., then $1,400 | Ded., then 50% | Ded., then 0% | 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 | 30-day supply | 30-day supply | 30-day supply |
| Rx Generic[5] | | $5 | $5 | $15 | Ded., then $20 | $25 | Ded.[9], then $10 | Ded.[9], then $10 | Ded.[9], then $12 | Ded., then $12 | Ded., then $5 | Ded., then $5 | Ded.[9], then $0 | Ded.[9], then $0 | Ded.[9], then $0 | $5 | Ded., then $5 | Ded.[9], then $20 | Ded., then 0% | $30 |
| Rx Preferred Brand[5] | | $50 | Ded., then $50 | Ded., then $60 | Ded., then $85 | Ded.[9], then $0 | Ded.[9], then $40 | Ded.[9], then $40 | Ded.[9], then 40% | Ded., then 40% | Ded., then 40% | Ded., then 40% | Ded.[9], then $0 | Ded.[9], then $0 | Ded.[9], then $0 | Ded., then $40 | Ded., then 50% | Ded.[9], then $90 | Ded., then 0% | Ded.[9], then $0 |
| Rx Non-Preferred Brand[5] | | 50% | Ded., then 50% | Ded., then 50% | Ded., then 60% | Ded., then $0 | Ded., then 50% | Ded., then 50% | Ded., then 60% | Ded., then 60% | Ded., then 60% | Ded., then 60% | Ded., then $0 | Ded., then $0 | Ded., then $0 | Ded., then 50% | Ded., then 50% | Ded., then 60% | Ded., then 0% | Ded., then $0 |
| **Additional Benefits** | | | | | | | | | | | | | | | | | | | | |
| Wellness Benefits | | N/A | 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 | VBID Rx co-pay of $1/$3, up to $50 in wellness rewards |
| **Premiums by Tier** | | 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 | Cost before subsidy | Cost before subsidy | Cost before subsidy |
| **Single** | BCBSVT | $751.92 | $657.15 | $561.02 | $488.26 | $499.22 | $571.48 | | $492.22 | | $633.59 | $549.55 | $484.78 | $607.36 | $484.56 | | | | | |
| | MVP | $705.42 | $596.79 | $528.79 | $425.27 | $456.68 | | $505.48 | | $429.17 | | | | | | $604.43 | $474.08 | $425.35 | $568.54 | $422.10 |
| **Couple** | BCBSVT | $1,503.84 | $1,314.30 | $1,122.04 | $976.52 | $998.44 | $1,142.96 | | $984.44 | | $1,267.18 | $1,099.10 | $969.56 | $1,214.72 | $969.12 | | | | | |
| | MVP | $1,410.84 | $1,193.58 | $1,057.58 | $850.54 | $913.36 | | $1,010.96 | | $858.34 | | | | | | $1,208.86 | $948.16 | $850.70 | $1,137.08 | $844.20 |
| **Parent and Child(ren)** | BCBSVT | $1,451.21 | $1,268.30 | $1,082.77 | $942.34 | $963.49 | $1,102.96 | | $949.98 | | $1,222.83 | $1,060.63 | $935.63 | $1,172.20 | $935.20 | | | | | |
| | MVP | $1,361.46 | $1,151.80 | $1,020.56 | $820.77 | $881.39 | | $975.58 | | $828.30 | | | | | | $1,166.55 | $914.97 | $820.93 | $1,097.28 | $814.65 |
| **Family** | BCBSVT | $2,112.90 | $1,846.59 | $1,576.47 | $1,372.01 | $1,402.81 | $1,605.86 | | $1,383.14 | | $1,780.39 | $1,544.24 | $1,362.23 | $1,706.68 | $1,361.61 | | | | | |
| | MVP | $1,982.23 | $1,676.98 | $1,485.90 | $1,195.01 | $1,283.27 | | $1,420.40 | | $1,205.97 | | | | | | $1,698.45 | $1,332.16 | $1,195.23 | $1,597.60 | $1,186.10 |

**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 (844-865-0250).
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 $72,900 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 $100/$300/$900 Rx Deductible per person, while MVP Standard Gold/Silver/Bronze plans have an Rx Deductible of $100/$300/$900 for a Single plan or $200/$600/$1,800 for a family plan.
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 aggregate family deductibles have an embedded individual maximum out-of-pocket of $7,350 to prevent one individual from paying the full family maximum out-of-pocket when it exceeds the federal maximum out-of-pocket of $7,350 for an individual.

**Abbreviations**– Ded: Deductible, Rx: Prescription Drugs, OV: Office Visits, UC: Urgent Care, Amb: Ambulance, VBID: Value-Based Insurance Design, Den1: Pediatric DentalClass 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 (844-865-0250).

*Updated 10/12/17*

[8] http://info.healthconnect.vermont.gov/sites/hcexchange/files/2018%20Plan%20Designs%20with%20Final%20Rates_final.pdf

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# APPENDIX C: SCORECARDS

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# P Admin Administrative Services Unit & Operations

## Budget Information

## What We Do

The Administrative Services Unit supports all staff within DVHA on the hiring processes. They work on the development of training program and AHS initiatives such as the Red Cross blood drives, merit committee and domestic violence prevention. Staff work with stakeholders on the process and procedures needed for HR requirements.

Operations staff manages building related issues such as moves, space planning and floor plans, VOIP phones, and IT equipment. Staff oversees the departmental purchasing card, approves all Department purchases and signs off on commodity invoices. Staff also manage fleet vehicles and act as lead on Continuity of Operations plan and Public Records Staff work with stakeholders on the process and procedures needed for purchases to ensure audit requirements are met.

## Who We Serve

## How We Impact

| Performance Measures | Time Period | Actual Value | Target Value | Current Trend | Baseline % Change |
|---|---|---|---|---|---|
| PM Admin % of DVHA staff that received an annual performance evaluation by the due date | SFY 2017 | 41.6% | – | ↘ 1 | -1% ↓ |
| Data Source: Human Resources Database | SFY 2016 | 42.0% | – | → 0 | 0% → |


Partners

- DVHA Senior Management Team
- DVHA Management Team
- DVHA Business Office
- Managers/Supervisors
- Administrative Staff
- Staff

Story Behind the Curve

Performance management is an effective supervisory tool that can enhance the productivity and motivation of employees. Clear job responsibilities and expectations are established in relation to organizational goals and objectives. Continuous feedback is provided to improve communication between employees and supervisors. Formal performance reviews document and evaluate performance in relation to established expectations.

The completion rate for DVHA evaluations is low. DVHA has grown in size year over year. In July of 2016, the Health Access Eligibility & Enrollment Unit (HAEEU) merged with DVHA, bringing an additional 165 staff to the department for a total staff of 334. At times of rapid growth and transition, therein lies an opportunity to address inconsistencies. The Business Office is partnering with DVHA leadership to explore improvement strategies in the future. The Business Office can dive deeper into the data to identify certain units or projects that may be failing to meet performance evaluation expectations and how work with that unit or manager to help them be more

successful for their staff moving forward.

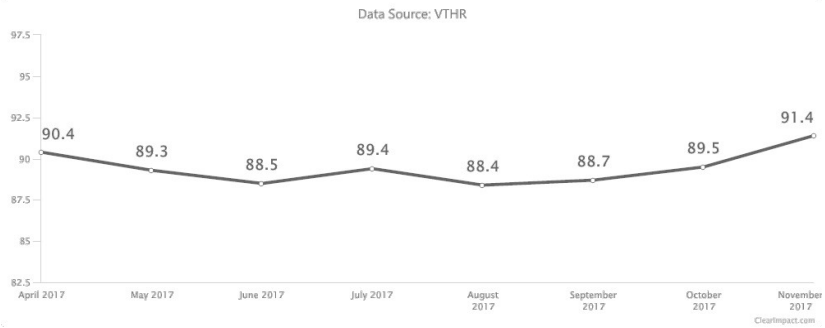
*Last updated: 08/31/17*

*Author: Administrative Services Unit*

Strategy

- Send monthly email reminders to managers/supervisors alerting them of any upcoming evaluations that are due for their staff.
- Ensure that new managers/supervisors receive a list of their staff evaluation due dates.
- Administrative staff can create reminders and block out time on a quarterly basis for working on evaluations for managers/supervisors.
- In order to create more of a culture around this and to express the importance, timely evaluations should be mentioned at all Senior Management Team, Management Team, and one-on-one check-ins with managers/supervisors.
- All managers/supervisors should have documented in their own evaluations the timely completion of evaluations for each of their staff. This should be a requirement across the board, and needs to be instituted from the top down organizationally.

PM Admin % of filled positions to total positions allocated to DVHA




| | | | | |
|---|---|---|---|---|
| Nov 2017 | 91.4% | – | ↗ 3 | 6% ↑ |
| Oct 2017 | 89.5% | – | ↗ 2 | 4% ↑ |
| Sep 2017 | 88.7% | – | ↗ 1 | 3% ↑ |
| Aug 2017 | 88.4% | – | ↘ 1 | 3% ↑ |
| Jul 2017 | 89.4% | – | ↗ 1 | 4% ↑ |
| Jun 2017 | 88.5% | – | ↘ 2 | 3% ↑ |
| May 2017 | 89.3% | – | ↘ 1 | 4% ↑ |
| Apr 2017 | 90.4% | – | ↗ 2 | 5% ↑ |
| Mar 2017 | 89.0% | – | ↗ 1 | 3% ↑ |
| Feb 2017 | 86.0% | – | → 0 | 0% → |

Partners

- Senior Leadership
- DVHA Managers

Story Behind the Curve

Adequate staffing resources is an important component in the success of the Department's initiatives. The Department of Vermont Health Access (DVHA) must have a focus on recruitment and on professional development in order to recruit and retain talent. DVHA needs to ensure that adequate resources are allocated in order to continue to meet our deadlines for important projects and initiatives.

This key performance indicator shows how well DVHA is managing and filling position vacancies.

*Last updated: 12/15/17*

*Author: Administrative Services Unit*

Strategy

- Managers identify & report resource deficiencies and needs to Senior Leadership.
- As positions become vacant, Senior Leadership reviews the needs of the unit as well as the needs of the department.

% of staff hired during the quarter who attend the first available New Employee Orientation (NEO) training

Notes on Methodology

- This is a new measure for the Administrative Services Unit; the first data point will be SFY18 Q1, available in January 2018.

| ***New Employee Orientation Training*** | **SFY18 Q1** | **SFY18 Q2** | **SFY18 Q3** | **SFY18 Q4** |
|---|---|---|---|---|
| **Total # New Hires** | | | | |
| **# Staff Attendance Waived** | | | | |
| **# Staff Attendance Required** | | | | |
| **% Staff Attend 1st Available NEO Training** | | | | |

Partners

- Senior Leadership
- DVHA Managers
- DVHA Supervisors
- New DVHA staff

Story Behind the Curve

Research indicates that a successful onboarding process improves employee engagement and leads to retaining top talent. The Department of Vermont Health Access (DVHA) New Employee Orientation provides an opportunity for new staff to make the connection between the work that they do in their position and how that rolls up to our overall department and agency mission.

The new employee orientation scheduled for September 27, 2017 is the first orientation that has been scheduled using the new LINC system. Previously, orientations have been scheduled via Outlook with no way to track attendance.

Going forward, all new employees will be assigned the DVHA New Employee Orientation in LINC as they are onboarded. There is a reporting feature in LINC that will allow the Business Office to track completion and develop this key performance indicator. The completion reports in LINC will be compared to reports in people soft (VTHR) for new hires/transfers into the department.

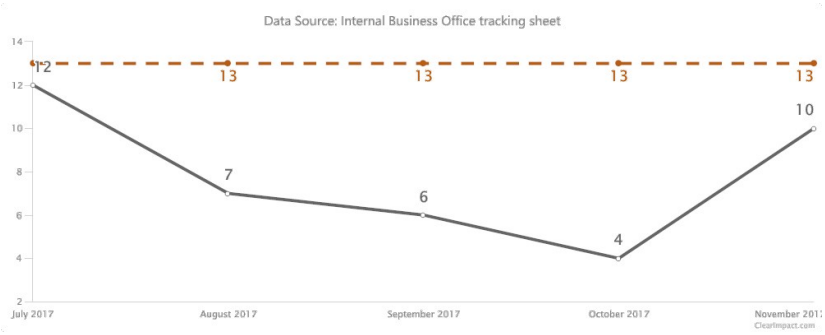
*Last updated: 11/02/17*

*Author: Administrative Services Unit*

Strategy

- DVHA's New Employee orientation is presented by Senior Leadership. They will continue to prioritize orientation as an opportunity to engage with new staff and provide insight into the important work that DVHA does.
- The DVHA Business Office will continue to work with Managers and Supervisors to ensure they are allowing and encouraging new staff to take time to attend orientation training in person at the Waterbury complex.

PM Operations Average # of business days to Agency of Digital Services (ADS) ticket fulfillment




| | | | | | |
|---|---|---|---|---|---|
| Nov 2017 | 10days | 13days | ↗ | 1 | -17% ↓ |
| Oct 2017 | 4days | 13days | ↘ | 3 | -67% ↓ |
| Sep 2017 | 6days | 13days | ↘ | 2 | -50% ↓ |
| Aug 2017 | 7days | 13days | ↘ | 1 | -42% ↓ |
| Jul 2017 | 12days | 13days | → | 0 | 0% → |

- The goal is to bring ADS tickets to fulfillment in ≤13 business days.

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Partners

- DVHA Staff
- DVHA Managers & Directors
- DVHA IT Support
- The Agency of Digital Services (ADS)

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Story Behind the Curve

If DVHA staff have a need for computer software or hardware, they submit an Agency of Digital Services (ADS) deployment request to their supervisor for approval. The ticket is then reviewed and approved by the DVHA Business Office, DVHA IT Support & the ADS. The total ticket turn around time is 13 business days; the Business Office has a turn around time of 3 business days & ADS has a turn around time of 10 business days.

This measure is important because it shows that the Business Office is ensuring that DVHA employees have equipment ordered and available for their use in a timely manner in order to deliver quality service to Vermonters.

**A variety of challenges may be faced in bringing a ticket to closure (including but not limited to):**

- ADS does not have some items in stock and they need to be ordered
- Some items require installation which must be coordinated with the end user
- Staff vacation and sick time can influence ticket closure time
- ADS may not recommend or support a purchase; the ticket may take some time to negotiate

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*Last updated: 12/15/17*

*Author: Operations Staff*

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## Actions

| Name | Assigned To | Status | Due Date | Progress |
|---|---|---|---|---|

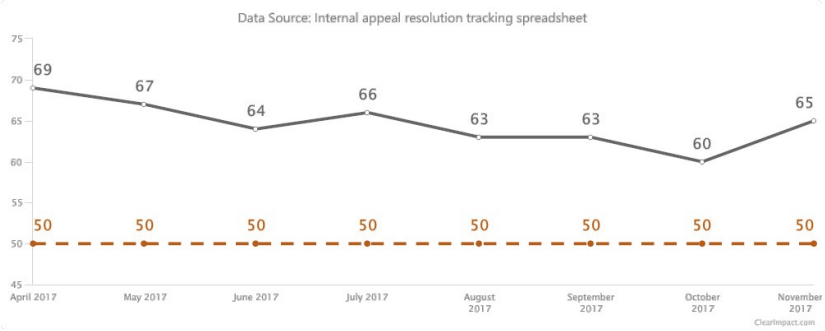
# P Appeals Appeals Unit

## What We Do

The health care appeals team is responsible for both covered services and eligibility appeals and fair hearing processes. It coordinates the internal covered services appeal process on standard and expedited timeframes. It also processes and, where possible, resolves requests for fair hearings on eligibility determinations. The health care appeals team serves both Medicaid and QHP members.

## Performance Measures

PM Appeals % of eligibility appeals that are resolved prior to the formal Fair Hearing process.




| Time Period | Actual Value | Target Value | Current Trend | Baseline % Change |
|---|---|---|---|---|
| Nov 2017 | 65% | 50% | ↗ 1 | -6% ↓ |
| Oct 2017 | 60% | 50% | ↘ 1 | -13% ↓ |
| Sep 2017 | 63% | 50% | → 1 | -9% ↓ |
| Aug 2017 | 63% | 50% | ↘ 1 | -9% ↓ |
| Jul 2017 | 66% | 50% | ↗ 1 | -4% ↓ |
| Jun 2017 | 64% | 50% | ↘ 6 | -7% ↓ |
| May 2017 | 67% | 50% | ↘ 5 | -3% ↓ |
| Apr 2017 | 69% | 50% | ↘ 4 | 0% → |
| Mar 2017 | 74% | 50% | ↘ 3 | 7% ↑ |
| Feb 2017 | 78% | 50% | ↘ 2 | 13% ↑ |

Partners

- Office of the Attorney General
- DVHA Health Access Eligibility & Enrollment Unit

Story Behind the Curve

This metric tracks the percentage of eligibility appeal requests received during a month that are resolved prior to a formal fair hearing. Because internal resolution may take longer than one month, the data points for previous months may be updated retrospectively.

This process benefits Vermonters by providing expeditious and favorable resolution to their eligibility appeals wherever possible. The appeals staff work to identify cases that can be resolved in the customer's favor prior to expending resources on the formal Fair Hearing process before the Human Services Board. The goal has been to resolve more than 50% in this manner. Given that the unit consistently surpassed this goal in SFY17, DVHA is increasing the goal to 65% for 2018.

*Author: Appeals Unit*

*Last updated: 12/15/17*

## Actions

| Name | Assigned To | Status | Due Date | Progress |
|---|---|---|---|---|

# P BO Business Office

## Budget Information

## What We Do

**The Business Office (BO)** supports, monitors, manages, and reports on all aspects of fiscal planning and responsibility. The unit includes Accounts Payable/Accounts Receivable (AP/AR), Grants and Contracts, & Fiscal Analytics.

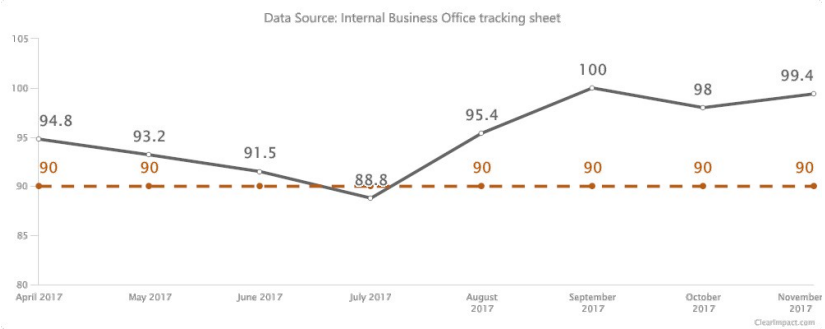
- AP/AR Team is responsible for provider and drug manufacturer assessment billing and receipts, vendor payments, drug rebate receipts, internal expense approvals, and administration appropriation financial monitoring. New to SFY 2017, this team also administers the ambulance assessments.
- The Grants and Contracts Team is charged with the procurement and management of DVHA's grants, contracts, Memorandums of Understanding (MOU), and any additional contractual agreements. Staff serve as liaisons throughout the entire life of an agreement, from initiating the Request for Procurement (RFP) through agreement close. This work requires close collaboration with Agency and state staff and a high degree of responsibility complying with processes, state statutes and bulletins, policies, and federal/state regulations. The team oversees the financial monitoring and management of invoices and payments in adherence with state and federal financial reporting requirements, responds to audit requests, and manages agreement closeout.
- The Fiscal Analytics Team formulates and performs analysis of the programmatic budget, periodic financial reporting, and ad-hoc research requests providing analytic support for DVHA leadership. This team monitors program changes to determine financial impact, assists with programmatic budget preparation, and ensures financial reporting alignment with federal and state regulations.

## Who We Serve

## How We Impact

### Performance Measures

| Performance Measures | Time Period | Actual Value | Target Value | Current Trend | Baseline % Change |
|---|---|---|---|---|---|
| PM BO Accounts Payable: % of invoices processed in under three business days of receipt in the AP/AR Unit | Nov 2017 | 99.4% | 90.0% | ↗ 1 | 5% ↑ |
| | Oct 2017 | 98.0% | 90.0% | ↘ 1 | 3% ↑ |
| | Sep 2017 | 100.0% | 90.0% | ↗ 2 | 5% ↑ |
| | Aug 2017 | 95.4% | 90.0% | ↗ 1 | 1% ↑ |
| | Jul 2017 | 88.8% | 90.0% | ↘ 3 | -6% ↓ |
| | Jun 2017 | 91.5% | 90.0% | ↘ 2 | -3% ↓ |
| | May 2017 | 93.2% | 90.0% | ↘ 1 | -2% ↓ |
| | Apr 2017 | 94.8% | 90.0% | → 0 | 0% → |




Partners

- Department of Vermont Health Access
  - Accounts Payable Team
  - Grants & Contracts Team
  - Operations Team
  - Administration Team
- Department of Finance & Management
- State of Vermont Treasurers Office
- DVHA Vendors
- DVHA Contractors
- DVHA Grantees

Story Behind the Curve

This measure shows how efficiently the Business Office (BO) is managing the financial and business aspects. The BO utilizes Key Performance Indicators (KPIs) to locate barriers to successful operations and design strategies that will lead to better performance.

The goal of the Business Office is to pay invoices as quickly as possible upon receipt, but at least 90% within three business days. At times, invoices require additional information, which results in a longer process time.

In July 2017, contract payments received in June could not be processed until July due to the VISION accounting system restrictions for year-end closeout. Therefore, the turnaround time exceeded the three-day goal for several invoices.

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*Last updated: 12/15/17*

*Author: Business Office*

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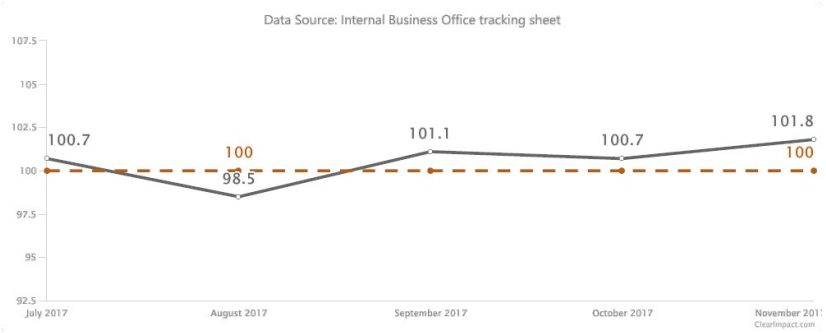
PM BO Accounts Receivable: % of provider taxes ($) collected by DVHA vs. invoiced/estimated




| | | | | | |
|---|---|---|---|---|---|
| Nov 2017 | 101.8% | 100.0% | ↗ | 1 | 1% ↑ |
| Oct 2017 | 100.7% | 100.0% | ↘ | 1 | 0% → |
| Sep 2017 | 101.1% | 100.0% | ↗ | 1 | 0% → |
| Aug 2017 | 98.5% | 100.0% | ↘ | 1 | -2% ↓ |
| Jul 2017 | 100.7% | 100.0% | → | 0 | 0% → |

Partners

- Department of Vermont Health Access
  - Accounts Receivable Team
  - Administration Team
  - Legal Unit
  - Payment Reform Unit
- Department of Finance & Management
- Agency of Human Resources Central Office
- State of Vermont Treasurer's Office
- Community Facilities including Hospitals, Nursing Home Facilities, & Independent Care Facilities
- Home Health Agencies
- Pharmacies
- TD Bank

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Story Behind the Curve

This performance measure shows how efficiently the DVHA Business Office is managing the financial and business aspects. Measure components include Provider Tax by type: Nursing Home Facilities, Hospitals, ICF (Independent Care Facilities), Home Health Agencies, and Pharmacies.

- Note 1: This excludes Ambulance Assessments, as they are only billed annually.
- Note 2: Pharmacies self-report each month, so some taxes are estimates.

DVHA has several providers that owe past due taxes. More aggressive collection processes were developed and implemented in the first half of 2017, accompanied by updated standard operating procedure (SOP)documents. This resulted in several providers making additional payments; which is reflected in the July statistics, as more taxes were collected than billed.

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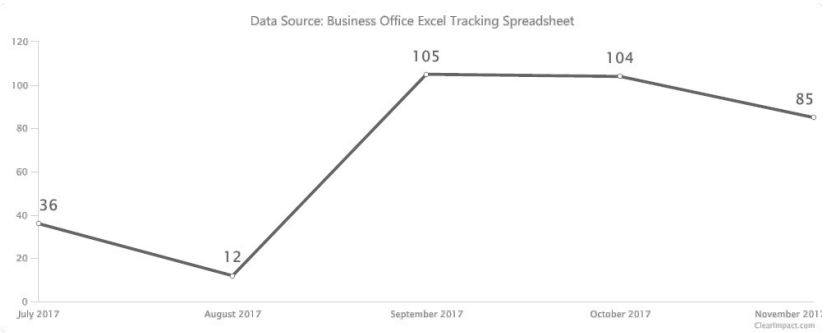
*Last updated: 12/15/17*

*Author: Business Office*

PM BO Contracts: The median # of business days contracts are in development




| | | | | | |
|---|---|---|---|---|---|
| Nov 2017 | 85 | – | ↘ | 2 | 136% ↑ |
| | | | | 1 | ↑ |
| Sep 2017 | 105 | – | ↗ | 1 | 192% ↑ |
| Aug 2017 | 12 | – | ↘ | 1 | -67% ↓ |
| Jul 2017 | 36 | – | → | 0 | 0% → |

Story Behind the Curve

In order to execute agreements that enable work to happen on schedule and within budget, contracts need to be drafted, routed, and signed for execution in a timely manner. In order for contracts to guide the delivery of results, contract language related to business need and expectations must be clear, accurate, and understood by all parties. The current process related to drafting, routing, and executing contracts involves many required reviewers and signatories per the Agency of Administration's Bulletin 3.5 requirements. Department program staff would like to see this process shortened, while Business Office staff must ensure that all requirements of Bulletin 3.5 are adhered to and that reviewers have adequate time to perform their review.

*Last updated: 12/15/17*

*Author: Business Office*

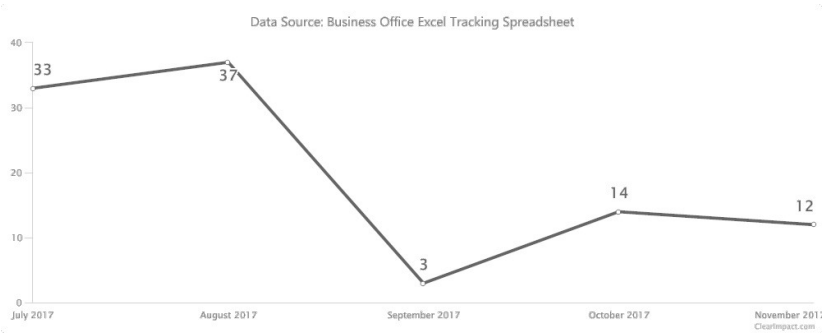
Strategy

With the help of the AHS Quality Improvement Manager, the DVHA Business Office is starting a Quality Improvement project to reduce the amount of time that it takes to execute a contract from the time drafting begins to a final signature. The goal is to reduce rework, duplication of efforts, and waste in the process.

Action Plan

The scope of this exercise is to document, analyze, and recommend improvements for the way that the DVHA Business Office works to execute contracts starting from the development of the first contract draft to the final signature.

PM BO Contracts: The median # of business days contracts are in routing for review




| | | | | | |
|---|---|---|---|---|---|
| Nov 2017 | 12 | – | ↘ | 1 | -64% ↓ |
| Oct 2017 | 14 | – | ↗ | 1 | -58% ↓ |
| Sep 2017 | 3 | – | ↘ | 1 | -91% ↓ |
| Aug 2017 | 37 | – | ↗ | 1 | 12% ↑ |
| Jul 2017 | 33 | – | → | 0 | 0% → |

Story Behind the Curve

In order to execute agreements that enable work to happen on schedule and within budget, contracts need to be drafted, routed, and signed for execution in a timely manner. In order for contracts to guide the delivery of results, contract language related to business need and expectations must be clear, accurate, and understood by all parties. The current process related to drafting, routing, and executing contracts involves many required reviewers and signatories per the Agency of Administration's Bulletin 3.5 requirements. Department program staff would like to see this process shortened, while Business Office staff must ensure that all requirements of Bulletin 3.5 are adhered

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*Last updated: 12/15/17*

*Author: Business Office*

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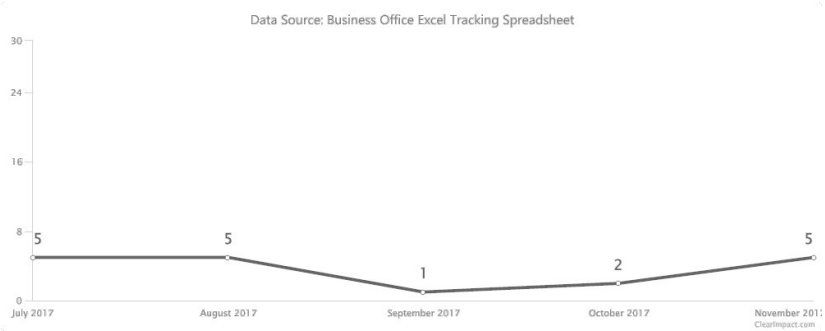
PM BO Contracts: The median # of business days contracts are in routing for signature




| | | | | |
|---|---|---|---|---|
| Nov 2017 | 5 | – | ↗ 2 | 0% → |
| Oct 2017 | 2 | – | ↗ 1 | -60% ↓ |
| Sep 2017 | 1 | – | ↘ 1 | -80% ↓ |
| Aug 2017 | 5 | – | → 1 | 0% → |
| Jul 2017 | 5 | – | → 0 | 0% → |

Story Behind the Curve

**In order to execute agreements that enable work to happen on schedule and within budget, contracts need to be drafted, routed, and signed for execution in a timely manner. In order for contracts to guide the delivery of results, contract language related to business need and expectations must be clear, accurate, and understood by all parties. The current process related to drafting, routing, and executing contracts involves many required reviewers and signatories per the Agency of Administration's Bulletin 3.5 requirements. Department program staff would like to see this process shortened, while Business Office staff must ensure that all requirements of Bulletin 3.5 are adhered to and that reviewers have adequate time to perform their review.**

*Last updated: 12/15/17*

*Author: Business Office*

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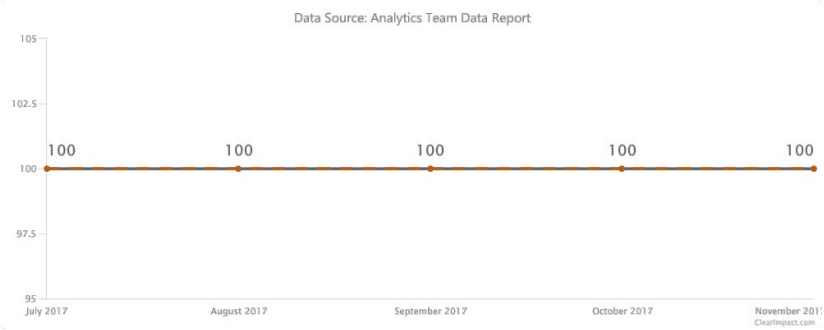
Action Plan

The scope of this exercise is to document, analyze, and recommend improvements for the way that the DVHA Business Office works to execute contracts starting from the development of the first contract draft to the final signature.

PM BO Reporting: The ratio (%) of timely & accurate submission of required financial reporting

| | | | | |
|---|---|---|---|---|
| Nov 2017 | 100.0% | 100.0% | → 4 | 0% → |
| Oct 2017 | 100.0% | 100.0% | → 3 | 0% → |
| Sep 2017 | 100.0% | 100.0% | → 2 | 0% → |
| Aug 2017 | 100.0% | 100.0% | → 1 | 0% → |
| Jul 2017 | 100.0% | 100.0% | → 0 | 0% → |




Partners

- DXC
- Change Health Care
- Business Office Account Receivable/Accounts Payable Team
- Business Office Administrative Team
- DVHA Policy Unit
- Vermont Health Connect
- Blueprint
- AHS Central Office

Story Behind the Curve

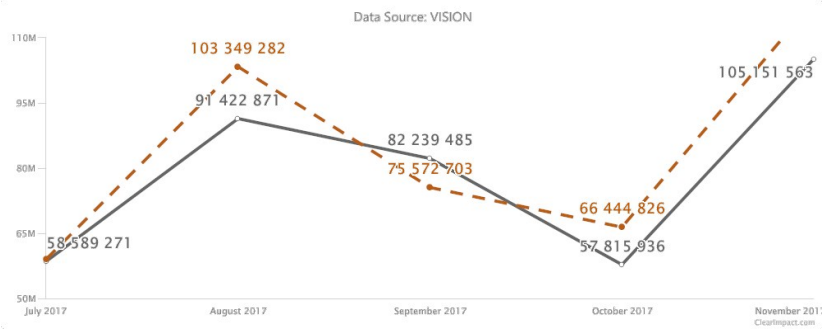
This performance measure shows how efficiently the Business Office (BO) is managing the financial and business aspects. The BO utilizes Key Performance Indicators (KPIs) to locate barriers to successful operations and design strategies that will lead to better performance.

*Last updated: 12/15/17*

*Author: Business Office*

PM BO Budget: Actual vs. estimated program budget

| | | | | |
|---|---|---|---|---|
| Nov 2017 | $105.15Mil | $118.38Mil | ↗ 1 | 79% ↑ |
| Oct 2017 | $57.82Mil | $66.44Mil | ↘ 2 | -1% ↓ |
| Sep 2017 | $82.24Mil | $75.57Mil | ↘ 1 | 40% ↑ |
| Aug 2017 | $91.42Mil | $103.35Mil | ↗ 1 | 56% ↑ |
| Jul 2017 | $58.59Mil | $59.07Mil | → 0 | 0% → |




Notes on Methodology

- **Please note that the dotted target trend line represents the estimated budget in the above chart.**

| Program Budget | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 |
|---|---|---|---|---|---|
| Estimated | $59,074,858 | $103,349,282 | $75,572,703 | $66,444,826 | $118,383,240 |
| Actual | $58,589,271 | $91,422,871 | $82,239,485 | $57,815,936 | $105,151,563 |
| Over/(Under) | $485,587 | $11,926,411 | ($6,666,782) | $8,628,890 | $13,231,677 |

Partners

- ADS

Story Behind the Curve

The Business Office (BO) utilizes KPIs to locate barriers to successful operations and to design strategies that will lead to better performance.

*Last updated: 12/15/17*

*Author: Business Office*

PM BO Budget: Actual vs. estimated administrative budget

Notes on Methodology

- **Please note that the dotted target trend line represents the estimated budget in the above chart.**

| *Administrative budget* | Report Period | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 | May-18 | Jun-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| General | Estim | | | | | | | | | | | | |
| | Actual | | | | | | | | | | | | |
| Claims | Estim | | | | | | | | | | | | |
| | Actual | | | | | | | | | | | | |
| Eligibility & Ernollment | Estim | | | | | | | | | | | | |
| | Actual | | | | | | | | | | | | |
| Quality | Estim | | | | | | | | | | | | |
| | Actual | | | | | | | | | | | | |
| IT Projects | Estim | | | | | | | | | | | | |
| | Actual | | | | | | | | | | | | |
| Total | Estim | | | | | | | | | | | | |
| | Actual | | | | | | | | | | | | |
| | O/(U) | | | | | | | | | | | | |

Partners

- DXC
- Change Health Care
- DVHA Account Receivable/Accounts Payable
- DVHA Business Office Admin
- DVHA Policy Unit
- Vermont Health Connect
- Blueprint
- AHS Central Office

Story Behind the Curve

The Business Office utilizes KPIs to locate barriers to successful operations and to design strategies that will lead to better performance.

*Last updated: 10/31/17*

*Author: Business Office*

## Actions

| Name | Assigned To | Status | Due Date | Progress |
|---|---|---|---|---|

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

# P BP Blueprint for Health

## What We Do

The Vermont Blueprint for Health is a state-led, nationally-recognized initiative that helps health care providers meet the medical and social needs of people in their communities. The Blueprint's aim is constant: better care, better health, and better control of health care costs.

The Blueprint encourages initiatives to support and improve health care delivery. It promotes innovative initiatives aimed at improving health outcomes, increasing preventive health approaches, addressing quality of life concerns, and increasing access to quality care through patient-centered medical homes and community health teams.

## Who We Serve

The Blueprint for Health serves all Vermonters.

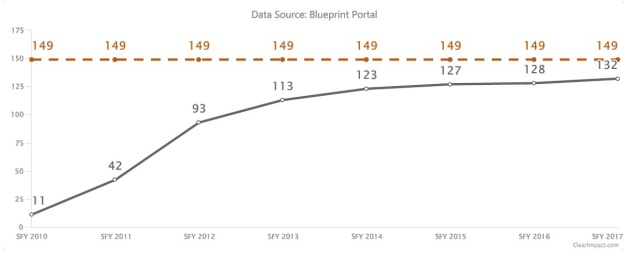
## How We Impact

The activities of the Blueprint serve as the foundation for strengthening primary care and expanding the ACO programs. This initiative is especially focused on building the links between community and medical services, so that patients have better coordinated care across the spectrum of services.

Together the following performance measures focus on whether Vermonters are better off as a result of this program. They do so by looking at the quality and efficiency of these programs and services.

## Performance Measures

PM BP # of primary care practices participating in the Blueprint




| Time Period | Actual Value | Target Value | Current Trend | Baseline % Change |
|---|---|---|---|---|
| SFY 2017 | 132 | 149 | ↗ 7 | 1100% ↑ |
| SFY 2016 | 128 | 149 | ↗ 6 | 1064% ↑ |
| SFY 2015 | 127 | 149 | ↗ 5 | 1055% ↑ |
| SFY 2014 | 123 | 149 | ↗ 4 | 1018% ↑ |
| SFY 2013 | 113 | 149 | ↗ 3 | 927% ↑ |

| | | | | |
|---|---|---|---|---|
| SFY 2012 | 93 | 149 | ↗ 2 | 745% ↑ |
| SFY 2011 | 42 | 149 | ↗ 1 | 282% ↑ |
| SFY 2010 | 11 | 149 | → 0 | 0% → |

Notes on Methodology

- The number of participating practices per quarter is generated from data stored in the Blueprint portal (https://blueprintforhealthport...). The Blueprint Data Analyst manages information stored in the Blueprint portal.
- The goal figure for this measure was obtained by identifying all primary care practices in the AHEC survey database and immunization registry database, validating these primary care practices with our Blueprint project managers, and eliminating from the count practices with 1 FTE or less of a provider.

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Partners

- The local Blueprint Transformation Network, which includes: Practice Facilitators, Community Health Team leaders, and Project Managers

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Story Behind the Curve

These are practices who meet the NCQA standard of a patient-centered medical home (PCMH) and participate in Blueprint initiatives. This measure is fundamental in assessing the reach of the Blueprint program. As larger numbers of practices are qualified as PCMHs and supported by Blueprint payments, increasing numbers of Vermonters should have access to high quality primary care.

The trend line above clearly highlights the rapid increase in practice participation in the Blueprint as NCQA-recognized Patient-Centered Medical Homes (PCMHs) in 2011. This rapid increase is the result of a coordinated effort by the Blueprint team to comply with the enactment of Act 128 in May 2010 by the Vermont General Assembly. The Act mandated the statewide expansion of the Blueprint, including practice recognition as PCMHs. Evidence of this expansion required a minimum of two primary care practices in each health service area (HSA) becoming PCMHs by July 2011. The Act additionally required the involvement of all willing primary care providers in Vermont by October 2013 (full statewide spread). A significant achievement in 2010 that paved the way towards compliance with Act 128 was the Blueprint's successful application for the Centers for Medicare & Medicaid Services' Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration Project. In mid-July, Medicare joined all other major insurers in Vermont in contributing to the financial payments to PCMHs.

Since the mandate that all willing primary care providers in Vermont be involved as a PCMH in the Blueprint by October 2013, Blueprint practice facilitators have continued to engage providers across the State to encourage and inspire participation. Practice facilitators, highly skilled and intensively trained clinical and process coaches, work with primary care practices throughout the state and guide them as they make quality improvement changes on the path towards becoming PCMHs. When practices achieve NCQA certification as a PCMH with the assistance of the Blueprint practice facilitators, they demonstrate adherence with important characteristics of high quality healthcare and well-coordinated health services. The practices find the NCQA PCMH standards and Blueprint program as value-adds to their practice, as since the inception of the Blueprint program, only one PCMH has dropped out of the Blueprint (pending an upcoming move out of state).

The Blueprint has approached a saturation point where the program has recruited most of the available primary care practices in the state, and the rate of onboarding of new practices has generally plateaued. Program expansion is continuing due to the outreach efforts of the Blueprint practice facilitators, who are making a coordinated effort to reach primary care practices in their communities that have not participated in the Blueprint as a patient-centered medical home in the past. Generally, the practices that are continuing to join the Blueprint are independent and naturopathic practices.

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*Last updated: 08/31/17*

*Author: Blueprint for Health*

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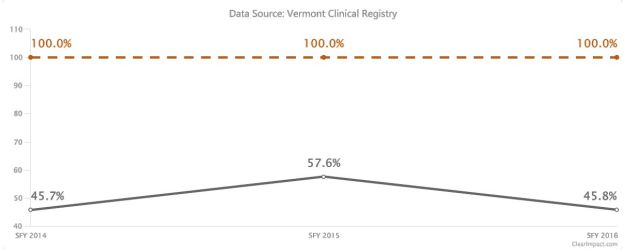
PM BP % of Blueprint patients with recorded measures in the Vermont Clinical Registry




| | | | | |
|---|---|---|---|---|
| SFY 2016 | 45.8% | 100.0% | ↘ 1 | 0% → |
| SFY 2015 | 57.6% | 100.0% | ↗ 1 | 26% ↑ |
| SFY 2014 | 45.7% | 100.0% | → 0 | 0% → |

Notes on Methodology

- The denominator is the number of Blueprint patients in the Vermont Clinical Registry who could be linked to claims data in VHCURES.
- The statewide average percentage of linked Blueprint patients with recorded measures in the Clinical Registry is generated by Onpoint Health Analytics, the statewide administrator of the All-Payer Claims Dataset (APCD). Onpoint links claims in the APCD to clinical records stored by Capitol Health Associates in the Clinical Registry. Onpoint updates this percentage every six months,

accounting for the next 6 month time period.
- The goal figure for this measure is 100%, as the Blueprint is aiming to have all Blueprint patients in the Vermont Clinical Registry who could be linked to claims data in VHCURES to also have at least one recorded measure within the Vermont Clinical Registry.

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Partners

- Vermont Information Technology Leaders (VITL)
- Capitol Health Associates
- Electronic Health Record (EHR) vendors
- Patient-Centered Medical Homes (PCMHs)
- HIE/HIT Unit

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Story Behind the Curve

This is a measure of the percentage of Blueprint patients that have been identified in claims and linked to the Clinical Registry, who also have key clinical measures recorded in the Clinical Registry.

This measure is an indicator of the effectiveness of the HIE to aggregate data and the effectiveness of the Clinical Registry to populate clinical measures. This measure also reflects the ability of EHR systems to send structured data in Clinical Continuity Documents (CCDs). These data can be used to enhance patient care and inform improvements throughout the system.

The trend line above suggests an opportunity for improvement given that the data is not moving in the right direction. Blueprint practices across the state have been populating the Clinical Registry for over 7 years. The Registry, previously referred to as DocSite, was purchased from Covisit under a perpetual software license and is now managed by Capitol Health Associates, LLC. After analysis of the data in the Clinical Registry for quality and completeness, the data are de-identified and linked at the person level with the corresponding individual's claims records in VHCURES. This linkage is conducted by the Blueprint's analytics vendor, Onpoint Health Analytics, who determines the portion of the population in VHCURES for which clinical data can be associated with claims, and of that population, the percentage that have recorded clinical measures.

In July 2015, a number of practices experienced interruptions in, or terminations to, their clinical data feeds to the VHIE as a result of upgrades made to their EHRs, including: switching to a cloud-based system, EHR vendors releasing updated software, and practices switching EHR vendors.

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*Last updated: 08/31/17*

*Author: Blueprint for Health*

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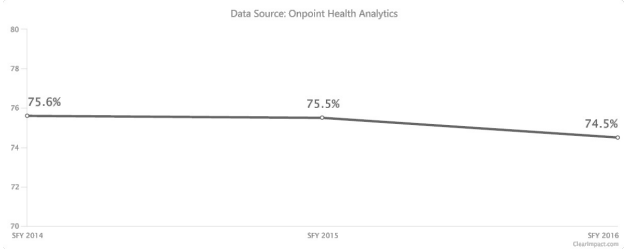
PM BP % of patients served by patient-centered medical homes (PCMHs)




| | | | | |
|---|---|---|---|---|
| SFY 2016 | 74.5% | – | ↘ 2 | -1% ↓ |
| SFY 2015 | 75.5% | – | ↘ 1 | 0% → |
| SFY 2014 | 75.6% | – | → 0 | 0% → |

Notes on Methodology

- The percentage of Blueprint patients from the population of VHCURES members with a primary care visit is generated by Onpoint Health Analytics, the statewide administrator of the All-Payer Claims Dataset. Onpoint updates this percentage every six months, accounting for the next 6 month time period.
- The trend line for this measure should increase as additional practices join the Blueprint.

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Partners

- The local Blueprint Transformation Network, which includes: Practice Facilitators, Community Health Team leaders, and Project Managers
- Staff at Blueprint Patient-Centered Medical Homes (PCMHs)
- Onpoint Health Analytics

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Story Behind the Curve

This is a measure of the percentage of Vermonters who receive their primary care from a Blueprint PCMH from the population of VHCURES members with a primary care visit. This is an access to care measure.

PCMHs provide top-quality primary care centered on several key evidence-based standards. By increasing the percentage of Vermonters who receive their primary care through PCMHs, we are increasing access to high quality care and the opportunity for improved health outcomes.

The trend line above, while moving towards the right direction, suggests an opportunity for improvement. Data points from 2013 to 2014 clearly highlight the effects of the rapid increase in practice participation in the Blueprint as NCQA-recognized Patient-Centered Medical Homes (PCMHs) in due to the mandate that all willing primary care providers in Vermont by involved as a PCMH in the

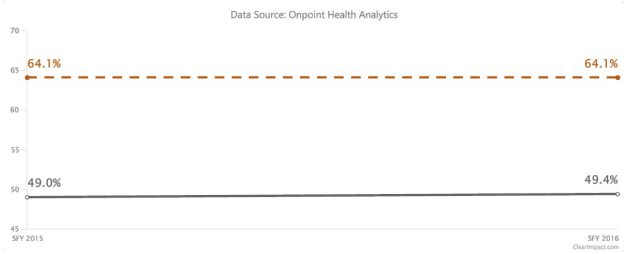
Blueprint by October 2013. Data points in 2015 show a decrease in the percentage of the Blueprint patients from the population of VHCURES members with a primary care visit due to either improvements in the accuracy of attributing individuals to PCMHs at Onpoint Health Analytics or access to care issues. The recent increase in the percentage in the latest study time period can be attributed to a continued engagement of providers across the State by Blueprint practice facilitators to encourage and inspire participation in the Blueprint.

*Last updated: 08/31/17*

*Author: Blueprint for Health*

PM BP Statewide average % for Adolescent Well-Care Visits

| | | | | | |
|---|---|---|---|---|---|
| SFY 2016 | 49.4% | 64.1% | ↗ | 1 | 1% ↑ |
| SFY 2015 | 49.0% | 64.1% | → | 0 | 0% → |




Notes on Methodology

- The statewide average percentage of the Adolescent Well-Child Visit performance measure is generated by Onpoint Health Analytics, the statewide administrator of the All-Payer Claims Dataset. Onpoint updates this measure every six months, accounting for the next 6 month time period. The statewide average percentage of the Adolescent Well-Child Visit performance measure is listed in every Health Service Area Pediatric profile, which can be found here (http://blueprintforhealth.verm...).
- The statewide average percentage of the Adolescent Well-Child Visit performance measure is a claim-based measure pertaining only to a subset of the Vermont population - insured patients who received the majority of their primary care from a Blueprint practice. This measure is not a Vermont population-level estimate.
- The goal figure for this measure represents the weighted average of the HEDIS national Medicaid 90$^{th}$ percentile benchmark for 2016 and the HEDIS national Commercial 90$^{th}$ percentile benchmark for 2016.

Partners

- The local Blueprint Transformation Network, which includes: Practice Facilitators, Community Health Team leaders, and Project Managers
- Staff at Blueprint Patient-Centered Medical Homes

- Onpoint Health Analytics

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Story Behind the Curve

The Adolescent Well Care (AWC) measure is the first of the four key indicators of quality health care. This measure assesses the statewide average percentage of members, ages 12–21 years, who had at least one well-care visit with a primary care practitioner or OB/GYN during the measurement year.

The Blueprint includes performance-based payments to encourage providers to participate in population and community health improvement initiatives with the goal of greater collaboration. These are key indicators that are in alignment with the All Payer Model core quality measures. Improvements in these areas are indicative of an evolving and improving system of care.

The trend line above, while moving towards the right direction, suggests an opportunity for improvement. The Blueprint implemented the pay for performance model on this measure in July 2015. This measure was chosen for payment because it reflected a priority of each of the provider networks (ACOs) in Vermont, it could be generated at the Health Service Area level using Vermont's centralized data source without any need for additional data collection or reporting by providers, it was tied to prevalent underlying health concerns involving complex medical and social determinants, and it could be improved through better coordination, outreach, and transitions between medical and non-medical providers. Since the implementation of the pay for performance model, a number of Health Service Areas have developed quality improvement policies on this measure, including Barre, Bennington, Burlington, Randolph, St. Albans, and Middlebury.

Middlebury in particular has been working on follow-up processes for patients that are overdue for adolescent well child visits (2016, 2017). Practice staff have been developing reports for the number of active 11-23 year old patients who have not had an adolescent well child visit in the past year, developing outreach materials and outreach processes for those patients that have not had a visit in the past year, and implemented a policy of ensuring that the next adolescent well child visit is scheduled when the patient visits the office for any reason. In addition, a reminder is sent to patients when the adolescent well child visit nears to avoid increased cancelations. Within the last year, there was an improvement in the rate of patients who had an adolescent well child visit.

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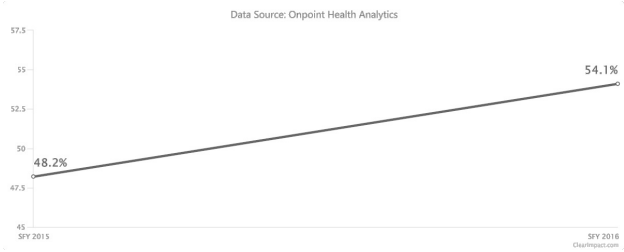
*Last updated: 08/31/17*

*Author: Blueprint for Health*

PM BP Statewide average % for Developmental Screening in the First Three Years of Life

| | | | | |
|---|---|---|---|---|
| SFY 2016 | 54.1% | – | ↗ 1 | 12% ↑ |
| SFY 2015 | 48.2% | – | → 0 | 0% → |




Notes on Methodology

- The statewide average percentage of the Developmental Screening in the First Three Years of Life performance measure is generated by Onpoint Health Analytics, the statewide administrator of the All-Payer Claims Dataset. Onpoint updates this measure every six months, accounting for the next 6 month time period. The statewide average percentage of the Developmental Screening in the First Three Years of Life performance measure is listed in every Health Service Area Pediatric profile, which can be found here (http://blueprintforhealth.verm...).
- The statewide average percentage of the Developmental Screening in the First Three Years of Life performance measure is a claim-based measure pertaining only to a subset of the Vermont population - insured patients who received the majority of their primary care from a Blueprint practice. This measure is not a Vermont population-level estimate.
- Since HEDIS does not produce national benchmarks on this measure, the goal has been identified as the Blueprint's metric of improvement in the Blueprint performance payment methodology, which is an increase of 5% change each study period. The Blueprint performance payment methodology can be found here (http://blueprintforhealth.verm...)

Partners

- The local Blueprint Transformation Network, which includes: Practice Facilitators, Community Health Team leaders, and Project Managers
- Staff at Blueprint Patient-Centered Medical Homes (PCMHs)
- Onpoint Health Analytics
- Vermont Department of Health
- Vermont Child Health Improvement Program

Story Behind the Curve

The Developmental Screening in the First Three Years of life (DEV) measure is the second of the four key indicators of quality health care. This measure assesses the percentage of children screened for risk of developmental, behavioral, and social

delays using a standardized screening tool in the 12 months preceding their first, second, or third birthday.

The Blueprint includes performance-based payments to encourage providers to participate in population and community health improvement initiatives with the goal of greater collaboration. These are key indicators that are in alignment with the All Payer Model core quality measures. Improvements in these areas are indicative of an evolving and improving system of care.

The trend line above shows that there has been significant improvement on this measure due to the coordinated efforts of internal and external partners. The Blueprint implemented the pay for performance model on this measure in July 2015. This measure was chosen for payment because it reflected a priority of each of the provider networks (ACOs) in Vermont, it could be generated at the Health Service Area level using Vermont's centralized data source without any need for additional data collection or reporting by providers, it was tied to prevalent underlying health concerns involving complex medical and social determinants, and it could be improved through better coordination, outreach, and transitions between medical and non-medical providers. Following this measure's implementation as a payment measure in July 2015, practices showed renewed interest in developmental screening with almost fifty practices participating in the University of Vermont College of Medicine's Child Health Advances Measured in Practice (CHAMP) initiative funded by the Vermont Department of Health (VDH). The Blueprint worked collaboratively with VCHIP to provide each practice with their practice-level results for this measure in Fall 2016 (rather than Health Service Area results), and is happy to announce that practice-level results for this measure will be reported on all Blueprint practice profiles starting with Calendar Year 2016 data, set to be released in November 2017.

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*Last updated: 08/31/17*

*Author: Blueprint for Health*

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PM BP Statewide average % for Diabetes in Poor Control

| | | | | |
|---|---|---|---|---|
| **SFY 2016** | **12.4%** | – | ↗ **1** | **9%** ↑ |
| **SFY 2015** | **11.4%** | – | → **0** | **0%** → |


Notes on Methodology

- The statewide average percentage of the Diabetes in Poor Control performance measure is generated by Onpoint Health Analytics, the statewide administrator of the All-Payer Claims Dataset. Onpoint links claims in the APCD to clinical records stored by Capitol Health Associates in the Clinical Registry. Onpoint updates this measure every six months, accounting for the next 6 month time period. The statewide average percentage of the Diabetes in Poor Control performance measure is listed in every Health Service Area Adult profile, which can be found here (http://blueprintforhealth.verm...). The statewide average percentage of the Diabetes in Poor Control performance measure relies on data from the Clinical Registry and therefore is influenced when practices interrupt their data feed to the Clinical Registry. The outcomes described here are estimated using data only from individuals for whom claims data could be linked with valid Clinical Registry data. This non-random sampling variability is not accounted for in the measure.
- It is important to note that the weighted average of the HEDIS national Medicaid 90$^{th}$ percentile benchmark for 2016 and the HEDIS national Commercial 90$^{th}$ percentile benchmark for 2016 is **28%**. Given that Vermont is performing significantly better than the national 90$^{th}$ percentile benchmark, the Blueprint has elected to not include a goal for this measure.

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Partners

- The local Blueprint Transformation Network, which includes: Practice Facilitators, Community Health Team leaders, and Project Managers
- Staff at Blueprint Patient-Centered Medical Home
- Onpoint Health Analytics

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Story Behind the Curve

The Diabetes in Poor Control (i.e., Hemoglobin A1c>9%) measure is the third of 4 key indicators of quality health care. This measure assesses the percentage of continuously enrolled members with diabetes, ages 18–75 years, whose last recorded hemoglobin A1c test in the Clinical Registry was in poor control (>9%). This is a mixed methods measure relying both on claims and clinical data.

The Blueprint includes performance-based payments to encourage providers to participate in population and community health improvement initiatives with the goal of greater collaboration. These are key indicators that are in alignment with the All Payer Model core quality measures. Improvements in these areas are indicative of an evolving and improving system of care.

The trend line above suggests an opportunity for improvement given that the data is not moving in the right direction. The Blueprint implemented the pay for performance model on this measure in July 2015. This measure was chosen for payment because it reflected a priority of each of the provider networks (ACOs) in Vermont, it could be generated at the Health Service Area level using Vermont's centralized data source without any need for additional data collection or reporting by providers, it was tied to prevalent underlying health concerns involving complex medical and social determinants, and it could be improved through better coordination, outreach, and transitions between medical and non-medical providers. Since the implementation of the pay for performance model, a number of Health Service Areas have developed quality improvement policies on this measure, most notably, Morrisville.

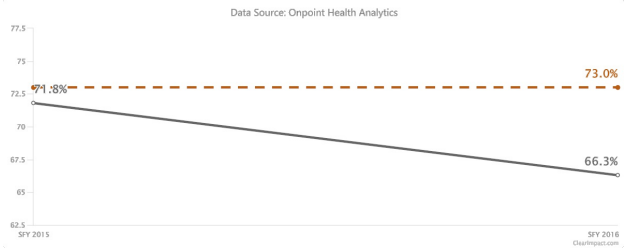
Morrisville has been working on follow-up appointment processes and referrals to self-management services for patients with diabetes (2016, 2017). With regard to quality improvement work directed towards diabetes, practice staff conducted outreach to patients that were overdue for follow-up appointments, reminded patients of the importance of regular appointments with their PCP, and new staff members were trained on how to review physician follow-up recommendations and complete appropriate scheduling for patients for the next visit prior to the patients leaving the office. An improvement in the rate of patients with diabetes who were overdue for an appointment was observed. In addition, the care coordinator nurse was provided with a list of patients with diabetes who were determined to have an A1C greater than 9%, chart review was completed to determine current status of self-management activities, and depending on patient needs, assistance and referrals were completed. There was an improvement in the rate of patients who are engaged with a form of self-management within the last year.

*Last updated: 08/31/17*

*Author: Blueprint for Health*

PM BP Statewide average % of Blood Pressure in Control

| | | | | |
|---|---|---|---|---|
| **SFY 2016** | **66.3%** | **73.0%** | ↘ **1** | **-8%** ↓ |
| **SFY 2015** | **71.8%** | **73.0%** | → **0** | **0%** → |




Notes on Methodology

- The statewide average % for the Blood Pressure in Control performance measure is generated by Onpoint Health Analytics, the statewide administrator of the All-Payer Claims Dataset. Onpoint links claims in the APCD to clinical records stored by Capitol Health Associates in the Clinical Registry. Onpoint updates this measure every six months, accounting for the next 6 month time period. The statewide average percentage of the Hypertension in Control performance measure is listed in every Health Service Area Adult profile, which can be found here (http://blueprintforhealth.verm...). The statewide average percentage of the Hypertension in Control performance measure relies on data from the Clinical Registry and therefore is influenced when practices interrupt their data feed to the Clinical Registry. The outcomes described here are estimated using data only from individuals for whom claims data could be linked with valid Clinical Registry data. This non-random sampling variability is not accounted for in the measure.
- The goal figure for this measure represents a weighted average of the HEDIS national Medicaid 90$^{th}$ percentile benchmark for 2016 and the HEDIS national Commercial 90$^{th}$ percentile benchmark for 2016.

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Partners

- The local Blueprint Transformation Network, which includes: Practice Facilitators, Community Health Team leaders, and Project Managers
- Staff at Blueprint Patient-Centered Medical Homes
- Onpoint Health Analytics
- Vermont Department of Health
- OneCare Vermont
- Support And Services at Home
- New England Quality Innovation Network-Quality Improvement Organization
- Community Health Accountable Care, LLC
- Vermont Program for Quality in Health Care, Inc.

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Story Behind the Curve

The Blood Pressure in Control measure is the fourth of 4 key indicators of quality health care. This measure assesses the percentage of continuously enrolled members with hypertension, ages 18-85 years, whose last recorded systolic blood pressure was less than 140 mm/Hg and whose last recorded diastolic blood pressure was less than 90 mm/Hg.

The Blueprint includes performance-based payments to encourage providers to participate in population and community health improvement initiatives with the goal of greater collaboration. These are key indicators that are in alignment with

the All Payer Model core quality measures. Improvements in these areas are indicative of an evolving and improving system of care.

The trend line above suggests an opportunity for improvement given that the data is not moving in the right direction. The Blueprint implemented the pay for performance model on this measure in July 2015. This measure was chosen for payment because it reflected a priority of each of the provider networks (ACOs) in Vermont, it could be generated at the Health Service Area level using Vermont's centralized data source without any need for additional data collection or reporting by providers, it was tied to prevalent underlying health concerns involving complex medical and social determinants, and it could be improved through better coordination, outreach, and transitions between medical and non-medical providers. The Blueprint for Health, in conjunction with the Vermont Department of Health, OneCareVT, SASH, New England QIN-QIO, CHAC, and VPQHC, has launched a 6-month long peer-learning community to support practices in implementing key strategies to improve blood pressure control in patients with hypertension. In the peer-learning community, we have bought together expert faculty to provide a dynamic learning environment and provided practices the opportunity to learn from peers and have quality improvement coaching support.

*Last updated: 08/31/17*

*Author: Blueprint for Health*

## Actions

| Name | Assigned To | Status | Due Date | Progress |
|---|---|---|---|---|

# P COB Coordination of Benefits Unit

## Budget Information

## What We Do

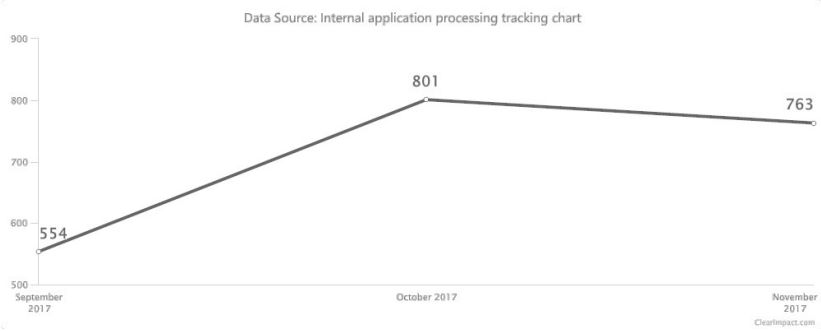
**The Coordination of Benefits (COB) Unit** works to coordinate benefit and collection practices with providers, members, and other insurance companies to ensure that Medicaid is the payer of last resort. COB is responsible for Medicare Part D casework including claims processing assistance, coverage 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.

## Who We Serve

## How We Impact

### Performance Measures

| | Time Period | Actual Value | Target Value | Current Trend | Baseline % Change |
|---|---|---|---|---|---|
| PM COB # of Vpharm 201P applications processed monthly by COB | Nov 2017 | 763 | – | ↘ 1 | 38% ↑ |
| | Oct 2017 | 801 | – | ↗ 1 | 45% ↑ |
| | Sep 2017 | 554 | – | → 0 | 0% → |




Notes on Methodology

| ***Applications Processed by COB*** | **Sep 2017** | **Oct 2017** | **Nov 2017** | **Dec 2017** | **Jan 2018** | **Feb 2018** |
|---|---|---|---|---|---|---|
| **# Applications Completed** | 527 | 760 | 722 | | | |
| **# Applications Pended** | 27 | 41 | 41 | | | |
| **Total # Applications** | 554 | 801 | 763 | | | |

Partners

- Health Access Eligibility & Enrollment Unit (HAEEU)
- OnBase (document processing)
- AHS Policy Unit
- Centers for Medicare & Medicaid Services (CMS)
- Social Security Administration (SSA)

Story Behind the Curve

This measure will show how many 201P applications are processed on a monthly basis by the COB Unit, and whether they are completed or pended due to incomplete information.

Vpharm eligibility is determined by members completing either the 1) Vpharm application (201P) or 2) Medicaid application (202MED).

- **If only the 201P Vpharm application is received, the Coordination of Benefit (COB) staff process it.**
- If both the 201P Vpharm mixed household application and 202MED applications are received, HAEEU staff process them.

This measure looks at **201P Vpharm** applications put into the Coordination of Benefit (COB) Unit's working que in OnBase by the Application Data Processing Center (ADPC). The COB Unit has 3 employees with access to OnBase and who have the ability to work these applications. Counts are systematically tracked in OnBase, a reporting tool and calculated monthly.

If an application is found to be incomplete (not worked) due to missing information, a notice is sent to the applicant requesting information and an extra 30 days is given to respond. Members that are given this extra time to follow up with requested information are tracked manually for measure purposes but there are system edits to either complete or close the application.

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*Last updated: 12/15/17*

*Author: Coordination of Benefits Unit*

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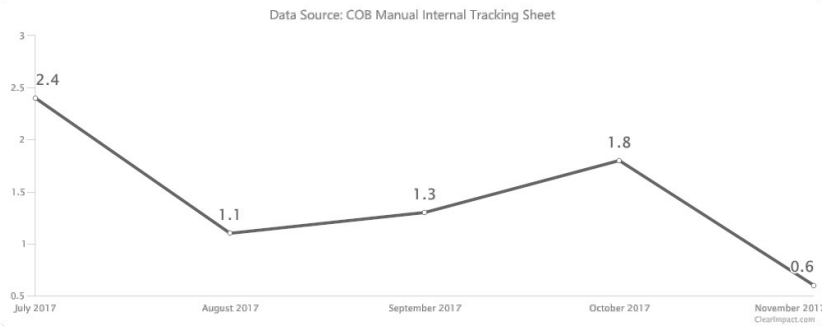
PM COB Average # of business days to respond to an attorney's request for information




| | | | | |
|---|---|---|---|---|
| Nov 2017 | 0.6 | – | ↘ 1 | -75% ↓ |
| Oct 2017 | 1.8 | – | ↗ 2 | -25% ↓ |
| Sep 2017 | 1.3 | – | ↗ 1 | -46% ↓ |
| Aug 2017 | 1.1 | – | ↘ 1 | -54% ↓ |
| Jul 2017 | 2.4 | – | → 0 | 0% → |

Partners

- Medicaid Beneficiaries
- Attorneys

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Story Behind the Curve

State of Vermont Legislation passed Title 33 VSA 1910 (amended) which enhances the ability to collect from third party payers by establishing procedures which third party payers must adhere to in the State of Vermont. Attorneys representing clients that are Vermont Medicaid members must follow Vermont Statute 33 V.S.A. § 1910: Liability of third parties; liens: "*(c) A recipient who has applied for or has received medical assistance under this subchapter and the recipient's attorney, if any, shall cooperate with the agency by informing the agency in writing within a reasonable period of time after learning that the agency has paid medical expenses for the recipient. The recipient's attorney shall take reasonable steps to discover the existence of the agency's medical assistance.*"

Attorneys outreach our Coordination of Benefits (COB) Casualty Recovery Team via phone, fax, email and snail mail to verify Medicaid coverage of their client and vice versa. This can begin with the client informing their attorney that they are covered by Medicaid, or by a returned Accident/Questionnaire, which states that the member has retained an attorney after a trauma related injury. Once the COB Unit receives an attorney's request for information, it has 45 days to respond. However, the goal has always been a timely and accurate response to all requests.

July 2017 results were a bit higher due to a couple of cases that had increased turn-around times. Sometime there are difficulties connecting with attorneys. Also, COB will not release information until a copy of an Authorization to Release Information form is received. This can increase the time to case closure.

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*Last updated: 12/15/17*

*Author: Coordination of Benefits Unit*

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PM COB % of insurance panels worked from data matching that were received during the month

| | | | | |
|---|---|---|---|---|
| Nov 2017 | 21.4% | – | ↗ 1 | 7% ↑ |
| Oct 2017 | 20.0% | – | → 0 | 0% → |


Notes on Methodology

| *Insurance Panels* | Oct 2017 | Nov 2017 |
|---|---|---|
| **Total # rows** | 9819 | 8811 |
| **Total rows # worked** | 1966 | 1883 |
| **% rows worked** | **20.0%** | **21.4%** |
| **# new panels** | 2740 | 2191 |
| **# updated panels** | 515 | 318 |
| **Total # panels worked** | **3255** | **2509** |

As rows of data are worked, they often need more than one panel worked in the ACCESS system. The chart above shows the number of rows of data worked, and the subsequent number of new and updated panels worked.

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Partners

- United Health Care (UHC)
- Blue Cross Blue Shield of Vermont (BCBSVT)

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Story Behind the Curve

Data matching uses data files required by State of Vermont Statute: 33 V.S.A. § 1908 Medicaid; payer of last resort:

(d) On and after July 1, 2016, an insurer shall accept the Agency's right of recovery and the assignment of rights and shall not charge the Agency or any of its authorized agents fees for the processing of claims or eligibility requests. *Data files requested by or provided to the Agency shall provide the Agency with eligibility and coverage information* that will enable the Agency to determine the existence of third-party coverage for Medicaid recipients, the period during which Medicaid recipients may have been covered by the insurer, and the nature of the coverage provided, including information such as the name, address, and identifying number of the plan.

These data files are "matched" with the insurance panels captured in the DVHA's ACCESS system. ACCESS is the repository of a member's insurance data and is transferred to the payment systems. An "insurance panel" is a screen within the systems that contains the member's policy and group numbers, for their primary insurance. This includes policy holder and family members covered. By matching the ACCESS system's information against data received from an insurer, DVHA is able to capture missing or incorrect information. When ACCESS is missing "other" insurance info, a provider's claim will be paid by Medicaid incorrectly. The correct information once added to ACCESS will re-direct a request for payment to the other insurer, and Cost Avoid any future claims. Currently, all updates to insurance screens "panels" in ACCESS resulting from data matching are manually done.

The Coordination of Benefits (COB) Unit currently receive between 2500 to 5000 lines of data per month from United Health Care. The unit has received test files from BCBSVT and is working to refine the matching process by the end of 2017. This process will then be used with MVP and Cigna, as they will be using the same data format as BCBSVT. The COB Unit does not have an exact estimate of how many data files will come in from BCBSVT, but anticipate a significant increase of data to match.

Correcting beneficiary's "other insurance" information, in part through 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, and maintains Medicaid as "payer of last resort". This is identified as Medicaid Cost Avoidance. The Medicaid Third Party Liability Cost Avoidance in 2017 was more than $130 Million, as stated data matching plays a part in this savings.

*Last updated: 12/15/17*

*Author: Coordination of Benefits Unit*

## Actions

| Name | Assigned To | Status | Due Date | Progress |
|---|---|---|---|---|

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

# P COU Clinical Operations Unit

## Budget Information

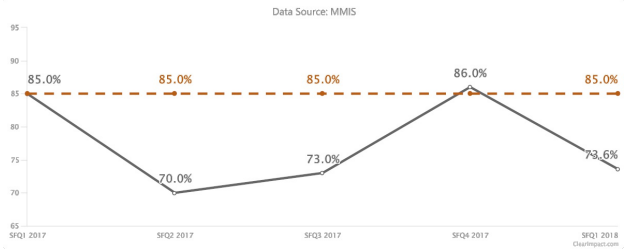
## What We Do

**The Clinical Operations Unit (COU)** monitors the quality, appropriateness, and effectiveness of healthcare services requested by providers for members. The COU 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.

## Who We Serve

## How We Impact

| Performance Measures | Time Period | Actual Value | Target Value | Current Trend | Baseline % Change |
|---|---|---|---|---|---|
| PM COU % of initial prior authorization requests that have a decision rendered within 3 days of receiving all necessary information | SFQ1 2018 | 73.6% | 85.0% | ↘ 1 | -13% ↓ |
| | SFQ4 2017 | 86.0% | 85.0% | ↗ 2 | 1% ↑ |
| | SFQ3 2017 | 73.0% | 85.0% | ↗ 1 | -14% ↓ |
| | SFQ2 2017 | 70.0% | 85.0% | ↘ 1 | -18% ↓ |
| | SFQ1 2017 | 85.0% | 85.0% | → 0 | 0% → |




Partners

- DXC contract staff
- Part time physician support
- Chief Medical Officer (CMO)

Story Behind the Curve

The Clinical Operations Unit (COU) staff determine the medical necessity of a service or product provided to its members using the prior authorization (PA) process. Medical necessity determinations are made using evidence-based clinical guidelines. PA decisions must be made within time frames specified in the Medicaid Rules and in Federal regulations.

The 3 day goal for a decision to be rendered is based on CMS rule. Reaching this goal is heavily dependent on having adequate staffing. The COU has had extended review time due to vacancies:

- Nurse out for 6 weeks due to injuries
- Chief Medical Officer position being vacant with only part time coverage
- Administrative vacancy

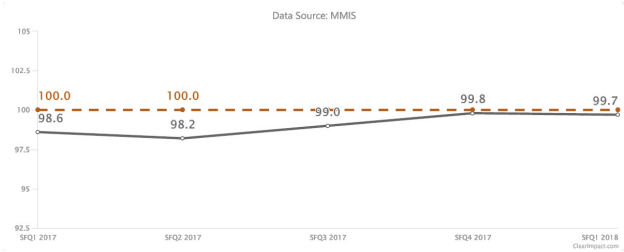
**This performance measure is important because it shows:**

- Timely access to treatment/services for members.
- Compliance with State and Federal Regulations.
- The PA turnaround times are reported to the External Quality Review Board (EQRO) and to KPMG, an auditing service that monitors the COU's regulatory compliance.

*Last updated: 10/31/17*

*Author: Clinical Operations Unit*

PM COU % of initial prior authorization requests closed out within 28 days




| | | | | | |
|---|---|---|---|---|---|
| SFQ1 2018 | 99.7 | 100.0 | ↘ | 1 | 1% ↑ |
| SFQ4 2017 | 99.8 | 100.0 | ↗ | 2 | 1% ↑ |
| SFQ3 2017 | 99.0 | 100.0 | ↗ | 1 | 0% → |
| SFQ2 2017 | 98.2 | 100.0 | ↘ | 1 | 0% → |
| SFQ1 2017 | 98.6 | 100.0 | → | 0 | 0% → |

Partners

- Part time physician support
- Chief Medical Officer (CMO)
- DXC contract staff
- DXC Provider Relations
- DVHA Provider Member Relations Unit
- DVHA Data Unit

- DVHA enrolled providers and vendors

---

Story Behind the Curve

The Clinical Operations Unit (COU) staff determine the medical necessity of a service or product provided to its members using the prior authorization (PA) process. Medical necessity determinations are made using evidence-based clinical guidelines. PA decisions must be made within time frames specified in the Medicaid Rules and in Federal regulations.

There is variation in this data that is out of the control of the COU. This data heavily relies on Medicaid providers sending sufficient clinical information so a complete clinical review and decision can be rendered.

The COU has had extended review time due to vacancies:

- Nurse out for 6 weeks due to injuries
- Chief Medical Officer position being vacant with only part time coverage.

This performance measure is important because it shows:

- Timely access to treatment/services for members
- Compliance with State and Federal Regulations
- The PA turnaround times are reported to the External Quality Review Board (EQRO) and to KPMG, an auditing service that monitors the COU's regulatory compliance

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*Last updated: 11/14/17*

*Author: Clinical Operations Unit*

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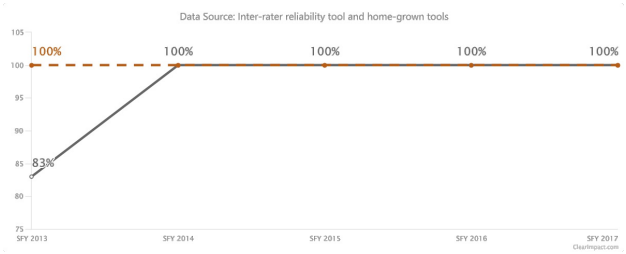
PM COU % of clinical staff with inter-rater reliability scores of 80% or higher




| | | | | | |
|---|---|---|---|---|---|
| SFY 2017 | 100% | 100% | → | 3 | 20% ↑ |
| SFY 2016 | 100% | 100% | → | 2 | 20% ↑ |
| SFY 2015 | 100% | 100% | → | 1 | 20% ↑ |
| SFY 2014 | 100% | 100% | ↗ | 1 | 20% ↑ |
| SFY 2013 | 83% | 100% | → | 0 | 0% → |

Partners

- Change Healthcare

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Story Behind the Curve

Inter-rater reliability (IRR) assessments are conducted on each of the clinical content areas, on an annual basis. They are performed to determine the uniform application of review criteria, confirm consistent clinical determinations are made by review staff and to ensure that the COU is in compliance with Federal and State Regulations.

The COU utilizes IRR tests created by Change Healthcare for the following:

- Durable Medical Equipment (DME)
- Acute Care – Adults
- Acute Care – Pediatric
- Outpatient Rehabilitation and Chiropractic
- Procedures

The COU has created IRR tests for administrative staff and for dental staff as these are not available from Change Healthcare.

The low score in 2013 was based on the subpar performance of one staff member. This staff had an extraordinary amount of one on one training, which still not help them become successful. This staff is no longer part of the COU.

**This measure is important to:**

- Determine the uniform application of review criteria
- Confirm that consistent clinical determinations are made by review staff
- Ensure that the COU is in compliance with the Code of Federal Regulations (CFR):§438.210 Coverage and authorization of services (b)(2)(i) "Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions;" §438.236 Practice guidelines (d) *Application of guidelines*. "Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines."

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*Last updated: 10/31/17*

*Author: Clinical Operations Unit*

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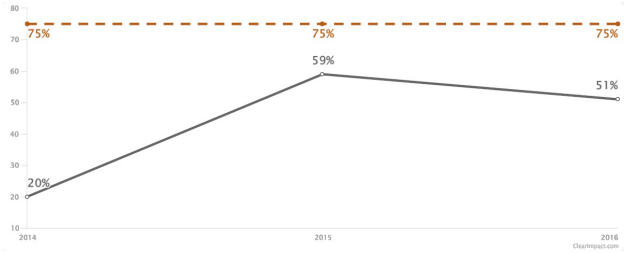
PM COU % of "homegrown" clinical criteria reviewed annually




| | | | | | |
|---|---|---|---|---|---|
| 2016 | 51% | 75% | ↘ | 1 | 155% ↑ |
| 2015 | 59% | 75% | ↗ | 1 | 195% ↑ |
| 2014 | 20% | 75% | → | 0 | 0% → |

Partners

- Part time physician support
- Chief Medical Officer (CMO)
- DXC contract staff

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Story Behind the Curve

DVHA Clinical Operations Unit (COU) purchases clinical criteria from Change Healthcare. The purchased criteria does not contain criteria for all the procedures that Medicaid covers, therefore COU staff research and develop "homegrown" criteria. Staff utilize Vermont State Medicaid Rules; Hayes and Cochrane (Peer review journal libraries); and other nationally recognized evidence based criteria). Also, some of the purchased criteria is not strong enough to support state policies. In these cases, staff create supplemental criteria that are used in conjunction with the purchased criteria.

It is important to know that the COU does not have dedicated staff to research and develop these criteria. This is an additional task added to the Utilization Review Nurses role. When a criteria is completed, it is then reviewed by the Nurse Administrator II, the Nursing Operations Director, and then reviewed and approved by the Chief Medical Officer.

The data is not strong for several reasons:

- The COU does not have dedicated staff to do this work
- Staff vacancies which has included the following:
    - In 2014, the COU had 2 nurses retire which significantly decreased work efficiency and therefore the ability to work on clinical criteria
    - In 2017, the COU has already experienced the following vacancies:
        - Administrative staff (which requires the nursing staff to help in this role to keep the COU work flow going)
        - Nurse out for 6 weeks due to injuries
        - Vacant nurse position
        - Chief Medical Officer position being vacant with only part time coverage

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*Last updated: 08/10/17*

*Author: Clinical Operations Unit*

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## Actions

| Name | Assigned To | Status | Due Date | Progress |
|---|---|---|---|---|

# P DATA Data Management & Integrity Unit

## Budget Information

## What We Do

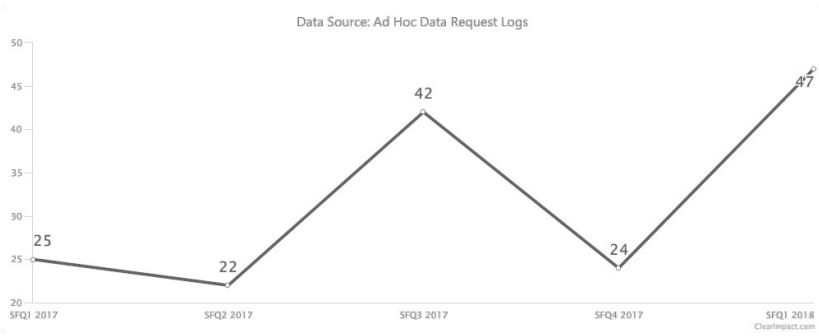
**The Data Management and Integrity Unit** provides data analysis, distribution of Medicaid data extracts, reporting to state agencies, the legislature, and other stakeholders and vendors. It also delivers mandatory federal reporting to the Centers for Medicare and Medicaid Services (CMS), develops the 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.

## Who We Serve

## How We Impact

### Performance Measures

| | Time Period | Actual Value | Target Value | Current Trend | Baseline % Change |
|---|---|---|---|---|---|
| PM DATA # of ad hoc data requests completed | SFQ1 2018 | 47 | – | ↗ 1 | 88% ↑ |
| | SFQ4 2017 | 24 | – | ↘ 1 | -4% ↓ |
| | SFQ3 2017 | 42 | – | ↗ 1 | 68% ↑ |
| | SFQ2 2017 | 22 | – | ↘ 1 | -12% ↓ |
| | SFQ1 2017 | 25 | – | → 0 | 0% → |




Partners

- Agency of Human Services Central Office
- Vermont Department of Health Alcohol & Drug Abuse Program
- Vermont Department of Health Oral Health Program
- Green Mountain Care Board
- OneCare Vermont
- Joint Fiscal Office
- Clinical Utilization Review Board
- DVHA Business Office
- DVHA Clinical Operations Unit
- DVHA Coordination of Benefits Unit
- DVHA Policy Unit
- DVHA Provider & Member Relations Unit
- DVHA Payments Reform Unit
- DVHA Quality Unit
- Vermont Health Connect

Story Behind the Curve

Number of ad hoc data requests completed by the Data Unit.

As a support entity within the department responsible for the development of information resources required for effective policy making, planning, regulation and evaluation for the state's Medicaid program it is important to know how often the Data Unit is asked and relied on to provide data analysis to support ongoing policy

development and implementation of Medicaid programs.  Requests come into the Data Unit from various program staff in DVHA and sister departments in the Agency on any given day.

*Author:  Data Management & Integrity Unit*

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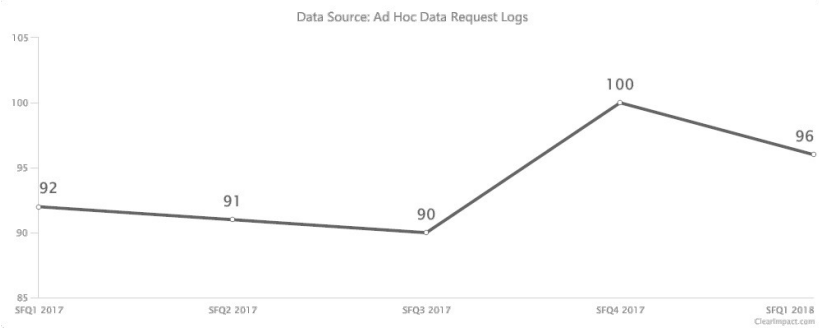
PM DATA % of ad hoc data requests completed on time




| | | | | |
|---|---|---|---|---|
| SFQ1 2018 | 96% | – | ↘ 1 | 4% ↑ |
| SFQ4 2017 | 100% | – | ↗ 1 | 9% ↑ |
| SFQ3 2017 | 90% | – | ↘ 2 | -2% ↓ |
| SFQ2 2017 | 91% | – | ↘ 1 | -1% ↓ |
| SFQ1 2017 | 92% | – | → 0 | 0% → |

Partners

- Agency of Human Services Central Office
- Vermont Department of Health Alcohol & Drug Abuse Program
- Vermont Department of Health Oral Health Program
- Green Mountain Care Board
- OneCare Vermont
- Joint Fiscal Office
- Clinical Utilization Review Board
- DVHA Business Office
- DVHA Clinical Operations Unit
- DVHA Coordination of Benefits Unit
- DVHA Policy Unit
- DVHA Provider & Member Relations Unit
- DVHA Payments Reform Unit
- DVHA Quality Unit
- Vermont Health Connect

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Story Behind the Curve

Percent of ad hoc data requests completed on time by the Data Unit.

As a support entity within the department responsible for the development of information resources required for effective policy making, planning, regulation and evaluation for the state's Medicaid program it is important to know how often the Data Unit is asked and relied on to provide data analysis to support ongoing policy development and implementation of Medicaid programs.

Requests come into the Data Unit from various program staff in DVHA and sister departments in the Agency on any given day. ASAP requests are assigned a 2 business day turn around time. As an example, if an ASAP request comes in on Monday, it is assigned a due date of Wednesday. Other requests that are not ASAP are assigned a 10 business day turn around time.

*Last updated:  10/31/17*

*Author:  Data Management & Integrity Unit*

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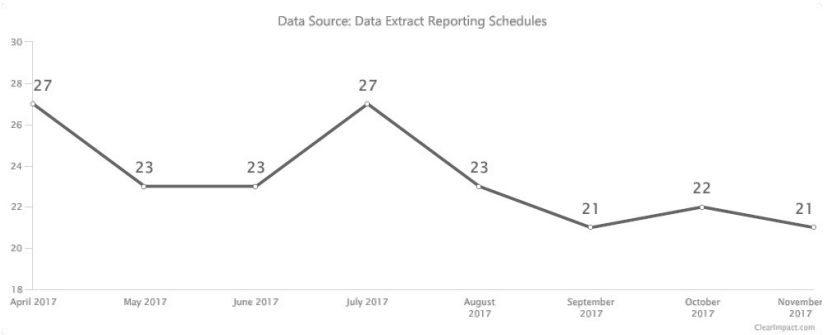


| | | | | | |
|---|---|---|---|---|---|
| | | | | 1 | |
| Jun 2017 | 23 | – | → | 1 | 0% → |
| May 2017 | 23 | – | ↘ | 2 | 0% → |
| Apr 2017 | 27 | – | ↘ | 1 | 17% ↑ |
| Mar 2017 | 31 | – | ↗ | 1 | 35% ↑ |
| Feb 2017 | 27 | – | → | 1 | 17% ↑ |

Partners

- Agency of Human Services Central Office
- Burns & Associates
- Centers for Medicare & Medicaid Services
- DVHA Business Office
- eQ Health Systems
- Onpoint Health
- OneCare Vermont

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Story Behind the Curve

Number of data extracts/required reporting deliverables completed by the Data Unit.

As a support entity within the department responsible for the development of information resources required for effective policy making, planning, regulation and evaluation for the state's Medicaid program it is important to know how often the Data Unit is asked and relied on to provide data analysis to support ongoing policy development and implementation of Medicaid programs.

The Data Unit routinely completes ad hoc data requests, receives and provides data extracts (files) to and from contracted business partners to support department initiatives and complementary data systems, and regularly provides mandated reporting to state and federal entities.

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*Last updated: 12/15/17*

*Author: Data Management & Integrity Unit*

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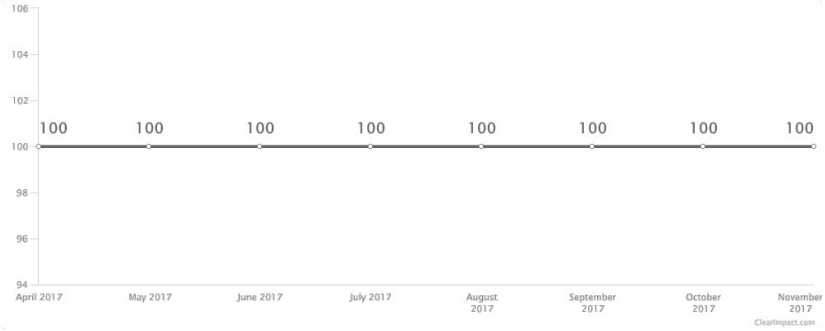
PM DATA % of required federal and state reporting initiatives completed on time




| | | | | | |
|---|---|---|---|---|---|
| Nov 2017 | 100% | – | → | 17 | 0% → |
| Oct 2017 | 100% | – | → | 16 | 0% → |
| Sep 2017 | 100% | – | → | 15 | 0% → |
| Aug 2017 | 100% | – | → | 14 | 0% → |
| Jul 2017 | 100% | – | → | 13 | 0% → |
| Jun 2017 | 100% | – | → | 12 | 0% → |
| May 2017 | 100% | – | → | 11 | 0% → |
| Apr 2017 | 100% | – | → | 10 | 0% → |
| Mar 2017 | 100% | – | → | 9 | 0% → |
| Feb 2017 | 100% | – | → | 8 | 0% → |

Partners

- Agency of Human Services Central Office

- Burns & Associates
  Centers for Medicare & Medicaid Services
  DVHA Business Office
  eQ Health Systems
- Onpoint Health
- OneCare Vermont

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Story Behind the Curve

Percent of data extracts/required reporting deliverables completed by the Data Unit prior to or on the due date.

As a support entity within the department responsible for the development of information resources required for effective policy making, planning, regulation and evaluation for the state's Medicaid program it is important to know how often the Data Unit is asked and relied on to provide data analysis to support ongoing policy development and implementation of Medicaid programs.

The Data Unit routinely completes ad hoc data requests, receives and provides data extracts (files) to and from contracted business partners to support department initiatives and complementary data systems, and provides mandated reporting to state and federal entities.

*Last updated: 12/15/17*

*Author: Data Management & Integrity Unit*

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## Actions

| Name | Assigned To | Status | Due Date | Progress |
|---|---|---|---|---|

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

# P HAEEU Healthcare Access, Eligibility & Enrollment Unit (HAEEU)

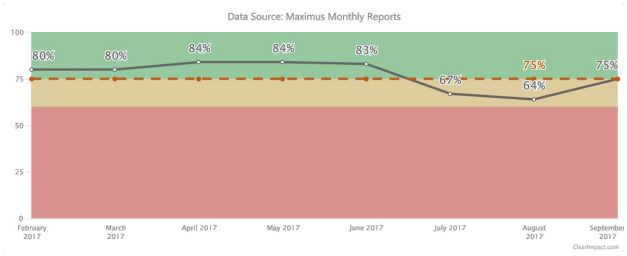
## What We Do

**The Health Access Eligibility and Enrollment Unit (HAEEU)** is responsible for eligibility and enrollment in Vermont's health care programs through Vermont Health Connect and Green Mountain Care. Vermont Health Connect includes MAGI-based Medicaid, Dr. Dynasaur, and Qualified Health Plans (QHP) including federal and state-based financial assistance. Green Mountain Care includes Medicaid for the Aged, Blind and Disabled, VPharm, and the Medicare Savings Programs. HAEEU is comprised of the following teams:

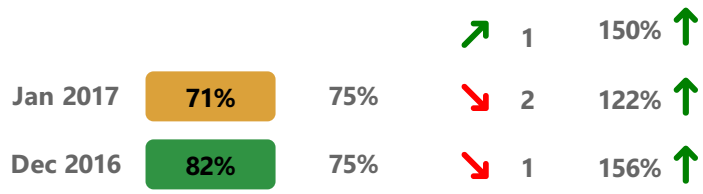
- Tier 2 Call Center - Determines applicant eligibility for health care programs and provide ongoing customer service to Vermonters enrolled in these programs.
- Tier 3 Call Center - Handles complex case resolution including extensive interaction with customers and ongoing customer service.
- Fair Hearing - Provides investigative research and support of eligibility appeals.
- Enrollment - Monitors the integrity, accuracy, and timeliness of transactions between the State's Case Management System, billing system, QHP issuers, and ACCESS. This team includes premium processing which researches and addresses customer and reconciliation issues related to premiums and the processing of payments.
- Training/Business Processes - Facilitates the learning and professional development of the organization's workforce through proper training.
- Workflow - Identifies resource needs and manages the assignment of resources. Staff are responsible for the development and utilization of consequent workflow forecasts to provide proactive staffing planning, as well as for day to day operational reporting.

## Performance Measures

PM HAEEU % of Calls Answered < 24 seconds




| Time Period | Actual Value | Target Value | Current Trend | Baseline % Change |
|---|---|---|---|---|
| Sep 2017 | 75% | 75% | ↗ 1 | 134% ↑ |
| Aug 2017 | 64% | 75% | ↘ 3 | 100% ↑ |
| Jul 2017 | 67% | 75% | ↘ 2 | 109% ↑ |
| Jun 2017 | 83% | 75% | ↘ 1 | 159% ↑ |
| May 2017 | 84% | 75% | → 1 | 163% ↑ |
| Apr 2017 | 84% | 75% | ↗ 1 | 163% ↑ |
| Mar 2017 | 80% | 75% | → 1 | 150% ↑ |
| Feb 2017 | 80% | 75% | | |




Partners

DVHA-HAEEU's Tier 1 Customer Support Center is contracted through Maximus. Vermonters who need to apply for health benefits can call the Customer Support Center, as can members who need to ask questions or report changes to their accounts. A Service Level Agreement (SLA) in the contract between DVHA and Maximus calls for Maximus to receive a performance bonus for any months in which they answer at least 75% of calls within 24 seconds and have an abandoned rate of no more than 5.0%. It also calls for a financial penalty if fewer than 60% of calls are answered within 24 seconds. Tier 2 Customer Support is run directly by DVHA, handling eligibility-related questions and other escalations.

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Story Behind the Curve

DVHA-HAEEU's contracted Customer Support Center has largely performed well in relation to its primary performance metrics since fall 2016. Prior to this period, members faced significant frustration and inefficiencies during much of the spring and summer of 2016 as the Burlington call center struggled to handled call volume related to Medicaid renewals. In early August 2016, the State worked with Maximus on a turn-around plan that included opening an overflow call center in Chicago. By late September, overflow staff had been trained and onboarded and performance dramatically improved.

The Customer Support Center earned their performance bonus in the first two months of 2017 Open Enrollment (November and December 2016) and just missed in January. With nearly 150,000 calls received over the three months of Open Enrollment, eight in ten (79%) calls were answered within 24 seconds, and the abandoned rate was 3.6% (performance targets are 75% answered within 24 seconds and a 5.0% abandoned rate). The average speed of answer was less than two minutes, more than twice as fast as the previous year’s Open Enrollment.

Call volume dipped after Open Enrollment and the Customer Support Center's strong performance continued. By July 2017 incoming call volume hit its lowest level since the 2013 launch of Vermont's health exchange as increasing numbers of Medicaid members were able to be renewed automatically and thus didn't need to call, Qualified Health Plan members had fewer reasons to call as Open Enrollment and tax season had passed, and improved system performance and work processing levels reduced the need for members to call multiple times to follow up on their requests.

As of July, Maximus had met their performance target in eight of the previous nine months. Unfortunately, their staffing then dipped in the summer and the Customer Support Center missed their target in July and August. In early August, DVHA-HAEEU asked Maximus to provide a corrective action plan that would be discussed on a weekly call, including reports on hiring progress and contingency planning. Twenty new staff members finished training and joined the phones in late August with more hiring cohorts coming on board in September and October. Maximus met their performance targets in September 2017.

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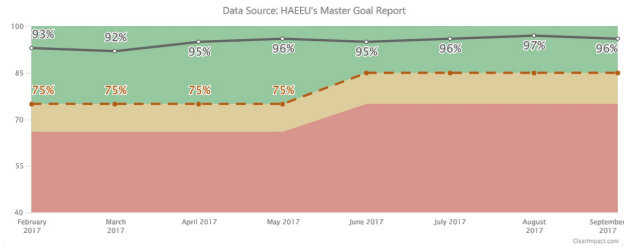
PM HAEEU % of Customer Requests Resolved in 10 Business Days




| | | | | |
|---|---|---|---|---|
| Sep 2017 | 96% | 85% | ↘ 1 | 92% ↑ |
| Aug 2017 | 97% | 85% | ↗ 2 | 94% ↑ |
| Jul 2017 | 96% | 85% | ↗ 1 | 92% ↑ |
| Jun 2017 | 95% | 85% | ↘ 1 | 90% ↑ |
| May 2017 | 96% | 75% | ↗ 2 | 92% ↑ |
| Apr 2017 | 95% | 75% | ↗ 1 | 90% ↑ |
| Mar 2017 | 92% | 75% | ↘ 1 | 84% ↑ |
| Feb 2017 | 93% | 75% | ↗ 1 | 86% ↑ |
| Jan 2017 | 90% | 75% | ↘ 1 | 80% ↑ |
| Dec 2016 | 92% | 75% | → 1 | 84% ↑ |

Story Behind the Curve

This metric measures the speed at which customer requests are processed. It includes requests related to Qualified Health Plan (QHP) and MAGI-Medicaid members in the Vermont Health Connect (VHC) system as well as those related to Medicaid for the Aged, Blind and Disabled (MABD) members in Green Mountain Care (GMC) programs in the State's legacy ACCESS system.

All Vermonters who are served by DVHA-HAEEU should expect that their requests will be addressed promptly. And yet, for the first few years of VHC, many requests took several weeks or months to complete. In the first quarter of 2016, fewer than 60% of requests were completed within ten business days. That spring HAEEU set a goal of completing 75% of customer requests within ten business days by October 2016 and 85% by June 2017.

In March 2016, the State of Vermont and VHC Systems Integrator Optum deployed their final major release to enable the processing of Medicaid renewals. With the completion of major system development work, the teams no longer had to manage continual cycles of major code changes. Instead they could focus

on identifying and remediating defects and making process improvements within a stable system. This effort came to be known as the Maintenance and Operations (M&O) Surge. The M&O Surge began in March 2016 and continued into the summer of 2016.

The results of the M&O Surge were clearly visible by late spring 2016. Escalated case inventories fell 80% from March levels. Integration errors were also cut 80%. Customer requests were processed in an increasingly timely manner.

In June 2016, HAEEU surpassed its October goal of completing 75% of requests in ten business days. In October 2016, they surpassed their June 2017 goal of 85%. Over the following months, performance continued to improve. With the 2017 QHP Open Enrollment and Renewal Period's successful completion, system integration improved over prior years and errors fell. As a result, customer requests were promptly completed on a more consistent basis.

The second week of March 2017 marked the first time that 95% of VHC requests were completed in ten days. Every subsequent week through the time of this writing (October 2017) then surpassed that mark. GMC requests have not had quite the same level of consistently strong performance as VHC requests over that time, yet the combined average for every month since April 2017 has been at least 95%.

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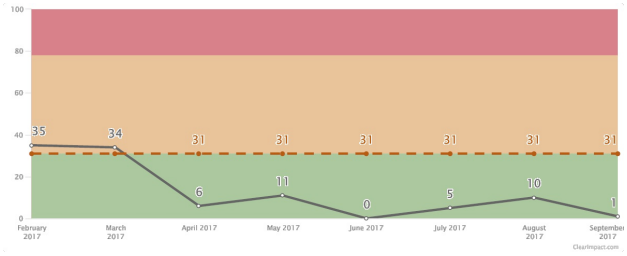
PM HAEEU # of VHC-Carrier Errors >10 Days Old




| | | | | |
|---|---|---|---|---|
| Sep 2017 | 1 | 31 | ↘ 1 | -100% ↓ |
| Aug 2017 | 10 | 31 | ↗ 2 | -96% ↓ |
| Jul 2017 | 5 | 31 | ↗ 1 | -98% ↓ |
| Jun 2017 | 0 | 31 | ↘ 1 | -100% ↓ |
| May 2017 | 11 | 31 | ↗ 1 | -96% ↓ |
| Apr 2017 | 6 | 31 | ↘ 2 | -98% ↓ |
| Mar 2017 | 34 | 31 | ↘ 1 | -87% ↓ |
| Feb 2017 | 35 | 31 | ↗ 1 | -87% ↓ |
| Jan 2017 | 17 | 31 | ↘ 4 | -94% ↓ |
| Dec 2016 | 25 | – | ↘ 3 | -91% ↓ |

Partners

DVHA-HAEEU partners with its three carrier partners (BlueCross BlueShield of Vermont, MVP Healthcare, and Northeast Delta Dental) as well as the State's systems integrator (Optum) to send new customer cases and changes to cases from the State's system to the partners' systems. Integration teams at DVHA-

HAEEU and the partners work together to clean up errors, identify the root cause of defects that cause errors, and deploy fixes to defects to reduce the occurrence of errors in the future.

---

Story Behind the Curve

This metric measures the inventory of integration errors between the State of Vermont's system and the insurance carriers' systems that have been open more than ten days as of the last Thursday of every month.

The State's system is the system of record for Qualified Health Plans (QHPs) and dental plans, while the insurance carriers' systems ensure that providers and pharmacies can see coverage and bill for service. In order to deliver a smooth customer experience, changes that are made to customers' accounts must promptly be integrated across systems, and errors that do occur must be resolved in a timely manner in order to avoid customer impact.

And yet, for the first few years of the Vermont's health insurance exchange, DVHA-HAEEU lacked the ability to resolve many errors through the system. Hundreds of cases lingered in error status for weeks at a time, resulting in billing problems, customer confusion, and Access-to-Care escalations.

In March 2016, the State and VHC Systems Integrator Optum deployed their final major release to enable the processing of Medicaid renewals. With the completion of major system development work, the teams no longer had to manage continual cycles of major code changes. Instead they could focus on identifying and remediating defects and making process improvements within a stable system. This effort came to be known as the Maintenance and Operations (M&O) Surge. The M&O Surge began in March 2016 and continued into the summer of 2016.

The results of the M&O Surge were clearly visible by late spring 2016. Escalated case inventories fell 80% from March levels. Integration errors were also cut 80%. Progress continued into the fall.

For 2017, DVHA-HAEEU set a goal of having less than one-tenth of one percent of cases sit in error status for more than ten days. With more than 31,000 subscriber cases across the three carriers, that equates to an inventory of 31 or fewer errors open more than ten days.

After just missing the target in February and March 2017, DVHA-HAEEU has exceeded the goal for six consecutive months.

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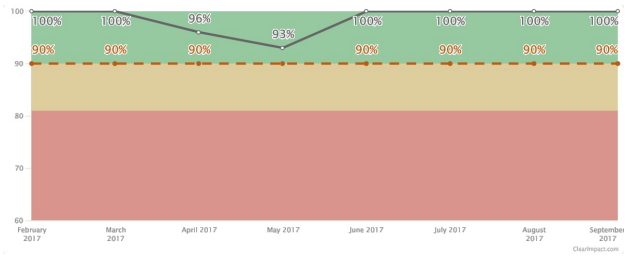
| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| PM | HAEEU | % of Discrepancy Work Completed in 30 Days | Sep 2017 | 100% | 90% | → | 3 | 0% → |




| | | | | |
|---|---|---|---|---|
| Aug 2017 | 100% | 90% | → 2 | 0% → |
| Jul 2017 | 100% | 90% | → 1 | 0% → |
| Jun 2017 | 100% | 90% | ↗ 1 | 0% → |
| May 2017 | 93% | 90% | ↘ 2 | -7% ↓ |
| Apr 2017 | 96% | 90% | ↘ 1 | -4% ↓ |
| Mar 2017 | 100% | 90% | → 1 | 0% → |
| Feb 2017 | 100% | 90% | → 0 | 0% → |

Partners

DVHA-HAEEU partners with its three carrier partners (BlueCross BlueShield of Vermont, MVP Healthcare, and Northeast Delta Dental) as well as its premium processing contractor (Wex Health).

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Story Behind the Curve

This metric looks at the number of discrepancies between the State's system and the systems of its carrier partners that are identified and should be worked within 30 days, then evaluates how many of those items actually are worked within the month.

The ability to perform ongoing monthly reconciliation between the State's system and the systems of its carrier partners is essential to maintaining data integrity, ensuring a positive customer experience, and limiting financial liabilities. If the State and its partners can identify discrepancies that arise and address the vast majority (>90%) of those discrepancies within the month, they will be in a strong position to avoid lingering inventories and the accompanying risks.

False positives and items related to the timing of reports are screened out. MVP Health Care needs to improve the quality of its reports in order to enable reconciliation, which will be a priority after its new integration vendor is successfully in place in fall 2017.

In October 2017, the reconciliation team reported that it had completed 100% of September discrepancy work -- all with the Blue Cross Blue Shield of Vermont and Northeast Delta Dental systems -- within 30 days, surpassing the 90% goal for the eighth straight month. In addition, the number of new discrepancies continued to fall, leaving the team with the shortest work list of the year to complete by November.

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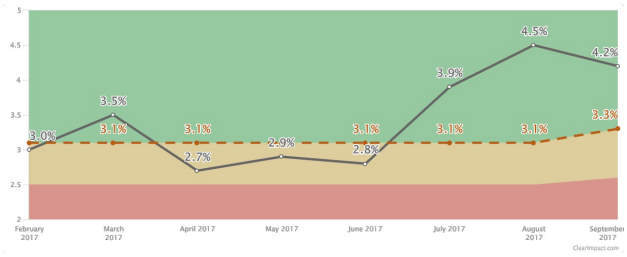
| | | | | | |
|---|---|---|---|---|---|
| PM | HAEEU | Self-Serve Change Requests (as % of total requests) | Sep 2017 | 4.2% | 3.3% |




| | | | | | |
|---|---|---|---|---|---|
| | 1 | 320% | | | |
| Aug 2017 | 4.5% | 3.1% | ↗ | 2 | 350% ↑ |
| Jul 2017 | 3.9% | 3.1% | ↗ | 1 | 290% ↑ |
| Jun 2017 | 2.8% | 3.1% | ↘ | 1 | 180% ↑ |
| May 2017 | 2.9% | 3.1% | ↗ | 1 | 190% ↑ |
| Apr 2017 | 2.7% | 3.1% | ↘ | 1 | 170% ↑ |
| Mar 2017 | 3.5% | 3.1% | ↗ | 1 | 250% ↑ |
| Feb 2017 | 3.0% | 3.1% | ↘ | 1 | 200% ↑ |
| Jan 2017 | 5.0% | 3.1% | ↗ | 3 | 400% ↑ |
| Dec 2016 | 4.6% | – | ↗ | 2 | 360% ↑ |

Partners

DVHA-HAEEU works with partners across the state, including libraries, clinics, and community organizations in HAEEU's Assister Program to encourage Vermonters to set-up online accounts with Vermont Health Connect and then use those accounts to access their documents and report changes.

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Story Behind the Curve

This metric measures the percentage of Vermont Health Connect (VHC) change requests that members make online themselves, as opposed to calling and talking to a Customer Support Representative.

The VHC system offers self-service options for Vermonters to pay their bills, report changes, and access tax documents and other forms. Self-service can lead to an improved customer experience as Vermonters can log in at their convenience. It can also save the State money through automation. The goal is for a continual increase in self-service adoption at a rate of at least 10% growth year-over-year.

The percentage of new VHC applications submitted via the online self-serve option has increased more than 50% year-over-year, from 29% in August 2016 to 44% in August 2017. The percentage of change requests made via the self-serve option has also increase more than 50%, from 2.7% in August 2016 to 4.5% in August 2017. Nonetheless, with the vast majority of change requests continuing to be made over the phone, more work needs to be done to increase the uptake of self-serve as an alternative to the call center for reporting changes to income and other household information.

In 2017, DVHA-HAEEU has promoted self-serve using bill stuffers, call center staff and partner organizations, and social media. During 2018 Open Enrollment, DVHA-HAEEU will promote the self-serve option in email, postcards, and other direct outreach.

Members who receive Medicaid for the Aged, Blind and Disabled and other non-MAGI benefit programs are served by the State's legacy ACCESS system and cannot currently utilize self-service options.

## Actions

| Name | Assigned To | Status | Due Date | Progress |
|---|---|---|---|---|

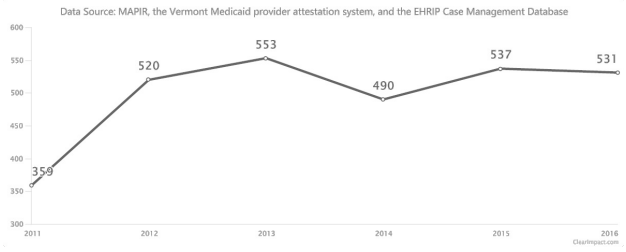
VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

P DVHA HIE & HIT Unit

## What We Do

## Performance Measures

| | Time Period | Actual Value | Target Value | Current Trend | Baseline % Change |
|---|---|---|---|---|---|
| PM HIE/HIT # of providers receiving a Vermont Medicaid Electronic Health Record Incentive Program (EHRIP) payment | 2016 | 531 | – | ↘ 1 | 48% ↑ |
| | 2015 | 537 | – | ↗ 1 | 50% ↑ |
| | 2014 | 490 | – | ↘ 1 | 36% ↑ |
| | 2013 | 553 | – | ↗ 2 | 54% ↑ |
| | 2012 | 520 | – | ↗ 1 | 45% ↑ |
| | 2011 | 359 | – | → 0 | 0% → |




Notes on Methodology

- This measure has no polarity because as more providers achieve their maximum six years of eligibility for payment, the number of payments each year will decrease.

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Partners

- The MAPIR 14-state Collaborative: System design and development; HITECH policy consultation; technical support
- DXC: Vendor technical partner for system integration with MMIS, system deployment and technical support
- Vermont Information Technology Leaders (VITL): Education and outreach support

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Story Behind the Curve

Providers receive an Electronic Health Record Incentive Program (EHRIP) payment for meeting acquisition and meaningful use standards for Certified Electronic Health Record (EHR) systems.

The EHRIP program was established by the 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act of the American Recovery & Reinvestment Act (ARRA). The program is designed to support providers during the period of health information technology transition and to improve the quality, safety and efficiency of patient health care through the use of EHRs.

The EHRIP provides incentive payments to Eligible Hospitals and to clinicians who are designated by CMS as Eligible Professionals as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology.

The Vermont Medicaid Electronic Health Record Incentive Program started issuing payments to providers for Program Year 2011, and will be issuing payments to through Program Year 2021. Eligible Hospitals can receive one payment per year for up to three years. Eligible Professionals (EPs) can receive one payment per year for up to 6 years. Not every provider can meet program requirements each year. EPs may skip a year of participation and resume in subsequent years.

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*Last updated: 10/31/17*

*Author: HIE-HIT Unit*

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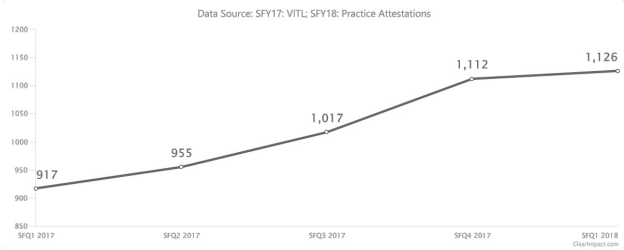
PM | HIE/HIT

# of practices contributing clinical data to the Vermont Health Information Exchange (VHIE) network




| | | | | |
|---|---|---|---|---|
| SFQ1 2018 | 1,126 | – | ↗ 4 | 23% ↑ |
| SFQ4 2017 | 1,112 | – | ↗ 3 | 21% ↑ |
| SFQ3 2017 | 1,017 | – | ↗ 2 | 11% ↑ |
| SFQ2 2017 | 955 | – | ↗ 1 | 4% ↑ |
| SFQ1 2017 | 917 | – | → 0 | 0% → |

Notes on Methodology

- VITL's goal for SFY18 is to establish 120 new interfaces. The state has contracted with VITL to remediate or create up to 85 interfaces.

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Story Behind the Curve

The Vermont Health Information Exchange (VHIE) exists to aggregate clinical data to support providers at the point of care and those measuring the population's health and the cost of health care. The mechanism for obtaining the clinical data is

an interface (technical connection) between an electronic health record system and the VHIE. Since 2009, the state has funded VITL to develop these interfaces and the VHIE to aggregate the clinical data documented in medical records.

The sharing of clinical data is essential to improving health care quality, making care more efficient, reducing administrative burden, engaging patients in their care, and supporting the health and well-being of the Vermont community. As more practices contribute to exchange data, the better able providers are to care for patients.

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*Last updated: 10/31/17*

*Author: HIE-HIT Unit*

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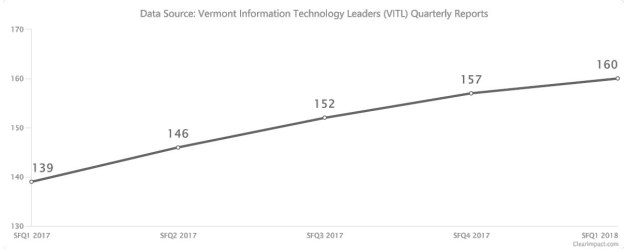
PM

HIE/HIT

# of providers gaining access to their patients' data through the Vermont Health Information Exchange (VHIE) network




| | | | | | |
|---|---|---|---|---|---|
| SFQ1 2018 | 160 | – | ↗ | 4 | 15% ↑ |
| SFQ4 2017 | 157 | – | ↗ | 3 | 13% ↑ |
| SFQ3 2017 | 152 | – | ↗ | 2 | 9% ↑ |
| SFQ2 2017 | 146 | – | ↗ | 1 | 5% ↑ |
| SFQ1 2017 | 139 | – | → | 0 | 0% → |

Notes on Methodology

- The goal for this measure is to increase the total health care locations (providers) that have gained access to their patient's clinical data via the VHIE by the close of SFY18 Q4.

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Partners

- Vermont Information Technology Leaders (VITL)
- Vermont Providers

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Story Behind the Curve

This measure quantifies the number of providers gaining access to their patients' clinical data via the Vermont Health Information Exchange (VHIE).

VHIE exists to provide clinical data to support providers at the point of care and to be used as a primary data source to assess population-level clinical outcomes and costs of care. The availability of clinical data from the VHIE, paired with claims data, helps AHS and DVHAs' partners quantify the impact of Vermont's health reform initiatives.

VITLAccess is a secure online provider portal supplied by VITL, the operator of Vermont's Health Information Exchange. The VITLAccess portal allows providers to access clinical data for their patients, which is not stored within their practice's electronic health record. The State paid VITL to develop VITLAccess and now supports the maintenance and continued operations of the tool. In SFY18, VITL is contracted to complete VITLAccess implementations that were not complete in SFY17 and continue to expand provider use of the tool.

*Last updated: 10/31/17*

*Author: HIE-HIT Unit*

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PM | HIE/HIT | % of Blueprint quality measures currently using Health Information Exchange (HIE) data as a primary or secondary source | – | – | – | – | –

Story Behind the Curve

**HIE & BP discussed this measure & feel that it's duplicative of the BP PM #2 of "% of BP patients with recorded measures in the Vermont Clinical Registry". It is their recommendation to remove this measure from this section.**

This measure will quantify the number of Blueprint quality measures quality measures that use HIE clinical data to support the measurement of health outcomes and health care costs.

Vermont's Health Information Exchange (HIE) exists to provide clinical data to support providers at the point of care and to be used as a primary data source to assess population-level clinical outcomes and costs of care. The availability of clinical data from the HIE, paired with claims data, helps AHS and our partners quantify the impact of Vermont's health reform initiatives.

*Last updated: 09/08/17*

*Author: HIE-HIT Unit*

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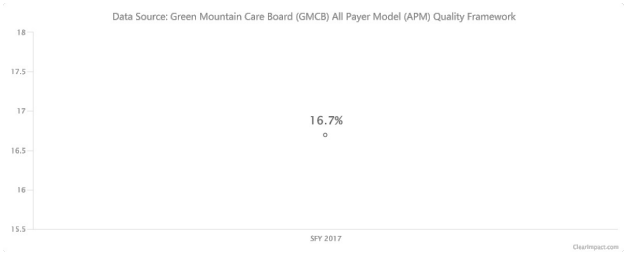
PM | HIE/HIT | % All-Payer Model quality measures currently using Vermont Health Information Exchange (VHIE) data as a primary or secondary source | **SFY 2017** | **16.7%** | – | → **0** | **0%** →




Notes on Methodology

- If clinical data from the VHIE is valued, the HIE-HIT Unit expects to see an annual increase in this figure.

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Partners

- Green Mountain Care Board

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Story Behind the Curve

Vermont's Health Information Exchange (HIE) exists to provide clinical data to support providers at the point of care and to be used as a primary data source to assess population-level clinical outcomes and costs of care. The availability of clinical data from the HIE, paired with claims data, helps AHS and our partners quantify the impact of Vermont's health reform initiatives.

**Vermont's All-Payer Model has a total of 18 measures supporting 3 overarching goals. The measures that currently rely on clinical data include:**

- Multi-Payer ACO Screening for Clinical Depression and Follow-Up Plan
- Medicare ACO chronic disease composite (specifically two sub-measures: Diabetes HbA1c Poor Control and Controlling High Blood Pressure)
- Multi-Payer ACO tobacco use assessment and cessation intervention

To fully understand how clinical data is used to assess population health and the costs of care, other measure-based programs should be evaluated including the Blueprint for Health and the Shared Savings Program.

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*Last updated: 08/31/17*

*Author: HIE-HIT Unit*

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## Actions

| Name | Assigned To | Status | Due Date | Progress |
| --- | --- | --- | --- | --- |

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

# P Legal Legal Unit

## What We Do

## Performance Measures

| | Time Period | Actual Value | Target Value | Current Trend | Baseline % Change |
|---|---|---|---|---|---|
| PM Legal # of legal &/or policy support requests handled | Oct 2017 | 65 | – | ↘ 1 | -35% ↓ |
| | Sep 2017 | 100 | – | → 0 | 0% → |


Story Behind the Curve

This metric will quantify how many legal and policy inquiries are handled by the unit.

The Legal Unit is in essence a support unit for the Department. This metric would provide visibility into how much support the Legal Unit is providing to DVHA.

*Last updated: 11/15/17*

*Author: Legal Unit*

| | Time Period | Actual Value | Target Value | Current Trend | Baseline % Change |
|---|---|---|---|---|---|
| PM Legal % of legal &/or policy support requests completed within 10 business days | Oct 2017 | 90% | – | ↗ 1 | 2% ↑ |
| | Sep 2017 | 88% | – | → 0 | 0% → |


Story Behind the Curve

This metric will provide visibility into the timeliness of the support the Legal Unit provides to DVHA.

The Legal Unit is in essence a support unit for the Department. This metric would provide visibility into how well the Legal Unit is providing that support to DVHA. The unit is tracking the source of the inquiry and aging/time to resolution. This will allow the unit to set goals for timeliness of resolution and identify substantive trends among the requests.

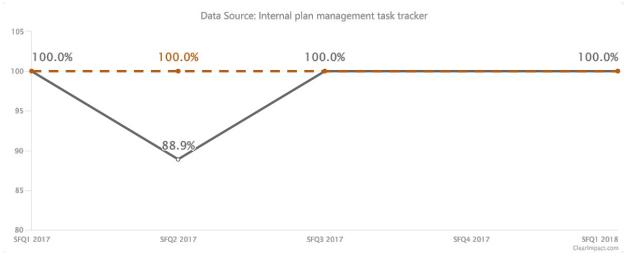
*Last updated: 11/15/17*

*Author: Legal Unit*

PM

Legal

% qualified health plan management milestones met by deadline




| | | | | |
|---|---|---|---|---|
| SFQ1 2018 | 100.0% | 100.0% | → 1 | 0% → |
| SFQ3 2017 | 100.0% | 100.0% | ↗ 1 | 0% → |
| SFQ2 2017 | 88.9% | 100.0% | ↘ 1 | -11% ↓ |
| SFQ1 2017 | 100.0% | 100.0% | → 0 | 0% → |

Partners

- Green Mountain Care Board
- Qualified Health Plan Issuers
- Department of Financial Regulation
- DVHA Health Access Enrollment & Eligibility Unit

Story Behind the Curve

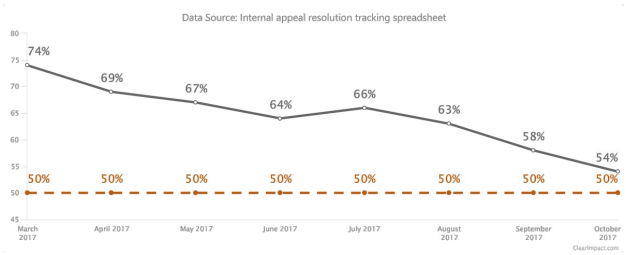
DVHA's Legal Unit manages the certification process for qualified health plans. This process takes place on an annual cadence. DVHA has up to 10 plan management milestones per quarter with the exception of spring quarter (when the plan management process is primarily in the hands of DFR and GMCB). Milestones include publishing the annual certification timeline, releasing plan design guidance, meeting with the stakeholder advisory group, certifying plans, filing the plans in the federal system. This metric tracks whether the Legal Unit achieves the milestones by their deadlines within each quarter. For SFY2017, DVHA met nearly all its milestones on time.

Last updated: 10/31/17

Author: Legal Unit

% of eligibility appeals that are resolved

PM Legal prior to the formal Fair Hearing process.




| | | | | |
|---|---|---|---|---|
| Oct 2017 | 54% | 50% | ↘ 3 | -22% ↓ |
| Sep 2017 | 58% | 50% | ↘ 2 | -16% ↓ |
| Aug 2017 | 63% | 50% | ↘ 1 | -9% ↓ |
| Jul 2017 | 66% | 50% | ↗ 1 | -4% ↓ |
| Jun 2017 | 64% | 50% | ↘ 6 | -7% ↓ |
| May 2017 | 67% | 50% | ↘ 5 | -3% ↓ |
| Apr 2017 | 69% | 50% | ↘ 4 | 0% → |
| Mar 2017 | 74% | 50% | ↘ 3 | 7% ↑ |
| Feb 2017 | 78% | 50% | ↘ 2 | 13% ↑ |
| Jan 2017 | 83% | 50% | ↘ 1 | 20% ↑ |

Partners

- Office of the Attorney General
- DVHA Health Access Eligibility & Enrollment Unit

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Story Behind the Curve

This process benefits Vermonters by providing expeditious and favorable resolution to their eligibility appeals wherever possible.

The appeals staff work to identify cases that can be resolved in the customer's favor prior to expending resources on the formal Fair Hearing process before the Human Services Board. The goal has been to resolve more than 50% in this manner. Given that the unit consistently surpassed this goal in SFY17, DVHA is increasing the goal to 65% for 2018.

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*Last updated: 11/15/17*

*Author: Legal Unit*

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## Actions

| Name | Assigned To | Status | Due Date | Progress |
|---|---|---|---|---|

# P LTC Long Term Care (LTC) Unit

## Budget Information

## What We Do

**Vermont's Long-Term Care (LTC) Medicaid Program is called *Choices for Care*.** Vermont's LTC staff assist eligible Vermonters with accessing services in their chosen setting. This could be in the client's home, an approved residential care home, assisted living facility or an approved nursing home.

**There are two parts to determining Vermont LTC eligibility:**

1. Clinical eligibility which is performed by the Department of Disabilities, Aging and Independent Living (DAIL)
2. Financial eligibility performed by the **Long Term Care Unit** in the Department for Vermont Health Access (DVHA)

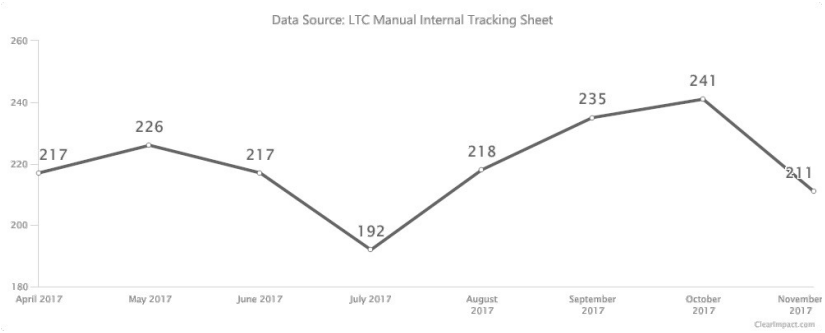
The LTC application is usually submitted to the DVHA Long Term Care Unit and a copy is forwarded to DAIL for the clinical assessment. In addition, upon receipt of the LTC application, DVHA workers begin the financial eligibility determination process. Many applicants have complex financial histories and have hired elder law attorneys to assist them with planning and sheltering their assets. The more complicated applications take a significant amount of staff time to analyze before making a final financial eligibility determination.

## Who We Serve

## How We Impact

### Performance Measures

PM LTC # of new LTC Medicaid applications processed




| Time Period | Actual Value | Target Value | Current Trend | Baseline % Change |
|---|---|---|---|---|
| Nov 2017 | 211 | – | ↘ 1 | 19% ↑ |
| Oct 2017 | 241 | – | ↗ 3 | 36% ↑ |
| Sep 2017 | 235 | – | ↗ 2 | 33% ↑ |
| Aug 2017 | 218 | – | ↗ 1 | 23% ↑ |
| Jul 2017 | 192 | – | ↘ 2 | 8% ↑ |
| Jun 2017 | 217 | – | ↘ 1 | 23% ↑ |
| May 2017 | 226 | – | ↗ 1 | 28% ↑ |
| Apr 2017 | 217 | – | ↘ 2 | 23% ↑ |
| Mar 2017 | 219 | – | ↘ 1 | 24% ↑ |
| Feb 2017 | 243 | – | ↗ 1 | 37% ↑ |

Partners

The Long Term Care (LTC) Unit has many internal & external partners. The eight most frequently contacted are:

- Family members of applicant
- Department of Disabilities, Aging and Independent Living (DAIL) staff
- DVHA Staff Attorney for LTC
- Area Agencies on Aging case managers
- Vermont nursing facility staff
- Vermont Assistant Attorney Generals
- Vermont Elder Law attorneys
- DCF Economic Services Division

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Story Behind the Curve

Total # of LTC Medicaid applications which received a financial eligibility determination during the month.

The Long Term Care (LTC) Unit is responsible for the financial eligibility determination necessary to ensure that eligible Vermonters are able to access high quality long term supports and services. The LTC financial eligibility rules are complex. Many Vermonters hire elder law attorneys to help them with the LTC planning and application process. The LTC applications have gotten increasingly detailed and complex over time.

For SFY17, there was an average of 571 Vermont LTC applications pending each month. LTC applications require a two part eligibility determination: DAIL nurses perform a clinical determination and DVHA workers perform the financial eligibility determination. LTC financial eligibility rules require a five year look back period of the applicant's financial documents. There are approximately 350 pages of financial documentation submitted with each LTC application which must be reviewed before a determination can be made.

The above trend line reflects the number of LTC applications that were processed in a given month of SFY17. An application was considered "processed" after both the DAIL LTC clinical eligibility and the DVHA LTC financial eligibility determinations are completed. The number includes both LTC application approvals and denials.

*Last updated: 12/15/17*

*Author: Long Term Care Unit*

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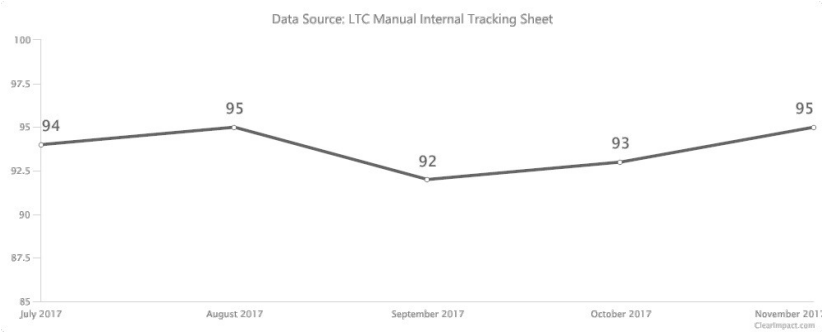
PM LTC Of the new LTC Medicaid applications processed during the month, the % that were processed within 45 days of receipt




| | | | | |
|---|---|---|---|---|
| Nov 2017 | 95% | – | ↗ 2 | 1% ↑ |
| Oct 2017 | 93% | – | ↗ 1 | -1% ↓ |
| Sep 2017 | 92% | – | ↘ 1 | -2% ↓ |
| Aug 2017 | 95% | – | ↗ 1 | 1% ↑ |
| Jul 2017 | 94% | – | → 0 | 0% → |

Partners

The Long Term Care (LTC) Unit has many internal & external partners. The eight most frequently contacted are:

- Family members of applicant
- Department of Disabilities, Aging and Independent Living (DAIL) staff
- DVHA Staff Attorney for LTC
- Area Agencies on Aging case managers
- Vermont nursing facility staff
- Vermont Assistant Attorney Generals
- Vermont Elder Law attorneys
- DCF Economic Services Division

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Story Behind the Curve

This is a measure of how well staff are processing applications relative to the current timeliness standard.

Long Term Care (LTC) Medicaid applications must be processed within the 45 day federal timeliness standard. Some clients cannot access long term supports and services until their LTC application has been processed. Other clients are admitted to nursing facilities (NF) prior to submission of their LTC application. The NF's depend upon timely processing as they need to know if the client is LTC Medicaid eligible. Additionally, delays in payments for Medicaid eligible LTC services can create revenue issues for the facilities.

Sometimes applications are delayed because the Department of Aging & Independent Living (DAIL) cannot find a clinical placement for the applicant. Other delays are the result of the client needing additional time to submit verification documents for the five year look back period (LBP). Applications with these two delays are not included in this performance measure because the financial eligibility worker has no control over those delays.

The percentage of applications processed within the 45 day federal timeliness standard reflects Vermont's level of compliance with that federal rule. The higher the level of compliance, the lower the risk of financial penalties related

to payment errors for exceeding the federal timeliness standard. This measure receives extensive focus from the LTC Unit, as staff seek to continuously improve in this error through business process efficiencies, worker training and

The unit continues to review cases for July - September to determine if any of them should not be counted as financial eligibility worker delays (as per the discussion with DVHA Program Integrity). Those cases that are due to DAIL clinical delays, penalty periods the client is assessed or client requested extensions and delays will not be included in the counts as they are not a financial eligibility error risk (they meet the administrative exceptions or would be an error for DAIL staff).

*Last updated: 12/15/17*

*Author: Long Term Care Unit*

PM LTC LTC Medicaid application audit error rate

Notes on Methodology

- This is a new performance measure for the Long Term Care (LTC) Unit. It is an annual State Fiscal Year measure & will be available in July 2018.

Partners

The Long Term Care (LTC) Unit has many internal & external partners. The eight most frequently contacted are:

- Family members of applicant
- Department of Disabilities, Aging and Independent Living (DAIL) staff
- DVHA Staff Attorney for LTC
- Area Agencies on Aging case managers
- Vermont nursing facility staff
- Vermont Assistant Attorney Generals
- Vermont Elder Law attorneys
- DCF Economic Services Division

Story Behind the Curve

Accuracy of determinations is an important indicator which ensures applications are processed according to federal and Vermont Health Benefits Eligibility and Enrollment (HBEE) rules. This not only ensures Vermonters receive parity in treatment but also ensures that DVHA remains compliant with federal regulations and does not expose Vermont to risk of financial penalties related to high error rates.

The most recent audit error rate information was the 2015 KPMG audit where the LTC Unit had zero case errors. Recently, a PERM pilot audit was conducted under the new draft rules in the federal register. The new draft rules have redefined the sample population and the definition payment error. Since receiving those audit results, there has been significant discussion between the Program Integrity Unit (PIU) and the Long Term Care (LTC) Unit around when DVHA can apply the federal rules for exceptions to avoid a payment error. These conversations continue in early October 2017. Additionally, there is currently a KPMG audit underway. Program Integrity will also be conducting Medicaid Quality Control reviews in the near future. These results will be reported to CMS.

**Other unreported indicators used for quality assurance:** The LTC supervisors will be conducting Supervisory Case Reviews (SCR's) periodically for all LTC workers. The audit and SCR results will be important indicators for the quality of the LTC eligibility decisions and the status of program integrity. Note that there is significant other "ad hoc" case reviews which are conducted by the LTC Benefit Programs Administration staff and the LTC supervisors. While this is useful in identifying trends or patterns, this is not captured as reportable data.

**Future Error Avoidance:** Very importantly, when reviewing all worker errors, the LTC Management team will identify the root cause of the error along with a corrective action plan (CAP). CAP's will include informing and training LTC workers to avoid future errors. All CAP's will be implemented fully and documented in a timely manner.

*Last updated: 10/04/17*

*Author: Long Term Care Medicaid Program*

## Actions

| Name | Assigned To | Status | Due Date | Progress |
|---|---|---|---|---|

# P DVHA Payment Reform Unit

## Budget Information

## What We Do

**The Payment Reform Unit** supports the Vermont Healthcare Innovation Project (VHCIP), a program developed from a three year, $45 million 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.

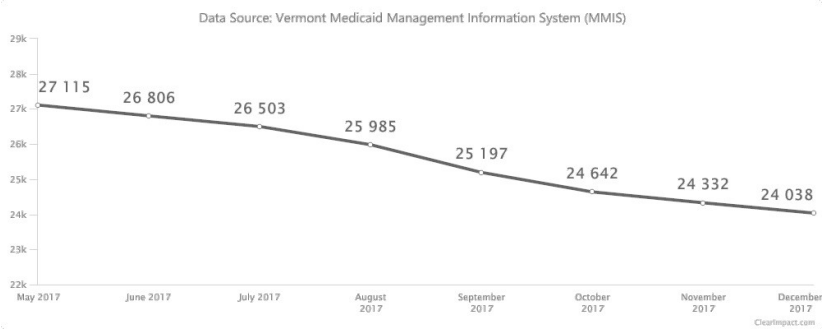
The primary areas of focus for Medicaid payment reform are to support the design, implementation, and evaluation of innovative payment initiatives, including an accountable care organization (ACO) Shared Savings Program (SSP).

The Payment Reform Unit 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.

## Who We Serve

## Performance Measures

PM Payment Reform — # of Medicaid members per month for whom a prospective payment was made to OneCare Vermont from DVHA as part of the Vermont Medicaid Next Generation (VMNG) ACO program




| Time Period | Actual Value | Target Value | Current Trend | Baseline % Change |
|---|---|---|---|---|
| Dec 2017 | 24,038 | – | ↘ 11 | -17% ↓ |
| Nov 2017 | 24,332 | – | ↘ 10 | -16% ↓ |
| Oct 2017 | 24,642 | – | ↘ 9 | -15% ↓ |
| Sep 2017 | 25,197 | – | ↘ 8 | -13% ↓ |
| Aug 2017 | 25,985 | – | ↘ 7 | -11% ↓ |
| Jul 2017 | 26,503 | – | ↘ 6 | -9% ↓ |
| Jun 2017 | 26,806 | – | ↘ 5 | -8% ↓ |
| May 2017 | 27,115 | – | ↘ 4 | -7% ↓ |
| Apr 2017 | 28,240 | – | ↘ 3 | -3% ↓ |
| Mar 2017 | 28,676 | – | ↘ 2 | -1% ↓ |

Notes on Methodology

| PMPM Payment Information by Medicaid Eligibility Group (MEG) by Month | | | | | | |
|---|---|---|---|---|---|---|
| Report Period | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 |
| % of 29,102 | 91.1% | 89.3% | 86.6% | 84.5% | 83.6% | 82.6% |
| Total # | 26,503 | 25,985 | 25,197 | 24,642 | 24,332 | 24,038 |
| ABD # | 1,790 | 1,791 | 1,773 | 1,764 | 1,755 | 1,742 |
| ABD % | 6.8% | 6.9% | 7.0% | 7.2% | 7.2% | 7.2% |
| Gen Adult # | 11,646 | 11,331 | 10,764 | 10,512 | 10,326 | 10,164 |
| Gen Adult % | 43.9% | 43.6% | 42.7% | 42.7% | 42.4% | 42.3% |
| Gen Child # | 13,067 | 12,863 | 12,660 | 12,366 | 12,251 | 12,132 |
| Gen Child % | 49.3% | 49.5% | 50.2% | 50.2% | 50.4% | 50.5% |

Partners

- DVHA Payment Reform Unit
- DXC Technology
  OneCare Vermont

Story Behind the Curve

This measure shows ACO Attribution. It is broken down by Medicaid Eligibility Group (MEG) and shows what percentage of each MEG makes up the reported total.

**This measure is a useful indicator of:**

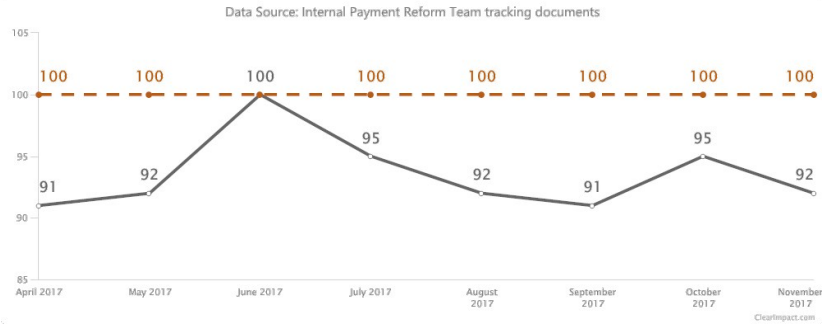
- How many actively attributed members the ACO has in a given month (which helps quantify the program's scale)
- Any fluctuation in attribution on a month-to-month basis, overall and by MEG (which helps quantify population dynamism and the effects of changing Medicaid eligibility on prospective ACO attribution).

Member attribution to the VMNG ACO program is set prospectively (at the beginning of a performance year), and no new members are added to the population during a performance year. However, prospectively attributed members may be considered ineligible for attribution in a given month due to a number of factors, including eligibility changes (e.g. loss of Medicaid coverage); evidence of an additional source of insurance coverage or ageing into Medicare eligibility; death; or termination of a contractual relationship between an attributing provider practice and the ACO (at which time all members that had been attributed through that practice are no longer considered attributed to the ACO). Some members may subsequently become eligible for attribution again after losing eligibility in an earlier point in the year, but a 1-1.5% decrease in the number of PMPM payments made is expected month-to-month in a given program year. The more significant decrease (4%) in the number of members for whom payments were made between April and May highlights an instance in which an entire practice's membership was removed from the ACO-attributed population due to termination of a contractual relationship between that practice and the ACO (OneCare Vermont).

*Last updated: 12/18/17*

*Author: Payment Reform Unit*

PM Payment Reform % of reporting deadlines adhered to according to the Vermont Medicaid Next Generation operational timeline




| | | | | | |
|---|---|---|---|---|---|
| Nov 2017 | 92% | 100% | ↘ | 1 | -8% ↓ |
| Oct 2017 | 95% | 100% | ↗ | 1 | -5% ↓ |
| Sep 2017 | 91% | 100% | ↘ | 3 | -9% ↓ |
| Aug 2017 | 92% | 100% | ↘ | 2 | -8% ↓ |
| Jul 2017 | 95% | 100% | ↘ | 1 | -5% ↓ |
| Jun 2017 | 100% | 100% | ↗ | 3 | 0% → |
| May 2017 | 92% | 100% | ↗ | 2 | -8% ↓ |
| Apr 2017 | 91% | 100% | ↗ | 1 | -9% ↓ |
| Mar 2017 | 43% | 100% | ↘ | 1 | -57% ↓ |
| Feb 2017 | 100% | 100% | → | 1 | 0% → |

Notes on Methodology

| % of reporting deadlines adhered to according to the VMNG operational timeline | | | | | |
|---|---|---|---|---|---|
| Report Period | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 |
| % met | 95% | 92% | 91% | 95% | 92% |
| % met after extension | 5% | 8% | 9% | 5% | 8% |
| % not met | 0% | 0% | 0% | 0% | 0% |

Partners

- DVHA Payment Reform Unit
- DVHA Data Unit

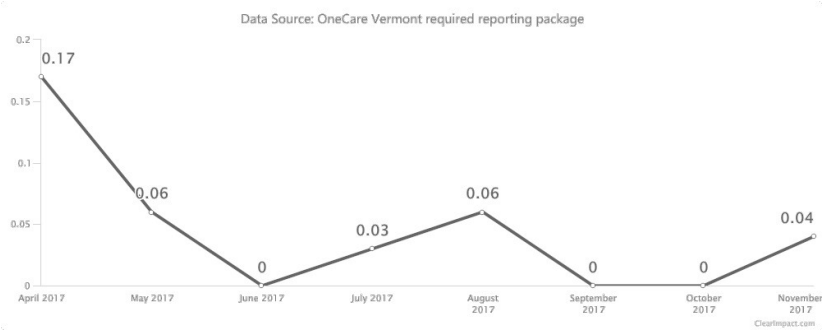
- OneCare Vermont

Reporting requirements for the ACO program began in January, 2017. Reporting considered for this measure includes ACO reports on performance (for example, member helpline reports, care management reports, and utilization reports) as well as DVHA data reports to the ACO (claims extracts for ACO attributed population). In general, close to 100% of reporting requirements have been met on time. To date, OneCare has submitted all required reports to DVHA, and DVHA has transferred all required data files to OneCare, either on time or by mutually agreed-upon adjusted deadlines (to allow other necessary processes to occur). For example, DVHA and OneCare agreed to extend the deadlines for OneCare's submission of four reports in March because OneCare would require claims-data to complete those reports, and DVHA's initial claims-sharing in that month could not occur until members had been notified of their initial opportunity to opt-out of having DVHA share their claims data with OneCare. As program operations continue and processes are streamlined to account for adjustments made to reporting templates and data elements, the Payment Reform team anticipates that 100% of reporting deadlines will be met on time month-to-month.

*Last updated: 12/18/17*

*Author: Payment Reform Unit*

PM Payment Reform # of member calls per 1000 received by OneCare Vermont regarding the Vermont Medicaid Next Generation (VMNG) Accountable Care Organization (ACO) program




| | | | | |
|---|---|---|---|---|
| Nov 2017 | 0.04 | – | ↗ 1 | -97% ↓ |
| Oct 2017 | 0.00 | – | → 1 | -35% ↓ |
| Sep 2017 | 0.00 | – | ↘ 1 | -35% ↓ |
| Aug 2017 | 0.06 | – | ↗ 2 | -96% ↓ |
| Jul 2017 | 0.03 | – | ↗ 1 | -98% ↓ |
| Jun 2017 | 0.00 | – | ↘ 4 | -35% ↓ |
| May 2017 | 0.06 | – | ↘ 3 | -96% ↓ |
| Apr 2017 | 0.17 | – | ↘ 2 | -89% ↓ |
| Mar 2017 | 1.00 | – | ↘ 1 | -35% ↓ |
| Feb 2017 | 1.54 | – | → 0 | 0% → |

Notes on Methodology

| # of member calls per 1000 members | | | | | |
|---|---|---|---|---|---|
| Report Period | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 |
| # Inquires | 1 | 2 | 0 | 0 | 1 |
| # Complaints | 1 | 0 | 0 | 0 | 0 |
| # Grievances | 0 | 0 | 0 | 0 | 0 |
| # Appeals | 0 | 0 | 0 | 0 | 0 |
| Total # Calls | 2 | 2 | 0 | 0 | 1 |
| Calls/1000 att mem | 0.03 | 0.06 | 0.00 | 0.00 | 0.04 |

Partners

- OneCare Vermont

Story Behind the Curve

This measure shows the number of member calls per 1000 members per month, broken out into the 4 categories of communication below:

1. Inquiry: routine communication from an ACO member or provider requesting information that is within the general scope of the ACO, or requesting a routine action be taken

2. Complaint: a routine communication from an ACO member or provider that requires the ACO to take an action to resolve issues
   Grievance: a complaint that is not readily resolved through discussion with the ACO when first presented, and is elevated to senior leadership of the ACO, the DVHA payment reform team, and the Health Care Advocate as appropriate
4. Appeal: a grievance that has not been resolved to the satisfaction of the member or provider. The member or provider can bring their grievance through an appeals process that will include continued support from DVHA, the ACO and the Health Care Advocate as appropriate.

Reporting requirements for the VMNG ACO program's member helpline began in February, 2017, and the ACO is required to report monthly the number of member inquiries, complaints, grievances, and appeals received via their member/provider helpline.

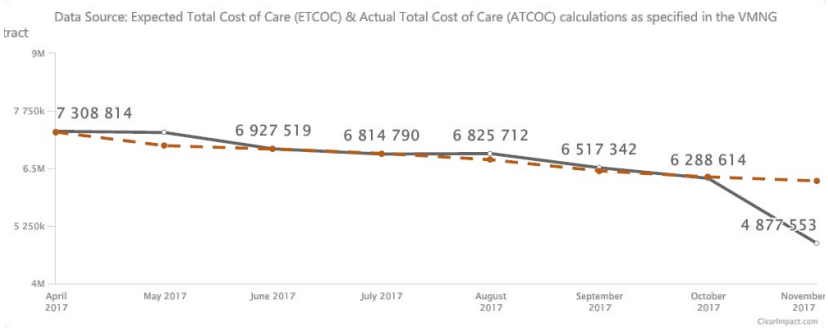
Since the beginning of the VMNG pilot, Medicaid members' primary reason for contacting OneCare pertained to opting out of having their Medicaid claims data shared with OneCare. Letters were mailed to Medicaid members attributed to OneCare in the middle of February; these letters explained what ACOs are, notified members that their primary care provider was participating in the ACO, and gave members the option of not having DVHA share their claims data with OneCare. The higher volume of member inquiries for February and March was in response to this initial mailing.

As the program continues, it is expected that the monthly number of member inquiries will remain steadily low, unless other targeted or widespread communication activities occur. Monitoring trends for these types of member contact will remain important as key indicators of program performance from the perspective of the member. Any increases in complaints, grievances, or appeals will be treated as priority areas for expedient investigation and resolution by both OneCare and DVHA.

*Last updated: 12/18/17*

*Author: Payment Reform Unit*

PM Payment Reform Expected vs. actual total cost of care for the Vermont Medicaid Next Generation (VMNG) Accountable Care Organization (ACO)




| | | | | | |
|---|---|---|---|---|---|
| Nov 2017 | $4.88Mil | $6.23Mil | ↘ | 3 | -36% ↓ |
| Oct 2017 | $6.29Mil | $6.32Mil | ↘ | 2 | -18% ↓ |
| Sep 2017 | $6.52Mil | $6.45Mil | ↘ | 1 | -15% ↓ |
| Aug 2017 | $6.83Mil | $6.69Mil | ↗ | 1 | -11% ↓ |
| Jul 2017 | $6.81Mil | $6.83Mil | ↘ | 4 | -11% ↓ |
| Jun 2017 | $6.93Mil | $6.92Mil | ↘ | 3 | -10% ↓ |
| May 2017 | $7.28Mil | $7.00Mil | ↘ | 2 | -5% ↓ |
| Apr 2017 | $7.31Mil | $7.29Mil | ↘ | 1 | -5% ↓ |
| Mar 2017 | $7.42Mil | $7.41Mil | ↗ | 1 | -3% ↓ |
| Feb 2017 | $7.39Mil | $7.50Mil | ↘ | 1 | -4% ↓ |

Notes on Methodology

****Please note in the chart above that the solid trend line shows the actual total cost of care (ATCOC) and the dotted trend line shows the expected total cost of care (ETCOC)**

| ETCOC & ATCOC for the Vermont Medicaid Next Generation Accountable Care Organization | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Report Period | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 |
| ETCOC | $7,522,630 | $7,498,277 | $7,413,414 | $7,292,219 | $6,997,783 | $6,923,243 | $6,829,556 | $6,691,562 | $6,449,538 | $6,318,547 | $6,231,854 |
| ATCOC* | $7,655,673 | $7,385,142 | $7,422,600 | $7,308,814 | $7,282,379 | $6,927,519 | $6,814,790 | $6,825,712 | $6,517,342 | $6,288,614 | $4,877,553 |
| Over/(Under)* | $133,043 | ($113,135) | $9,186 | $16,595 | $284,596 | $4,276 | ($14,766) | $134,150 | $67,804 | ($29,933) | ($1,354,301) |
| *Please note that data for ATCOC and the over/(under) will be updated for all historical months on a monthly basis as additional claims are processed. Expected values will remain constant. | | | | | | | | | | | |

Partners

- Payment Reform Unit
- Business Office
- DXC
- OneCare Vermont

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Story Behind the Curve

The Accountable Care Organization's (ACO's) expected total cost of care (ETCOC) is derived based on actuarial projections of the cost of care in 2017 for the population of prospectively attributed Medicaid members, using 2015 claims for the attributed members as a baseline and trending it forward to 2017.

The ACO's actual total cost of care (ATCOC) is the sum of the Fixed Prospective Payment (FPP) paid to the ACO and the total actual Fee-For-Service expenditures paid by DVHA on behalf of the ACO to its providers for services not covered by the FPP.

The ACO has agreed to a risk-based spending target for the full attributed population during the performance year. If the ACO exceeds its spending target for the Performance Year, it is liable for expenses up to 103% of the target; if the ACO spends less than its target, it may retain savings to 97% of the target. This arrangement provides an incentive to use resources efficiently. If the ETCOC and ATCOC are equal, then the ACO's actual spending is on consistent with its projected spending for the performance year, and a minimal amount of financial reconciliation will occur between the ACO and DVHA during the final financial reconciliation. If the ETCOC is greater than the ATCOC, the ACO's spending has been less than the financial target, and the ACO would be eligible to retain a portion of the dollars saved relative to the target. Conversely, if the ATCOC is higher than the ETCOC, the ACO's spending has exceeded its financial target, and the ACO would be liable for a portion of the dollars spent in excess of the target.

Caution should be exercised when using this information to evaluate financial performance during the performance year, as claims lag has a significant impact on financial data, and the data does not factor in claims or payments that will need to be reconciled after the program year. At this time, the ACO's overall expenditure for January through June of 2017 is higher than the expected total cost of care for the corresponding months.

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*Last updated: 12/18/17*

*Author: Payment Reform Unit*

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## Actions

| Name | Assigned To | Status | Due Date | Progress |
|---|---|---|---|---|

# P PU Pharmacy Unit

## Budget Information

## What We Do

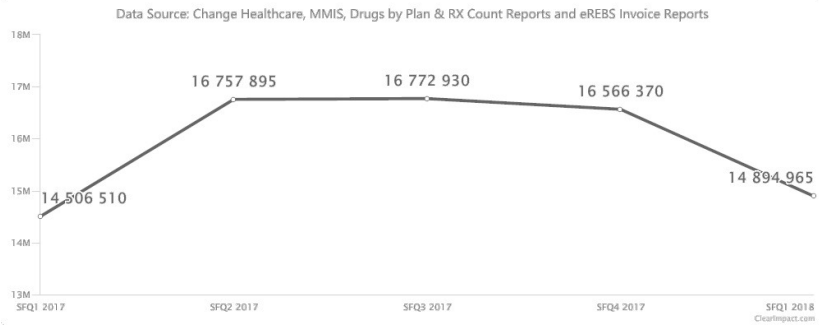
**The Pharmacy Unit (PU)** manages the pharmacy benefit for members enrolled in Vermont's publicly funded healthcare programs. Responsibilities include ensuring members receive medically necessary medications in the most timely, cost-effective manner. Pharmacy unit staff and DVHA's contracted pharmacy 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.

## Who We Serve

## How We Impact

### Performance Measures

PM PU Adjusted $$ Pharmacy Spend (actual spend minus invoiced rebates)




| Time Period | Actual Value | Target Value | Current Trend | Baseline % Change |
|---|---|---|---|---|
| SFQ1 2018 | $14.89Mil | – | ↘ 2 | 3% ↑ |
| SFQ4 2017 | $16.57Mil | – | ↘ 1 | 14% ↑ |
| SFQ3 2017 | $16.77Mil | – | ↗ 2 | 16% ↑ |
| SFQ2 2017 | $16.76Mil | – | ↗ 1 | 16% ↑ |
| SFQ1 2017 | $14.51Mil | – | → 0 | 0% → |

Notes on Methodology

| *Spend/Rebate by Quarter* | Total Drug Spend | Total Rebate Invoiced | Estimated Net Spend |
|---|---|---|---|
| **SFY17 Q1** | $47,963,613 | $33,457,103 | $14,506,510 |
| **SFY17 Q2** | $47,495,762 | $30,737,867 | $16,757,895 |
| **SFY17 Q3** | $49,338,141 | $32,565,210 | $16,772,930 |
| **SFY17 Q4** | $50,412,440 | $33,846,070 | $16,566,370 |
| **SFY18 Q1** | $47,469,475 | $32,574,510 | $14,894,965 |

Partners

- Change Healthcare
- Pharmaceutical Manufacturers

Story Behind the Curve

The Pharmacy Unit oversees the rebate programs. DVHA's Pharmacy Benefit Manager, Change Healthcare, manages

the rebate processes. Rebates are invoiced every quarter. The measure shows an estimated net spend because it is based on rebates invoiced, not rebates collected.

The rebate program is vitally important to DVHA's overall healthcare spending. DVHA receives approximately 50-60% of its drug spend back in the form of federal, state and supplemental rebates.

The ultimate goal is to manage drug spend by maximizing rebate opportunities.

*Last updated: 12/15/17*

*Author: Pharmacy Unit*

PM PU % of manufacturers' fees collected 2016 65.3% – → 0 0% →


Notes on Methodology

| *% of Manufacturer's Fees Collected* | Total $ Amount Invoiced | Total $ Amount Received | % Collected |
|---|---|---|---|
| **CY 2016*** | $3,235,116 | $2,113,311 | 65.3% |

*Invoices are billed in April of the following year (for the previous calendar year)

Partners

- Change Healthcare
- Pharmaceutical Manufacturers

Story Behind the Curve

The Pharmacy Unit, in collaboration with its pharmacy benefit manager Change Healthcare, annually invoices a fee to each pharmaceutical manufacturer paid by the Department of Vermont Health Access for prescriptions for individuals participating in Medicaid, Dr. Dynasaur or VPharm. The fee is 1.5 percent of the previous calendar year's prescription drug spend by the Department of Vermont Health Access.

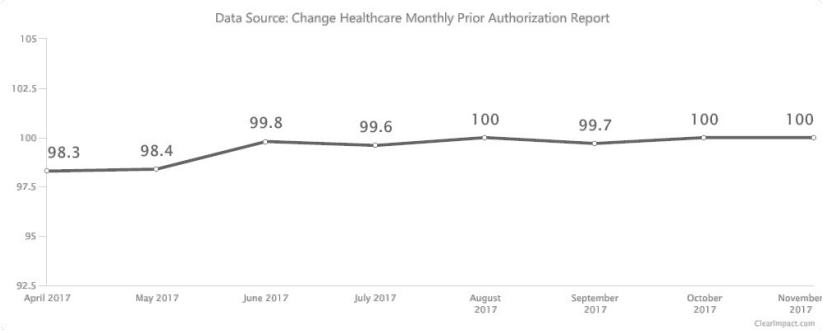
The manufacturer fee funds the collection and analysis of information on pharmaceutical marketing activities, analysis of prescription drug data needed by the attorney general's office for enforcement activities, and the evidence-based education program established in subchapter 2 of chapter 91 of Title 18.

The Pharmacy Unit will provide further analysis as more data becomes available, with the goal of increasing the percentage of collections.

*Last updated: 12/15/17*

*Author: Pharmacy Unit*

PM PU % of pharmacy prior authorizations processed within 24 hours




| | | | | |
|---|---|---|---|---|
| Nov 2017 | 100.0% | – | → 1 | 1% ↑ |
| Oct 2017 | 100.0% | – | ↗ 1 | 1% ↑ |
| Sep 2017 | 99.7% | – | ↘ 1 | 1% ↑ |
| Aug 2017 | 100.0% | – | ↗ 1 | 1% ↑ |
| Jul 2017 | 99.6% | – | ↘ 1 | 1% ↑ |
| | | | ↗ | ↑ |
| | | | ↗ | → |
| Apr 2017 | 98.3% | – | ↗ 1 | -1% ↓ |
| Mar 2017 | 97.3% | – | ↘ 2 | -2% ↓ |
| Feb 2017 | 98.2% | – | ↘ 1 | -1% ↓ |

Partners

- Change Healthcare

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Story Behind the Curve

This performance measure allows the Pharmacy Unit to monitor prior authorization (PA) processing turnaround times. PA turn-around time is important to ensure that DVHA's Service Level Agreements are met by our vendor, Change Healthcare, in servicing our prescribers.

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*Last updated: 12/15/17*

*Author: Pharmacy Unit*

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## Actions

| Name | Assigned To | Status | Due Date | Progress |
|---|---|---|---|---|

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

# P PIU Program Integrity Unit

## Budget Information

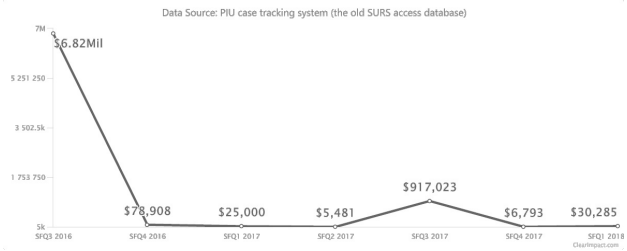
## What We Do

**The Program Integrity Unit (PIU)** consists of three teams; the Medicaid Audit and Compliance Unit (MACU), Oversight & Monitoring (O&M) and most recently, Beneficiary Healthcare Fraud. The MACU team works to establish and maintain integrity within the Medicaid Program and 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 Oversight & Monitoring (O&M) team is responsible for ensuring the effectiveness and efficiency of departmental control environments, operational processes, regulatory compliance, and financial and performance reporting in line with applicable laws and regulations. The third team to complete the Program Integrity Unit is the Beneficiary Healthcare Fraud team. This new team joined the Program Integrity Unit in July, 2015. The responsibility of this team is to investigate detect and prevent healthcare eligibility and enrollment fraud in the Vermont Medicaid Program.

## Who We Serve

## How We Impact

| Performance Measures | Time Period | Actual Value | Target Value | Current Trend | Baseline % Change |
|---|---|---|---|---|---|
| PM PIU $ amount cost avoidance generated by the Program Integrity / Medicaid Audit & Compliance Unit | SFQ1 2018 | $30,285 | – | ↗ 1 | -100% ↓ |
| | SFQ4 2017 | $6,793 | – | ↘ 1 | -100% ↓ |
| | SFQ3 2017 | $917,023 | – | ↗ 1 | -87% ↓ |
| | SFQ2 2017 | $5,481 | – | ↘ 3 | -100% ↓ |
| | SFQ1 2017 | $25,000 | – | ↘ 2 | -100% ↓ |
| | SFQ4 2016 | $78,908 | – | ↘ 1 | -99% ↓ |
| | SFQ3 2016 | $6.82Mil | – | | |



→ 0 0% →

Partners

- Other DVHA Units (such as Clinical or Policy) who assist in policy or systems change in support of future "cost avoidance"

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Story Behind the Curve

The Program Integrity / Medicaid Audit & Compliance Unit (MACU) measures cost avoidance or cost saving, when it refers to the projected reduction in future Medicaid expenditures for services/claims being reimbursed improperly. The actual avoidance occurs when edits and/or policy changes occur which support the case closure plan. This measure is time based and projects the potential reduction of expense within the category (claim type). These dollars are used in the system to provide additional services to qualified beneficiaries. Program Integrity cost saving based on the anticipated decrease or avoidance of future Medicaid expenditures related to the issue. Cost saving is projected and counted for a 1year period.

The MACU works to ensure Medicaid federal and state dollars are spent on authorized expenditures and to recover dollars expended on unauthorized expenditures. The goal of the Program Integrity Unit to increase payment integrity by recommending changes to DVHA policies or edits and audits within the MMIS. When these conditions are met, the projected cost avoidance represents future dollars remain available to be further reallocated to other services. This situation of cost avoidance doesn't exist with each case opened with PI.

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*Last Updated: 11/14/17*

*Author: Program Integrity / Medicaid Audit & Compliance Unit (MACU)*

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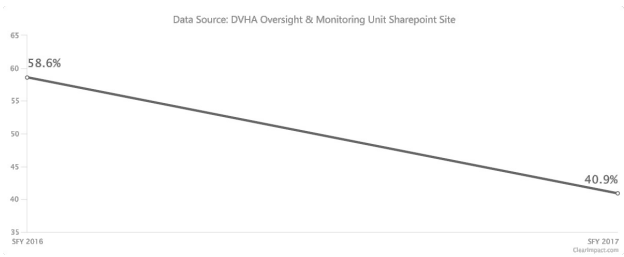
PM PIU % of overall DVHA audit findings that are repeat audit findings

| | | | | |
|---|---|---|---|---|
| SFY 2017 | 40.9% | – | ↘ 1 | -30% ↓ |
| SFY 2016 | 58.6% | – | → 0 | 0% → |




Notes on Methodology

| Audit Name | SFY16 | | | SFY17 | | |
|---|---|---|---|---|---|---|
| | Total # | Repeat # | Repeat % | Total # | Repeat # | Repeat % |
| 45 CFR VHC | 10 | 0 | 0.0% | 4 | 1 | 25.0% |
| CAFR | 5 | 5 | 100.0% | 4 | 4 | 100.0% |
| A133 | 14 | 12 | 85.7% | 6 | 3 | 50.0% |
| CMS PI | N/A | N/A | | 8 | 1 | 12.5% |
| Total | 29 | 17 | 58.6% | 22 | 9 | 40.9% |

**45 CFR** is an annual audit of the Vermont State Exchange "VHC" by an independent qualified auditing entity which follows generally accepted governmental auditing standards (GAGAS) to perform an annual independent external financial and programmatic audit and must make such information available to HHS for review by CMS/CIIO/HHS.

**The Comprehensive Annual Financial Report (CAFR)** is a thorough and detailed annual presentation of the state's financial condition. It reports on the state's activities and balances for each fiscal year. The State's external accounting firm works with the State of Vermont to review prepared modified accrual financial statements for compliance with GAAS and GAAP guidelines.

**The A133 Single Audit** is an annual review by the State's external audit firm to ensure a recipient of federal funds is in compliance with the federal program's requirements for how the money can be used. Each federal agency that gives out grants outlines specific items it feels are important for recipients to meet to ensure the successful management of the program and alignment with the legislative intent of the program. These items are laid out in the A-133 Compliance Supplement.

**CMS PI Review** - Every 3 or 4 years, the Centers for Medicare & Medicaid Services (CMS) conduct a focused review to determine the extent of program integrity oversight of the managed care program at the state level.

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Story Behind the Curve

This measure is shows the total number of audit findings in audits that closed during a state fiscal year (SFY) and the % that are repeat findings from previous audits.

DVHA is required to be compliant with all Federal and State policies regarding the administration of the Medicaid Program and the Qualified Health Plans. When DVHA is audited by an external auditor or regulator, and findings are identified, DVHA will correct the issue, in the approved time frames to ensure there are no repeat findings when that auditor or regulator returns.

Federal and State policies define the regulations for which DVHA must follow to be compliant with the administration of the Medicaid Program, including the Qualified Health Plans. When repeat findings exist, it brings to light that

deficiencies and/or material weaknesses remain and that the programs are not compliant with the requirements. A compliant program will help to strengthen the economy, make Vermont more affordable and protect the most vulnerable.

Tracking of this data is limited, historically, as the Oversight & Monitoring unit has only been in existence for a few years. Historical data is captured, as current audits present, where repeat findings may be brought forward. At present, approximately 2 years of data has been captured so for any audit that happens more than every 2 years (CMS IAG Review is every 3-4 years), the data may need to be captured for the first time, as the beginning of the next review time frame.

The 45 CFR VHC audit that closed in SFY 2016 was the first audit of VHC and resulted in an Adverse Opinion due to the lack of documented Standard Operating Procedures (SOPs). A tremendous undertaking was made by DVHA HAEEU with assistance from Oversight & Monitoring to complete numerous SOPs before the next year's review. As noted in the above table, there was only one repeat finding and an Unqualified Opinion was issued.

In 2016, the Oversight & Monitoring unit was established within Program Integrity to formalize an Oversight & Monitoring Program for the Medicaid Program, including the Vermont Health Connect, in line with the strategic direction of DVHA and Agency Leadership to ensure the effectiveness and efficiency of departmental control environments and operational processes in alignment with applicable laws and regulations. Working closely with DVHA departments, corrective action plans were put in place and actively pursued to ensure a reduction in repeat findings. The result was a reduction from 12 to 3 repeat findings reduction for SFY 2017 Single audit.

**Adverse Opinion** – the State did not comply in all material respects with the federal compliance requirements that could have a direct and material effect on major federal programs.

**Unqualified Opinion** – The State compiled in all material respects with federal requirements that could have a direct and material effect on major federal programs.

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*Last updated: 11/14/17*

*Author: Program Integrity Oversight & Monitoring Unit*

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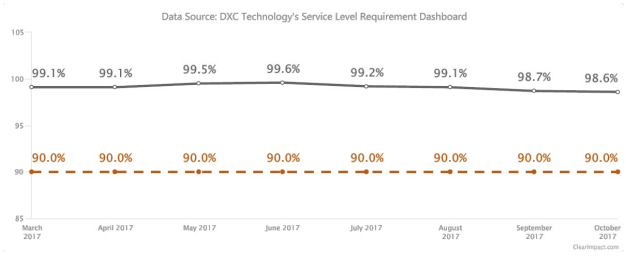
| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| PM | PIU | % of clean claims adjudicated during the month within 30 days of receipt (excluding drug claims) | **Oct 2017** | **98.6%** | **90.0%** | ↘ | **4** | **-1%** ↓ |




| | | | | |
|---|---|---|---|---|
| Sep 2017 | 98.7% | 90.0% | ↘ 3 | 0% → |
| Aug 2017 | 99.1% | 90.0% | ↘ 2 | 0% → |
| Jul 2017 | 99.2% | 90.0% | ↘ 1 | 0% → |
| Jun 2017 | 99.6% | 90.0% | ↗ 2 | 1% ↑ |
| May 2017 | 99.5% | 90.0% | ↗ 1 | 0% → |
| Apr 2017 | 99.1% | 90.0% | → 1 | 0% → |
| Mar 2017 | 99.1% | 90.0% | ↘ 1 | 0% → |
| Feb 2017 | 99.4% | 90.0% | ↗ 1 | 0% → |
| Jan 2017 | 99.1% | 90.0% | → 0 | 0% → |

Partners

- DXC Technology Claims Processing Unit

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Story Behind the Curve

In accordance with federal rules for prompt payments (31 U.S Code Chapter 39 – Prompt Payment), any bills or invoices submitted to government must be paid within 30 days. DXC SLR 3.1.8 requires that at least 90% of clean claims (those without missing or invalid information) are adjudicated within 30 calendar days of receipt.

The Vermont Medicaid Provider network relies on timely Medicaid payments to maintain their operations and facilities so that they can continue to serve Vermont Medicaid members.

This requirement has been consistently met and exceeded for many years. The current claims processing system is able to auto-adjudicate a high percentage of claims.

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*Last updated: 11/15/17*

*Author: Program Integrity Unit*

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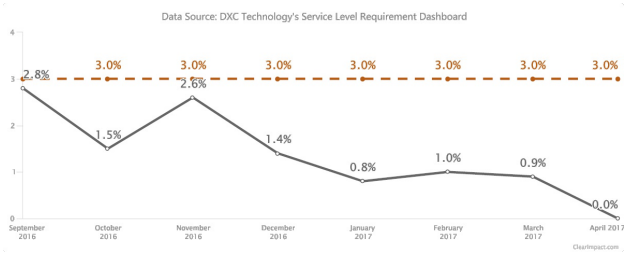
| | | | | | | | |
|---|---|---|---|---|---|---|---|
| PM | PIU | % error rate for all processed claims | Apr 2017 | 0.0% | 3.0% | ↘ 2 | -29% ↓ |




| | | | | |
|---|---|---|---|---|
| Mar 2017 | 0.9% | 3.0% | ↘ 1 | -36% ↓ |
| Feb 2017 | 1.0% | 3.0% | ↗ 1 | -29% ↓ |
| Jan 2017 | 0.8% | 3.0% | ↘ 2 | -43% ↓ |
| Dec 2016 | 1.4% | 3.0% | ↘ 1 | 0% → |
| Nov 2016 | 2.6% | 3.0% | ↗ 1 | 86% ↑ |
| Oct 2016 | 1.5% | 3.0% | ↘ 1 | 7% ↑ |
| Sep 2016 | 2.8% | 3.0% | ↗ 2 | 100% ↑ |
| Aug 2016 | 2.4% | 3.0% | ↗ 1 | 71% ↑ |
| Jul 2016 | 1.4% | 3.0% | → 0 | 0% → |

Notes on Methodology

- The goal is to have a **less than 3%** error rate for all claims processed.

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Partners

- DXC Technology Claims Processing Unit

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Story Behind the Curve

In accordance with the DXC contract, a quality assurance review is performed on a sample of claims that were adjudicated by the DXC Claims Unit staff. DXC SLR 3.1.12 requires that the error rate for the sample is less than 3%.

This is important because Vermont Medicaid and the Vermont Medicaid Provider network rely on DXC to process claims correctly in order to have proper reimbursement.

The claim error rate methodology changed, effective January 2017, with increased criteria for the quality review. Prior to 2017, the quality review comprised of a much smaller sample that was derived for each of the claims processing clerks. Due to the increased scrutiny and sample size, the error rate may fluctuate in early 2017.

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*Last updated: 10/31/17*

*Author: Program Integrity Unit*

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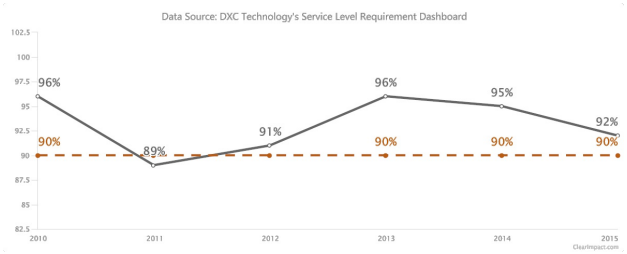
% of all VT Medicaid providers who respond to

PM PIU the Annual Provider Survey who answer that overall they are satisfied or very satisfied with DXC




| | | | | |
|---|---|---|---|---|
| 2015 | 92% | 90% | ↘ 2 | -4% ↓ |
| 2014 | 95% | 90% | ↘ 1 | -1% ↓ |
| 2013 | 96% | 90% | ↗ 2 | 0% → |
| 2012 | 91% | 90% | ↗ 1 | -5% ↓ |
| 2011 | 89% | 90% | ↘ 1 | -7% ↓ |
| 2010 | 96% | 90% | → 0 | 0% → |

Notes on Methodology

| ***Overall Performance*** | **Very Satisfied** | **Satisfied** | **Dissatisfied** | **Very Dissatisfied** |
|---|---|---|---|---|
| **2010** | 48% | 48% | 3% | 1% |
| **2011** | 33% | 56% | 9% | 2% |
| **2012** | 38% | 53% | 9% | 0% |
| **2013** | 35% | 61% | 4% | 0% |
| **2014** | 45% | 50% | 3% | 2% |
| **2015** | 39% | 53% | 5% | 3% |

Partners

- DXC Technology Provider Services Unit
- DVHA Provider & Member Relations Unit

Story Behind the Curve

In accordance with the DXC contract, a survey is made available to all Vermont Medicaid enrolled providers. This survey asks the provider to rate their overall satisfaction with DXC.

This is important because allowing providers to give their feedback is key to provider relations. Understanding the Vermont Medicaid provider network's overall satisfaction with the Vermont Medicaid Fiscal Agent (DXC) is critical to maintaining good relationships between DVHA and providers. The information gathered from the survey is analyzed and used to implement improvements within DXC. The annual provider survey is under way during September 2017 and the results for 2016 will be available soon.

*Last updated: 10/04/17*

*Author: Program Integrity Unit*

## Actions

| Name | Assigned To | Status | Due Date | Progress |
|---|---|---|---|---|

# P PMR Provider Member Relations Unit

## Budget Information

## What We Do

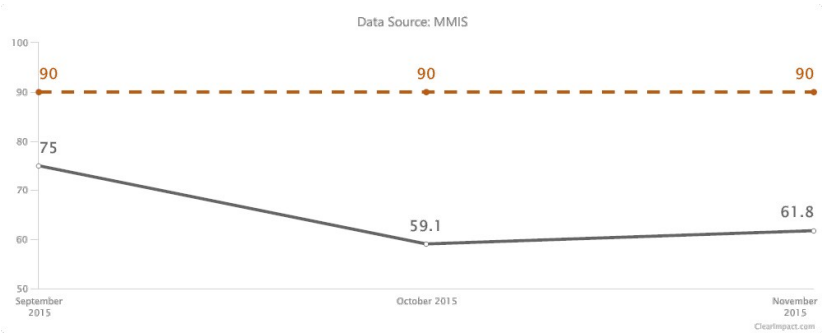
**The Provider and Member Relations Unit (PMR)** ensures members have access to appropriate healthcare for their medical, dental, and mental health needs. The unit monitors the adequacy of the Green Mountain Care (GMC) network of providers and ensures that members are served in accordance with managed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

## Who We Serve

## How We Impact

### Performance Measures

| | Time Period | Actual Value | Target Value | Current Trend | Baseline % Change |
|---|---|---|---|---|---|
| PM PMR % of out-of-state emergency/post stabilization claims processed within 2 years | Nov 2015 | 61.8% | 90.0% | ↗ 1 | -18% ↓ |
| | Oct 2015 | 59.1% | 90.0% | ↘ 1 | -21% ↓ |
| | Sep 2015 | 75.0% | 90.0% | → 0 | 0% → |




Notes on Methodology

| *Out-of-State Emergency/Post Stabilization Claims* | Sep 2015 | Oct 2015 | Nov 2015 | Dec 2015 | Jan 2016 | Feb 2016 |
|---|---|---|---|---|---|---|
| **# claims submitted** | 4 | 44 | 34 | | | |
| **34# claims paid w/in 2 years** | 3 | 26 | 21 | | | |
| **% claims paid w/in 2 years** | 75.0% | 59.1% | 61.8% | | | |

Partners

- Medicaid members
- Out of state providers
- DXC

Story Behind the Curve

DVHA is required to pay for out-of-state emergency/post-stabilization claims that are brought to the Department's attention by Medicaid members. These claims must be paid within 2 years of the date of service to receive federal dollars. None of the providers rendering these services are enrolled with VT Medicaid. The Provider Member Relations (PMR) Unit assures that claims are emergency/post stabilization and are valid to be paid under this process to ensure that DVHA is not paying for services that could be covered by an enrolled provider. The PMR Unit manages the process of getting these claims paid by DXC.

This measure is important as many Medicaid members are faced with collection agency notices for claims that were emergency related. The PMR Unit helps to assure Medicaid members are afforded the coverage they are entitled

to. The unit also monitors whether services are being utilized correctly and whether or not the member is entitled for payment of the claims.

In 2011, the PMR Unit began to handle all work related to provider outreach, member communication and DXC oversight with respect to the out of network emergency related claims. DVHA's mission was two-fold: remain compliant with 42 CFR 438.114 and attend to members' needs. A call with the regional CMS office in 2011 proved that the unit was headed in the right direction. CMS staff were surprised to hear that the unit was even attempting to reconcile such cases, as other states rarely, if ever, attempt to actively resolve out of network billing issues, emergent or not.

Since the PMR Unit has taken over outreach and tracking of these cases, hundreds of claims have been successfully paid that would have otherwise remained a financial burden to VT Medicaid members who simply had no choice but to seek emergency medical services at the time. And although it remains difficult to convince certain providers to willingly submit a claim and accept the VT Medicaid rate as payment in full, the unit's outreach efforts have proven to be a success and have alleviated many Vermonters of unnecessary stress.

*Last updated: 12/15/17*

*Author: Provider & Member Relations Unit*

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PM PMR % of pickup/return trips the transportation contractor completes on time

| | | | | |
|---|---|---|---|---|
| Oct 2017 | 96.3% | – | ↗ 1 | 3% ↑ |
| Sep 2017 | 93.5% | – | → 0 | 0% → |


Notes on Methodology

| ***Member Rides*** | **Sep 2017** | **Oct 2017** | **Nov 2017** | **Dec 2017** |
|---|---|---|---|---|
| **# rides given** | 34,345 | 45,119 | | |
| **# rides on time** | 32,115 | 43,456 | | |
| **% rides on time** | 93.5% | 96.3% | | |

Story Behind the Curve

This measure captures the non-emergency transportation (NEMT) timely pick up and drop off of Medicaid members to medical appointments. The measure is important to the Provider Member Relations (PMR) Unit because it looks at whether or not Medicaid members are receiving NEMT services within the designated timeframes as defined in the NEMT manual. The PMR Unit is monitoring this measure because significant complaints have been received from members not getting to appointments and not getting picked up in a timely manner.

Prior to August 2017, NEMT was operating as 8 separate entities As of 8/1/2017, the Vermont Public Transportation Association (VPTA) holds the sole contract for non-emergency transportation. Therefore, the measure data will begin at the start of the VPTA contract. VPTA reporting is due to the PMR Unit within 30 days of the end of the month.

*Last updated: 12/15/17*

*Author: Provider & Member Relations Unit*

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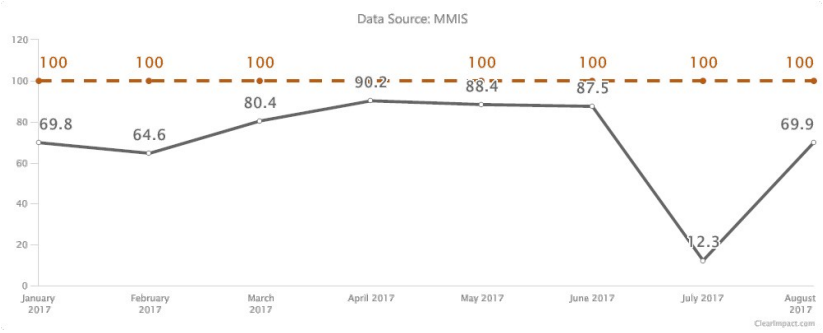
PM PMR % of providers enrolled within 90 days of submitting application to DXC




| | | | | |
|---|---|---|---|---|
| Aug 2017 | 69.9% | 100.0% | 1 | -18% |
| May 2017 | 88.4% | 100.0% | 1 | 3% |
| Apr 2017 | 90.2% | 100.0% | 2 | 5% |
| Mar 2017 | 80.4% | 100.0% | 1 | -6% |
| Feb 2017 | 64.6% | 100.0% | 2 | -24% |
| Jan 2017 | 69.8% | 100.0% | 1 | -18% |
| Dec 2016 | 85.5% | 100.0% | 0 | 0% |

Notes on Methodology

**# of days it took to process all provider applications that came in during the month:**

| *# Days* | Feb 2017 | Mar 2017 | Apr 2017 | May 2017 | Jun 2017 | Jul 2017 | Aug 2017 |
|---|---|---|---|---|---|---|---|
| 1-30 days | 10 | 54 | 57 | 35 | 36 | 15 | 34 |
| 31-60 days | 31 | 18 | 6 | 4 | 5 | 5 | 54 |
| 61-90 days | 134 | 183 | 276 | 374 | 274 | 4 | 79 |
| 91-120 days | 30 | 55 | 23 | 39 | 45 | 128 | 64 |
| 121+ days | 66 | 7 | 14 | 15 | 0 | 43 | 8 |
| **Total** | **271** | **317** | **376** | **467** | **360** | **195** | **239** |
| **% w/in 90 days** | **64.6%** | **80.4** | **90.2%** | **88.4%** | **87.5%** | **12.3%** | **69.9%** |

Partners

- Medicaid Providers
- DXC

Story Behind the Curve

The Provider Member Relations (PMR) Unit ensures that providers are enrolled in Medicaid in a timely manner to ensure access to services for members.

This measure is important to the PMR Unit because their goal is to ensure Medicaid members have the ability to see enrolled providers for their medical needs as well as to ensure Medicaid providers have the ability to bill and be paid for the services they deliver.

The data that is currently being inputted into MMIS by the DXC Enrollment team to capture the enrollment application received date and application completion date is not always being used correctly. This has been addressed and meetings are happening the week of November 13th to better understand the numbers. Starting in June 2017, a high number of new applications starting coming to DXC as any provider listed on a claim must be actively enrolled with Vermont Medicaid. The PMR Unit is closely monitoring these numbers.

*Last updated: 12/15/17*

*Author: Provider & Member Relations Unit*

## Actions

| Name | Assigned To | Status | Due Date | Progress |
|---|---|---|---|---|

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

# P Special Proj MMIS, IE & HITECH Projects

## What We Do

The Agency of Human Services' Health and Human Services Enterprise (HSE) activities are building a foundation of our business and technological transformations for enhancing the intersection of AHS' service delivery. DVHA is responsible for a vast array of business demands including health care eligibility and claims processing.

Vermont continues to proceed with the building of the HSE in a modular fashion transforming into a data driven, person-centric enterprise. The first step is the implementation of the HSEP (Platform), providing a shared suite of modern technology services, tools, and components that are positioned to be utilized to address business needs for optimizing service delivery including transactional capabilities, analytic performance and all aspects of data management.

**There are three primary programs under which this work is being performed:**

1. Medicaid Management Information System (MMIS) program
2. Integrated Eligibility and Enrollment (IE) program
3. Health Information Exchange/Health Information Technology (HIE/HIT) program

**The MMIS claims processing and provider payment system** allows Vermont to maintain compliance with Federal and State regulations for administering Medicaid. The State processes over $1 billion in Medicaid claims annually and the claims information itself (e.g., the services an individual receives) provides care and case managers with the information they need to effectively serve our members.

**Through the Integrated Eligibility and Enrollment (IE) program**, additional capabilities will be added to the HSEP allowing for automation and standardization of the health & human services case management and program administration systems (screening, application, eligibility determination and enrollment). This represents the continued integration of the Agency's programs as part of one enterprise. This means that our staff and the Vermonters we serve will use one system - one door - to manage services resulting in more efficient accessibility to programs and services for those in need.

**The Health Information Technology (HIT) program** exists to put high quality health data in the hands of those who need it, whether their focus is caring for individual patients or working to improve the health of Vermont's population through health analytics. Health information informs our decisions and allows us to see opportunities and progress made with regards to controlling health care costs and improving Vermonter's health and well-being. The HIT program initiatives are federally and state funded to support a variety of dependent HIT efforts such as Vermont's **Health Information Exchange (HIE)**, the Blueprint for Health's Clinical Registry, and the Department of Health's Immunization Registry. The HIT program continues to evolve as state policy evolves as a tool to understand, coordinate and support the health care landscape. The Medicaid **Electronic Health**

**Record (EHR) Incentive Program** provides incentive payments to eligible professionals, eligible hospitals and critical access hospitals as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. The funds used to support the incentive payment are 100% federal.

## Partners

- New England States Consortium of Systems Organization

## Strategy

| Projects Included in Each Category | | |
|---|---|---|
| **MMIS Projects** | **IE Projects** | **HITECH Projects** |
| • Pharmacy Benefit Management (PBM)<br>• Care Management<br>• Provider Management Module<br>• SSNRI<br>• T-MSIS<br>• Electronic Visit Verification System (EVVS)<br>• State Self-Assessment (SS-A) update<br>• Medicaid Analytics (DVHA pilot)<br>• Electronic Data Interface (EDI)<br>• On-Demand (ECM solution for MMIS)<br>• Business Objects (BOBJ)<br>• Coordination of Benefits (COB) Analysis<br>• Program Integrity (PI) Analysis | • Asset Verification Service (AVS)<br>• Plan the Business<br>• ESD - Business Rules Management (BRM)<br>• House of Brick (HOB) - Oracle Roadmap<br>• Oracle Policy Modeler (OPM)<br>• IE RFP Creation/Release | • HIT/HIE Evaluation (VITL evaluation)<br>• EHRIP / MAPIR<br>• HIE Development<br>• Blueprint Infrastructure Development<br>• VHIE Interface Extension (SFY17)<br>• VHIE Connectivity & Access<br>• Bi-State Quality Improvement Initiative<br>• Blueprint Clinical Registry M & O<br>• VCCI Interfaces Phase 2 |

**The MMIS Program addresses:**

- The modernization of the current MMIS solution in a modular way
- CMS mandated business and system requirements for components that are in-addition to traditional MMIS solution
- Provider Management environment which overlaps in certain areas of HITECH and value-based payment and payment reform efforts

**The HIT program** focuses on health information exchange (HIE) in Vermont - the electronic sharing of clinical data which supports doctors in providing the highest level of care and enables measurement of the health care system to: improve health care quality, make care more efficient, reduce administrative burden, engage patients in their care, and support the health and well-being of the Vermont community.

| Performance Measures | Time Period | Actual Value | Target Value | Current Trend | Baseline % Change |
|---|---|---|---|---|---|
| PM Special Proj % MMIS, IE & HITECH projects on time | SFQ1 2018 | 82.1% | – | → 0 | 0% → |


Notes on Methodology

| % MMIS, IE & HITECH projects on time | | | | | | |
|---|---|---|---|---|---|---|
| Report Period | SFY18 Q1 | | | SFY18 Q2 | | |
| | Total # Projects | # Projects on time | % Projects on time | Total # Projects | # Projects on time | % Projects on time |
| MMIS | 13 | 11 | 84.6% | | | |
| IE | 6 | 5 | 83.3% | | | |
| HITECH | 9 | 7 | 77.8% | | | |
| Total | 28 | 23 | 82.1% | | | |

Story Behind the Curve

**For the % behind schedule, the story behind why:**

**MMIS:** PBM and Care Management are running behind pending approved Change Requests (CR) to align remaining DDI activities.

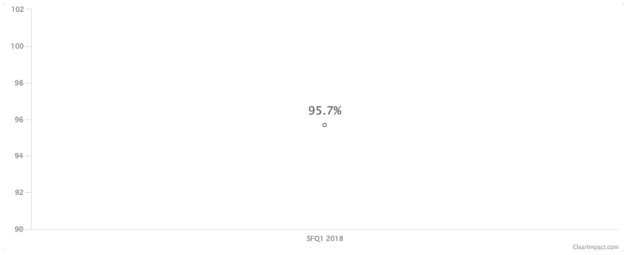
**IE:** AVS is running behind on time due to complexities with executing a Software as a Service (SaaS) solution involving a third party vendor. Additionally, resource constraints during procurement have also hindered progress.

**HITECH:** IAPD is late. Feds have exceeded 60-day review period which includes Blueprint infrastructure development projects. Blueprint is pursuing two development contracts, one RFP has been published, the other still in develoment.

*Last updated: 11/15/17*

*Author: ??*

PM | Special Proj | % MMIS, IE & HITECH projects within scope | **SFQ1 2018** | **95.7%** | – | → **0** | **0%** →




Notes on Methodology

| % MMIS, IE & HITECH projects within scope | | | | | | |
|---|---|---|---|---|---|---|
| Report Period | SFY18 Q1 | | | SFY18 Q2 | | |
| | Total # Projects | # Projects w/in scope | % Projects w/in scope | Total # Projects | # Projects w/in scope | % Projects w/in scope |
| MMIS | 13 | 13 | 100.0% | | | |
| IE | 6 | 6 | 100.0% | | | |
| HITECH | 9 | 9 | 100.0% | | | |
| Total | 28 | 28 | 100.0% | | | |

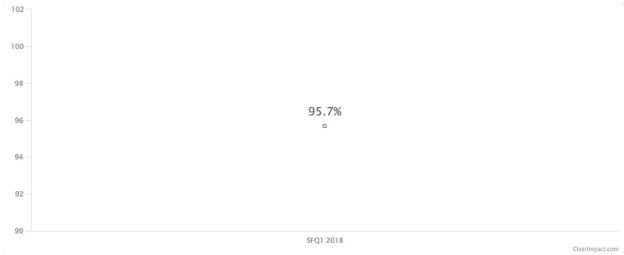
Story Behind the Curve

## For the % that is behind schedule, scope or budget - what's the story behind why?

*Last updated: 11/15/17*

*Author: ???*

PM Special Proj % MMIS, IE, & HITECH projects on budget **SFQ1 2018** **95.7%** – → **0** **0%** →




Notes on Methodology

| % MMIS, IE & HITECH projects on budget | | | | | | |
|---|---|---|---|---|---|---|
| Report Period | SFY18 Q1 | | | SFY18 Q2 | | |
| | Total # Projects | # Projects on budget | % Projects on budget | Total # Projects | # Projects on budget | % Projects on budget |
| MMIS | 13 | 13 | 100.0% | | | |
| IE | 6 | 5 | 83.3% | | | |
| HITECH | 9 | 9 | 100.0% | | | |
| Total | 28 | 27 | 96.4% | | | |

Story Behind the Curve

**For the % that is behind budget - what's the story behind why?**

**IE:** AVS is over-budget because initial estimated costs were less than contractual costs.

**HITECH:** For the HIT/HIE Evaluation (VITL evaluation), VITL has requested additional budget for evaluation support.

*Last updated: 11/15/17*

*Author: ??*

## Actions

| Name | Assigned To | Status | Due Date | Progress |
|---|---|---|---|---|

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

# P QICIU Quality Improvement & Clinical Integrity Unit

## Budget Information

## What We Do

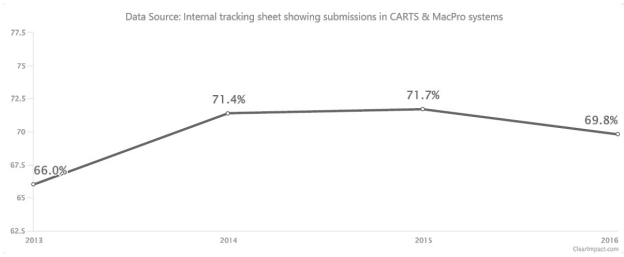
**The Quality Improvement & Clinical Integrity Unit (QICIU)** includes the Quality Team and the Clinical Utilization Review Team. The Quality Team collaborates with AHS partners to develop a culture of continuous quality improvement, maintains the Vermont Medicaid Quality Plan and Work Plan, coordinates quality initiatives including formal performance improvement projects, coordinates the production of standard performance measure, and is the DVHA lead unit for the Results Based Accountability (RBA) methodology & produces the DVHA RBA Scorecards.

The Clinical Utilization Review Team (UR) is responsible for the utilization management of mental health and substance use disorder services. The team works toward the integration and coordination of services provided to Vermont Medicaid members with substance use disorder and mental health needs. The team performs utilization management activities including concurrent review and authorization of mental health and substance use disorder services. The UR Team also administers the Team Care program, which locks a member to a single prescriber and a single pharmacy. In addition, the Autism Specialist prior authorizes applied behavior analysis (ABA) services for children.

## Who We Serve

## How We Impact

| Performance Measures | Time Period | Actual Value | Target Value | Current Trend | Baseline % Change |
|---|---|---|---|---|---|
| PM QICIU % of the total measures in the Medicaid Quality Adult & Child Core Measure Sets reported to Centers for Medicaid & Medicare Services (CMS) by the Quality Unit | 2016 | 69.8% | – | ↘ 1 | 6% ↑ |
| | 2015 | 71.7% | – | ↗ 2 | 9% ↑ |
| | 2014 | 71.4% | – | ↗ 1 | 8% ↑ |
| | 2013 | 66.0% | – | → 0 | 0% → |



Partners

- DVHA Data Unit
- Contractor to produce the performance measures

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Story Behind the Curve

Medicaid provides coverage to low-income adults, children, elderly persons, pregnant women, and people with disabilities. In short, Medicaid covers some of the most high-need populations in the country.

Accordingly, federal legislation called for the creation of core sets of healthcare quality measures to assess the quality of care for adults and children enrolled in Medicaid. The U.S. Department of Health & Human Services established the Adult and Child Core Sets to standardize the measurement of healthcare quality across state Medicaid programs, assist states in collecting and reporting on the measures, and facilitate use of the measures for quality improvement.

The Adult and Child Core Sets are often used to provide a snapshot of quality within Medicaid. They are not comprehensive, but prior to their creation and implementation, performance measurement varied greatly by state, and it was not possible to glean an overall picture of quality. Statute requires CMS to release annual reports on behalf of the Secretary on the reporting of state-specific adult Medicaid quality information.

The DVHA was awarded Adult Medicaid Quality Grant funding starting in CY 2013 through CY 2015. A portion of this funding was used to facilitate quality improvement projects, as well as to assist in collecting and reporting on these core measures. The DVHA focused some of the funding on producing measures that require medical record review in order for results to be accurate and complete. This funding was no longer available to the State starting in 2016, so the Department was not able to produce the measures that require record review, thus the drop in the trend line above. We strive to build this funding back into our budget in years to come, as the production of measures that require record review will be key to the state's ability to keep pace with other state Medicaid plans and to evaluate the effectiveness of our payment reform models. These models are required to report out on key health indicators (hypertension for example) for their attributed populations. In order to achieve alignment and a comparison cohort, we need to produce these same measures for the general Medicaid population.

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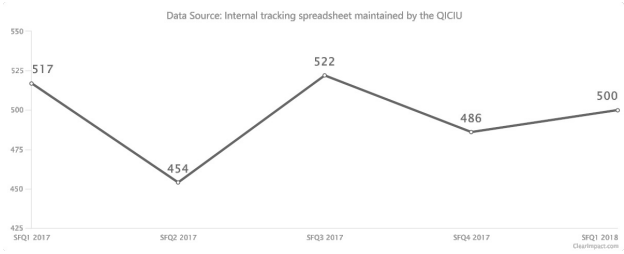
*Last updated: August 2017*

*Author: Quality Improvement & Clinical Integrity Unit*

PM QICIU # of adult, detox & child inpatient admissions




| | | | | |
|---|---|---|---|---|
| SFQ1 2018 | 500 | – | ↗ 1 | -3% ↓ |
| SFQ4 2017 | 486 | – | ↘ 1 | -6% ↓ |
| SFQ3 2017 | 522 | – | ↗ 1 | 1% ↑ |
| SFQ2 2017 | 454 | – | ↘ 1 | -12% ↓ |
| SFQ1 2017 | 517 | – | → 0 | 0% → |

Notes on Methodology

| Admissions by Type | SFY17 Q1 | SFY17 Q2 | SFY17 Q3 | SFY17 Q4 | SFY18 Q1 |
|---|---|---|---|---|---|
| **Adult** | 282 | 280 | 312 | 288 | 330 |
| **Detox** | 156 | 97 | 109 | 106 | 77 |
| **Children** | 79 | 77 | 101 | 92 | 93 |
| **Total** | **517** | **454** | **522** | **486** | **500** |

Partners

- Vermont Medicaid Inpatient Providers

Story Behind the Curve

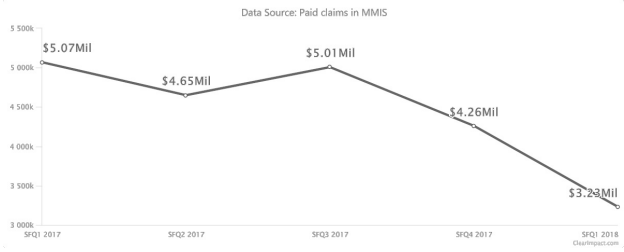
This measure reflects the total number of behavioral health inpatient admissions authorized by the Quality Unit Clinical Utilization Review (UR) Team. The UR Team reviews all admission notifications within 1 business day of receipt.

The data shows that for the adult and children admissions there was a jump in the third quarter of the fiscal year. The Quality Unit has outreached their partners to determine an explanation for the shift. The detox admissions showed a different trend. Q1 was significantly (50) higher than the other quarters. Looking at co-occurring mental health and substance use conditions, it can be noted that most of the detox admissions were withdrawing from alcohol. Because opiate withdrawal usually doesn't require medical management and isn't a covered benefit without medical necessity, there was concern that members withdrawing from opiates would be admitted for mental health needs. The data suggests that concern was not realized in this fiscal year.

*Last updated: 10/19/17*

*Author: Quality Improvement & Clinical Integrity Unit*

PM QICIU $$ amount of paid claims for adult, detox & child inpatient admissions




| | | | | |
|---|---|---|---|---|
| SFQ1 2018 | $3.23Mil | – | ↘ 2 | -36% ↓ |
| SFQ4 2017 | $4.26Mil | – | ↘ 1 | -16% ↓ |
| SFQ3 2017 | $5.01Mil | – | ↗ 1 | -1% ↓ |
| SFQ2 2017 | $4.65Mil | – | ↘ 1 | -8% ↓ |
| SFQ1 2017 | $5.07Mil | – | → 0 | 0% → |

Notes on Methodology

| Paid Claims by Type | SFY17 Q1 | SFY17 Q2 | SFY17 Q3 | SFY17 Q4 | SFY18 Q1 |
|---|---|---|---|---|---|
| **Adult** | $2,454,107 | $2,418,881 | $2,571,705 | $2,073,740 | $2,203,703 |
| **Detox** | $845,469 | $437,773 | $545,029 | $496,944 | $232,521 |
| **Children** | $1,769,510 | $1,793,968 | $1,890,571 | $1,690,421 | $796,255 |
| **Total** | **$5,069,086** | **$4,650,622** | **$5,007,305** | **$4,261,105** | **$3,232,479** |

Partners

- Vermont Medicaid Inpatient Providers
- DVHA Business Office
- DXC Technology

Story Behind the Curve

The Quality Unit reviews paid claims and tracks the costs of inpatient hospitalization for specific populations. The $ amounts above include all paid claims for the Medicaid members who had an inpatient stay prior authorized by a Quality Unit Utilization Review Clinician.

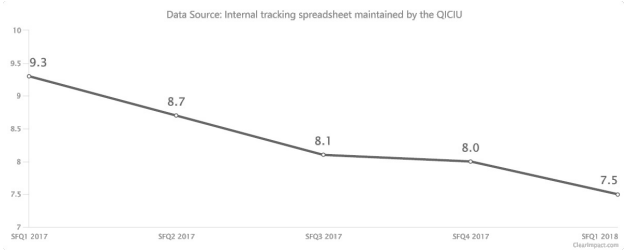
The Quality Unit is currently working with the Business Office to review the claims reconciliation process with the goals of ensuring that the appropriate paid claims are being captured in the most efficient way and that DVHA is paying for the approved level of care at the appropriate rate. It is anticipated that process will be revised by the end of CY2017.

*Last updated: 10/19/17*

*Author: Quality Improvement & Clinical Integrity Unit*

Average length of stay (LOS) for adult, detox

PM QICIU & child inpatient admissions




| | | | | |
|---|---|---|---|---|
| SFQ1 2018 | 7.5 | – | ↘ 4 | -19% ↓ |
| SFQ4 2017 | 8.0 | – | ↘ 3 | -14% ↓ |
| SFQ3 2017 | 8.1 | – | ↘ 2 | -13% ↓ |
| SFQ2 2017 | 8.7 | – | ↘ 1 | -6% ↓ |
| SFQ1 2017 | 9.3 | – | → 0 | 0% → |

Notes on Methodology

| Average LOS by Type | SFY17 Q1 | SFY17 Q2 | SFY17 Q3 | SFY17 Q4 | SFY18 Q1 |
|---|---|---|---|---|---|
| **Adult** | 8.3 | 7.4 | 6.7 | 7.0 | 7.2 |
| **Detox** | 5.5 | 4.9 | 5.5 | 5.1 | 4.8 |
| **Children** | 19.8 | 18.0 | 15.4 | 14.6 | 10.8 |
| **Total** | **9.3** | **8.7** | **8.1** | **8.0** | **7.5** |

Partners

- Vermont Medicaid Inpatient Providers
- Department of Children & Families
- Department of Mental Health

Story Behind the Curve

As a part of DVHA's utilization management program, the Quality Unit impacts and tracks the average length of inpatient psychiatric and detox stays for Vermont Medicaid members over time.

The Utilization Review (UR) Clinicians conduct numerous utilization management and review activities to ensure that quality services, those which increase the likelihood of desired health outcomes and are consistent with prevailing professionally-recognized standards of medical practice, are provided to members and that providers are using the program appropriately, effectively and efficiently. The UR Clinicians utilize clinical criteria for making utilization review decisions that are objective and based on sound medical evidence.

The data in the above trend lines show relatively consistent average lengths of stay for the psychiatric adult and detox populations. In January of 2017, UR Clinicians began participation in weekly status calls for all children placed in the Brattleboro Retreat. In doing so, some disposition issues were addressed. This may have contributed to the decrease in the average length of stay for children.

*Last updated: 10/19/17*

*Author: Quality Improvement & Clinical Integrity Unit*

## Actions

| Name | Assigned To | Status | Due Date | Progress |
|---|---|---|---|---|

# P Reimbursement Reimbursement Unit

## Budget Information

## What We Do

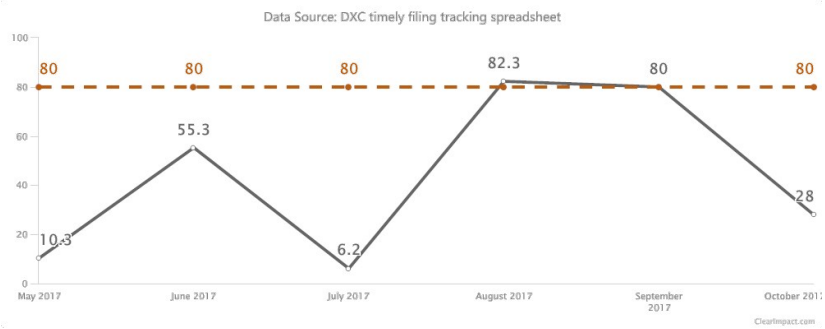
**The Reimbursement Unit** oversees rate setting, pricing, provider payments and reimbursement methodologies for a large array of services provided under Vermont's Medicaid Program. The unit works with Medicaid providers and other stakeholders to support equitable, transparent, and predictable payment 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 payments 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 tests, 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.

## Who We Serve

## How We Impact

### Performance Measures

PM Reimbursement % of claims that were originally submitted in a timely manner but were denied payment (timely filing) turned around in 15 business days or less




| Time Period | Actual Value | Target Value | Current Trend | Baseline % Change |
|---|---|---|---|---|
| Oct 2017 | 28.0% | 80.0% | ↘ 2 | 172% ↑ |
| Sep 2017 | 80.0% | 80.0% | ↘ 1 | 677% ↑ |
| Aug 2017 | 82.3% | 80.0% | ↗ 1 | 699% ↑ |
| Jul 2017 | 6.2% | 80.0% | ↘ 1 | -40% ↓ |
| Jun 2017 | 55.3% | 80.0% | ↗ 1 | 437% ↑ |
| May 2017 | 10.3% | 80.0% | → 0 | 0% → |

Partners

- Medicaid Providers
- DXC
- Department of Mental Health
- Department of Aging & Independent Living
- Department for Children & Families

Story Behind the Curve

Medicaid has regulations on how long providers have to submit claims for reimbursement, this is called timely filling. For claims originally submitted in a timely manner but denied payment, The DVHA Reimbursement Unit will review for payment. This performance measure will track how long the Reimbursement Unit takes to review denied claims and make a final decision on whether or not to pay them.

This measure is important to ensure that provider reviews of timely filings are processed in a consistent and timely manner. Providers will appreciate having a decision sooner rather than later.

The Reimbursement Unit recently worked with DXC to update the Timely Filing process. Prior to the update, the process was entirely manual with claims handed off in person from DXC to DVHA Reimbursement staff to work the timely filing request and then return to DXC for MMIS processing, if approved for payment. No tracking system was

in place so it was difficult and time consuming to determine where a claim was in the process when a provider called for a status update. With the Reimbursement Unit's move to the Waterbury complex the process became even more difficult and lengthier. Claims now had to be transported between Williston and Waterbury by currier, adding an additional 3 to 6 days on each end to the time it took to determine whether to pay the claim(s) or not.

The Reimbursement Unit, recognizing the process was inefficient and cumbersome, started working with DXC staff to update and streamline the process. Starting in June 2017, scanned documentation replaced the need for a currier and a tracking spreadsheet is now available in SharePoint that is continually updated and viewable by both DXC and Reimbursement. The electronic process tracks the timely filing request from the day it arrives at DXC to the day a final determination is made by Reimbursement and communicated to DXC.

Now that a tracking system is in place, the Reimbursement Unit has set a goal to review and make a payment determination on 80% of timely filing requests within 15 business days of being received in the unit. There are various challenges to achieving this goal such as:

1. The free flow of requests in a timely manner to the unit
2. The appropriateness of documentation included in the request (i.e. does it support the providers claim or is additional support needed to make a determination)
3. Complexity of the case
4. For timely filing requests received that require a determination by a sister department, receiving the determination in a timely manner
5. Obtaining management approval, when appropriate
6. Working out the "bugs" of a new process.

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*Last updated: 12/15/17*

*Author: Reimbursement Unit*

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PM Reimbursement % of annual fee schedule updates that are posted for public notice 30 days prior to the effective date of the rate change

| | | | | |
|---|---|---|---|---|
| SFY 2017 | 50% | 100% | ↗ 1 | 4900% ↑ |
| SFY 2016 | 0% | 100% | → 0 | 0% → |


Partners

- Burns and Associates Inc. (consultants)
- Medicaid Providers
- Trade associations such as Vermont Association of Hospitals and Health Systems (VAHHS), VNA's of Vermont and Bi-State, etc.
- DXC
- DVHA Policy Unit
- DVHA Business Office
- DVHA Program Integrity Unit

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Story Behind the Curve

During the 2016 legislative session the Reimbursement Unit received a lot of push back from hospitals related to its proposed policy to eliminate Provider Based Billing (PBB), with specific complaints on the length of the public notice period. In this case, public notice was posted to the Global Commitment Register on February 13, 2016 and slated to run until February 29th (Leap Year), a total of 17 days. The new policy was to have been implemented on March 1, 2016.

While Vermont Medicaid does not have a specific policy related to the length of a public notice period, it has

followed Medicare guidelines which states public notice should be posted for a "reasonable" length of time. As a result, the Reimbursement Unit has established the goal that 100% of annual fee schedule/policy change updates

There are many challenges to the Reimbursement Unit meeting the goal of posting public notice 30 days prior to the effective date for a fee schedule/policy change update. Some of those barriers are as follows:

1. Obtaining consensus of stakeholders
2. Having clear and concise language in legislative directives
3. Having sufficient time to review and model rate/policy changes prior to legislatively directed implementation dates
4. Estimating budget impacts and obtaining PBR approval
5. Length of time needed by DXC to make necessary system changes to MMIS

*Last updated: 09/08/17*

*Author: Reimbursement Unit*

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PM Reimbursement % of annual fee schedule updates implemented by goal date – – – – –

Notes on Methodology

- This is a new performance measure for the Reimbursement Unit; the SFY18 data point will be available in July 2018.

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Story Behind the Curve

Currently there are no specific requirements on how often or exactly when Medicaid fee schedules get updated, so the Reimbursement Unit sets an internal target date for annual updates. This measure tracks what percentage of the time the unit is able to meet its target goal date.

Fee schedules let providers know what they will get reimbursed for providing a particular service. It is important to have consistency and predictability for fee schedule updates both for workflow purposes within the unit and for DVHA to continue to align with Medicare fee schedule updates and policy changes.

*Last updated: 10/03/17*

*Author: Reimbursement Unit*

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## Actions

| Name | Assigned To | Status | Due Date | Progress |
|---|---|---|---|---|

# P VCCI Vermont Chronic Care Initiative (VCCI)

## Budget Information

## What We Do

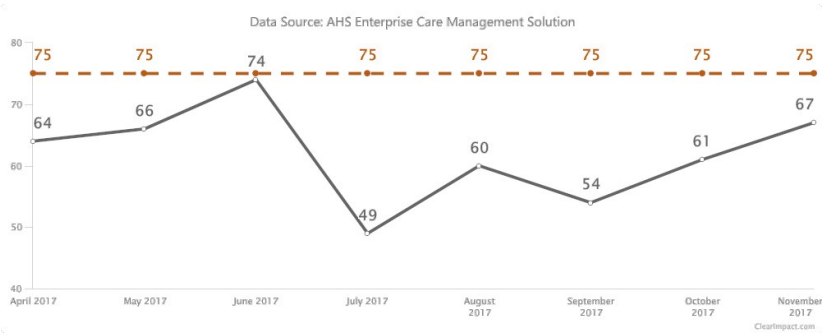
**The Vermont Chronic Care Initiative (VCCI)** is a healthcare reform strategy to support Medicaid members with chronic health conditions and/or high utilization of medical services to access clinically appropriate healthcare information and services; to coordinate the efficient delivery of healthcare 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.

## Who We Serve

## How We Impact

### Performance Measures

PM VCCI # new VCCI eligible members enrolled in care management




| Time Period | Actual Value | Target Value | Current Trend | Baseline % Change |
|---|---|---|---|---|
| Nov 2017 | 67 | 75 | ↗ 2 | 24% ↑ |
| Oct 2017 | 61 | 75 | ↗ 1 | 13% ↑ |
| Sep 2017 | 54 | 75 | ↘ 1 | 0% → |
| Aug 2017 | 60 | 75 | ↗ 1 | 11% ↑ |
| Jul 2017 | 49 | 75 | ↘ 1 | -9% ↓ |
| Jun 2017 | 74 | 75 | ↗ 2 | 37% ↑ |
| May 2017 | 66 | 75 | ↗ 1 | 22% ↑ |
| Apr 2017 | 64 | 75 | ↘ 1 | 19% ↑ |
| Mar 2017 | 69 | 75 | ↗ 3 | 28% ↑ |
| Feb 2017 | 51 | 75 | ↗ 2 | -6% ↓ |

Partners

- Medicaid Medical Director
- Medicaid Providers
- Community Health Teams
- MMIS & Care Management vendors

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Story Behind the Curve

The Vermont Chronic Care Initiative (VCCI) eligible cohort is established based on criteria including high risk/cost members that are Medicaid primary and receive no other waiver services (CRT, Choices for Care). This measure represents the total number of **new enrollments** during the reporting month and directly impacts the VCCI ability to meet clinical and financial outcome measures among the target population. This measure captures new cases only, not the total case load. Staff case loads average 20- 25 members per month for 'short term, intensive case management, prior to transition to a lower level of case management within the medical home''.

The VCCI implemented a new Care Management system for member identification and case management documentation during SFYs 2016 & 2017; in 2018 there are continued deployments of new functionality and related user acceptance testing by and training requirements for end users. In January 2017, the VCCI lost the ability to enroll members assigned to the ACO. This prompted a related transfer of active members and a drop in both the eligible population and provider referrals in these communities.

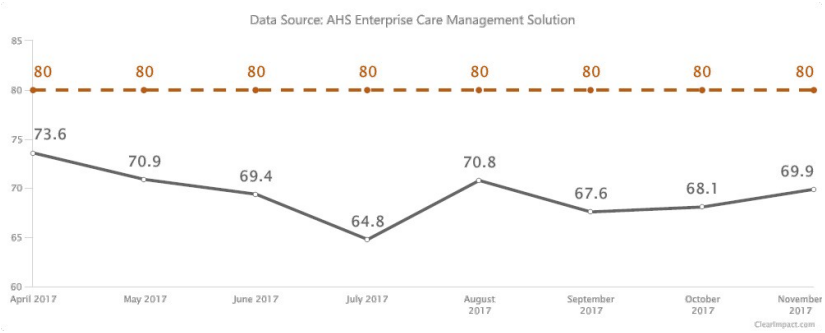
The VCCI turn over in SFY 2017 (6 FTE's) and SFY to date 2018 (3 FTE's) due to career advancement, retirement and

out-of-state relocation has adversely impacted VCCI enrollment. The required recruitment, orientation, training and case load development for new staff hired in the past 6 months, pushes down our team's case load capacity. Concurrently, the VCCI new target population identification methodology and testing, necessitated by the next generation ACO pilot efforts, were manually being implemented by field staff, pending the deployment of new logic into production; and, the new ACO population exclusion rules, which are currently in development, also generates a manual workaround by professional staff performing outreach to our target population. Summer vacations and staff out on FMLA further confound performance in the last 2 measurement months. A continued drop in VCCI enrollment over desired levels may continue to be a risk in the near term, as the final deployment of the care management system (originally targeted for 12/31/17) will require significant end user testing and pre-deployment training, prior to the final scheduled deployment. As the MMIS/Care Management project slows in 2018 and the business stabilizes the operating system, VCCI will continue PDSAs toward increasing member engagement.

*Last updated: 12/15/17*

*Author: Vermont Chronic Care Initiative*

PM VCCI % of VCCI enrolled members with a face to face visit during the month




| | | | | |
|---|---|---|---|---|
| Nov 2017 | 69.9% | 80.0% | 2 | 9% |
| Oct 2017 | 68.1% | 80.0% | 1 | 6% |
| Sep 2017 | 67.6% | 80.0% | 1 | 6% |
| Aug 2017 | 70.8% | 80.0% | 1 | 11% |
| Jul 2017 | 64.8% | 80.0% | 3 | 1% |
| Jun 2017 | 69.4% | 80.0% | 2 | 8% |
| May 2017 | 70.9% | 80.0% | 1 | 11% |
| Apr 2017 | 73.6% | 80.0% | 2 | 15% |
| Mar 2017 | 66.6% | 80.0% | 1 | 4% |
| Feb 2017 | 60.8% | 80.0% | 2 | -5% |

Partners

- Medicaid Beneficiaries
- Medicaid Providers
- Community Health Teams
- Housing Coalitions
- AHS Field Directors
- Probation & Parole
- Others who support intensive case management of high risk/cost members and opportunities for face to face visiting in the safest environment

Story Behind the Curve

One of the important and differentiating elements of the Vermont Chronic Care Initiative (VCCI) model is member face to face meetings as a measure of member engagement and trust, to support effective self-management and sustainable change. This measure is calculated as the percent of all members enrolled during the reporting month that received at least one face to face visit.

Face to face visits are a component of short term, intensive case management and a factor in overall assessment of need and relationship building. Both are required to generate effective self-management and sustainable change.

The VCCI continues to work on staffing goals and standardized documentation and reporting in the new MMIS/Care Management system. While measurement is based on the month activity, there may be new enrollments for a partial month, members lost to contact (phone/home address change), member 'no shows' and/or case closures during the enrollment month, thus impacting face to face visit calculation in the measurement period. Staff goals are set toward improvement using PDSA cycles and to better evaluate baseline and 'stretch' goals.

While face to face visits have increased over prior months, the overall percentage of VCCI enrolled members with visits is under goal. This may be related to general issues of member no show rates, being lost to follow up or incarcerated or inpatient; as well as the method for calculation. For example, staff close a case after 3 unsuccessful attempts to reach a member, which could result in a member on their monthly case load with no face to face visits or successful interventions, as they are 'lost to follow-up' during the reporting period, although still on the active case load. Staff re-education related to timing of cases is in process to facilitate the case closure timeline (i.e. on 10/30 vs. on 11/6, thus showing no activity for the month of November)

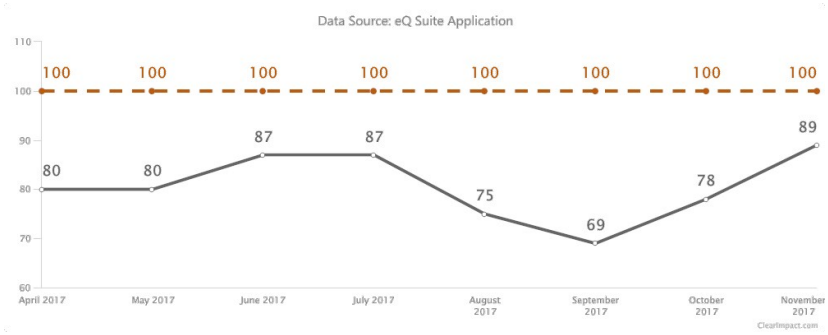
*Last updated: 12/15/17*

*Author: Vermont Chronic Care Initiative*

What Works

Face to face visits offer an opportunity for further member assessment and establishing meaningful relationship/engagement and trust required for health coaching/education on behavioral changes required for improved health. Home visits support assessment of the home environment, precipitating factors in their health/chronic health conditions (i.e. mold exposure for asthmatics with recurrent ED usage) and also offer the chance to perform medication reconciliation and assess adherence to pharmacy treatment. The literature does support the effectiveness of face to face case management vs. telephonic as regards results and sustainable change.

PM VCCI % of VCCI case managers who score 90% or better on workflow and clinical supports audit




| | | | | |
|---|---|---|---|---|
| Nov 2017 | 89% | 100% | ↗ 2 | 68% ↑ |
| Oct 2017 | 78% | 100% | ↗ 1 | 47% ↑ |
| Sep 2017 | 69% | 100% | ↘ 2 | 30% ↑ |
| Aug 2017 | 75% | 100% | ↘ 1 | 42% ↑ |
| Jul 2017 | 87% | 100% | → 1 | 64% ↑ |
| Jun 2017 | 87% | 100% | ↗ 1 | 64% ↑ |
| May 2017 | 80% | 100% | → 1 | 51% ↑ |
| Apr 2017 | 80% | 100% | ↗ 1 | 51% ↑ |
| Mar 2017 | 53% | 100% | → 0 | 0% → |

Notes on Methodology

- Scores are generated by a manual review of records in the eQ Suite application using audit tool designed to measure adherence VCCI workflow. One case/month is "self-audited" and the remainder performed by designated staff. Only scores of current staff still working with VCCI are included.

Story Behind the Curve

Monthly staff audits on priority elements of workflow and clinical supports are performed using 5 cases/month on each staff, with the goal of each staff averaging a 90% audit results toward a team goal of 90%. Individual staff with 90% in each of 3 consecutive months are then audited only once each quarter. The measure is calculated monthly based on the average of a rolling 3 months.

Audits are an indicator of staff understanding of and adherence to the VCCI workflow and which inform program outcome reporting on population intervened, goals achieved, etc.

VCCI audits demonstrate improvement over prior months, however there remain individual staff members who 'hover' below the 90% benchmark and thus, continue to be audited monthly versus every 3 months for those demonstrating successful results, thus holding the overall result below goal (100% of staff hitting 90% on audit). A variable in the September result is a change in the auditing approach from one non-clinical staff member to several clinical auditors. This change was necessitated by the ramp up in the MMIS care management effort and reassignment of the lead auditor to a broader role in the time sensitive final deployment, with a goal of completion of 12/31/17.

Additional strategies toward improvement of scores is the availability of 1:1 staff training as indicated by audit

scores. These will be scheduled over the next month using trained trainers in the system workflow.

*Last updated: 12/15/17*

*Author: Vermont Chronic Care Initiative*

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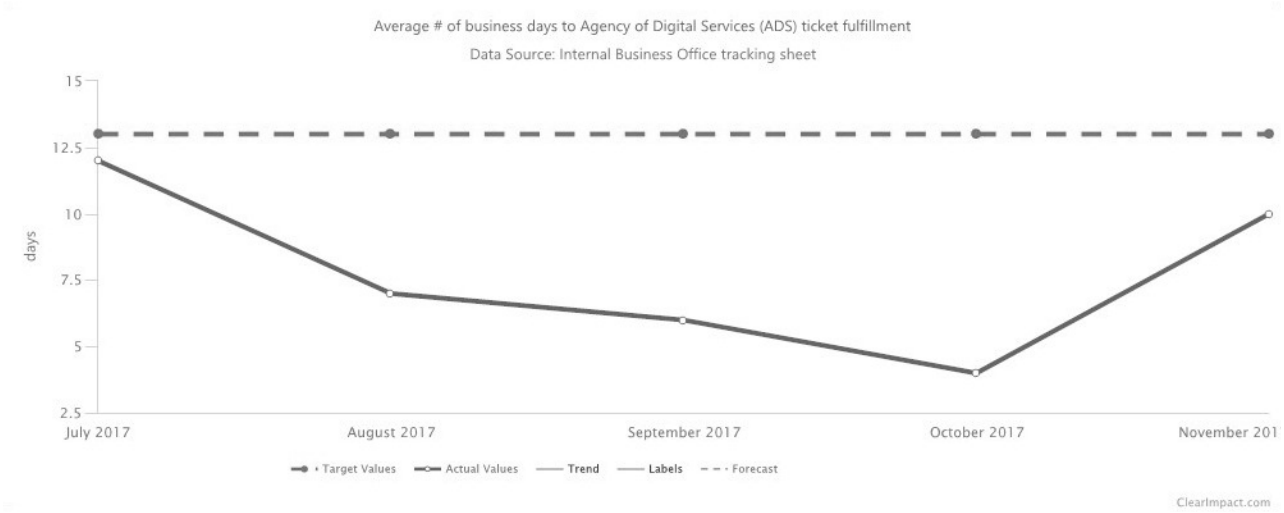
## Actions

| Name | Assigned To | Status | Due Date | Progress |
|---|---|---|---|---|

# P Administrative Services Unit & Operations

## PM Operations Average # of business days to Agency of Digital Services (ADS) ticket fulfillment




### Notes on Methodology

- The goal is to bring ADS tickets to fulfillment in ≤13 business days.

### Partners

- DVHA Staff
- DVHA Managers & Directors
- DVHA IT Support
- The Agency of Digital Services (ADS)

### Story Behind the Curve

If DVHA staff have a need for computer software or hardware, they submit an Agency of Digital Services (ADS) deployment request to their supervisor for approval. The ticket is then reviewed and approved by the DVHA Business Office, DVHA IT Support & the ADS. The total ticket turn around time is 13 business days; the Business Office has a turn around time of 3 business days & ADS has a turn around time of 10 business days.

This measure is important because it shows that the Business Office is ensuring that DVHA employees have equipment ordered and available for their use in a timely manner in order to deliver quality service to Vermonters.

**A variety of challenges may be faced in bringing a ticket to closure (including but not limited to):**

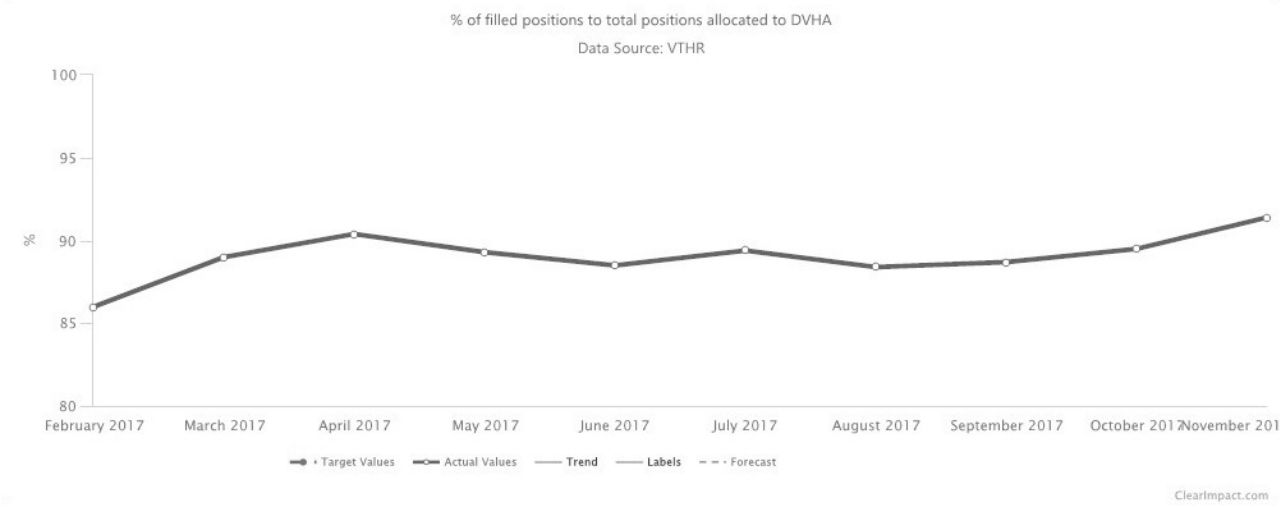
- ADS does not have some items in stock and they need to be ordered
- Some items require installation which must be coordinated with the end user
- Staff vacation and sick time can influence ticket closure time
- ADS may not recommend or support a purchase; the ticket may take some time to negotiate

*Last updated: 12/15/17*

*Author: Operations Staff*

# P Administrative Services Unit & Operations

## PM Admin % of filled positions to total positions allocated to DVHA




## Partners

- Senior Leadership
- DVHA Managers

## Story Behind the Curve

Adequate staffing resources is an important component in the success of the Department's initiatives. The Department of Vermont Health Access (DVHA) must have a focus on recruitment and on professional development in order to recruit and retain talent. DVHA needs to ensure that adequate resources are allocated in order to continue to meet our deadlines for important projects and initiatives.

This key performance indicator shows how well DVHA is managing and filling position vacancies.

*Last updated: 12/15/17*

*Author: Administrative Services Unit*

## Strategy

- Managers identify & report resource deficiencies and needs to Senior Leadership.
- As positions become vacant, Senior Leadership reviews the needs of the unit as well as the needs of the department.

# APPENDIX D: AHS OVERVIEW

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 health care 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 and coordinates agency budget submission;
- Updates federal cost allocation plans;
- Works with the Medicaid Policy Unit to update the State plan; and
- Coordinates the master grant negotiations with Designated Agencies (DAs) and Specialized Service Agencies (SSAs).

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 (DAIL) and private non-medical institutions for the Department of Children and Family (DCF).

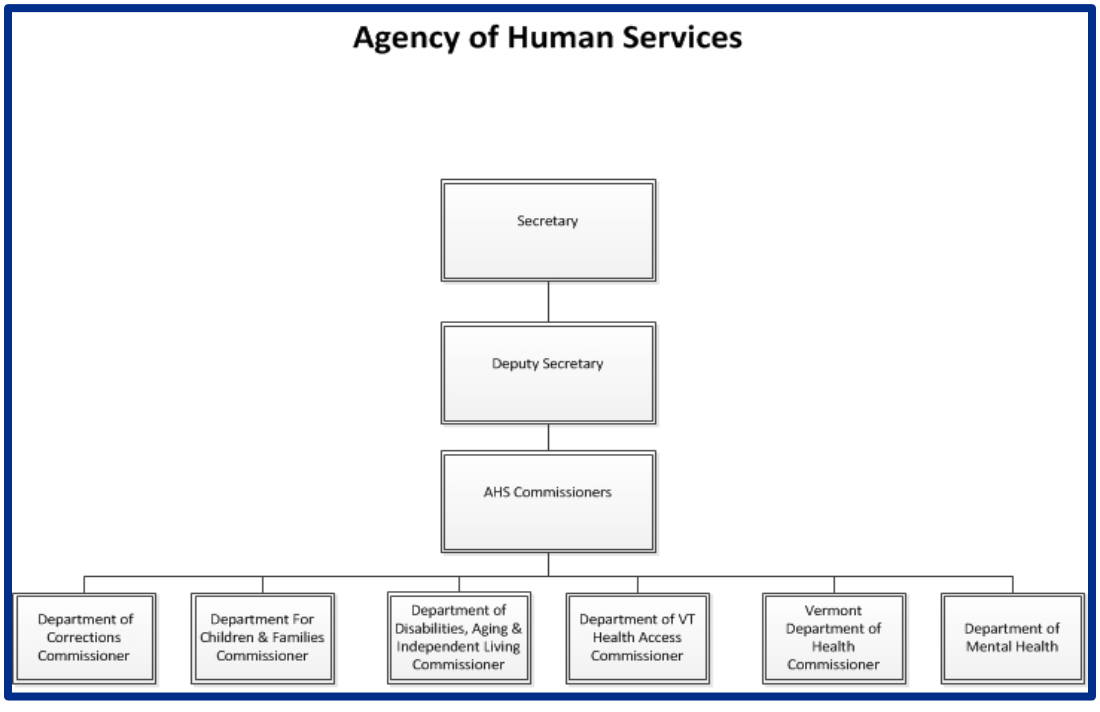
The AHS Healthcare Operations, Compliance, and Improvement Unit manages activities pertaining to Medicaid and associated healthcare operations. It is responsible for integrated planning, policy development, regulatory compliance and funding. These initiatives require cross-departmental (and intra-governmental) 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.

| State Fiscal Year | VT Population Estimate[7] | Green Mountain Care Enrollment | Percent of Population Enrolled |
|---|---|---|---|
| **SFY 2017** | 623,657 | 206,955 | 33.18% |
| **SFY 2016** | 624,594 | 220,556 | 35.31% |
| **SFY 2015** | 626,562 | 209,395 | 33.42% |
| **SFY 2014** | 626,855 | 178,650 | 28.50% |
| **SFY 2013** | 626,138 | 173,849 | 27.77% |
| **SFY 2012** | 626,450 | 171,610 | 27.39% |
| **SFY 2011** | 625,792 | 169,179 | 27.03% |

[7]Annual estimates of the Resident Population: April 1, 2010 to July 1, 2017, U.S. Census Bureau, Population Division, Release Date: July 2017

## AHS Organization Chart



### Medicaid within AHS

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 (DVHA) manages the State's Medicaid program, which is 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 and services managed by each department is below:

| **Department** | **Division/Programs/Services** |
|---|---|
| Department of Vermont Health Access (DVHA) | Traditional Healthcare Services<br>Blueprint for Health<br>Coordination of Benefits (COB)<br>Mental Health and Substance Use<br>Program Integrity (PI)<br>Vermont Chronic Care Initiative (VCCI)<br>Quality Reporting<br>Eligibility and Enrollment |
| Agency of Education (AOE) | School-based Health Services (IEP) Program |
| Department of Disabilities, Aging and Independent Living (DAIL) | Adult Services Division (ASD)<br>Developmental Disabilities Services (DDS) Program<br>Traumatic Brain Injury Services (TBI) Program<br>Long Term Care (LTC or CFC) Program |
| Department for Children and Families (DCF) | Child Development Division (CDD)<br>Children's Integrated Services (CIS) Program<br>Family Services Division (FSD)<br>Contracted Treatment Service Programs |

| | |
|---|---|
| Department of Corrections (DOC) | Medicaid for Incarcerated Individuals Admitted to Hospital or Other Facility |
| Department of Mental Health (DMH) | Adult Mental Health Division (AMH)<br><br>Children's Mental Health Division (CMH) |
| Vermont Department of Health (VDH) | Alcohol and Drug Abuse Program (ADAP)<br><br>Ladies First Program<br><br>HIV/AIDS Program |

Since 2005, Vermont has used the Global Commitment to Health (GCH) Waiver to operate its Medicaid program under an innovative model developed to provide essential services for Vermont's most vulnerable populations including people with disabilities, seniors, and those with low incomes; and ensuring affordable health care coverage for children and adults alike. These efforts have positioned Vermont as a national leader in state-based health care reform.

AHS received Center for Medicare and Medicaid Services (CMS) approval to continue the waiver for an additional five-year term from January 1, 2017 through December 31, 2021. This extension allows Vermont to preserve several key benefits for our Medicaid members:

- Medicaid coverage of essential services for Vermont's most vulnerable populations, including people with disabilities, seniors, and those with low incomes;
- Affordable health care coverage for children through Dr. Dynasaur;
- Premium assistance for Vermonters through Vermont Health Connect; and
- Payment and delivery system reform by ensuring Medicaid participation and alignment with the All-Payer Model.

The extension will require additional reporting and federal oversight monitoring and requires restructuring of the funding of certain investments, formerly commonly known as MCO (Managed Care Organization) Investments. With the changes in the Global Commitment Waiver, the investment will henceforth be termed just "Investments".

Department of Vermont Health Access will be subject to the requirements that are applicable to a non-risk pre-paid inpatient health plan (PIHP). Vermont will continue adhering to the managed care requirements for risk-bearing entities including the rate certification requirements and the value-based payment requirements for any payment that is made outside of the traditional fee-for-service model.

Under the extension, Vermont has moved from an aggregate budget neutrality agreement to a per member per month (PMPM) budget neutrality model. This will safeguard the State against risks of caseload growth.

In support of the CMS, the AHS is pursuing an amendment to the GCH waiver to support its substance use disorder initiatives. An estimated 12 percent of the adult Medicaid population aged 18–64 are experiencing substance use disorders. CMS is interested in working with the State to provide the necessary support and the efforts in Vermont are closely aligned with CMS' goals.

| SFY 2017 Medicaid Spend - Global Commitment, CHIP, & CFC - BY CATEGORY OF SERVICE | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Category of Service** | **DVHA** | **DMH** | **VDH** | **DCF** | **AOE** | **DAIL** | **Total AHS** |
| Inpatient | $ 138,544,384 | $ 10,605,351 | $ - | $ 18,672 | $ - | $ (1,260) | $ 149,167,146 |
| Outpatient | $ 118,139,830 | $ - | $ 28,344 | $ 28,226 | $ - | $ - | $ 118,196,400 |
| Physician | $ 119,045,147 | $ (164) | $ 25,287 | $ 219,544 | $ 220,186 | $ - | $ 119,509,999 |
| Pharmacy | $ 191,311,860 | $ - | $ 606,289 | $ 10,113 | $ - | $ - | $ 191,928,262 |
| Nursing Home | $ 125,765,820 | $ - | $ - | $ - | $ - | $ - | $ 125,765,820 |
| ICF/MR Private | $ - | $ - | $ - | $ - | $ - | $ 1,150,508 | $ 1,150,508 |
| Mental Health Facility | $ 350,934 | $ 17,088 | $ - | $ - | $ - | $ - | $ 368,022 |
| Dental | $ 27,664,428 | $ - | $ - | $ 192,304 | $ - | $ - | $ 27,856,732 |
| MH Clinic | $ 215,437 | $ 138,014,669 | $ - | $ - | $ - | $ 645,877 | $ 138,875,983 |
| Independent Lab/Xray | $ 12,371,572 | $ - | $ 701 | $ - | $ - | $ - | $ 12,372,273 |
| Home Health | $ 6,610,943 | $ - | $ - | $ 423,125 | $ (250) | $ - | $ 7,033,818 |
| Hospice | $ 5,719,227 | $ - | $ - | $ - | $ - | $ - | $ 5,719,227 |
| FQHC & RHC | $ 35,260,367 | $ - | $ - | $ - | $ - | $ - | $ 35,260,367 |
| Chiropractor | $ 1,220,268 | $ - | $ - | $ - | $ - | $ - | $ 1,220,268 |
| Nurse Practitioner | $ 805,429 | $ - | $ 79 | $ - | $ - | $ - | $ 805,508 |
| Skilled Nursing | $ 2,695,313 | $ - | $ - | $ - | $ - | $ - | $ 2,695,313 |
| Podiatrist | $ 221,835 | $ - | $ - | $ - | $ - | $ - | $ 221,835 |
| Psychologist | $ 26,887,786 | $ (329) | $ - | $ - | $ - | $ - | $ 26,887,457 |
| Optometrist/Optician | $ 2,426,714 | $ - | $ - | $ - | $ - | $ - | $ 2,426,714 |
| Transportation | $ 12,517,142 | $ - | $ - | $ - | $ - | $ - | $ 12,517,142 |
| Therapy Services | $ 6,282,319 | $ - | $ - | $ 1,303,226 | $ - | $ - | $ 7,585,545 |
| Prosthetic/Ortho | $ 3,620,818 | $ - | $ - | $ - | $ - | $ - | $ 3,620,818 |
| Medical Supplies & DME | $ 10,262,729 | $ - | $ - | $ - | $ - | $ - | $ 10,262,729 |
| H&CB Services | $ 60,086,859 | $ - | $ - | $ - | $ - | $ - | $ 60,086,859 |
| H&CB Services Mental Service | $ 735,548 | $ 1,741,224 | $ - | $ 41,300 | $ - | $ - | $ 2,518,072 |
| H&CB Services Development Services | $ - | $ - | $ - | $ - | $ - | $ 184,962,391 | $ 184,962,391 |
| TBI Services | $ - | $ 101,993 | $ - | $ - | $ - | $ 5,207,584 | $ 5,309,578 |
| Enhanced Resident Care | $ 9,519,611 | $ - | $ - | $ - | $ - | $ - | $ 9,519,611 |
| Personal Care Services | $ 11,585,183 | $ - | $ - | $ - | $ - | $ 1,334,107 | $ 12,919,290 |
| Targeted Case Management (Drug) | $ 77,996 | $ (359,286) | $ - | $ - | $ - | $ 382,613 | $ 101,324 |
| Assistive Community Care | $ 13,772,830 | $ 5,347,715 | $ - | $ 11,953,279 | $ - | $ - | $ 31,073,825 |
| Day Treatment MHS | $ - | $ 59,656,611 | $ - | $ - | $ - | $ 2,034,549 | $ 61,691,160 |
| OADAP Families in Recovery | $ 3,194,014 | $ - | $ 28,516,223 | $ - | $ - | $ - | $ 31,710,237 |
| Rehabilitation | $ 535,325 | $ - | $ - | $ - | $ - | $ - | $ 535,325 |
| D & P Dept of Health | $ 264,610 | $ 581,400 | $ 2,162,152 | $ 37,419,340 | $ 51,815,340 | $ - | $ 92,242,841 |
| PcPlus Case Mgmt and Special Program Payments | $ 3,231,590 | $ - | $ - | $ - | $ - | $ - | $ 3,231,590 |
| Blue Print & CHT Payments | $ 15,453,914 | $ - | $ - | $ - | $ - | $ - | $ 15,453,914 |
| ACO Capitation | $ 29,164,439 | $ - | $ - | $ - | $ - | $ - | $ 29,164,439 |
| PDP Premiums | $ 1,492,070 | $ - | $ 614 | $ - | $ - | $ - | $ 1,492,684 |
| VPA Premiums | $ 6,100,378 | $ - | $ - | $ - | $ - | $ - | $ 6,100,378 |
| Ambulance | $ 6,424,310 | $ - | $ - | $ - | $ - | $ - | $ 6,424,310 |
| Dialysis | $ 1,410,716 | $ - | $ - | $ - | $ - | $ - | $ 1,410,716 |
| ASC | $ 58,653 | $ - | $ - | $ - | $ - | $ - | $ 58,653 |
| Other Expenditures | $ 117,251,704 | $ - | $ 43,847 | $ 288,400 | $ - | $ - | $ 117,583,951 |
| Total Offsets | $ (122,948,201) | $ (2,264) | $ (81,879) | $ (1,938) | $ - | $ (61,883) | $ (123,096,166) |
| **Total All Program Expenditures** | $ 1,005,351,851 | $ 215,704,009 | $ 31,301,656 | $ 51,895,589 | $ 52,035,275 | $ 195,654,486 | $ 1,551,942,867 |

# APPENDIX E: VANTAGE REPORTS

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**Report ID:** VTPB-11-BUDRLLUP
**Run Date:** 01/25/2018
**Run Time:** 10:54 AM

# State of Vermont

## FY2019 Governor's Recommended Budget: Rollup Report

**Organization: 3410010000 - Department of Vermont Health Access -**

**Administration Budget Object Group: 1. PERSONAL SERVICES**

| Budget Object Rollup Name | FY2017 Actuals | FY2018 Original As Passed Budget | FY2018 Governor's BAA Recommended Budget | FY2019 Governor's Recommended Budget | Difference Between FY2019 Governor's Recommend and FY2018 As Passed | Percent Change FY2019 Governor's Recommend and FY2018 As Passed |
|---|---|---|---|---|---|---|
| Salaries and Wages | 20,532,589 | 22,048,610 | 22,077,884 | 22,579,249 | 530,639 | 2.4% |
| Fringe Benefits | 9,370,838 | 11,238,541 | 11,238,253 | 11,710,000 | 471,459 | 4.2% |
| Contracted and 3rd Party Service | 88,260,889 | 143,899,121 | 118,057,873 | 115,702,534 | (28,196,587) | -19.6% |
| PerDiem and Other Personal Services | 9,075 | 4,212 | 4,212 | 9,075 | 4,863 | 115.5% |
| **Budget Object Group Total: 1. PERSONAL SERVICES** | **118,173,391** | **177,190,484** | **151,378,222** | **150,000,858** | **(27,189,626)** | **-15.3%** |

**Budget Object Group: 2. OPERATING**

| Budget Object Rollup Name | FY2017 Actuals | FY2018 Original As Passed Budget | FY2018 Governor's BAA Recommended Budget | FY2019 Governor's Recommended Budget | Difference Between FY2019 Governor's Recommend and FY2018 As Passed | Percent Change FY2019 Governor's Recommend and FY2018 As Passed |
|---|---|---|---|---|---|---|
| Equipment | 127,873 | 52,710 | 52,710 | 120,157 | 67,447 | 128.0% |
| IT/Telecom Services and Equipment | 1,257,572 | 1,617,501 | 1,617,233 | 1,488,161 | (129,340) | -8.0% |
| Travel | 120,352 | 160,032 | 154,600 | 116,577 | (43,455) | -27.2% |
| Supplies | 258,179 | 199,549 | 199,549 | 244,166 | 44,617 | 22.4% |
| Other Purchased Services | 8,677,397 | 1,442,426 | 1,442,426 | 1,512,469 | 70,043 | 4.9% |
| Other Operating Expenses | 37,383 | 0 | 0 | 37,383 | 37,383 | 0.0% |
| Rental Other | 47,011 | 13,166 | 13,166 | 47,011 | 33,845 | 257.1% |
| Rental Property | 1,665,484 | 1,580,263 | 1,580,263 | 1,825,879 | 245,616 | 15.5% |
| Property and Maintenance | 37,265 | 21,064 | 21,064 | 37,268 | 16,204 | 76.9% |
| Rentals | 51,924 | 455,322 | 455,322 | 0 | (455,322) | -100.0% |
| Repair and Maintenance Services | 449,347 | 0 | 0 | 449,348 | 449,348 | 0.0% |
| **Budget Object Group Total: 2. OPERATING** | **12,729,787** | **5,542,033** | **5,536,333** | **5,878,419** | **336,386** | **6.1%** |

**Report ID:** VTPB-11-BUDRLLUP
**Run Date:** 01/25/2018
**Run Time:** 10:54 AM

# State of Vermont

## FY2019 Governor's Recommended Budget: Rollup Report

**Organization: 3410010000 - Department of Vermont Health Access - Administration Budget Object Group: 3. GRANTS**

| Budget Object Rollup Name | FY2017 Actuals | FY2018 Original As Passed Budget | FY2018 Governor's BAA Recommended Budget | FY2019 Governor's Recommended Budget | Difference Between FY2019 Governor's Recommend and FY2018 As Passed | Percent Change FY2019 Governor's Recommend and FY2018 As Passed |
|---|---|---|---|---|---|---|
| Grants Rollup | 18,954,774 | 7,314,742 | 7,314,742 | 7,314,742 | 0 | 0.0% |
| **Budget Object Group Total: 3. GRANTS** | **18,954,774** | **7,314,742** | **7,314,742** | **7,314,742** | **0** | **0.0%** |
| **Total Expenses** | **149,857,951** | **190,047,259** | **164,229,297** | **163,194,019** | **(26,853,240)** | **-14.1%** |

| Fund Name | FY2017 Actuals | FY2018 Original As Passed Budget | FY2018 Governor's BAA Recommended Budget | FY2019 Governor's Recommended Budget | Difference Between FY2019 Governor's Recommend and FY2018 As Passed | Percent Change FY2019 Governor's Recommend and FY2018 As Passed |
|---|---|---|---|---|---|---|
| General Funds | 19,339,180 | 31,518,780 | 28,580,516 | 26,674,061 | (4,844,719) | -15.4% |
| Special Fund | 984,465 | 3,577,938 | 3,577,938 | 3,522,585 | (55,353) | -1.5% |
| State Health Care Resources Fund | 0 | 0 | 0 | 0 | 0 | 0.0% |
| Federal Funds | 85,247,812 | 139,552,196 | 116,793,972 | 118,955,295 | (20,596,901) | -14.8% |
| ARRA Funds | 0 | 0 | 0 | 0 | 0 | 0.0% |
| Global Commitment | 39,566,813 | 7,915,736 | 7,915,736 | 6,795,089 | (1,120,647) | -14.2% |
| IDT Funds | 4,719,681 | 7,482,609 | 7,361,135 | 7,246,989 | (235,620) | -3.1% |
| **Funds Total** | **149,857,951** | **190,047,259** | **164,229,297** | **163,194,019** | **(26,853,240)** | **-14.1%** |

| | | | | | | |
|---|---|---|---|---|---|---|
| Position Count | | | | 370 | | |
| FTE Total | | | | 366.63 | | |

**Report ID:** VTPB-11-BUDRLLUP
**Run Date:** 01/25/2018
**Run Time:** 10:54 AM

# State of Vermont

## FY2019 Governor's Recommended Budget: Rollup Report

**Organization: 3410015000 - DVHA- Medicaid Program/Global Commitment**

**Budget Object Group: 1. PERSONAL SERVICES**

| Budget Object Rollup Name | FY2017 Actuals | FY2018 Original As Passed Budget | FY2018 Governor's BAA Recommended Budget | FY2019 Governor's Recommended Budget | Difference Between FY2019 Governor's Recommend and FY2018 As Passed | Percent Change FY2019 Governor's Recommend and FY2018 As Passed |
|---|---|---|---|---|---|---|
| Contracted and 3rd Party Service | 452,459 | 0 | 0 | 0 | 0 | 0.0% |
| **Budget Object Group Total: 1. PERSONAL SERVICES** | **452,459** | **0** | **0** | **0** | **0** | **0.0%** |

**Budget Object Group: 2. OPERATING**

| Budget Object Rollup Name | FY2017 Actuals | | | | Difference Between Recommend and As Passed | Percent Change Recommend and As Passed |
|---|---|---|---|---|---|---|
| Other Purchased Services | 0 | 0 | 0 | 0 | 0 | 0.0% |
| **Budget Object Group Total: 2. OPERATING** | **0** | **0** | **0** | **0** | **0** | **0.0%** |

**Budget Object Group: 3. GRANTS**

| Budget Object Rollup Name | FY2017 Actuals | FY2018 Original As Passed Budget | FY2018 Governor's BAA Recommended Budget | FY2019 Governor's Recommended Budget | Difference Between FY2019 Governor's Recommend and FY2018 As Passed | Percent Change FY2019 Governor's Recommend and FY2018 As Passed |
|---|---|---|---|---|---|---|
| Grants Rollup | 718,741,414 | 752,459,668 | 719,641,059 | 727,932,838 | (24,526,830) | -3.3% |
| **Budget Object Group Total: 3. GRANTS** | **718,741,414** | **752,459,668** | **719,641,059** | **727,932,838** | **(24,526,830)** | **-3.3%** |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Total Expenses** | **719,193,873** | **752,459,668** | **719,641,059** | **727,932,838** | **(24,526,830)** | **-3.3%** |

**Report ID:** VTPB-11-BUDRLLUP
**Run Date:** 01/25/2018
**Run Time:** 10:54 AM

# State of Vermont

## FY2019 Governor's Recommended Budget: Rollup Report

**Organization: 3410015000 - DVHA- Medicaid Program/Global Commitment**

| Fund Name | FY2017 Actuals | FY2018 Original As Passed Budget | FY2018 Governor's BAA Recommended Budget | FY2019 Governor's Recommended Budget | Difference Between FY2019 Governor's Recommend and FY2018 As Passed | Percent Change FY2019 Governor's Recommend and FY2018 As Passed |
|---|---|---|---|---|---|---|
| Global Commitment | 719,193,873 | 752,459,668 | 719,641,059 | 727,932,838 | (24,526,830) | -3.3% |
| **Funds Total** | **719,193,873** | **752,459,668** | **719,641,059** | **727,932,838** | **(24,526,830)** | **-3.3%** |

| | | | | | | |
|---|---|---|---|---|---|---|
| Position Count | | | | | | |
| FTE Total | | | | | | |

**Report ID:** VTPB-11-BUDRLLUP
**Run Date:** 01/25/2018
**Run Time:** 10:54 AM

# State of Vermont

## FY2019 Governor's Recommended Budget: Rollup Report

**Organization: 3410016000 - DVHA-Medicaid/Long Term Care Waiver**

**Budget Object Group: 3. GRANTS**

| Budget Object Rollup Name | FY2017 Actuals | FY2018 Original As Passed Budget | FY2018 Governor's BAA Recommended Budget | FY2019 Governor's Recommended Budget | Difference Between FY2019 Governor's Recommend and FY2018 As Passed | Percent Change FY2019 Governor's Recommend and FY2018 As Passed |
|---|---|---|---|---|---|---|
| Grants Rollup | 192,637,243 | 196,483,201 | 197,420,739 | 203,050,763 | 6,567,562 | 3.3% |
| **Budget Object Group Total: 3. GRANTS** | **192,637,243** | **196,483,201** | **197,420,739** | **203,050,763** | **6,567,562** | **3.3%** |
| **Total Expenses** | **192,637,243** | **196,483,201** | **197,420,739** | **203,050,763** | **6,567,562** | **3.3%** |

| Fund Name | FY2017 Actuals | FY2018 Original As Passed Budget | FY2018 Governor's BAA Recommended Budget | FY2019 Governor's Recommended Budget | Difference Between FY2019 Governor's Recommend and FY2018 As Passed | Percent Change FY2019 Governor's Recommend and FY2018 As Passed |
|---|---|---|---|---|---|---|
| General Funds | 512,724 | 753,720 | 512,723 | 0 | (753,720) | -100.0% |
| Federal Funds | 1,731,386 | 896,280 | 896,280 | 0 | (896,280) | -100.0% |
| Global Commitment | 190,393,133 | 194,833,201 | 196,011,736 | 203,050,763 | 8,217,562 | 4.2% |
| **Funds Total** | **192,637,243** | **196,483,201** | **197,420,739** | **203,050,763** | **6,567,562** | **3.3%** |

| | | | | | | |
|---|---|---|---|---|---|---|
| Position Count | | | | | | |
| FTE Total | | | | | | |

**Report ID:** VTPB-11-BUDRLLUP
**Run Date:** 01/25/2018
**Run Time:** 10:54 AM

# State of Vermont

## FY2019 Governor's Recommended Budget: Rollup Report

**Organization: 3410017000 - DVHA- Medicaid/State Only Programs**

**Budget Object Group: 3. GRANTS**

| Budget Object Rollup Name | FY2017 Actuals | FY2018 Original As Passed Budget | FY2018 Governor's BAA Recommended Budget | FY2019 Governor's Recommended Budget | Difference Between FY2019 Governor's Recommend and FY2018 As Passed | Percent Change FY2019 Governor's Recommend and FY2018 As Passed |
|---|---|---|---|---|---|---|
| Grants Rollup | 44,577,958 | 50,175,082 | 48,052,430 | 47,355,940 | (2,819,142) | -5.6% |
| **Budget Object Group Total: 3. GRANTS** | **44,577,958** | **50,175,082** | **48,052,430** | **47,355,940** | **(2,819,142)** | **-5.6%** |
| **Total Expenses** | **44,577,958** | **50,175,082** | **48,052,430** | **47,355,940** | **(2,819,142)** | **-5.6%** |

| Fund Name | FY2017 Actuals | FY2018 Original As Passed Budget | FY2018 Governor's BAA Recommended Budget | FY2019 Governor's Recommended Budget | Difference Between FY2019 Governor's Recommend and FY2018 As Passed | Percent Change FY2019 Governor's Recommend and FY2018 As Passed |
|---|---|---|---|---|---|---|
| General Funds | 35,838,878 | 40,507,054 | 38,794,096 | 38,474,163 | (2,032,891) | -5.0% |
| Global Commitment | 8,739,080 | 9,668,028 | 9,258,334 | 8,881,777 | (786,251) | -8.1% |
| **Funds Total** | **44,577,958** | **50,175,082** | **48,052,430** | **47,355,940** | **(2,819,142)** | **-5.6%** |

| | | | | | | |
|---|---|---|---|---|---|---|
| Position Count | | | | | | |
| FTE Total | | | | | | |

**Report ID:** VTPB-11-BUDRLLUP
**Run Date:** 01/25/2018
**Run Time:** 10:54 AM

# State of Vermont

## FY2019 Governor's Recommended Budget: Rollup Report

**Organization: 3410018000 - DVHA-Medicaid/Non-Waiver Matched Programs**

**Budget Object Group: 1. PERSONAL SERVICES**

| Budget Object Rollup Name | FY2017 Actuals | | | | Difference Between Recommend and As Passed | Percent Change Recommend and As Passed |
|---|---|---|---|---|---|---|
| Contracted and 3rd Party Service | 1,010,783 | 0 | 0 | 0 | 0 | 0.0% |
| **Budget Object Group Total: 1. PERSONAL SERVICES** | **1,010,783** | **0** | **0** | **0** | **0** | **0.0%** |

**Budget Object Group: 3. GRANTS**

| Budget Object Rollup Name | FY2017 Actuals | FY2018 Original As Passed Budget | FY2018 Governor's BAA Recommended Budget | FY2019 Governor's Recommended Budget | Difference Between FY2019 Governor's Recommend and FY2018 As Passed | Percent Change FY2019 Governor's Recommend and FY2018 As Passed |
|---|---|---|---|---|---|---|
| Grants Rollup | 47,931,994 | 37,213,898 | 41,163,801 | 31,345,248 | (5,868,650) | -15.8% |
| **Budget Object Group Total: 3. GRANTS** | **47,931,994** | **37,213,898** | **41,163,801** | **31,345,248** | **(5,868,650)** | **-15.8%** |
| **Total Expenses** | **48,942,777** | **37,213,898** | **41,163,801** | **31,345,248** | **(5,868,650)** | **-15.8%** |

| Fund Name | FY2017 Actuals | FY2018 Original As Passed Budget | FY2018 Governor's BAA Recommended Budget | FY2019 Governor's Recommended Budget | Difference Between FY2019 Governor's Recommend and FY2018 As Passed | Percent Change FY2019 Governor's Recommend and FY2018 As Passed |
|---|---|---|---|---|---|---|
| General Funds | 17,895,238 | 13,685,694 | 13,594,534 | 11,400,406 | (2,285,288) | -16.7% |
| Federal Funds | 31,047,539 | 23,528,204 | 27,569,267 | 19,944,842 | (3,583,362) | -15.2% |
| **Funds Total** | **48,942,777** | **37,213,898** | **41,163,801** | **31,345,248** | **(5,868,650)** | **-15.8%** |

| | | | | | | |
|---|---|---|---|---|---|---|
| Position Count | | | | | | |
| FTE Total | | | | | | |

# State of Vermont
## FY2019 Governor's Recommended Budget: Detail Report

**Organization: 3410010000 - Department of Vermont Health Access - Administration**

### Budget Object Group: 1. PERSONAL SERVICES

| Salaries and Wages | | FY2017 Actuals | FY2018 Original As Passed Budget | FY2018 Governor's BAA Recommended Budget | FY2019 Governor's Recommended Budget | Difference Between FY2019 Governor's Recommend and FY2018 As Passed | Percent Change FY2019 Governor's Recommend and FY2018 As Passed |
|---|---|---|---|---|---|---|---|
| **Description** | **Code** | | | | | | |
| Classified Employees | 500000 | 20,056,083 | 21,451,672 | 21,480,946 | 21,879,687 | 428,015 | 2.0% |
| Exempt | 500010 | 0 | 1,290,456 | 1,290,456 | 1,474,368 | 183,912 | 14.3% |
| Other Regular Employees | 500020 | 0 | 63,128 | 63,128 | 0 | (63,128) | -100.0% |
| Overtime | 500060 | 476,506 | 0 | 0 | 0 | 0 | 0.0% |
| Market Factor - Classified | 500899 | 0 | 681,371 | 681,371 | 643,399 | (37,972) | -5.6% |
| Vacancy Turnover Savings | 508000 | 0 | (1,438,017) | (1,438,017) | (1,418,205) | 19,812 | -1.4% |
| **Total: Salaries and Wages** | | **20,532,589** | **22,048,610** | **22,077,884** | **22,579,249** | **530,639** | **2.4%** |

| Fringe Benefits | | FY2017 Actuals | FY2018 Original As Passed Budget | FY2018 Governor's BAA Recommended Budget | FY2019 Governor's Recommended Budget | Difference Between FY2019 Governor's Recommend and FY2018 As Passed | Percent Change FY2019 Governor's Recommend and FY2018 As Passed |
|---|---|---|---|---|---|---|---|
| **Description** | **Code** | | | | | | |
| FICA - Classified Employees | 501000 | 1,503,523 | 1,655,374 | 1,655,374 | 1,722,688 | 67,314 | 4.1% |
| FICA - Exempt | 501010 | 0 | 94,861 | 94,861 | 106,346 | 11,485 | 12.1% |
| Health Ins - Classified Empl | 501500 | 4,068,470 | 4,928,988 | 4,928,988 | 4,904,651 | (24,337) | -0.5% |
| Health Ins - Exempt | 501510 | 0 | 170,734 | 170,734 | 231,389 | 60,655 | 35.5% |
| Retirement - Classified Empl | 502000 | 3,472,002 | 3,780,314 | 3,780,314 | 3,926,193 | 145,879 | 3.9% |
| Retirement - Exempt | 502010 | 0 | 185,810 | 185,810 | 218,282 | 32,472 | 17.5% |
| Dental - Classified Employees | 502500 | 200,149 | 260,459 | 260,459 | 279,291 | 18,832 | 7.2% |

# State of Vermont

## FY2019 Governor's Recommended Budget: Detail Report

**Organization: 3410010000 - Department of Vermont Health Access - Administration**

| Fringe Benefits | | FY2017 Actuals | FY2018 Original As Passed Budget | FY2018 Governor's BAA Recommended Budget | FY2019 Governor's Recommended Budget | Difference Between FY2019 Governor's Recommend and FY2018 As Passed | Percent Change FY2019 Governor's Recommend and FY2018 As Passed |
|---|---|---|---|---|---|---|---|
| **Description** | **Code** | | | | | | |
| Dental - Exempt | 502510 | 0 | 9,529 | 9,529 | 11,358 | 1,829 | 19.2% |
| Life Ins - Classified Empl | 503000 | 61,746 | 75,858 | 75,858 | 78,289 | 2,431 | 3.2% |
| Life Ins - Exempt | 503010 | 0 | 5,448 | 5,448 | 5,966 | 518 | 9.5% |
| LTD - Classified Employees | 503500 | 4,148 | 2,991 | 2,991 | 2,914 | (77) | -2.6% |
| LTD - Exempt | 503510 | 0 | 2,970 | 2,970 | 3,389 | 419 | 14.1% |
| EAP - Classified Empl | 504000 | 9,420 | 10,722 | 10,722 | 10,650 | (72) | -0.7% |
| EAP - Exempt | 504010 | 0 | 391 | 391 | 450 | 59 | 15.1% |
| Employee Tuition Costs | 504530 | 2,444 | 0 | 0 | 2,444 | 2,444 | 0.0% |
| Workers Comp - Other | 505030 | 0 | 0 | 0 | 205,700 | 205,700 | 0.0% |
| Workers Comp - Ins Premium | 505200 | 0 | 54,092 | 53,804 | 0 | (54,092) | -100.0% |
| Unemployment Compensation | 505500 | 36,984 | 0 | 0 | 0 | 0 | 0.0% |
| Catamount Health Assessment | 505700 | 11,953 | 0 | 0 | 0 | 0 | 0.0% |
| **Total: Fringe Benefits** | | **9,370,838** | **11,238,541** | **11,238,253** | **11,710,000** | **471,459** | **4.2%** |

| Contracted and 3rd Party Service | | FY2017 Actuals | FY2018 Original As Passed Budget | FY2018 Governor's BAA Recommended Budget | FY2019 Governor's Recommended Budget | Difference Between FY2019 Governor's Recommend and FY2018 As Passed | Percent Change FY2019 Governor's Recommend and FY2018 As Passed |
|---|---|---|---|---|---|---|---|
| **Description** | **Code** | | | | | | |
| IT Contracts - IT Finance & Administration | 507105 | 0 | 538,583 | 538,583 | 0 | (538,583) | -100.0% |
| Contr&3Rd Pty-Educ & Training | 507350 | 198 | 0 | 0 | 198 | 198 | 0.0% |
| IT Contracts - Project Managment | 507542 | 5,728,661 | 0 | 0 | 8,307,500 | 8,307,500 | 0.0% |
| IT Contracts - Storage | 507544 | 873,869 | 0 | 0 | 873,870 | 873,870 | 0.0% |
| IT Contracts - Application Development | 507565 | 4,403,034 | 0 | 0 | 42,500,765 | 42,500,765 | 0.0% |
| IT Contracts - Application Support | 507566 | 22,526,470 | 0 | 0 | 33,467,637 | 33,467,637 | 0.0% |

# State of Vermont

## FY2019 Governor's Recommended Budget: Detail Report

**Organization: 3410010000 - Department of Vermont Health Access - Administration**

| Contracted and 3rd Party Service | | FY2017 Actuals | FY2018 Original As Passed Budget | FY2018 Governor's BAA Recommended Budget | FY2019 Governor's Recommended Budget | Difference Between FY2019 Governor's Recommend and FY2018 As Passed | Percent Change FY2019 Governor's Recommend and FY2018 As Passed |
|---|---|---|---|---|---|---|---|
| **Description** | **Code** | | | | | | |
| Other Contr and 3Rd Pty Serv | 507600 | 54,687,588 | 143,360,538 | 117,519,290 | 30,511,494 | (112,849,044) | -78.7% |
| Interpreters | 507615 | 40,900 | 0 | 0 | 40,900 | 40,900 | 0.0% |
| Custodial | 507670 | 170 | 0 | 0 | 170 | 170 | 0.0% |
| **Total: Contracted and 3rd Party Service** | | **88,260,889** | **143,899,121** | **118,057,873** | **115,702,534** | **(28,196,587)** | **-19.6%** |

| PerDiem and Other Personal Services | | FY2017 Actuals | FY2018 Original As Passed Budget | FY2018 Governor's BAA Recommended Budget | FY2019 Governor's Recommended Budget | Difference Between FY2019 Governor's Recommend and FY2018 As Passed | Percent Change FY2019 Governor's Recommend and FY2018 As Passed |
|---|---|---|---|---|---|---|---|
| **Description** | **Code** | | | | | | |
| Per Diem | 506000 | 7,925 | 4,212 | 4,212 | 7,925 | 3,713 | 88.2% |
| Other Pers Serv | 506200 | 0 | 0 | 0 | 0 | 0 | 0.0% |
| Sheriffs | 506230 | 1,150 | 0 | 0 | 1,150 | 1,150 | 0.0% |
| **Total: PerDiem and Other Personal Service** | | **9,075** | **4,212** | **4,212** | **9,075** | **4,863** | **115.5%** |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Total: 1. PERSONAL SERVICES** | **118,173,391** | **177,190,484** | **151,378,222** | **150,000,858** | **(27,189,626)** | **-15.3%** |

## Budget Object Group: 2. OPERATING

| Equipment | | FY2017 Actuals | FY2018 Original As Passed Budget | FY2018 Governor's BAA Recommended Budget | FY2019 Governor's Recommended Budget | Difference Between FY2019 Governor's Recommend and FY2018 As Passed | Percent Change FY2019 Governor's Recommend and FY2018 As Passed |
|---|---|---|---|---|---|---|---|
| **Description** | **Code** | | | | | | |

# State of Vermont

## FY2019 Governor's Recommended Budget: Detail Report

**Organization: 3410010000 - Department of Vermont Health Access - Administration**

| Equipment | | FY2017 Actuals | FY2018 Original As Passed Budget | FY2018 Governor's BAA Recommended Budget | FY2019 Governor's Recommended Budget | Difference Between FY2019 Governor's Recommend and FY2018 As Passed | Percent Change FY2019 Governor's Recommend and FY2018 As Passed |
|---|---|---|---|---|---|---|---|
| **Description** | **Code** | | | | | | |
| Hardware - Desktop & Laptop Pc | 522216 | 57,802 | 0 | 0 | 57,803 | 57,803 | 0.0% |
| Hw - Printers,Copiers,Scanners | 522217 | 18,303 | 0 | 0 | 18,303 | 18,303 | 0.0% |
| Hardware - Data Network | 522273 | 7,347 | 0 | 0 | 0 | 0 | 0.0% |
| Software-Application Development | 522283 | 2,640 | 0 | 0 | 2,640 | 2,640 | 0.0% |
| Software - Application Support | 522284 | 9,184 | 0 | 0 | 9,184 | 9,184 | 0.0% |
| Software - Desktop | 522286 | 6,689 | 0 | 0 | 6,689 | 6,689 | 0.0% |
| Software-Security | 522288 | 578 | 0 | 0 | 578 | 578 | 0.0% |
| Other Equipment | 522400 | 370 | 0 | 0 | 0 | 0 | 0.0% |
| Furniture & Fixtures | 522700 | 24,960 | 52,710 | 52,710 | 24,960 | (27,750) | -52.6% |
| **Total: Equipment** | | **127,873** | **52,710** | **52,710** | **120,157** | **67,447** | **128.0%** |

| IT/Telecom Services and Equipment | | FY2017 Actuals | FY2018 Original As Passed Budget | FY2018 Governor's BAA Recommended Budget | FY2019 Governor's Recommended Budget | Difference Between FY2019 Governor's Recommend and FY2018 As Passed | Percent Change FY2019 Governor's Recommend and FY2018 As Passed |
|---|---|---|---|---|---|---|---|
| **Description** | **Code** | | | | | | |
| Communications | 516600 | 0 | 0 | 0 | 0 | 0 | 0.0% |
| Telecom-Data Telecom Services | 516651 | 0 | 0 | 0 | 0 | 0 | 0.0% |
| Telecom-Video Conf Services | 516653 | 0 | 7,372 | 7,372 | 0 | (7,372) | -100.0% |
| Telecom-Conf Calling Services | 516658 | 31,155 | 0 | 0 | 31,156 | 31,156 | 0.0% |
| It Intsvccost-Vision/Isdassess | 516671 | 512,617 | 520,575 | 520,307 | 636,348 | 115,773 | 22.2% |
| ADS Centrex Exp. | 516672 | 51,910 | 0 | 0 | 489,307 | 489,307 | 0.0% |
| It Intsvccos-Dii Data Telecomm | 516673 | 0 | 42,128 | 42,128 | 0 | (42,128) | -100.0% |
| It Inter Svc Cost User Support | 516678 | 437,397 | 368,722 | 368,722 | 0 | (368,722) | -100.0% |
| It Inter Svc Cost Webdev&Maint | 516682 | 14,468 | 0 | 0 | 0 | 0 | 0.0% |

# State of Vermont

## FY2019 Governor's Recommended Budget: Detail Report

**Organization: 3410010000 - Department of Vermont Health Access - Administration**

| IT/Telecom Services and Equipment | | FY2017 Actuals | FY2018 Original As Passed Budget | FY2018 Governor's BAA Recommended Budget | FY2019 Governor's Recommended Budget | Difference Between FY2019 Governor's Recommend and FY2018 As Passed | Percent Change FY2019 Governor's Recommend and FY2018 As Passed |
|---|---|---|---|---|---|---|---|
| **Description** | **Code** | | | | | | |
| ADS Allocation Exp. | 516685 | 209,882 | 409,875 | 409,875 | 331,350 | (78,525) | -19.2% |
| Hw - Other Info Tech | 522200 | 0 | 163,509 | 163,509 | 0 | (163,509) | -100.0% |
| Hw - Computer Peripherals | 522201 | 143 | 0 | 0 | 0 | 0 | 0.0% |
| Software - Other | 522220 | 0 | 105,320 | 105,320 | 0 | (105,320) | -100.0% |
| **Total: IT/Telecom Services and Equipment** | | **1,257,572** | **1,617,501** | **1,617,233** | **1,488,161** | **(129,340)** | **-8.0%** |

| Other Operating Expenses | | FY2017 Actuals | | | FY2019 Governor's Recommended Budget | Difference Between FY2019 Governor's Recommend and As Passed | Percent Change FY2019 Governor's Recommend and As Passed |
|---|---|---|---|---|---|---|---|
| **Description** | **Code** | | | | | | |
| Single Audit Allocation | 523620 | 37,100 | 0 | 0 | 37,100 | 37,100 | 0.0% |
| Bank Service Charges | 524000 | 283 | 0 | 0 | 283 | 283 | 0.0% |
| Cost of Property Mgmt Services | 525280 | 0 | 0 | 0 | 0 | 0 | 0.0% |
| **Total: Other Operating Expenses** | | **37,383** | **0** | **0** | **37,383** | **37,383** | **0.0%** |

| Other Purchased Services | | FY2017 Actuals | FY2018 Original As Passed Budget | FY2018 Governor's BAA Recommended Budget | FY2019 Governor's Recommended Budget | Difference Between FY2019 Governor's Recommend and FY2018 As Passed | Percent Change FY2019 Governor's Recommend and FY2018 As Passed |
|---|---|---|---|---|---|---|---|
| **Description** | **Code** | | | | | | |
| Insurance Other Than Empl Bene | 516000 | 96,938 | 1,800 | 1,800 | 0 | (1,800) | -100.0% |
| Insurance - General Liability | 516010 | 0 | 28,912 | 28,912 | 121,541 | 92,629 | 320.4% |
| Dues | 516500 | 48,919 | 31,596 | 31,596 | 48,919 | 17,323 | 54.8% |

# State of Vermont

## FY2019 Governor's Recommended Budget: Detail Report

**Organization: 3410010000 - Department of Vermont Health Access - Administration**

| Other Purchased Services | | FY2017 Actuals | FY2018 Original As Passed Budget | FY2018 Governor's BAA Recommended Budget | FY2019 Governor's Recommended Budget | Difference Between FY2019 Governor's Recommend and FY2018 As Passed | Percent Change FY2019 Governor's Recommend and FY2018 As Passed |
|---|---|---|---|---|---|---|---|
| **Description** | **Code** | | | | | | |
| Licenses | 516550 | 37,253 | 20,436 | 20,436 | 37,254 | 16,818 | 82.3% |
| Telecom-Mobile Wireless Data | 516623 | 0 | 15,798 | 15,798 | 0 | (15,798) | -100.0% |
| Telecom-Telephone Services | 516652 | 85,018 | 169,828 | 169,828 | 85,018 | (84,810) | -49.9% |
| ADS PM SOV Employee Expense | 516683 | 247,191 | 345,448 | 345,448 | 247,192 | (98,256) | -28.4% |
| Advertising | 516800 | 0 | 58,979 | 58,979 | 0 | (58,979) | -100.0% |
| Advertising-Other | 516815 | 6,573 | 0 | 0 | 6,574 | 6,574 | 0.0% |
| Advertising - Job Vacancies | 516820 | 10,488 | 0 | 0 | 10,488 | 10,488 | 0.0% |
| Sponsorships | 516872 | 500 | 0 | 0 | 0 | 0 | 0.0% |
| Printing and Binding | 517000 | 358,789 | 210,640 | 210,640 | 358,790 | 148,150 | 70.3% |
| Photocopying | 517020 | 69 | 0 | 0 | 70 | 70 | 0.0% |
| Registration For Meetings&Conf | 517100 | 5,729 | 10,532 | 10,532 | 5,728 | (4,804) | -45.6% |
| Training - Info Tech | 517110 | 3,500 | 0 | 0 | 3,500 | 3,500 | 0.0% |
| Empl Train & Background Checks | 517120 | 479 | 0 | 0 | 479 | 479 | 0.0% |
| Postage | 517200 | 353,183 | 263,670 | 263,670 | 353,184 | 89,514 | 33.9% |
| Freight & Express Mail | 517300 | 24,237 | 15,283 | 15,283 | 24,237 | 8,954 | 58.6% |
| Instate Conf, Meetings, Etc | 517400 | 25,873 | 0 | 0 | 25,873 | 25,873 | 0.0% |
| Catering-Meals-Cost | 517410 | 1,145 | 0 | 0 | 0 | 0 | 0.0% |
| Outside Conf, Meetings, Etc | 517500 | 16,147 | 0 | 0 | 16,147 | 16,147 | 0.0% |
| Other Purchased Services | 519000 | 32,784 | 73,724 | 73,724 | 32,785 | (40,939) | -55.5% |
| Human Resources Services | 519006 | 98,600 | 195,780 | 195,780 | 118,776 | (77,004) | -39.3% |
| Administrative Service Charge | 519010 | 15,915 | 0 | 0 | 15,914 | 15,914 | 0.0% |
| Infrastructure as a Service | 519081 | 7,208,068 | 0 | 0 | 0 | 0 | 0.0% |
| **Total: Other Purchased Services** | | **8,677,397** | **1,442,426** | **1,442,426** | **1,512,469** | **70,043** | **4.9%** |

# State of Vermont

## FY2019 Governor's Recommended Budget: Detail Report

**Organization: 3410010000 - Department of Vermont Health Access - Administration**

| Property and Maintenance | | FY2017 Actuals | FY2018 Original As Passed Budget | FY2018 Governor's BAA Recommended Budget | FY2019 Governor's Recommended Budget | Difference Between FY2019 Governor's Recommend and FY2018 As Passed | Percent Change FY2019 Governor's Recommend and FY2018 As Passed |
|---|---|---|---|---|---|---|---|
| **Description** | **Code** | | | | | | |
| Water/Sewer | 510000 | 67 | 0 | 0 | 68 | 68 | 0.0% |
| Disposal | 510200 | 940 | 0 | 0 | 940 | 940 | 0.0% |
| Repair & Maint - Buildings | 512000 | 4,064 | 21,064 | 21,064 | 4,064 | (17,000) | -80.7% |
| Repair & Maint - Office Tech | 513010 | 29,619 | 0 | 0 | 29,620 | 29,620 | 0.0% |
| Other Repair & Maint Serv | 513200 | 16 | 0 | 0 | 16 | 16 | 0.0% |
| Repair&Maint-Property/Grounds | 513210 | 2,559 | 0 | 0 | 2,560 | 2,560 | 0.0% |
| **Total: Property and Maintenance** | | **37,265** | **21,064** | **21,064** | **37,268** | **16,204** | **76.9%** |

| Rental Other | | FY2017 Actuals | FY2018 Original As Passed Budget | FY2018 Governor's BAA Recommended Budget | FY2019 Governor's Recommended Budget | Difference Between FY2019 Governor's Recommend and FY2018 As Passed | Percent Change FY2019 Governor's Recommend and FY2018 As Passed |
|---|---|---|---|---|---|---|---|
| **Description** | **Code** | | | | | | |
| Rental - Auto | 514550 | 20,594 | 13,166 | 13,166 | 20,594 | 7,428 | 56.4% |
| Rental - Office Equipment | 514650 | 26,417 | 0 | 0 | 26,417 | 26,417 | 0.0% |
| **Total: Rental Other** | | **47,011** | **13,166** | **13,166** | **47,011** | **33,845** | **257.1%** |

| Rental Property | | FY2017 Actuals | FY2018 Original As Passed Budget | FY2018 Governor's BAA Recommended Budget | FY2019 Governor's Recommended Budget | Difference Between FY2019 Governor's Recommend and FY2018 As Passed | Percent Change FY2019 Governor's Recommend and FY2018 As Passed |
|---|---|---|---|---|---|---|---|
| **Description** | **Code** | | | | | | |
| Rent Land & Bldgs-Office Space | 514000 | 1,359,731 | 1,343,618 | 1,343,618 | 1,461,768 | 118,150 | 8.8% |
| Rent Land&Bldgs-Non-Office | 514010 | 0 | 21,064 | 21,064 | 0 | (21,064) | -100.0% |

# State of Vermont

## FY2019 Governor's Recommended Budget: Detail Report

**Organization: 3410010000 - Department of Vermont Health Access - Administration**

| Rental Property | | FY2017 Actuals | FY2018 Original As Passed Budget | FY2018 Governor's BAA Recommended Budget | FY2019 Governor's Recommended Budget | Difference Between FY2019 Governor's Recommend and FY2018 As Passed | Percent Change FY2019 Governor's Recommend and FY2018 As Passed |
|---|---|---|---|---|---|---|---|
| **Description** | **Code** | | | | | | |
| Fee-For-Space Charge | 515010 | 305,753 | 215,581 | 215,581 | 364,111 | 148,530 | 68.9% |
| **Total: Rental Property** | | **1,665,484** | **1,580,263** | **1,580,263** | **1,825,879** | **245,616** | **15.5%** |

| Supplies | | FY2017 Actuals | FY2018 Original As Passed Budget | FY2018 Governor's BAA Recommended Budget | FY2019 Governor's Recommended Budget | Difference Between FY2019 Governor's Recommend and FY2018 As Passed | Percent Change FY2019 Governor's Recommend and FY2018 As Passed |
|---|---|---|---|---|---|---|---|
| **Description** | **Code** | | | | | | |
| Office Supplies | 520000 | 64,820 | 81,624 | 81,624 | 64,820 | (16,804) | -20.6% |
| Gasoline | 520110 | 305 | 0 | 0 | 305 | 305 | 0.0% |
| It & Data Processing Supplies | 520510 | 108 | 0 | 0 | 0 | 0 | 0.0% |
| Recognition/Awards | 520600 | 414 | 3,158 | 3,158 | 0 | (3,158) | -100.0% |
| Food | 520700 | 4,425 | 7,372 | 7,372 | 4,425 | (2,947) | -40.0% |
| Water | 520712 | 1,160 | 0 | 0 | 1,160 | 1,160 | 0.0% |
| Electricity | 521100 | 855 | 36,861 | 36,861 | 855 | (36,006) | -97.7% |
| Propane Gas | 521320 | 400 | 0 | 0 | 400 | 400 | 0.0% |
| Books&Periodicals-Library/Educ | 521500 | 936 | 65,268 | 65,268 | 936 | (64,332) | -98.6% |
| Subscriptions | 521510 | 169,615 | 5,266 | 5,266 | 169,915 | 164,649 | 3,126.6% |
| Other Books & Periodicals | 521520 | 13,792 | 0 | 0 | 0 | 0 | 0.0% |
| Household, Facility&Lab Suppl | 521800 | 304 | 0 | 0 | 304 | 304 | 0.0% |
| Paper Products | 521820 | 1,046 | 0 | 0 | 1,046 | 1,046 | 0.0% |
| **Total: Supplies** | | **258,179** | **199,549** | **199,549** | **244,166** | **44,617** | **22.4%** |

# State of Vermont

## FY2019 Governor's Recommended Budget: Detail Report

**Organization: 3410010000 - Department of Vermont Health Access - Administration**

| Travel | | FY2017 Actuals | FY2018 Original As Passed Budget | FY2018 Governor's BAA Recommended Budget | FY2019 Governor's Recommended Budget | Difference Between FY2019 Governor's Recommend and FY2018 As Passed | Percent Change FY2019 Governor's Recommend and FY2018 As Passed |
|---|---|---|---|---|---|---|---|
| **Description** | **Code** | | | | | | |
| Travel-Inst-Auto Mileage-Emp | 518000 | 58,615 | 107,373 | 101,941 | 55,899 | (51,474) | -47.9% |
| Travel-Inst-Other Transp-Emp | 518010 | 4,866 | 0 | 0 | 4,866 | 4,866 | 0.0% |
| Travel-Inst-Meals-Emp | 518020 | 599 | 0 | 0 | 599 | 599 | 0.0% |
| Travel-Inst-Lodging-Emp | 518030 | 274 | 0 | 0 | 0 | 0 | 0.0% |
| Travel-Inst-Incidentals-Emp | 518040 | 1,059 | 0 | 0 | 274 | 274 | 0.0% |
| Travl-Inst-Auto Mileage-Nonemp | 518300 | 3,928 | 0 | 0 | 3,928 | 3,928 | 0.0% |
| Travel-Outst-Auto Mileage-Emp | 518500 | 717 | 0 | 0 | 717 | 717 | 0.0% |
| Travel-Outst-Other Trans-Emp | 518510 | 20,866 | 52,659 | 52,659 | 20,865 | (31,794) | -60.4% |
| Travel-Outst-Meals-Emp | 518520 | 3,213 | 0 | 0 | 3,213 | 3,213 | 0.0% |
| Travel-Outst-Lodging-Emp | 518530 | 24,470 | 0 | 0 | 24,470 | 24,470 | 0.0% |
| Travel-Outst-Incidentals-Emp | 518540 | 1,746 | 0 | 0 | 1,746 | 1,746 | 0.0% |
| **Total: Travel** | | **120,352** | **160,032** | **154,600** | **116,577** | **(43,455)** | **-27.2%** |

| Rentals | | FY2017 Actuals | FY2018 Original As Passed Budget | FY2018 Governor's BAA Recommended Budget | FY2019 Governor's Recommended Budget | Difference Between FY2019 Governor's Recommend and FY2018 As Passed | Percent Change FY2019 Governor's Recommend and FY2018 As Passed |
|---|---|---|---|---|---|---|---|
| **Description** | **Code** | | | | | | |
| Software-License-ApplicaSupprt | 516551 | 51,924 | 0 | 0 | 0 | 0 | 0.0% |
| Software-License-ApplicaDevel | 516552 | 0 | 0 | 0 | 0 | 0 | 0.0% |
| Software-License-Security | 516554 | 0 | 0 | 0 | 0 | 0 | 0.0% |
| Software-License-DeskLaptop PC | 516559 | 0 | 455,322 | 455,322 | 0 | (455,322) | -100.0% |
| **Total: Rentals** | | **51,924** | **455,322** | **455,322** | **0** | **(455,322)** | **-100.0%** |

# State of Vermont

## FY2019 Governor's Recommended Budget: Detail Report

**Organization: 3410010000 - Department of Vermont Health Access - Administration**

| Repair and Maintenance Services | | FY2017 Actuals | | | FY2019 Governor's Recommended Budget | Difference Between FY2019 Governor's Recommend and As Passed | Percent Change FY2019 Governor's Recommend and As Passed |
|---|---|---|---|---|---|---|---|
| **Description** | **Code** | | | | | | |
| Software-Rep&Maint-ApplicaSupp | 513050 | 449,347 | 0 | 0 | 449,348 | 449,348 | 0.0% |
| **Total: Repair and Maintenance Services** | | **449,347** | **0** | **0** | **449,348** | **449,348** | **0.0%** |
| **Total: 2. OPERATING** | | **12,729,787** | **5,542,033** | **5,536,333** | **5,878,419** | **336,386** | **6.1%** |

## Budget Object Group: 3. GRANTS

| Grants Rollup | | FY2017 Actuals | FY2018 Original As Passed Budget | FY2018 Governor's BAA Recommended Budget | FY2019 Governor's Recommended Budget | Difference Between FY2019 Governor's Recommend and FY2018 As Passed | Percent Change FY2019 Governor's Recommend and FY2018 As Passed |
|---|---|---|---|---|---|---|---|
| **Description** | **Code** | | | | | | |
| Grants | 550220 | 0 | 3,900,028 | 3,900,028 | 3,900,028 | 0 | 0.0% |
| Other Grants | 550500 | 10,148,922 | 3,414,714 | 3,414,714 | 3,414,714 | 0 | 0.0% |
| Medical Services Grants | 604250 | 8,805,852 | 0 | 0 | 0 | 0 | 0.0% |
| Ahs Cost Allocation Exp. Acct. | 799090 | (0) | 0 | 0 | 0 | 0 | 0.0% |
| **Total: Grants Rollup** | | **18,954,774** | **7,314,742** | **7,314,742** | **7,314,742** | **0** | **0.0%** |
| **Total: 3. GRANTS** | | **18,954,774** | **7,314,742** | **7,314,742** | **7,314,742** | **0** | **0.0%** |
| **Total Expenses:** | | **149,857,951** | **190,047,259** | **164,229,297** | **163,194,019** | **-26,853,240** | **-14.1%** |

# State of Vermont

## FY2019 Governor's Recommended Budget: Detail Report

**Organization: 3410015000 - DVHA- Medicaid Program/Global Commitment**

### Budget Object Group: 1. PERSONAL SERVICES

| Contracted and 3rd Party Service | | FY2017 Actuals | FY2018 Original As Passed Budget | FY2018 Governor's BAA Recommended Budget | FY2019 Governor's Recommended Budget | Difference Between FY2019 Governor's Recommend and FY2018 As Passed | Percent Change FY2019 Governor's Recommend and FY2018 As Passed |
|---|---|---|---|---|---|---|---|
| **Description** | **Code** | | | | | | |
| Other Contr and 3Rd Pty Serv | 507600 | 452,459 | 0 | 0 | 0 | 0 | 0.0% |
| **Total: Contracted and 3rd Party Service** | | **452,459** | **0** | **0** | **0** | **0** | **0.0%** |
| **Total: 1. PERSONAL SERVICES** | | **452,459** | **0** | **0** | **0** | **0** | **0.0%** |

### Budget Object Group: 2. OPERATING

| Other Purchased Services | | FY2017 Actuals | | | | Difference Between Recommend and As Passed | Percent Change Recommend and As Passed |
|---|---|---|---|---|---|---|---|
| **Description** | **Code** | | | | | | |
| Registration For Meetings&Conf | 517100 | 0 | 0 | 0 | 0 | 0 | 0.0% |
| **Total: Other Purchased Services** | | **0** | **0** | **0** | **0** | **0** | **0.0%** |
| **Total: 2. OPERATING** | | **0** | **0** | **0** | **0** | **0** | **0.0%** |

### Budget Object Group: 3. GRANTS

# State of Vermont

## FY2019 Governor's Recommended Budget: Detail Report

**Organization: 3410015000 - DVHA- Medicaid Program/Global Commitment**

| Grants Rollup | | FY2017 Actuals | FY2018 Original As Passed Budget | FY2018 Governor's BAA Recommended Budget | FY2019 Governor's Recommended Budget | Difference Between FY2019 Governor's Recommend and FY2018 As Passed | Percent Change FY2019 Governor's Recommend and FY2018 As Passed |
|---|---|---|---|---|---|---|---|
| **Description** | **Code** | | | | | | |
| Grants | 550220 | 0 | 0 | 0 | 0 | 0 | 0.0% |
| Other Grants | 550500 | 547,983 | 0 | 0 | 0 | 0 | 0.0% |
| Medical Services Grants | 604250 | 713,559,761 | 752,459,668 | 719,641,059 | 727,932,838 | (24,526,830) | -3.3% |
| Ahs Cost Allocation Exp. Acct. | 799090 | 4,633,670 | 0 | 0 | 0 | 0 | 0.0% |
| **Total: Grants Rollup** | | **718,741,414** | **752,459,668** | **719,641,059** | **727,932,838** | **(24,526,830)** | **-3.3%** |
| **Total: 3. GRANTS** | | **718,741,414** | **752,459,668** | **719,641,059** | **727,932,838** | **(24,526,830)** | **-3.3%** |
| **Total Expenses:** | | **719,193,873** | **752,459,668** | **719,641,059** | **727,932,838** | **-24,526,830** | **-3.3%** |

# State of Vermont

## FY2019 Governor's Recommended Budget: Detail Report

**Organization: 3410016000 - DVHA-Medicaid/Long Term Care Waiver**

### Budget Object Group: 3. GRANTS

| Grants Rollup | | FY2017 Actuals | FY2018 Original As Passed Budget | FY2018 Governor's BAA Recommended Budget | FY2019 Governor's Recommended Budget | Difference Between FY2019 Governor's Recommend and FY2018 As Passed | Percent Change FY2019 Governor's Recommend and FY2018 As Passed |
|---|---|---|---|---|---|---|---|
| **Description** | **Code** | | | | | | |
| Medical Services Grants | 604250 | 190,604,437 | 196,483,201 | 197,420,739 | 203,050,763 | 6,567,562 | 3.3% |
| Ahs Cost Allocation Exp. Acct. | 799090 | 2,032,805 | 0 | 0 | 0 | 0 | 0.0% |
| **Total: Grants Rollup** | | **192,637,243** | **196,483,201** | **197,420,739** | **203,050,763** | **6,567,562** | **3.3%** |
| **Total: 3. GRANTS** | | **192,637,243** | **196,483,201** | **197,420,739** | **203,050,763** | **6,567,562** | **3.3%** |
| **Total Expenses:** | | **192,637,243** | **196,483,201** | **197,420,739** | **203,050,763** | **6,567,562** | **3.3%** |

# State of Vermont
## FY2019 Governor's Recommended Budget: Detail Report

**Organization: 3410017000 - DVHA- Medicaid/State Only Programs**

### Budget Object Group: 3. GRANTS

| Grants Rollup | | FY2017 Actuals | FY2018 Original As Passed Budget | FY2018 Governor's BAA Recommended Budget | FY2019 Governor's Recommended Budget | Difference Between FY2019 Governor's Recommend and FY2018 As Passed | Percent Change FY2019 Governor's Recommend and FY2018 As Passed |
|---|---|---|---|---|---|---|---|
| **Description** | **Code** | | | | | | |
| Other Grants | 550500 | 3,500,000 | 0 | 0 | 0 | 0 | 0.0% |
| Medical Services Grants | 604250 | 46,467,444 | 50,175,082 | 48,052,430 | 47,355,940 | (2,819,142) | -5.6% |
| Ahs Cost Allocation Exp. Acct. | 799090 | (5,389,486) | 0 | 0 | 0 | 0 | 0.0% |
| **Total: Grants Rollup** | | **44,577,958** | **50,175,082** | **48,052,430** | **47,355,940** | **(2,819,142)** | **-5.6%** |
| **Total: 3. GRANTS** | | **44,577,958** | **50,175,082** | **48,052,430** | **47,355,940** | **(2,819,142)** | **-5.6%** |
| **Total Expenses:** | | **44,577,958** | **50,175,082** | **48,052,430** | **47,355,940** | **-2,819,142** | **-5.6%** |

# State of Vermont

## FY2019 Governor's Recommended Budget: Detail Report

**Organization: 3410018000 - DVHA-Medicaid/Non-Waiver Matched Programs**

### Budget Object Group: 1. PERSONAL SERVICES

| Contracted and 3rd Party Service | | FY2017 Actuals | | | | Difference Between Recommend and As Passed | Percent Change Recommend and As Passed |
|---|---|---|---|---|---|---|---|
| **Description** | **Code** | | | | | | |
| Other Contr and 3Rd Pty Serv | 507600 | 1,010,783 | 0 | 0 | 0 | 0 | 0.0% |
| **Total: Contracted and 3rd Party Service** | | **1,010,783** | **0** | **0** | **0** | **0** | **0.0%** |
| **Total: 1. PERSONAL SERVICES** | | **1,010,783** | **0** | **0** | **0** | **0** | **0.0%** |

### Budget Object Group: 3. GRANTS

| Grants Rollup | | FY2017 Actuals | FY2018 Original As Passed Budget | FY2018 Governor's BAA Recommended Budget | FY2019 Governor's Recommended Budget | Difference Between FY2019 Governor's Recommend and FY2018 As Passed | Percent Change FY2019 Governor's Recommend and FY2018 As Passed |
|---|---|---|---|---|---|---|---|
| **Description** | **Code** | | | | | | |
| Medical Services Grants | 604250 | 49,208,983 | 37,213,898 | 41,163,801 | 31,345,248 | (5,868,650) | -15.8% |
| Ahs Cost Allocation Exp. Acct. | 799090 | (1,276,989) | 0 | 0 | 0 | 0 | 0.0% |
| **Total: Grants Rollup** | | **47,931,994** | **37,213,898** | **41,163,801** | **31,345,248** | **(5,868,650)** | **-15.8%** |
| **Total: 3. GRANTS** | | **47,931,994** | **37,213,898** | **41,163,801** | **31,345,248** | **(5,868,650)** | **-15.8%** |
| **Total Expenses:** | | **48,942,777** | **37,213,898** | **41,163,801** | **31,345,248** | **-5,868,650** | **-15.8%** |

# State of Vermont

## FY2019 Governor's Recommended Budget: Detail Report

| Fund Name | Fund Code | FY2017 Actuals | FY2018 Original As Passed Budget | FY2018 Governor's BAA Recommended Budget | FY2019 Governor's Recommended Budget | Difference Between FY2019 Governor's Recommend and FY2018 As Passed | Percent Change FY2019 Governor's Recommend and FY2018 As Passed |
|---|---|---|---|---|---|---|---|
| Default Fund | 0 | 0 | 0 | 0 | 0 | 0 | 0.0% |
| General Fund | 10000 | 73,586,020 | 86,465,248 | 81,481,869 | 76,548,630 | (9,916,618) | -11.5% |
| Global Commitment Fund | 20405 | 957,892,900 | 964,876,633 | 932,826,865 | 946,660,467 | (18,216,166) | -1.9% |
| Insurance Regulatory & Suprv | 21075 | 0 | 0 | 0 | 0 | 0 | 0.0% |
| Inter-Unit Transfers Fund | 21500 | 4,719,681 | 7,482,609 | 7,361,135 | 7,246,989 | (235,620) | -3.1% |
| Evidence-Based Educ & Advertis | 21912 | 137,609 | 0 | 0 | 0 | 0 | 0.0% |
| Vermont Health IT Fund | 21916 | 846,856 | 3,577,938 | 3,577,938 | 3,522,585 | (55,353) | -1.5% |
| State Health Care Resources Fd | 21990 | 0 | 0 | 0 | 0 | 0 | 0.0% |
| Federal Revenue Fund | 22005 | 118,026,737 | 163,976,680 | 145,259,519 | 138,900,137 | (25,076,543) | -15.3% |
| ARRA Federal Fund | 22040 | 0 | 0 | 0 | 0 | 0 | 0.0% |
| **Funds Total:** | | **1,155,209,803** | **1,226,379,108** | **1,170,507,326** | **1,172,878,808** | **(53,500,300)** | **-4.4%** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Position Count | | | | | 370 | | |
| FTE Total | | | | | 366.63 | | |

Report ID : VTPB - 14
Run Date : 01/25/2018
Run Time : 10:58 AM

# State of Vermont

## FY2019 Governor's Recommended Budget
## Position Summary Report

### 3410010000-Department of Vermont Health Access - Administration

| Position Number | Classification | FTE | Count | Gross Salary | Benefits Total | Statutory Total | Total |
|---|---|---|---|---|---|---|---|
| 730001 | 501100 - DVHA Program Consultant | 1 | 1 | 54,205 | 33,763 | 4,147 | 92,115 |
| 730002 | 002000 - Administrative Secretary | 1 | 1 | 36,212 | 25,083 | 2,771 | 64,066 |
| 730003 | 499800 - DVHA COB Director | 1 | 1 | 85,738 | 24,627 | 6,559 | 116,924 |
| 730005 | 459400 - Managed Care Compliance Dir | 1 | 1 | 94,473 | 41,184 | 7,227 | 142,884 |
| 730006 | 495100 - Pharmacy Project Administrator | 1 | 1 | 73,278 | 30,842 | 5,606 | 109,726 |
| 730007 | 495900 - Med Hlthcare Data & Stat Anal | 1 | 1 | 71,281 | 13,595 | 5,454 | 90,330 |
| 730009 | 460500 - Program Integrity Director | 1 | 1 | 97,636 | 41,758 | 7,470 | 146,864 |
| 730011 | 534900 - Business Appl Support Manager | 1 | 1 | 82,950 | 38,905 | 6,346 | 128,201 |
| 730012 | 000070 - Nurse Case Manager / URN I | 1 | 1 | 79,101 | 23,440 | 6,051 | 108,593 |
| 730013 | 004700 - Program Technician I | 1 | 1 | 39,500 | 7,908 | 3,022 | 50,430 |
| 730014 | 499700 - Medicaid Operations Adm | 1 | 1 | 66,435 | 35,950 | 5,082 | 107,467 |
| 730018 | 089130 - Financial Director I | 1 | 1 | 67,766 | 30,728 | 5,184 | 103,678 |

Report ID : VTPB - 14
Run Date : 01/25/2018
Run Time : 10:58 AM

# State of Vermont

## FY2019 Governor's Recommended Budget
## Position Summary Report

| Position Number | Classification | FTE | Count | Gross Salary | Benefits Total | Statutory Total | Total |
|---|---|---|---|---|---|---|---|
| 730020 | 495600 - Associate Prog Integrity Dir | 1 | 1 | 72,738 | 30,745 | 5,565 | 109,048 |
| 730021 | 459800 - Health Program Administrator | 1 | 1 | 70,991 | 30,433 | 5,431 | 106,855 |
| 730023 | 501100 - DVHA Program Consultant | 1 | 1 | 50,773 | 18,157 | 3,884 | 72,814 |
| 730024 | 089240 - Administrative Srvcs Cord III | 1 | 1 | 59,239 | 19,885 | 4,531 | 83,655 |
| 730025 | 501100 - DVHA Program Consultant | 1 | 1 | 61,402 | 20,273 | 4,698 | 86,373 |
| 730027 | 459500 - Provider Relations Specialist | 1 | 1 | 63,190 | 12,149 | 4,833 | 80,172 |
| 730028 | 469900 - Provider & Member Serv Dir | 1 | 1 | 80,267 | 38,426 | 6,141 | 124,834 |
| 730029 | 459800 - Health Program Administrator | 1 | 1 | 65,000 | 20,642 | 4,972 | 90,614 |
| 730030 | 514400 - Dir Data Mgn Analysis & Integ | 1 | 1 | 88,649 | 39,655 | 6,781 | 135,085 |
| 730031 | 498800 - Medicaid Fiscal Analyst | 1 | 1 | 62,837 | 12,083 | 4,807 | 79,727 |
| 730032 | 089120 - Financial Manager III | 1 | 1 | 80,558 | 32,143 | 6,162 | 118,863 |
| 730034 | 000070 - Nurse Case Manager / URN I | 1 | 1 | 96,230 | 34,751 | 7,362 | 138,342 |
| 730035 | 000078 - Nurse Auditor | 1 | 1 | 87,313 | 39,685 | 6,679 | 133,677 |
| 730036 | 000070 - Nurse Case Manager / URN I | 1 | 1 | 76,181 | 32,235 | 5,827 | 114,243 |

# State of Vermont

## FY2019 Governor's Recommended Budget
## Position Summary Report

| Position Number | Classification | FTE | Count | Gross Salary | Benefits Total | Statutory Total | Total |
|---|---|---|---|---|---|---|---|
| 730037 | 501100 - DVHA Program Consultant | 1 | 1 | 50,773 | 37,673 | 3,884 | 92,330 |
| 730047 | 000086 - Nurse Administrator II | 1 | 1 | 123,227 | 22,890 | 9,427 | 155,544 |
| 730049 | 089150 - Financial Director III | 1 | 1 | 77,189 | 32,594 | 5,904 | 115,687 |
| 730050 | 000090 - Nursing Operations Director | 1 | 1 | 100,984 | 27,588 | 7,725 | 136,297 |
| 730051 | 089210 - Administrative Srvcs Tech IV | 1 | 1 | 47,403 | 26,212 | 3,626 | 77,241 |
| 730053 | 089120 - Financial Manager III | 1 | 1 | 87,735 | 33,427 | 6,712 | 127,874 |
| 730054 | 089060 - Financial Administrator II | 1 | 1 | 50,169 | 33,037 | 3,840 | 87,046 |
| 730056 | 459500 - Provider Relations Specialist | 1 | 1 | 61,318 | 11,814 | 4,691 | 77,823 |
| 730059 | 089141 - Financial Director IV | 1 | 1 | 97,636 | 41,754 | 7,468 | 146,858 |
| 730060 | 495900 - Med Hlthcare Data & Stat Anal | 1 | 1 | 64,542 | 35,611 | 4,937 | 105,090 |
| 730061 | 480200 - DVHA Quality Improvement Dir | 1 | 1 | 85,572 | 39,374 | 6,546 | 131,492 |
| 730067 | 501100 - DVHA Program Consultant | 1 | 1 | 55,952 | 34,076 | 4,280 | 94,308 |
| 730068 | 533500 - Coord of Benefits Supervisor | 1 | 1 | 70,887 | 21,671 | 5,423 | 97,981 |
| 730069 | 000075 - Nurse Case Manager / URN II | 1 | 1 | 102,212 | 42,351 | 7,820 | 152,382 |

# State of Vermont

## FY2019 Governor's Recommended Budget
## Position Summary Report

| Position Number | Classification | FTE | Count | Gross Salary | Benefits Total | Statutory Total | Total |
|---|---|---|---|---|---|---|---|
| 730070 | 000070 - Nurse Case Manager / URN I | 1 | 1 | 76,181 | 32,235 | 5,827 | 114,243 |
| 730073 | 000070 - Nurse Case Manager / URN I | 1 | 1 | 93,197 | 33,816 | 7,130 | 134,143 |
| 730074 | 000070 - Nurse Case Manager / URN I | 0.34 | | 38,697 | 7,208 | 2,960 | 48,865 |
| 730074 | 000075 - Nurse Case Manager / URN II | 0.66 | 1 | 75,757 | 14,112 | 5,795 | 95,664 |
| 730075 | 000075 - Nurse Case Manager / URN II | 1 | 1 | 117,767 | 45,135 | 9,009 | 171,911 |
| 730076 | 000070 - Nurse Case Manager / URN I | 1 | 1 | 98,926 | 26,569 | 7,568 | 133,062 |
| 730078 | 000090 - Nursing Operations Director | 1 | 1 | 132,612 | 33,319 | 9,809 | 175,741 |
| 730081 | 089040 - Financial Specialist III | 1 | 1 | 46,446 | 32,371 | 3,554 | 82,371 |
| 730082 | 486400 - Project & Operations Dir | 1 | 1 | 82,805 | 38,879 | 6,335 | 128,019 |
| 730084 | 464900 - DVHA Program & Oper Auditor | 1 | 1 | 62,836 | 12,084 | 4,807 | 79,727 |
| 730086 | 486400 - Project & Operations Dir | 1 | 1 | 94,473 | 34,235 | 7,227 | 135,935 |
| 730087 | 735500 - Healthcare Assistant Admin II | 1 | 1 | 66,435 | 21,173 | 5,082 | 92,690 |
| 730088 | 501100 - DVHA Program Consultant | 1 | 1 | 59,675 | 19,964 | 4,565 | 84,204 |
| 730089 | 501100 - DVHA Program Consultant | 1 | 1 | 57,824 | 27,880 | 4,424 | 90,128 |

# State of Vermont

## FY2019 Governor's Recommended Budget
## Position Summary Report

| Position Number | Classification | FTE | Count | Gross Salary | Benefits Total | Statutory Total | Total |
|---|---|---|---|---|---|---|---|
| 730090 | 533500 - Coord of Benefits Supervisor | 1 | 1 | 77,875 | 37,998 | 5,958 | 121,831 |
| 730091 | 000075 - Nurse Case Manager / URN II | 1 | 1 | 84,072 | 38,837 | 6,431 | 129,339 |
| 730093 | 000070 - Nurse Case Manager / URN I | 1 | 1 | 79,101 | 14,995 | 6,051 | 100,147 |
| 730094 | 000075 - Nurse Case Manager / URN II | 1 | 1 | 98,926 | 35,430 | 7,568 | 141,923 |
| 730097 | 089150 - Financial Director III | 1 | 1 | 91,438 | 34,300 | 6,995 | 132,733 |
| 730098 | 000070 - Nurse Case Manager / URN I | 1 | 1 | 76,181 | 32,235 | 5,827 | 114,243 |
| 730102 | 498000 - Health Enterprise Director II | 1 | 1 | 107,452 | 43,537 | 8,221 | 159,210 |
| 730103 | 050200 - Administrative Assistant B | 1 | 1 | 43,077 | 25,438 | 3,293 | 71,808 |
| 730105 | 089210 - Administrative Srvcs Tech IV | 0.76 | 1 | 21,539 | 27,646 | 1,648 | 50,833 |
| 730105 | 089210 - Administrative Srvcs Tech IV | 0.76 | 1 | 25,262 | 28,313 | 1,933 | 55,508 |
| 730107 | 501100 - DVHA Program Consultant | 1 | 1 | 54,205 | 18,985 | 4,147 | 77,337 |
| 730108 | 536900 - VHC Support Services Spec | 1 | 1 | 50,772 | 18,371 | 3,883 | 73,026 |
| 730109 | 460600 - Coordination of Benefit Spec | 1 | 1 | 54,829 | 27,541 | 4,195 | 86,565 |
| 730110 | 478100 - Business Process Manager | 1 | 1 | 80,558 | 32,145 | 6,162 | 118,865 |

# State of Vermont

## FY2019 Governor's Recommended Budget
## Position Summary Report

| Position Number | Classification | FTE | Count | Gross Salary | Benefits Total | Statutory Total | Total |
|---|---|---|---|---|---|---|---|
| 730112 | 536900 - VHC Support Services Spec | 1 | 1 | 50,772 | 33,150 | 3,883 | 87,805 |
| 730113 | 536900 - VHC Support Services Spec | 1 | 1 | 55,952 | 19,199 | 4,282 | 79,433 |
| 730114 | 536900 - VHC Support Services Spec | 1 | 1 | 52,416 | 18,443 | 4,010 | 74,869 |
| 730115 | 499700 - Medicaid Operations Adm | 1 | 1 | 64,293 | 35,568 | 4,918 | 104,779 |
| 730123 | 434100 - Public Health Dentist | 0.83 | 1 | 50,940 | 29,901 | 3,897 | 84,738 |
| 730123 | 434100 - Public Health Dentist | 0.75 | 1 | 25,469 | 4,586 | 1,948 | 32,003 |
| 730123 | 434100 - Public Health Dentist | 0.75 | 1 | 23,337 | 5,017 | 1,785 | 30,139 |
| 730124 | 464900 - DVHA Program & Oper Auditor | 1 | 1 | 53,248 | 28,132 | 4,074 | 85,454 |
| 730125 | 459450 - MMIS Compliance Specialist | 1 | 1 | 73,008 | 22,349 | 5,585 | 100,942 |
| 730126 | 498800 - Medicaid Fiscal Analyst | 1 | 1 | 69,056 | 21,643 | 5,282 | 95,981 |
| 730127 | 499400 - Medicaid Transptation QC Chief | 1 | 1 | 71,281 | 30,484 | 5,454 | 107,219 |
| 730129 | 550200 - Contracts & Grants Administrat | 1 | 1 | 60,882 | 19,923 | 4,657 | 85,462 |
| 730130 | 034550 - HCR-HIT Integration Manager | 1 | 1 | 94,473 | 26,409 | 7,228 | 128,110 |
| 730131 | 000070 - Nurse Case Manager / URN I | 1 | 1 | 90,080 | 33,849 | 6,892 | 130,821 |

# State of Vermont

## FY2019 Governor's Recommended Budget
## Position Summary Report

| Position Number | Classification | FTE | Count | Gross Salary | Benefits Total | Statutory Total | Total |
|---|---|---|---|---|---|---|---|
| 730132 | 000070 - Nurse Case Manager / URN I | 1 | 1 | 79,101 | 14,995 | 6,051 | 100,147 |
| 730133 | 000070 - Nurse Case Manager / URN I | 1 | 1 | 96,230 | 41,281 | 7,362 | 144,872 |
| 730134 | 000070 - Nurse Case Manager / URN I | 1 | 1 | 79,101 | 38,217 | 6,051 | 123,369 |
| 730135 | 482800 - Clinical Social Worker | 1 | 1 | 73,278 | 37,175 | 5,605 | 116,058 |
| 730136 | 482800 - Clinical Social Worker | 1 | 1 | 66,726 | 20,944 | 5,104 | 92,774 |
| 730137 | 089260 - Administrative Srvcs Mngr I | 1 | 1 | 60,487 | 28,552 | 4,628 | 93,667 |
| 730138 | 068510 - Blueprint Data Analyst | 1 | 1 | 60,487 | 21,497 | 4,626 | 86,610 |
| 730139 | 034550 - HCR-HIT Integration Manager | 1 | 1 | 94,474 | 41,184 | 7,227 | 142,885 |
| 730140 | 458902 - Health Services Researcher | 1 | 1 | 85,571 | 39,372 | 6,545 | 131,488 |
| 730141 | 501100 - DVHA Program Consultant | 1 | 1 | 54,205 | 33,762 | 4,147 | 92,114 |
| 730142 | 464900 - DVHA Program & Oper Auditor | 1 | 1 | 60,881 | 34,700 | 4,657 | 100,238 |
| 730143 | 464900 - DVHA Program & Oper Auditor | 1 | 1 | 55,182 | 27,604 | 4,222 | 87,008 |
| 730144 | 495600 - Associate Prog Integrity Dir | 1 | 1 | 72,738 | 37,078 | 5,565 | 115,381 |
| 730145 | 486300 - Clinical Util Rev Data Analyst | 1 | 1 | 62,546 | 20,214 | 4,785 | 87,545 |

# State of Vermont

## FY2019 Governor's Recommended Budget
## Position Summary Report

| Position Number | Classification | FTE | Count | Gross Salary | Benefits Total | Statutory Total | Total |
|---|---|---|---|---|---|---|---|
| 730146 | 486200 - Asst Dir of Blueprint for Hlth | 1 | 1 | 72,738 | 22,302 | 5,564 | 100,604 |
| 730147 | 486200 - Asst Dir of Blueprint for Hlth | 1 | 1 | 67,767 | 36,187 | 5,184 | 109,138 |
| 730170 | 550200 - Contracts & Grants Administrat | 1 | 1 | 55,183 | 9,905 | 4,220 | 69,308 |
| 730171 | 464900 - DVHA Program & Oper Auditor | 1 | 1 | 60,881 | 20,081 | 4,657 | 85,619 |
| 730172 | 480210 - DVHA Quality Assurance Mgr | 1 | 1 | 66,726 | 20,944 | 5,105 | 92,775 |
| 730174 | 464900 - DVHA Program & Oper Auditor | 1 | 1 | 65,000 | 29,361 | 4,972 | 99,333 |
| 730175 | 499700 - Medicaid Operations Adm | 1 | 1 | 68,640 | 36,345 | 5,252 | 110,237 |
| 730176 | 498800 - Medicaid Fiscal Analyst | 1 | 1 | 62,837 | 20,165 | 4,807 | 87,809 |
| 730177 | 499700 - Medicaid Operations Adm | 1 | 1 | 77,876 | 37,997 | 5,957 | 121,830 |
| 730178 | 004800 - Program Technician II | 1 | 1 | 47,403 | 27,085 | 3,627 | 78,115 |
| 730180 | 735700 - Healthcare Eligib & Enorll Dir | 1 | 1 | 97,634 | 41,347 | 7,468 | 146,449 |
| 730181 | 334100 - Audit Liaison/Int Control | 1 | 1 | 58,594 | 34,548 | 4,483 | 97,625 |
| 730182 | 536900 - VHC Support Services Spec | 1 | 1 | 52,416 | 18,443 | 4,010 | 74,869 |
| 730183 | 494000 - Exchange Project Director | 1 | 1 | 96,200 | 41,274 | 7,359 | 144,833 |

# State of Vermont

## FY2019 Governor's Recommended Budget
## Position Summary Report

| Position Number | Classification | FTE | Count | Gross Salary | Benefits Total | Statutory Total | Total |
|---|---|---|---|---|---|---|---|
| 730184 | 089080 - Financial Manager I | 1 | 1 | 60,487 | 20,108 | 4,628 | 85,223 |
| 730185 | 464910 - DVHA Healthcare QC Auditor | 1 | 1 | 53,248 | 28,130 | 4,074 | 85,452 |
| 730186 | 550200 - Contracts & Grants Administrat | 1 | 1 | 53,248 | 28,130 | 4,072 | 85,450 |
| 730187 | 089240 - Administrative Srvcs Cord III | 1 | 1 | 52,146 | 9,358 | 3,989 | 65,493 |
| 730188 | 089080 - Financial Manager I | 1 | 1 | 56,431 | 34,158 | 4,316 | 94,905 |
| 730189 | 089090 - Financial Manager II | 1 | 1 | 62,276 | 11,983 | 4,763 | 79,022 |
| 730190 | 536900 - VHC Support Services Spec | 1 | 1 | 50,772 | 18,157 | 3,883 | 72,812 |
| 730192 | 000070 - Nurse Case Manager / URN I | 1 | 1 | 110,775 | 30,751 | 8,474 | 150,001 |
| 730193 | 000075 - Nurse Case Manager / URN II | 1 | 1 | 95,697 | 34,853 | 7,320 | 137,870 |
| 730194 | 089220 - Administrative Srvcs Cord I | 1 | 1 | 51,168 | 32,733 | 3,915 | 87,816 |
| 730195 | 503801 - Data Analytics & Info Admin | 1 | 1 | 85,758 | 15,374 | 6,561 | 107,693 |
| 730196 | 630500 - Pharmacy Operations Manager | 1 | 1 | 67,767 | 30,729 | 5,184 | 103,680 |
| 730197 | 090000 - Dir. of Integrated Health Care | 1 | 1 | 90,210 | 16,982 | 6,901 | 114,093 |
| 730198 | 334000 - DVHA Bhav Hlth Cnrnt RvwCre Mg | 1 | 1 | 60,486 | 11,408 | 4,627 | 76,521 |

# State of Vermont

## FY2019 Governor's Recommended Budget
## Position Summary Report

| Position Number | Classification | FTE | Count | Gross Salary | Benefits Total | Statutory Total | Total |
|---|---|---|---|---|---|---|---|
| 730199 | 334000 - DVHA Bhav Hlth Cnrnt RvwCre Mg | 1 | 1 | 73,278 | 37,175 | 5,606 | 116,059 |
| 730200 | 000086 - Nurse Administrator II | 1 | 1 | 119,683 | 45,207 | 9,157 | 174,047 |
| 730201 | 000086 - Nurse Administrator II | 1 | 1 | 106,380 | 36,764 | 8,139 | 151,281 |
| 730202 | 053100 - DVHA Data Anlyst and Info Chie | 1 | 1 | 75,504 | 14,351 | 5,776 | 95,631 |
| 730204 | 334000 - DVHA Bhav Hlth Cnrnt RvwCre Mg | 1 | 1 | 69,035 | 36,416 | 5,281 | 110,732 |
| 730205 | 334000 - DVHA Bhav Hlth Cnrnt RvwCre Mg | 1 | 1 | 64,542 | 20,834 | 4,937 | 90,313 |
| 730206 | 487900 - Reimbursement Analyst | 1 | 1 | 58,905 | 34,354 | 4,506 | 97,765 |
| 730207 | 499700 - Medicaid Operations Adm | 1 | 1 | 66,435 | 12,728 | 5,082 | 84,245 |
| 730208 | 454300 - DVHA Rate Setting Mang | 1 | 1 | 93,351 | 34,433 | 7,141 | 134,925 |
| 730210 | 000070 - Nurse Case Manager / URN I | 1 | 1 | 79,101 | 14,995 | 6,051 | 100,147 |
| 730211 | 497901 - Health Reform Portfo Dir II | 1 | 1 | 91,437 | 56,927 | 6,995 | 155,359 |
| 730212 | 464900 - DVHA Program & Oper Auditor | 1 | 1 | 56,992 | 27,929 | 4,359 | 89,280 |
| 730213 | 422000 - Clinical Informatics Analyst | 1 | 1 | 69,035 | 30,083 | 5,281 | 104,399 |
| 730214 | 468600 - Legal Hearing Support Speciali | 1 | 1 | 49,546 | 17,942 | 3,788 | 71,276 |

# State of Vermont

## FY2019 Governor's Recommended Budget
## Position Summary Report

| Position Number | Classification | FTE | Count | Gross Salary | Benefits Total | Statutory Total | Total |
|---|---|---|---|---|---|---|---|
| 730215 | 000070 - Nurse Case Manager / URN I | 1 | 1 | 96,230 | 34,948 | 7,362 | 138,539 |
| 730216 | 000070 - Nurse Case Manager / URN I | 1 | 1 | 96,230 | 34,948 | 7,362 | 138,539 |
| 730218 | 000070 - Nurse Case Manager / URN I | 1 | 1 | 79,101 | 38,217 | 6,051 | 123,369 |
| 730219 | 537300 - DVHA Quality Improvement Admin | 0.87 | 1 | 60,216 | 34,567 | 4,606 | 99,389 |
| 730222 | 089120 - Financial Manager III | 1 | 1 | 66,290 | 21,050 | 5,070 | 92,410 |
| 730226 | 735800 - Healthcare Deputy Dir of Ops | 1 | 1 | 75,192 | 37,201 | 5,752 | 118,145 |
| 730227 | 089130 - Financial Director I | 1 | 1 | 96,200 | 28,143 | 7,359 | 131,702 |
| 730229 | 410300 - Workforce Management Coord II | 1 | 1 | 56,992 | 34,262 | 4,360 | 95,614 |
| 730230 | 330310 - VHC Business Process Coord | 1 | 1 | 66,436 | 29,140 | 5,082 | 100,658 |
| 730232 | 590200 - VHC Educ & Outreach Coord | 1 | 1 | 60,486 | 21,754 | 4,628 | 86,868 |
| 730233 | 735800 - Healthcare Deputy Dir of Ops | 1 | 1 | 105,560 | 42,680 | 8,076 | 156,316 |
| 730234 | 496600 - Grant Programs Manager | 1 | 1 | 56,430 | 28,702 | 4,316 | 89,448 |
| 730235 | 089270 - Administrative Srvcs Mngr II | 1 | 1 | 66,436 | 32,907 | 5,082 | 104,425 |
| 730236 | 087800 - Dir. VHC Customer Srv Center | 1 | 1 | 70,449 | 21,891 | 5,389 | 97,729 |

# State of Vermont

## FY2019 Governor's Recommended Budget
## Position Summary Report

| Position Number | Classification | FTE | Count | Gross Salary | Benefits Total | Statutory Total | Total |
|---|---|---|---|---|---|---|---|
| 730238 | 459800 - Health Program Administrator | 1 | 1 | 62,837 | 35,309 | 4,806 | 102,952 |
| 730239 | 459800 - Health Program Administrator | 1 | 1 | 53,248 | 28,131 | 4,073 | 85,452 |
| 730240 | 857200 - Communications & Outreach Coor | 1 | 1 | 52,416 | 27,109 | 4,010 | 83,535 |
| 730241 | 463100 - Health Care Project Director | 1 | 1 | 80,267 | 38,426 | 6,141 | 124,834 |
| 730242 | 463100 - Health Care Project Director | 1 | 1 | 91,541 | 27,193 | 7,004 | 125,738 |
| 730243 | 550200 - Contracts & Grants Administrat | 1 | 1 | 58,906 | 19,826 | 4,506 | 83,238 |
| 730244 | 442100 - Project Administrator Bluepri | 1 | 1 | 62,546 | 34,983 | 4,783 | 102,312 |
| 730245 | 098300 - Quality Oversight Analyst II | 1 | 1 | 80,288 | 14,868 | 6,142 | 101,298 |
| 730248 | 854000 - Senior Policy Advisor | 1 | 1 | 62,546 | 28,461 | 4,785 | 95,792 |
| 730249 | 854000 - Senior Policy Advisor | 1 | 1 | 60,486 | 20,108 | 4,627 | 85,221 |
| 730251 | 464950 - Grant Project Programs Manager | 1 | 1 | 59,946 | 29,328 | 4,586 | 93,860 |
| 730252 | 533900 - Medicaid Provider Rel Oper Chf | 1 | 1 | 69,035 | 36,416 | 5,281 | 110,732 |
| 730253 | 049601 - Grants Management Specialist | 1 | 1 | 50,169 | 27,578 | 3,840 | 81,587 |
| 730254 | 048000 - Health Senior Policy Analyst | 1 | 1 | 56,992 | 19,244 | 4,359 | 80,595 |

# State of Vermont

## FY2019 Governor's Recommended Budget
## Position Summary Report

| Position Number | Classification | FTE | Count | Gross Salary | Benefits Total | Statutory Total | Total |
|---|---|---|---|---|---|---|---|
| 730255 | 735750 - HAEEU Reporting Manager | 1 | 1 | 63,773 | 30,015 | 4,879 | 98,667 |
| 730256 | 496600 - Grant Programs Manager | 1 | 1 | 66,726 | 29,670 | 5,105 | 101,501 |
| 730257 | 857300 - Communications & Notices Mgr | 1 | 1 | 73,278 | 37,176 | 5,607 | 116,061 |
| 730260 | 089090 - Financial Manager II | 1 | 1 | 62,276 | 29,745 | 4,763 | 96,784 |
| 730261 | 208800 - Business Analyst | 1 | 1 | 64,543 | 20,834 | 4,937 | 90,314 |
| 730263 | 089230 - Administrative Srvcs Cord II | 1 | 1 | 50,772 | 33,146 | 3,885 | 87,803 |
| 730265 | 410300 - Workforce Management Coord II | 1 | 1 | 60,882 | 34,701 | 4,657 | 100,240 |
| 730266 | 460550 - Oversight & Monitoring Dir | 1 | 1 | 82,930 | 38,901 | 6,343 | 128,174 |
| 730267 | 089290 - Administrative Srvcs Dir I | 1 | 1 | 67,766 | 30,729 | 5,184 | 103,679 |
| 730268 | 089270 - Administrative Srvcs Mngr II | 1 | 1 | 59,946 | 11,568 | 4,586 | 76,100 |
| 730271 | 089280 - Administrative Srvcs Mngr III | 1 | 1 | 75,503 | 37,575 | 5,776 | 118,854 |
| 730272 | 501100 - DVHA Program Consultant | 1 | 1 | 54,205 | 18,985 | 4,147 | 77,337 |
| 730273 | 513410 - HAEEU Training/Commun Admin | 1 | 1 | 73,008 | 30,793 | 5,585 | 109,386 |
| 730275 | 089220 - Administrative Srvcs Cord I | 1 | 1 | 49,546 | 9,498 | 3,790 | 62,834 |

# State of Vermont

## FY2019 Governor's Recommended Budget
## Position Summary Report

| Position Number | Classification | FTE | Count | Gross Salary | Benefits Total | Statutory Total | Total |
|---|---|---|---|---|---|---|---|
| 730276 | 089270 - Administrative Srvcs Mngr II | 1 | 1 | 68,640 | 36,343 | 5,251 | 110,234 |
| 730277 | 499700 - Medicaid Operations Adm | 1 | 1 | 59,945 | 29,329 | 4,586 | 93,860 |
| 730278 | 501100 - DVHA Program Consultant | 1 | 1 | 50,773 | 18,371 | 3,884 | 73,028 |
| 730279 | 501100 - DVHA Program Consultant | 1 | 1 | 47,403 | 27,085 | 3,626 | 78,114 |
| 730280 | 543701 - Senior Program Consultant | 1 | 1 | 64,292 | 29,038 | 4,918 | 98,248 |
| 730281 | 501100 - DVHA Program Consultant | 1 | 1 | 49,130 | 9,631 | 3,759 | 62,520 |
| 730282 | 459800 - Health Program Administrator | 1 | 1 | 58,905 | 34,603 | 4,506 | 98,014 |
| 730283 | 501100 - DVHA Program Consultant | 1 | 1 | 49,130 | 26,520 | 3,759 | 79,409 |
| 730284 | 148400 - Senior Autism Specialist | 1 | 1 | 73,278 | 21,990 | 5,606 | 100,874 |
| 730286 | 499700 - Medicaid Operations Adm | 0.89 | 1 | 68,640 | 36,345 | 5,252 | 110,237 |
| 730287 | 442100 - Project Administrator  Bluepri | 1 | 1 | 56,430 | 33,889 | 4,316 | 94,635 |
| 730288 | 463100 - Health Care Project Director | 1 | 1 | 85,738 | 24,627 | 6,559 | 116,924 |
| 730289 | 735200 - Benefits Program Mentor | 1 | 1 | 52,146 | 33,174 | 3,989 | 89,309 |
| 730290 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 50,772 | 33,150 | 3,883 | 87,805 |

# State of Vermont

## FY2019 Governor's Recommended Budget
## Position Summary Report

| Position Number | Classification | FTE | Count | Gross Salary | Benefits Total | Statutory Total | Total |
|---|---|---|---|---|---|---|---|
| 730291 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 49,130 | 32,043 | 3,759 | 84,932 |
| 730292 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 50,772 | 18,371 | 3,883 | 73,026 |
| 730293 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 50,772 | 18,371 | 3,883 | 73,026 |
| 730294 | 735110 - VT Healthcare Service Spec III | 1 | 1 | 50,170 | 27,581 | 3,839 | 81,590 |
| 730295 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 50,772 | 19,803 | 3,883 | 74,458 |
| 730296 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 49,130 | 9,632 | 3,759 | 62,521 |
| 730297 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 50,772 | 18,371 | 3,883 | 73,026 |
| 730298 | 735000 - VT Healthcare Service Spec I | 1 | 1 | 47,944 | 17,863 | 3,668 | 69,475 |
| 730299 | 735000 - VT Healthcare Service Spec I | 1 | 1 | 47,944 | 17,863 | 3,668 | 69,475 |
| 730300 | 480210 - DVHA Quality Assurance Mgr | 1 | 1 | 56,430 | 28,701 | 4,316 | 89,447 |
| 730301 | 735110 - VT Healthcare Service Spec III | 1 | 1 | 53,746 | 18,577 | 4,112 | 76,435 |
| 730302 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 50,772 | 26,816 | 3,883 | 81,471 |
| 730303 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 50,772 | 18,371 | 3,883 | 73,026 |
| 730304 | 735000 - VT Healthcare Service Spec I | 1 | 1 | 46,446 | 9,152 | 3,554 | 59,152 |

# State of Vermont

## FY2019 Governor's Recommended Budget
## Position Summary Report

| Position Number | Classification | FTE | Count | Gross Salary | Benefits Total | Statutory Total | Total |
|---|---|---|---|---|---|---|---|
| 730305 | 735000 - VT Healthcare Service Spec I | 1 | 1 | 47,944 | 9,419 | 3,668 | 61,031 |
| 730306 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 47,403 | 16,955 | 3,627 | 67,985 |
| 730307 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 49,130 | 18,076 | 3,759 | 70,965 |
| 730308 | 735000 - VT Healthcare Service Spec I | 1 | 1 | 46,446 | 31,563 | 3,554 | 81,563 |
| 730309 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 49,130 | 9,632 | 3,759 | 62,521 |
| 730310 | 735000 - VT Healthcare Service Spec I | 1 | 1 | 46,446 | 9,152 | 3,554 | 59,152 |
| 730311 | 208800 - Business Analyst | 1 | 1 | 56,430 | 34,162 | 4,316 | 94,908 |
| 730312 | 330320 - Knowledge Management Sys Admin | 1 | 1 | 56,992 | 10,798 | 4,360 | 72,150 |
| 730313 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 50,772 | 33,150 | 3,883 | 87,805 |
| 730314 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 49,130 | 30 | 3,759 | 52,919 |
| 730315 | 735000 - VT Healthcare Service Spec I | 1 | 1 | 46,446 | 32,375 | 3,554 | 82,375 |
| 730316 | 735000 - VT Healthcare Service Spec I | 1 | 1 | 49,545 | 32,931 | 3,791 | 86,267 |
| 730317 | 735000 - VT Healthcare Service Spec I | 1 | 1 | 46,446 | 9,152 | 3,554 | 59,152 |
| 730318 | 735100 - VT Healthcare Service Spec II | 0.36 | | 19,574 | 12,167 | 1,497 | 33,238 |

# State of Vermont

## FY2019 Governor's Recommended Budget
## Position Summary Report

| Position Number | Classification | FTE | Count | Gross Salary | Benefits Total | Statutory Total | Total |
|---|---|---|---|---|---|---|---|
| 730318 | 735110 - VT Healthcare Service Spec III | 0.64 | 1 | 34,172 | 21,242 | 2,615 | 58,029 |
| 730319 | 735000 - VT Healthcare Service Spec I | 1 | 1 | 46,446 | 9,152 | 3,554 | 59,152 |
| 730320 | 735000 - VT Healthcare Service Spec I | 1 | 1 | 46,446 | 9,152 | 3,554 | 59,152 |
| 730321 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 50,772 | 18,371 | 3,883 | 73,026 |
| 730322 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 52,416 | 18,664 | 4,010 | 75,090 |
| 730323 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 50,772 | 18,157 | 3,883 | 72,812 |
| 730324 | 735000 - VT Healthcare Service Spec I | 1 | 1 | 47,944 | 26,106 | 3,668 | 77,718 |
| 730325 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 50,772 | 18,371 | 3,883 | 73,026 |
| 730326 | 735110 - VT Healthcare Service Spec III | 1 | 1 | 52,146 | 26,643 | 3,989 | 82,778 |
| 730327 | 735110 - VT Healthcare Service Spec III | 1 | 1 | 52,146 | 18,615 | 3,989 | 74,750 |
| 730328 | 735200 - Benefits Program Mentor | 1 | 1 | 50,170 | 27,581 | 3,839 | 81,590 |
| 730329 | 735200 - Benefits Program Mentor | 1 | 1 | 53,746 | 18,901 | 4,112 | 76,759 |
| 730330 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 50,772 | 9,927 | 3,883 | 64,582 |
| 730331 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 49,130 | 9,632 | 3,759 | 62,521 |

# State of Vermont

## FY2019 Governor's Recommended Budget
## Position Summary Report

| Position Number | Classification | FTE | Count | Gross Salary | Benefits Total | Statutory Total | Total |
|---|---|---|---|---|---|---|---|
| 730332 | 735200 - Benefits Program Mentor | 1 | 1 | 50,170 | 26,511 | 3,839 | 80,520 |
| 730333 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 49,130 | 26,521 | 3,759 | 79,410 |
| 730334 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 49,130 | 32,855 | 3,759 | 85,744 |
| 730335 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 52,416 | 10,220 | 4,010 | 66,646 |
| 730336 | 735110 - VT Healthcare Service Spec III | 1 | 1 | 50,170 | 18,263 | 3,839 | 72,272 |
| 730337 | 735200 - Benefits Program Mentor | 1 | 1 | 52,146 | 9,951 | 3,989 | 66,086 |
| 730338 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 50,772 | 26,602 | 3,883 | 81,257 |
| 730339 | 735110 - VT Healthcare Service Spec III | 1 | 1 | 53,746 | 18,901 | 4,112 | 76,759 |
| 730340 | 536900 - VHC Support Services Spec | 1 | 1 | 47,403 | 27,085 | 3,627 | 78,115 |
| 730341 | 459800 - Health Program Administrator | 1 | 1 | 55,183 | 10,715 | 4,221 | 70,119 |
| 730342 | 735300 - Fair Hearing Specialist | 1 | 1 | 53,746 | 10,457 | 4,112 | 68,315 |
| 730343 | 536900 - VHC Support Services Spec | 1 | 1 | 49,130 | 19,722 | 3,759 | 72,611 |
| 730344 | 004700 - Program Technician I | 1 | 1 | 38,168 | 16,113 | 2,920 | 57,201 |
| 730345 | 735000 - VT Healthcare Service Spec I | 1 | 1 | 46,446 | 9,152 | 3,554 | 59,152 |

# State of Vermont

## FY2019 Governor's Recommended Budget
## Position Summary Report

| Position Number | Classification | FTE | Count | Gross Salary | Benefits Total | Statutory Total | Total |
|---|---|---|---|---|---|---|---|
| 730346 | 536900 - VHC Support Services Spec | 1 | 1 | 49,130 | 26,117 | 3,759 | 79,006 |
| 730347 | 735000 - VT Healthcare Service Spec I | 1 | 1 | 49,130 | 26,521 | 3,759 | 79,410 |
| 730348 | 536900 - VHC Support Services Spec | 1 | 1 | 49,130 | 9,425 | 3,759 | 62,314 |
| 730349 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 49,130 | 18,076 | 3,759 | 70,965 |
| 730350 | 089220 - Administrative Srvcs Cord I | 1 | 1 | 47,944 | 9,419 | 3,668 | 61,031 |
| 730352 | 735200 - Benefits Program Mentor | 1 | 1 | 63,190 | 35,370 | 4,834 | 103,394 |
| 730353 | 513700 - Benefits Programs Specialist | 1 | 1 | 64,958 | 35,686 | 4,970 | 105,614 |
| 730354 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 64,958 | 12,464 | 4,970 | 82,392 |
| 730355 | 503400 - Benefits Progrms Administrator | 1 | 1 | 90,834 | 33,982 | 6,949 | 131,765 |
| 730356 | 513700 - Benefits Programs Specialist | 1 | 1 | 55,952 | 33,804 | 4,282 | 94,038 |
| 730357 | 513700 - Benefits Programs Specialist | 1 | 1 | 50,772 | 18,372 | 3,884 | 73,028 |
| 730358 | 513700 - Benefits Programs Specialist | 1 | 1 | 50,772 | 32,934 | 3,884 | 87,590 |
| 730359 | 459900 - ESD Health Care Elig Dir | 1 | 1 | 94,474 | 26,408 | 7,228 | 128,110 |
| 730360 | 735510 - Healthcare Assistant Admin I | 1 | 1 | 62,837 | 28,709 | 4,806 | 96,352 |

# State of Vermont

## FY2019 Governor's Recommended Budget
## Position Summary Report

| Position Number | Classification | FTE | Count | Gross Salary | Benefits Total | Statutory Total | Total |
|---|---|---|---|---|---|---|---|
| 730361 | 735500 - Healthcare Assistant Admin II | 1 | 1 | 64,292 | 35,297 | 4,917 | 104,506 |
| 730362 | 513700 - Benefits Programs Specialist | 1 | 1 | 61,402 | 20,274 | 4,696 | 86,372 |
| 730363 | 513700 - Benefits Programs Specialist | 1 | 1 | 59,676 | 28,410 | 4,566 | 92,652 |
| 730364 | 735200 - Benefits Program Mentor | 1 | 1 | 70,782 | 36,728 | 5,414 | 112,924 |
| 730365 | 503400 - Benefits Progrms Administrator | 1 | 1 | 80,288 | 32,095 | 6,141 | 118,524 |
| 730366 | 503400 - Benefits Progrms Administrator | 1 | 1 | 88,255 | 33,326 | 6,752 | 128,333 |
| 730367 | 513700 - Benefits Programs Specialist | 1 | 1 | 55,952 | 27,742 | 4,282 | 87,976 |
| 730368 | 513700 - Benefits Programs Specialist | 1 | 1 | 66,788 | 29,682 | 5,108 | 101,578 |
| 730369 | 513700 - Benefits Programs Specialist | 1 | 1 | 54,204 | 33,762 | 4,146 | 92,112 |
| 730370 | 735510 - Healthcare Assistant Admin I | 1 | 1 | 62,837 | 20,264 | 4,806 | 87,907 |
| 730371 | 513700 - Benefits Programs Specialist | 1 | 1 | 55,952 | 10,852 | 4,282 | 71,086 |
| 730372 | 513700 - Benefits Programs Specialist | 1 | 1 | 50,772 | 9,926 | 3,884 | 64,582 |
| 730373 | 513700 - Benefits Programs Specialist | 1 | 1 | 52,416 | 26,914 | 4,010 | 83,340 |
| 730374 | 513700 - Benefits Programs Specialist | 1 | 1 | 52,416 | 27,112 | 4,010 | 83,538 |

# State of Vermont

## FY2019 Governor's Recommended Budget
## Position Summary Report

| Position Number | Classification | FTE | Count | Gross Salary | Benefits Total | Statutory Total | Total |
|---|---|---|---|---|---|---|---|
| 730375 | 735510 - Healthcare Assistant Admin I | 1 | 1 | 62,837 | 34,772 | 4,806 | 102,415 |
| 730377 | 735500 - Healthcare Assistant Admin II | 1 | 1 | 70,886 | 36,748 | 5,422 | 113,056 |
| 730378 | 501200 - Economic Services Supervisor | 1 | 1 | 64,542 | 20,836 | 4,938 | 90,316 |
| 730379 | 735500 - Healthcare Assistant Admin II | 1 | 1 | 68,640 | 12,311 | 5,251 | 86,202 |
| 730380 | 050200 - Administrative Assistant B | 1 | 1 | 40,290 | 24,940 | 3,082 | 68,312 |
| 730381 | 735510 - Healthcare Assistant Admin I | 1 | 1 | 56,992 | 19,144 | 4,360 | 80,496 |
| 730382 | 735500 - Healthcare Assistant Admin II | 1 | 1 | 68,640 | 30,014 | 5,252 | 103,906 |
| 730383 | 513700 - Benefits Programs Specialist | 1 | 1 | 50,772 | 33,148 | 3,884 | 87,804 |
| 730384 | 513700 - Benefits Programs Specialist | 1 | 1 | 50,772 | 18,372 | 3,884 | 73,028 |
| 730385 | 501200 - Economic Services Supervisor | 1 | 1 | 71,282 | 30,484 | 5,454 | 107,220 |
| 730386 | 513400 - Healthcare Training/Curr Coord | 1 | 1 | 50,170 | 26,708 | 3,839 | 80,717 |
| 730387 | 503400 - Benefits Progrms Administrator | 1 | 1 | 67,766 | 30,729 | 5,184 | 103,679 |
| 730388 | 503400 - Benefits Progrms Administrator | 1 | 1 | 88,254 | 24,978 | 6,752 | 119,984 |
| 730389 | 735500 - Healthcare Assistant Admin II | 1 | 1 | 62,276 | 20,165 | 4,765 | 87,206 |

# State of Vermont

## FY2019 Governor's Recommended Budget
## Position Summary Report

| Position Number | Classification | FTE | Count | Gross Salary | Benefits Total | Statutory Total | Total |
|---|---|---|---|---|---|---|---|
| 730390 | 735510 - Healthcare Assistant Admin I | 1 | 1 | 55,183 | 19,159 | 4,221 | 78,563 |
| 730391 | 735510 - Healthcare Assistant Admin I | 1 | 1 | 53,248 | 28,131 | 4,073 | 85,452 |
| 730392 | 735500 - Healthcare Assistant Admin II | 1 | 1 | 59,946 | 29,330 | 4,586 | 93,862 |
| 730393 | 735510 - Healthcare Assistant Admin I | 1 | 1 | 56,992 | 33,991 | 4,360 | 95,343 |
| 730394 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 50,772 | 18,371 | 3,883 | 73,026 |
| 730395 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 47,403 | 27,085 | 3,627 | 78,115 |
| 730396 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 50,772 | 33,150 | 3,883 | 87,805 |
| 730397 | 089280 - Administrative Srvcs Mngr III | 1 | 1 | 73,008 | 37,127 | 5,585 | 115,720 |
| 730398 | 735110 - VT Healthcare Service Spec III | 1 | 1 | 52,146 | 9,359 | 3,989 | 65,494 |
| 730399 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 50,772 | 26,816 | 3,883 | 81,471 |
| 730400 | 735110 - VT Healthcare Service Spec III | 1 | 1 | 52,146 | 37,698 | 3,989 | 93,833 |
| 730401 | 735200 - Benefits Program Mentor | 1 | 1 | 55,516 | 10,540 | 4,248 | 70,304 |
| 730402 | 735400 - VT Healthcare Srvc Supervisor | 1 | 1 | 60,486 | 28,298 | 4,628 | 93,412 |
| 730403 | 735200 - Benefits Program Mentor | 1 | 1 | 65,083 | 35,439 | 4,980 | 105,502 |

# State of Vermont

## FY2019 Governor's Recommended Budget
## Position Summary Report

| Position Number | Classification | FTE | Count | Gross Salary | Benefits Total | Statutory Total | Total |
|---|---|---|---|---|---|---|---|
| 730404 | 735200 - Benefits Program Mentor | 1 | 1 | 57,304 | 34,077 | 4,384 | 95,765 |
| 730405 | 735000 - VT Healthcare Service Spec I | 1 | 1 | 52,416 | 18,664 | 4,010 | 75,090 |
| 730406 | 735400 - VT Healthcare Srvc Supervisor | 1 | 1 | 62,545 | 12,032 | 4,785 | 79,362 |
| 730407 | 735400 - VT Healthcare Srvc Supervisor | 1 | 1 | 60,486 | 19,853 | 4,628 | 84,967 |
| 730408 | 735400 - VT Healthcare Srvc Supervisor | 1 | 1 | 60,486 | 11,664 | 4,628 | 76,778 |
| 730409 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 49,130 | 18,076 | 3,759 | 70,965 |
| 730410 | 735110 - VT Healthcare Service Spec III | 1 | 1 | 52,146 | 26,863 | 3,989 | 82,998 |
| 730411 | 735200 - Benefits Program Mentor | 1 | 1 | 63,190 | 20,592 | 4,835 | 88,617 |
| 730412 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 61,402 | 20,273 | 4,697 | 86,372 |
| 730413 | 735100 - VT Healthcare Service Spec II | 0.36 | | 19,574 | 6,801 | 1,497 | 27,872 |
| 730413 | 735110 - VT Healthcare Service Spec III | 0.64 | 1 | 34,172 | 11,874 | 2,615 | 48,661 |
| 730414 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 52,416 | 10,220 | 4,010 | 66,646 |
| 730415 | 735600 - Healthcare Call Center Dir | 1 | 1 | 72,738 | 30,745 | 5,564 | 109,047 |
| 730416 | 735000 - VT Healthcare Service Spec I | 1 | 1 | 54,205 | 18,756 | 4,147 | 77,108 |

# State of Vermont

## FY2019 Governor's Recommended Budget
## Position Summary Report

| Position Number | Classification | FTE | Count | Gross Salary | Benefits Total | Statutory Total | Total |
|---|---|---|---|---|---|---|---|
| 730417 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 54,204 | 18,984 | 4,147 | 77,335 |
| 730418 | 735400 - VT Healthcare Srvc Supervisor | 1 | 1 | 56,430 | 28,701 | 4,316 | 89,447 |
| 730420 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 47,404 | 17,570 | 3,626 | 68,600 |
| 730421 | 735400 - VT Healthcare Srvc Supervisor | 1 | 1 | 62,545 | 28,921 | 4,785 | 96,251 |
| 730422 | 735400 - VT Healthcare Srvc Supervisor | 1 | 1 | 71,281 | 30,486 | 5,452 | 107,219 |
| 730423 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 47,403 | 27,085 | 3,627 | 78,115 |
| 730424 | 089230 - Administrative Srvcs Cord II | 1 | 1 | 54,204 | 27,201 | 4,147 | 85,552 |
| 730425 | 735200 - Benefits Program Mentor | 1 | 1 | 55,516 | 33,998 | 4,248 | 93,762 |
| 730426 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 50,772 | 18,371 | 3,883 | 73,026 |
| 730427 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 55,952 | 33,840 | 4,282 | 94,074 |
| 730428 | 735400 - VT Healthcare Srvc Supervisor | 1 | 1 | 60,486 | 20,108 | 4,628 | 85,222 |
| 730429 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 52,416 | 18,345 | 4,010 | 74,771 |
| 730430 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 50,772 | 26,816 | 3,883 | 81,471 |
| 730431 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 47,403 | 17,767 | 3,627 | 68,797 |

# State of Vermont

## FY2019 Governor's Recommended Budget
## Position Summary Report

| Position Number | Classification | FTE | Count | Gross Salary | Benefits Total | Statutory Total | Total |
|---|---|---|---|---|---|---|---|
| 730432 | 208800 - Business Analyst | 1 | 1 | 56,430 | 19,383 | 4,316 | 80,129 |
| 730433 | 735400 - VT Healthcare Srvc Supervisor | 1 | 1 | 60,486 | 34,887 | 4,628 | 100,001 |
| 730434 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 49,130 | 9,632 | 3,759 | 62,521 |
| 730435 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 47,403 | 17,767 | 3,627 | 68,797 |
| 730436 | 536900 - VHC Support Services Spec | 1 | 1 | 47,403 | 17,767 | 3,627 | 68,797 |
| 730437 | 735300 - Fair Hearing Specialist | 1 | 1 | 52,146 | 33,123 | 3,989 | 89,258 |
| 730438 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 49,130 | 9,632 | 3,759 | 62,521 |
| 730439 | 536900 - VHC Support Services Spec | 1 | 1 | 50,772 | 18,371 | 3,883 | 73,026 |
| 730440 | 735100 - VT Healthcare Service Spec II | 1 | 1 | 47,403 | 27,085 | 3,627 | 78,115 |
| 730441 | 735110 - VT Healthcare Service Spec III | 1 | 1 | 52,146 | 26,643 | 3,989 | 82,778 |
| 730442 | 735400 - VT Healthcare Srvc Supervisor | 1 | 1 | 60,486 | 10,852 | 4,628 | 75,966 |
| 730443 | 735300 - Fair Hearing Specialist | 1 | 1 | 52,146 | 18,395 | 3,989 | 74,530 |
| 730444 | 735300 - Fair Hearing Specialist | 1 | 1 | 53,746 | 18,901 | 4,112 | 76,759 |
| 730445 | 513400 - Healthcare Training/Curr Coord | 1 | 1 | 55,516 | 18,984 | 4,248 | 78,748 |

# State of Vermont

## FY2019 Governor's Recommended Budget
## Position Summary Report

| Position Number | Classification | FTE | Count | Gross Salary | Benefits Total | Statutory Total | Total |
|---|---|---|---|---|---|---|---|
| 730446 | 735300 - Fair Hearing Specialist | 1 | 1 | 55,516 | 33,998 | 4,248 | 93,762 |
| 730447 | 735300 - Fair Hearing Specialist | 1 | 1 | 63,190 | 35,371 | 4,835 | 103,396 |
| 730448 | 080400 - Program Integrity Investigator | 1 | 1 | 49,546 | 18,152 | 3,790 | 71,488 |
| 730449 | 048500 - Hlth AccessPolicy & Plng Chief | 1 | 1 | 63,772 | 30,014 | 4,879 | 98,665 |
| 730450 | 454200 - AHS Director Healthcare Policy | 1 | 1 | 85,572 | 39,209 | 6,546 | 131,327 |
| 730451 | 459800 - Health Program Administrator | 1 | 1 | 77,272 | 31,231 | 5,911 | 114,414 |
| 730452 | 501100 - DVHA Program Consultant | 1 | 1 | 52,416 | 33,442 | 4,009 | 89,867 |
| 730453 | 081550 - Appeals Manager | 1 | 1 | 68,640 | 30,011 | 5,251 | 103,902 |
| 730454 | 459800 - Health Program Administrator | 1 | 1 | 58,905 | 28,270 | 4,506 | 91,681 |
| 730455 | 459800 - Health Program Administrator | 1 | 1 | 72,967 | 37,119 | 5,582 | 115,668 |
| 737001 | 95010E - Executive Director | 1 | 1 | 137,862 | 49,048 | 9,885 | 196,795 |
| 737002 | 90120A - Commissioner | 1 | 1 | 125,922 | 46,883 | 9,634 | 182,439 |
| 737003 | 90570D - Deputy Commissioner | 1 | 1 | 101,711 | 36,162 | 7,780 | 145,653 |
| 737004 | 90570D - Deputy Commissioner | 1 | 1 | 100,006 | 42,184 | 7,650 | 149,840 |

# State of Vermont

## FY2019 Governor's Recommended Budget
## Position Summary Report

| Position Number | Classification | FTE | Count | Gross Salary | Benefits Total | Statutory Total | Total |
|---|---|---|---|---|---|---|---|
| 737006 | 91590E - Private Secretary | 1 | 1 | 173,827 | 38,508 | 10,408 | 222,743 |
| 737008 | 95867E - Staff Attorney II | 1 | 1 | 63,960 | 16,930 | 4,893 | 85,783 |
| 737012 | 95360E - Principal Assistant | 1 | 1 | 173,827 | 39,381 | 10,408 | 223,616 |
| 737014 | 95866E - Staff Attorney I | 1 | 1 | 53,394 | 24,985 | 4,083 | 82,462 |
| 737015 | 95866E - Staff Attorney I | 1 | 1 | 53,830 | 33,816 | 4,119 | 91,765 |
| 737016 | 95870E - General Counsel I | 1 | 1 | 90,002 | 16,341 | 6,885 | 113,228 |
| 737028 | 95880E - Deputy State's Attorney | 1 | 1 | 68,016 | 21,612 | 5,203 | 94,831 |
| 737036 | 95867E - Staff Attorney II | 1 | 1 | 61,797 | 18,056 | 4,728 | 84,581 |
| 737037 | 95868E - Staff Attorney III | 1 | 1 | 80,122 | 23,806 | 6,129 | 110,057 |
| 737038 | 95868E - Staff Attorney III | 1 | 1 | 80,122 | 32,250 | 6,129 | 118,501 |
| 737100 | 96700E - Director  Blueprint for Health | 1 | 1 | 109,970 | 30,872 | 8,412 | 149,254 |
| **Total** | | **368.6** | **370** | **23,997,461** | **9,672,822** | **1,829,034** | **35,499,310** |

| Fund Code | Fund Name | FTE | Count | Gross Salary | Benefits Total | Statutory Total | Total |
|---|---|---|---|---|---|---|---|
| 0 | Default Fund | 0 | 1 | 0 | 0 | 0 | 0 |
| 10000 | General Fund | 141.99 | 24 | 9,362,948 | 3,778,377 | 715,281 | 13,856,602 |

**Report ID** : VTPB - 14
**Run Date** : 01/25/2018
**Run Time** : 10:58 AM

# State of Vermont

## FY2019 Governor's Recommended Budget
## Position Summary Report

| Fund Code | Fund Name | FTE | Count | Gross Salary | Benefits Total | Statutory Total | Total |
|---|---|---|---|---|---|---|---|
| 20405 | Global Commitment Fund | 6.86 | | 526,264 | 207,790 | 40,255 | 774,309 |
| 21500 | Inter-Unit Transfers Fund | 7.85 | | 452,137 | 183,761 | 34,578 | 670,476 |
| 21916 | Vermont Health IT Fund | 0.6 | | 42,203 | 19,352 | 3,231 | 64,786 |
| 22005 | Federal Revenue Fund | 211.3 | 345 | 13,613,909 | 5,483,542 | 1,035,689 | 20,133,137 |
| **Total** | | **368.60** | **370** | **23,997,461** | **9,672,822** | **1,829,034** | **35,499,310** |

Note: Numbers may not sum to total due to rounding.

| Report ID: | VTPB-24 EST_FED_RECEIPTS |
|---|---|

# State of Vermont

## FY2019 Governor's Recommended Budget
## Federal - Receipts Detail Report


## Department: 3410010000 - Department of Vermont Health Access - Administration

| Budget Request Code | Fund | Justification | Est Amount |
|---|---|---|---|
| 8243 | 22005 | CFDA 93.778 | $118,955,295 |
| | | **Total** | **$118,955,295** |

| Report ID: | VTPB-24 EST_FED_RECEIPTS |
|---|---|

# State of Vermont

## FY2019 Governor's Recommended Budget
## Federal - Receipts Detail Report

### Department: 3410018000 - DVHA-Medicaid/Non-Waiver Matched Programs

| Budget Request Code | Fund | Justification | Est Amount |
|---|---|---|---|
| 8244 | 22005 | CFDA 93-767 | $7,519,919 |
| 8244 | 22005 | CFDA 93-778 | $12,424,923 |
| | | **Total** | **$19,944,842** |

| Report ID: | VTPB-23 IDT_RECEIPTS |
|---|---|

# State of Vermont
# FY2019 Governor's Recommended Budget
# Interdepartmental Transfers Inventory Report

## Department: 3410010000 - Department of Vermont Health Access - Administration

| Budget Request Code | Fund | Justification | Est Amount |
|---|---|---|---|
| 8245 | 21500 | ADAP 3420060000 | $395,000 |
| 8245 | 21500 | IE 3400991601 | $3,780,853 |
| 8245 | 21500 | VHC Sust. 3400004000 | $3,071,136 |
| | | **Total** | **7,246,989** |

| Report ID: | VTPB-28 GRANTS_INVENTOR` |
|---|---|

# State of Vermont
# FY2019 Governor's Recommended Budget
# Grants Out Inventory Report

## Department: 3410018000 - DVHA-Medicaid/Non-Waiver Matched Programs

| Budget Request Code | Fund | Justification | Est Amount |
|---|---|---|---|
| 8292 | 10000 | Non Waiver Program | $11,400,406 |
| 8292 | 22005 | Non Waiver Program | $19,944,842 |
| | | **Total** | **31,345,248** |

| Report ID: | VTPB-28 GRANTS_INVENTOR` |
|---|---|

# State of Vermont
# FY2019 Governor's Recommended Budget
# Grants Out Inventory Report

## Department: 3410017000 - DVHA- Medicaid/State Only Programs

| Budget Request Code | Fund | Justification | Est Amount |
|---|---|---|---|
| 8291 | 10000 | State Only Program | $38,474,163 |
| 8291 | 20405 | GC Investments Program | $8,881,777 |
| | | **Total** | **47,355,940** |

| Report ID: | VTPB-28 GRANTS_INVENTOR` |
|---|---|

# State of Vermont
# FY2019 Governor's Recommended Budget
# Grants Out Inventory Report

## Department: 3410016000 - DVHA-Medicaid/Long Term Care Waiver

| Budget Request Code | Fund | Justification | Est Amount |
|---|---|---|---|
| 8290 | 20405 | CFC Program | $203,050,763 |
| | | **Total** | **203,050,763** |

| Report ID: | VTPB-28 GRANTS_INVENTOR` |
|---|---|

# State of Vermont
# FY2019 Governor's Recommended Budget
# Grants Out Inventory Report

## Department: 3410015000 - DVHA- Medicaid Program/Global Commitment

| Budget Request Code | Fund | Justification | Est Amount |
|---|---|---|---|
| 8289 | 20405 | GC Program | $727,932,838 |
| | | **Total** | **727,932,838** |

# State of Vermont
## FY2019 Governor's Recommended Budget
## Grants Out Inventory Report

## Department: 3410010000 - Department of Vermont Health Access - Administration

| Budget Request Code | Fund | Justification | Est Amount |
|---|---|---|---|
| 8238 | 10000 | AAA Grants | $119,261 |
| 8238 | 10000 | Blueprint Annual Conference | $3,422 |
| 8238 | 10000 | Blueprint Facilitator | $117,901 |
| 8238 | 10000 | Blueprint H.S.A. Grants | $436,646 |
| 8238 | 10000 | Blueprint WHI | $38,610 |
| 8238 | 10000 | Navigator Grants | $22,889 |
| 8238 | 20405 | Blueprint Annual Conference | $12,656 |
| 8238 | 20405 | Blueprint Facilitator | $435,998 |
| 8238 | 20405 | Blueprint H.S.A. Grants | $1,800,635 |
| 8238 | 20405 | Blueprint WHI | $142,780 |
| 8238 | 20405 | HIT Grants | $1,755,824 |
| 8238 | 21500 | AAA Grants | $15,418 |
| 8238 | 21500 | Blueprint ADAP | $395,000 |
| 8238 | 21500 | Navigator Grants | $31,017 |
| 8238 | 21916 | HIT Grants | $602,043 |
| 8238 | 22005 | AAA Grants | $125,321 |
| 8238 | 22005 | Blueprint Annual Conference | $3,422 |

| Report ID: | VTPB-28 GRANTS_INVENTOR` |
|---|---|

# State of Vermont
## FY2019 Governor's Recommended Budget
## Grants Out Inventory Report

| Budget Request Code | Fund | Justification | Est Amount |
|---|---|---|---|
| 8238 | 22005 | Blueprint Facilitator | $117,901 |
| 8238 | 22005 | Blueprint H.S.A. Grants | $486,921 |
| 8238 | 22005 | Blueprint WHI | $38,610 |
| 8238 | 22005 | HIT Grants | $588,416 |
| 8238 | 22005 | Navigator Grants | $24,052 |
| | | **Total** | **7,314,743** |

# ACRONYMS

| A | B | C | D | E | F | G | H | I | J | K | L | M | N | O | P | Q | R | S | T | U | V | W | X | Y | Z |

## A

**A/R**.....Accounts Receivable

**AAA** .....Area Agencies on Aging

**AAG**.....Assistant Attorney General

**ABA** .....Applied Behavior Analysis

**ABD**.....Aged Blind and Disabled

**ACA** .....Affordable Care Act

**ACCESS** .....Legacy Eligibility System

**ACH** .....Automated Clearing House

**ACO**.....Accountable Care Organization

**ACT 248**.....Supervision of people with developmental disabilities

**AD**.....Active Directory

**ADAP**.....Alcohol and Drug Abuse Programs

**ADD** .....Attention deficit disorder

**ADS** .....Agency of Digital Services

**AEP** .....Annual Enrollment Period

**AG**.....Attorney General

**AGO** .....Office of the Attorney General

**AHS**.....Agency of Human Services

**AIDS**.....Acquired Immune Deficiency Syndrome

**ALS**.....Advanced Life Support

**AMA**.....American Medical Association

**AMH** .....Adult Mental Health Division

**ANFC**.....Aid to Needy Families with Children

**AOA**.....Agency of Administration

**AOE** .....Agency of Education

**AOEP**.....Annual Open Enrollment Period

**AOPS**..... Assistant Operations Unit

**APA** ..... Administrative Procedures Act

**AP/AR**..... Accounts Payable/Accounts Receivable

**APD**..... Advanced Planning Document

**APDU** ..... Advance Planning Document Update

**APM** ..... All Payer Model

**APTC**..... Advanced Premium Tax Credit

**ARRA**..... American Recovery & Reinvestment Act of 2009

## B

**BA**..... Business Analyst
**BAA**..... Budget Adjustment Act
**BAFO**..... Best and Final Offer
**BC/BS**..... Blue Cross/Blue Shield
**BCBSVT**..... Blue Cross/Blue Shield of Vermont
**BCCT** Breast & Cervical Cancer Treatment
**BCS**..... Breast Cancer Screening
**BD**..... Blind & Disabled
**BFIU**..... Beneficiary Healthcare Fraud Investigative Unit
**BGS**..... Building and General Services
**BIPA**..... Benefits Improvement and Protection Act
**BO**..... Business Office
**BP** ..... Blueprint
**BPFH**..... Blueprint for Health

## C

**CAC**..... Certified Application Counselors
**CAFR**..... Comprehensive Annual Financial Report
**CAH**..... Critical Access Hospital
**CAP**..... Corrective Action Plan
**CC**..... Chronic Care
**CFC**..... Choices for Care
**CFR**..... Code of Federal Regulations
**CHAC**..... Community Health Accountability Care
**CHC**..... Change Healthcare
**CHIP**..... Children's Health Insurance Program
**CHT**..... Community Health Team
**CIS**..... Children's Integrated Services
**CLD**..... Claim Level Detail

**CMC**.....Case Manager Conference
**CMH**.....Children's Mental Health Division
**CMHC**.....Community Mental Health Center
**CMMI**.....Center for Medicare and Medicaid Innovation
**CMS**.....Centers for Medicare & Medicaid Services
**CO**.....Compliance officer
**COB**.....Coordination of Benefits
**COBRA**.....Consolidated Omnibus Reconciliation Act of 1986 (health coverage)
**COLA**.....Cost of Living Adjustment
**CON**.....Certificate of Need
**COPD**.....Chronic Obstructive Pulmonary Disease
**CORF**.....Comprehensive Outpatient Rehabilitation Facilities
**COS**.....Category of Service
**COS**.....Cost of Service
**COU**.....Clinical Operations Unit
**CPT**.....Common Procedural Terminology
**CSHN**.....Children with Special Health Needs
**CSR**.....Cost Sharing Reductions
**CVH**.....Central Vermont Hospital
**CY**.....Calendar Year

## D

**DA**.....Designated Agency
**DAIL**.....Department of Disabilities, Aging & Independent Living
**DCF**.....Department for Children & Families
**DCF BO**.....Department for Children and Families Business Office
**DD**.....Developmental Disabilities
**DD HCBS**.....Developmental Disability Home and Community Based Services
**DDI**.....Design, Development & Implementation
**DDS**.....Developmental Disability Services
**DEA**.....Drug Enforcement Administration
**DFCU**.....DVHA Fiscal Compliance Unit
**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
**DME**.....Durable Medical Equipment
**DMEPOS**.....Durable Medical Equipment Prosthetics, Orthotics, and Supplies
**DMH**.....Department of Mental Health
**DOB**.....Date of Birth

**DOC**.....Department of Corrections
**DOS**.....Date of Service
**DRA**.....Deficit Reduction Act
**DR. D**.....Dr. Dynasaur Program
**DRG**.....Diagnosis Related Grouping
**DS**.....Developmental Services
**DS**.....Day Supply
**DSH**.....Disproportionate Share Hospital
**DSHP**.....Designated State Health Plan
**DSR**.....Delivery System Reform
**DUR**.....Drug Utilization Review (Board)
**DVHA**.....Department of Vermont Health Access

## E

**E&E**.....Eligibility & Enrollment (Funding for more than IE)
**EA**.....Emergency Assistance
**EA**.....Enterprise Architecture
**EA**.....Economic Assistance
**eAVS**.....Electronic Asset Verification System
**ECS**.....Electronic Claims Submission
**ED**.....Emergency Department
**EDI**.....Electronic Data Interchange
**EFT**.....Electronic Funds Transfer
**EFT**.....Enhanced Family Treatment
**EHR**.....Electronic Health Record
**EHRIP**.....Electronic Health Record Incentive Program
**EMS**.....Emergency Medical Services
**EOB**.....Explanation of Benefits
**EOMB**.....Explanation of Medicare (or Medicaid) Benefits
**EPCP**.....Enhanced Primary Care Payment
**EPMO**.....Enterprise Project Management Office
**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
**ESD**.....Economic Services Division (part of DCF)
**ESI**.....Employer Sponsored Insurance
**ESIA**.....Employer Sponsored Insurance Assistance
**ESRD**.....End Stage Renal Disease

**EVAH** ..... Enhanced Vermont Ad Hoc (query & reporting system)
**EVS** ..... Eligibility Verification System

## F

**FA** ..... Fiscal Agent
**FADS** ..... Fraud, Abuse & Detection System
**FAQ** ..... Frequently Asked Questions
**FBR** ..... Fiscal Budget Report
**FCR** ..... Federal Case Registry
**FDA** ..... Food & Drug Administration
**FED** ..... Front End Deductible
**FEIN** ..... Federal Employer's Identification Number
**FEMA** ..... Federal Emergency Management Administration
**FFP** ..... Federal Financial Participation
**FFS** ..... Fee for Service
**FFY** ..... Federal Fiscal Year
**FH** ..... Fair Hearing
**FHU** ..... Fair Hearing Unit
**FI** ..... Fiscal Intermediary
**FICA** ..... Federal Insurance Contribution Act
**FITP** ..... Family, Infant and Toddler Program
**FMAP** ..... Federal Medical Assistance Percentage
**FOA** ..... Funding Opportunity Announcement
**FPL** ..... Federal Poverty Level
**FQHC** ..... Federally Qualified Health Center
**FSA** ..... Flexible Spending Account
**FSD** ..... Family Services Division
**FTE** ..... Full Time Equivalent
**FUL** ..... Federal Upper Limit (for pricing & payment of drug claims)
**FYE** ..... Fiscal Year End

## G

**G/L** ..... General Ledger
**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
**GCH** ..... Global Commitment to Health
**GEP** ..... General Enrollment Period
**GF** ..... General Fund

**GMC**.....Green Mountain Care
**GMCB**.....Green Mountain Care Board
**GME**.....Graduate Medical Education

## H

**HAEEU** .....Health Access Eligibility and Enrollment Unit
**HB** .....Home-based
**HBE**.....Health Benefit Exchange
**HBEE Rule**...Health Benefits Eligibility and Enrollment Rule
**HBKF** .....Healthy Babies, Kids and Families
**HCBS**.....Home & Community Based Services
**HCPCS**.....Healthcare Common Procedure Coding System
**HCQC**.....HealthCare Quality Control Unit
**HCR**.....Healthcare Reform
**HEDIS** .....Health Plan Employer Data and Information Set
**HEDIS** .....Healthcare Effectiveness Data & Information Set
**HEPO**.....Healthcare Eligibility Policy and Operations
**HHA** .....Home Health Agency
**HHS**.....Health & Human Services (U.S. Department of)
**HIE** .....Health Information Exchange
**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
**HIT** .....Health Information Technology
**HITECH** .....HIT for Economic & Clinical Health
**HIV** .....Human Immunodeficiency Virus
**HPE** .....Hewlett-Packard Enterprise Services
**HR** .....Health Reform
**HRA**.....Health Reimbursement Account
**HRA**.....Health Risk Assessment
**HSB**.....Human Services Board
**HVP** .....Healthy Vermonters Program

## I

**IAPD**.....Implementation Advance Planning Document
**IAPDU**.....Implementation Advanced Planning Document Update
**IBNR** .....Incurred but Not Reported
**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

**ICF**.....Intermediate Care Facility
**ICF/DD**.....Intermediate Care Facility for people with Developmental Disabilities
**ICF/MR**.....Intermediate Care Facilities for Mentally Retarded
**ICN**.....Internal Control Number
**ICU**.....Intensive Care Unit
**ID**.....Identification
**IDT**.....Interdepartmental Transfer
**IDTF**.....Independent Diagnostic Testing Facilities
**IEP**.....Initial Enrollment Period
**IET**.....Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
**IFS**.....Integrating Family Services
**IFSP**.....Individual Family Services Plan
**IG**.....Inspector General
**IL**.....Independent Living
**ILA**.....Independent Living Assessment
**IMD**.....Institute for Mental Disease
**INS**.....Immigration and Naturalization Service
**IP**.....Internet Protocol
**IPA**.....In-Person Assister
**IRS**.....Internal Revenue Service
**ISAP**.....Intense Substance Abuse Program
**IT**.....Information Technology
**IV-A**.....Title IV-A of the Social Security Act governing TANF programs (Temporary Assistance to Needy Families)
**IV-D**.....Title IV-D of the Social Security Act governing child support program
**IV E**.....Title of the Social Security Act governing foster care
**IV&V**.....Independent Verification and Validation

## J

**JFO**.....Joint Fiscal Office
**JR**.....Judicial Review

## K

**KPI**.....Key Performance Indicator

## L

**LAMP**.....Legal Aid Medicaid Project
**LARC**.....Long Acting Reversible Contraception
**LOC**.....Level of Care
**LTC**.....Long-Term Care

## M

**M&O**.....Maintenance and Operations

**MA** ..... Medicare Advantage (Medicare Part C in Vermont)
**MA** ..... Medical Assistance
**MAB** ..... Medicaid Advisory Board
**MABD** ..... Medicaid for the Aged, Blind, and Disabled
**MACRA** ..... Medicare Access and CHIP Reauthorization Act
**MACU** ..... Medicaid Audit & Compliance Unit
**MAGI** ..... Modified Adjusted Gross Income (expanded Medicaid)
**MAP** ..... Medical Audit Program
**MAPIR** ..... Medicaid Assistance Provider Incentive Repository
**MARS** ..... Management & Administrative Reporting System
**MAT** ..... Medication Assisted Therapy
**MCA** ..... Medicaid for Children and Adults
**MCO** ..... Managed Care Organization
**MCP** ..... Managed Care Plan
**MEAB** ..... Medicaid & Exchange Advisory Board
**MEC** ..... Minimum Essential Coverage
**MECT** ..... Medicaid Enterprise Certification Toolkit
**MEG** ..... Medicaid Eligibility Group
**MED** ..... Mental or emotional disturbance (or disorder)
**MEI** ..... Medicare Economic Index
**MEQC** ..... Medicaid Eligibility Quality Control
**MES** ..... Medicaid Enterprise Solution
**MFCU** ..... Medicaid Fraud & Control Unit
**MFP** ..... Money Follows the Person (DAIL)
**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
**MID** ..... Medicaid Identification Number (for member, see UID)
**MIS** ..... Management Information System
**MITA** ..... Medicaid Information Technology Architecture
**MMA** ..... Medicare Modernization Act
**MMIS** ..... Medicaid Management Information System
**MOMS** ..... Medicaid Obstetrical and Maternal Supports
**MOU** ..... Memorandum Of Understanding
**MPU** ..... Medicaid Policy Unit
**MSIS** ..... Medicaid Statistical Information System
**MSP** ..... Medicare Savings Programs

**MU**.....Meaningful Use
**MUA**.....Medically Underserved Areas
**MVP**.....MVP Health Care

## N

**NCCI**.....National Correct Coding Initiative
**NCQA**.....National Committee for Quality Assurance
**NDC**.....National Drug Code
**NEDD**.....Northeast Delta Dental
**NEMT**.....Non-Emergency Medical Transportation
**NESCSO**.....New England States Consortium Systems Organization
**NF**.....Nursing Facility
**NH**.....Nursing Home
**NICU**.....Neonatal Intensive Care Unit
**NIMH**.....National Institute of Mental Health
**NOD**.....Notice of Decision
**NP**.....Naturopathic Physician
**NP**.....Nurse Practitioner
**NPF**.....National Provider File
**NPI**.....National Provider Identifier
**NPRM**.....Notice of Proposed Rulemaking
**NQF**.....National Quality Forum
**NSF**.....Non-Sufficient Funds

## O

**OADAP**.....Office of Alcohol & Drug Abuse Programs
**OEP**.....Open Enrollment Period
**O&E**.....Outreach and Education
**OIG**.....Office of the Inspector General
**O&M**.....Oversight and Monitoring
**OPPS**.....Outpatient Prospective Payment System
**OPS**.....Operations
**OSHA**.....Occupational Safety & Health Administration
**OTC**.....Over the Counter

## P

**PA**.....Payment Authorization
**PA**.....Physician Assistant
**PA**.....Prior Authorization
**PA**.....Public Assistance
**PAPD**.....Planning Advanced Planning Document (CMS)
**PATH**.....Prevention, Assistance, Transition and Health Access

**PBM** ..... Pharmacy Benefit Management
**PBMS** ..... Pharmacy Benefits Management System
**PC Plus** ..... Primary Care Plus (Vermont Program)
**PCA** ..... Personal Care Attendant
**PCA** ..... Primary Care Association
**PCCM** ..... Primary Care Case Management
**PCMH** ..... Patient-Centered Medical Home
**PCN** ..... Primary Care Network
**PCP** ..... Primary Care Provider
**PCS** ..... Procedure Coding System
**PDL** ..... Preferred Drug List
**PDP** ..... Prescription Drug Plan
**PDP** ..... Pharmacy Drug Plan
**PDP** ..... Medicare Part D Prescription Drug Plan
**PDP** ..... Pharmacy Discount Program
**PDSA** ..... Plan-Do-Study-Act
**PE** ..... Presumptive Eligibility
**PERM** ..... Payment Error Rate Measurement
**PES** ..... Provider Electronic Solutions
**PHC** ..... Personalized Healthcare
**PHI** ..... Protected Health Information
**PHR** ..... Personal Health Record
**PI** ..... Program Integrity
**PIDL** ..... Physician Injectable Drug List
**PIE** ..... Payer Initiated Eligibility
**PIHP** ..... Prepaid Inpatient Hospital Plan
**PII** ..... Personally Identifiable Information
**PIL** ..... Protected Income Level (Poverty Income Guidelines)
**PIP** ..... Performance Improvement Project
**PIRL** ..... Plan Information Request Letter
**PM** ..... Project Manager
**PMM** ..... Provider Management Module
**PMPM** ..... Per Member Per Month
**PMPY** ..... Per Member Per Year
**PMR** ..... Provider and Member Relations
**POC** ..... Plan of Care
**POLST** ..... Physician Orders for Life-Sustaining Treatment
**POS** ..... Place of Service
**POS** ..... Point of Sale
**POS** ..... Point of Service

**PPA**.....Prior Period Adjustment
**PPACA**.....Patient Protection & Affordable Care Act
**PPO**.....Preferred Provider Organization
**PPS**.....Prospective Payment System
**PQA**.....Prior Quarter Adjustment
**PQAS**.....Prior Quarter Adjustment Statement
**ProDUR**.....Prospective Drug Utilization Review
**PSU**.....Provider Services Unit
**PT**.....Physical Therapy
**PXRS**.....Portable X-rays Suppliers

## Q

**QA**.....Quality Assurance
**QC**.....Quality Control
**QHP**.....Qualified Health Plans
**QI**.....Qualified Individual
**QI**.....Quality Improvement
**QMB**.....Qualified Medicare Beneficiary

## R

**RA**.....Remittance Advice
**RBA**.....Results Based Accountability
**RBRVS**.....Resource-Based Relative Value Scale
**RCH**.....Residential Care Home
**REMS**.....Risk Evaluation and Mitigation Strategies
**REOMB**.....Recipient Explanation of Medicaid Benefits
**RetroDUR**.....Retrospective Drug Utilization Review
**REVS**.....Recipient Eligibility Verification System
**RFB**.....Request for Bid
**RFI**.....Request for Information
**RFP**.....Request for Proposals
**RFQ**.....Request for Quote
**RHC**.....Rural Health Clinic
**RMP**.....Risk Management Plan
**RN**.....Registered Nurse
**ROP**.....Reasonable Opportunity Period
**ROSI**.....Reconciliation of State Invoice
**RPMS**.....Resource and Patient Management System
**RPU**.....Rebate Price per Unit
**RSV**.....Respiratory Syncytial Virus
**RVU**.....Relative Value Units
**RWJ**.....Robert Wood Johnson Foundation

## S

**SAD** ..... Screening, Application and Determination
**SAMHSA**..... Substance Abuse & Mental Health Services Administration
**SAS**..... Statement on Auditing Standards
**SASH**..... Support and Services at Home
**SBC**..... Summary of Benefits & Coverage
**SBM**..... State-Based Marketplace
**SDX** ..... State Data Exchange System
**SE**..... Systems Engineer
**SEP**..... Special Enrollment Periods
**SEVCA**..... Southeastern Vermont Community Action
**SFY** ..... State Fiscal Year
**SGF**..... State General Fund
**SGO** ..... Surgeon General's Office
**SHIP** ..... State Health Insurance (and Assistance) Program
**SHIP** ..... Senior Health Insurance Program
**SI** ..... Systems Integration
**SI** ..... Systems Integrator
**SIDS** ..... Sudden Infant Death Syndrome
**SIM**..... State Innovation Model
**SIT**..... System Integration Test
**SLA**..... Service Level Agreement
**SLC**..... Service Level Credits
**SLMB**..... Specified Low-income Medicare Beneficiary
**SLR**..... System/Service Level Requirement
**SMA**..... State Medicaid Agency
**SMDL** ..... State Medicaid Directors Letter
**SME**..... Subject Matter Expert
**SNF** ..... Skilled Nursing Facility
**SO** ..... State Office
**SOP**..... Standard Operating Procedure
**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
**SPP** ..... Specialized Programs Project (under the MMIS program)
**SR**..... Supplemental Rebate

**SRA**.....Supplemental Rebate Agreement
**SSA**.....Specialized Service Agency
**SSDC**.....Sovereign States Drug Consortium
**SSI**.....Supplemental Security Income
**SSN**.....Social Security Number
**STD**.....Sexually Transmitted Disease
**SUR**.....Surveillance & Utilization Review
**SURS**.....Surveillance and Utilization Review Subsystem

## T

**TB**.....Tuberculosis
**TBD**.....To Be Determined
**TBI**.....Traumatic Brain Injury
**TCR**.....Therapeutic Class Review
**TCS**.....Therapeutic Classification
**TDOC**.....Total Days of Care
**TM**.....Transitional Medicaid
**TMSIS**.....Transformed Medicaid Statistical Information System
**TPA**.....Third Party Administrator
**TPCM**.....Third Party Claim Management
**TPL**.....Third Party Liability
**TRS**.....Treatment and Recovery Services
**TXIX**.....Title XIX

## U

**UB**.....Uniform Billing/Uniform Bill
**UID**.....Unique Identification Number
**UM**.....Utilization Management
**UR**.....Utilization Review
**URA**.....Unit Rebate Amount
**UVM**.....University of Vermont

## V

**VA**.....Vaccine Administration
**VBC**.....Value-Based Contracts
**VCCI**.....Vermont Chronic Care Initiative
**VCHIP**.....Vermont Child Health Improvement Program
**VCSA**.....Vermont Cost Sharing Assistance
**VCSR**.....Vermont Cost Sharing Reduction
**VDH**.....Vermont Department of Health
**VHAP**.....Vermont Health Access Plan
**VHC**.....Vermont Health Connect

**VHCURES**.... Vermont Healthcare Claims Uniform Reporting and Evaluation System

**VHIE**..... Vermont Health Information Exchange

**VHITP**..... Vermont Health Information Technology Plan

**VISION**..... Vermont's Integrated Solution for Information and Organizational Needs – the statewide accounting system

**VITL**..... Vermont Information Technology Leaders

**VLA**..... Vermont Legal Aid

**VMAP**..... Vermont Medication Assistance Program

**VMNG**..... Vermont Medicaid Next Generation

**VNA**..... Visiting Nurses Association

**VPA**..... Vermont Premium Assistance

**VPharm**..... Vermont Pharmacy Program

**VPTA**..... Vermont Public Transportation Agency

**VRU**..... Voice Response Unit

**VScript**..... Vermont Pharmacy Assistance Program

**VSEA**..... Vermont State Employees Association

**VTHR**..... Vermont Human Resources

## W

**WC**..... Worker's Compensation

**WRAP**..... Wellness Recovery Action Plan

## X

## Y

## Z